Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 27th January 2021, commencing at 12:00pm

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**21/22/239**	**12:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/240**	**12:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/241**	**12:02 (1 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 16th December 2021.**	**D**	Read enclosure
4.	**21/22/242**	**12:03 (2 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
POST COVID-19 Recovery Plan 2021/22							
5.	**21/22/243**	**12:05 (30 mins)**	**Delivering a Safe Winter; including:** - **Operational update on Omicron, winter pressures and recovery of services.** - **Update on People Issues.** - **Staff vaccine status.** - **IPC update.**	A Bateman M. Swindell M. Swindell B. Larru	To provide an update on the development of operational plans for the 2021/22 winter period. To receive an update on workforce issues. To receive an update. To receive an update.	**A** **A** **A** **A**	Read report Presentation Presentation Presentation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**21/22/244**	**12:35 (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

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	**21/22/245**	**12:40 (5 mins)**	***Corporate Report – Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** ***Cumulative Corporate Report Metrics – Top Line Indicators:** • **Quality.** • **Safety.** • **Effective/Responsive.**	U. Das L. Cooper A. Bass N. Askew A. Bass A. Bateman	To receive a report on Trust performance for scrutiny, highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
8.	**21/22/246**	**12:45 (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 *(to follow)* Verbal
9.	**21/22/247**	**12:50 (5 mins)**	**Freedom to Speak Up.**	K. Turner	To receive an update on the current position.	A	Read report
Sustainability through Partnerships							
10.	**21/22/248**	**12:55 (5 mins)**	**Developing the Children's Hospital Alliance – Next Steps.**	J. Grinnell/ D. Jones	For information and discussion.	I	Presentation
Strong Foundations (Board Assurance)							
11.	**21/22/249**	**13:00 (5 mins)**	***Reducing the Burden of Reporting and Releasing Capacity to Manage the Covid-19 Pandemic.**	E. Saunders	For information purposes.	N	Verbal
12.	**21/22/250**	**13:05 (15 mins)**	**2021/22 H2 Plan; including:** • **Planning guidance for 2022/23.**	R. Lea	To provide an overview of the H2 plan, the planning guidance for 2022/23 and the position for Month 9.	**A**	Presentation

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			• **Financial update, M9, 2021/22.**				
13.	**21/22/251**	**13:20 (5 mins)**	***Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
14.	**21/22/252**	**13:25 (5 mins)**	***Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 20.1.22.** - **Approved minutes from the meeting held on the 18.11.21.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 24.1.22.** - **Approved minutes from the meeting held on the 15.12.21.** • **Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 19.1.22.** - **Approved minutes from the meeting held on the 15.12.21.** • **People and Wellbeing Committee:** - **Chair's Highlight Report from the meeting held on the 18.1.22.**	K. Byrne I Quinlan F. Beveridge F. Marston	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Approved minutes from the meeting held on the 23.11.21.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 24.1.22.**	S. Arora			
Items for information							
15.	**22/22/253**	**13:30 (1 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
16.	**21/22/254**	**13:31 (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, 24th February 2022, 12:00pm, via Microsoft Teams.							

NB * Agenda items/reports will be taken as read with questions **(only)** to be put forward.

REGISTER OF TRUST SEAL
The Trust Seal was used in December 2021 and January 2022
- 378: Section 106 Agreement – Liverpool City Council/Alder Hey – Ref. No: LS/20511ME.
- 379: Letter of Indemnity – Medical Photography.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M9 2021/22	R. Lea
DIPC Monthly Exception Report	B. Larru
Campus Development Update	D. Powell
Vaccination as a Condition of Deployment for Healthcare Workers	M. Swindell
Reducing the Burden of Reporting and Releasing Capacity to Manage the Covid-19 Pandemic	E. Saunders

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 16th December 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)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(ABASS)
	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	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing	Prof. J. Jankowski	Member of the public.	(JJ)
	Ms. M. Mornington	Lead Governor	(MM)
	Ms. L. Smith	Governor	(LS)
Apologies:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
Staff Story	Martin Crowder-James	Member of the Wingman Lounge team	(MCJ)
Item 21/22/219	Dr. B. Larru	Director of Infection Prevention Control	(BL)

Staff Story

The Chair welcomed Martin Crowder-James who had been invited to December's Trust Board to share his experience of working in the Wingman Lounge.

Martin is a First Officer for Jet 2.com/Jet 2 Holidays and has been a commercial pilot for the last 10 years. A charity was formed and over time has been able to provide eighty Wingman Lounges across the UK, with over 6.500 volunteers involved. At one point there were fifty volunteers based at Alder Hey which enabled the Wingman Lounge to provide a continuous opportunity for staff to take time away from their job, to have a cup of tea, see a friendly face and decompress. Martin informed the Board that Trust staff have fed back on their experiences

of the Wingman Lounge with many stating that it was a breath of fresh air, it has given them time to de-stress and go back to their job feeling refreshed and able to continue with their work.

Martin pointed out that it has been an amazing experience for the volunteers, who also benefited professionally and personally in terms of being able to give something back, volunteers were welcomed into the Alder Hey family.

The Chair thanked Martin for taking the time to come and speak with Board members. On behalf of the Board, the Chair wished Martin and his colleagues all the very best for the festive period and the New Year.

21/22/210 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. Board members were advised of the strategy session that is in the process of being scheduled for the 27.1.22. It was confirmed that the format of the day is yet to be determined.

21/22/211 Declarations of Interest

The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine. Fiona Beveridge declared her association with the University of Liverpool in terms of agenda item 21/22/225.

21/22/212 Minutes of the previous meetings held on Thursday 25th November 2021
Resolved:
The minutes from the meeting held on the 25th November 2021 were agreed as an accurate record of the meeting.

21/22/213 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 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)* – Work has taken place to broaden the EDI agenda, and the SALS team are supporting the re-establishment of the Disability Network and the LGBQT Network. **ACTION CLOSED**

Action 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)* – This action is ongoing and will be picked up by the new EDI lead going forward. **ACTION CLOSED**

Action 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)* – Jo Potier is leading on this piece of work which will be included in the Wellbeing Guardian Action Plan, once complete. **ACTION CLOSED**

Action 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)* – It was reported that all outlets have been dismantled and treated. Filters are in place and screens have been erected in the operating theatre around the sinks. Strong antibacterial handwash is also available for use in operating theatres. The outcome of the investigation suggests that pseudomonas was found at the end of the taps due to an incorrect cleaning policy being referred to when cleaning the end of the taps. This policy has been re-written, and monitoring of the water system has been introduced. **ACTION CLOSED**

Action 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)* – It was confirmed that PAWC will progress the action plan for the North West Wellbeing Pledges. **ACTION CLOSED**

21/22/214 Chair and CEO's Update.

The Chair advised members that today's meeting was the Chief Medical Officer's last Board meeting. On behalf of the Board, the Chair thanked Nicki Murdock for the immeasurable impact that she has had on the Trust and wished her all the very best for the future.

The Chair thanked the Executive Team and the Non-Executive Directors for their dedication and thoughtfulness throughout the year in terms of their determination to restore/maintain services, and the positive way in which everyone has approached their role. The Chair pointed out that the effort that has taken place Trust wide has been humbling to see and the compassion and care that has been shown has meant a great deal to so many families. The Chair drew attention to the importance of taking time over the festive period to rest and recuperate in preparation for the coming year.

On behalf of the Executive Team, the Acting CEO thanked the Chair for her kind words and advised that the team had felt fully supported by her throughout the year and able to raise issues.

John Grinnell informed the Board that the Executive Team are proud of the progress that has been made with regard to the recovery of services/elective recovery whilst maintaining services, taking into account the extreme pressures and the challenging environment. It was reported that the Trust is continuously focussing on the wellbeing of its workforce which has been key during the pandemic, but it was pointed out that in light of the new variant the Trust needs to make the right judgment for its services in terms of keeping them functioning whilst planning for the worst case scenario in terms of being able to respond to a surge in demand/staff availability. It was confirmed that the Trust is working hard on contingency plans to address this matter.

An update was provided on the Covid-19 Booster Programme. It was reported that a decision was made to open a 'Grab a Jab' Centre at Alder Hey to provide vaccinations for all with a real focus on the 12+ age group including those who are clinically vulnerable, patients with learning disabilities and anyone who is needle phobic/anxious. The Board was advised that the response has been astounding with fifty people having accessed the service within the first half hour of it opening. Nathan Askew thanked all those involved in this venture for their support, especially

the student nurses who put themselves forward for training so that they could help administer vaccinations.

Attention was drawn to the cyber vulnerability highlighted on the 10.12.21 which has spanned parts of Europe and is causing some concerns across the global cyber community. There has been no activity in the UK to date, but an incident response has been instated along with an emergency response structure. It was confirmed that there is no immediate risk to Alder Hey, but work is taking place internally, with the local system and nationally to identify any risks that will need to be addressed. Attention was drawn to the exceptional response by the IT team with regard to this matter.

The Board was informed that one of the Trust's Diabetes Consultant, Dr. Fulya Mehta, has been appointed as the national clinical director for paediatric diabetes and will be working alongside Prof. Simon Kenny. It was agreed to invite Dr. Mehta to a future Board to hear how the role is progressing.

21/22/214.1 Action: KMC

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

21/22/215 Post Covid-19 Recovery Plan 2021/22

Delivering a Safe Winter:

The Board was provided with an update on winter and recovery of access to services for CYP. Attention was drawn to the key concerns for January following the outbreak of the new variant Omicron; a rise in staff absence and staff availability, high urgent and emergency care demand which combined will create extreme pressures for the Trust. A number of slides were shared which provided information on the following areas:

Gold Command priorities and guiding principles;

- The Trust's priority is to provide safe care and keep staff safe.
- Key actions:
  - Take action now to pre-empt high urgent and emergency care demand.
  - Take action now to moderate, and mitigate the effect of, a rise in staff absence from Omicron.
  - Deliver vaccines (including boosters) with a focus on 12 to 15 year olds, families and staff.
  - Reduce routine work and maintain essential activities that keep the Trust safe.

Progress on Winter Preparedness

- The goal was to provide timely urgent and emergency care to children and young people (CYP). The highlights that are in place are;
  - Health visitor service in partnership with Mersey Care.
  - Rapid assessment and treatment.
  - Streaming approach at triage.
  - The Symptom Checker, a resource for self-care, went live on the 14.12.21. This was a collaboration between the ED team, Communications and the Digital team. The Chief Operating Officer, Adam Bateman, paid tribute to those involved in implementing this resource.

- Level of investment that has been secured via external funding to try and increase capacity in urgent and emergency care. The Trust has received £450k through a number of bids to develop four new services;
    - Multi-professional urgent care MDT service including a GP and health visitor.
    - Physio/OT in reach to ED and early mobilisation for Musculoskeletal patients.
    - Non-urgent paediatric patient transfer service across Cheshire and Merseyside (C&M).
    - Improvements to day case unit to increase capacity and release elective inpatient beds to accommodate a rise in emergency admissions.

- C&M paediatric partnership working interventions for winter;
    - C&M paediatric escalation plan agreed.
    - Paediatric transport service.
    - Patient Clinical Assessment Service (NHS 111).
    - Working collaboratively to increase the training and resources for the Complex Behavioural Support teams that will be in place to care for CYP with complex behaviours.

Progress on recovering access to services for CYP

- The goal is to maintain access to planned care. During November the Trust has achieved 100% recovery for outpatients, elective and day case surgery which means that the Trust is treating more CYP now than prior to the pandemic. Work is also taking place to try and eradicate long waiting times for CYP.
- November 2021 planned care recovery improvements – key factor;
    - Theatre Utilisation Policy agreed and implemented.
    - A new Standard Operating Procedure has been agreed for starting theatres on time.
    - *Outpatients* – Additional resources have been allocated in order to take on additional nursing and administrative staff. It was reported that the recruitment process is ongoing at the present time.
    - *Pre-op Assessment Service* – Additional anaesthetic clinicians have been appointed via the Accelerator Programme to support the expansion of the Pre-op Assessment Service and the development of new pathways.

The Chair queried as to whether the Trust is marketing the Symptom Checker resource that the Trust has developed. It was confirmed that it is being marketed nationally and with local partners.

The Chair thanked all those involved in compiling the update and felt that it was really positive to see an all system approach implemented across C&M to address some of the pressures that are being experienced at the present time.

Deep Dive into the Emergency Department (ED)

The Board was provided with an update on the work that is being undertaken within ED to ensure CYP who attend the department receive safe, effective and responsive care.

It was reported that between April and November 2021 the Trust has received 6000+ patients via the front door. During the last three months patients who have been presenting at ED have been very unwell, hence the increase in admissions.

The Board was advised that performance is fluctuating at the present time depending on the acuity/flow of patients, but this is something that the ED team are working hard to address on a daily basis.

Over the course of the last few months work has been taking place within the department and the Division of Medicine to review departmental processes, ultimately, to reduce the overcrowding and exit block from ED.

A number of slides were shared with the Board that provided an overview of the progress that has been made by the 5 workstreams that have been implemented. It was reported that a suite of metrics that have also been designed to track improvement.

Fiona Marston asked as to whether the Trust is seeing any trends inpatient conditions as admissions increase. It was confirmed that the Trust is seeing more patients with respiratory illnesses that are not all Covid related, but there are some children who have Covid and have to be admitted to ICU, for example, patients who have multiple inflammatory problems related to Covid.

Fiona Marston queried as to how the GP stream will work. It was reported that the Trust is looking to recruit three general paediatricians to look after the green stream patients. These are patients with mild ailments who can't get an appointment in the Walk-in Centre and would otherwise have been seen in a GP setting.

The Chair acknowledged the challenges that ED are experiencing and noted that the team is doing everything possible to address the day to day issues whilst preparing for the weeks ahead.

Update on People Issues

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

- There are 19 staff members absent at the present time due to having Covid symptoms.
- There are 21 staff members absent as a result of having to self-isolate.
- The Board was advised that trusts have been asked to prepare for an increase in Covid related staff absences.
- It was reported that there has been an increase in non-Covid related absences which the Trust is focussing on.

Flu Vaccine Update

It was reported that 63% of the workforce has had a flu vaccination. It is expected that this figure will increase once the Trust has received the data relating to staff members who have received a flu vaccine via their GP or in a community setting. It was pointed out that the uptake of flu vaccinations across the NHS is lower in 2021 compared to previous years. It was confirmed that Alder Hey is not an outlier.

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

21/22/216 Serious Incident Report

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

- It was reported that the Trust has declared two StEIS reportable incidents requiring investigation, that met SI criteria;
  - StEIS Reference No: 2021/24660 – This was a near miss incident that was reported due to the potential for learning and improvement.
  - StEIS Reference No: 2021/24473 – This related to the delay of treatment that met the SI criteria.

Resolved:
The Board received and noted the contents of the Serious Incident report for period from the 1.11.21 to the 30.11.21.

21/22/217 Nurse Staffing Assurance Report.

The Winter 2021 Preparedness Nursing and Midwifery Safer Staffing report was submitted to the Board to provide assurance that plans are in place to ensure safe nurse staffing levels over the winter period and that plans are connected to the wider system staffing planning, resourcing and mutual aid. The report included a completed assurance framework against the four domains as set out by NHSE/I and identified where any improvement in systems can be made to further enhance safety and assurance.

It was reported that there are a number of actions that need to be addressed following the self-assessment against the criteria in the four domains. Overall, it was felt that the Trust has got very high levels of assurance in terms of having the right systems and processes in place for the daily monitoring of staff movement/ensuring wards remain as safe as possible. The Safe Staffing Nursing report is to be submitted to the Safety and Quality Assurance Committee (SQAC) on a monthly basis from January 2022 and the outstanding actions will be monitored via the monthly workforce meeting that is held with divisional and corporate staff.

A number of slides were shared with the Board to provide an overview of the PICU staffing model. The Board was advised that ICU has increased bed capacity with the support of staff who volunteered for the 'Buddy Role'. It was reported that the volunteers were part of a very intense programme, which included a one-week training course and two weeks of supernumerary status.

Resolved:
The Board received and noted the contents of:

- The Winter 2021 Preparedness Nursing and Midwifery Safer Staffing report.
- The PICU staffing model update.

21/22/218 Q2 Mortality Report

The Board received the Mortality Report for Q2, 2021/22. The following points were highlighted:

- It was reported that there has been a spike of deaths in September due to trauma cases through ED. There has also been a change in the recording of figures in Q2 as the Trust is now including the sudden unexpected death of an infant/child (SUDI/SUDIC) cases whereas previously they were recorded separately as Emergency Department deaths. The Board was advised that work is taking place to evaluate the spike in deaths in Q2 and draw up a comparison for the last five years.
- Attention was drawn to the forthcoming introduction of the Medical Examiner process which will be a legal requirement by April 2022 to provide scrutiny for all deaths. It was pointed out that the Trust already scrutinises all deaths but as a result of having low numbers won't qualify for funding for a Medical Examiner. A meeting is due to take place with the CEO of LHCH week commencing 20.12.21 to discuss Alder Hey sharing their resource. John Grinnell agreed to follow this matter up in the new year.

21/22/218.1 Action: JG

John Grinnell referred to the recent spike in trauma deaths and the impact that they have had on staff in ED. It was reported that the Trust has put in additional support from a welfare perspective for staff based in ED. John Grinnell also advised that the Trust is looking at linking in with the Children's Hospital Alliance to look at trends across other trusts in terms of the spike in trauma deaths.

The Chair asked as to whether enough has been done, as a group of paediatric hospitals, to raise the issue of the recent spike in trauma deaths and queried as to whether this matter should be escalated to the Children's Commissioner 's office to enable these issues to be broached at a higher level. It was reported that this matter has been raised via the Children's Hospital Alliance and the national safeguarding route.

Fiona Beveridge referred to a conversation that took place during SQAC re the spike in trauma deaths and pointed out that sometimes when numbers are so small it can be very difficult to draw any firm conclusions. Fiona Beveridge felt that it would be beneficial to link in with other trusts to understand whether there is a trend or whether it's just a couple of cases.

Fiona Beveridge drew attention to the data that was shared at SQAC in respect to the small number of Covid related deaths. It was felt that reflection is required in terms of communicating this information in order to allay fears as it was very clear in the presentation that these patients had multiple co-morbidities and Covid was one of the many factors.

Resolved:
The Board received and noted the contents of the Mortality Report for Q2.

21/22/219 Q2 Director of Infection, Prevention and Control (DIPC) Report

The Board received an update from the Director of Infection, Prevention and Control, Beatriz Larru for Q2. The following points were highlighted:

- It was reported that there has been an increase in the transmission of RSV and MSSA cases.
- The Board was advised that there have been two cases of C. difficile in immune-compromised 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

- *Pseudomonas in Theatre outlets* - All Theatre outlets were sampled after a patient developed a Pseudomonas wound infection. Point of use filters are now used on all Theatre outlets. Outlets that have tested positive been cleaned and disinfected. Pseudomonas isolate from patient and from Theatre outlets have been sent off for Typing. These are different indicating that the Theatre taps weren't the source of the organism causing the young patients wound infection.
- *Covid Hospital Acquired Infection on the Dewi Jones Unit* – It was reported that a patient had tested positive. Staff were screened to identify if there were any asymptomatic staff. It was confirmed that there were no staff or additional patients identified.
- The Board received an update on Omicron and was advised of the Trust's escalation of strategies to manage staff exposed to Covid-19 and the Omicron variant.

Jon Grinnell queried as to whether the IPC team requires further support and asked as to whether there is continuity in terms of staff communications relating to Omicron and the process to follow if they test positive. Bea Larru felt that improved communications are required to ensure continuity across the Trust and highlighted the strains that the IPC team are under. Following discussion, it was agreed to have a conversation about the additional support that the IPC team requires and also reflect upon the message for staff ahead of the briefing scheduled for the 22.12.21.

21/22/219.1 Action: Executive Team/BL

Fiona Marston pointed out that the evidence is showing how important it is for staff to have a booster and offered her support, if needed, to encourage staff to have a booster.

The Chair thanked Beatriz Larru and her team for the work that is taking place to keep the hospital safe for patients, families and staff and highlighted how proud the Board is of everything that is being done.

Resolved:
The Board noted the update provided by the DIPC for Q2.

21/22/220 Mental Health Services Update

The Board received an update on activities and financial investments in Alder Hey's Specialist Mental Health Services during the last 12 months. A number of slides were shared which provided information on the following areas:

- An overview of the services that are provided to CYP living in Liverpool and Sefton.
- The services response to Covid-19.
- The increase in demand for community mental health services.
- Crisis Care activity.
- Increase in eating disorder referrals.
- Increase in admissions.
- ED activity in terms of mental health attendances, admission to acute hospital and the number of patients referred to Crisis Care.
- Secured investment for Q4 in 2020/21; £5.5m non-recurrent funding for eating disorders, Crisis Care and community based mental health services.
- Agreed investment in 2021/22;
    - sensory OT service for Sefton.
    - Sensory Environment project.

- Key Worker pilot.
- Framework for Integrated Care Vanguard (North Mersey).
- ADHD investment.
- Mental Health Winter Capacity non-recurrent bids;
  - Element 1 – The appointment of two additional healthcare assistants for the Eating Disorder Service. Funding is available until the end of March, but it has been agreed that the Trust will fund these posts via the Division at risk, for a twelve month period.
  - Element 2 – Funding has been received for the appointment of a consultant nurse in mental health. This role will be based with the Community Division and will be responsible for the leadership and the embedding of Section 31 work, the restraint practice and work with staff on the hospital site around the parity of esteem work.

- Opportunities in 2022/23.
- Additional improvements.

The Chair congratulated Lisa Cooper and her team for the all that has been achieved during the year. The Chair referred to the funding that the Trust has received for mental health services and highlighted the importance of developing KPIs and dashboards to enable the Trust to evaluate the investment and demonstrate the interventions that were successful so that resources can be allocated appropriately. It was also felt that this area of work should be monitored via SQAC.

The Chair requested that data be compiled to provide information on the amount of repeat referrals that are being received by Crisis Care, the pathways of patients who access this service and their outcomes in order to gain an overview of this tremendous work and capture how the Trust is responding to patients. It was suggested that this information be shared with SQAC in order to look at trends and how the Trust is responding to those who are seeking crisis support.

21/22/220.1 Action: LC (Feb 2022)

The Board was advised that the final element of the Crisis Care service is the development of the Crisis Care Resolution Home Team. The long-term plan, with the support of the funding, is to provide a crisis resolution with up to six weeks of intensive support while patients wait to access their community-based service. The Chair felt that it is important to understand the journey of these patients, the points of intervention and whether the resources are being used to the best advantage of patients. It is also about receiving assurance as a Board.

Resolved:
The Board noted the Mental Health services update.

21/22/221 Divisional Updates

Medicine

Request from NHSE - The Board was advised that NHSE has made contact with the Trust re the administering of monoclonal antibodies to vulnerable patients in the 12 to 13 age group who have tested positive for Covid. It was confirmed that Alder Hey has established a team and discussions are taking place to address this request/ look at the options for receiving these patients, for example, Catkin Building, a portacabin in front of ED, a cubicle on Ward 3C/4C. It was pointed out that the

guidance that was published week commencing 6.12.21 related initially to very vulnerable children who are Covid+ but this has since been extended.

Community and Mental Health

It was reported that the staff survey compliance for the division was slightly under 66%.

Surgery

Attention was drawn to the forthcoming challenges of providing treatment to patients during the next two months.

21/22/222 North West Wellbeing Pledges

The Board was provided with a re-cap of the discussions that took place during December's Trust Board in relation to the North West (NW) Wellbeing Pledges that organisations have been asked to commit to.

The actions required for this area of work was to **1.** Sign up to the NW Wellbeing Pledges, which was approved by the Board on the 25.11.21. **2.** To submit an action plan to the Board in December.

There were three areas of enabling work that the Trust had been asked to look at;

- *Holistic wellbeing services that supports all colleagues* – It was pointed out that the Trust has a well-developed Wellbeing Strategy, SALS service, an established Wellbeing Guardian in post and the Board is fully supportive of wellbeing, therefore it was agreed that no new actions are required.
- *A new person-centred wellbeing approach and an attendance management policy framework* – The Trust will work with the regional group, and staff-side colleagues to contribute to the development of this approach and share learning from the evidence based work that the organisation has been undertaking on wellbeing at Alder Hey. There are no timeframes for this at the present time, but the Trust's commitment is to work with the regional group to help shape/evolve it.
- *Leadership development that supports managers in a new approach* – The Trust's approach to leadership already focusses on person centred wellbeing, however the organisation is willing to adapt the training policy framework that has been developed. There is no timeframe for this to date.

It was pointed out that the Trust has a well-established steering group who monitor the Wellbeing Strategy and report into PAWC. In order to avoid duplication, it was proposed that the actions relating to the NW Wellbeing Pledges are included in the organisation's strategy, rather than a separate action plan, and monitored via the Wellbeing Steering Group.

The Chair asked as to whether there are any opportunities to share the Trust's work on wellbeing across the ICS. The Board was advised of the national podcast that Alder Hey is taking part in to talk about the wellbeing work that has taken place across Alder Hey and the lessons that have been learnt. It was also pointed out that Jo Pottier networks with colleagues across C&M and the wider NW.

Resolved:
The Board noted the update provided on the North West Wellbeing Pledges.

21/22/223 People and Wellbeing Update

Staff Survey, 2021

It was reported that the 2021 Staff Survey closed on the 30.11.21 with 52% of the workforce having responded. The Board was advised that the responses were slightly higher than those of the 2020 Staff Survey and the results are encouraging, with a number of questions scoring higher than comparators, at this stage.

Vaccine Update

Attention was drawn to the new legislation that was passed on the 14.12.21 by the Government with regards to vaccinations being a condition of employment for healthcare workers. The Trust has received part one of the new guidance and is requesting clarification on a number of areas detailed in the guidance. It was confirmed that staff who deliver healthcare will be required to be fully vaccinated by the 1.4.22.

The Board was advised that the Trust is going to write members of its workforce that it doesn't have a vaccination record for and will tailor support to help those who haven't had a vaccine. Further guidance will be published mid-January which will be specific on how to address staff members who refuse to be vaccinated. A further update will be provided during the next meeting.

21/22/223.1 Action: MS

BAME Inclusion Taskforce update

It was reported that the BAME Network was launched w/c 13.12.21 and members received a warm welcome from the Chair and Acting CEO of Alder Hey via a video. The inaugural meeting was well attended, and a discussion took place in terms of moving the taskforce forward.

Resolved:
The Board received and noted the contents of the People and Wellbeing report and the BAME Inclusion Taskforce update.

21/22/224 Collaborating for Child Heath

The Board received a report on improving Children & Young People's life chances and tackling health inequalities. The purpose of the report was to; outline the national, regional, local and Alder Hey context pertaining to health inequalities and improving child health, outline the Trust's plan to address health inequalities which impact upon CYP and embed prevention throughout the Trust's services and system partnerships and to make recommendations on next steps to be taken as a Trust.

A number of slides were shared with the Board to highlight elements of the report. Attention was drawn to the following areas:

- *Best Start in Life* - In C&M, CYP experience poorer than national average outcomes across almost every key indicator. Evidence shows the most important drivers of good health are wider determinants 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 reason as to why Alder Hey should help to address health inequalities.
- Regulatory context.
- The Trust's approach.
- The Trust's Strategic Plan; Alder Hey's prevention pledge, targeted action on health inequalities, partnership and Trust governance.
- Targeted action on Health Inequalities via partnership, communications, data and intelligence, Board assurance.
- Initial priorities of the C&M CYP Transformation Programme; Obesity, Mental Health, Respiratory and LD/Autism
- The governance process for the Health Inequalities Prevention Steering Group (HIP) with a reporting line into SQAC and up to Trust Board.

The Chair thanked Dani Jones for setting the framework to enable the Trust to progress this work and felt that the contents of the report will support the thinking during January's Board Strategy Session.

Resolved:
The Trust Board:

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

21/22/225 Memorandum of Understanding

The Board received two Memoranda of Understanding (MoU) for information and approval purposes;

- *NW Clinical Research Facility Alliance* - Multi-partite collaborative agreement with various NHS partners in the North West, each of which has an adult and /or paediatric clinical research facility (CRF) to facilitate partnership in the specific area of clinical trials.
- University of Liverpool/Alder Hey - Bilateral agreement with the University of Liverpool (UoL) to facilitate various interactions across research and innovation.

It was confirmed that the NW Clinical Research Facility Alliance MoU is a declaration of interest and not a legally binding document. In terms of the MoU for UoL/Alder Hey, it is a very mature document that formalises the collaborations of two key partners in respect to research, innovation and education. The Director of Research, John Chester, felt that both documents are uncontroversial and therefore commended them to the Board for approval.

Claire Liddy pointed out that the agreement between UoL/Alder Hey is a big step forward for both organisations and advised that the Trust's IP lawyers have

reviewed the MoU and confirmed that it is a suitable document in terms of IP ownership and proportions.

Resolved:
The Trust Board approved the NW Clinical Research Facility Alliance MoU, and the UoL/Alder Hey MoU.

21/22/226 2021/22 H2 Plan; including; Financial Update, M8 2021/22.

The Trust has submitted its plan with a breakeven position to the end of march, however there is a c£3m risk within that plan. The organisation has achieved an in-month surplus of £365k against a breakeven plan. The YTD deficit is £0.5m behind plan and cash in the bank is £94m. Capital spend YTD is £11.1m in line with plan YTD.

It was reported that the CIP shortfall remains a high risk for the Trust with a gap of £1.3m. It was agreed to pause any further recovery investment in H2 which has allowed the Trust to fund part of the CIP gap. There is also going to be a focus on benefits in terms of quick wins for Q4.

Key drivers relate to;

- *Surgery* - Increased pay costs in month which are to be reviewed.
- *Medicine* - High non pay costs relating to consumables and an increased number of patients.
- *Facilities* - Positive surplus in month following a pay run reduction.
- There has been a reduced reduction in capital charges.

Latest H2 Position

- It was reported that the ICS has established four workstreams across the finance system; Capital, Run Rate, H2 and System Allocation with representation from each provider. The intention of these groups is to gain a clear understanding of the C&M position in order to agree a number of actions that that will influence and drive this area of work forward in 2022/23. It was confirmed that Alder Hey will lead on the Capital workstream.
- The Board was informed that C&M did not achieve the ERF thresholds in M7 and are not likely to in M8, however Alder Hey did achieve 98%, but this is a risk of £1m in the Trust's H2 plan.
- The Trust has been successful in securing bids to the value of £2m for H2 relating to winter, theatre management, ED and critical care.

Resolved:
The Board noted the H2 Plan/M8 update.

21/22/227 Board Assurance Framework

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

- The Board was advised that the principle risks have been scrutinised by the respective Assurance Committees.
- Following a discussion during RABD, it has been agreed to incorporate the risk relating to building issues in the BAF as this is developing into a more strategic issue.

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

21/22/228 Board Assurance Committees

RABD – The approved minutes from the meeting that took place on the 22.11.21 were submitted to the Board for information and assurance purposes. During December's meeting the Committee received an update on all elements of business that come under the remit of the Committee. A discussion also took place around the long-term Capital Plan and it was pointed out that further mitigation will be required at the end of the five-year plan.

SQAC – The approved minutes from the meeting that took place on the 24.11.21 were submitted to the Board for information and assurance purposes. During December's meeting a deep dive was conducted on the deteriorating patient. It was reported that an assuring overview was provided of the progress that is being made and how it is becoming embedded to support a change in culture. An update was also received on the STAT programme. The Committee received a very impressive account of the work that has been taking place to transform the culture in theatres and were advised of the evidence that is filtering through in terms of the impact of the programme.

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

21/22/229 Any Other Business

There was none to discuss.

21/22/230 Review of the Meeting

The Chair thanked everyone for their contribution during the meeting and felt that the time spent discussing the plans have been implemented to address the forthcoming months was appropriate. It was felt that a focus is required in the New Year around governance and time will also need to be set aside to address strategic matters. The Chair thanked the governors and observers for their attendance and wished everybody the very best for the festive period and the forthcoming year.

Date and Time of Next Meeting: Thursday the 22nd January 2022 at 12.00pm 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 January 2022							
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.	N. Murdock/ A. Bass	27.1.22	Closed	**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. **24.1.22 -** It was confirmed that all was compliant bar the ME process which is being discussed with LHCH in terms of Alder Hey sharing LHCH's Medical Examiner resource. This action has been superseded by action 21/22/218.1.
28.10.21	21/22/156.1	Alder Hey in the Park Campus Development Update	**1.** 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. **2.** 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	27.1.22	Closed	**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. **25.1.22** - **Point 1 of the action** - Due to not receiving any further queries from NHSE regarding this matter it is felt that this part of the action can be closed. **Point 2 of the action** - A report is to be presented in the private element of January's Trust Board on the potential for the team to be based in the STEP development. An update will be provided on a monthly basis regarding this matter. **ACTION CLOSED**
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	27.1.22	Closed	**11.12.21** - An update will be provided on the 16.12.21. **16.12.21** - An update will be provided on the 27.1.22. **24.1.22** - Garth Dallas has agreed to participate in the ICH working group which is meeting on the 11.2.22. **ACTION CLOSED**
16.12.21	21/22/219.1	Q2 Director of Infection, Prevention and Control (DIPC) Report	Discuss the possibility of additional support for the IPC team with Bea Larru, and reflect upon the message for staff ahead of the weekly briefing re the process that staff should follow in the event of testing Covid+.	J. Grinnell	27.1.22	Closed	**24.1.22** - The Exec Team reflected upon the message for staff ahead of the briefing scheduled for the 23.12.22 re the process that staff should follow in the event of testing Covid+, and a plan is now in place to address the additional support required by the IPC team. **ACTION CLOSED**
16.12.21	21/22/223.1	People and Wellbeing Update	Provide a further update on the new legislation that was passed on the 14.12.21 by the Government with regards to vaccinations being a condition of employment for healthcare workers.	M. Swindell	27.1.22	Closed	**21.1.22** - This item has been included on January's agenda. **ACTION CLOSED**
Actions for February 2022							
16.12.21	21/22/218.1	Q2 Mortality Report	Follow-up on the meeting that took place between Nicki Murdock and the CEO of LHCH to confirm as to whether Alder Hey is able to share LHCH's Medical Examiner resource from April 2022 onwards.	J. Grinnell	24.2.22		

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
16.12.21	21/22/220.1	Mental Health Services Update	Compile the following data and submit if to SQAC in order to look at trends and how the Trust is responding to those who are seeking crisis support; **1**. The number of repeat referrals being received by Crisis Care, **2**. The pathways of patients who access this service. **3**. Patient outcomes.	L. Cooper	24.2.22	Closed	**28.1.22** - This information is reqported to SQAC on a quarterly basis. **ACTION CLOSED**
Actions for March 2022							
16.12.21	21/22/214.1	Chair's/CEO's Update	Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.	K. McKeown	31.3.22		
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	30.6.22		

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th January 2022

Paper Title:	**Operational update: Omicron, winter pressures and recovery of services**
Report of:	**Adam Bateman, Chief Operating Officer**
Paper Prepared by:	Adam Bateman, Chief Operating Officer Alex Garbett, Associate Director of Data & Analytics Hannah Rogers, Service Manager Andy Hanson, General Manager Rachel Greer, Associate Chief Operating Officer

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

In December we took urgent action to deploy an emergency preparedness plan to deal with the threat of Omicron. We focused on mitigating the expected adverse impact on staff availability, and a possible surge in emergency care demand. Against strong headwinds, generated from rising staff absence, we have maintained full access to urgent and emergency services and sustained a high level of access to elective services.

Omicron has caused a significant increase in staff absence. We have deployed additional support to our track and trace team to enhance the service for staff. We also stepped up our on-site vaccination and booster offer to increase the number of staff who have received protection.

In December, there has been a reduction in attendances to the Emergency Department, associated with behavioural changes pertaining to the transmission risk of Omicron. Admissions for RSV have reduced. Emergency admissions in December relative to November have fallen, which has led to lower levels of ward occupancy.

2. Omicron preparedness and response

2.1 Omicron emergency preparedness

Our overall Omicron emergency preparedness framework is as follows:

Our priority:

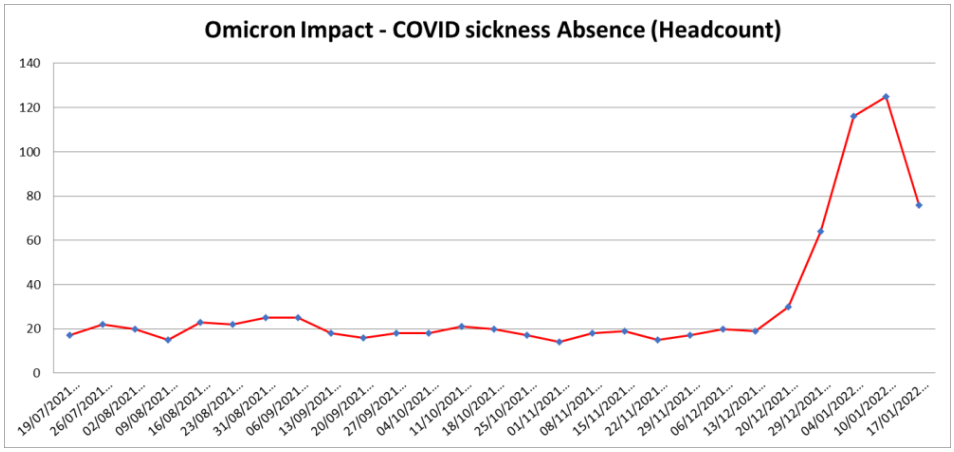
- Provide safe care and keep staff safe

Our key actions:

- Take action *now* to pre-empt high urgent and emergency care demand
- Take action *now* to moderate, and mitigate the effect of, a rise in staff absence [from Omicron]
- deliver vaccines (including boosters): for all, but with a focus on 12- 15 year olds
- maintain essential activities that keep us safe (e.g. training, clinical governance meetings)

2.2 Impact of Omicron on staff absence

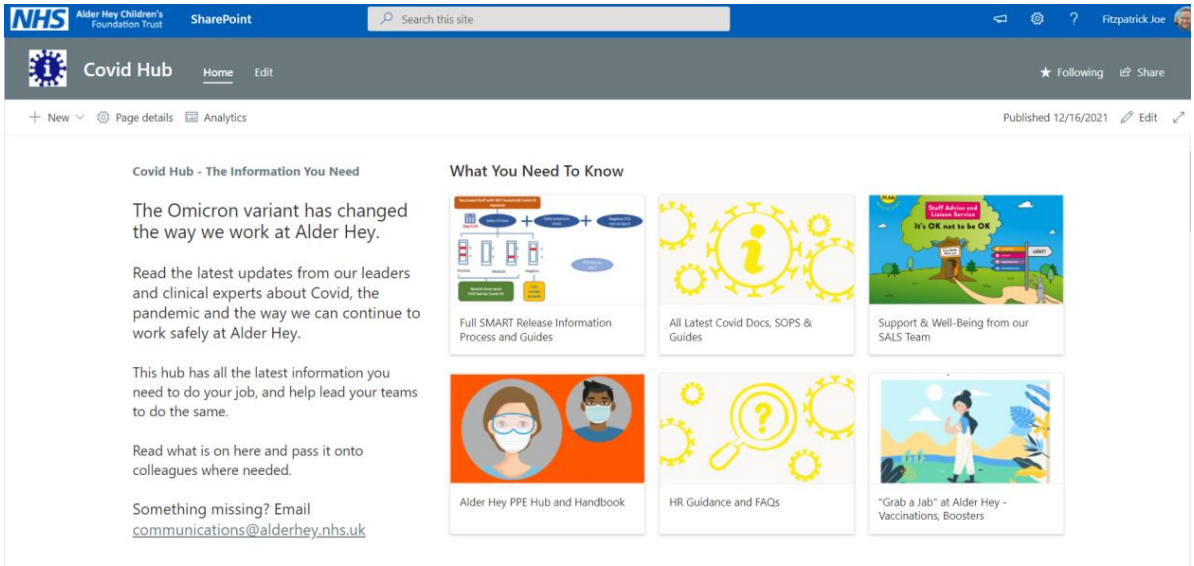
Absence has increased from 6.3% in November to 12% in early January 2022. We have observed a surge in staff sickness absence and unavailability to work related to isolation, caused by Omicron.



In order to deliver resilience and mitigate the effect of higher staff absence we took the following pre-emptive actions:

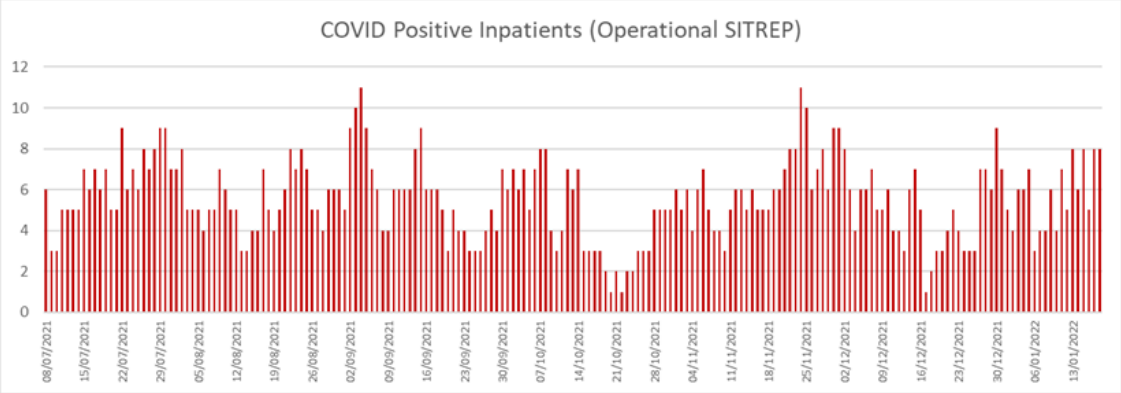
- Urgent HR support and advice via manager briefings and HR clinics
- Annual leave and carry over
- Hybrid working guidance
- Supporting staff to access the booster shot
- Risk assessments (including pregnancy)
- Environmental risk assessments
- Use SMART release and adapted SMART release to support return to work where appropriate
- Departmental preparedness plans submit to Consider standby/ back-up rosters
- Consider split working patterns (e.g. team A and B)/ creating separation within the team

The Covid-19 information hub was updated to share the key information and guidance with staff:



2.3 Omicron impact on admissions to hospital for children and young people

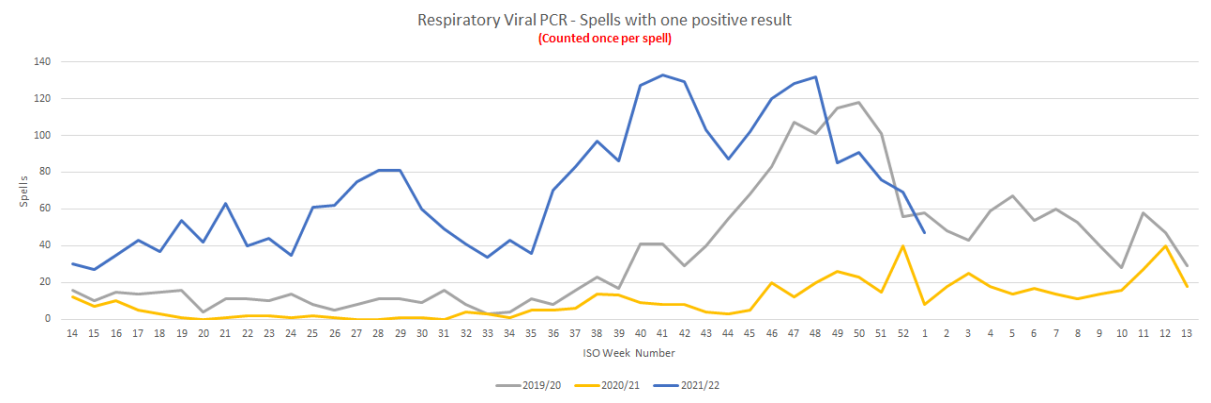
To date we have not seen Omicron elicit a sharp rise in hospital admissions to Alder Hey. The number of patients in hospital at Alder Hey for Covid-19 between July 2021 and January 2022 is illustrated below:



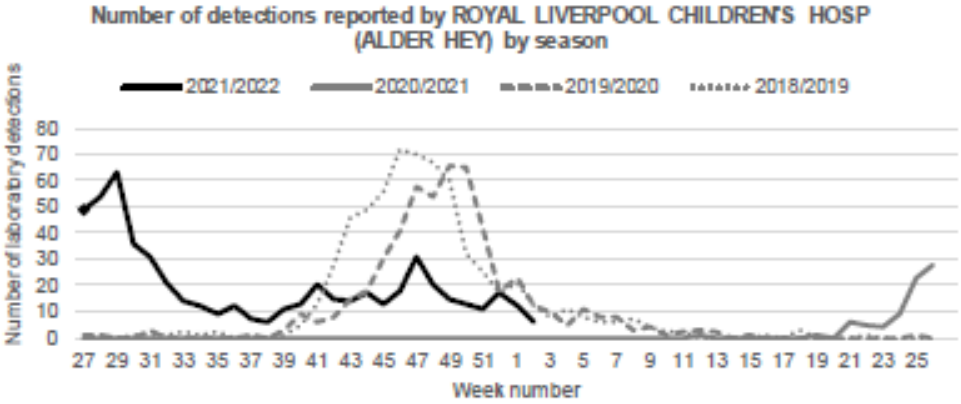
3. Emergency and urgent care admissions and attendances

3.1 Respiratory admissions to hospital

During December we saw a downward trend in patients in hospital with a respiratory condition:



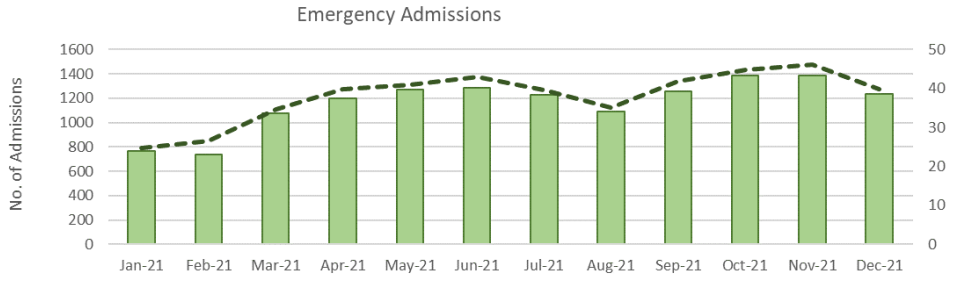
Similarly, the number of patients with a positive test for respiratory syncytial virus (RSV) has fallen at the end of December, with the peak now well passed.



Data source: UK Health Security Agency. North West Respiratory Report.

3.2 Emergency admissions to hospital

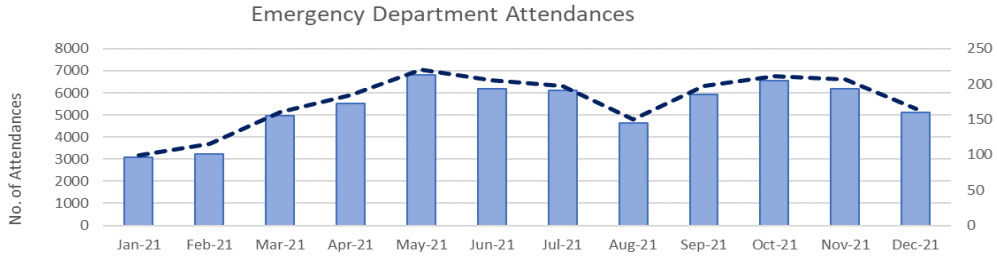
The number of emergency admission per day reduced in December, relative to November.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Emerg Admissions	766	741	1074	1198	1269	1287	1228	1089	1255	1386	1388	1234
Avg Emerg Admiss. Per Day	25	26	35	40	41	43	40	35	42	45	46	40

3.3 Emergency Department Clinical Quality Standards

In December there was a sharp decline in attendances to the Emergency Department, probably associated with changes in public behaviour relating to Omicron.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Attends	3069	3228	4971	5528	6817	6175	6099	4645	5917	6539	6189	5113
Avg Attends Per Day	99	115	160	184	220	206	197	150	197	211	206	165

In December 74.9% of children and young people were treated within 4 hrs, an improvement on the past 3 months.

Performance	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Attendances	3226	4971	5519	6797	6171	6094	4639	5912	6532	6186	5103
Performance	98.4%	95.4%	92.7%	81.7%	85.6%	68.1%	88.1%	73.4%	72.5%	66.4%	74.9%
% change in attendances relative to 2019	-29.4%	25.8%	11.9%	29.2%	20.4%	17.2%	8.9%	12.8%	16.5%	-0.8%	-8.5%

In April 2022, new Emergency Department clinical quality standards will be introduced: time to triage and time for clinical assessment. We currently have a quality improvement project running to improve time to clinical assessment. We are presently achieving the time to triage standard of 15 minutes. Our performance data is below:

Clinical quality standard		06-Dec	13-Dec	20-Dec	27-Dec	03-Jan	10-Jan
Time to Triage (Median)	15 mins	13	17	10	10	7	9
Time to Clinical Assessment Median	60 mins	96	129	62	66	61	71

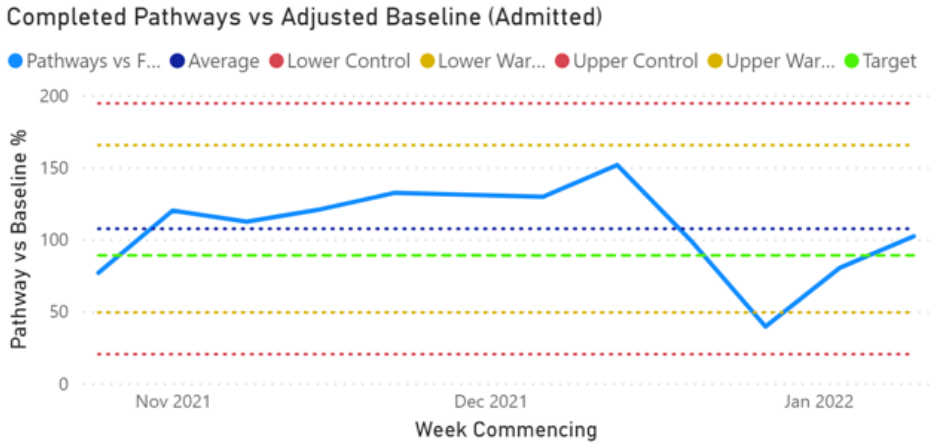
4. Elective care services

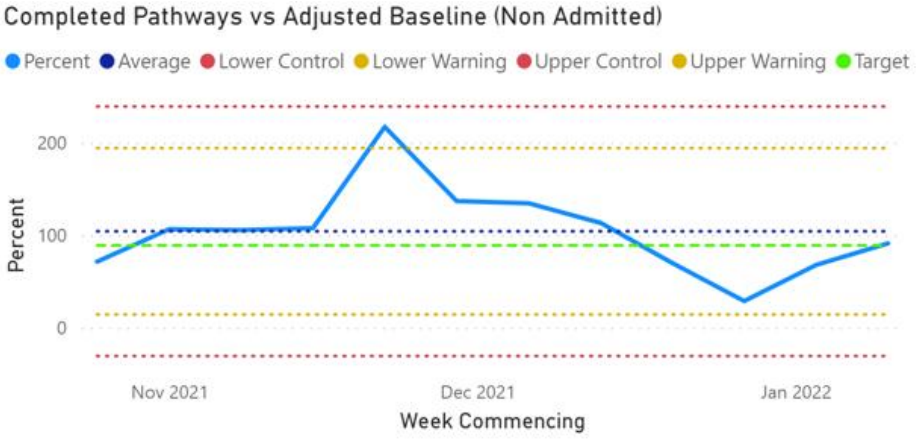
4.1 Progress in recovery of services

The headwinds that Omicron has generated, particularly the effect of high staff absence, has moderated our progress with elective recovery. Nonetheless, the actual impact on recovery levels is in line with our best-case scenario forecast: that is, we have maintained the high levels of elective and outpatient services, relative to 2019.

Delivery	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Elective Inpatient & Daycase Recovery	95%	82%	84%	100%	105%	107%	113%	97%	91%	92%	103%	103%	97%
Acute Outpatient Recovery	98%	89%	95%	124%	111%	119%	110%	100%	98%	98%	96%	106%	93%
All Outpatient Recovery	104%	95%	100%	126%	118%	128%	115%	104%	104%	103%	100%	109%	98%

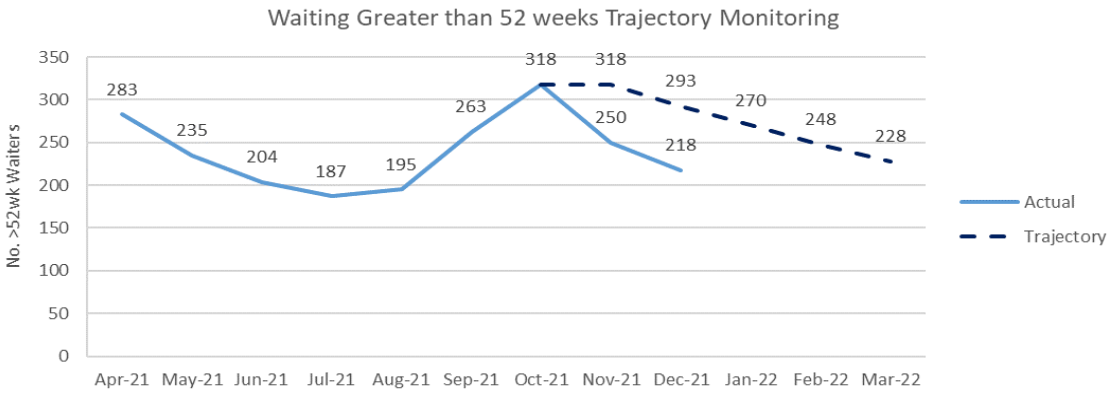
Nationally, levels of recovery is now being measured against a target of 89% of completed patient pathways (rather than the previous measure of activity levels) against a 2019 baseline. Overall, we have delivered this standard in December for completed admitted and completed non-admitted pathways:



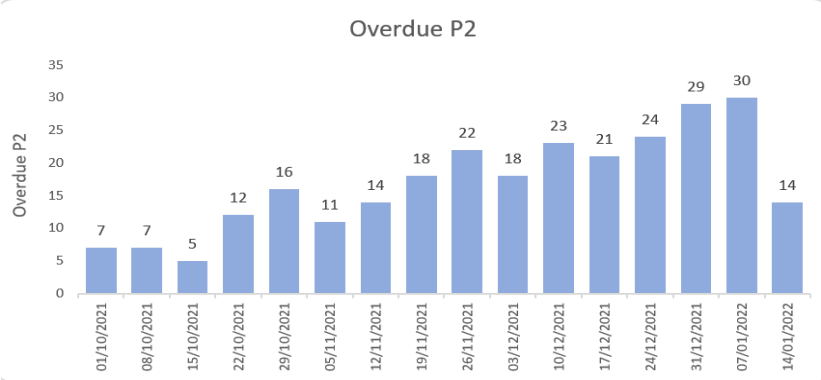


4.2 Waiting times for patients on a referral to treatment (RTT) pathway

The high level of service recovery is supporting a reduction in the number of patients waiting over 52 weeks for treatment. We are presently ahead of our trajectory for reducing the number of patients with a long waiting time:

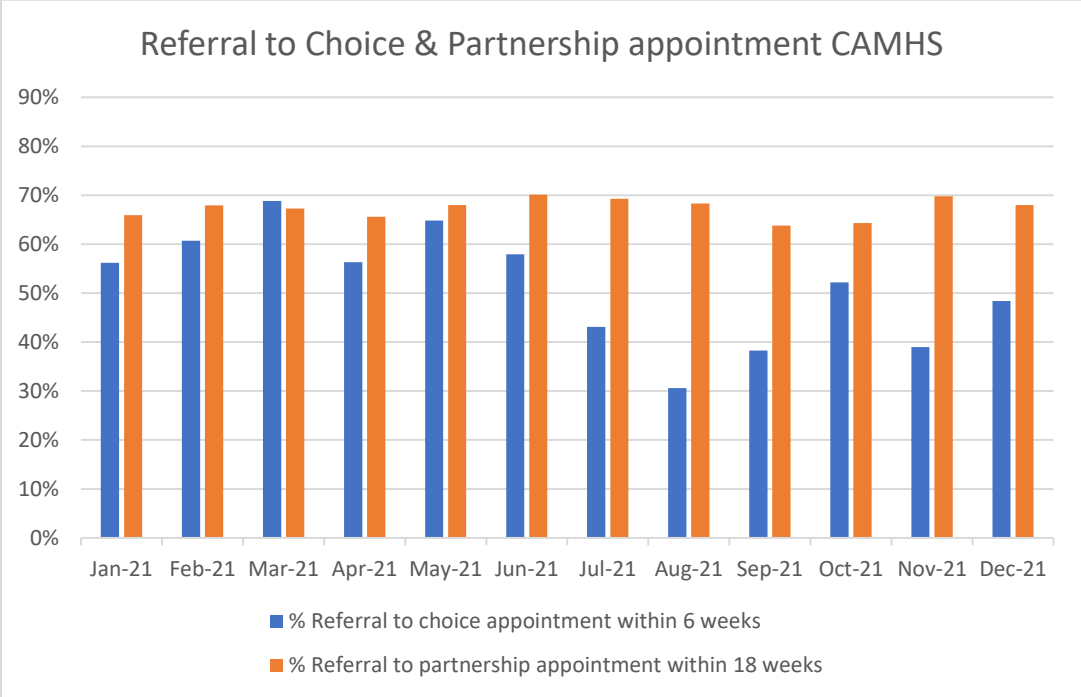


We have systems in place to book patients according to clinical urgency. P2 is a category that denotes patients who should have treatment within 1 month of being listed on the waiting list for a procedure. P2 performance in January has significantly improved following a peak of overdue P2 patients in November/December. We have set a goal of zero P2 patients waiting over 1 month for treatment, by April 2022.



4.3 Waiting times for Child and Adolescent Mental Health services (CAMHS)

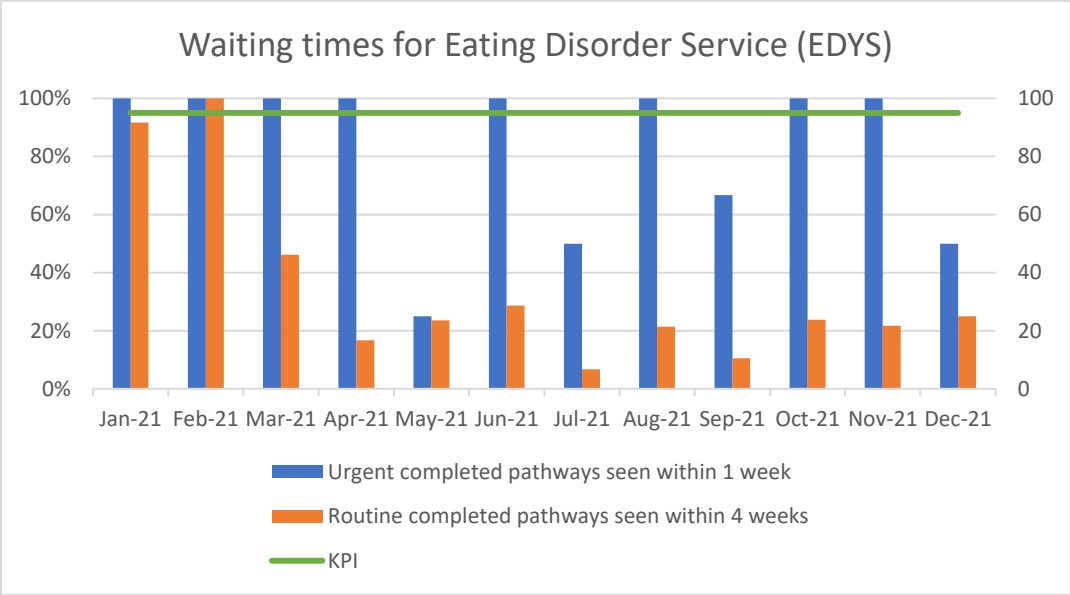
Specialist CAMHS



Alder Hey specialist mental health services continue to experience high demand for services with a 46% increase in 2021 referrals year to date (Apr – Dec) compared to 2019. There is a significant recruitment drive underway following new investment agreed for 21/22 to provide additional capacity to reduce waiting times. Other actions in addition to recruitment include:

- Significant recruitment to new posts within both Liverpool and Sefton CAMHS teams during Q3
- Recruitment incentive scheme approved which will support increase in workforce requirement
- Additional lottery funding secure to continue to run "Calm and Connected" anxiety group for the next two years.

Eating Disorder Service

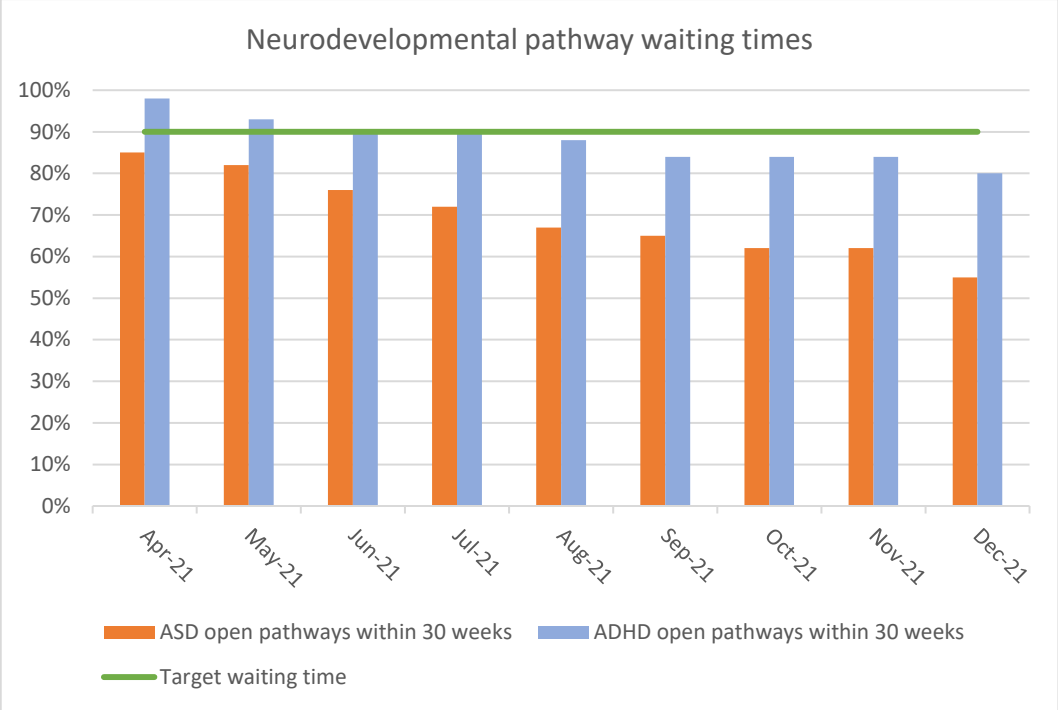


The Eating Disorder service is also experiencing unprecedented demand for support and has experience a **157%** increase in referral in 2021 compared to 2019. These pressures are also being faced nationally across community eating disorder and inpatient mental health services.

This increase in demand as well as the increased number of acute paediatric admissions for eating disorders is significantly impacting on capacity within the service. Actions to support improvements include:

- Recruitment to additional posts following investment, this includes training posts to support future sustainability
- New assessment model implemented which increased number of available slots and ensure sufficient capacity for urgent appointments which are required within 7 days of referral.
- Winter capacity funding for HCA posts to support acute admissions for children and young people with eating disorders on the wards.
- Move to automatic direct booking of appointments using the Sefton and Liverpool CAMHS referral platform is due to go live in February 2022.

Waiting times for Neurodevelopmental diagnostic pathways (ASD & ADHD)



There has been a sustained increase in referrals to the ASD and ADHD pathways in Liverpool and Sefton which are significantly higher than planned (90%), this is impacting on the service capacity and waiting times. At the end of December, 55% of children waiting for ASD assessment were below 30 weeks and 80% for ADHD. Despite this, there have been several improvements including:

- Maintenance of referral to triage times within 12 weeks. have been maintained and all referrals are now triaged within 12 weeks,
- Continued use of independent sector providers to support assessments for new ASD pathway.
- Agreement from Liverpool and Sefton CCGs to invest in increased capacity within services to support a reduction in length of diagnostic pathways.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 27th January 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st December 2021 – 31st December 2021
Report of:	Chief Nursing Officer
Paper Prepared by:	Chief Nursing Officer & 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 Introduction

Alder Hey Children's Hospital NHS Foundation Trust is committed to the provision of high quality, patient centred care. Responding appropriately when things go wrong is one of the ways the Trust demonstrates its commitment to continually improve the safety of the services it provides.

Serious Incidents are adverse events where the consequences to patients, families, staff or the organisation are so significant or the potential for learning so great, that a heightened level of response is justified. When events of this kind occur, the organisation undertakes comprehensive investigations using root cause analysis techniques to identify any sub-optimal systems or processes that contributed to the occurrence. The National Serious Incident framework (NHS England 2015) describes the circumstances in which such a response is required and the processes and procedures to be followed which ensure that Serious Incidents are identified correctly, investigated thoroughly and importantly, learning is embedded to prevent the likelihood of the same or similar incidents happening again.

The Trust is required to report certain serious incidents to the Strategic Executive Information System (StEIS) and share investigation reports with our commissioners. The Trust recognises that some events that do not meet the criteria of an StEIS Serious Incident can also benefit from comprehensive RCA investigations; as part of our commitment to improving patient safety the Trust undertakes detailed investigation of these incidents using the same methodology and with the same oversight as StEIS Serious Incidents. The Trust is not mandated to report these events on StEIS or share the reports with our commissioners.

Outcomes from all serious Incidents are considered at Divisional Quality Boards, Clinical Quality Steering Group, Quality and Safety Assurance Committee so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

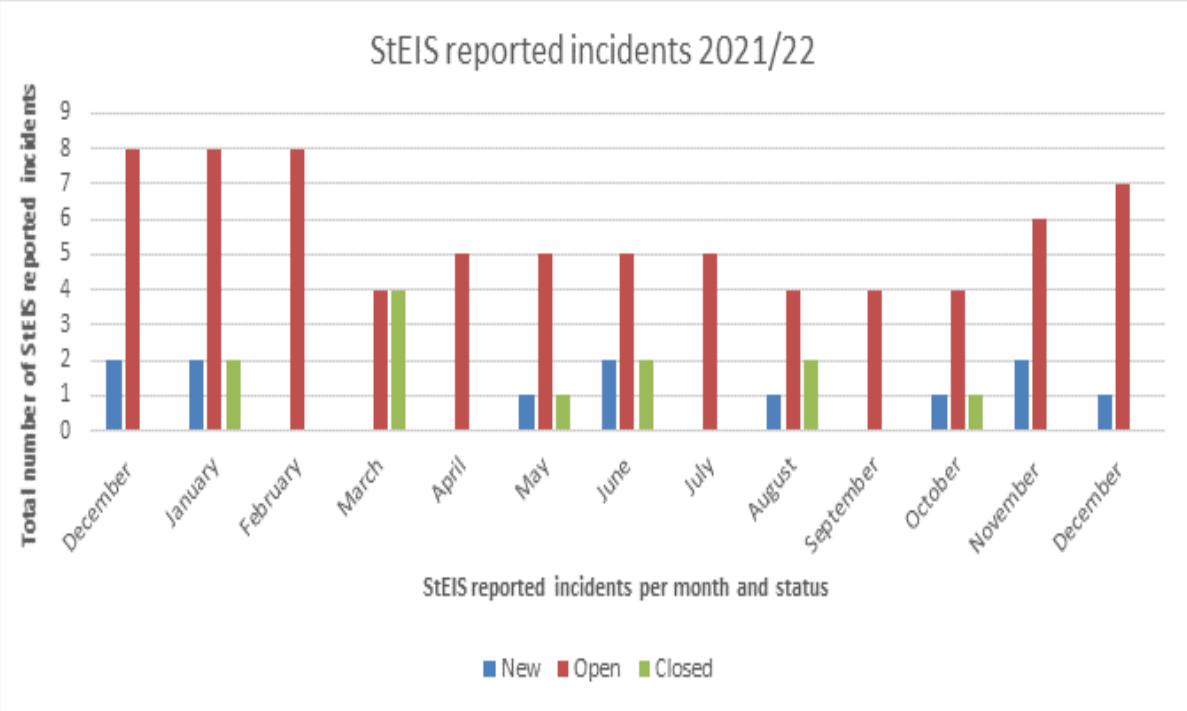
Serious incidents that do not meet the StEIS criteria are discussed at the weekly patient safety meeting and where appropriate an RCA level 2 is instigated.

2. Serious Incidents activity December 2020 – December 2021

Between 1ST December 2020 and 31st December 2021, the Trust reported as follows

- 9 incidents reported to StEIS
- 1 Never Event (included in StEIS reported incidents)
- 1 Internal level 2 RCA Investigation (ongoing)

Note: Five StEIS reportable incidents were carried forward from the previous financial year for investigations, all five concluded in 2021-22.



Graph 1 – StEIS reported incident status by month

3. Serious Incident declared in December 2021

- The Trust commissioned zero internal RCA level 2 investigations which did not meet the externally reportable criteria but would benefit from a comprehensive RCA review.
- The Trust declared one StEIS reportable incident requiring investigation, that met SI criteria (Table 2).

Division	Speciality	Ref	Brief Description
Division of Medicine	Haematology/Oncology	2021/25961	Patient receiving active treatment for leukaemia, relapsed

Table 2: StEIS reported serious incident in December 2021

4. Never Events

Zero 'never events' were declared in December 2021.

5. Serious incident reports completed in December 2021

Zero 'serious incident' investigations were closed in December 2021

6. Learning from serious incidents

The Serious Incident investigations are designed to identify weaknesses in our systems and processes that could lead to harm occurring. It is incumbent on the Trust to continually strive to reduce the occurrence of avoidable harm by embedding effective controls and a robust programme of quality improvement.

6.1. Serious Incident action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan is developed to address these factors. Action plan completion is monitored by Clinical Quality Steering Group (CQSG) to ensure barriers to completion are addressed and change is introduced across the organisation (when required). At the time of writing there are 10 SI action plans that have passed their expected due date.

Table 1 below provides and overview for progress position of open action plans. The Division of surgery have the most action plans past expected date of completion. The division continues to address a backlog of incomplete historic action plans during this year and have made considerable progress in this regard. The expectation is that with the improved governance processes in place, progress will continue at pace.

Table 1

Division	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Surgery	11	4	4	5	5	5	3	6	6	49
Medicine	3	1	3	1	1	1	3	4	4	21
CMH	0	0	0	0	0	0	0	0	0	0
Corporate	0	0	0	0	0	0	0	0	0	0
Total	14	5	7	6	6	6	6	10	10	70

6.2 Measuring the effectiveness of serious incident actions

Serious incident investigation reports occur either because existing controls are not sufficiently robust to prevent the ‘swiss cheese’ effect or in some cases the necessary controls are not in place.

All action plans are expected to be specific, measurable, achievable, realistic, timebound (SMART) in their design. Although the Trust monitors the effectiveness of actions, in many cases via audit, there is not a current system of hierarchy of controls, therefore going forward using the risk management methodology including impact x likelihood (5x5 matrix) will be implemented. This is in process of being piloted. There is evidence of positive changes in practice that have led to improvements and reduced incidents, for example.

- Development and implementation of Standard Operating Procedure (SOP) for clear handover arrangements between Haematology/Oncology staff including management of critical or potentially critical patients.
- Plan in place to develop/show care management plans clearly on the new Expanse/AlderCare system when it goes live expected mid - 2022. As an interim the haematology service has implemented an APML ‘Coagulopathy Management Guideline’, to be completed by haematology consultant for management of patients, to minimise patient risk.
- The trust blood product guideline has been updated to include signposting to the fibrinogen concentrate specific guideline.
- Escalation guidance reviewed and updated.

7. Quality Improvement

Action plans arising from incidents do help to support organisation wide improvement projects and this is reflected in the current safety priorities including:

- Management of the deteriorating patient
- Parity of esteem
- Medicines management

The ambition of the organisation is to use quality improvement methodology to demonstrate a culture of curiosity and learning through continuous improvement. Stronger links will be formed between serious incidents and our quality improvement teams, the thematic review of SI's will strengthen this work. Progress with this work is monitored via Safety and Quality Assurance Committee (SQAC).

8. Thematic Review

Serious incident investigations explore problems in care (Why?). the contributory factors to such problems (how?) and the root causes /fundamental issues (Why?). To support understanding a process of theming across these areas has been undertaken to identify commonalities across StEIS reported incidents submitted to commissioners since April 2021.

The review did not seek to weigh the themes according to their influence on an incident. but to identify there occurrence, the rationale being to increase insight into the most common factors associated with serious incidents and increase the opportunity to identify overarching improvement actions.

Since the 1st April 2021, there were six reports submitted to commissioners and 46 themes were identified. Key themes contributing to the serious incidents included:

- Communication issues (6/6)
- Guidelines, Policies, Procedures not adhered to/not followed (4/6)
- Documentation not clearly visible/not completed (5/6)
- Escalation processes not followed (3/6)

There were no clear commonalities in terms of root causes for the six incidents in this reporting period, although clearly communication featured as a main contributory factor and linked in with the root causes in all incidents which included

- Missed opportunities to address the issues at an earlier point in pathways
- Pathway understanding and interpertation issues
- Failures to escalate at earlier points
- Poor rule compliance
- Leadership issues.
- Governance issues

The previous thematic review presented to Board in May 2021 covered the period March 2019/April 2021and showed some similar themes to this review. The 26 incidents scrutinised the contributory factors showed the primary theme identified was communication issues, both verbal and written. Also, documentation issues were a recurring theme, and linked to communication factors. A further two linked contributory factors to both communication and documentation was human factors and escalation issues. Although Human Factors was not a recurring theme in this reporting period, it was cited in one of the incidents.

9. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Correctable causes and themes are tracked by the Clinical Quality Steering Group to ensure change is embedded in practice.

Appendix 1 - Precise StEIS reported incidents in months and internal commissioned Level 2 RCA'S

1. StEIS 2021/25961 (Ulysses ref: 54286)

Background

Patient with leukaemia relapsed. Concerns raised about pathway of care and treatment; therefore level 2 investigation instigated.

Immediate lessons learned and actions for improvement

The protocol was incorrectly assessed. This has now changed to a process by which all members agree the interpretation of a result and check against the relevant protocol or guidelines.

Further actions

- 72-hour review completed.
- Lead investigator agreed.
- RCA level 2 investigation to establish the increased risk of relapse relevant for this patient as a result of this error and describe the extra burden of treatment and anticipated late effects of this treatment.
- External expert to be engaged to support investigation panel
- Panel to be agreed and date of panel meeting
- Decision points for all on-treatment patients to be retrospectively reviewed by leukaemia team including look-back at previous patients where appropriate for past 5 years.

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report December 2021

How Did We Do?

Executive Summary **Month: December** **Year: 2021**

Alder Hey Children's NHS NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Continued challenges meeting the sepsis treatment targets both in ED and the wider Trust, reflecting the pressures the Teams are currently experiencing.
- Despite experiencing extreme pressures relating to the pandemic and unprecedented activity levels, patient safety data is providing us with the necessary assurance that we are delivering safe and effective care.

Highlight

- 0 clinical incidents resulting in moderate harm and above.
- 0 pressure ulcers category 3 or 4 for 12 consecutive months.
- 0 never events.
- 0 Hospital acquired MRSA or C Difficile.

Challenges

- 5 medication errors resulting in harm- 1. Clonidine infusion running at a lower rate resulting in extra bolus needing to be given for pain. 2.Patient had 3 days of dosing omitted without ward staff contacting for more stock after drug left out of fridge. Patient had an increase of abnormal movements. 3.Patient had duplicate dose given 2hrs apart after staff did not sign the MAR. Patient needed bloods and ECG. 4.Patient had given an extra dose of Paracetamol in 24hrs. Bloods done. 5.Patient was distressed and noted to have had no analgesia for over 12hrs resulting increase in pain and distress. All incidents have been thoroughly investigated, actions identified, and learning has been shared with teams.
- 1 hospital acquired MSSA – relating to PICU baby with complex cardiac condition known to be colonized with MSSA. Source of the blood stream infection is probable line sepsis. Investigation underway.

The Best People Doing their Best Work

Caring

- Overall Friends and Family score above 90%.
- Low level of complaints and PALS referrals in December- 9 and 107 respectively.

Highlight

- Excellent Friends and Family scores across Community and Mental Health Division. 100% in mental health.
- Improved Friends and Family score in AED up to 71.7% albeit still significantly down from a year ago.

Challenges

- Complaints and PALS numbers may reflect seasonality.

Delivery of Outstanding Care

Effective

In December we saw the number of ED attendances contract, relative to November and relative to December 2019. This has alleviated pressure on staff and waiting times, which in conjunction with the delivery of service enhancements (health visitor service, symptom checker, rapid assessment and treatment) led to an increase in the proportion of patients treated within 4 hours.

Following very high cancelled operations in November, caused by an unprecedented level of inpatient bed occupancy, we took action to institute a cap on the number of inpatient procedures, and to prioritise a shift to day case procedures. It was pleasing to see a reduction in cancelled operations of 59% and over 90% theatre utilisation.

Highlight

- Improvement in patients treated in the Emergency Department within 4 hours.

Challenges

- 28 day breaches.
- Overall number of on-the-day cancelled operations remain high.
- Percentage of patients treated in the Emergency Department within 4 hours.

Delivery of Outstanding Care

Responsive

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 267 patients on the 8 December 2021 to 210 in December, from 250 in November.

Whilst there was non-compliance in two of the cancer standards, we are assured this is not a systemic issue with access to cancer care. Instead this related to complexities with two individual pathways.

Highlight

- Reduction in the number of children and young people waiting over 52 weeks for treatment
- Overall access to cancer care.

Challenges

- Percentage of patients on an RTT pathway treated within 18 weeks.

The Best People Doing their Best Work

Well Led

Finance
The month 9 position is showing a deficit of £0.4m which is an improvement from last month of £0.1m however we still remain £0.4m away from the break-even planned control total.

Cash in the bank at the end of December was £90.4m.
The overall capital expenditure year to date to December was £16.2m year to date which is largely in line with planned spend year to date.

Mandatory Training
As of the 31st 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

Highlight

Challenges

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

Level 2 which had seen significant compliance drops due largely to the impact of COVID on face to face training restrictions. **PDR** As of the 31st December 2021, our Trust appraisal rate was 72.04%, 18% 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** The Trust, like other NHS employers is currently experiencing an increase in absence levels linked to the COVID pandemic and other winter pressures. The number of staff absent from work (COVID and non-COVID) is fluid in nature as the picture alters daily, however an increase to 10%+ is currently being recorded. Staff availability is under particular scrutiny, with a daily update being provided to Tactical Command / Daily Operations Group; information from which feeds into Safer Staffing meetings. **Turnover** Turnover is an increasing area of focus across the Trust as it has recently been subject to an increase in the % of staff leaving. An initial analysis has been undertaken, which has been reported to PAWC; the finding of which includes that the largest reason for people leaving the organisation is linked to career progression / development opportunities. Therefore, there is an intention for this to be considered as part of workforce planning / career development discussions going forward, to support the Trust to be future proofed from a staffing availability perspective.	

Game Changing Research and Innovation

Research and Development

Month 9 Research Activity:

- 187 research studies currently open
- 816 patients recruited to research studies (9,658 in 21/22)

Divisional Participation:

- Division of Medicine – 153 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

- Level of research activity

Challenges

- Staffing levels

Contents

Contents

Contents

Contents

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	5	0	75.86 %
Dec 2021	Dec 2021	Dec 2021	Dec 2021	Dec 2021	Dec 2021

Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
77.42 %
Dec 2021

CARING

Friends & Family: Overall Percentage Recommended Trust
90.68 %
Dec 2021

EFFECTIVE

ED: 95% Treated within 4 Hours
74.92 %
Dec 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
50 %	100 %	95.24 %	92.11 %
Dec 2021	Dec 2021	Dec 2021	Dec 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 %	64.17 %	218	19127
Dec 2021	Dec 2021	Dec 2021	Dec 2021

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
90450	166.47	87.48 %	84.54 %	7.42 %
Dec 2021	Dec 2021	Dec 2021	Dec 2021	Dec 2021

Delivery of Outstanding Care

SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	74	53	63	98	79	81	89	74	62	89	85	66	78		No Threshold	✔
Clinical Incidents resulting in No Harm	D	314	287	333	401	395	363	322	330	298	314	280	273	263		No Threshold	✔
Clinical Incidents resulting in minor, non permanent harm	D	75	81	76	95	91	80	72	95	88	75	86	133	76		No Threshold	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	1	1	1	1	4	1	1	1	0	1	1	0		No Threshold	✔
Clinical Incidents resulting in severe, permanent harm	D	0	1	0	0	0	1	0	0	0	0	1	1	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	0	6	3	4	4	2	2	2	6	4	2	3	5		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	W	1	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	✔
Never Events	W	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%	75.9%		>=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	1	0	0	0	1	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	3	1	0	0	1	0	2	0	0	1	3	1		No Threshold	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%		>=95 % >=90 % <90 %	✔
Complaints	W	10	15	11	23	5	9	15	10	12	13	13	14	9		No Threshold	
PALS	W	65	68	88	110	101	119	150	122	88	148	136	141	107		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	W	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%		No Threshold	
ED: 95% Treated within 4 Hours	D	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%		>=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	10	5	7	12	13	7	13	13	12	32	23	56	23		<=20 N/A >20	✔
28 Day Breaches	W	3	3	1	2	4	3	0	3	8	5	11	12	25		0 N/A >0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	60.9%	61.1%	63.2%	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	10,443	10,648	11,453	11,892	11,110	11,564	11,414	12,096	13,286	13,092	18,495	18,976	19,127		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	W	184	222	307	361	283	235	204	187	195	263	318	250	218		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%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%		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	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%		>=99 % N/A <99 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%		100 % N/A <100 %	✔
PFI: PPM%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	97.0%	99.0%			>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	W	687	243	591	3,825	-954	593	392	-588	-50	836	-853	382	166		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	1,610	-1,979	-3,207	-5,794	-910	974	13	162	234	-339	-221	-159	406		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	110,776	110,776	110,871	92,708	92,708	88,440	82,001	82,006	82,121	88,514	94,111	91,971	90,450		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	235	228	2,310	18,172	-494	716	1,598	2,981	-1,713	2,767	-2,609	149	1,475		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-192	-373	-387	-13,171	-308	-370	-545	553	71	-2,466	2,477	676	-15		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	644	387	-1,333	-1,176	-153	247	-661	-4,122	1,591	534	-720	-443	-1,293		>=-5% >=-20% <-20%	✔
AvP: IP - Non-Elective	W		747	731	1,066	-97	-100	1,291	-185	-141	-67	1,373	1,365	1,258		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W		340	357	455	-89	-62	451	-22	-113	-81	400	385	322		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W		1,514	1,611	2,091	201	23	2,137	305	-91	219	1,971	2,173	1,825		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W		23,261	23,039	27,507	2,356	5,021	28,144	5,792	1,191	6,071	25,298	28,581	22,197		>=0 N/A <0	✔
PDR	W	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%		No Threshold	✔
Medical Appraisal	W	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%		No Threshold	✔
Mandatory Training	W	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%		>=90 % >=80 % <80 %	✔
Sickness	D	5.6%	7.2%	5.7%	4.7%	4.6%	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.2%	7.4%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.1%	2.3%	1.2%	1.2%	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.6%		<=1 % N/A >1 %	✔
Long Term Sickness	D	4.5%	4.9%	4.5%	3.6%	3.5%	3.9%	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.8%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	1,392	1,373	1,279	2,272	1,071	1,040	960	1,130	1,096	1,368	1,137	1,590	1,520		No Threshold	✔
Staff Turnover	D	9.0%	9.0%	8.8%	8.8%	9.4%	9.7%	9.3%	9.7%	9.7%	10.2%	10.7%	11.2%	10.9%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	90.4%	94.4%	97.7%	97.7%	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%		>=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

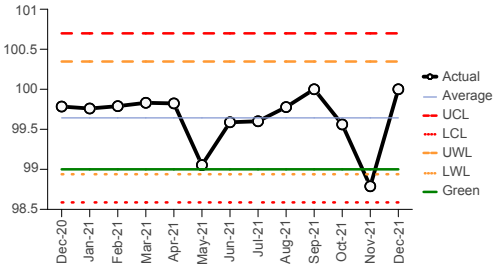
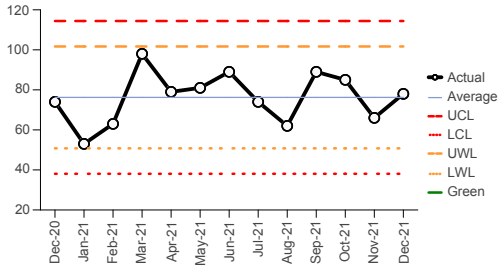
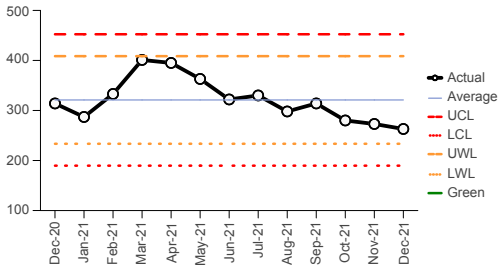
		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	76	80	80	90	100	103	108	117	125	132	139	142	145		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	36	36	36	36	34	36	38	37	38	40	43	44	42		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	4	1	0	6	7	2	3	7	3	7	7	4	1		>=3	>=2	<2	
Number of New Studies Opened - Commercial	W	0	0	0	2	0	3	1	1	0	2	3	3	0		>=1	N/A	<1	
Number of patients recruited	W	182	504	403	105	1,055	1,039	896	439	1,060	983	931	1,038	816		>=100	>=86	<86	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	100 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nicki Murdock **Committee:** SQAC	78	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	263	No Threshold		

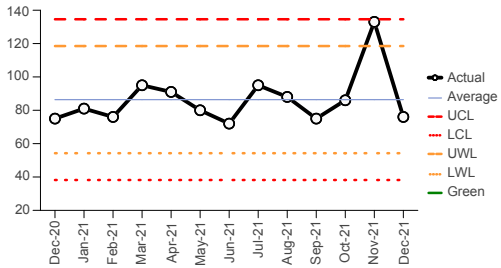
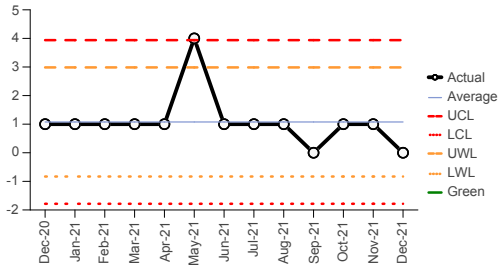
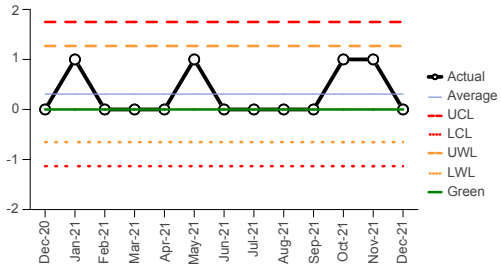
Delivery of Outstanding Care

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

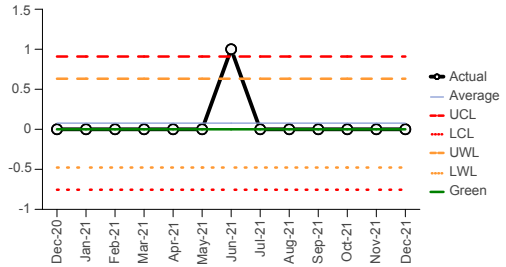
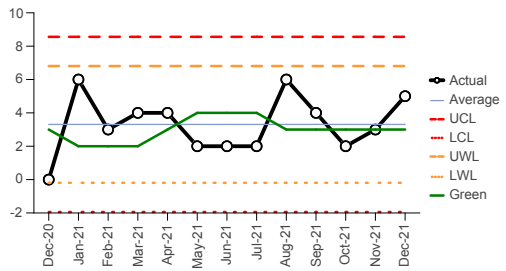
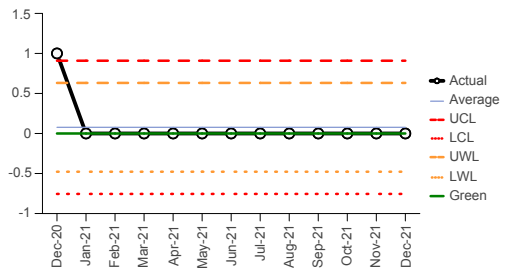
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

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 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	5	R >3 A N/A G <=3		5 incidents of harm reported this month: 1. Clonidine infusion was given at a lower rate than intended resulting in inadequate pain relief. 2. Patient missed a medication for 3 days resulting in increased abnormal movements. 3. Patient received 2 doses of medication within 2 hour in error requiring additional tests. 4. Patient exceeded 4 doses of Paracetamol in 24 hours requiring a blood test to ensure no harm. 5. Patient did not receive analgesia for over 12hrs resulting in pain and distress.
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

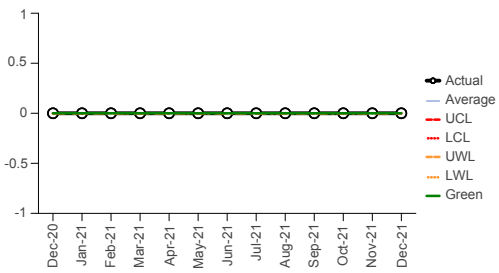
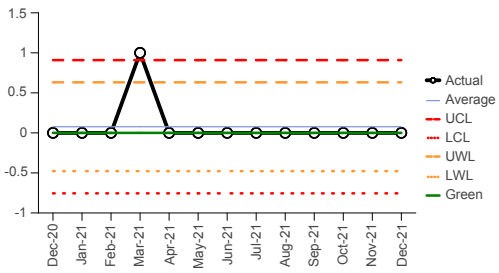
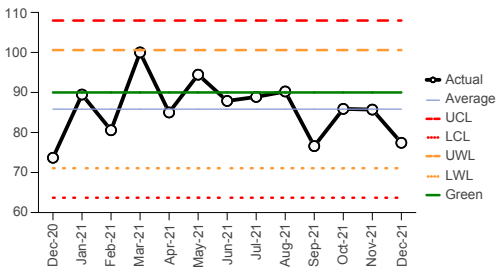
Delivery of Outstanding Care

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	77.42 %	R <90 % A N/A G >=90 %		Fourteen patients did not receive antibiotics within 60 minutes and 6 within 90 minutes; 7 were due to difficulty gaining intravenous access or difficulty carrying out lumbar puncture, 1 patient required stabilising initially, 1 was delayed due to no suitable gripper needles within the department, 1 had a delay in prescribing, 3 had no clear cause for delay and were incidented for further investigation and 1 was slightly over by 5 minutes

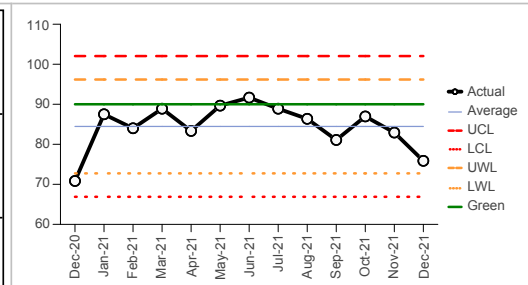
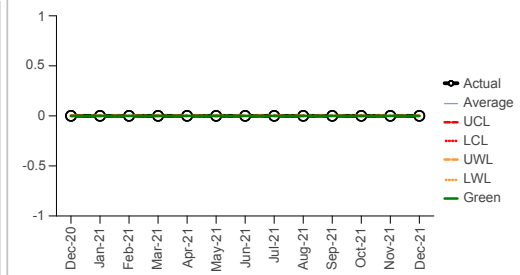
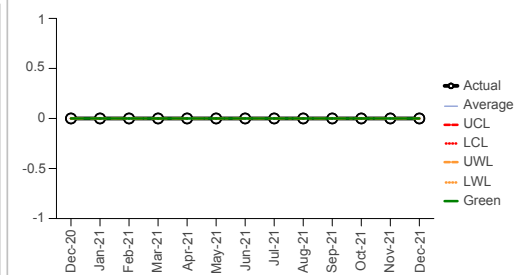
Delivery of Outstanding Care

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	75.86 %	R <90 % A N/A G >=90 %		No patients came to harm/had further clinical deterioration however numerous factors in relation to delays, incorrect initial prescription, availability of nursing staff to check IVAB, difficulty in gaining IV access. Divisions/wards updated and encouraged to seek support from all services where able during difficult times. Higher number of patients identified with a positive microbiology result which shows good awareness of locating source of infection and reducing potential for sepsis developing.
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

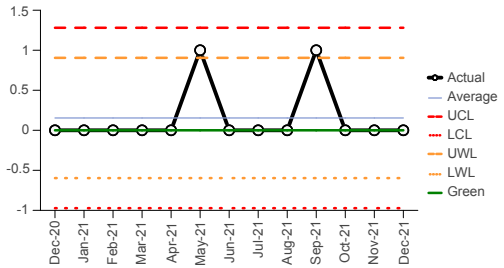
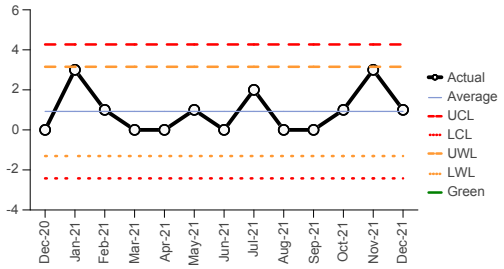
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

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	1	No Threshold		HAI case PICU 1m baby with complex cardiac condition known to be colonized with MSSA probable Line sepsis

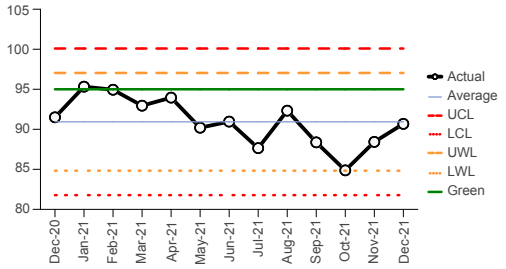
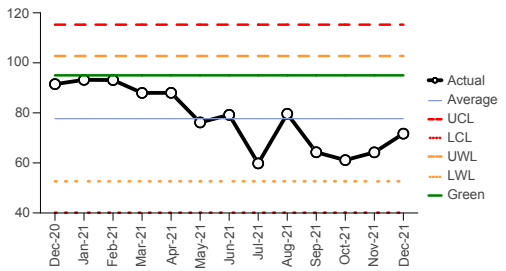
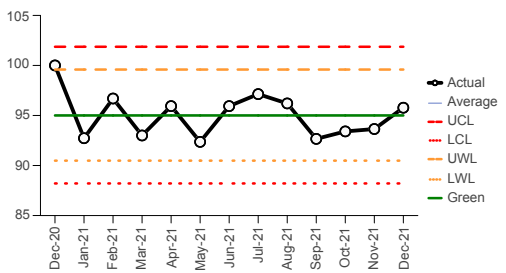
The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

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	90.68 %	R <90 % A >=90 % G >=95 %		FFT - In December 2021, there were 1,108 responses to the Family & Friends Test out of a possible average of 35,096, (Nov 2021) which gave an overall Trust FFT percentage of 90.66%. who found their experiences to be either good or very good? This is a 2% increase compared to November. Medicine and community have both increased from the previous month by 3% this is a 10% increase for medicine since October. Surgery has had a slight increase to 95% this month.
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	71.69 %	R <90 % A >=90 % G >=95 %		A&E data has increased by 7% from the previous month, but is slightly lower than the month of august (80%). This relates to high number of attendances which impacted on patient experiences due to long waiting times. When respondents were asked how we could improve only 80 comments highlighted waiting times, this is a significant improvement on the previous lower months. One comment highlighted "Amazed with the waiting time, expected a very long wait. Staff were courteous and kind."
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	95.77 %	R <90 % A >=90 % G >=95 %		No Action Required

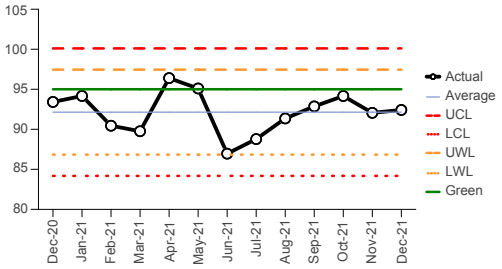
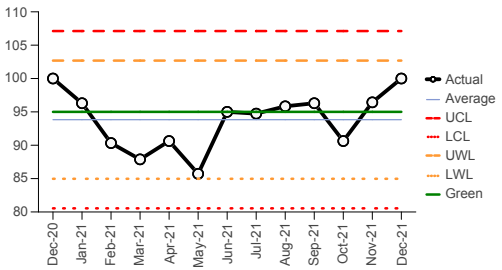
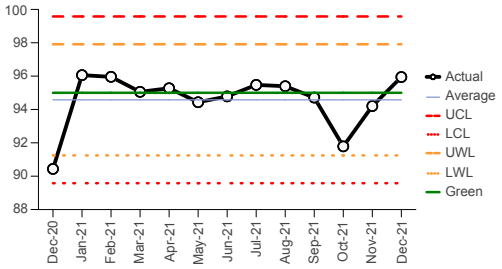
The Best People doing their best Work

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	92.41 %	R <90 % A >=90 % G >=95 %		In December there has been a slight improvement in comparison to previous month (92%), with 145 responses. Medical day case Unit, Ward 4B and 1B had the greatest decline in comparison to October. Positive comments highlighted: "Excellent care, I genuinely can't think of how the service could be improved". Negative comments: made suggestion for waiting times for appointments and surgeries were an issue, if surgeries are cancelled many parents advised they would like to know what is next.
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	100 %	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	95.94 %	R <90 % A >=90 % G >=95 %		No Action Required

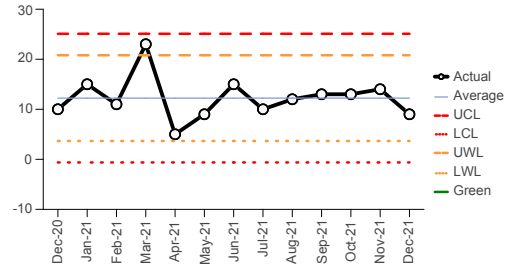
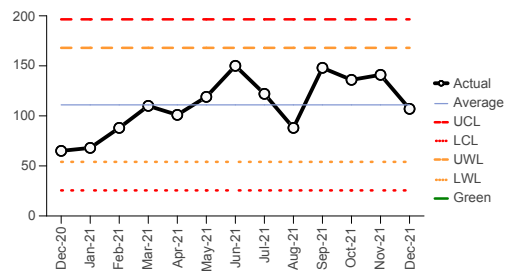
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

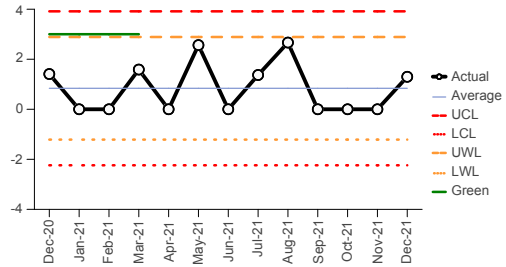
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nicki Murdock **Committee:** SQAC	9	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	107	No Threshold		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

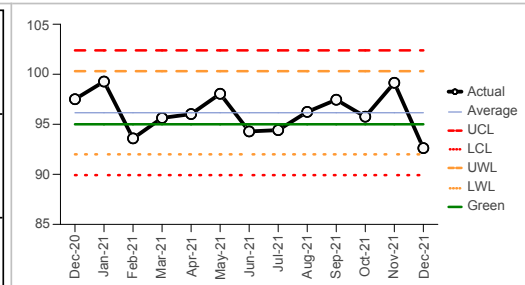
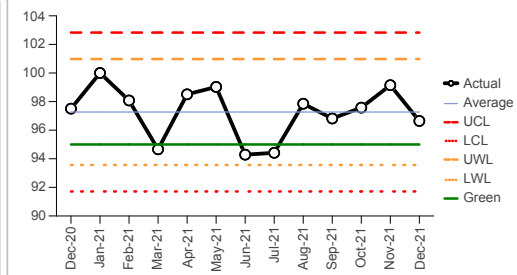
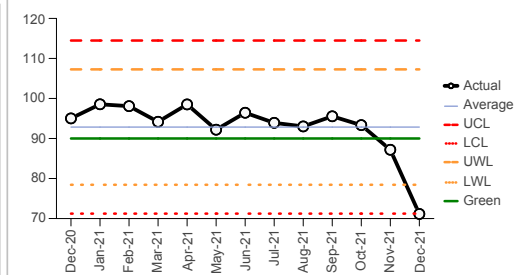
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally 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	1.30 %	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	92.62 %	R <90 % A >=90 % G >=95 %		This is a decline from the previous high of 98%. The survey response rates have been lower than previous months. Comments have highlighted that the care offered is sometimes unclear for a non medical person and some plans that are in place for the patient is unclear also. As increasing response rates will be a strong focus next month to ensure we have accurate consistent information that we can build and improve on.
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	96.64 %	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	71.14 %	R <85 % A >=85 % G >=90 %		There has been a significant decline in the month of December with regards to discharge. The main area affected was the medicine division. The survey response rates have been lower than previous months. Comments have highlighted that the discharge process is often longer than it needs to be and unclear. Other comments have highlighted that the process is inefficient and needs to be reviewed, as there needs to be better communication between different departments .

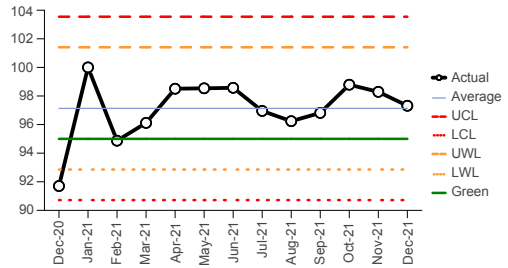
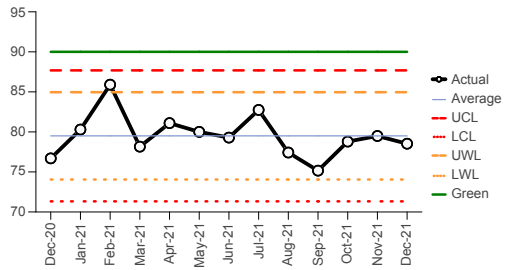
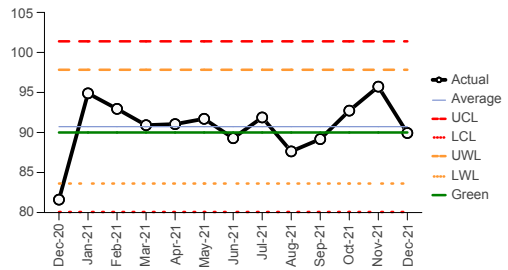
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % 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	97.32 %	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	78.52 %	R <85 % A >=85 % G >=90 %		There has been a plateau with play the month of December. When looking through comments many parents/patients werent sure that this service existed. Due to current situation many staff members have been absent due to COVID and filling in these gaps are a priority to ensure that this figure is improved in the future.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	89.93 %	R <85 % A >=85 % G >=90 %		The month of December has seen a decline due to the school holidays coming in at the end of the year. This has affected the overall score for this month and should see an improvement next month.

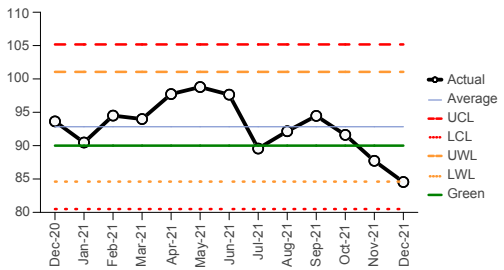
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

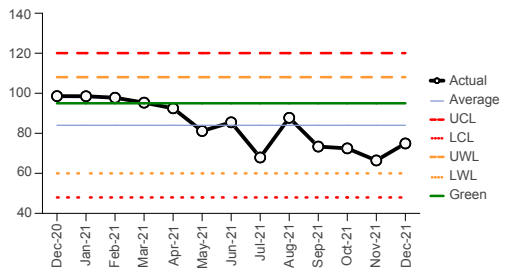
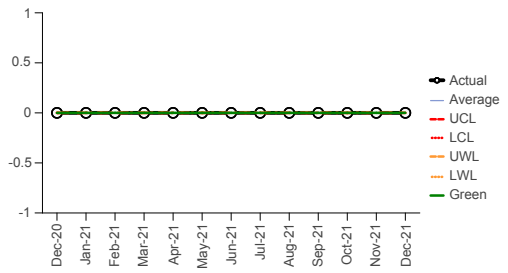
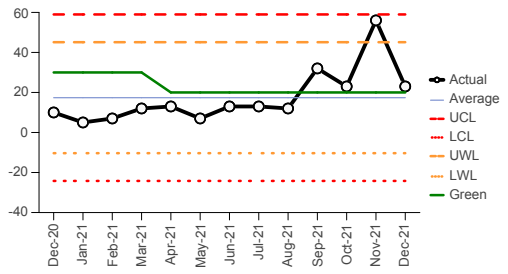
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	84.54 %	R <90 % A N/A G >=90 %		The Safer Staffing meeting is Chaired by an Associate Chief Nurse in hours or Patient Flow at weekends; designated senior nursing staff are allocated to review staffing for their Division and make plans to maintain safe staffing levels. Due to sickness, staff availability has been reduced. All staffing has been maintained with the Green, Amber, Red model devised and agreed to manage staffing at times of winter pressure or surge. In response to the NHSE/I paper published in November 2021: Winter 2021 preparedness: Nursing and midwifery safer staffing, report has been provided to 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.

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

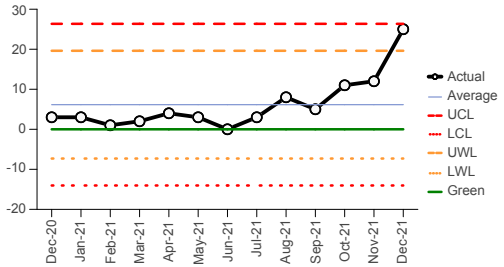
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	74.92 %	R <95 % A N/A G >=95 %		ED performance is still deteriorating against the 95% target. This is due to Staffing pressures due to COVID isolation guidelines. Acuity of patients and clinically unwell patients too. There was also a problem with Bed capacity due to ward staffing Issues.
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	23	R >20 A N/A G <=20		Although still non-compliant with target, significant improvement from previous month. Majority cancelled due to bed capacity on the day and patient sickness.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	25	R >0 A N/A G 0		All previously cancelled patients have a new TCI date, a number of which are just outside of 28 day target due to clinical priorities and limitations in rebooking Covid positive patients.

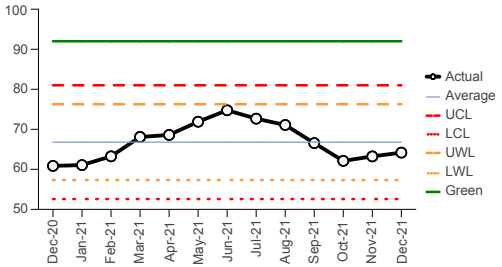
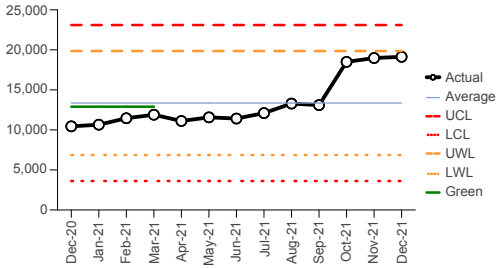
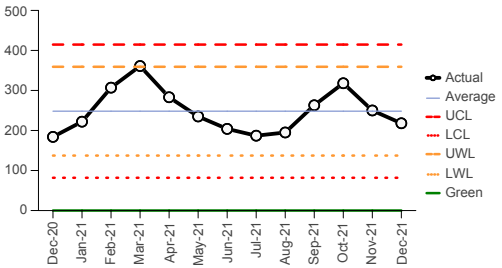
Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

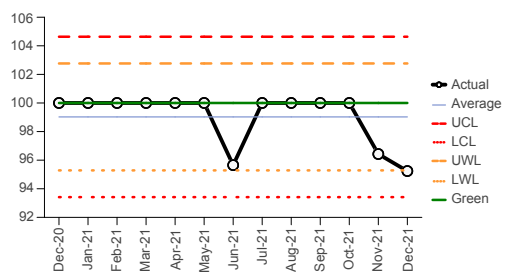
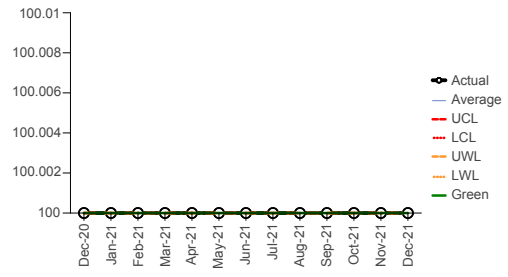
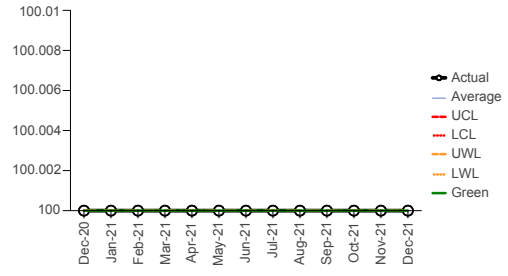
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	64.17 %	R <90 % A >=90 % G >=92 %		RTT compliance remains a challenge but has increased month on month since September. Targeted work is underway to continue to bring the division closer to compliance. January has the added challenge of reduced theatre capacity due to Covid surge plans but the division is planning to increase within the coming weeks.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	19127	No Threshold		
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	218	R >0 A N/A G 0		The number of patients waiting over 52 weeks continues to decrease despite capacity challenges.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	95.24 %	R <100 % A N/A G 100 %		Last month saw 1 breach of the 2 week wait cancer standard. The patient was offered an appointment earlier in the pathway, however this was declined by parents. Patient accepted appointment to be seen on day 8, however parent phoned to cancel the appointment on the day, due to having covid. The patient was rebooked and seen on day 15, so this pathway breached by 1 day.
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

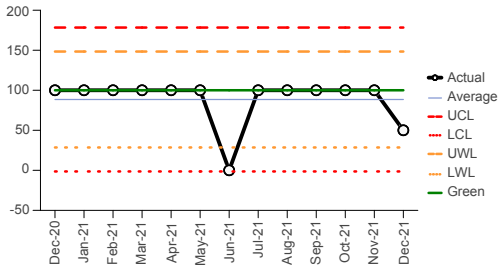
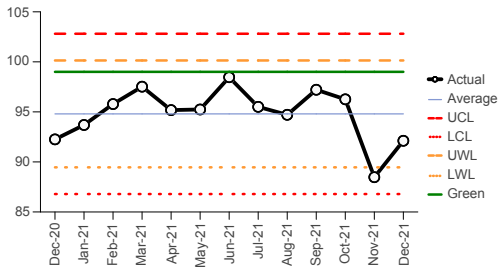
Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
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	50 %	R <100 % A N/A G 100 %		Last month saw 1 breach of the 31 day treatment target. Patient was referred on 2 week wait pathway and seen within target. Patient received appropriate imaging and discussed at MDT where an incidental lesion found on site that was different to that of original referral. Patient referred to specialist team at RLUBTH, where further imaging, MDT discussion and clinical input required. Surgery required with input from both AH & RLUBTH surgeons. Surgery was performed on Day 49 so a breach of 18 days.
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	92.11 %	R <99 % A N/A G >=99 %		Gastroscopy performance dropped to 65% in month due to a large volume of short notice cancellations which could not be backfilled due to bowel prep. The service are reviewing the cancellation data to identify if there is any opportunity to catch these patients sooner.

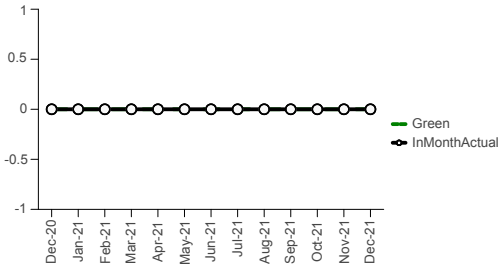
The Best People doing their best Work

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

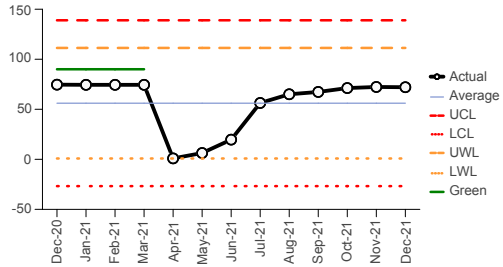
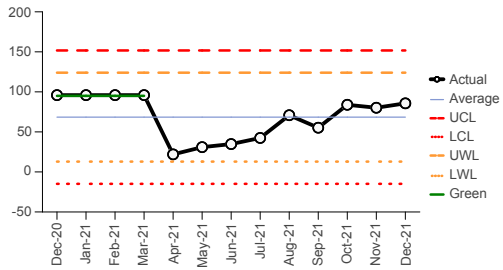
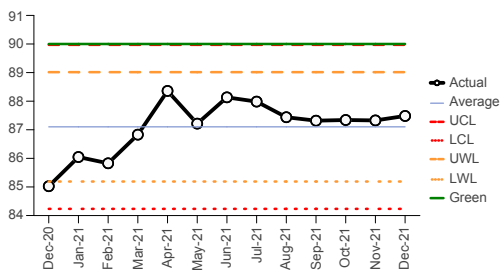
The Best People doing their best Work

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	72.04 %	No Threshold		As of the 31st December 2021, our Trust appraisal rate was 72.04%, 18% 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	85.66 %	No Threshold		We have recently completed the first appraisal year using the birth month of each appraisee. The model has been successful and we have achieved 93% compliance which will increase by the end of January when the December appraisals have been completed.
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	87.48 %	R <80 % A >=80 % G >=90 %		As of the 31st 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.

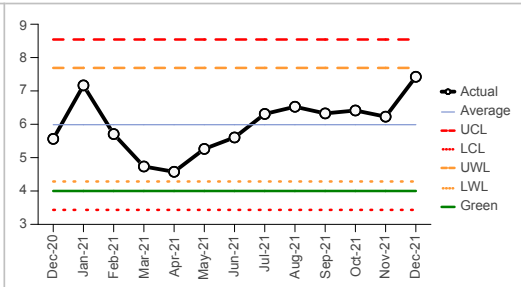
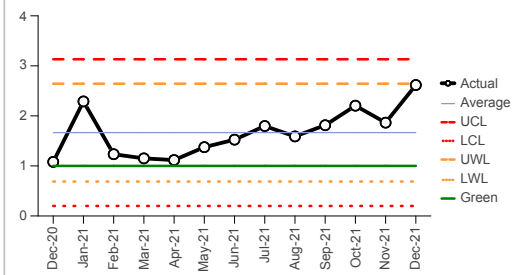
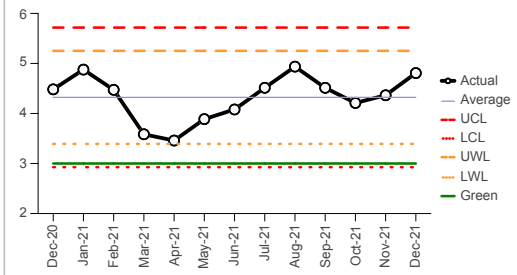
The Best People doing their best Work

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	7.42 %	R >4.5 % A <=4.5 % G <=4 %		The Trust, like other NHS employers is currently experiencing an increase in absence levels linked to the COVID pandemic and other winter pressures. The number of staff absent from work (COVID and non-COVID) is fluid in nature as the picture alters daily, however an increase to 10%+ is currently being recorded. Staff availability is under particular scrutiny, with a daily update being provided to Tactical Command / Daily Operations Group; information from which feeds into Safer Staffing meetings.
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	2.62 %	R >1 % A N/A G <=1 %		As part of this: • The Track and Trace process for SMART and Advanced SMART release schemes have been confirmed and additional resources identified. • HR continue to up-to-date Manager's guidance/FAQ's in relation to the emerging advice around support for Covid absences. • HR have updated and relaunched FAQ's including use of Annual Leave. • The Recruitment team have been successful in reducing the Time To Hire time to fall in line with the KPI, supporting new employees to enter the organisation as quickly as possible.
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	4.81 %	R >3 % A N/A G <=3 %		• The HR BP team are robustly monitoring absence, assisting managers to utilise the sickness absence policy to support people who are off ill and facilitate prompt return to work for colleagues, wherever possible, including the identification of reasonable adjustments etc; ensuring return to work discussions take place and that well-being remains high on the agenda. • Line Manager training on the topic of Attendance Management training is currently being developed and will be launched shortly.

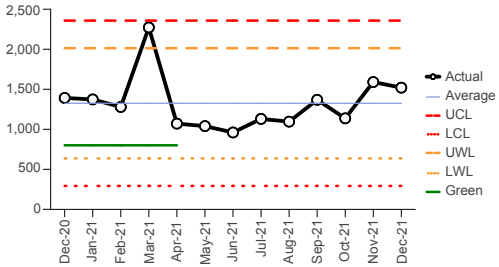
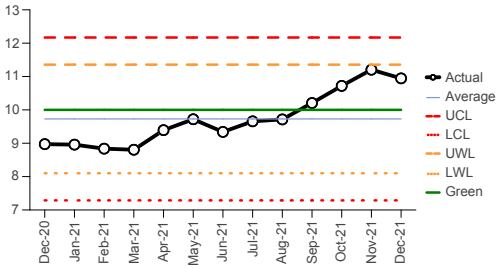
The Best People doing their best Work

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	1520.11	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	10.94 %	R >11 % A <=11 % G <=10 %		Turnover is an increasing area of focus across the Trust as it has recently been subject to an increase in the % of staff leaving. An initial analysis has been undertaken, which has been reported to PAWC; the finding of which includes that the largest reason for people leaving the organisation is linked to career progression / development opportunities. Therefore, there is an intention for this to be considered as part of workforce planning / career development discussions going forward, to support the Trust to be future proofed from a staffing availability perspective.

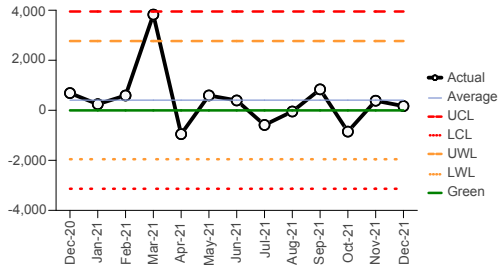
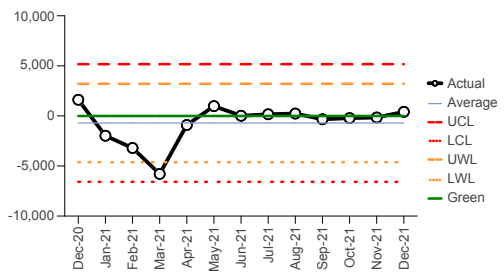
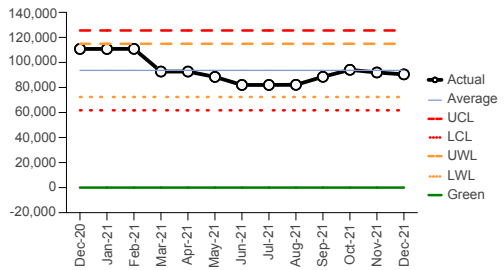
The Best People doing their best Work

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	166	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	406	R <-10% A >=-10% G >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	90,450	R <-20% A >=-20% G >=-5%		No Action Required

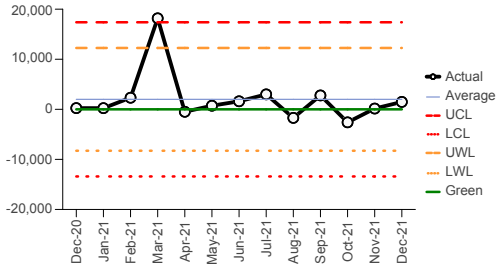
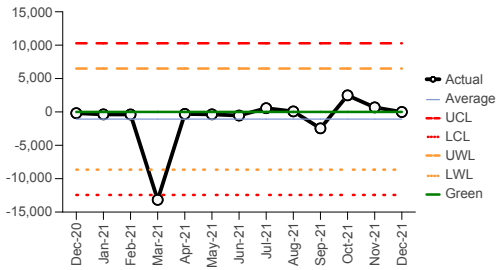
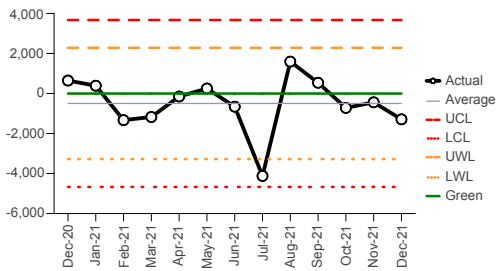
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,475	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	-15	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	-1,293	R <-20% A >=-20% G >=-5%		

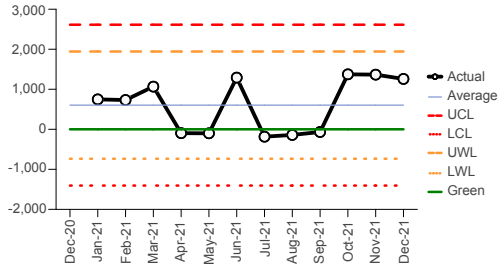
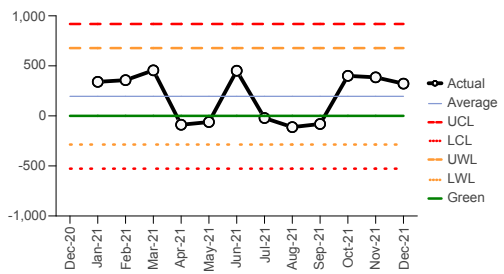
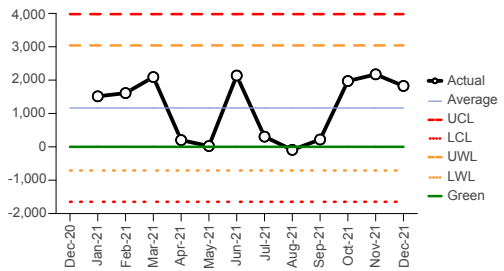
The Best People doing their best Work

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	1258	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	322	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	1825	R <0 A N/A G >=0		No Action Required

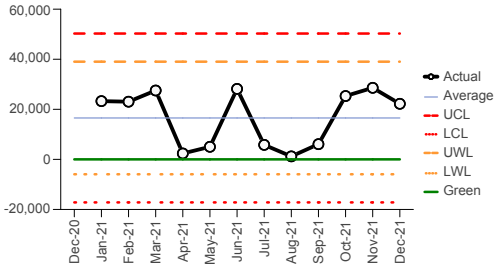
The Best People doing their best Work

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	22197	R <0 A N/A G >=0		No Action Required

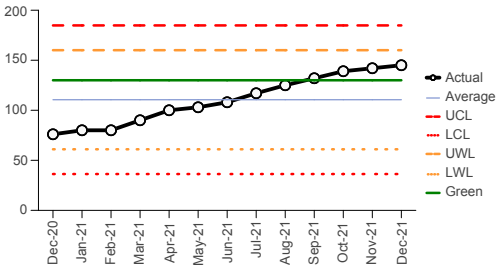
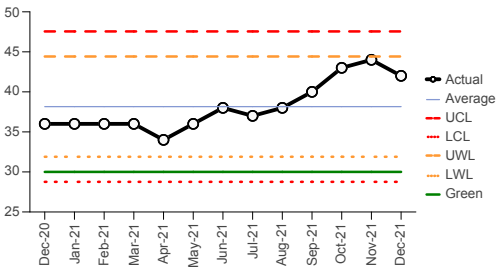
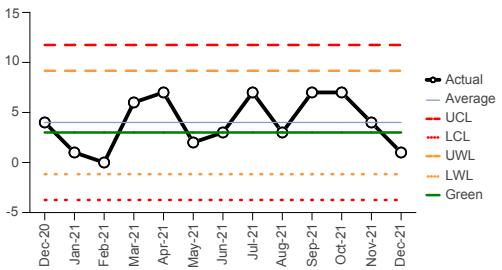
Game Changing Research & Innovation

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	145	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	42	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	1	R <2 A >=2 G >=3		

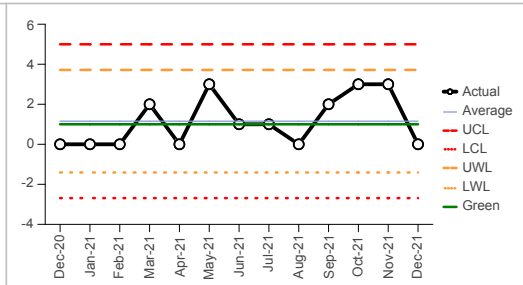
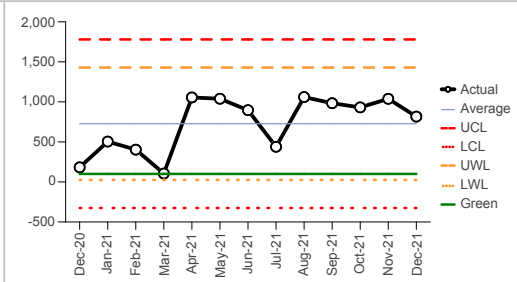
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

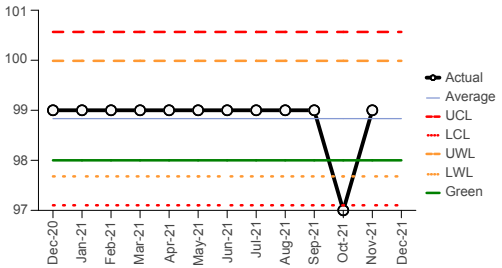
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	0	R <1 A N/A G >=1		
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	816	R <86 A >=86 G >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

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

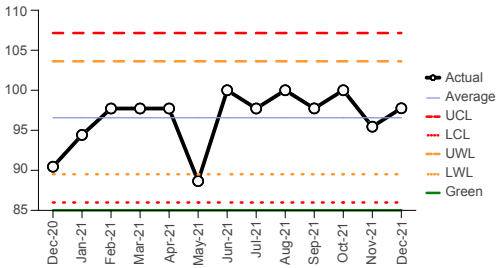
The Best People doing their best Work

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	97.75 %	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	5	49	22	No Threshold
Clinical Incidents resulting in No Harm	D	28	102	127	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	5	18	39	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	1	4	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%	75.0%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	1	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	3	2	4	No Threshold
PALS	W	25	43	33	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			1.3%	No Threshold
ED: 95% Treated within 4 Hours	D		74.9%		>=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	0	23	No Threshold		
28 Day Breaches	W	0	2	23	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		92.5%	92.7%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		98.1%	95.8%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		58.5%	78.1%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		96.2%	97.9%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		73.6%	81.2%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		92.5%	88.5%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	56.9%	67.4%	63.5%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,563	5,943	11,621	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	15	202	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		95.2%		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		92.3%	83.3%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		50.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	185	87	-657	No Threshold
Income In Month Variance (£'000s)	W	118	829	59	No Threshold
Pay In Month Variance (£'000s)	W	-9	70	-331	No Threshold
Non Pay In Month Variance (£'000s)	W	76	-813	-385	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	0	857	401	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	91	231	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,144	681	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	3,754	7,321	9,204	>=0	N/A	<0
PDR	W	83.6%	73.7%	60.9%	No Threshold		
Medical Appraisal	W	84.6%	80.3%	91.0%	No Threshold		
Mandatory Training	W	91.1%	86.7%	87.6%	>=90 %	>=80 %	<80 %
Sickness	D	5.7%	9.2%	0.0%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.7%	3.4%	0.0%	<=1 %	N/A	>1 %
Long Term Sickness	D	4.0%	5.8%	0.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	273	370	535	No Threshold		
Staff Turnover	D	11.1%	10.1%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	96.8%	79.3%	87.0%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Weekly meetings take place to review all incidents reported within the Medicine Division with senior management. The division continues to work with the staff to ensure the incidents are closed in a timely manner. Closure process should include quality assurance review of the cause group and type of incident therefore ensuring reporting of trends and themes is accurate. Themes: •Medication incidents: Medicines Safety Officer attends DIG to highlight any areas of the concerns and provides link with trust wide medication committee. She attends the weekly incident review meeting to advise on any actions required following an incident reported. •Access incidents: the highest area of reporting is AED due to the pressures this area is currently under with volume of work, staffing issues and waiting times. Actions – reviewing ongoing issues daily in huddles to identify are areas that require action. **Sepsis:** Q3 = 86% for 60minute target Q3 = 94% for 90minute target. Difficult to identify specific reasons for delay. In some cases difficult IV Access. However, noted an increase in administration time linked to nursing documentation reporting poor staffing levels. Escalation occurred and a number of patients requiring sepsis bundle management. 90 minute target for Oct/Nov/Dec 94% which is very good especially in relation to the activity and acuity across the medical division	**Highlight** • Good levels of incident reporting have been maintained. **Challenges** • RCAs completion on time – we currently have two that we have requested extensions from the CCG for. • Incidents remain open on Ulysses for extended periods. • Attendance of senior staff to weekly incident review to allow good discussions and dissemination of information.
CARING	**Complaints**: No significant themes noted but process of responding to the complaints within the time frames required is under review. New process with tighter turnaround time frames under development to increase awareness of the requirement to respond to provide an excellent family/patient experience. Lessons learnt and actions to be taken will now be including in the responses, recorded on a log and monitored to provide assurance the issues have been taken seriously and the division has learnt from this. **FFT**: Access to the FFT system and reports has now been given to the Risk and Governance Lead to allow analysis of the data to be carried out effectively and themes can be picked up and actions agreed to improve patient/family experiences. Area with highest % of poor/very poor experiences to be starting point.	**Highlight** • Historic complaints within the division have been reduced with only 2 outstanding but progress being made to close asap. **Challenges** • FFT data to be reviewed to identify themes and areas of concern has not been completed yet due to workload.

EFFECTIVE	The Divisions performance against a range of indicators remains challenging; COVID absence and patient availability is a factor; The Divisional General Manger is undertaking a review of the Performance meeting terms of reference and Cross Trust Access to Care meetings remain focused on sustained improvement.	**Highlight** • **Challenges** • ED performance against the 4 Hour Quality standard remains challenged, with some improvement in months; not included in the report but recorded and reported via Trust Gold Command the team have continued to improve against the time to clinician standard of 60 mins with median time now at 77 minutes.
RESPONSIVE	Recovery of 52-week RTT breaches continues with challenges remaining in the Sleep service; a refresh of Cancer performance reporting is underway by the Divisional General Manager. Cleansing of the OP and IP new PTL's is identifying and rectifying data quality issues.	**Highlight** ▪ Continue to maintain the Cancer FDS performance **Challenges** ▪ Diagnostics challenges remain; the Division has commissioned a review of the Diagnostics PTL management.
WELL LED	Sickness absence rates remain a significant cause for concern, impacted further by COVID absences.	**Highlight** • Managers are referring staff to Occupational Health for guidance on how to support employees to remain in work, demonstrating support through a proactive and preventative approach. **Challenges** • Focus in key areas with the support of the HR/OD teams e.g. ED and Pharmacy • Review of all LTS and triggers to be presented to Divisional team w/c 17th January • Return to Work Interviews taking place within 2 days is an area of concern e.g. ED.

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	22	18	23	33	42	32	35	31	28	31	36	27	49		No Threshold
Clinical Incidents resulting in No Harm (D)	99	89	97	125	123	125	91	100	99	134	95	86	102		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	19	21	17	19	23	24	17	18	17	15	29	24	18		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	1	1	0	2	1	1	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	1	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	0	4	1	2	0	0	1	0	2	3	1	0	1		No Threshold
Medication Errors (Incidents)	36	34	28	39	29	42	26	14	20	35	25	20	30		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	1	0	2	4	1	3	2	0	2	1	6	7	4		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)	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%	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	1	0	0	0	1	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	2	2	2	1	5	0	0	2	3	3	4	2	1		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	1	1	0	0	0	0	0	0	0	1	1	0		No Threshold
Cleanliness Scores	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%		No Threshold
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	71.3%	53.9%	68.2%												>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	85.0%	85.0%	84.0%												>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes		100.0%	100.0%												>=90 % N/A <90 %

CARING

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Complaints (W)	6	8	3	12	4	5	2	4	4	3	5	6	2		No Threshold
PALS (W)	27	25	20	37	25	23	41	41	25	48	50	48	43		No Threshold

EFFECTIVE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Referrals Received (Total)	1,707	2,091	1,695	2,238	2,143	2,244	2,413	2,259	1,919	2,467	2,607	2,667	2,999		No Threshold
ED: 95% Treated within 4 Hours (D)	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%	6.1%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	1	0	1	4		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	1	0	0	3		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	7.9%	9.0%	7.9%	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%	9.1%	9.6%	9.9%		No Threshold
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

Medicine

D Drive W Watch P Programme

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Theatre Utilisation - % of Session Utilised (W)	84.0%	83.7%	87.8%	86.3%	86.6%	81.9%	80.1%	82.4%	80.2%	82.7%	81.4%	80.7%	72.7%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	2	0	0	1	2	0	1	0	3	2	3	5	0		No Threshold
28 Day Breaches (W)	0	1	0	0	0	0	0	0	0	1	1	2	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	47	16	14	18	21	19	21	37	42	30	43	45	40		No Threshold
OP Appointments Cancelled by Hospital %	13.4%	12.3%	12.4%	11.6%	9.9%	10.7%	11.6%	15.1%	15.2%	14.2%	15.8%	12.6%	12.4%		<=5 % N/A >10 %
Was Not Brought Rate (W P)	10.5%	11.2%	9.4%	9.0%	9.3%	8.8%	9.7%	11.5%	12.0%	10.0%	9.5%	9.5%	10.0%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	11.5%	11.7%	10.9%	9.4%	12.3%	10.2%	11.2%	10.5%	11.3%	9.2%	9.7%	8.6%	9.2%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	10.3%	11.1%	9.1%	9.0%	8.7%	8.5%	9.4%	11.7%	12.2%	10.1%	9.5%	9.7%	10.1%		<=14 % <=16 % >16 %
Coding average comorbidities	5.50	5.45	5.54	5.41	5.14	5.17	5.58	5.47	5.58	5.49	5.67	5.57	5.47		No Threshold

RESPONSIVE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care (W)	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect (W)	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge (D P)	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care (W)	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%	97.8%	93.1%	87.2%	90.2%	100.0%	94.9%	96.2%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play (D)	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning (D)	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks (W)	88.1%	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%		>=92 % >=90 % <90 %
Waiting List Size (W)	1,785	1,731	2,110	2,280	2,509	2,819	3,122	3,338	3,507	3,565	5,605	5,842	5,943		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways (W)	0	1	16	4	4	3	6	11	7	13	23	10	15		0 N/A >0
Waiting Times - 40 weeks and above	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%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. (W)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments (W)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks (W)	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%		>=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%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%	88.2%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%		>=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	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%		>=99 % N/A <99 %

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

WELL LED

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	41	189	160	-586	263	200	-1,036	-347	-58	253	-127	-199	87				
Income In Month Variance (£'000s)	W	142	10	36	170	37	-26	-1	209	-490	201	-184	1,138	829				
Pay In Month Variance (£'000s)	W	30	-61	-52	-148	-64	60	-150	48	47	121	-35	15	70				
AvP: IP - Non-Elective	W		405	416	676	-153	-78	807	-82	-19	-42	1,002	954	857		>=0	N/A	<0
AvP: IP Elective vs Plan	W		123	139	154	-16	-10	160	-25	-58	-25	119	122	91		>=0	N/A	<0
AvP: OP New			1,180.00	1,087.00	1,229.00	-383.97	-406.28	1,295.00	-508.93	-569.20	-322.45	1,323.00	1,378.00	1,028.00		>=0	N/A	<0
AvP: OP FollowUp			5,810.00	5,212.00	6,141.00	1,657.17	1,398.80	6,484.00	1,172.46	1,137.03	1,715.47	5,676.00	6,351.00	5,639.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,009	1,041	1,279	261	216	1,346	262	111	413	1,240	1,345	1,144		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W		7,832	7,399	8,528	828	699	8,786	86	-83	805	7,586	8,410	7,321		>=0	N/A	<0
PDR	W	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%				
Medical Appraisal	W	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%				
Mandatory Training	W	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%	86.7%		>=90 %	>=80 %	<80 %
Sickness	D	4.9%	6.4%	5.2%	4.2%	4.5%	5.5%	5.3%	6.4%	7.2%	6.4%	6.6%	7.4%	9.2%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.3%	2.0%	1.4%	1.1%	1.2%	1.5%	1.6%	2.0%	1.9%	1.8%	2.3%	2.2%	3.4%		<=1 %	N/A	>1 %
Long Term Sickness	D	3.7%	4.3%	3.8%	3.1%	3.4%	4.0%	3.7%	4.4%	5.3%	4.6%	4.3%	5.1%	5.8%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	213	247	267	261	210	262	230	265	263	292	311	373	370				
Staff Turnover	D	7.2%	6.6%	6.5%	6.0%	6.5%	6.8%	7.3%	7.5%	8.3%	9.4%	9.6%	9.9%	10.1%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%		>=90 %	>=80 %	<90 %

Surgical Division		
SAFE	• Slight increase in clinical incidents (no harm) 118>124 • Increase in medication error causing harm 1<1<3<4 • Highest cleanliness scores in over 12 months at 99.3%	**Highlight** • Significant reduction in month of clinical incidents resulting in near miss and minor non-permanent harm • 0 incidents resulting in moderate and severe harm **Challenges** • Reduction in % of patients treated for Sepsis within 60 minutes- 75% compared to previous month 82%
CARING	• Reduction in formal complaints and PALS	**Highlight** • **Challenges** •
EFFECTIVE	• Reduction in elective LOS • Increase in NEL LOS • 33 CCAD cases despite CC capacity constraints	**Highlight** • Theatre utilisation improved significantly- 95.5% • Cancelled operations on the day almost halved 51>23 • **Challenges** • Increase in 28 day breaches- mainly due to Covid restrictions & theatre session reduction • WNB rate continues to increase month on month- 10.3% (highest proportion News) •
RESPONSIVE	• Overall waiting list size continues to grow- 11,621 (April 2021- 7773)	**Highlight** • RTT compliance continues to increase (marginally) at 63.5% • Patients waiting over 52 weeks reduced significantly despite pressures- 239>196 **Challenges** • Diagnostics compliance low- new reporting for Urodynamics
WELL LED	• Mandatory training increased at 87.6% • Medical appraisal rates increased at 91% • HR metrics not available	**Highlight** • **Challenges** • Safer staffing shift fill rate decreased at 87%

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	31	24	25	46	23	32	43	26	25	42	32	32	22		No Threshold
Clinical Incidents resulting in No Harm (D)	143	108	140	174	166	165	163	119	114	107	103	118	127		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	42	38	27	33	35	28	38	32	49	39	43	81	39		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	1	0	0	1	2	0	0	1	0	1	1	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	1	1	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	1	2	2	4	2	1	2	3	1	1	3	4		No Threshold
Medication Errors (Incidents)	44	23	40	45	43	36	29	24	27	26	21	28	29		No Threshold
Pressure Ulcers (Category 3) (W)	1	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
Never Events (W)	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%	88.9%	66.7%	100.0%	75.0%	82.6%	82.4%	75.0%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	1	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	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	0	2	0	0	0	1	0	2	0	0	0	2	1		No Threshold
Cleanliness Scores	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%		No Threshold

CARING

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Complaints (W)	2	2	3	7	0	4	5	3	4	6	4	6	4		No Threshold
PALS (W)	23	16	22	27	34	42	43	33	25	30	29	40	33		No Threshold

EFFECTIVE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	1	0	0	1	0	2	0	1	2	0	0	0	1		No Threshold
% Readmissions to PICU within 48 hrs (W)	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%		No Threshold
Referrals Received (Total)	2,812	2,698	2,907	4,045	3,964	4,117	4,371	3,756	3,231	3,887	3,536	3,889	3,077		No Threshold
Theatre Utilisation - % of Session Utilised (W)	85.0%	87.6%	90.3%	89.5%	84.0%	88.8%	85.2%	85.1%	86.8%	85.3%	87.8%	85.5%	95.5%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	8	5	7	11	11	7	12	13	9	30	20	51	23		No Threshold
28 Day Breaches (W)	3	2	1	2	4	3	0	3	8	4	10	10	23		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	45	38	50	37	47	46	59	63	74	54	78	43	51		No Threshold
OP Appointments Cancelled by Hospital %	10.6%	10.6%	10.9%	11.8%	10.1%	10.2%	11.3%	9.8%	11.6%	11.6%	10.9%	9.1%	10.9%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	9.9%	10.3%	7.8%	7.2%	6.1%	6.9%	7.1%	8.8%	9.8%	8.6%	8.8%	9.2%	9.8%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	11.6%	11.5%	10.3%	8.3%	6.9%	8.9%	8.4%	11.2%	11.6%	9.7%	9.5%	10.2%	10.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	9.3%	9.9%	6.9%	6.7%	5.8%	6.1%	6.6%	7.9%	9.1%	8.1%	8.6%	8.9%	9.5%		<=14 % <=16 % >16 %
Coding average comorbidities	4.48	4.40	4.43	4.54	4.63	4.40	4.49	4.62	4.57	4.50	4.50	4.28	4.41		No Threshold
CCAD Cases	28	25	29	34	34	31	39	28	19	23	29	24	33		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%	88.5%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%		>=92 % >=90 % <90 %
Waiting List Size	W	7,858	8,132	8,432	8,701	7,773	7,980	7,484	7,787	8,632	8,319	11,360	11,505	11,621		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	183	221	291	357	276	232	197	174	186	249	294	239	202		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%		>=99 % N/A <99 %

WELL LED

		Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-498	-241	57	-708	-716	217	108	583	-5	-137	-349	-598	-657		
Income In Month Variance (£'000s)	W	34	0	83	152	47	49	209	223	28	-144	-43	68	59		
Pay In Month Variance (£'000s)	W	-394	-360	-157	-526	-599	28	-116	541	-64	-158	-82	-452	-331		
AvP: IP - Non-Elective	W		341	308	390	57	-20	484	-102	-121	-24	371	411	401		>=0 N/A <0
AvP: IP Elective vs Plan	W		217	218	300	-74	-51	290	2	-55	-57	279	263	231		>=0 N/A <0
AvP: OP New			1,955.00	2,065.00	2,601.00	369.54	-64.15	2,827.00	709.90	-106.72	404.80	2,777.00	2,882.00	2,157.00		>=0 N/A <0
AvP: OP FollowUp			6,182.00	6,421.00	7,887.00	-2,414.10	590.79	8,048.00	1,757.00	-1,026.90	1,257.00	7,587.00	8,827.00	5,989.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W		503	570	809	-61	-192	790	41	-203	-195	729	827	681		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W		9,332	9,755	12,062	-1,997	549	12,417	2,771	-1,316	1,947	11,663	13,235	9,204		>=0 N/A <0
PDR	W	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%		
Medical Appraisal	W	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%		
Mandatory Training	W	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%		>=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	415	434	382	542	515	457	332	445	469	532	363	631	535		
Safer Staffing (Shift Fill Rate)	W	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 54288** (Community Physiotherapy and OT) During treatment session, child slipped forwards, banging their chin on the floor. **Improvement** – There are always risks associated with physically challenging a child's physical abilities – staff to continue to dynamically risk assess situations. **Incident 54128** (Tier 4 Inpatient Unit) - Child burnt their right finger whilst making a hot drink in microwave under staff supervision. **Improvement** – Review of crockery used for hot drinks/food to minimise risk of accidental scalds. **Incident 54167** (Rainbow Centre) - Colleague advised that the email address used to contact children's social care had been obtained from the guidance under the Safeguarding section on the intranet and was incorrect. **Improvement** – Contact details changed, and lesson shared with staff to ensure timely updated to contact details across all accessible staff platforms.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 77 incidents reported (38 clinical, 39 non-clinical) • Lowest reported medication errors recorded in December (5 reported). **Challenges** • Significant damage to three rooms in the Catkin building owing to heavy rain and insufficient ceiling protection.
CARING	Improvement changes from complaints: **SO18736** (Developmental Paediatrics) Wait for review for two children – complaint upheld. **Improvement –** Siblings to be given appointments on the same day where possible to avoid families making multiple trips to Alder Hey **SO17842** (ASD/ADHD) Communication concerns in complex case involving separated parents. Complaint upheld. **Improvement –** Both parents to be invited to the start of the ASD assessment process to participate in the assessment and contribute their views. Letters and other information to be sent to both parents where possible.	**Highlight** • 11 Excellent Reports submitted in December • 18 Compliments submitted in December • 95% FFT scores for Community & OPD • 100% FFT scores for Mental Health Services **Challenges** • 26 PALS recorded in December. This is a significant decrease from November (71 recorded) due to a change in process for logging general queries. • 3 formal complaints logged in December (1 x developmental paediatrics relating to a delayed referral. 2 x community SALT relating to waiting times)
EFFECTIVE	Integrated Care Framework Bid commenced with a three-year programme working with partner organisations to support children and young people at risk of exploitation. The programme was presented at the NHSE Vanguard shared learning event in December.	**Highlight** • Reduction in hospital clinic cancellations in December (17 recorded, compared to 41 in November) **Challenges** • Continued high number of calls received to the Crisis Care Service in December (616) and response required from Crisis Care for attendances to ED with a mental health presentation (59 recorded).

RESPONSIVE	There are continued challenges with the achievement of access standards in the division due to significant ongoing referral demand. This is particularly affecting Mental Health Services, the ASD pathway, community paediatrics and SALT. Challenge boards and improvements plans are in place for all services and are monitored routinely through the access to care delivery group.	**Highlight** • ePPF compliance target ensuring no child unaccounted for 30 days after clinic attendance achieved for all services in December 2021. **Challenges** • 2 breaches of the urgent waiting time standard for Eating Disorders. This was due to limited capacity and reduction in working days over Christmas.
WELL LED	Research grant allocated for proposal with Alder Hey as a partner entitled: "Arts for the Blues: Towards integrating the use of the arts in healthcare and cultural settings to tackle depression and improve wellbeing in the North West"	**Highlight** • Mandatory training remains above Trust target at 91.1% for December • Return to Work recording improved to 91.5% in December **Challenges** • Sickness absence levels remain above Trust target at 5.6%. HR support in place for managers offering additional drop-in sessions. • Time to Hire for the division remains higher than target at 50 days (with a target of 42 days).

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	16	5	5	9	7	12	7	11	4	8	4	2	5		No Threshold
Clinical Incidents resulting in No Harm (D)	53	63	75	84	74	54	51	92	65	50	65	56	28		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	9	11	21	35	28	19	11	20	10	14	7	8	5		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	1	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	16	19	17	23	17	9	9	10	8	12	18	13	5		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%				98.6%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Complaints (W)	2	5	4	3	1	0	8	0	3	4	2	2	3		No Threshold
PALS (W)	15	14	39	41	40	50	55	39	34	62	51	48	25		No Threshold

EFFECTIVE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Referrals Received (Total)	847	776	884	1,106	911	1,317	1,324	1,061	726	1,019	1,116	1,229	1,016		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	5	7	10	7	11	5	9	21	22	17	25	41	17		No Threshold
OP Appointments Cancelled by Hospital %	8.1%	12.7%	9.9%	12.4%	11.7%	9.0%	10.4%	12.0%	13.7%	10.8%	15.0%	8.5%	11.7%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	8.1%	8.9%	10.2%	13.5%	12.7%	14.0%	10.3%	15.5%	10.2%	13.9%	15.8%	16.4%	18.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	12.9%	12.2%	10.8%	12.8%	13.6%	13.0%	12.1%	15.2%	15.4%	13.0%	12.5%	15.8%	17.1%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	9.3%	10.5%	15.2%	17.5%	16.7%	17.7%	13.3%	18.4%	14.7%	16.8%	14.6%	15.6%	18.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	16.2%	17.6%	14.4%	17.6%	17.3%	16.9%	18.5%	21.9%	24.3%	24.0%	20.2%	20.3%	21.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	13.5%	20.3%	11.5%	15.1%	6.9%	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	13.1%	11.9%	10.8%	12.7%	14.0%	13.3%	12.0%	15.8%	15.3%	10.9%	12.1%	15.2%	16.9%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	109.7%	110.1%	106.6%	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%		No Threshold
CAMHS: Tier 4 DJU Bed Days	239	238	210	248	239	248	237	217	216	214	267	217	198		No Threshold
Coding average comorbidities	3.00	3.00		4.00	9.00		2.00		8.00			4.50	7.00		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU	2		1		1					1	1	1			No Threshold
CAMHS: Referrals Received	340	268	351	469	396	536	638	374	297	475	526	567	431		No Threshold
CAMHS: Referrals Accepted By The Service	198	158	182	251	198	254	316	173	141	233	302	308	216		No Threshold

Community

D Drive W Watch P Programme

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	58.2%	59.0%	51.9%	53.5%	50.0%	47.4%	49.5%	46.3%	47.5%	49.1%	57.4%	54.3%	50.1%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks (W)	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%		>=92 % >=90 % <90 %
Waiting List Size (W)	800	785	911	911	828	765	808	971	1,147	1,208	1,530	1,629	1,563		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways (W)	1	0	0	0	3	0	1	2	2	1	1	1	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity	698	657	804	807	744	756	717	573	367	674	563	766	616		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks (W)	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%		>=92 % >=90 % <88 %
ASD: Completed Pathways	64	94	97	109	105	139	128	82	219	37	57	64	45		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	85.9%	66.0%	76.3%	67.0%	24.8%	23.7%	15.6%	8.5%	4.1%	13.5%	7.0%	4.7%	11.1%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P)			100.0%	46.2%	16.7%	23.5%	28.6%	6.7%	21.4%	10.5%	23.8%	21.7%	25.0%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P)			100.0%	100.0%	100.0%	25.0%	100.0%	50.0%	100.0%	66.7%	100.0%	100.0%	50.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals (W)	127	119	139	169	120	135	150	582	144	143	165	168	177		No Threshold
CCNS: Number of Contacts (D)	844	783	826	896	791	821	835	959	809	736	931	959	951		No Threshold

WELL LED

	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s) (W)	45	321	221	-41	14	212	-11	287	250	540	16	60	185		
Income In Month Variance (£'000s) (W)	75	148	996	150	94	88	50	154	75	118	-78	59	118		
Pay In Month Variance (£'000s) (W)	12	65	-81	137	5	-49	-87	260	167	15	142	319	-9		
AvP: OP New		643.00	521.00	614.00	113.50	350.95	652.00	-103.00	-2.30	-114.00	593.00	650.00	507.00		>=0 N/A <0
AvP: OP FollowUp		3,815.00	3,795.00	4,123.00	1,446.90	1,416.84	4,230.00	1,014.00	688.30	1,239.00	3,423.00	4,074.00	3,247.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan (W)		4,460	4,316	4,737	1,561	1,768	4,882	911	686	1,126	4,016	4,724	3,754		>=0 N/A <0
PDR (W)	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%		
Medical Appraisal (W)	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%		
Mandatory Training (W)	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%		>=90 % >=80 % <80 %
Sickness (D)	4.5%	5.7%	4.7%	3.9%	3.1%	3.9%	4.9%	5.6%	6.4%	5.8%	6.0%	5.5%	5.7%		<=4 % <=4.5 % >4.5 %
Short Term Sickness (D)	0.9%	1.9%	1.0%	1.0%	0.9%	1.2%	1.5%	1.4%	1.5%	1.5%	2.1%	1.8%	1.7%		<=1 % N/A >1 %
Long Term Sickness (D)	3.6%	3.8%	3.7%	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%	4.3%	3.8%	3.7%	4.0%		<=3 % N/A >3 %
Temporary Spend ('000s) (D)	355	226	169	141	183	192	229	171	127	168	192	166	273		
Staff Turnover (D)	8.7%	9.3%	9.5%	9.8%	10.7%	9.6%	9.8%	9.8%	9.9%	10.1%	10.9%	12.1%	11.1%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) (W)	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF working at Gold accreditation on the perfect ward inspection, action plan being reviewed. • CRD division working to Trust covid 19 guidance and has reverted back to safety measures with reduced footfall. • 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** • Out of hours research blood samples for oncology trials • 0 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. 2 research presentations in December to group. • Research Patient stories included on agenda **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 as standard practice
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 AH one of chosen sites nationally to continue with UPH studies (Recovery) • Trust participating in extension COV09 vaccine study with LSTM. • AH sponsoring flagship Asymptomatic Study • Stop RSV trial. (one of two national sites) now actively recruiting • Portfolio growth in line with plan. **Challenges** • CRF housekeeping/ HCA role advertised but long delays with recruitment process affecting appointment. • 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.	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners continues • TNA requests for CPD training approved for all applicants • Engagement with staff in utilising team fund. Staff requests have been mobilised.

	• H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local providers to offer joint training programmes.	**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) • CRD engaging staff with SALS • Core business hours established through recent service re-org • Model for the future working under development **Challenges** • Recruitment and retention being monitored carefully due to increase in leavers • Some staff who have recently returned to work are completing phased return which reduces capacity • Increase in SSS and SI in December due to covid 19 cases

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 27th January 2022

Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards
Purpose of Paper:	To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP QUARTERLY PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the Board with a summary of the actions taken by the FTSU team in the last quarter and to outline the actions planned for the coming six to twelve month period.

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

3. FTSU Champions

We are continuing to actively recruit to our team of FTSU Champions, now having a diverse group, from a significant number of specialties/departments across the organisation, thus allowing staff to have a greater selection of FTSU champions to approach at local level. Our FTSU Champions' profile database is continuing to be developed and monitored, to ensure this picture remains positive and inclusive of all areas. The team is mindful of the unprecedented impact upon staff across the whole organisation resulting from the toll that a two year pandemic has taken upon us all, coupled with the current operational pressures that the Trust has seen.

In order to understand why our staff are keen to enroll into our FTSU team, we have asked two of the team to attend a future Board meeting to tell their stories and explain what FTSU means for them. This will provide an illustration of our staff survey feedback in relation to raising concerns.

4. Communication

Key messages and awareness continue to be extended to all staff through the intranet, communications cascade and other internal communications e.g. screensavers.

During 2021/22, the Trust FTSU Guardian (FTSUG) continued to use various channels to communicate the role of the FTSU function and the importance of raising concerns; these included:

- FTSU intranet page
- Speak Up Month in October 2021
- Promoting the Freedom to Speak Up Champions
- Attendance at Joint Consultative Negotiating Committee (JCNC) meetings
- Freedom to speak up T-Shirts, lanyards and banners
- Regular updates on FTSU via Comms Cascade
- Trust staff networks

5. FTSU Training

Uptake of the NGO E-Learning modules, *Speak Up, Listen Up*, remains low within the organisation. There has been an increase in communication cascades in regard to this training, via screensavers and emails, in an attempt to improve completion rates, however to date this has seen only a minor improvement. It is acknowledged that we have recently experienced a period of intense operational pressure and staff absence which has impacted upon training uptake across the organisation. Options for consideration to improve are to mandate the training for all staff or to include the FTSU E-Learning package at induction instead of the FTSU Guardian presenting, the second option would be to target specific staff groups within teams, which would limit numbers but help to promote and embed FTSU ie. create a 'subject matter expect' at local level.

5. Guardian activity report

There were 11 cases submitted to the NGO for Q2 and 11 cases for Q3. These numbers are an increase on Q1 submission and Q4, based on current numbers, is likely to see a further increase.

Of the 22 cases raised in Q2 and Q3, 4 were done so anonymously.
.

During Q2, 3 were related to process/policy,1 to patient B&H, 1 relating to patient safety, 2 to staff safety and 4 relating to behaviour and relationships. Of the 11 cases, 6 are closed.

During Q3, 3 related to process/policy, 2 to B&H, 1 to patient safety,1 to staff safety, 2 relating to behaviour and relationships and 2 to infrastructure. Of the 11 cases, 5 are now closed. The closed cases include those concerns raised regarding patient safety. Also, it should be noted that those concerns that within some cases there are secondary concerns of staff safety.

Feedback to the FTSUG from those raising concerns when closing the case, has identified that that they would use the service again and have scored the process highly in terms of satisfaction.

6. Learning and Improvement

The purpose of creating a speaking up culture is to keep our patients safe, improve the working environment of staff and to promote learning and improvement; we strive to achieve this by:

- Continuing to develop the Just Culture in accordance with the NHS Improvement toolkit
- FTSU Guardian triangulates the data with key HR data such as grievances and disciplinary statistics
- FTSU Guardian will continue to work closely with HR and SALS to review key data and identify themes
- Monthly meeting between the FTSU Guardian, Executive Lead and Non-Executive lead
- Learning events for FTSU Champions to be held going forward
- Working with our local and regional staff side colleagues
- Seeking feedback from those who raise concerns and those involved in the FTSU systems and processes
- Supporting our staff networks by encouraging staff to share their lived experience with the Trust
- Action planning linked to the national self-assessment tool.

The importance of learning from Freedom to Speak Up cases cannot be underestimated. Improvements made following previous cases include:

- Ensuring that national guidance on Covid 19 was being followed across Trust services; processes regularly updated, and staff reminded on any changes
- Ensuring that emotional and wellbeing support is available to all staff who are involved in speaking up processes, with supports from SALS
- Supporting managers on handling staff pressure and ensure that the Trust continues to provide outstanding care to patients and support to staff
- Review of policies to ensure 'language' is in line with the principles of Just Culture
- Working with HR to ensure managers and those with staff management responsibility are accustomed to the correct adoption and interpretation of employment policies.

For reference please see the attached FTSU Improvement Action Plan 2022/23.

Kerry Turner
Freedom to Speak Up Guardian
January 2022

FTSU IMPROVEMENT ACTIONPLAN 2022-23

Action	Owner	Status
To continue promoting and publicising the role of our Freedom to Speak Up Champions by providing regular communications to all staff (including volunteers, temporary/ contracted workers and trainees).	KT	
Further work to capture and share good practice and learning from concerns raised, with the key aim of fostering openness and transparency, such as staff briefings, team meetings and the intranet	KT	
To support leaders and managers on improving staff experience and ensure a positive culture of speaking up is embedded in all services	KT/JP	
To continue to work with the National Guardians Office to ensure that the Trust learns from national best practice.	KT	
To use local intelligence from exit interviews as way of example to understand and support staff and provide additional information on how culture can continue to be improved	KT/ HR	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th January 2022

Paper Title:	**Board Assurance Framework 2021/22 (December)**
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 14th January 2022

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 14th January 2022

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 AB	**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 December's updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well' and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Refreshed 2030 Vision & objectives in draft - preparing for Trust Board, CYP Forum & Divisional/Clinical & corporate engagement Q4 21/22.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score in month. Controls and assurance evidence updated. National delay to transition into ICB's noted - now July 22 - current action plans remain appropriate.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Agreement reached with LWH MD to pilot framework with Neonatal Partnership. Plan agreed for April 22.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed and actions updated. Head of EDI commenced in post Jan 2022.

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).***
  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 267 patients on the 8 December 2021 to 234 on the 5 January 2022. Omicron is the biggest threat to access to services presently as it has caused an increase in staff absence which is leading to a reduction in capacity. Absence has increased from 6.3% in November to 12% in early January 2022. We are mitigating this through track and trace and team resilience measures. Presently the theatre schedule is holding up well against strong headwinds with 126-129 of 139 theatre sessions scheduled on average per week. In November we launched a new live outpatient waiting list, following completion of the validation of all new outpatient records. This has improved the accuracy and transparency of our waiting list and is reducing the risk of an avoidable delay to care from sub-optimal waiting list management.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (AB).***
  In December we saw a contraction in the number of ED attendances, relative to 2019, and this has continued into week 1 and week 2 of January 2022. This has led to an increase in the proportion of patients treated within 4 hours (to 74.9%). Presently the biggest threat to safe urgent and emergency care is very high levels of staff absence, caused by Omicron . Gold command operation is in place with all key departments completing a January preparedness plan to deal with high staff absence. Actions taken include a pivot towards emergency activity, split team working and resilience shifts.

- ***Inability to deliver safe and high quality services (NA).***
  This risk has been reviewed. Current controls remain on track.

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

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

- ***Digital Strategic Development and Delivery (KW).***
  BAF reviewed. Good progress. Some delays anticipated and continue to be progressed with regards to the Aldercare programme.

- ***Workforce Sustainability and Development (MS).***
  This risk is monitored through the gold command structure. Daily reports and key actions are in place in respect of staff availability. Staff availability will be further impacted as a result of the legislative changes in respect of the Covid19 vaccine as a condition of employment. Working group identifying those in scope.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions updated to reflect progress. 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).***
  Jan review - no change

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

BAF Risk

Related Corporate Risk's

1.1 Inability to deliver safe and high-quality services **(3x3=9)**

Strategic Aim

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 caused by lack of capacity. * (linked to 2.1)
(2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors
(2233) Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies
(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, caused by un-validated follow up waiting list and training issues leading to patients not being booked appropriately for follow up appointments
(2312) Patients not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial caused by lack of medical cover for Neurosurgical and Craniofacial patients. *(Linked to 2.1)
(2326) Delayed diagnosis and treatment for children and young people caused by lack of paediatric phlebotomy provision in the local area for children and young people requiring blood tests requested from primary care providers. *
(2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available Monday to Friday, caused by significant staffing gaps due to sickness. *
(2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval caused by UNHM and Alder Hey are served by two different transport services (KIDS & NWTS) meaning neither will transport non-time critical patients between trusts. Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours.
(2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs * (Linked to 1.2 &1.6)
(2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. *(Linked to 2.1)
(2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.* (Linked to 2.1)
(2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.6 &2.1.)
(2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.* (linked to 1.2 & 2.1)
(2501). Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic *(linked to 1.2. & 2.1)
(2327) Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence

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 **(4x5 =20)**

1.2

(2233) Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies.(Linked to 1.1)
(2501) Risk of inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic leading to a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. (Linked to(1.1 & 1.6)
(2463) Risk of children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. (Linked to 1.1 & 1.6)
(2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. (linked to1.1 & 2.1)
(2501). *Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by* COVID 19 pandemic (Linked to 1.1 & 2.1)

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. **(4x5 =20)**

1.6

(2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020 (linked to 1.2)
(2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service has increased. (linked to 1.1)
(2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. (linked to 1.1)
(2501). Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic (Linked to 1.1 & 2.1)

The best people doing their best work

2.1 Workforce Sustainability & Capability **(4X4 =16)**

2.2 Employee Wellbeing **(3X3 =9)**

2.3 Workforce Equality, Diversity & Inclusion **(4X3 =12)**

2.1
(1910) Risk of being unable to provide interventional Radiology service caused by caused by only one consultant radiologist being in post (linked to 1.1)
(2100) Risk of inability to provide safe staffing levels.(Linked to 1.1)
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients(Linked to 1.1)
(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, caused by insufficient staff in resuscitation team. (linked to 1.1)
(2501). *Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by* COVID 19 pandemic (linked to 1.1)
(2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. (linked to 1.1)
(2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. (linked to 1.1)
(2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately. (linked to 1.1)
(2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.1 & 1.6 .)

Sustainability through **external partnerships**

3.1 Failure to fully realise the Trust's vision for the Park (**3X3 = 9**)

3.2 Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships. **4X3 =12**

3.4 Financial environment **4X4 =16**

3.5 ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.

3.6 Risk of partnership failures due to robustness of partnership governance

2.2 None

2.3 None

3.1 None

3.2 None

3.4 None

3.5 None

3.6 None

Game-changing research and innovation

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

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, 2436, 2332, 2441, 2461, 2265, 2427, 2326, 2501, 2514, 2384, 2233, 2230, 2434, 2100, 2415, 2340, 2463, 2516, 2235, 2312, 2229		
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

January 2022 - Nathan Askew
This risk has been reviewed. current controls remain on track

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.

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: 2233, 2270		
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.

January 2022 - Adam Bateman
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 267 patients on the 8 December 2021 to 234 on the 5 January 2022. Omicron is the biggest threat to access to services presently as it has caused an increase in staff absence which is leading to a reduction in capacity. Absence has increased from 6.3% in November to 12% in early January 2022. We are mitigating this through track and trace and team resilience measures. Presently the theatre schedule is holding up well against strong headwinds with 126-129 of 139 theatre sessions scheduled on average per week.

In November we launched a new live outpatient waiting list, following completion of the validation of all new outpatient records. This has improved the accuracy and transparency of our waiting list and is reducing the risk of an avoidable delay to care from sub-optimal waiting list management.

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.

Board Assurance Framework 2021-22

NHS Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

January 2022 - Adam Bateman
In December we saw a contraction in the number of ED attendances, relative to 2019, and this has continued into week 1 and week 2 of January 2022. This has led to an increase in the proportion of patients treated within 4 hours (to 74.9%. Presently the biggest threat to safe urgent and emergency care is very high levels of staff absence, caused by Omicron . Gold command operation is in place with all key departments completing a January preparedness plan to deal with high staff absence. Actions taken include a pivot towards emergency activity, split team working and resilience shifts.

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.

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: 2100, 2415, 2340, 1910, 2312		
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	28/02/2022	Overall Mandatory Training still at 88% as of 31/12/2021. Key hot spots in Resus and Estates staff have been improving - Resus is now at 81% overall and Estates staff at 75%. Plan to roll out 8 day's of intense training for practical moving and handling level 2 to improve compliance in this area in early February.

3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/01/2022	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	31/01/2022	This group meeting has been paused whilst transactional recruitment is put back on track. It is anticipated that this group will be set up again end Jan 22.

Executive Leads Assessment

January 2022 - Sharon Owen
This risk is monitored through the gold command structure. Daily reports and key actions are in place in respect of staff availability. Staff availability will be further impacted as a result of the legislative changes in respect of the Covid19 vaccine as a condition of employment. Working group identifying those in scope.

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.

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	30/01/2022	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	30/01/2022	IRG meetings on hold so unable to take Business case. Interim plan developed with the Alder Centre to address current waiting list for counselling with support from SALS until business case agreed and new model fully operational. SALS and Alder Centre to meet w/c 10th January to fully operationalise plan and develop communications for the organisation as Alder Centre will stop taking direct referrals until waiting list is cleared.
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.	23/01/2022	Review commenced w/c 20th December lead by Deputy Chief People Officer. To continue in early January.
Executive Leads Assessment		
December 2021 - Jo Potier Risk reviewed and actions updated to reflect progress. No change to risk rating.		
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		

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 BME 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

Executive Leads Assessment

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

January 2022 - Melissa Swindell
Risk reviewed, actions updated. Head of EDI commenced in post Jan 2022.

December 2021 - Melissa Swindell
risk reviewd, 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	
Set up a campus review	31/03/2022	

Executive Leads Assessment

January 2022 - David Powell
Review prior to January Board

December 2021 - David Powell
End of year review

November 2021 - David Powell Prior to November Board
October 2021 - David Powell Prior to October Board
September 2021 - David Powell Prior to Sept Board

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

2030 Vision: Alder Hey vision and strategic objectives refresh - Q4 21/22	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22

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

January 2022 - Dani Jones
Risk reviewed; no change to score in month. Refreshed 2030 Vision & objectives in draft - preparing for Trust Board, CYP Forum & Divisional/Clinical & corporate engagement Q4 21/22

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.

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	31/03/2022	Executive review panel taken place December with various mitigations agreed to reduce overall capital funding pressure. Update to be provided to RABD and Trust Board. Risk still remains on the CDEL allowance for C&M in 22/23 and beyond however release of multi-year capital allocations may help with this.
1. Uncertainty of H2 21/22 framework and beyond	31/01/2022	22/23 planning guidance now shared however financial and technical guidance still to be confirmed. Timetable extended to allow for impact of current wave, expect plans to be submitted April.
4. Long Term Financial Plan	31/12/2021	This joint work has been delayed through Q3 and update is required on if this is still to be undertaken as a joint work. Alder Hey are in progress of compiling 22/23 plan and will as part of this undertake a forward look on overall 5 year. As part of updated trust strategy, requirement for new 5 year financial strategy which will then inform this modelling.

Executive Leads Assessment

January 2022 - Rachel Lea
Risk reviewed and actions updated.

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.
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, Dec ICS Board development session complete
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	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans

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)
National delay to transition into ICB's announced over Christmas 21 - projected transfer date now July 22 - meaning continued uncertainly in the interim

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	28/04/2022	
Continue to develop collaborative arrangements with key partners and shape the service offering	31/03/2022	

Executive Leads Assessment

January 2022 - Dani Jones
Risk reviewed; no change to score in month. Controls and assurance evidence updated. National delay to transition into ICB's noted - now July 22 - current action plans remain appropriate

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.

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	Pilot of Partnership Quality Assurance Round approach agreed with LWH MD - to be piloted via Liverpool Neonatal Partnership and presented to LNP Board in April 22
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	
Agreement to pilot Pship Assurance Round approach with LWH and Liverpool Neonatal Partnership. Pack development to be undertaken during Feb & March, for presentation to LNP Board in April. Learning to be shared and co-design to pack to be incorporated	28/04/2022	

Executive Leads Assessment

January 2022 - Dani Jones
Risk reviewed; no change to score in month. Agreement reached with LWH MD to pilot framework with Neonatal Partnership. Plan agreed for April 22.

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.

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		
January 2022 - Claire Liddy Jan review - - no change		
November 2021 - Claire Liddy NOV review - risk static		
October 2021 - Claire Liddy OCT review - no change		

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy 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

January 2022 - Kate Warriner
BAF reviewed. Good progress. Some delays anticipated and continue to be progressed with regards to Aldercare programme.

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.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th January 2021

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

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 20th January 2022, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 18th November 2021.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

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

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

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

- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register
- Analysis of the Trust Risk Register
- CQC Action Plan (for the action overseen by ARC)
- Presentation on risk management processes within CAMHS
- Assurance presentation on Cyber Security
- Verbal update on the matter relating to stolen iPads
- Report on the action plan relating to the Data Protection and Security Toolkit
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Draft Internal Audit Plan for 22/23
- Anti-Fraud Service Progress Report
- Proposal for the review of External Audit Services
- Updated Governance Manual (for ratification)
- Update on actions arising from the Audit & Risk Committee self-assessment exercise

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

None.

4. Positive highlights of note

We received a detailed presentation from the Director of CAMHS on risk management practices, highlighting how risk is embedded and overseen within the Division.

Throughout the year the Committee has looked across the Trust to identify any further functions that can provide assurance on key risk areas. Following on from prior presentations on Clinical Audit, Data Quality and Project Assurance we received a presentation on Cybersecurity.

In December 2021 a review of the respective of operation of ARC and the RMF was undertaken by a number of the attendees for each meeting. The overall conclusion was that both groups are operating effectively and the split of responsibilities is appropriate. It was felt that the focus of oversight of the two

groups is appropriate with risk themes being identified at RMF and reported to ARC and that RMF provides a forum for the Executive to challenge each other's risks and take action if things become "stuck". A small number of minor changes were agreed and the operation of both groups will continue to be reviewed during "governance lite".

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 18th November 2021**

Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mr. A. Bass	Director of Surgery	(ABASS)
	Mr G Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Ken Jones	Associate Finance Director	(KJ)
	Mrs R Lea	Acting Director of Operational Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Ms. C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Apologies:	Urmi Das	Director of Medicine	(UD)
	Mrs. F. Marston	Non-Executive Director	(FM)
	John Grinnell	Acting CEO	(JG)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
Item 21/22/93	Ms. N. Deakin	DMO Lead	(ND)
	Ms. N. Palin	Assoc. Director of Transformation	(NP)

21/22/81 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. The new E&Y Accounts Manager, Dan Spiller, introduced himself and pointed out that today's meeting was his first.

21/22/82 Declarations of Interest

There were no interests declared.

21/22/83 Minutes from the Meeting held on the 23rd September 2021

Resolved:

The minutes from the meeting that took place on the 23rd of September were agreed as an accurate record of the meeting.

21/22/84 Matters Arising and Action Log

Action 20/21/57.1: *Non-Clinical Claims/Clinical Claims (Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* – A discussion has taken place with Melissa

Swindell about gaining more visibility from a non-clinical claims perspective from which feedback will be provided in due course. It was pointed out that this action has led to a review of the processes in place in terms of the level of seniority of the person signing off claims, etc. It was agreed to provide an update in April 2022 on the changes that have been made to processes/sign off level following a further piece of work. The owners for this action are Erica Saunders and Ken Jones. **ACTION TO REMAIN OPEN**

Action 21/22/46.1: *Trust Risk Register Analysis (Look into a process for tracking the progress of overdue risks/risks without an action plan rather than displaying this information via a graph/chart in the Trust Risk Register Analysis report)* – An update will be provided in January. **ACTION TO REMAIN OPEN**

Action 20/21/48.1: *Clinical Audit Presentation (Agree the timings of clinical audit updates that are to be submitted to the Audit and Risk Committee in 2021/22)* – A meeting has taken place with Steven Riley to advise of the information that the Committee would like to see from an assurance perspective. The Chair has agreed to liaise with Steven Riley re the timings for the submission of clinical audit updates, going forward. **ACTION TO REMAIN OPEN**

Action 20/21/48.2: *Clinical Audit Presentation (Meeting to take place in September to discuss the progress of the Clinical Audit Plan)* - Refer to action 21/22/48.1. **ACTION CLOSED**

Action 21/22/71.1: *Progress against actions from the Audit and Risk Committee Self-Assessment (Meeting to take place to review the operation of the Audit and Risk Committee/Risk Management Forum and the interaction between them)* – A meeting has been scheduled for the 9.12.21. A report on the outcome will be submitted to the Committee during January's meeting. **ACTION TO REMAIN OPEN**

Action 21/22/62.1: *Trust Risk Management Analysis Report (Incorporate the risks captured under the category of 'other risks' into the appropriate service/Division)* – This action has been addressed. **ACTION CLOSED**

Action 21/22/67.1*: Internal Audit Progress Report (Discuss the possibility of inviting Paul Grimes to November's meeting to provide an update and submit the action plan that supports the DSPT work that is taking place to address gaps)* - Paul Grimes will be attending January's meeting to provide an update. **ACTION CLOSED**

Action 21/22/70.1: *Anti-Fraud Progress Report (Declarations of Interest - Agree a percentage/target for achieving a green rating / percentage for achieving DoI compliance)* – A meeting took place with Virginia Martin and it has been agreed to set a target of 80% for 2021/22. The Trust is going to look at increasing this target on an incremental basis therefore the target for 2022/23 may increase to 85%. Contact was made with the Centre who advised that there wasn't a target for this area of work, but one could be set locally. It was pointed out that the Divisions have been asked to include Declarations of Interest as a standing item on the agenda so that it can be discussed on a quarterly basis during governance meetings to raise awareness for decision makers. **ACTION CLOSED**

Action 21/22/71.2: *Progress against actions from the Audit and Risk Committee Self-Assessment (Submit a questionnaire to enable the Audit and Risk Committee to conduct a self-assessment)* – A self-assessment questionnaire is in the process of being compiled

and will be circulated in the next two weeks so that it can be completed ahead of January's meeting. **ACTION TO REMAIN OPEN**

Action 21/22/74.1: *Alder Hey Innovation Company Structure; including Acorn Action Plan. (Discuss the reporting structure for the Innovation Committee and RABD. Review the oversight of both committees in terms of the submission of appropriate information, expertise and decision making)* - Discussions are on-going in terms of this action and a meeting is to be scheduled between Erica Saunders, Fiona Marston and Rachel Lea. An update will be provided on the 20.1.22. **ACTION TO REMAIN OPEN**

Action 21/22/80.1: *Meeting review (Discussion to take place around the starring of items on the Audit and Risk Committee agenda which will be taken as read with questions only)* – This action has been addressed. **ACTION CLOSED**

The Chair referred to the risk management e-learning package for staff and queried as to whether it was rolled out in November. It was reported that the risk management presentation, which is based on the strategy and procedure, is to be uploaded onto the system to enable staff to access it. In addition, there is an expectation that Governance Leads will promote this area of work within their respective Division to ensure staff are trained.

21/22/85 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF as at the 29.10.21. The following points were highlighted:

- It was confirmed that all risks have been reviewed by the Executive Leads.
- There has been a focus on operational risks that have arisen as a result of the pressures the organisation is experiencing at the present time.
- The Trust Board is receiving regular updates on the risks relating to the implementation of Integrated Care Systems (ICSs).
- The Committee was advised that there is still a lot of emphasis on the workforce risks. It was reported that the People and Wellbeing Committee (PAWC) has agreed to meet on a monthly basis to provide continuity on assurance levels in terms of the risks that need mitigating.
- *Financial Environment* – Further narrative is to be incorporated in the BAF to reflect the latest financial position following submission of the H2 Plan on the 18.11.21. The Committee was advised that the Trust is carrying financial risks in terms of H2 and longer-term risks as it heads into the post Covid-19 period in 2022/23. Work is taking place to try and mitigate these risks.

The Chair asked as to whether the Risk Management Forum (RFM) discusses the corporate risks that link in with the BAF to identify the impact to the BAF in the event of any changes to corporate risks. The Chair also pointed out that the majority of the risks included in the BAF don't have corporate risks sat beneath them and queried as to whether a sense check could take place to determine if there have been any high level risks (15 +) omitted.

Erica Saunders felt that further consideration should be given to this matter with a view to improving linkages and assisting senior teams in the Divisions to determine what a

strategic risk means to the various services. It was also pointed out that the BAF is designed to address risks at a strategic level therefore there aren't many highly scored operational risks that connect at this level. Following discussion, it was agreed to take this matter off-line to discuss it further.

21/22/85.1 **Action: ES/AB/CU**

The Chair queried as to whether the check list for risk owners had been completed. It was confirmed that a guide has been produced and is being piloted prior to roll out.

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 29.10.21

21/22/86 **Risk Management Forum Update; including Corporate Risk Register**

The Committee received an overview of the RMF that took place on the 2.11.21.
It was reported that an in-depth discussion took place around access to services, people, major trauma and the risk management report for the Division of Community and Mental Health. Two deep dives also took place; 10 x medication errors and Building Services.

The focus area for January's RMF will be on people risks and the Building Service due to ongoing concerns regarding potential further emerging risks. The deep dives for January's meeting will focus on the Division of Community and Mental Health risks, and the risks relating to the Major Trauma service. In addition to this the RMF will focus on longstanding high moderate risks.

Corporate Risk Register

The Committee received the Corporate Risk Register for the period from the 1.6.21 to the 16.9.21. It was pointed out there had been two changes to the report since November's RMF;

Risk 2501 (4x4=16) – *Risk of not being able to safely staff the Outpatient Department in relation to the Waiting List Initiative*: It was reported that a number of actions have taken place to address the gap in resources. The Committee was advised that the Trust is looking to expand the nursing workforce in the Outpatient Department on a substantive basis, therefore work is taking place to finalise a business case to address nursing resources from an operational perspective as well as the additional activity that is required and the provision of the seven day week. It was pointed out that this risk relates to a gap in resources and is not about staff working above their contractual hours to accommodate additional activity as this is already being done.

Risk 2550 (4x3=12) – *Reduced emphasis on quality improvement and co-design for CYP:* This risk was incorporated on the register in the reporting period and was discussed at the RMF. Work has taken place to reduce this high risk to a 12.

The Chair pointed out that it is harder to identify risks that require a longer period of time in which to address them and asked as to whether it could be highlighted in the report the likely timescale for resolving each risk. It was felt that this would enable the Committee to have a detailed discussion and escalate the issue if required.

21/22/86.1 **Action: CU**

Resolved:
The Audit and Risk Committee noted the update from the RMF meeting that took place on the 2.11.21 and the contents of the Corporate Risk Register.

21/22/87 Trust Risk Management Analysis

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

- During November's RMF it was noted that there were a considerable number of risks that were past the expected date of review. Since that time there has been a significant improvement therefore it was concluded that this was a one off occurrence. It was confirmed that this area of work will continue to be monitored.
- The Chair referred to table 3 in the report and pointed out that quite a number of areas across the Trust are only reporting one or two low risks. It was queried as to whether this is correct. A suggestion was made in terms of asking the Divisions to speak to each of their services in order to confirm whether this information is correct, with Divisional Leads providing an update to the Audit and Risk Committee in January. It was agreed that this is a piece of work that should be actioned.

21/22/87.1 Action: CU

The Committee was advised that not all areas sit within the Divisions therefore it was felt that an additional action is required in terms of Exec leads requesting Heads of Departments to conduct this exercise. It was reported that there isn't an overall reporting governance structure for feedback therefore it was agreed to give some thought to this matter.

21/22/87.2 Action: ES/AB

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

21/22/88 CQC Action Plan
Resolved:
The Audit and Risk Committee noted the CQC Action Plan.

21/22/89 Update on Risk Management Process within the Division of Surgery

A number of slides were shared with the Audit and Risk Committee to describe the Division of Surgery's approach in terms of assisting clinical departments within the Division to identify risks, describe risks and advise how risks are managed. The following information was shared on the process used for reviewing risks:

- Approach to risk in the Division of Surgery;
  - Rapid review bi-weekly meetings with proposal form; review all newly proposed risks for the risk register prior to submission on Ulysses and define action and ownership of risks with current and target ratings proportionate to the risk and acceptable tolerances.

- Department/Ward monthly reports regarding open risks; including details of new and closed risks.
- Divisional Integrated Governance (DIG) meetings.
- Monthly Risk and Governance review;
    - Risk and Governance Team meet on a monthly basis to review all risks within the Division.
    - Escalation and troubleshooting.
    - Challenge when risks reviews have not been performed.
    - Summary presented to DIG, opportunity to highlight new risks and raise issues.
    - Shared learning via DIG and local meetings.
- Risk and Governance support for teams; information can be found on surgery governance on MS Teams page and the Risk and Governance Quality Co-ordinator is on hand to provide Ulysses training and assistance.

It was reported that this approach to risk and governance has been in place for a period of six months and feedback from the organisation's clinicians has been positive. The Committee was advised of the forthcoming Risk Ward Rounds that are going to take place to help pinpoint risks that haven't been identified in areas reporting few or zero risks.

The Chair queried as to how a decision is made in terms of target risk scoring. It was reported that discussions take place between risk owners, those who know the risks intimately and the Governance Team around balancing a degree of risk when risks can't be removed from the register and articulating ongoing risks that have been mitigated but still present a certain element of risk to the organisation.

Adam Bateman paid recognition to the thoroughness and comprehensiveness of the work that has taken place in the Division of Surgery. It was felt that there has been a lot of best practice identified in the processes implemented across the Division and it was queried as to whether a set of best practice standards should be put into operation Trust wide in order to have a standard approach for risks and incidents.

Erica Saunders concurred with this suggestion and felt that the exercise would have a two-fold benefit in terms of returning to a more routine raising of the Trust's risk / governance profile and having a focus on regulation throughout the organisation in preparation for next CQC inspection. Attention was drawn to the importance of focussing on these two areas of work in order to sustain the level of rating that the Trust has under the 'Well Led' domain. Following discussion it was agreed to link in with the RMF regarding the suggestion relating to the sharing of best practices and provide the Committee with an update on the outcome in April 2022.

21/22/89.1 **Action: AB**

21/22/90 **Internal Audit Progress Report**

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

- It was reported that there are five reviews currently in progress;

  - Risk Management Thematic Review.
  - Key Financial Controls.
  - Lessons Learnt.
  - Complaints and PALS.
  - IT Service Continuity and Resilience Review.
- A meeting has taken place to scope out the Committee Effectiveness review which will commence towards the middle of December 2021.
- There are two pieces of work that will commence in Q4;
  - Data Quality.
  - Recruitment Processes.

Attention was drawn to the lack of final reports submitted during November's meeting. It was pointed out that, as a result, a large number of reports will be received by the Committee in both January and April.

The Chair informed the Committee that discussions have taken place regarding this matter and it has been agreed that, to start the internal audit programme for 2022/23 promptly MIAA will present a draft Internal Audit Plan in January 2022. If approved, MIAA will arrange for audits to commence in April 2022. Going forward, an appendix will be included in the Progress Report which will provide information on the dates when reports are due and identify which Committee will receive them so that any slippage against agreed times can easily be identified.

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

21/22/91 Internal Audit Follow Up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made during the period September 2021 to October 2021. The following points were highlighted:

- In terms of follow up, MIAA has been able to confirm the implementation of eight recommendations from the Clinical Audit Review and the Delivery Management Office Review.
- There are four reviews where the dates have been extended; Consultant Job Planning, Project Management and PFI which will be followed up by December 2021, and Mandatory Training Review has been deferred to March 2022. It was reported that mandatory training is now the remit of the new Academy Director, Katherine Birch, who is in the process of looking into the outstanding recommendations/actions.

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

21/22/92 External Audit Update

There was nothing to report.

21/22/93 **Project Assurance**

The Audit and Risk Committee received a presentation from the DMO in order to gain assurance in terms of project oversight processes. The following information was shared:

- Vision of the DMO.
- Purpose of the presentation; context, Improvement Board scope, how the DMO provides project assurance and project/programme approach.
- Background information;
  - Robust project governance disrupted during the pandemic.
  - Substantial assurance received from MIAA.
  - Introduction of Brilliant Basics.
  - Revised project/Quality Improvement approach with updated assurance framework.
- Improvement Board - Focus on what matters;
  - Outpatients.
  - Theatres.
  - ED.
  - STAT
  - Parity of esteem.
  - Medication errors.
  - Deterioration.
  - Brilliant Basics – HR.
  - AlderC@re.
- How assurance is provided.
- Assurance Project Table; nine strategic improvement areas from an Improvement Board perspective.
- Project/programme approach; identify, diagnose and initiate, develop, implement, sustain and review.
- System of control; projects are assessed against the eight PMO standards/Brilliant Basics principles as well as financial delivery.
- Portfolio summary.

The Chair felt that the update was really useful and highlighted the link to the Brilliant Basics programme which is starting to reach out to all areas. It was pointed out that the major projects the Trust undertakes are there for strategic purposes and therefore it is important from an Audit & Risk Committee perspective to receive assurance in terms of how well governed projects are and the extent as to which the organisation is realising the benefits. The Committee was advised that the DMO Annual Report will enable the Audit and Risk Committee to provide assurance to the Board. The caveat for the DMO team in producing the 2021/22 Annual Report is the pausing of a large number of projects due to the pandemic.

Resolved:
The Audit and Risk Committee noted the project assurance update.

21/22/94 Audit and Risk Committee Terms of Reference/Workplan for 2022/23

The Audit and Risk Committee received the draft Audit and Risk Committee Terms of Reference and the draft Workplan for 2022/23. It was reported that minor comments were received from members of the Committee therefore it was agreed to update both documents accordingly and re-circulate them.

21/22/94.1 Action: KMC

Resolved:
The Audit and Risk Committee approved the draft Audit and Risk Committee Terms of Reference and the draft Workplan for 2022/23.

21/22/95 Waiver Activity Report.

The Audit and Risk Committee were provided with an overview of the activity in relation to approved waiver requests during the period from the 1.4.21 to the 31.10.21.

It was reported that there were 31 waivers approved during this period. The total value of the approved waivers during the seven-month period was £1,414,005.20 including VAT. The Committee was advised that the waiver activity by spend reduced during 2021/22 when compared with 2020/21. Going forward it is expected see further reductions to a level in line with previous years. It was pointed out that waiver activity in 2020/21 saw a huge increase predominantly due to Covid-19 related purchases.

The Committee was informed that the Trust is part of the 'Health Procurement Liverpool' collaboration. The collaboration is looking towards raising awareness of procurement processes to ensure staff members are sighted on the appropriate use of waivers. Kath Stott felt that it might be beneficial for the Committee to look at how it can receive assurance in respect to collaboration/partnership arrangements.

The Chair referred to the partnership work that the Director of Strategy and Partnerships, Dani Jones, is involved with and felt that it would be useful to have oversight of the partnerships that the Trust is collaborating with and look towards implementing a process to gain assurance. It was reported that there are seven workstreams open at the present time with health inequalities at the forefront. The Chair requested that a discussion take place, as part of the draft Internal Audit Plan preparation, with Dani Jones to confirm as to whether there are any specific relationships that need to be thought about more urgently than others. It was pointed out that partnership governance may be an area of work that needs to be addressed during 2022/23.

21/22/95.1 Action: KS

21/22/96 Any Other Business

There was none to discuss.

21/22/97 Meeting Review

It was felt that the Committee had a number of good discussions that resulted in thought being given to other areas of work and looking at them in a different way in terms of risk, for example, partnership governance and how this will impact the 2022/23 Internal Audit Plan. The Chair referred to the action on the log relating to

the Key Financial Controls Audit and suggested bringing this forward to early January in 2022/23. It was agreed to discuss this matter outside of the meeting.

Date and Time of the Next Meeting: Thursday 20th January 2022, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Wednesday 15th December at 13:00, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	Rachel Lea	Acting Director of Finance	(RL)
	Anita Marsland	Non-Executive Director	(AM)
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Robin Clout	Deputy Chief Digital Information Officer	(RC)
	John Grinnell	Acting CEO	(JG)
	Russell Gates	Associate Commercial Director Development	(RG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Ken Jones	Acting Director of Operational Finance	(KJ)
	Claire Liddy	Managing Director of Innovation	(CL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Jason Taylor	Acting Associate Chief Operating Officer Research	(JPT)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Lisa Cooper	Director of Community & Mental Health Services	(LC)
	Rachel Greer	ACOO Community	
	Catherine Kilcoyne	Deputy Director of Business Development	

20/21/3330 **Apologies:**
Apologies were received from:

Shalni Arora	Non-Executive Director	(SA)
Mark Flannagan	Director of Communications	(MF)
Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
Nicki Murdock	Chief Medical Officer	(NM)
Kate Warriner	Chief Digital & Information Officer	(KW)

20/21/331 **Minutes from the meeting held on 22nd November 2021.**
The minutes were approved as a true and accurate record.

20/21/332 **Matters Arising and Action log**
RL agreed to meet with CL and ES to align both RABD and Innovation Committee Terms of Reference.

All other actions have been updated in the log.

20/21/333 **Declarations of Interest**
There were no declarations of interest.

20/21/318 **Finance Report**
Month 8 Financial Position
The H2 financial plan was submitted in November reporting a break-even position in line with C&M requirements. The delivery of break-even is subject to significant risk in particular with regards to income of £3.4m which is yet to be confirmed by C&M.

The in-month position for November is a £0.4m surplus which is £0.4m ahead of the break-even plan position however the year to date (month 1-8) is showing a deficit

of £0.5m which is £0.5m adverse to the break-even plan but slightly ahead of anticipated position when assessing 2 months' worth of the £3.4m income risk.

CIP gap at £2.8m of (£7.13m target). At the Service Delivery Group (SDG) meeting on Monday it was agreed that £1.5m for recurrent investment will now be used to reduce the gap. The £1.3m gap will be distributed across the divisions.

An emergency risk fund of £750k is to be used for 9 transformational schemes and other winter pressures.

A breakdown was received on the divisional position.

Resolved:
RABD received and noted the M8 Finance report.

Write-offs for Month 8
Resolved:
RABD APPROVED the Write Offs for Month 8 total £914.96.

20/21/3335 **2021/22 H2 Plan**
RL gave a verbal update noting the ERF target for C&M M8 has not been met. A meeting detailing the shortfall is due to be held in the new year.

2022/23 planning guidance is due to be circulated by the end of this week.

C&M have agreed 4 workstreams: H2, Capital, System Allocation and Funding, Run Rate and Cost reduction. Alder Hey will be supporting the Capital workstream, the rest will be shared between Liverpool Heart and Chest FT and the Walton Centre.

Successful Bids: £1.3m for target investment fund for Critical Care Digital Management system.
£700k to support winter pressures within ED.
£113k to support the complex discharge team.
£17m for Digital and Innovation across C&M.

Resolved:
RABD noted the current position against the H2 Plan.

H2 Financial Bids Mental Health and Community Operational
LC gave a presentation on successful investments noting this would also be shared at the Trust Board meeting tomorrow.

A recurrent £5.5m has been secured from NHSE/local CCG as part of delivering the Mental Health long term plan. This will go towards: eating disorder access, community waiting times and crisis care.

Non-recurrent digital funding of £500k has been secured as well as £228k for a one-year trial to support access to Mental Health services within 4 weeks.

LC went through 5 agreed investment projects that totalled over £1m. Going forward £1.6m is likely to be shared across Liverpool and Sefton CCG. RG noted discussions were ongoing with the CCG to understand the amount that would be available to Alder Hey.

LC noted her thanks to Kerry Lythgoe, Business Accountant for negotiating the successful outcome.

Resolved:
RABD noted the successful position congratulating all those involved.

20/21/336 **Capital & Cash Updates**

KJ noted good progress made with overall reduction in initial capital following first reviews of business critical programmes of £4.8m, this leaves £17.5m outstanding. An Exec review panel is taking place next week to review opportunities to reduce the gap. Work will continue with the Alder Hey Charity to see if they will be able to provide some further support for a number of the programmes. CL and DJ noted the support Capital programmes have received from the AH Charity agreeing to look into a more strategic approach. RL noted a workshop due to take place with the Charity in Q4 to find a balance with supporting both Capital Programmes and a strategic approach.

Going forward £70m of programmes are not contractually committed and could be delayed until later in the year. £19m expenditure may be re-classified as revenue, this will take some pressure out of the capital allocation process over the next 5 years.

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

20/21/337 **Campus & Park Updates**

Galliford Try appointed for the next stage of the Neonatal project to bring the scheme back to revised budget. The outcome will be reported to the January RABD.

Leases for police accommodation in final iteration.

Histopathology temporary accommodation tenders over budget, scope being reviewed.

Medical photography have moved to a temporary home in the institute to be ready before Christmas.

Innovation Park 2 for CAMHS tenders have been returned and are being analysed.

RG reported on Guilford and Try's delays to the Cluster build that could potential push completion back to April 2022. A meeting to discuss this further is taking place tomorrow and RABD will receive a further update at the January meeting.
Action: RG
To confirm if Guilford and Try are able to keep to original deadlines.

Resolved:
RABD received and noted the Campus update.

20/21/338 **Approach to Transformation Plan**

RL went through a revised split approach to identifying and delivering cash releasing benefits:
- Divisional CIP – reducing run rate
- Cross-cutting/trust wide projects

Progress made to date includes: partnership working between Finance and Transformation teams to support both the corporate and clinical divisions.

9 key areas have been agreed, a benefits realisation piece is being developed for each area. An update on clear responsibilities and ownership will be presented to the January RABD.

Resolved:
RABD noted the Approach to Transformation Plan and a further update to be received at the January RABD.

20/21/339 **Business Development Update**

CK has been invited and funded by UK Department of International Trade to represent AH and the UK as a member of the UK delegation at Arab Health in January 2022. This opportunity may provide non-NHS revenue.

AH has developed a global export telemedicine platform in conjunction with Teladoc to provide a second opinion to clinicians. This will be launched as a pilot in January 2022 – January 2023. 10 Clinicians have been involved in the development and design of the platform and have committed to support the pilot. This will be conducted an on a private patient's basis, carried out by clinicians in their own time. No Impact on NHS jobs plans. Rate has been agreed on WLI terms.

Initial investment for the project is estimated to be £26k based on quotes from Teledoc for 10 licences for 1 year (£5.4k) and one-off integration costs (£20k spread over 21/22 and 22/23). CL went through the revenue expected over the next five years if the one-year pilot is successful.

Resolved:
RABD received and noted the Business Development update.

20/21/340 **Recovery & Urgent Care October Update**

AB noted the key concerns with the Omicron variant are high numbers in staff absence and a high attendance to ED particularly in January 2022. AB went through the actions in place to mitigate these concerns.

Tomorrow, the Innovation Hub at Alder Hey will be used as a walk-in facility to vaccinate Children aged 12-15 with Covid 19 vaccines.

Emergency department attendance is up 9% and emergency admissions is up 16% when compared to this time last year. In November 66% of patients were seen within 4 hours for December this has increased to 75%.

A slide was shared on actions complete from Gold Command this included a symptom checker that is now live on the AH website and has received positive feedback.

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

20/21/341 **Safe Waiting List Management Update**

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

RABD agreed going forward SWLM would be managed operationally and would continue to report to Safety and Quality Assurance Committee. SWLM updates would be received under Recovery & Urgent Care as and when required.

On behalf of RABD the Chair thanked AB and those involved in reviewing and reducing patients waiting over 52 weeks.

NHSE have asked AH to provide support to a Trust in Manchester in reducing their waiting times. Negotiations are due to commence.

Resolved:
RABD received the final monthly update on Safe Waiting List Management noting SQAC will continue to receive reports. Waiting Time Performance will continue to be reported to RABD under the Recovery item.

20/21/342 **Month 8 Corporate Report**
Resolved:
RABD received and noted the M8 Corporate report.

20/21/343 **PFI Report**
GD noted energy consumption is 10% over the annual target, this is due to increased air changes due to covid requirements.

Pipework survey continues.

Update on Commercial position
GD updated RABD on a meeting held earlier today with senior SPV representatives which centre around the misreporting of Service Failure Points. SPV reps have been asked to comment on the points raised in a letter with a view to agreeing a settlement amount in conjunction with the requested Standstill Agreement. A further update would be received at the January RABD.

RABD noted the seriousness of some of the service failure points and a near miss that would of caused a lot of interruption to services across the Trust. Due to this RABD noted that risks need to be visible and monitored clearly through the Board Assurance Framework.

Resolved:
RABD received and noted the M8 PFI report as well as the current commercial position.

20/21/344 **Board Assurance Framework**
ES looking at governance light, this will include * items to note a paper has been circulated and only questions/answer-based discussions will be noted in the minutes.

The December issue will include details surrounding the Omicron Covid-19 variant.

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

20/21/345 **Any Other Business**
No other business was reported.

20/21/346 **Review of Meeting**

The Chair noted the through updates that had been received.

Date and Time of Next Meeting: Wednesday 24th January 2022, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday15th December 2021
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Chair of SQAC)	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Robin Clout	Interim Deputy CIO	(RC)
	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)
	Nicki Murdock	Medical Director	(NM)
	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)
	Rachel Greer	Chief Operating Officer, Community & MH Division	(RG)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
21/22/150	Jennie Williams	Head of Quality Hub	(JW)
21/22/150	James Ashton	Sepsis Lead	
21/22/155	Julie Grice	AED Consultants, HMRG Lead	(JG)
21/22/160	Harriett Corbett	Consultant Paediatric Neurologist/Associate Divisional Research Director, Surgery Consent Lead	(HC)
21/22/160	Jason Taylor	Acting Associate Chief Operating Officer	(JT)

21/21/146 **Apologies:**

Lisa Cooper	Director - Community & Mental Health Division	(LC)
Urmi Das	Director – Medicine Division	(UD)
Erica Saunders	Director of Corporate Affairs	(ES)

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

21/22/147 **Declarations of Interest**
SQAC noted that there were no items to declare.

21/21/148 **Minutes of the previous meeting held on 24th November 2021 –**
Resolved: Committee members were content to **APPROVE** the minutes of the meeting held on 24 November 2021.

21/21/149 **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

21/22/150 Quality Priorities Monthly update

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

JW advised that the Medication Safety had focussed on local quality improvement regarding the interruption bundle. The quality improvement team had also supported pharmacy colleagues with regards to the Business Case for additional resources for the three priority actions. Business Case had been submitted to NA on 14th December 2021, and MA is currently awaiting feedback. NA advised that the Business Case had been well written, and that the Business Case is due to be presented to the next Improvement Board meeting.

Parity of Esteem is progressing well and is on plan. Mental Health Champions are established and are working well. JW referred to escalation regarding clinical health psychology waiting list, and advised that a workforce review is taking place.

KB advised that it would be helpful for future reports to include timescales within the metrics information. JW confirmed that this would be included in future reports.

JA, Sepsis Lead, Ward Manager for Ward 4C provided an update on the Deep Dive regarding the Deteriorating patient, and updated SQAC on the RAPID pathway trial on Ward 4C. JA advised on the use of an amalgamated pathway form, which is due to be in use on meditech within the next two week period. Delays of the roll out were noted due to Covid, and the requirement of colleagues supporting the roll out having to isolate.

JW advised that focused work is required in terms of interdependencies regarding medical workforce, in order to create a streamlined pathway and process for medical cover for every patient, and escalation for consultant review in the event of a deterioration.

JW advised that the Quality Improvement Team are working with the Resus team, in order to improve the bleep system.

SQAC **NOTED** the Recommendation to continue with the RAPID Pathway Trial further PDSA cycles on 4C; Further clarity on the use of CareFlow to be provided for the Medical Workforce, and to continue to progress the deteriorating patient pathway, and governance moving away from project status into operational business as usual.

KB requested that the summary slides in the pack be reviewed, and improved to include time scales, and clear updates on progress.

NA thanked JA for his leadership on 4C, and for the ongoing work, and support provided to 4C. NA emphasised the need to explore artificial intelligence options for this project.

FB referred to I.T development, and queried whether this was aligned, JW advised that the team are awaiting detail regarding EXPANSE, and that the team are progressing as much as is currently possible, with the current system.

FB reiterated NA comments, and thanked JA for his leadership, and expressed thanks to JW, BP and the quality improvement team for ongoing continued focus, and progress across all areas.

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

Resolved: SQAC received and **NOTED** the Quality Priorities Monthly Update

21/22/151 CQC Action Plan

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

21/22/152 DIPC Exception Report

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

21/22/153 ED Activity Monthly Update

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

21/22//154 Safer Teams at Alder Hey Theatres Update (STAT)

CT presented on overview of the STAT programme; key issues as follows:-
CT shared the core values of the STAT programme which centred around culture, civility, communication and concentration. Over 100 staff had been trained to date, and positive feedback had been received to date.

CT advised that the STAT programme should be completed by August 2023. Faculty recruitment is required, with 4 new faculty members trained. With the aim to roll out to trainee induction bi-annually.

CT referred to the challenges with regards to delivery of the STAT programme, versus theatre productivity/loss of theatre capacity, and the importance of allocated 'ring fenced' time for colleagues to participate in the STAT programme.

FB thanked CT for informative presentation, FB recognised the clear challenges.

AB thanked CT for the update, and suggested the team consider how to measure the effectiveness of the programme on the culture in theatres.

JG reiterated AB's comments, and welcomed the STAT programme update. JG advised that it would be helpful to liaise with N Palin, with regards to any shared learning for staff.

FB acknowledged the strong leadership, and outstanding work to support the STAT programme. SQAC recognised the challenges, with balancing time and resources, against other ongoing pressures. FB thanked CT for the STAT update.

Resolved: SQAC received and **NOTED** the contents of the STAT presentation, and the wider actions required.

21/22/155 Quarter 2 Mortality Report

JG presented the Quarter 2 Mortality Report which provided a report from the Hospital Mortality Review Group (HMRG).

Trends – JG advised that the 4/12 mortality review figures are slightly lower than for the preceding period, due to increased complexity of the children death review process. No concerning trends had been identified in the reviews undertaken.

JG advised that during the month of September 2021, there had been an increase in deaths, however assurance was given, that there does not appear to be a clear link to any specific factor relating to these.

During January 2020 – December 2020, there had been 55 deaths, 24 deaths had been reviewed. Departmental/Service Group mortality reviews within 2 months – 89%, HMRG Primary Reviews within 4 months – 72%, and HMRG Primary Reviews within 6 months – 80%.

JG referred to the Introduction of Medical Examiner process which is a legal requirement by April 2022 – without delaying our current process, and discussion regarding options to ensure that this is completed optimally. 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.

NM advised that she had previously discussed the ME process with colleagues at Liverpool Heart and Chest, who had agreed in principle, however NM has had no further feedback or assurance. NM advised that she is due to meet with the CEO of Liverpool Heart and Chest on 21st December 2021, and plans to expedite the ME process again to the CEO.

DJ queried whether there was any correlation regarding delayed ambulances, with regards to the out of hospital paediatric arrests. JG advised that paediatric cardiac arrest usually happens extremely suddenly, and usually results in a very poor outcome. DJ questioned whether the Trust is likely to see an increase in deaths over the coming months, given the current national pressures, and longer backlogs etc. JG stated that given that children are now mixing and socialising more, and together with viral loads, that she envisaged an increase in mortality during January, February and March 2022.

J Grinnell referred to trend data, and queried whether this should be discussed through the Medical Directors Children's Alliance Forum, to ensure national messages, in terms of safeguarding, ambition, delays and youth justice. NM advised that the challenge for children relate to a small number. J Grinnell advised that it would be helpful to raise at the C&YP National Transformation Board meeting.

FB thanked JG for Quarter 2 Mortality Report Update.

SQAC received and **NOTED** the Quarter 2 Mortality Report
SQAC **NOTED** that there are plans in place to facilitate this improving over the next few months.
Resolved: SQAC received and **NOTED** the Quarter 2 Mortality Report.

21/22/156 Safe Waiting List update

AB presented the Safe Waiting List Update; key issues as follows:-

- AB confirmed that all 56,618 records had been validated on the Inpatient and Outpatient waiting lists. This review had identified 541 records for

patients waiting >52 weeks, and they had been added to the RTT waiting list. From those patients, 267 patients are still awaiting treatment, this is being managed through BAU processes.

- 541 Clinical reviews had been completed.
- 1 case of confirmed harm, which had previously been reported through to SQAC at the September 2021 SQAC meeting, relating to a child under Ophthalmology, who did not receive a prescription for spectacles at an earlier opportunity.
- CCG are no longer monitoring the safe waiting list process, as they had been satisfied with assurance that the issues had been well managed.
- To validate the full follow-up waiting list – circa 96,000 records, use of Robotic process automation, and MBI support with Artificial intelligence process and prioritisation methods. A sample of 1,000 records had been validated, which demonstrated 97.8% data accuracy in reporting of pathways.
- Next steps are to focus on follow-up care, data quality dashboard, training and reporting.

FB noted the new areas of risk, and queried whether this is anticipated as a short term process. AB advised that this would be a significant programme of work, and anticipated it would take approximately 6-9 months, given that there are 96,000 records to validate.

JG welcomed the continued progress made, and suggested a risk stratification approach would be helpful in managing the follow up patients.

AH commended the ongoing work to address the Safe Waiting List, and advised that next steps would be to review variants of different patient groups, and those health inequalities, in terms of patients who are disadvantaged.

KB stated that the Safe Waiting List process had been very well controlled, and well governed. KB advised that there is a need to ensure that going forward, that no data errors reoccur in the future, and highlighted the importance of ensuring that staff are fully aware of any potential data errors, and the impact of them.

FB referred to the process for future audits, JG confirmed that audits are planned to take place.

FB commended the Safe Waiting List process, which had been undertaken efficiently and effectively, with a well-documented process, with clear reporting which continues to be well managed.

Resolved: SQAC received and **NOTED** the Safe Waiting List Update, and the continued progress regarding the completed actions.

FB thanked AB for Safe Waiting List Update

21/22/157 Winter 2021 preparedness: Nursing & Midwifery safer staffing

PB presented the Winter 2021 preparedness: Nursing & Midwifery safer staffing report, in order to provide assurance that the Trust have robust plans, for nurse staffing over the winter period.
The report provided assurance framework for nurse staffing.
PB stated that in terms of Trust preparedness framework Alder Hey was rated

highly, with some actions required.

An overview of the ITU surge model agreed by NHS England was shared with the group, and a brief overview provided of the current staffing models in ITU.

Resolved: SQAC received and **NOTED** the Winter 2021 preparedness: Nursing and midwifery safer staffing report, and **NOTED** the governance, and reporting mechanisms in place, SQAC **NOTED** that the careful attention is also being given elsewhere.

FB thanked PB & NA for Winter 2021 preparedness: Nursing & Midwifery safer staffing report

Clinical Governance Effectiveness

22/22/158 CQSG Key issues update

NA advised that the Clinical Quality Steering Group had met on 14th December 2021, the meeting had focussed on governance arrangements, with excellent progress made with regards to policies and guidelines, with over 90% of Policies and Guidelines in date, with a clear plan in place for those remaining policies planned to be reviewed by the end of 2021.
NA advised on the continued focus regarding metrics, which are monitored through Gold Command, with regards to keeping patients safe, which relate primarily to closing down of actions relating to incidents, compliance & responsiveness with PALS and complaints timeframes, with a real focus on getting those remaining metrics on trajectory.

Discussion also took place at CQSG regarding NICE compliance, with clear progress made in terms of deadlines.

CQSG had received several policies which had been ratified, with 1 amendment made to the Resuscitation policy.

FB thanked NA for CQSG key issues update.

Resolved: SQAC received and NOTED CQSG Key issues verbal update.

21/22/159 NICE Compliance Monthly Update

CU presented the NICE Compliance Monthly update.

Overall Trust compliance is based on 48 open documents:

- 3 Under assessment/review
- 3 Recommendations and associated actions completed – closed
- 24 - Partial compliance
- 12 Non-compliant
- 6 for audit.

KB referred to the number of items, and action plans that have minimum, or no progress, and noted that a number of these had deadlines of December 2021 or January 2022. KB noted that the majority of these deadlines, are for when the assessment would take place, however until the assessment had taken place, colleagues would not know what the issues are, and the timeframe needed to address any non-compliance. KB questioned whether across a number of areas whether collegues needed to address performance, to become compliant to our external regulator.

NA thanked KB for comments, and advised that there is some dedicated resource commencing within the team from January 2022, with a specific focus on addressing these issues.

NM commented that at present many staff are diverted to other priorities, such as supporting the covid vaccination programme, and this will likely have a negative impact on our performance, in a range of areas, given the national focus on this.

Resolved SQAC received and **NOTED** the National Institute for Health & Care Excellence, SQAC would continue to receive a monthly NICE update, in order to review and track progress.

Resolved: (NICE) Guidance compliance position report, received and SQAC **NOTED** comments regarding resources, and the wider competing pressures across the organisation.

FB thanked CU for NICE Compliance update, and for the ongoing work. FB welcomed those assessments being completed, and SQAC receiving an update on clear progress at the January 2022 meeting.

21/22/160 Annual Research Update

HC presented the Annual Research Update which included details of National Safety Processes, Key Research Safety Processes, safety metrics, key issues as follows:-

- The Clinical Research Division had reported 13 Serious Adverse events (SAEs) to sponsors in the past year, all within 24 hours of becoming aware of the event. No Serious unexpected suspected adverse reactions (SUSAR) had occurred.
- The Clinical Research Facility (CRF) had recently been awarded gold standard for the Trust internal ward accreditation scheme. This had been an increase from silver at the last inspection.
- Patient centred follow up care is in place on all clinical trials, and patient feedback is used to improve quality of the patients, care and experience.
- Alder Hey was the leading NHS recruiter of patients to research studies in the North West Coast Local Clinical Research Network in 19/20 and 20/21. Performance for 21/22 is encouraging.
- The Trust has had a significant impact across the city in a range of COVID-19 related Research, in both adults and children, delivering urgent public health (UPH) research to our paediatric population, and taking on adult research to ensure capacity at other centres. The CRD continues to support delivery of Covid-19 studies.
- During this period, the Division's leadership had changed culminating in the appointment of Professor John Chester, as Director of Research & Innovation, Dr. Harriet Corbett as Clinical Director of Research and Jason Taylor as (acting) Associate Chief Operating Officer.
- Next steps – the new Research and Innovation Framework is under development, and operational plans would be developed, to drive its delivery.

Resolved: SQAC received and NOTED the Annual Research Update

FB thanked HC for Annual Research Update.

21/22/161 Board Assurance Framework

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

21/22/162 Divisional Reports by exception/Quality Metrics

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

- The Division had undertaken a deep dive on lone working during November 2021, following a home visit incident. The deep dive was undertaken to strengthen the support for staff.
- New phone system had recently been implemented within the division, for community paediatrics, in order to support parents in contacting the Division, which is going well.
- Division are continuing to see an increased number of referral rates for Neurodevelopmental services, ASD & ADHD, and to the mental health teams, with impact on waiting list and staff wellbeing.
- The Division are continuing to see a significant increase in the number of calls made to the crisis care team.

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

- AH advised that there are currently 524 open incidents which are required to be closed within the next 10 days. The team had successfully cleared numerous historic events from 2020.
- Division continue to focus on workforce challenges, with particular focus on ED workforce, in order to ensure alignment to pressures.
- Division are working closely with the General paediatric team, with a focus on patient flow.

FB welcomed the progress made on clearing those historic incidents, and noted the ongoing challenges.

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

- The Division welcomed Camille Cortez-James, Risk & Governance Lead within the Division, who commenced in post on 1st December 2021.
- The Division had 1 serious harm, and 1 moderate harm. Duty of Candour, rapid review panel, 72 hour review had been undertaken, and RCA panel for both had been aligned, to be undertaken for investigation and review.
- Challenges regarding RTT – 63%.
- Staffing levels remain challenging, with increased numbers and acuity of patients, it is envisaged that these challenges would continue over the coming months.

JG acknowledged, and commended the ongoing recovery efforts within the Surgery Division, with regards to the elective programme, and to service delivery at pre Covid levels, and acknowledged the ongoing efforts across the whole organisation.

FB thanked the Divisional Leads for the Divisional Updates.

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.

Resolved: SQAC received and **NOTED** the Divisional updates.

21/22/163 Patient & Family feedback quarterly report

SQAC received and **NOTED** the Patient & Family feedback quarterly report. NA advised that performance had decreased in month, which related mainly to a decline in Medicine Division. This had been discussed at Clinical Quality Steering Group, focussing on ED, experience and performance, linked to capacity and demand.

KB requested further updates to include Leads/detail regarding who is responsible, and

reporting mechanisms/timescales for the recommendations in the report. NA confirmed that this would be included for the next update.

Resolved: SQAC received and **NOTED** the Patient and Family feedback quarterly report.

21/22/164 SIRI report

NA presented the SIRI report, and apologised for the report being issued late, and outside of the meeting pack.

The report presented was in response to feedback about the current reporting style. The new report would provde a monthly thematic review, and include more detail on the incident reports, and associated actions.

FB advised that this is much more fit for purpose. NA advised that the next steps are to embed thematic reviews, with a continued focus on learning from the incidents in 2022. FB endorsed this.

KB noted that 4 reports at SQAC were also due to be presented to Trust Board, and questioned whether they should be presented to both Trust Board and SQAC, or if SQAC could provide the assurance to Trust Board for some of these reports.

FB advised that a decision is required regarding where scrutiny takes place, and where the reports are being received. JG suggested that a wider offline discussion takes place in the new year.

Resolved: Offline discussion to take place in January 2022

FB thanked NA for SIRI report.

SQAC received and **NOTED** the SIRI report.

21/22/165 Any other business

FB advised that it was Nicki Murdock's last meeting, and expressed personal thanks, and gratitude from SQAC for Nicki's continued contributions made, in terms of safety and quality to SQAC.

21/22/166 Review the key assurances and highlight to report to the Board

The reports presented were noted and 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.
- 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.

21/22/167 Date and Time of Next meeting

19TH January 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

27.01.2022

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	18TH January 2022 – Summary 23rd November 2021 - Approved Minutes
Report of:	Fiona Marston, Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 18th January 2022 along with the approved minutes from the 23rd November 2021 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3 BAF 2.2 - Employee Wellbeing – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. **Introduction**
   The People & Wellbeing Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

   Under its terms of reference, the Committee is responsible for providing strategic direction and board assurance in relation to all workforce matters including monitoring progress against workforce indicators and supporting the organisation in delivering a positive patient centred culture.

2. **Agenda items received, discussed / approved at the meeting)**
   - People Plan
   - Staff Survey 2021
   - Recruitment Recovery Plan
   - Corporate Report Metrics/Workforce KPIs for November 2021
   - Board Assurance Framework/Key Workforce Risks – November 2021
   - CQC Action Plan – November 2021
   - Wellbeing Guardian Update
   - Non-Clinical Claims Update
   - Vaccination as a Condition of Deployment
   - Policies Ratified:
     - Mandatory Training Policy
     - Retirement Policy
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 06.10.21
     - Health & Safety Committee – 21.10.21
     - JCNC – 20.10.21
     - Education Governance – 14.10.21
     - BAME Task Force Action Log – 9.12.21

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   Vaccination as a condition of deployment has been mandated by Government. Alder Hey has an action plan in place and implemented to support staff. Ongoing guidance is being received and we are awaiting national templates

4. **Positive highlights of note**
   Staff Survey 2021 was completed in November 2021 with a 52% response rate. Although lower than our previous response rate it reflects the Covid-related environment and is higher than the national average of 45%.

   The HR **Recruitment** team has seen a >100% increase (year on year) in jobs processed for recruitment in the 6-months to Jan 2022 This impacted the quality of services and in particular time to hire. Implementation of an automated system (TRAC) has reduced time to hire from >65 days to 36 days. This together with temporary additional resourcing, daily huddles, recruitment drop-in sessions and Brilliant Basics is embedding improvement into everyday practices.

   The **Corporate report** metrics highlights increases staff sickness rates and staff turnover. The latter has changed recently and the committee were advised of the deep dive in progress.

5. **Issues for other committees**
   None raised.

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

NHS
Alder Hey Children's
NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 23rd November 2021
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Fiona Beveridge	Non-Executive Director (Deputy Chair)
	Melissa Swindell	Chief People Officer
	Mark Flannagan	Director of Communications & Marketing
	Erica Saunders	Director of Corporate Affairs
	Adam Bateman	Chief Operating Officer (Part attendance)
	Nathan Askew	Chief Nurse
	Racheal Greer	ACOO – Community & Mental Health
In attendance:	Sharon Owen	Deputy Chief People Officer
	Jo Potier	Associate Director of Organisational Development
	Angela Ditchfield	Interim Head of Equality, Diversity & Inclusion
	Clare Shelley	Associate Director of Operational Finance
	Jason Taylor	Acting Associate COO - Research
	Katherine Birch	Director – Alder Hey Academy
	Pauline Brown	Director of Nursing
	Tony Johnson	Staff Side Vice Chair
	Dot Brannigan	Governor
	Amanda Kinsella	Head of Health & Safety
	John Chester	Director of Research & Innovation
	Adrian Hughes	Deputy Medical Director
	Rachel Hanger	Associate Chief Nurse - Surgery
	Jeanette Chamberlain	SALS Manager
	Urmi Das	Divisional Director of Medicine
	Cath Wardell	Associate Chief Nurse – Medicine
	Mark Carmichael	Associate Chief COO - Medicine
	Jackie Friday	Executive Assistant (Minutes)
Apologies:	Nicki Murdock	Medical Director
	Ian Quinlan	Non-Executive Director
	Lisa Cooper	Director of Community & Mental Health Services

21/22/56 **Declarations of Interest**
Fiona Marston – Liverpool School of Tropical Medicine

Introductions
Received for Fiona Marston the new PAWC Chair.

21/22/57 **Minutes of the previous meeting held on 21st September 2021**

Resolved : The minutes of the last meeting were approved as an accurate record (subject to update of minor typing errors)

21/22/58 Matters Arising and Action Log

Matters Arising
None.

Action Log
21/22/39 – Raise the requirement of senior representation with the 3 at the top in the Divisions – MKS confirmed senior representation were at the Committee. **Action Closed**

21/22/44-01 – National Pay Update – Raise at SQAC as key risk – access to care – in the event of industrial action – MKS confirmed this was raised at SQAC by FB. FB added it will be a 'watching brief' should any industrial action take place. Also MKS confirmed it has been added as part of Staff Availability risk on the BAF register. **Action Closed.**

21/22/44-02 – Share with the Committee – The presentation on National Pay Update & NHS corrective Payments Framework in relation to overtime payment and pay during annual leave. MKS confirmed. **Action closed.**

21/22/45 – R&I Division – present metrics. JT has joined the Committee today to present Research metrics. **Action closed**.

21/22/46 – BAF – Discuss inclusion of pay award as a strategic risk. MKS confirmed industrial action has been included as an element of risk in the BAF**. Action closed**.

20/20, 17/13, 19/68 – Review approach to EDI – noted as an agenda item today. Following completed WRES/WDES Action Plan & BAME Taskforce Action Plan, MKS suggested this action be re-worded to read – to monitor at this meeting the 3 action plans. The update was agreed by the Chair. **Action closed**.

21/22/23 – Education Activity Update & Terms of Reference – (an agenda item today)

21/22/49 – Induction Policies – convene meeting to review (outcomes will inform an updated Induction Policy to adapt/reflect the current climate – MKS confirmed an initial meeting has taken place – DS/JP – to update at a future Committee.

21/22/53 – Present on Wellbeing Guardian role and the progress against the 9 principles that the Trust is being monitored against. FM advised that she is the Trust appointed Wellbeing Guardian and is working with JP/JC & Sarah Robertson to develop this role. The forward plan is to engage/update this Committee going forward. **Action deferred to January 2022**.

Trust People Plan 2019-2024

21/22/59 Staff Survey 2021
The Committee received an update report, noted as read. JP shared an overview, headlines and numbers have changed slightly from the submission of report last week. The response rate for the whole organisation stands at 50% (the target was initially set at 65% which was ambitious). JP acknowledged that under current pressures 50% is a fantastic achievement (above average nationally for the sector and not far from the top). JP thanked everyone involved. MKS concurred and advised that colleagues

across Liverpool have shared their struggles to engage staff at the moment. Next steps will be about the push to get as many people as possible to respond to the Staff Survey, then agree how this information is disseminated and is fed back to staff/filtered down (staff survey closes end of the week).

MF referred to next year's Staff Survey campaign and suggested a narrative needs to start in the summer months (around recovery/how staff are doing and the chance to feed that back and have proper conversations).

FM agreed with MF's comments – and acknowledged that whilst teams are doing a brilliant job trying to get people to fill in the survey and seeing change as a result of completion is important to people.

21/22/60 **Non-Agenda for Change Pay Update**

The Committee received a paper (included in the pack and presented by the Deputy Chief People Officer) in relation to those staff members who are not covered under AFC & VSM Terms and Conditions (17 staff – 11 of which have remained on Whitley terms and conditions and pay, remaining staff are Associate Chief Operating Officers and other senior managers).

The national pay award received this year was 3%. The paper sets out a proposal as to what will be put in place for the small group of staff not covered under AFC. SO outlined the proposals and recommendations for the pay increase and increase to on-call payments. The ACOO's have been removed from this proposal as further conversations are required around options (to be reviewed by Chief People Officer, Chief Operating Office and Finance Director). SO sought Committee agreement to the proposal.

FM summarised the two recommendations - a 3% pay award is applied to those staff not on the agenda for change terms and conditions and on-call availability allowances are uplifted by 3% in line with the national pay award. FM asked the Committee for any comments/concerns to be raised for discussion by the Committee.

NA questioned why we are applying agenda for change terms and conditions to staff who have chosen not to transfer over to AFC. SO advised that when people decided not to transfer across to AFC, best practice suggests that retained Whitley Terms and Conditions should be on a 'marked time basis' with the aim of phasing out these contracts i.e. retirement etc., yet these individuals would be disadvantaged by assimilation to AFC in respect of remuneration or other terms. NA was happy to go with consensus, but felt the point needed raising.

FM asked for clarification of what 'marked time' meant. SO advised that when the transition from Whitley to AFC was implemented, the expectation for most individuals transferring is that it was more favourable in terms of remuneration/terms and conditions, but for some individuals it wasn't (i.e. more favourable hours of work under Whitley for some) they decided they would retain the Whitley terms and conditions. The term 'marked time' is that there was an expectation that at some point it would be more favourable for those individuals to transition across. SO acknowledged that applying an increase in pay, decreases likelihood of individuals transitioning across to AFC. Although other benefits that came across with the transition have not been applied to Whitley (e.g. Increased annual leave) just the pay element has been applied. There is an expectation that due to retirement the numbers will significantly reduce.

FB referred to when the transition took place (2004) and advised there are lessons to be learned in relation to making it clear from outset about what the expectations are

and not accommodating preference beyond a transitional period (i.e. people will transfer over sooner rather later culminating a small group still being managed in 2021). FB understood the motivation to not see staff disadvantaged financially.

AB initiated a discussion as to whether a different approach is required going forward with this small group, rather than it continuing indefinitely. Whilst ensuring a caveat is in place so no one is affected in terms of the living wage and there are no detrimental impacts to lowest paid staff. SO noted for assurance purposes that none of this group are affected in terms of living wage. MKS welcomed the challenge and advised that it is hoped to run a review on pay across the organisation in the Spring (following winter pressures). A small number of practices are in place that have developed over time that need looking at as small anomalies are taking place locally. Non-AFC update could be included in that in that review in relation to national terms and conditions. MKS sought the Committee's agreement on this.

NA suggested deferring changes to on-call payments as he and AB are currently reviewing the on-call arrangements and how the rosters work. NA advised it would be sensible to wrap it up together (any payments could be backdated). SO offered to be included in that piece of work.

The Committee agreed to the following: 3% increase for the small cohort of staff that are still on the Whitley terms and conditions to go ahead. A pause will be put in place on the increase to on-call payments and will be included in review of on-call arrangements. A pay review to commence in the Spring inclusive of review of approach for non-AFC practices.

Action 21/22/60-1 – NA/AB – Deferred increase to on-call payments to be included in overall review of on-call arrangements

Action 21/22/60-2 MKS/SO - Pay Review (anomalies across the Trust – inclusive of review of approach for Non-AFC practices

Resolved: PAWC approved the 3% increase for Non-AFC staff.

21/22/61 Internal Communications

The Committee received a report outlining current events at the Trust and ongoing developments of the Comms Team (i.e. Black History Month and Christmas tree launch - virtual). MF highlighted current focus of the team strategically – helping to ensure the Brilliant Basics approach has landed effectively and is embedded; winter plan ensuring the cascade is right with Comms. Going forward to next year – internal and external engagement stakeholder comms function – will be looking to get the go ahead to develop this as will be important and impact on how the team will operate in the future. FM thanked MF for the report and reflected on how good the social media posts of Alder Hey are with good response rates.

Resolved: PAWC received and noted the contents of the Communications Update

21/22/62 Winter Plan – Staff Availability & Wellbeing

The Committee received an update (included in the pack) on how HR & SALS are going to maximise staff availability and support staff wellbeing particularly over winter.

Staff Availability - SO shared a snapshot of the data (nursing availability in ED, PICU, ODP as of 17.11.221) that will be monitored on a weekly basis. Staff availability is impacted not just by sickness, but maternity leave, vacancies, turnover etc. With the

increase in activity/demand across the Trust, HR will continue to monitor this data, particularly the 3 areas mentioned. SO outlined the HR immediate support plans put in place to aid staff availability as outlined in the presentation, with particular attention brought recruitment (targeted campaign for nursing, national shortage) to encourage people to come to Alder Hey.

Retention of staff – this has been reviewed by the HR team with a suite af actions being reviewed i.e. review of retire and return policy, focus on return to work meetings to take place within 48 hours to support meaningful discussion/support plans and wellbeing discussions; HR presence in departments – drop in sessions for a consistent HR advice support on immediate staff concerns - particularly in the 3 areas mentioned; careful consideration around flexible shifts etc.

Staff wellbeing, support and advice – JP shared the additional support available from a SALS point of view. To provide assurance, in addition to the model around improving personal health and wellbeing, JP talked the Committee through the various aspects of support available, such as professional wellbeing support; digital insights; environment; managers and leaders; fulfilment at work; relationships – with the overall aim to minimise distress and maximise trust. JP acknowledged how busy it has been in terms of the number of contacts that come through SALS, but recognised that if we want to provide the best support through winter to the more challenged areas (mentioned earlier by SO) a targeted approach is required and this is what the team are working towards offering through winter. JP shared an example of how that might work (currently being trialled in ED).

SALS Pals - The Committee received a paper outlining the plan of SALS to develop and deliver a cohort of SALS Pals across the organisation to offer departmental support to teams and departments. JC advised a model has been developed, the aim is to incorporate the roles and models of the wellbeing champions (recommended in the people plan by NHS England), mental health first aiders and a lot of the work done by the Pastoral Support Team. Rolled out to those Departments that need it most in the winter (i.e. ED, theatres, wards). Training/support would be given to staff in those departments, so that they can support their colleagues. Envisage staff would be remunerated for SALS Pals, the Executive Team are supportive in principle with further conversations to take place. JP emphasised that it is key to note people would be paid to take on this role. JP referred to last year's staff survey where people feel they are already performing above and beyond their work requirements and suggested it sends a mixed message if people are not paid to perform this role. FM thanked JC for a good paper and was supportive of this model and acknowledged the great work and commitment accomplished by the Team.

MKS sought the Committee's views around the staff availability/wellbeing piece of work and advised the team had been really thoughtful and have worked with a lot of colleagues across the organisation to really think about focus requirements. MKS noted staff availability will be reviewed at Gold Command that day. FM advised that a number of comments were left on the chat i.e. MF suggesting incorporating some of this information on the intranet. RG suggested incorporating the hard to recruit to area in the relocation office offers.

NA referred to the difficult to recruit areas and added that some really careful thought has gone into this, which will hopefully have a real impact. NA acknowledged that there are areas, that nationally, are really difficult to recruit to as well. Rather than individual posts this is entire departments that are very difficult to recruit to. NA is happy to work with SO and the team to focus where needed and to hopefully see increased fill rates.

AB paid recognition to the offer of the deeper departmental support that was outlined in the plan to help with staff availability. AB recognised the importance of the care of frontline staff and getting the right mix of support that works for them and thought it would be well received. AB brought attention to looking beyond winter to really think deeply about workforce planning in the new year and consider how we get better and would welcome something medium term where we all come together to progress workforce planning. AB advised it would be good to have a comprehensive plan (attract the very best, develop new skills etc) and noted that looking at the figures you can see just how critical it can get when we struggle to get the skill mix and volume of staff needed to deliver outstanding care.

Resolved: PAWC received and noted the contents of Winter Plan for Staff Availability & Wellbeing and approved the recommendation received for SALS Pals to continue to develop plans.

Governance

21/22/63 **Corporate Report Metrics – 2021**

The Committee received the Corporate Report and a paper from each of the Divisions to present their people metrics, current position and feedback on any actions as a result. Highlights as follows:

Trust Metrics

Community & Mental Health - RG shared a summary – as of end the of previous week PDR rate reached 90%, pleasing result for the Division, there has been real focus over the last months to improve. Sickness absence has been a challenge over the last few months, down a little bit at 5.7%, some hotspots – 22 on long term sick, all have action plans in place and working closely with colleagues and HR to support that. There are a number of teams where sickness absence is significantly high and some specific actions are taking place to support teams to address. As at yesterday the Staff Survey response rate is 62%. Focussed on that as acknowledge it is really important to receive that feedback.

Medicine Division – MC shared an overview for October – incremental month on month improvement in PDR rates – 72%. Mandatory training – sees a slight dip to 86.1% , some challenges in ED, the team have been working to put some supportive measures in to allow the team to complete, despite the pressures. Sickness absence will have a deep dive, supported by HRBP in terms understanding some of the long-term cases, although GF had advised that some are coming to conclusion, so should hopefully see an improvement in sickness rates in the coming months. Staff Survey as of yesterday was 48.81, quite a good response in comparison to experience in medicine elsewhere (about 30% improvement since dashboard was pulled together). Encouraging teams to support.
CW referred to staff survey completion on the wards. Focus on wards continues this week (speaking to individuals & email), so we will see improvements on completion rates by end of the week. CW acknowledged the support for staff re mental health and wellbeing, staff have benefitted from SALS, but sickness is a concern as of today short term/long term sickness is up to 8.8%, which equates to about 102 staff off within the Division of Medicine. Spoken to the HRBP in relation to putting in place individual target focus on areas that are really challenged. In particular on the wards, focus on really pushing that return to work interview within 48 hours. CW advised that a colleague who is on long term sick, who is unable to work clinically, is supporting the push for Staff Survey completion.

Research Division – JT advised that the update is for the Research Division only. Currently there are no mechanisms in place for inclusion of Innovation. PDR data – there is a gap in the data that is currently being worked on by HRBPs. PDR's have been above 90% for the last 3 months. Mandatory training is positive at 94% in October. JT referred to sickness being in the red, but advised for context that their establishment is less than 70 people, so one person being off sick shows at 2%, currently 5 staff off sick (3 long term, 2 short term), no concerns at a Divisional level. Return to works - more work is undergoing to make sure that is picked up. Staff Survey is positive, as of yesterday 68%.

Surgery Division – RH referred to good processes in the past for PDR's/Staff Survey (reminders for completion via email re compliance etc.). The past year has not seen that clear process possibly due to lots of change with senior structure. RH advised that we need to learn from that to look at how we approach the process in the future to get it were it needs to be. Mandatory training – the teams have worked really hard to keep it at a consistent level, it's just that next push to get above 90% and keep it there. Short term sickness (5.9%) is an issue for the Division, aligns with returns to work and making sure that they're happening way above 68.5%. There has been a lot of work gone into long term sickness to really get that down to 3%, intensive support of staff, making sure staff welfare has taken place etc. RH suggested as a Trust we need to look at staff turnover and exit interviews and feedback from them and making sure that they are fed back to the teams and that we are learning and acting on what people tell us.

MKS thanked the Divisions and acknowledged the challenges faced. MKS shared some general reflections and suggested the requirement to get underneath the metrics a bit more with the support of the HR Team may help. A general view about return to works needs more focus, particularly for short term (supports people to not go off again/people feeling welcomed back into the organisation). Started to see a trend in turnover across the divisions always hovered as a Trust around 9.5% - seeing a slight incremental rise. MKS agreed with RH about the requirement to get underneath the information on leavers more and understand what it is telling us to do. More focus is required working together with the HR Team to understand that.

MKS shared with the Chair that this is the first time we have had some good metrics/conversations with each of the Divisions and advised it is needed at this Committee. MKS exhorted to divisional colleagues that attended the Committee today that it is really important that one of the 'three at the top' from each of the Divisions attend to discuss this data. Thanks were paid to the divisional colleagues for attending today, good data/feedback/conversations were had.

NA agreed completely in relations to return to work interviews. Turnover, it would be good to understand this more. NA suggested it may be to do with post Covid (people perhaps would have left a year ago but didn't). Commented that it is great to have this data, work is needed with the Research Division to bring together Research & Innovation in terms of bringing data together for the next Committee. Also it might be helpful to have an oversight here too of Corporate metrics.

FB added to reinforce what was said about increased turnover. Would welcome a deeper conversation at some point to understand how it is calculated/is it turnover from posts or is it turnover from the organisation/where are people going and what is known about that from exit interviews/what is the organisations approach – strategy to retention/how much of this is actually good news turnover and how much is bad news turnover. FB reiterated she would welcome more information on that in the future.

JP added to the staff turnover discussions and highlighted from readings both nationally/globally it is being referred to as the great attrition, so we should expect to see it as part of the psychological impact of Covid (post traumatic growth where for some people have made decisions that are right for them – positive move alert towards something versus a very negative move away from something). JP agreed it is an important topic to discuss and not just happening in the NHS.

FM acknowledged the good valid points raised above and to be noted as such. FM reflected on JT's comment's – that percentages can be misleading. The metrics are really good and show us a picture immediately but acknowledged the importance of identifying the total figures in each Division so we are aware and can understand the impact on the percentage. MKS advised it can be arranged easily and will ensure it is included in the metrics for the next Committee.

FM thanked the Committee; the metrics gave a good understanding on a broad number of subjects in a single slide and raised good valid points for discussion.

Action 21/22/63 – MKS/HRBP's/Divisions - include the number of staff in each Divisional metric report

Resolved: PAWC received and noted the update on the content of Divisional metrics.

20/22/64 Board Assurance Framework – September 2021 & HR & Workforce Risk Presentation

The Committee received a full BAF report for September, noted as read. ES confirmed that the 3 risks that belong to this Committee continue to be well described and updated. That said following discussions today a mixture of assurance on these risks has been shared. The focus has got to continue to be on the mitigations put in place. ES referred to the focus on mandatory training and the support that has gone into date, but still seeing issues, this links back to the fact that this does sit under the well lead domain. ES shared with the Committee that a lengthy discussion with the Executive Team took place recently about the CQC and planning for the next time when they inspect the Trust. A very focused piece of work is required to ensure all of these issues are addressed. More talks will take place increasingly in the coming months in preparation for an inspection by the regulator. Everything in this Committee falls within that well lead domain, which is key (high/good achieved last time and we wouldn't like to see that slip). ES emphasised the requirement to keep on top of these risks. MKS thanked ES for the feedback.

FM suggested it would be really useful offline to have a chance to reflect back with ES/MKS on the experience of the last CQC inspection (as FM only in post 2 months at that time).

FB referred to some thinking about which of these risks are under the Trust control and which risks aren't. FB shared some examples and advised that it is one of the themes that comes up again and again with specialisms. I.e. national shortage of staff in certain speciality areas. FB referred to the developments in the system and the possibility of addressing workforce issues across the system (Cheshire & Merseyside and more broadly). FB queried; do we ensure that we are capturing opportunities to have that wider conversation to make sure that risks not under Trust control are becoming more amendable to our input. MKS reflected on recent conversations with Sir David Behan, Chair of HEE, when he visited the Trust, around the challenges and innovations taking place at the Trust, where positive feedback

was received. Whilst he acknowledged it is up to the system to sort challenges, MKS agreed more conversations are to be had across Cheshire & Mersey. MKS advised that the HRD community have a joint meeting with Finance Directors coming up soon and one of the things to be talked about is how we can work together on supply.

NA advised we need to maximise the training capacity we have with conversion of our students into full time employees, both for ourselves and across Cheshire & Mersey. Also we need to exploit new models of care (whether that's physicians associates, nurse associates and others). NA added there is scope to do more than we already have both in terms of our own workforce and the training provision across the patch. There is a willingness from HEE to explore alternative options with the Trust at the moment (simulated placement training for nursing staff/to then increase capacity overall). Particularly from a nursing perspective, changing the makeup of our workforce and really embracing all of the opportunities that are there. NA advised that in addition to this, a plan will be coming to Execs in early 2022 around training a large cohort of nurse associates, so that they can be utilised across a small number of departments to a greater effect than at present.

UD updated the Committee on a recent meeting with Cheshire & Mersey. An issue the Trust is facing relating to the restriction on numbers of trainees we receive (tiers between ST3 to SD8 restricted to 39 trainees). Manchester receive more trainees than the Trust, this is an historic system which has never been addressed as the Trust has the capacity to train more. UD was not sure where the conversation needs to be picked up but will take off-line with MKS.

Resolved: PAWC received and noted the latest position of the Board Assurance Framework

21/22/65 CQC Action Plan – November 2021

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. ES advised this action is down as completed but noted as outlined above the Trust are still experiencing high levels of pressure. The intention is to close the CQC Action Plan down, the current inspector is not focussed on it. From a process point of view - going forward the remit of the remaining actions will become part of business as usual rather than having them on a plan. Whilst making sure we are prepared for any future inspections.

Resolved: PAWC received and noted the content of the CQC Action Plan

21/22/66 Health & Safety Update

The Committee received a report prepared by the Head of Health & Safety. AK shared an overview of Health & Safety performance monitoring for the period 1st April – 30th September 2021. Detailed in the report is performance information regarding reactive monitoring, where incidents have occurred and proactive monitoring to show what is being done to ensure that the Trust has robust systems in place to prevent injury and ill-health. Health & Safety Advisors continue to work closely and regularly with the Divisions and each Division currently has a dedicated H&S Advisor assigned to them and this is well received by the Divisions. Highlights as follows:

AK reflected on the report – there has been a significant level of health and safety focused activity that has been undertaken to improve the management of H&S across the Trust, with strong formed with relationships Mitie, Building Services Teams and Staff Side Safety Reps, who have undertaken internal inspections to try to eliminate some of those risks.

FM thanked AK for a comprehensive report and recognised just how much work had been progressed by AK and the Team. Questions raised:

NA referred to manual handling compliance and the risk to patients/staff. NA asked if there is a trajectory of when we will become compliant, if so where is that monitored? AK advised that work is currently taking place on the recovery plan and is happy to share this going forward. MKS confirmed the recovery plans for resus and manual handling training are to be monitored at Gold Command. AB confirmed that this will be monitored at Gold Command as part of 'keeping safe' piece of work to ensure compliancy with all regulatory standards. AB to connect AK offline with BI and advised that we do want to reach that high level of compliance. MKS thanked NA for raising.

FB acknowledged Health & Safety is everywhere and it is really difficult to benchmark as related to levels of activity that increases/decreases, particularly over recent months. FB added that it was reassuring to hear so much has taken place, particular the good engagement with Divisions, contractors etc.

FB referred to the report from an assurance/Board point of view and questioned how we would know if enough was being done, or if this was falling below where we should be up to.

FB raised a number of queries for consideration: what do the annual objectives look like for H&S; how would they be measured across the Trust to ensure they are met; what would be happening if they were not being met and needed more focussed attention; what is the overall objective here and what do you feel about progress and where perhaps there is more that needs to be done or where you were particular happy about progress.

AK drew attention to where more could be done. Moving forward the aim is to put in the robust systems, i.e. training of managers/workforce in what they need to look for in relation to how they manage their workplace activities safely going forward.

MKS reflected on discussions and confirmed this is the first time this report has been brought to the Committee and recognised that the report will develop over time (the request for the report was to report on 6 months of activity that had taken place). MKS referred to the current unusual circumstances at the Trust that impacts on our H&S Team resource (major focus on the campus build), ordinarily the H&S Team resource would just be focussed on the premises you currently have and the staff. Work continues (i.e. business case preparation) to ensure we have enough resource to focus on staff and the current buildings and the campus development that is taking place over the next couple of years. MKS welcomed FB's helpful challenge and suggested putting a dashboard together to bring all information together (i.e. categorise increasing decreasing incidents/areas – to inform response to high risk/change in trends). MKS confirmed all this data reports into the Health & Safety Committee, the minutes of that meeting are shared with PAWC. AK confirmed all data sets are available for Health & Safety and would be happy to share that information.

FM thanked the Committee for a really positive discussion and confirmed some form of dashboard of current status would keep the Board informed and assured.

Action – 21/22/66 – MKS/AK to produce a current status dashboard for Health & Safety to inform the Board

Resolved : PAWC received and noted the contents of the Health & Safety Update

21/22/67 **Policies**

The Committee received the following policy and Equality Assessment for formal ratification/approval.

MKS advised the following policies have been through approval process and discussion process (with management/Staff Side input) at the Committees noted below and are presented here for final ratification. A record of any changes is recorded on page 2 of the policy.

Manual Handling Policy & Associated Papers (approved at H&SC)
Fire Procedures Policy (approved at H&SC)
Consultant SAS Doctor Leave Policy (approved at LNC)
Flexible Working Policy (approved at PRG)

FM acknowledged everyone is really busy and the policy section can run to 100's of pages. It would help the Committee if a summary page could be added for all policies outlining key points of change. MKS agreed this would be helpful.

21/22/67 – MKS/SO - Policies – key points of change summary to be added - to inform the Committee of changes made

Resolved: PAWC received and ratified the above policies.

21/22/68 **EDI Taskforce & LGBTQIA/Disability Networks**

AD shared an update as to progress so far with staff networks and the EDI agenda. AD advised that staff networks had been disbanded over time and the Trust is in a much stronger position now to relaunch them and take the EDI agenda forward as an organisation.

AD advised that the networks are a priority to ensure that staff feel supported, valued and that they have a voice in creating some change within the organisation and improve their working lives and experiences. A commitment was made at Alder Hey to become an anti-racist organisation and Claire Dove was commissioned as Non-Executive Director to lead the BAME Taskforce and introduce a positive experience for staff at Alder Hey. CD and the Taskforce members have worked really hard in setting achievable objectives, highlighting gaps and celebrating success and there is going to be an imminent launch of the BAME Staff Network. The work that CD and the Taskforce have done will continue and the BAME Staff Network will take that forward. AD advised that it is still a long journey with a long way to go, but the launch of the Network will drive that with the commitment, dedication and passion of the staff involved.

AD referred to the LGBTQIA+ Network and advised that will be relaunched soon. On the 1st December 2021 is World Aids Day and there is going to be a huge celebration event at the Trust, with guest speakers represented. AD thanked NA for the work undertaken, holding listening/discussion events with staff and really trying to understand what staff want, it's a great achievement for the Trust and to have the drive and support of NA and the team. It is hoped with this great support that the LGBTQIA Plus Network will soon have an elected chair/deputy chair to move the Network forward as well.

AD referred to the Disability & Wellbeing Staff Network and advised that it urgently needs to relaunch following the fantastic work that the SALS Team have done in helping to provide listening events for staff. AD attended the last one and advised there are some common themes coming through i.e. the need for relaunch of the Network, training, raising awareness and promotion of disabilities both seen and unseen, along with gaining trust with the leadership team and organisation so that staff are more open to disclose that they have a disability. Lots of work to be done in that and to secure some executive sponsorship for this network, with the requirement to appoint a chair who is passionate and committed to drive this forward. The plan is to hold another event before year end to outline clear plans/next steps and once executive sponsor is sourced a relaunch of the network can commence next year. Staff have indicated they want to model the network something similar to the BAME Taskforce, once launched that can be developed.

AD briefly updated the Committee on collaboration – we are going to be working as a collaboration with Alder Hey, Clatterbridge and the Walton Centre, which is a new model. The collaboration will share ideas, training, resources and best practice. It will be really good for us all to come together. An online platform has been developed which each Trust can access to enable communication/sharing. It is hoped that each Trust will have their own Networks in place but come together maybe once or twice a year to celebrate what they've done and to share that good practice. It will help to develop training/resources and will support recruitment and panels. It is exciting to see the direction that the Trust is moving into. AD acknowledged it's a long journey for EDI, but the journey has been started. It is going to help the staff immensely that the Trust is giving them a voice so that they can be involved in change and development at Alder Hey. AD thanked everybody for their support to help move EDI forward. FM understood that AD's role was an interim post and thanked AD for doing a great job and making such a good contribution.

Resolved: PAWC received and noted the content of the update.

21/22/69 **Board of Directors Summary**

- Staff Survey – The Committee recognised the effort made to improve response rates.
- Non-AFC Pay Update, local principles discussed.
- Winter Plan – noted all the initiatives – good support in place, SALS and wellbeing initiatives.
- Divisional Metrics – good discussion/representatives from the Divisions and identified risks that are progressing.
- Health & Safety update – robust discussion – challenges raised on how we measure going forward.
- EDI Taskforce & LGBTQIA/Disability Network – launch networks, collaboration model for EDI shared.

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

21/22/70 The Committee received the minutes for the following for information, noted as read.

- Local Negotiating Committee – 04.08.2021
- Health & Safety Committee – 09.09.2021
- JCNC – 22.07.21 & 22.09.21
- Education Governance – 20.08.21 (incl. of Activity Update)
- Education Governance – Terms of Reference
- BAME Task Force Action Plan – 19.11.21

MKS advised the above are shared for information – No questions raised.

KB referred to Education Governance (EG) minutes and advised they represent a shift in how they report on EG into PAWC, alongside that, a review has been undertaken of EG systems and processes. Also a revised Terms of Reference (TOR) has been shared with the Committee and the Divisions, circulated widely. The TOR has also been shared with partners in terms of how they would wish EG to be sighted at Board level, this has been picked up both by GMC and University of Liverpool in their Quality Reviews. KB advised she is comfortable that the revised TOR really strengthens what's been in place before and provides that really clear line of sight from Board through PAWC to EG and vice versa.

Resolved: PAWC noted the content of the minutes and approved the Terms of Reference for Education Governance Committee

21/22/71 **Any other business**

Resolved : PAWC noted there were no further items raised under AOB.

21/22/72 **Review of Meeting**

FM thanked MKS for her support at today's meeting and thanked everybody for their input.

21/22/73 **Date and Time of Next meeting**

Tuesday 18th January 2022, at 10am-12noon via Microsoft Teams.

Minute Reference	Action	Who	When	Status
Matters Arising				
21/22/39	Raise the requirement of senior representation with the 3 at the top in the Divisions	MKS	September 2021	Noted on 23.11.2021 senior representation were at the Committee - Closed
Trust People Plan 2019-24				
21/22/60-1 **21/22/60-2**	Non Agenda for Change (AFC) Pay Update • Deferred increase to on-call payments to be included in overall review of on-call arrangements • Pay Review – small anomalies across the Trust – to also include review of approach for Non-AFC practices	NA/AB MKS/SO	March 2022 Spring 2022	
21/22/44-01 **21/22/44-02**	National Pay Update • Raise at SQAC – key risk – access to care in the event of industrial action • Share with the Committee – The presentation on National Pay Update & NHS Corrective Payments Framework in relation to overtime payment and pay during annual leave	FB MKS	Next SQAC Immediate	Noted on 23.11.2021 – shared with SQAC – Closed Noted on 23.11.2021 - MKS confirmed - Closed
Governance				
21/22/64	Divisional Metrics • Include the number of staff in each Divisional metric report	MKS/HRBP's/ Divisions	Immediate	
21/22/66	Health & Safety • To produce a current status dashboard for Health & Safety to inform the Board	MKS/AK	Immediate	
21/22/67	Policies • Policies – key points of change summary to be added - to inform the Committee of changes made	MKS/SO		
21/22/45	• R&I Division present metrics	JT	November 2021 - ongoing	Noted on 23.11.2021 – JT presented the

				Research metrics - Closed
21/22/46	BAF • Discuss inclusion of pay award as a strategic risk	ES/MKS	September 2021	Noted on 23.11.2021 – MKS confirmed industrial action has been confirmed as an element of risk - Closed
Equality, Diversity & Inclusion				
21/22/58	• Monitor 3 action Plans WRES/WDES/BAME		Ongoing	
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD SM	TBC 1/4ly Update 6 monthly Review	Noted on 23.11.2021 – these actions have been reworded as (above action 21/22/58) following new approach to EDI - Closed WRES/WDES action plans completed BAME Taskforce Action Plans completed
Education Governance Update				
21/22/23	• Education Activity Update	KB	November 2021	Noted on 23.11.2021 – this update was included in the EG 20.08.21 minutes received – The TOR was approved - Closed
Policies				
21/22/49	• Convene a meeting with JP/KB/MF to review Inductions at the Trust (outcomes will inform an updated Induction Policy to adapt/reflect the current climate)	MKS	TBC	Noted on 23.11.2021 – MKS confirmed an initial meeting took place with DS/JP
AOB				

21/22/53	• Present about the Wellbeing Guardian role and the progress against the 9 principles that the Trust is being monitored against.	FM	January 2022	Deferred to January 2022