NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 29th July 2021, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:15am)							
1.	**21/22/84**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/85**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/86**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 24th June 2021.**	**D**	Read minutes
4.	**21/22/87**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read action log
POST COVID-19 Recovery Plan 2021/22							
5.	**21/22/88**	**9:25 (25 mins)**	• **Preparedness Plan for ED surge, RSV and elective care; including:** - **Update on restoration and recovery.** • **Staff/Patient Safety:** - **Staff safety and support.** - **IPC assurance.**	A. Bateman M. Swindell N. Murdock	To receive the Trust's Preparedness Plan for the ED surge, RSV and elective care, and an update on access, restoration and recovery of services. To provide an update on staff support and welfare To provide the Board with an update on IPC.	**A** **A** **A**	Read report Presentation Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**21/22/89**	**9:50 (10 mins)**	**Draft Patient Safety Strategy.**	N. Murdock/ N. Askew	To receive and approve the draft Patient Safety Strategy.	**A**	Read report
7.	**21/22/90**	**10:00 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
8.	**21/22/91**	**10:05 (5 mins)**	**Nurse Workforce Annual Report 2020/21.**	N. Askew	To receive the Nurse Workforce Annual Report for 2020/21.	**R/A**	Read report
9.	**21/22/92**	**10:10 (5 mins)**	**Digital and Information Technology Update.**	K. Warriner	To provide an update.	**A**	Read report
10.	**21/22/93**	**10:15 (25 mins)**	**Corporate Report – Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** **Cumulative Corporate Report Metrics – Top Line Indicators:** • **Quality.** • **Safety.** • **Effective/Responsive.**	U. Das J. Pointon A Bass N. Murdock N. Askew A. Bateman	To receive a report on Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
11.	**21/22/94**	**10:40 (5 mins)**	**Alder Hey Wellbeing Guardian.**	F. Marston	To provide an update the Wellbeing Guardian's actions.	**A**	Read report
12.	**21/22/95**	**10:45 (5 mins)**	**Cumulative Corporate Report Metrics – Top Line Indicators:** • **People.**	M. Swindell	To receive a report on Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	*Refer to item 10*
13.	**21/22/96**	**10:50 (10 mins)**	**Alder Hey People Plan Update:** • **BAME Inclusion**	M. Swindell C. Dove	To provide an update on the Alder Hey People Plan. To provide an update on the work conducted by the	**A** **A**	Read report Presentation

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			Taskforce update.		BAME Inclusion Taskforce.		
14.	**21/22/97**	**11:00 (5 mins)**	**Medical Revalidation Update.**	N. Murdock	To provide an update medical revalidation.	**A**	Read report
15.	**21/22/98**	**11:05 (10 mins)**	**Freedom to Speak Up.**	K. Turner	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
16.	**21/22/99**	**11:15 (10 mins)**	**2021/22 H2 Update:** - **Financial Update, M3 2021/22.**	R. Lea	To provide an overview of the position for Month 3 and the latest financial guidance.	**A**	Presentation
17.	**21/22/100**	**11:25 (5 mins)**	**Directors' Register of Interests.**	E. Saunders	To receive and note the Directors' Register of Interests for 2020/21.	A	Read report
18.	**21/22/101**	**11:30 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
19.	**21/22/102**	**11:35 (10 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 26.7.21.** - **Approved minutes from the meeting held on the 21.6.21** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 21.7.21.** - **Approved minutes from**	I Quinlan K. Byrne	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			the meeting held on the 23.6.21. • **People and Wellbeing Committee:** - **Chair's Highlight Report from the meeting held on the 20.7.21** - **Approved minutes from the meeting held on the 18.5.21.**	C. Dove			
Strategic Update							
20.	**21/22/103**	**11:45 (30 mins)**	**ICS Development Update:** • **Cheshire and Merseyside arrangements.** • **Update re Health and Care Bill.** • **Top line issues, implications for Alder Hey's Strategy – Planning session for September.** • **Cheshire and Merseyside NHS Mental Health, Learning Disabilities and Community Services Provider Collaborative MoU.**	L. Shepherd/ D. Jones	To receive an update on the development of ICSs. For approval in order to provide the Chief Executive with delegated authority to sign the MoU on behalf of the Trust.	**A** **D**	Presentation *(Refer to item 6 in the information pack)*
21.	**21/22/105**	**12:15 (5 mins)**	**Alder Hey in the Park Campus Development update:** • **Update on Springfield Park.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation. To receive an update on progress with the Park development.	**A** **A**	Report to follow Verbal
Items for information							

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22.	**22/22/106**	**12:20 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**21/22/107**	**12:24 (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, 30th September 2021, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in June 2021:
373 – Hill Dickinson – Plans for Baird House – Alder Hey, Liverpool Innovation Park

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan	E. Saunders
Financial Metrics, M3, 2021/22	R. Lea
DIPC Monthly Exception Report	N. Murdock
Register of Company Shareholdings as at the 30.6.21	R. Lea
ICS Design Framework	D. Jones
C&M NHS Mental Health, Learning Disabilities and Community Services Provider Collaborative MoU.	D. Jones

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 24th June2021 at 9:00am,**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/ Deputy 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. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Mr. A. Bass	Director of Surgery	(AB)
	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. C. Liddy	Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Apologies:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
Staff Story	Ms. V. Bucknall	Orthopaedic Surgeon	(VB)
Item 21/22/59	Mr. R. Tyler	Ernst and Young	(RT)
Item 21/22/62	Dr. B. Larru	Director of Infection Prevention Control	(BL)
Item 21/22/70	Ms. J. Deeney	Liverpool Neonatal Partnership Team	(JD)
Item 21/22/71	Dr. C. Dewhurst	Liverpool Neonatal Partnership Team	(CD)
Item 21/22/71	Ms. H. Rogers	Liverpool Neonatal Partnership Team	(HR)

Staff Story

The Chair welcomed the Clinical Lead for the 'Safer Teams at Alder Hey Theatres' (STAT) programme, Vittoria Bucknall, who had been invited to June's Trust Board to provide information on the programme.

Vittoria provided an overview of the mission of the STAT programme; thinking laterally to improve practice, teaching staff to recognise human factors that play a part in critical incidents so that they can be mitigated and having a team approach which incorporates all members of the Theatre Team. The programme is being taught via a three-pronged approach; teaching human factors, showing staff how human factors actually cause critical events via the use of simulation, and coaching. In terms of coaching, the Faculty Team will re-visit staff in a theatre

environment at a later date to help develop the team and keep the momentum going. Vittoria offered Board members the opportunity to attend a session if they wished to.

It was reported that the STAT programme takes place over the duration of a day and a half and is going to be delivered to all Theatres teams, with each team being taught together as a whole. Following a pilot with members of the Orthopaedic Team, the programme was refined and rolled out to ENT Teams in February 2021. It was reported that the feedback received from staff was really positive with comments such as; "I really enjoyed it", "It was not what I expected", "I would recommend the programme", "I feel empowered to speak up", "I understand everyone's role in the team".

The Board was advised that teaching has commenced and will continue every 2 weeks on a bi-monthly basis for the coming year. It has been predicted that the completion of the programme will take three and a half years. Following roll out of the programme staff have reported a number of issues that with small improvements will make a big difference to people working on the ground, therefore the Faculty Team have created a STATS CV of the issues that can be improved.

A discussion took place around how to capture the learning from the STAT programme and it was agreed that this should be done as part of the continuous improvement work that the Trust is conducting. Nathan Askew also agreed to meet with Vittoria and Alfie Bass to discuss a process for reporting learning and issues via CQSG and SQAC.
Action: NA

Alf Bass drew attention to the intensity of the programme, the length of time it is going to take to complete the programme, the commitment by the Trust to enable clinician participation in terms of taking clinicians away from their work, and advised that a report will be submitted to the Board in the near future on the options and costs for accelerating the programme.

On behalf of the Board, the Chair thanked Vittoria for her leadership and progressing the programme with a passion that is a feature of its success. The Chair agreed with the importance of accelerating the programme and asked Board members to take time out to learn about the programme so that the Board can offer support in the progression of this work across the Trust.

21/22/55 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. Congratulations were offered to Fiona Marston for receiving an OBE in the Queen's Birthday Honours.

21/22/56 Declarations of Interest

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

21/22/57 Minutes of the previous meetings held on Thursday 27th May 2021
Resolved:
The minutes from the meeting held on the 25.3.21 were agreed as an accurate record of the meeting.

21/22/58 Matters Arising and Action Log

Matter Arising

There was nothing to discuss.

Action Log

Action 21/22/09.2: SALs update *(Look at the possibility of evaluating the SALS service/model and link in with the Psychology Department at the University of Liverpool to capture the outcome in a framework in terms of demonstrating the difference/impact that the service has made)* – The Trust has an extensive plan in place to look at how it will address research and evidence based outcomes for the SALS Programme. This is supported via the funding that Alder Hey received from the NHS National Leadership Academy for Sarah Robertson's post. Sarah Robertson is a Psychologist with the Trust and is progressing this work.
ACTION CLOSED

21/22/59 Draft Annual Report and Accounts for 2020/21

The Trust Board received the draft Annual Report and Accounts for 2020/21. The Board was advised that Richard Tyler from the Trust's external auditor has been invited to present the ISA260 and provide an overview of the work that has been completed by Ernst and Young as part of the audit. The draft set of reports were submitted to the Audit and Risk Committee on the 17.6.21, this included a briefing paper to bring the accounts to life in terms of the Trust achieving its breakeven target, the organisation's fixed asset impairment along with key variants and movements. It was reported that the Chair of the Resources and Business Development Committee (RABD), Ian Quinlan, attended June's Audit and Risk Committee to offer assurance on the consistency of the information/data that is included in the draft 2020/21 Financial Accounts, from a RABD perspective.

Erica Saunders advised that the Centre has continued to relax some of the expectations of the content in the Annual Report in response to Covid and attention was drawn to the separate submission of the Quality Account for the second year running, which the Trust is aiming to publish by the 30.6.21. It was confirmed that the Quality Account is not subject to a limited assurance audit process by Ernst and Young and is presently being shared with commissioners and other stakeholders for feedback purposes.

The Board was provided with an overview of the Annual Report which includes a strong emphasis on patient care, the 'People' agenda, innovation and digital. It was pointed out that within the report there is a section on the organisation's strategic pillar in terms of the delivery of outstanding care therefore there is a some overlap with the Quality Account when reporting on the Trust's activities and focus on safety and quality during the year. Erica Saunders pointed out that there is a lot more content in terms of the organisation's external facing work with stakeholders and there was also a new requirement in 2020/21 for organisations to reflect upon how they have ensured equality of services.

The Annual Report has been checked for consistency by E&Y along with the Annual Governance Statement, of which, it was confirmed that there were no material differences found. The date of submission to NHSI/E is the 29.6.21 and thereafter the Trust will lay the Annual Report and Accounts before Parliament. It was proposed that this be done after the summer recess rather than on the 9.7.21 to enable the Trust's designers to compile the report into its usual Alder Hey branded format.

The Chair felt that the Annual Report and Accounts reflects the amazing year that the Trust has had despite the pandemic and on behalf of the Board thanked everyone across the Trust for their hard work and team effort to achieve this position. The Chair also thanked Erica Saunders and all those involved in producing a very compelling report.

Louise Shepherd reiterated the Chair's comments and reflected upon the governance of the organisation and the 'lite' approach that was applied in a meaningful way throughout the year thus enabling the Trust to respond efficiently to the pandemic. Louise Shepherd thanked the Non-Executive Directors for their support and understanding of the situation the Trust was facing and their agreement to the changes that were required in terms of how the Board governed itself. As a result of a unitary Board the Executive Team felt safe and secure in the work that they were conducting.

Shalni Arora felt that the outcome of the report was really positive and the detail showcased how agile and dynamic the Trust is.

Resolved:
The Board approved the Annual Audit Report and Financial Accounts for 2020/21.

External Audit 'ISA260' and new draft Annual Audit Report, 2020/21 – ISA260

The Board received the draft External Audit Year-end Report for 2020/21. Richard Tyler thanked the Director of Finance and his team for their co-operation with the audit process and drew attention to the following areas in the report:

- '*ISA260'* - E&Y have completed the testing of the Trust's Remuneration Report which is subject to audit and have concluded the related parties testing which was outstanding on the last version of the report submitted to the Audit and Risk Committee on the 17.6.21. Attention was drawn to an outstanding expenditure item that related to a bad debt provision that was subject to management judgment. Testing has concluded and it was confirmed that E&Y are satisfied that the figure is within an acceptable range and won't have a material impact on the financial statements and therefore have given a clean opinion.
- *Value for Money (VFM)* – It was confirmed that VFM procedures have been completed and E&Y did not identify any risks that required further work to be undertaken, or any significant weaknesses.
- *Proposed Opinion* – The Board was advised of the changes to this area of work in terms of key audit matters and the responsibilities for the reporting of VFM under the new audit practice (*refer to section 4 of the ISA260*). It is proposed that E&Y will sign their opinion on the 28.6.21 and return it on the same day for signing by the Trust.
- *Draft Annual Audit Report* – E&Y are required to prepare an Annual Audit Report in addition to the ISA260. This is submitted in draft form under the new regulations and will be finalised following the issue of E&Y's audit opinion. It was confirmed that there is a requirement for the Trust to publish this new report.

The Chair of the Audit and Risk Committee, Kerry Byrne, confirmed that the Committee had received the ISA260, the draft Annual Audit Report and the Letter of Representations and advised that only minor queries were raised which were answered during the meeting.

Resolved:
The Board approved the ISA260 and the draft external Annual Audit Report.

Draft Letter of Representations
Resolved:
The Board received and noted the draft letter of representation.

21/22/60 Committee Annual Reports 2020/21

The Board received the following Committee Annual Reports for 2020/21, noting how each Committee had fulfilled its terms of reference and managed its governance processes during the pandemic; it also acknowledged the future priorities for each Committee during 2021/22:

- Audit and Risk Committee (ARC).
- Safety and Quality Assurance Committee (SQAC).
- Resources and Business Development Committee (RABD).
- People and Wellbeing Committee (PAWC).
- Innovation Committee.

Fiona Beveridge advised that the CQC Action Plan was due to be closed in May 2021, but will remain open until this can be agreed with the new CQC Inspector. The Annual Report is to be amended, confirming that the recommendations in the plan have been actioned and that the Trust is seeking sign off from CQC to enable the action plan to be closed.

21/22/60.1 Action: KMC

Ian Quinlan pointed out that the committee priorities in the RABD Annual Report should read; 2021/22. It was agreed to amend the report to reflect this change.

21/22/60.2 Action: KMC

The Chair thanked each of the Assurance Committee Chairs for their leadership during an unprecedented year.

Resolved:
The Board received and noted the contents of the 2020/21 Annual Reports for each of the Assurance Committee.

21/22/61 Board Self-Certification of Compliance with the Provider Licence
Resolved:
The Board received and approved the Self-Certification of Compliance with the Trust's Provider Licence, together with the annual self-assessment.

21/22/62 Post Covid-19 Recovery Plan 2021/22

Access and Restoration

The Board received a summary of the progress that has been made in restoring access/recovery of services for children and young people (CYP) during the month of May 2021. The following information was shared with the Board:

- The Trust has delivered substantial progress in the recovery of services for CYP, providing more consultations and treatment in May 2021 than in May 2019 prior to the Covid-19 pandemic;115% recovery was achieved in outpatients.
- 107% recovery was achieved in inpatients and day case.
- 97% recovery was achieved in diagnostics.

- The number of children waiting over 52 weeks for treatment on an open referral to treatment pathway (RTT) has reduced from a peak of 338 in March 2021 to 235 in May 2021. Attention was drawn to the difficulties that will be

experienced in the months ahead in terms of continuity in the reduction of waiting times but it is expected that the accelerator programme will deliver a return to an underlying trend of reducing numbers of patients waiting 52 weeks for treatment.

- It was reported that the Trust's Emergency Department (ED) is experiencing a rising wave in attendances which began in March 2021 and has grown in May 2021 to be 134% of attendances seen in May 2019. This is affecting ED and putting pressure on staff. It was also pointed out that the NHS as a whole is experiencing a surge in urgent care.
- The Board was advised that the Trust has mobilised preparedness for a respiratory syncytial virus (RSV) epidemic, with a potential surge in cases modelled from August 2021. The confluence of high levels of elective capacity against an outlook of rising demand for unplanned care and a possible RSV epidemic requires an organisation-wide capacity and workforce plan for September to March 2022. This is being prepared and the integrated plan will be shared with the Trust Board in July 2021.

Fiona Marston drew attention to the huge surge of children and young people (CYP) with mental health needs and asked as to whether the Trust is receiving any additional support to help provide care for these patients. It was reported that there is a huge focus on this area of work which is being managed nationally via a separate workstream. £5m of investment has been secured which will help support Crisis Care, the Eating Disorder Service, the reduction of waiting times and see the workforce grow.

Fiona Beveridge advised that a presentation was shared with SQAC in June that provided an overview of the increase in patients being experienced by ED along with the known issues, threats, risks and mitigations. It was confirmed that SQAC will receive a monthly update on this issue.

Paediatric Accelerator Bid Summary Position

The Board was provided with an overview of the various funding streams that have been put in place to support the Trust's elective recovery plans and to outline the impact of the accelerator bid in clearing waiting list backlogs and managing demand going forward.

It was reported that the elective recovery fund (ERF) will potentially provide additional income over and above the Trust's core funding predicated on delivery of activity thresholds during H1. In addition to this, it has been confirmed that the Trust will receive funding of £2.75m via the paediatric accelerator bid to support a long-term, sustainable step-up of activity levels. It has been forecast that 3,844 patients will receive treatment sooner as a result of the investment.

The Trust's accelerator funds will be used to support delivery of sustainable, transformational change through:

- Workforce modernisation and new models of care, for example, in anaesthesia to support sedation pathways.
- Stepped release of bed capacity to manage the anticipated increase in RSV and thereby minimise the risk of theatre cancellations due to bed shortages.
- Transformational change through the use of technology.
- The use of capital as an enabler to support an increase in clinic capacity.

The Chair pointed out that this is a huge remit and queried as to whether the Trust will be able to recruit to the required positions to support the accelerator programme.

It was pointed out that it is not going to be an easy feat but there are options available. The Board was advised that Alder Hey appointed four anaesthetists on the 18.6.21 who will commence in post in February 2022, and in addition the Trust had recently recruited fifty nurses. The challenging aspect of recruitment is ensuring staff members are in post in a timely manner.

Fiona Marston asked for further clarification in terms of whether the Trust is dependent on the ICS as a whole in terms of achieving the 120% ERF target. The Board was advised that receipt of ERF funds is incumbent on the system meeting the criteria and at the present time the data is showing that the system is overachieving. It was reported that there are six gateways that have to be met in terms of actual performance and at the present moment this is a low risk. Louise Shepherd pointed out that the system and the Trust will do everything possible to achieve the 120% target, but it does not necessarily mean that this will be the final outcome and this has been recognised nationally. On behalf of the Board, Louise Shepherd thanked Sarah Jane Marsh, CEO at Birmingham Women's and Children's Hospital for her leadership on this area of work.

A discussion took place around the possibility of working collaboratively across the system to provide mutual aid, the challenges ahead for the Trust, the issue of mutual aid being provided by District General Hospitals across Cheshire and Merseyside in the event of an RSV surge and the impact that this could have on the Trust.

Fiona Beveridge queried Alder Hey's role across the collaborative from a technological innovation perspective. The Board was advised that the Trust has seen this as a high priority for the collaborative and Adam Bateman has agreed to lead on this work. It was reported that £1m has been set aside to co-develop a deep exploration of Artificial Intelligence to predict Was Not Brought patients and the development of a digital platform for CYP to assist with access to care. It was confirmed that an Innovation sub-group has been established which the Trust is involved in.

The Chair concluded this item by drawing attention to the importance of recognising the risks that will have an impact on the Trust achieving the ERF target and pointed out that this will become an increasing issue for Alder Hey over the coming years.

Staff/Patient Safety

IPC Assurance

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

- It was reported that there has been one case of C. difficile in the Trust. This case was not as a result of a lapse in care, but it was reported that work is going to take place on a diagnostic Standard Operating Procedure for C. difficile in oncology patients.
- *Vaccination rates* – 85% of staff have received the second dose of the vaccine.
- *Fit Testing* – The number of staff who have been fit tested has increased (94% as at the 31.5.21). There is a strategy in place for twelve monthly updates of all staff, this will start in June 2021 with staff who were tested in August 2020.
- The Trust has seen an increase in staff testing Covid-positive with a total of 10 staff members having a positive test as at the 23.6.21.

- There has been a new update on the IPC guidance that was published at the beginning of June. It was confirmed that the Trust does not need to change anything in terms of PPE as the organisation has incorporated all of the recommendations made by Public Health England.
- *Prevalence Estimates made by Public Health England* – It was reported that the North West will move from a green rating (*prevalence of less than 0.5*) to an amber rating (prevalence of 0.5% - 2%). The Trust has very low numbers of pre-op cases that are positive and has low admissions of patients with Covid-19.
- *Monitoring of vaccine effectiveness* – There are ten members of staff who have tested positive for Covid even though the majority of staff have been fully vaccinated. The Trust is also seeing an increase in staff members having to isolate due to household contact.
- It was reported that the Trust is hoping to have a tool that will assist with the reopening of non-clinical activities for staff on the Campus.
- *Clinical research* – The Trust is looking to use technology to speed up the output of results.

Fiona Beveridge drew attention to the reduction in staff self-testing/LAMP uptake and queried as to whether a communication needs to be circulated with a focus on patient safety and what it means to work in a hospital environment. It was pointed out that one of the biggest concerns is staff not using masks as much and it was felt that a more personalised communication is required. The Board was advised that the Communications Team is working on a poster and a message refresh.

The Chair thanked Beatriz Larru for the work that is taking place around Infection, Prevention and Control and pointed out that the awareness of risk provided in the update is invaluable to the Trust.

Staff Safety Metrics

An update was provided to the Board on figures relating to staff absence as at the 21.6.21. The following points were highlighted:

- Overall staff absence as at the 21.6.21 was 5.5%, with non-Covid absence just over 5%.
- There are seven members of staff absent due to being symptomatic.
- There are six members of staff absent due to self-isolating.
- The Trust has two members of staff shielding.
- There are a number of colleagues who are suffering from long Covid and it was confirmed that the organisation is putting measures in place to support these employees. The Trust is awaiting national guidance on the payment mechanism for long Covid and what it means for the organisation and its employees.
- The Board was advised that the Executive Team will be having a detailed look into sickness levels on the 1.7.21 during their weekly meeting.

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

21/22/63 Serious Incident Report

The Serious Incident report was submitted to the Trust Board to provide a performance position for open and closed incident investigations that met the serious

incident criteria and were reported externally to the Strategic Executive Information System (StEIS). The following points were highlighted:

- It was reported that there were zero Never Events in May 2021.
- There are five ongoing incidents currently under investigation of which four are due to be signed off and submitted to Liverpool CCG.
- *StEIS Reference 2020/16210 (patient death following a brain haemorrhage)* – This investigation has been closed.
- *StEIS Reference 2021/10050* - There is one new incident that relates to the management of a deteriorating patient. An RCA was conducted following this incident in order to look at the management of the patient, the coming together of teams and the onward referral to HDU/Critical Care in line with the work that the Trust is doing in terms of safety priorities and deteriorating patients. The Board was advised that there are a number of key lessons to be learnt in terms of this patient's journey that will feed into the safety strategy.

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

21/22/64 Position Statement for PALS and Complaints, Q4

The Trust Board was provided with an update and assurance on the performance against complaints and PALS targets in Q4 and the full year for 2020/21, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised and proposed developments planned in 2021/22. The following points were highlighted:

- There has been an increase in trend during 2020/21 in terms of formal complaints with 53 being submitted in Q4 compared to 45 in Q3. Despite the increased number of formal complaints there has been a vast improvement with a 100% of formal complaints received being acknowledged within 3 working days and 81% being acknowledged on the same day. The Team has been working really hard to ensure that each complainant receives a elephone call to clarify the key issues of their complaint or, where possible resolve the issue informally or via the PALS route.
- *Compliance within 25-day response rate* – There has been a decrease in month but in terms of actual figures there have been more complaints responded to within 25 days. Attention was drawn to the metrics in the monitoring pack which highlight that 75% compliance was achieved in April and 100% compliance was achieved in May.
- *Second stage complaints* - There were 22 second stage complaints in 2020/21 which is a 14% re-open rate. This is in line with the national average of 15%. It was reported that there is a real commitment from the Complaints Team to improve the quality of complaints and reduce this figure to 10% in 2021/22.
- *Referrals to the Parliamentary and Health Service Ombudsman* (PHSO) – There is one on-going investigation related to the Surgical Division that has been delayed due to the pandemic. The Trust is continuing to work with the PHSO and will await their outcome.
- *PALS* – There has been an increase in trend during 2020/21 in terms of informal PALS concerns but in context of historical concerns there has been a reduction. The team is improving response times with 75% of PALS issues logged with the organisation being responded to within 5 days.

- *Compliments* – It was reported that the Trust still needs to find a better way of recording compliments. Lisa Cooper suggested encouraging staff to report compliments on the system. The Board was advised that the reporting and recording of compliments will be addressed as part of the improvement plan for 2021/22.
- *Themes* - The themes of complaints in 2021/22 relate to the Tics and Tourette's service, access/provision of care and disagreement with clinical advice. It was confirmed that all of these complaints were managed appropriately.

The Board was advised that there has been a real commitment from all concerned to prioritise complaints and PALS going forward and that the Complaints Action Plan will be monitored via CQSG and SQAC.

Fiona Marston queried as to whether the Trust will see further complaints in 2021/22 relating to the Tics and Tourette's service. It was reported that all 200 cases have been reviewed on an individual basis and onward referrals have been made where appropriate which has enabled the waiting list to be closed. There is an opportunity for people to raise a further complaint within a twelve-month period after an issue was identified therefore there is a possibility that the Trust will receive further complaints. In the event of this happening the Trust will address them accordingly, even if the complaint falls outside of the twelve-month period.

Shalni Arora referred to the complaint relating to a confidentiality breach and requested some further information regarding this matter. It was reported that the confidentiality breach relates to a couple of small cases where letters have been sent to the wrong patient. This wasn't the main feature of the complaint, but each case has been reviewed by the Trust in association with the family and it was confirmed that none of the incidents met the ISO reporting threshold.

The Chair felt that real progress has been made and thanked all those involved in the improvement work.

Resolved:
The Board noted the position statement for PALS and Complaints for Q4.

21/22/65 Approach to End of Life Care when there is a dispute

A number of slides were submitted to the Board to provide an overview of the Trust's process that supports end of life discussions and disagreements. The following information was shared with the Board:

- *The Co Lab Partnership* – This is a partnership that aims to improve the life of children who live with complex illnesses/conditions and have helped to find new ways of debating emotionally charged ethical dilemmas that some families and clinicians face, in a quiet and thoughtful way rather than in the glare of publicity.
- *ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)* – This is a process used for achieving consensus with families.
- *Clinical Decision-Making Committee* – This committee was established at the beginning of the pandemic in association with the University of Liverpool to enable the Trust to develop processes for making difficult decisions regarding patient treatment and end of life. A national workshop has also taken place to discuss the difficult decisions that trusts have to make and the actions that they sometimes have to take.

- Planning ahead includes looking at operational systems, staff culture and the culture of the public.
- Children's and Young Person's Advanced Care Plan:
  - Incorporates ReSPECT.
  - Work is to be carried out in terms of EMR.
  - Plan to be compiled for rollout across the Trust.
  - Business case is in the process of being developed.
  - Royal Manchester Children's Hospital and Great Ormand Street Hospital have agreed to share their policies with the Trust, along with staff education resources and the patient and family leaflets that they use.
- When there is a disagreement:
  - Template letters to be reviewed.
  - Look into the possibility of a formal second opinion process being established.
  - Assistance from other children's hospitals.
  - Acquire legal advice sooner rather than later.

The Chair asked as to whether this area of work feeds into the Trust's Ethics Committee. It was reported that cases do get discussed during committee meetings, but it was felt that this doesn't happen as much as it should. It was pointed out that the Clinical Decision-Making Committee has become a forum for discussions around disagreement and complex patients and takes place on a weekly basis. Attention was drawn to the importance of conducting further work around pathways and making better use of both forums. Fiona Beveridge informed the Board that the Ethics Committee also offer support in terms of discussion when a number of parties involved with a patient cannot agree on a treatment pathway.

Fiona Marston asked as to how the Trust can help families who are impacted following an end of life decision and queried the involvement of existing families from a policy aspect etc following this type of sad situation. It was reported that the Trust is involved with patients via the Bereavement Centre, but it was agreed to look into a process for providing feedback to families.

21/22/65.1 Action: AH

The Chair felt that a lot of positive and proactive work has taken place but pointed out that there are a number of challenges that need addressing and embedding Trust wide. Following discussion, it was agreed to provide a progress update in twelve months' time.

21/22/65.2 Action: NM/AH

Resolved:
The Board received and noted the presentation on the Trust's processes that support end of life discussions.

21/22/66 Cumulative Corporate Report – Top Line Indicators

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

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

21/22/67 Cumulative Corporate Report – Top Line Indicators

People

Resolved:

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

21/22/68 Alder Hey People Plan

The Board was provided with a strategic update on the Alder Hey People Plan and the Trust's response to the requirements of the national NHS People Promise. The following points were highlighted:

- The SALS Service has been shortlisted for an award by the Healthcare People Management Association for the work that has been done around health and wellbeing. It was reported that the amount of interest that the service has received since winning the HSJ award has been phenomenal. Jo Potier is currently working with NWAS in terms of psychological debriefing sessions for staff, which could lead to a potential commercial opportunity for the Trust.
- During a national webinar the Chief People Officer advised of two priorities that need to be actioned; health and wellbeing conversations with staff and a review of recruitment practices.
- Work is taking place in partnership with LHCH and Clatterbridge to appoint an EDI Team. It was confirmed that the EDI Lead position has been recruited to. Claire Dove pointed out that this appointment is going to be pivotal taking the taskforce forward but drew attention to the importance of establishing a team to support this role.

BAME Inclusion Taskforce

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

- The Taskforce received a presentation from the Managing Director of Black United Representation Network, Lisa Maynard-Atem, on the diversifying of structures, professional planning and planning for the future. This looked at bringing new diverse members onto the boards of organisations along with young people and providing them with a skill set to contribute and fully participate, via Board apprenticeships.
- A meeting has taken place with an organisation who specialise in racism awareness training in the equality arena. A bespoke programme is to be compiled for the Trust and rolled out in September 2021.
- The recruitment process has closed with regards to the 10 available apprenticeships at the Trust and the organisation is awaiting feedback on the diversity of the applicants. The Board was advised that the Trust has compiled a data base of organisations that it distributes all vacancies to, of which, positive feedback has been received.
- The Community Division has commenced a work placement programme for young people that targets BAME communities. This is taking place in partnership with the Prince's Trust.
- During a recent listening event the group focussed on the Trust's Zero Tolerance Policy and it was decided that staff members at the listening event would work together to agree as to what should be included in the policy and the impact that it should have. Following on from this, one of the Trust's managers gave a presentation on what she felt that the Trust should be doing to support zero tolerance at Alder Hey. Claire Dove advised that the

presentation was excellent, and it was agreed to invite Charlee Martin and Rushownara Miah to July's Board to share the presentation with members.

21/22/68.1 Action: KMC

A query was raised as to whether there is anything being done to ensure that the Trust's LGBTQ population feels included in the organisation and has equal representation across the Trust. The Board was advised of the challenge that the Trust has in terms of the resources required to address all groups. It was reported that the organisation is holding a number of listening events about disability which have been advertised to staff and the newly appointed EDI Lead will look at inclusivity for all, once in post. The NHS has been set three tasks nationally; to establish a BAME network, LGBT network and a Disability network. Alder Hey is looking into this matter but want to ensure it's done properly and that the networks are sustainable.

A suggestion was made about including LGBTQ as part of the work that the BAME Taskforce is conducting. It was pointed out that there are some major issues at the present time and the work of the taskforce needs to remain focussed on the Trust's BAME population and not become fragmented. Claire Dove asked for patience whilst the taskforce continues on its pathway which will produce a blueprint that can be applied to other groups.

Nathan Askew felt that it would be beneficial for a number of the Executive Directors to meet to discuss the broadening of the EDI agenda for all staff in order to give this area of work some traction. The Chair drew attention to the importance of addressing the required resources to enable the Trust to establish the EDI Team.

21/22/68.2 Action: NA/NM/MS

Shalni Arora suggested circulating a communication to the respective groups advising staff of the programme of work that the Trust has planned to ensure inclusivity for all.

21/22/68.3 Action: MG

The Chair summarised the discussion that took place and drew attention to the progress that the taskforce has made and the importance of driving this work forward. It was also pointed out that there is an appetite for conducting some parallel work in terms of other groups and the Chair thanked Nathan Askew for his offer of support, and Claire Dove and Melissa Swindell for taking the taskforce forward.

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

21/22/69 Cheshire and Merseyside NHS Mental Health, Learning Disabilities and Community Services Provider Collaborative Memorandum of Understanding

This item was deferred.

21/22/70 LNP Update (12:55pm)

A number of slides were submitted to the Board to provide an update on the Liverpool Neonatal Partnership (LNP) and the progress that has been made. The following information was shared:

- The outcome of the Johnsons and Johnson Social Media Campaign; #firstmomentsmatter and the comments received from parents.

- Feedback from families about what they would like to see in a world class Neonatal Unit.
- The progress that has been made from April 2020 to June 2021.
- NICU design; current build programme plan, timescale of build with risks.
- Benefits of the new Neonatal Unit.
- The support that is already being provided to the Partnership.
- Challenges.
- The next six months.
- The layout of this unique facility for Neonates in the UK.

The Board was advised of the Exec to Exec meeting that took place w/c 17.6.21 between Alder Hey and LWH where it was agreed that a review of the arrangements should take place in terms of the vision for Phase 2, along with an analysis of the workforce and governance arrangements. Once completed a report will be submitted to both trust boards for approval ensuring that there is a commitment for fulfilling the agreed vision for the Neonatal Service over the next two years.

Melissa Swindell drew attention to the workforce element of the project and queried the recruitment source for the large number of employees required to staff the new Neonatal Unit. The Team are confident that there won't be any issues recruiting to posts and advised that they have received applications from 10 members of staff based with the LNP along with 54 applications for the recruitment of 8 nurses. Work is also going to take place with the cohort of nurses from India. It was pointed out that the challenge will relate to the retention of staff.

Claire Dove advised that diversity is a top priority for Alder Hey and queried the process for ensuring staff diversity when recruiting staff to work in the new Neonatal Unit. Jen Deeney informed the Board that the LNP always embraces the person and their skills and are very proud of the diversity they have in the team.

Louise Shepherd thanked the team for the progress that has been made over the last four years which has resulted in the commencement of what is going to be a nationally renowned Neonatal Unit.

Resolved:
The Board received and noted the LNP update.

21/22/71 Alder Hey in the Park Campus Development Update

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

- *Neonatal Scheme* – The tender for the design of the new Neonatal Unit has been issued.
- *Park Reinstatement* – Phase 1 of the park reinstatement is complete and in the process of being handed over to Liverpool City Council. Phase 2 has commenced and will be finished in spring 2022 with Phase 3 being complete in spring 2023. The Community Interest Company is now established and has a number of ideas about the types of activities that could take place in the park including looking into the possibility of having a café in the park. There is a focus on two big bids; the Heritage bid and the Sport England bid, which if successful will enable activities to take place in the park

- *Schemes* – The construction of the Sunflower Building and Catkin Building is progressing, and a bid is to be submitted to the Charity to request funding for an Arts Programme to compliment the buildings.
- *Step Places Scheme* – The planning application for Step Places is due to be submitted to the Committee on the 6.7.21.
- *North East Plot* – Work is continuing with the developer to progress potential service enhancements around the options for new family/patient accommodation at the top end of the site. It was reported that there is a slight matching issue, but this is progressing.
- *Nursing Home* - Work is taking place to re-house staff following the fire at the Knotty Ash Nursing Home.
- It was reported that the Alder Centre won a European Health Design award on the 17.6.21.

Shalni Arora queried the delay in the planning process for the Neonatal Scheme. It was reported that the issue relates to the timing of July's RABD Committee and not the planning process. It was reported that the business case for the lower floor of the scheme needs to be approved prior to the 26.7.21 in order to meet the timescales of the programme. A report has been submitted to the Director of Finance to advise of the issue and propose a £5k trigger to enable the design of the lower floor to commence. In the event that RABD don't approve the business case in July the funding can be withdrawn.

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

21/22/72 Financial Update

Month 2 YTD Financial Position

The Trust is reporting an in-month surplus of £941k which is £0.6m ahead of plan. YTD is £629k deficit which is £390k behind plan. ERF is in line with plan with YTD income of £4.1m and contribution of £1.8m. Cash in the bank is £88.4m and Capital Spend YTD is £2.1m.

It was reported that the drivers for the YTD variance relate to:

- Surgery £0.5m – Additional costs not in budget related to unfunded historical cost pressures. A deep dive is underway which will be reported via RABD with actions required.
- Research £0.2m – Increase of costs or CORE/Infrastructure and commercial income lower than plan.
- Facilities £0.3m – Catering and car parking income shortfall and porters' pay costs. An action plan has been produced for the switch on of car park income and to agree a recovery trajectory for income.

The key assumptions of the H1 Breakeven Plan included:

- CIP/Efficiency £3m (full year £6m).
- ERF additional income £10m.
- Cap on costs to deliver ERF at £6m = £4m contribution.
- Non-clinical income restored to 2019/20 levels.

It was reported that 55% of the CIP programme has been identified to date with the rest of the focus on big transformation programmes. Non-clinical is not achieving

in a number of areas and continues to be a challenge for the Trust. The Board was advised of the medium risk to the delivery of breakeven for H1.

The H2 framework is still unknown as the present time but the Board was advised of the forthcoming challenges if the current model is extended but with an increase in CIP requirements, higher recovery targets and a lower ERF incentive model. It was reported that a meeting is taking place on the 25.6.21 with the local ICS to discuss this matter. Attention was drawn to the challenging position that Cheshire and Merseyside will remain in, along with the continued pressure to drive waste reduction and improve productivity.

Attention was drawn to the importance of having an agile approach for H2 and it was reported that the Trust is going to focus on; reducing waste, improving productivity, maximising new investments, gaining quick wins from non NHS areas and look towards funding increasing capital charges from prior investments via cash releasing benefits.

The Chair noted that the Trust is facing some big challenges during 2021/22 and pointed out that the progress with the alliance is crucial.

Resolved:
The Board received and noted the financial update for M2.

21/22/73 Board Assurance Framework

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

- It was reported that all of the risks incorporated in the BAF have been reviewed by the respective Assurance Committees, with the majority having had a deep dive through substantive update papers being brought.
- Following the Board Strategy Session in June two new risks have been included on the BAF relating to external risks; ICS architecture and partnership governance.
- The Trust received positive feedback from the new CQC Inspector in terms of SQAC's processes: the quality of the papers, the depth of the scrutiny that takes place and the action plans in place.

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

21/22/74 Board Assurance Committees

Audit and Risk Committee – The approved minutes from the meeting that took place on the 22.4.21 were submitted to the Board for information and assurance purposes. During the meeting on the 17.6.21 there was a focus on the Annual Report and Accounts for 2020/21 and the client questionnaire that was produced to enable client feedback to be provided on audits and the work of MIAA, which was positive.

RABD – The approved minutes from the meeting that took place on the 24.5.21 were submitted to the Board for information and assurance purposes. During the meeting on the 21.6.21 there was a focus on top priority areas and pressures.

SQAC – The approved minutes from the meeting that took place on the 19.5.21 were submitted to the Board for information and assurance purposes. During the meeting on the 23.6.21 the Committee focussed on patient and family feedback for Q4, the Never Event relating to the wrong side block, the CQC Action Plan, IPC, the Neurology Action Plan, Safeguarding Compliance, Safe Waiting List Management, Clinical Audit, ED review, Complaints and PALS and the Prevent Policy.

Innovation Committee – The approved minutes from the meeting that took place on the 19.4.21 were submitted to the Board for information and assurance purposes. During the meeting on the 14.6.21 the Committee was updated on the progress that is being made in terms of the development of the Innovation Strategy.

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

21/22/75 Any Other Business

There was none to discuss.

21/22/76 Review of the Meeting

The Chair felt that there had been a number of good debates during the meeting. Board members were frank which highlighted an issue that needed addressing. It was also noted that there are enormous pressures within the Divisions who have been open about the issues and the lack of solutions.

Date and Time of Next Meeting: Thursday the 24th June 2021 at 9:00 am via Teams.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 29th July 2021							
25.2.21	20/21/252.1	Mortality Report, Q2	*National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance.	Nicki Murdock	27.5.21	On Track	**19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21 -** It was reported that the Trust is awaiting a reply from David Levy's office. **29.4.21 -** It was reported that the Trust is awaiting a reply from David Levy's office. **20.5.21** - The Medical Examiner regional lead, Dr Huw Twamley, has discussed the Trust's Medical Examiner proposal with Julie Grice. He awaits national guidance with reference to the stand alone tertiary paediatric centres. The national Medical Examiner, Alan Fletcher, has also looked at this. There is no further guidance available yet, but Alder Hey's system is more rigorous than the national process. **ACTION TO REMAIN OPEN**
24.6.21		Staff Story	Meeting to take place with Nathan Askew, Alfie Bass and Vittoria Bucknall to discuss a process for reporting via CQSG and SQAC the learning from the STAT programme and the issues captured in the STAT CV that can't be resolved.	Nathan Askew	29.7.21	On Track	**23.7.21** - An update in relation to this action will be provided during the Divisional update on the 29.7.21.
24.6.21	21/22/60.1	Committee Annual Reports 2020/21	*SQAC Annual Report 2020/21* - Annual Report to be amended to reflect that the recommendations in the CQC Action Plan have been actioned and that the Trust is seeking sign off from CQC to enable the action plan to be closed.	Karen McKeown		Closed	**22.7.21** - This action has been addressed. **ACTION CLOSED**
24.6.21	21/22/60.2	Committee Annual Reports 2020/21	*RABD Annual Report 2020/21* - Committee priorities in the Annual Report should read; 2021/22. Report to be amended.	Karen McKeown		Closed	**22.7.21** - This action has been addressed. **ACTION CLOSED**
24.6.21	21/22/68.1	BAME Inclusion Taskforce	Invite Charlee Martin and Rushownara Myah to July's Trust Board to share the presentation that they gave at the last BAME listening event.	Karen McKeown		Closed	**22.7.21** - This action has been addressed. **ACTION CLOSED**
24.6.21	21/22/68.1	BAME Inclusion Taskforce	Meeting to take place to discuss the broadening of the EDI agenda for all staff in order to give this area of work some traction.	Nathan Askew/ Nicki Murdock/ Melissa Swindell	29.7.21	On Track	**23.7.21** - A meeting took place on the 23.7.21. It was agreed to submit an action plan to the Board in the autumn.
24.6.21	21/22/68.1	BAME Inclusion Taskforce	Circulate a communication advising staff of the programme of work that the Trust has planned to ensure inclusivity for all.	Mark Flannagan	29.7.21	On Track	**23.7.21** - This action is in the proccess of being addressed.
Actions for the 30th September 2021							
25.2.21	20/21/252.2	Mortality Report, Q2	*Adult Covid Deaths* - Conduct a deep dive into the six Covid-19 adult deaths that took place at Alder Hey during the pandemic and submit a report to the Board on the overall outcome, in April/May 2021.	Nicki Murdock	30.9.21	On Track	
24.6.21	21/22/65.1	Approach to End of Life Care when there is a dispute	Look into agreeing a process to provide families with feedback following an end of life decision.	Adrian Hughes	30.9.21	On Track	
Actions for June 2022							
24.6.21	21/22/65.2	Approach to End of Life Care when there is a dispute	Provide a progress update on the Trust's process that supports end of life discussions and agreements.	Nicki Murdock/ Adrian Hughes	Jun-22		

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
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th July 2021

Paper Title:	**An integrated and adaptive preparedness plan for an RSV epidemic, high urgent and emergency care demand and access to elective care**
Report of:	**Adam Bateman, Chief Operating Officer**
Paper Prepared by:	Adam Bateman, Chief Operating Officer Ronnie Viner, Safe Waiting List Management Advisor Andy Hanson, Acting Associate Chief Operating Officer Raman Chhokar, 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**	■ ■ ■ ☐ ☐

1. Introduction

Presently, a number of services are under significant pressure. For example, paediatric attendances to emergency departments are at 136% of 2019 levels and referrals to the CAMHS service are 154% of 2019 levels. Moreover, it is predicted that an RSV epidemic will put unprecedented pressure on paediatric services, with a possible 50%- 100% rise in RSV admissions. The North West has the highest RSV case numbers in the country. At the same time, there is huge focus on access to planned care.

This plan recognising the competing demands and pressures that these developments are already having on staff and services, and how demand could grow further within the next six months as RSV, flu and other viruses become more prevalent. Our planning exercises have confirmed that we cannot sustain current levels of elective recovery and create additional surge capacity. Thus, we have created an adaptable plan that will adjust levels of elective care in accordance to the surge in RSV cases and emergency care.

We have committed additional investment in staff and teams to support our response to the rise in service demand.

2. Respiratory Syncytial Virus (RSV)

2.1 Overview of RSV

- RSV usually causes mild respiratory infection in adults and children, but it can be severe in infants who are at increased risk of acute lower respiratory tract infection. RSV is the most common cause of bronchiolitis in children aged under 2 years.

- RSV typically circulates during winter in temperate climates, much like influenza. The UK season of RSV starts in September and peaks around December followed by a sharp decline in presentations and admissions from January to March.

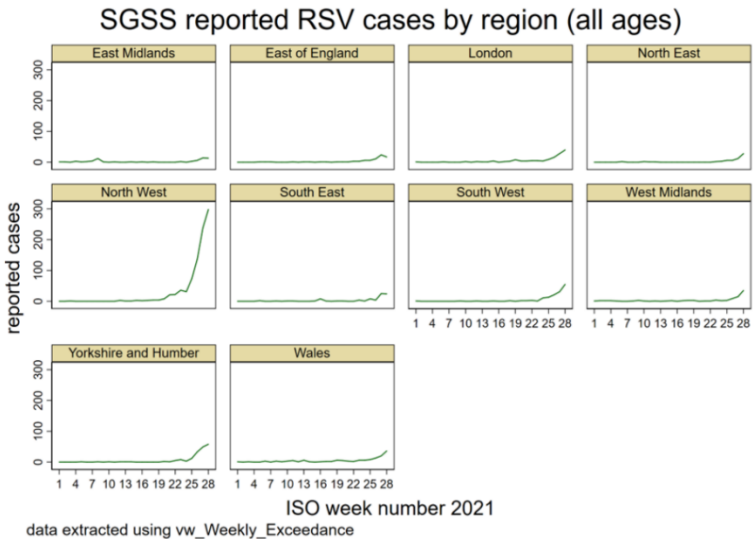
- Following the Covid 19 pandemic and the trends observed in the Southern Hemisphere, Public Health England (PHE) modelling suggest an earlier start to the RSV season with a peak in November which will last throughout the winter period.

- Following the suggestions in the PHE modelling, a request has been received from NHS England to bring forward annual winter surge planning plans which will support the increased capacity in beds, workforce, equipment, consumables and transport services, to enable a response to an increase in paediatric respiratory infections.

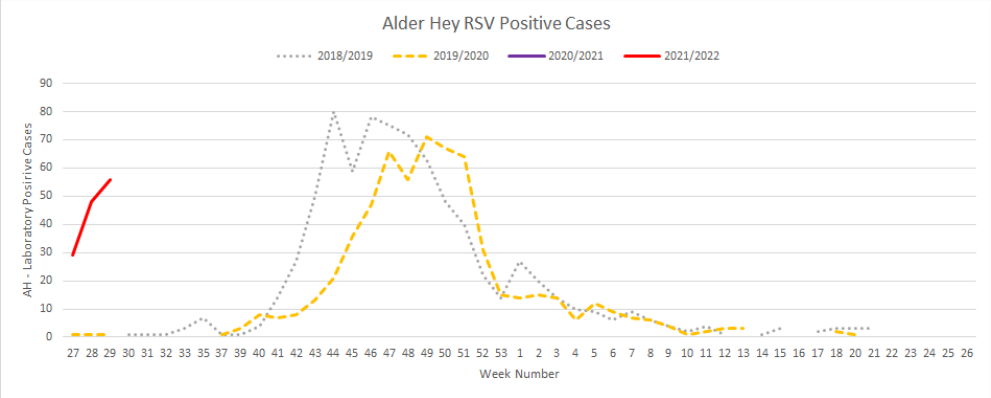
- Trusts have been requested to prepare for an earlier outbreak with a 20%, 50% and 100% increase in the total number of RSV cases / admissions.

2.2 RSV modelling

The regional RSV reported cases data from Public Health England confirms the onset of the RSV season in the North West, ahead of the rest of the country.



The graph below demonstrates the earlier onset of the RSV season in 2021-22 and is based on positive lab detections up to week 29. In response, we need to be ready to bring forward the start of our actions contained in the preparedness plan (see section 2.3 below).



2.3 RSV preparedness plan

Alde Hey has an RSV & Flu preparedness plan in place. In summary, escalation is triggered by:

- **Bed occupancy**: when in excess of 92% indicates significant pressures and surge capacity is required.

  and/ or

- **(Low) Staff Availability:** staff availability directly impacts the number of beds that are or can be opened with a safe level of care.

We have prepared for five scenarios and the escalation framework for each is summarised in the table below:

Escalation Status	1 Low Pressure (mild winter pressures with mild RSV)	2 Moderate Pressure (20% RSV Surge)	3 Severe Pressure (50% RSV Surge)	4 Extreme Pressure (100% RSV Surge)	5 Maximum Surge
Escalation status triggers (one of the triggers below is met)					
Ward or critical care occupancy	<85%	>85%	>92%	>95%	>98%
Staff unavailability	<6%	7-10%	10-17.5%	>17.5%	>20%
Surge capacity required to meet demand					
Surge medical ward (G&A) beds	7	12	16	23	33
Surge PICU beds	0	5	5	7	9
Surge HDU Bed requirement	0	3	4	5	8
Total surge	7	20	25	35	50
Total capacity					
Medical ward (G&A) beds	111	123	127	134	144
Surgical ward (G&A) beds	100	88	84	77	67
PICU	21	26	26	28	30
HDU	15	18	19	20	23
Response					
Service Provision	Routine & Emergency	Routine & Emergency	Urgent & Emergency, very limited routine	Urgent & Emergency Only	Emergency Only
Staffing Arrangements	Staff medical ward surge beds	*Level 1 plus* covering absence	Level 1&2 plus: · medical escalation ward · staff to critical care	Level 1- 3 plus additional staff to: · medical escalation ward · critical care	Level 1-4 plus additional staff to: · medical escalation ward · critical care
Weekly Theatre sessions	139 (daycase and Inpatient)	120 (more daycase with reduced inpatient)	95-105	50	40
Nursing WTE staff allocation to surge areas	0	59.4	75.6	97.2	138.9
% Theatre Capacity	100%	100%	64%	34%	34%
% Elective Theatre	93%	93%	47%	0%	0%
% Emergency / Urgent Theatre	7%	7%	53%	100%	100%
Financial Impact	£2,014,715	£4,178,301	£5,260,801	£6,935,552	£8,095,303

In the maximum surge scenario our capacity plans provides an 50 medical and critical care surge beds (although this is partly achieved by a contraction of 23 surgical beds and the number of theatre sessions we can operate). Escalation in response to severe pressures impacts upon the elective care programme through both the use of surgical ward capacity for medical patients and staff to support providing support to HDU and PICU.

The RSV plan is built upon additional investment in the following staffing and resources:

- Additional nursing staffing requirement to open 7 general beds
- Additional nursing staffing requirement to open up to 17 critical care beds (9PICU/8HDU)
- Additional equipment and consumables associated with increased activity
- Medical staffing in respiratory, ED and HDU required to support with RSV surge

We have proceeded to invest in some critical roles to support readiness for the RSV epidemic. This is set out in the table below. Additional support beyond this would enhance our response and a bid to NHS England has been submitted for c. £3.7m of investment in RSV preparedness.

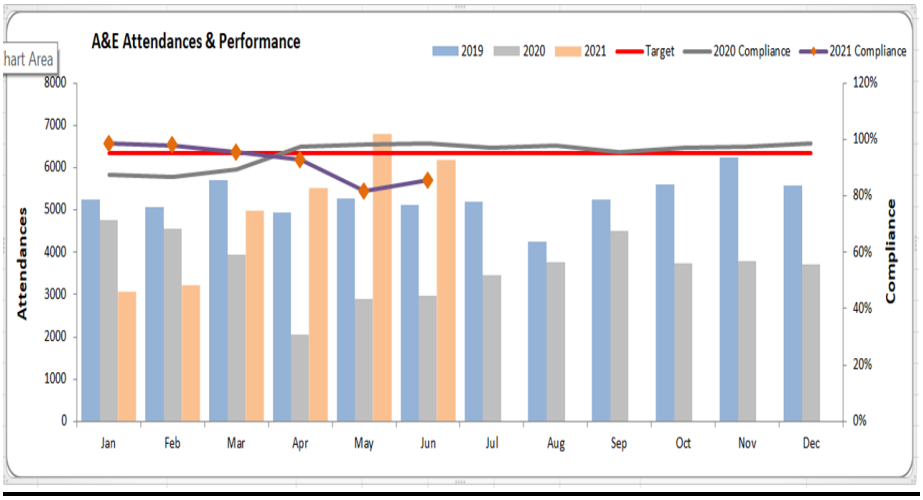
		£
RSV	2 Locum consultant HDU August -March	192,000
RSV	2 Nurse education training posts July -March	104,000
RSV	28 WTE CC nursing (4 per shift on bank) at winter incenti	205,618
RSV	Locum consultant in Respiratory August-March	96,000
RSV	8 junior doctors in ED Sept -March	326,667
RSV	Microbiology 2 B6 August -march	63,431
RSV	6 months fellow for rapid access clinics	30,000
RSV	CCNT virtual ward B5 3 WTE September - March	52,500

The different RSV scenarios financial cost and risk associated with extreme pressures. This is driven by the investment above and a potential reduction in income from less elective activity. There are mitigation plans in place for this which is covered in our financial reporting.

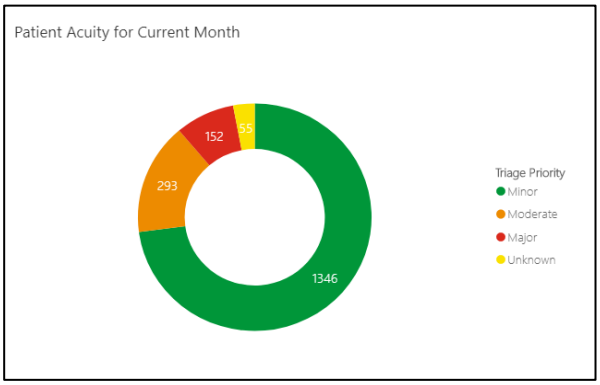
3. Urgent & emergency care

3.1 Overview of attendances and demand

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



An audit has been undertaken of the acuity of the attendances. This identified 65% of all attendances are triaged as 'green' patients, which includes patients with minor injuries and minor ailments that can be treated in community services.



The most common presenting conditions to the Emergency Department are:

- Respiratory conditions: including upper tract, bronchiolitis, asthma, croup are our highest attendances to the department.
- Gastrointestinal conditions
- Infectious Diseases, such as viral illness and rash
- Head injury & some orthopaedic conditions
- Psychiatric & mental health conditions

3.2 Urgent & emergency care support plan

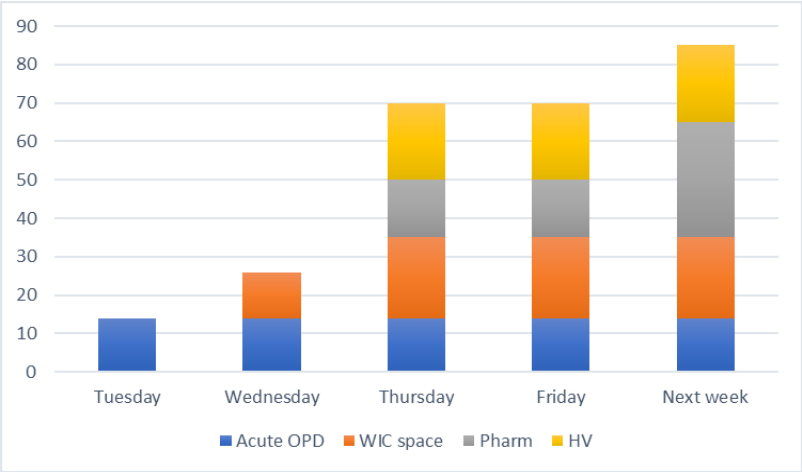
The high-level of demand has led to an increase in waiting times in the Emergency Department. We have subsequently taken the difficult decision to adapt our service model for urgent paediatric and emergency care needs to mitigate the risk the current pressures (which manifest in the form of overcrowding and longer waiting times) represent to safe and high-quality care.

The high-imapct changes we will take are as follows:

High-impact change description	Anticipated Delivery date	Current Status
Low acuity clinics to be delivered by General Paediatricians (patients streamed away from ED into outpatients)	19 July	Started, but some gaps in cover 14 slots per day Monday to Friday and 7 Saturday morning
Community pharmacist minor ailment clinics	4 August	Triage nursing team provided with local minor ailment pharmacy services. In-house service to be established following agency recruitment.
Signpost and deflection policy for low acuity attenders	26 July	Policy for new pathway for minor injury and illness agreed
Advice and sign posting service	22 July	Mersey Care are working in partnership to deliver this service and have provided a health visitors will service 09.00-17.00hrs, 7 days a week
Access to appointment slots in Walk-in Centres	21 July	24 slots per day to be ring fenced for booking of patients attending at ED.

The impact of these developments in terms of the volume of capacity being made available to ED is displayed in the chart below:

Future additional appointment capacity per day



In the medium term we will also implement the following:

- An **improved Alder Hey website** relating to our Emergency Department including up-to-date department status, key messages and advice videos for self-care
- Development of a **symptom tracker** building on examples of best practice in this area from other UK centres and abroad
- **Virtual urgent care consultations**
- **Recruitment of locum general paediatricians to sustain additional clinic capacity**

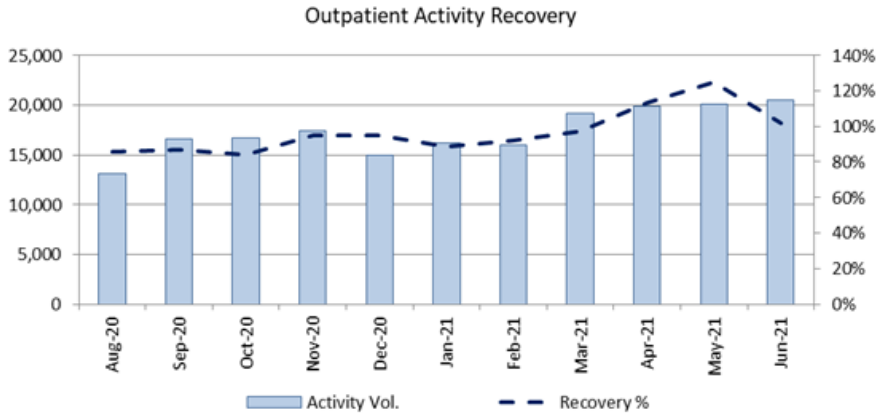
4. Elective care

4.1 Progress in recovery of services

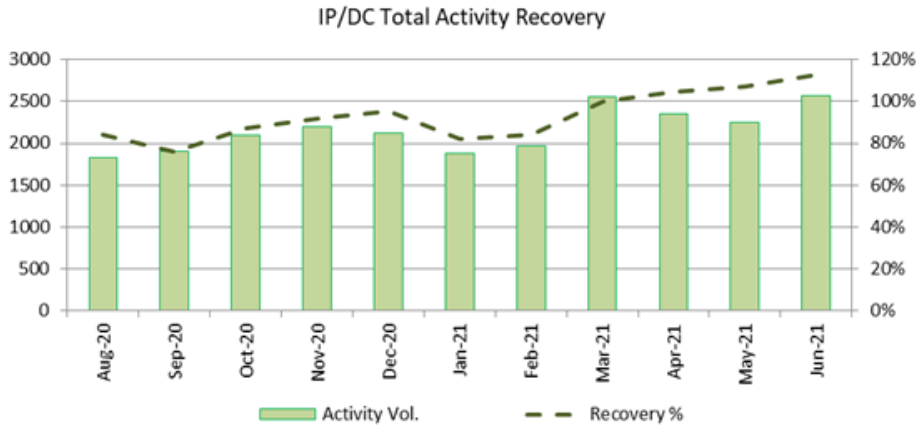
We continue to sustain extremely high levels of recovery; in outpatients and elective care we are treating more patients than the corresponding month in 2019. In July and August we are stepping down some weekend working to support staff rest and in response to reduced staff availability caused by higher levels of Covid-19.

Service area	ERF Target 2021/22	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Outpatients	95%	86%	87%	84%	95%	95%	89%	92%	97%	113%	125%	102%
Inpatients & day case	95%	84%	76%	87%	92%	95%	82%	84%	100%	105%	107%	113%
Diagnostics	n/a	92%	90%	86%	90%	105%	97%	98%	87%	91%	97%	96%

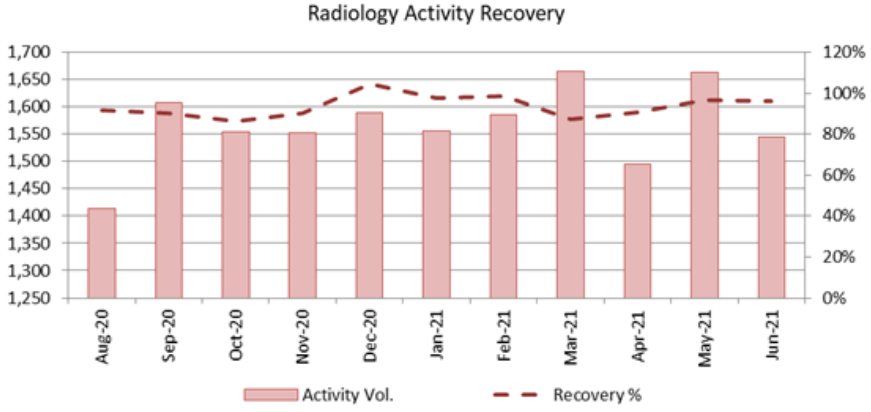
Our outpatient recovery progress and profile is shown below:



Our combined elective (inpatient and daycase) recovery progress and profile is shown in the char below (with a continued upward trend in percentage recovery relative to 2019):

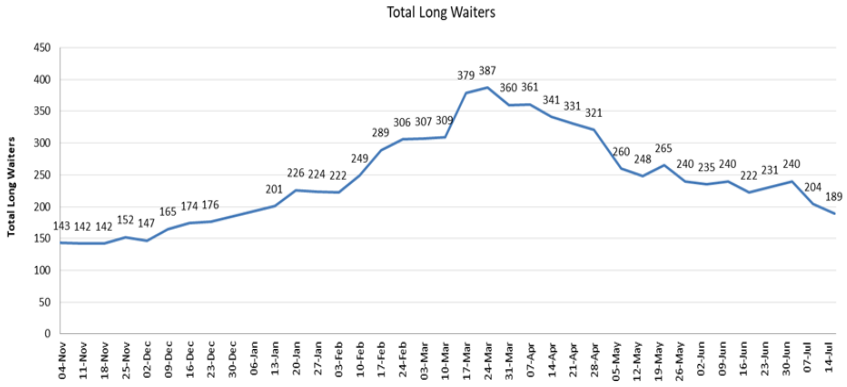


Our radiology recovery progress and profile is shown below:



4.2 Access times

The high levels of service recovery has supported a continued reduction in the number of children and young people waiting over 52 weeks for treatment:



4.2 Revised forecast for elective recovery and paediatric accelerator

The half one (H1) activity plan and financial forecasts associated with the elective recovery fund (ERF) and the paediatric accelerator have been revised for the following reasons:

- a reduction in staff availability to cover the required number of theatre and outpatient sessions to meet the trajectories
- impact of a respiratory syncytial virus (RSV)/flu surge response
- a change in the elective recovery fund (ERF) threshold.The basis of the calculations was is changed with effect from 1st July, trusts will receive 100% tariff if they achieve 95%-100% of pre-Covid levels of activity and 120% tariff is paid for all additional activity above 100% of pre-Covid levels

The impact of RSV

Inpatients/daycases* - all specialties

H1 Revised Activity Plans and Trajectories	April - September IP/DC		
	Revised % Recovery	Original % Recovery	Variance
Scenario 1 - low pressure (mild winter pressures with mild RSV)	105%	104%	1%
Scenario 2 - moderate pressure (20% RSV Surge)	105%		1%
Scenario 3 - severe pressure (50% RSV Surge)	102%		-1%
Scenario 4 - extreme pressure (100% RSV Surge)	98%		-6%
Scenario 5 - maximum surge	76%		-28%

Inpatients/daycases - 5 accelerator specialties

H1 Revised Activity Plans and Trajectories	April - September IP/DC		
	Revised % Recovery	Original % Recovery	Variance
Scenario 1 - low pressure (mild winter pressures with mild RSV)	101%	113%	-12%
Scenario 2 - moderate pressure (20% RSV Surge)	101%		-12%
Scenario 3 - severe pressure (50% RSV Surge)	97%		-16%
Scenario 4 - extreme pressure (100% RSV Surge)	86%		-27%
Scenario 5 - maximum surge	44%		-69%

** the revised trajectories under scenarios 1 and 2 show an improvement to the original. This is because on the revised version April-June are based on the latest actual data and the activity levels during these months were higher than originally anticipated.*

Based on this revised activity trajectory, ERF income for H1 would be reduced by between £2m-£4m from the original forecast depending on which escalation scenario the trust enters (it should be noted however that the ERF calculation changes account for an estimated £2.4m of this reduction). The table below summarises the estimated income against each RSV escalation scenario.

H1 Revised ERF Income Forecast	Total for H1
Scenario 1 - low pressure (mild winter pressures with mild RSV)	£8,369,855
Scenario 2 - moderate pressure (20% RSV Surge)	£8,369,855
Scenario 3 - severe pressure (50% RSV Surge)	£7,280,129
Scenario 4 - extreme pressure (100% RSV Surge)	£6,588,245
Scenario 5 - maximum surge	£6,400,000

The Trust will receive funding of £2.75m via the paediatric accelerator bid to support a long-term, sustainable step-up of activity levels, The income associated with the paediatric accelerator bid of £2.75m is not expected to be at risk by virtue of the revised activity plan and trajectories. Alder Hey's part of the bid has been split into several key themes that are focussed on sustainable, long-term solutions to clearing current waiting list backlogs whilst also meeting an anticipated, post-Covid increase in demand going forward. The themes and some of the specific initiatives associated with them include:

4.2 Investment in staffing and services

Through the accelerator and ERF we are making the following investments to support teams:

Workforce expansion and new models of care:

- Additional clinical staff in anaesthesia and radiology to support sedation pathways, pre-op. assessment pathways and radiographer support in OPs and theatres.
  - **1 x consultant anaesthetist**
  - **2 x senior clinic fellows in anaesthesia**

        - **1 x consultant radiologist**
        - **2 x radiographers**
    - Appointment of physician associates to undertake some of the minor theatre work and outpatient follow-up work, and thereby free up consultants' time to focus on the more complex work.
        - **10 x physician associates**
    - Additional OP staff to help minimise existing bottlenecks in patient pathways including the plaster room, chaperoning and basic observations.
        - **1 x registered nurse**
        - **1 x plaster technician**
        - **5 x healthcare assistants**

<u>Stepped release of bed capacity</u>

    - Additional beds to support an anticipated increase in RSV admissions and thereby prevent cancellation of theatre activity due to medical outliers on surgical wards.
        - **4 x fully staffed beds**

<u>Transformational change through the use of technology</u>

    - Virtual consultations.
    - Natural language processing to reduce clinical administrative burden.
    - Robotic process automation to better manage waiting lists to deliver equality of access and risk stratification.
    - Patient portal for self-care, chat bot and booking.
    - Asthma mapping including home sensors and "nudge" therapy.

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th July 2021

Paper Title:	**Patient Safety Strategy**
Report of:	**Nathan Askew, Chief Nursing Officer & Nicki Murdock, Chief Medical Officer**
Paper Prepared by:	Nathan Askew & Nicki Murdock

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ■
Background Papers and/or supporting information:	The NHS Patient Safety Strategy (2019) set out a framework and approach to managing patient safety in the NHS. This framework has been adapted to form the Alder Hey Patient Safety Strategy. The strategy has three main pillars of insight, involvement and improvement. There is a strong focus on developing a safety culture, a just culture and supporting staff to learn from what works well alongside learning from errors happen. The strategy will develop a programme of engagement for children, young people and their families to be involved in all aspects of patient safety and will ensure that a strong focus on the use of data through a QI approach drives our areas for improvement. The strategy will require the development of an implementation plan which will be monitored through SQAC and brings together a range of work streams currently underway. The board are asked to approve the strategy and support the development of an implementation plan monitored through SQAC
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:	Resources for this strategy will be identified through the development of the implementation programme, many of the areas for improvement are aligned to current work within the organisation

1. Introduction

2. Background

3. Conclusion

4. Recommendations

PATIENT SAFETY STRATEGY

INTRODUCTION

The NHS has published a new Patient Safety Strategy which puts it firmly at the centre of clinical care, running as a "Golden Thread" through healthcare. The strategy was developed through examination of contemporary theory and practice and consultation with and listening to staff, patients and senior leaders. As a result, the strategy is a document curated on behalf of the NHS and is a statement of the collective intent to improve safety. That improvement will be achieved by improving how we learn, how we treat staff and how we involve patients and their families.

The NHS strategy intends to move the management of clinical incidents from remediating individual effort to examining how normal behaviour and systems interact to create the opportunity for harm. Concentrating on Human Factors contribution to both incidents and safety needs to be further understood.

The NHS Safety Strategy underpins and is central to the Alder Hey Safety Strategy. This strategy sits alongside other plans, including "Our People Plan", our Trust Strategic Plan.

The Alder Hey and NHS vision is to continuously improve patient safety. The Trust will do this by focusing on patient safety culture and patient safety systems. We are committed to continue transforming the culture of the Trust to that of a "Just Culture" where staff do not fear to raise or report issues. Healthcare staff operate in complex systems, with many factors influencing the likelihood of error. These factors include medical device design, volume of tasks, clarity of guidelines and policies, and behaviour of others. A 'systems' approach to error considers all relevant factors and means our pursuit of safety focuses on strategies that maximise the frequency of things going right.

Blaming individuals achieves nothing and negatively hinders the development of safer services. Our staff need to feel safe to tell us what happened or what contributed to a clinical incident. Improving culture is dependent on valuing diversity and all our staff, compassionate leadership and a culture of learning.

Creating safer systems involves the use of Human Factors theory, digital improvements and technology improvements. It is essential that these three approaches are used wisely and that any advance is introduced across the Trust in a timely manner with adequate training and support, and adequate time made for that training.

The two foundations of culture and systems will be supported by

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)

- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

INSIGHT

Alder Hey will:

- Create a suite of metrics that tell and guide us to support us to understand the problem in a way that assists creating the solutions
- Develop relevant key safety measurements and use culture metrics from the staff survey to better understand how safe care is
- Adopt the Patient Safety Incident Response Framework (PSIRF)
- Ensure our HMRG process is aligned with the Medical Examiner System, liaising with other Trusts when appropriate
- Ensure communications from National Patient Safety Alerts Committee and the litigation learning are shared effectively with staff.

INVOLVEMENT

Alder Hey will ensure

- Staff understand the why and the how to involve children and young people, families and carers in providing safer care through the Brilliant Basics System
- We use the new patient safety syllabus for education and training of our staff
- We increase staff understanding of the importance of looking at what works as well as what isn't working
- That all staff have some understanding of how to promote patient safety within the Trust

IMPROVEMENT

Alder Hey will

- Continue to focus on recognition and reaction to the deteriorating child through the Sepsis programme
- Train our staff in Quality Improvement and contemporary safety interventions
- Build upon our Medication Safety programme to reduce errors, using a number of interventions and teams, including digital and innovation
- Develop a Mental Health Improvement programme focusing on the priority areas of children and young people, using the principles of Parity of Esteem
- Work with partners, both local and national to increase the safety of those with learning disabilities, autism spectrum condition, communication issues and those with behaviour that can challenge.

- Continue to develop our AMR programme.
- Continue to increase the innovation and research involvement and contribution to patient safety improvement.

INSIGHT

One of the biggest challenges to measuring safety is that it is a moving target. As with the high jumper, as soon as the bar is cleared it is raised. They will not clear the bar as often once it is raised but overall will be jumping to a higher level. The fact that what we consider to be 'safe' constantly shifts means we will never have a universal objective measure of how safety has improved over time.

Establishing measures and aims for safety improvement need to be balanced between stretch goals and achievable results. Too ambitious a goal can deter staff from trying when they see the goal as completely unrealistic and unachievable. For that reason, whilst zero medication errors might be our ultimate aim the interim goal might be reduction by 25% for an annual goal.

Creation of the metrics will consider the following:

- Benchmarking with peers, both nationally and internationally, maintaining an understanding on advancements across the paediatric world
- Expert advice, children, young people, carer and family views and the views and experience of staff.
- Setting goals whose achievement is within the control of the staff who are asked to meet them.

We will use the following principles to create our dashboards and scorecards:

1. Be clear about the purpose of each measure, 'dashboard' or 'scorecard'.
2. Be clear when a change is an improvement.
3. Measure what we need to know, not just because we can
4. Measures of culture, infrastructure, process and outcomes (PROM) are all useful.
5. Use the same measure for the same purpose across all departments.
6. Make data collection easy, using existing data where possible, creating automatic "pull" indices wherever possible.
7. The terms 'avoidable' and 'unavoidable' are unhelpful for patient safety.
8. Incident reporting is never a measure of actual harm.
9. The design of data presentation is critical to how it is interpreted.
10. Work in partnership with analysts, children and young people, carers, families, and staff.

New Digital system to support Patient Safety Learning

A new system is being created to replace the NRLS and StEIS systems, bringing reporting, learning and monitoring into one place. A single digital portal with improved data sets and a user-friendly input system will improve the information available, leading to improved analysis and improved learning to reduce harm in healthcare. The definitions of harm will be updated, with clear scales for physical and psychological harm. The link between complaints and incidents will be examined, acknowledging that a complaint is a form of clinical incident.

Using data-cleansing algorithms and AI analysis new information will be collected. The system will also link with the Medical Examiner system. The system will facilitate access to information enabling the creation of relevant reports for different parts of the organisation.

The Patient Safety Incident Response Framework

The 2015 Serious Incident Framework set the expectations for when and how the NHS should investigate Serious Incidents. However, compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these. A full summary is available online at https://improvement.nhs.uk/resources/future-of-patient-safetyinvestigation/23

While recognising the importance of learning from what goes well, identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence remain essential to improving safety. Doing this well requires the right skills, systems, processes and behaviours throughout the healthcare system.

Individuals within the trust are all responsible for improving safety and the Trust has electronic systems to encourage reporting, as well as regular safety governance meetings to encourage involvement in improving patient safety in the trust. These meetings are part of the divisional clinical governance structure and include Mortality and Morbidity reviews, divisional clinical incident meetings and investigations. The trust has a governance structure that ensures involvement of front-line staff as well as oversight from the executive.

Alder Hey supported by the PSIRF will operate systems, underpinned by behaviours, decisions and actions, that assist learning and improvement, encourage staff to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

The PSIRF proposals explore:

- A broader scope: describing principles, systems, processes, skills and behaviours for incident management as part of a broader system approach, providing and signposting guidance and support for preparing for and responding to patient safety incidents in a range of ways, moving away from a focus on current thresholds for ‘Serious Incidents’
- Transparency and support for those affected: setting expectations for informing, involving and supporting children, young people, families, carers and staff affected by patient safety incidents.
- A risk-based approach: we think organisations should develop a patient safety incident review and investigation strategy to allow them to use a range of proportionate and effective learning responses to incidents. The proposal is to explore basing the

selection of incidents for investigation on the opportunity they give for learning; and ensuring that providers allocate sufficient local resources to implement improvements that address investigation findings.

- Purpose: reinforcing the purpose of patient safety investigation and insulating it against scope creep and inappropriate use, so that safety investigations are no longer asked to judge 'avoidability', predictability, liability, fitness to practise or cause of death. Note there is no intention to alter the need to investigate specified incidents such as deaths where there is reason to believe the death may have resulted from problems in care as set out in the Learning from Deaths framework.
- Governance and oversight: taking a different approach to the oversight and assurance provided by commissioners, emphasising instead the role of provider boards and leaders in overseeing individual investigations.
- Terminology: making references to 'systems-based patient safety investigation', not 'root cause analysis', to reflect the 'systems' approach to safety.
- Timeframes: instead of applying a strict 60 working day deadline, adopting timeframes based on an investigation management plan that is agreed where possible with those affected, particularly patients, families and carers.
- Investigation standards and templates: introducing national standards and standard report templates.
- Investigator time and expertise: requiring investigations to be led by those with safety investigation training and expertise, and with dedicated time and resource to complete the work.
- Cross-setting investigation and regionally commissioned investigation: to better reflect the patient experience, co-ordination of investigation across multiple settings will be supported. This will include clearer roles and responsibilities for NHS regional teams to support investigation of complex cross-system incidents where needed.

The PSIRF

The PSIRF is a foundation for change. Local, regional and national work will be required to introduce this approach. Early adopters across several local systems will give insight into how the new expectations are best implemented and this used to support subsequent national implementation. Further support will be provided by:

- establishing a national implementation group including patient representation, to provide strategic direction and leadership and help solve challenges identified during implementation
- working across regional teams to support alignment of responsibilities
- developing an investigation training supplier procurement framework so that organisations can access high quality training more easily
- regional leads working to support a broader approach to cross-system and regionally commissioned investigation
- setting key objectives to support implementation as part of the NHS Long Term Plan and ensuring local implementation plans are developed
- developing resources for boards to include content in existing board development programmes.

The medical examiner system will be a transformative part of the NHS safety system, giving the bereaved a voice, while ensuring that the period after death is as problem free as possible. Alder Hey will work with the Regional Medical Examiner to ensure the robust process in place is not diluted by the new system.

The Alder Hey medical examiner will:

- agree the proposed cause of death with the qualified attending practitioner to ensure the death certificate is accurate
- for non-coroner cases, discuss the cause of death with the next of kin and establish if they have any concerns with the care provided
- act as a source of medical advice to the local coroner and facilitate notification of deaths to them appropriately.

At Alder Hey there are processes that all death in Alder Hey are reviewed through the Hospital Mortality Review Group (HMRG) and for children and young people with a learning disability we partake in the LeDeR process. Alder Hey also contributes to the review of children and young people who die in the local hospices and the local hospitals's. There is a link with Liverpool Women's Hospital for review of neonatal deaths in the surgical NICU, PICU and cardiac HDU when necessary. The medical examiner will support clinical governance processes, helping to identify where greater scrutiny may be needed or where systemic patient safety issues warrant an organisation-wide or broader response.

The medical examiner will provide a report to the Chief Medical Officer for presentation to the board on a quarterly basis.

National Patient Safety Alerts

The Chief Medical Officer, DHSC Supply Disruption, MHRA, NHS Digital, NHS England, NHS Improvement Estates and Facilities, national patient safety team and Public Health England (PHE) all currently issue safety messages, notices, letters or alerts through the Central Alerting System (CAS). NaPSAC is developing common standards and thresholds across these organisations. A single format for alerts will make it much easier for local systems to see what they need to do, by when and why. The standards and thresholds agreed by NaPSAC will underpin CQC's inspection of National Patient Safety Alerts and any regulatory response to noncompliance. Alder Hey has a system for receiving and disseminating these alerts to relevant staff in a timely way 24/7, 365 days a year.

Clinical negligence and litigation

NHS Resolution has commissioned and published research on the period between when a harmful incident happens, and the patient decides to make a legal claim. This is being used to develop a national programme of work to improve the NHS's response when things go wrong, including by supporting NHS staff to be open, raise concerns and deliver duty of candour and apologise with confidence.

Alder Hey will support and encourage staff to attend workshops. Research and analysis published by NHS Resolution, DHSC, the Parliamentary and Health Service Ombudsman, which looks at how to deliver effective and sustainable action to improve its response to concerns and complaints from children, young people and their carers or families will be disseminated and discussed at a suitable forum. Staff will be given access to the NHS Faculty of Learning, where all information is gathered.

The GIRFT programme in collaboration with NHS Resolution continues to develop improvements in patient safety through claims learning. GIRFT will publish best practice guidance based on claims learning in different specialties. These will be predominantly in adult care but Alder Hey will seek to have analysis of paediatric care analysed by GIRFT. Any lessons to be learnt will be disseminated to staff.

INVOLVEMENT

'Involvement' work aims to ensure that children, young people, carers, families, staff and our partners have the skills and opportunities to improve patient safety. We will strive to ensure that children and young people and their carers and families are involved in all aspects of the safety work that we do. This strategy sets out a range of methods that will be used to actively increase this partnership approach to patient safety.

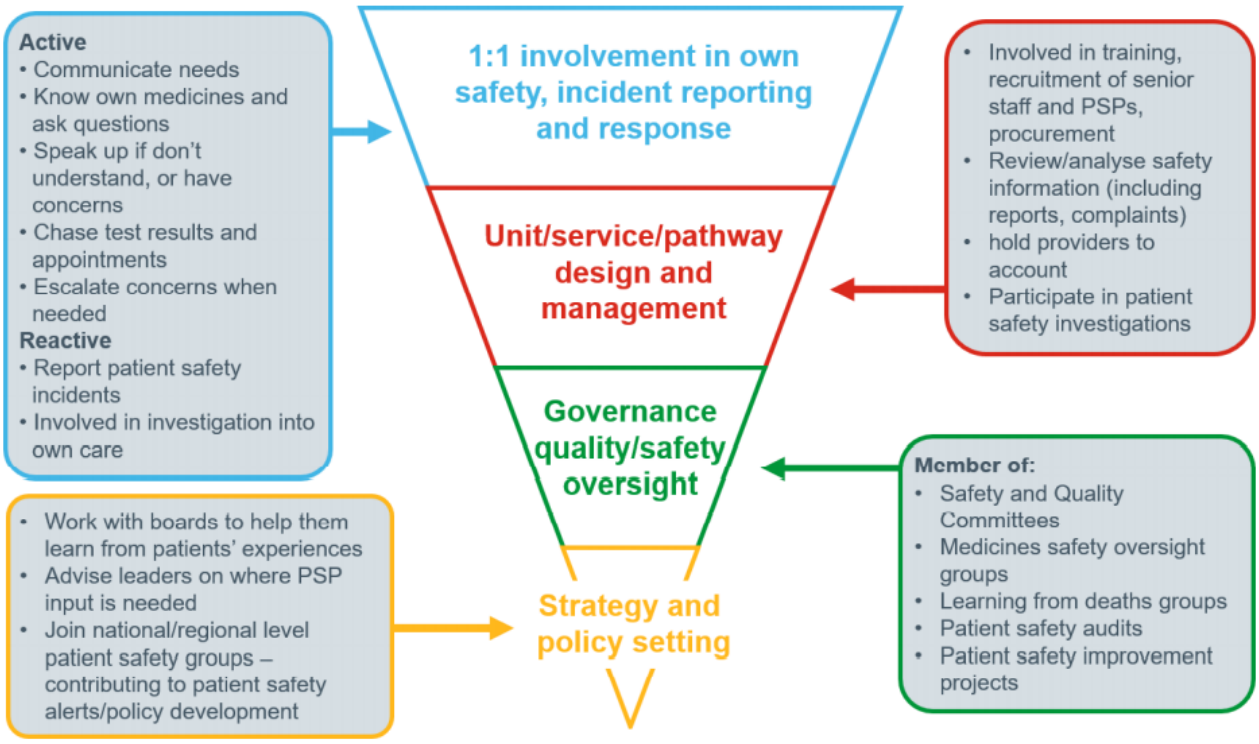
1 - Patient Safety Partners (PSPs)

Creating 'patient safety partners' (PSPs) is a clear way to ensure that the voice of children, young people and their carers and families is heard through all our safety work at all levels of the organisation.

General principles

These roles require support from senior leadership in the organisation, including by committing to give them an equal voice and empowerment to speak up, as well as the co-production of ways for their voices to be heard up to board level. This support will come from a non-executive director, the Chief Nurse and Chief Medical Officer, the executive directors with responsibility for patient safety. The PSP's will be supported by and link closely with the Divisional Directors who have a clear role in patient safety.

The PSPs model can be particularly effective when the organisation recruits a team of PSPs that includes people who have been harmed when in the care of the NHS. For Alder Hey that would be both children and young people but also their families and carers. PSPs should be involved in deciding where their input might be needed and working in partnership with the executive and non-executive director responsible for safety. Those with experience of being harmed can be particularly effective as patient safety champions and in staff training. Potential roles for PSP's are outlined below:



The PSP role

PSPs should be involved in:

Service and pathway design

PSP's are involved in facility design but should also be involved in service and pathway design. Concerns raised by the PSP or other patient representatives should be raised with relevant staff members in the service redesign team, listened to and responded to.

Safety governance

PSPs can contribute and add value to safety governance by, for example, sitting on relevant committees to support compliance monitoring, responding to safety issues, reviewing data and reports, and providing appropriate challenge to ensure learning and change. Alder Hey will appoint two PSP's to sit on safety committees together to provide peer support.

Strategy and policy

PSPs will ensure children and young people's perspectives are considered and provide valuable insights on the risks to children and young people; for example, where transitions in care and integration of care pathways are being considered.

Although not employees, once recruited, PSPs should be annually appraised, with clear objectives and training needs agreed. The new patient safety specialists once identified will also have a role in supporting PSPs. We will produce clear specifications for the different PSP roles, so preventing tokenistic involvement, and will ensure the roles are time limited,

ensuring that there is turnover bringing fresh eyes to the role over time. The term of office will be 2 years with a maximum term of 4 years.

Alder Hey will

- Recruit a team of Patient Safety Partners which will include children, young people and their carers and families
- Train those appointed to ensure they have the skills, knowledge and understanding for the role
- Work with those appointed to define the programmes of work that need their support
- Develop an ongoing programme of training and support
- Utilise the following guidance on embedding this approach in the organisation https://www.england.nhs.uk/patient-safety/framework-for-involving-patients-in-patient-safety/

2 – Children, Young People and their families as partners in their own safety

Children, young people and their carers and families should be encouraged and empowered to become involved in safety, moving from passive recipients of care to active partners in care in a way that is developmentally appropriate.

Involving people in their own safety means producing tools and resources to support people's involvement in their own care, improving access to their own data, including clinical test results, as well as providing mechanisms for people to report safety incidents.

If harm occurs, children, young people carers and families will be supported to be as involved as they wish to be in the work to develop an understanding of what happened so that the contributory factors can be identified and learned from. They should also be able to access support to aid their recovery.

Alder Hey will:

- Develop the patient portal giving access to care records for children, young people, carers and their families
- Ensure that staff are trained in the importance of child, young person, carer and parental concerns in highlighting safety issues and ensure there are systems in place that allow children, young people, carers and parents to escalate these where they feel they are not heard
- Ensure that our patient safety investigation approach involves children, young people, carers and their families to a level they feel comfortable with.

3 - Patient safety education and training

Patient safety experts use guidance, tools, methodologies, programmes, initiatives, projects and policies to encourage, cajole and incentivise people to do what safety experts believe is necessary. While safety is now better understood, significant numbers of people still have a limited understanding of safety science. We will enable the workforce to understand the reasons for involving patients and families in their own care and will give them the skills to make this happen.

Other high-risk industries teach their workforce about safety and the NHS should do the same. This is not the same as teaching clinicians how to practise safely – that happens already. It is about teaching everyone in healthcare that error is normal, and the right approaches needed to reduce risk and maximise the chances of things going well.

A National Patient Safety Syllabus has been launched that:

- provides a robust, achievable and aspirational plan for patient safety training for the NHS
- make safety training within professional educational programmes explicit and mapped to the competencies in a national syllabus
- ensure every member of the NHS has access to patient safety training; from ward to board and from commissioner to provider

The patient safety syllabus covers all staff and all areas of the NHS and will link from pre-registration university education through to all trusts in the country. While all staff will receive safety training this will be relevant to their role and level. A key aspect of the training will be allowing staff to fail safely, with no risks to patients and enabling them to learn from this. Modules of the national syllabus will cover:

Alder Hey will:

- Adopt the national syllabus
- Review current education and training opportunities and identify where explicit safety training can be incorporated
- Ensure that where possible training is multi-professional
- Ensure that specific training on human factors and safety culture are deployed across the organisation

4 - Patient safety specialists

Giving everyone in the NHS a foundation level understanding of patient safety is critical, but we also need to have experts leading on safety at organisational level. These specialists should be recognised as key leaders within the safety system, visible to the organisation and able to support the organisations' safety work. In some ways the concept is like designating someone a Caldicott Guardian, Director of Infection Prevention and Control or Freedom to Speak Up Guardian.

The patient safety specialist will have oversight of and provide support for patient safety activities across the organisation. Part of their role will be to ensure that systems thinking, human factors and just culture principles are embedded in all patient safety activity. They will need to work closely with others, including the Quality Hub, medical device safety officers and medication safety officers, and should support the fundamental principle that patient safety is everyone's responsibility – a specialist is not accountable for the organisation's safety on their own.

Alder Hey will:

- Appoint a patient safety specialist (this may be a job share)
- Ensure that the specialist(s) have undertaken the required training and development for the role
- Ensure that the role is embedded in all aspects of safety work across the organisation
- Empower the patient safety specialist to direct streams of work and report on progress to the board

5 - Safety I and Safety II

There is clear enthusiasm and interest in widening patient safety thinking beyond a focus on the rare examples of things going wrong ('Safety I') to why things routinely go right in healthcare ('Safety II').

Asking how we 'do' Safety II is a fair and important question, but it is problematic. People ask the question because the case for Safety II is compelling; they feel inspired by it. But Safety II is not about writing procedural documents, checklists or top-down interventions. Asking for the checklist or policy on what to do retains a Safety I mindset. Safety II needs a different form

of insight; understanding the messy details of work, the nuances and subtleties of what it means to get stuff done despite the pressures, the resource limitations and goal conflicts.

Safety II in practice

People need to know that the act of keeping children and young people safe is about having a constantly enquiring mind; noticing what happens every moment of every day; noticing when things go right; noticing when they could go wrong; and noticing when they do go wrong. They will then appreciate how they constantly adapt their behaviour and practice to work safely.

Appreciative inquiry and learning from excellence create a more positive culture and provide meaningful positive feedback. We should develop a culture that asks people who complete certain tasks every day how they get them done and what gets in the way of doing their daily work. This will lead to a more constructive conversation about how improvement can occur rather than waiting for an incident to arise and then retrospectively seeking to make changes which may have been known about in advance.

Alder Hey will:

- embed training in learning from what goes well alongside other prospective safety improvement techniques, in line with the new national safety syllabus
- embed Safety II principles in the system that will replace the NRLS. We will communicate and raise staff awareness about the changes, how they affect reporting and feedback mechanisms.

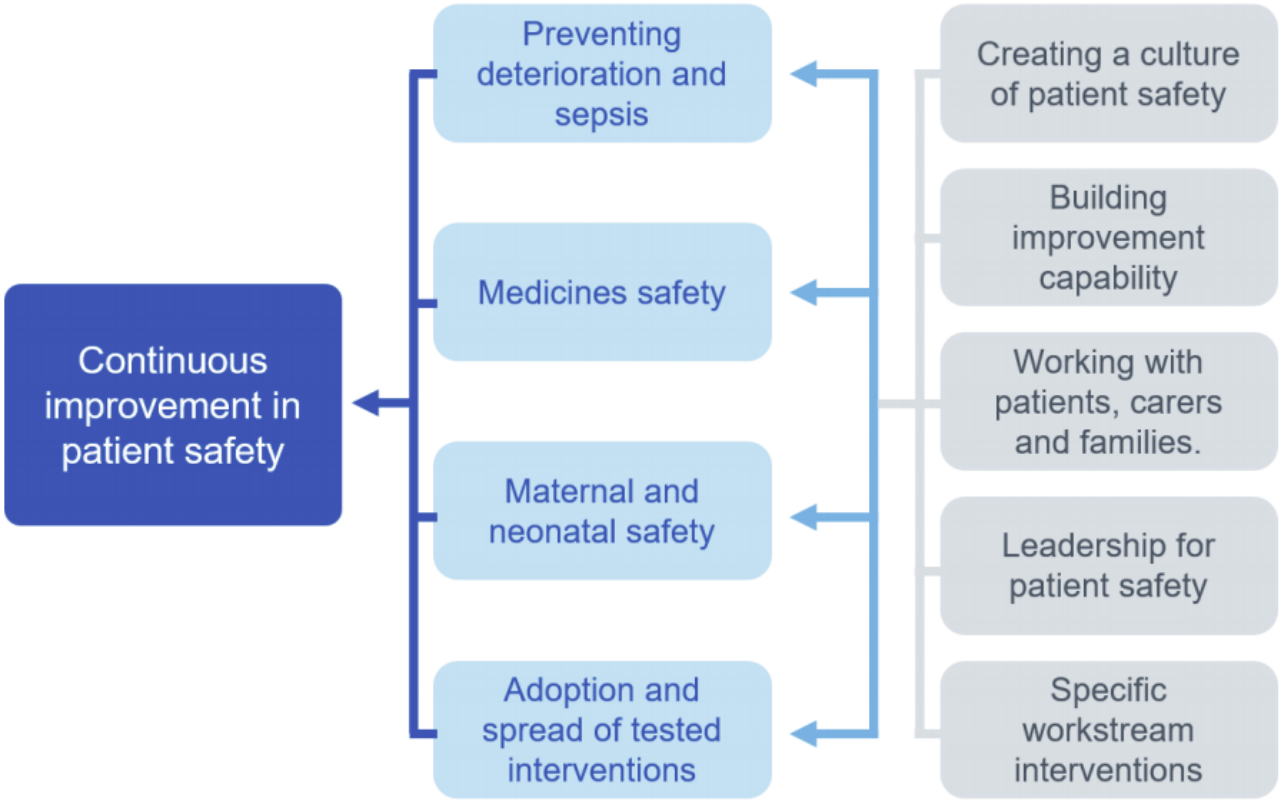
IMPROVEMENT

'Improvement' work aims to develop and support safety improvement programmes that prioritise the most important safety issues and employ consistent measurement and effective improvement methods.

Continuous improvement

The Alder Hey safety system will support continuous and sustainable improvement, with everyone habitually learning from insights to provide safer care tomorrow than today. Quality improvement provides the necessary coherence and aligned understanding of this shared approach to maximise its impact. It offers tools to understand variation, study systems, build learning and capability, and determine evidence-based interventions and implementation approaches to achieve the desired outcomes.

The National Patient Safety Improvement Programme has highlighted 4 national priorities which should be addressed to have a demonstratable improvement in patient care



The Trust will continue the Quality Priorities approach to improving patient safety, led by the Quality Hub, which has focussed on three main programmes of work for the year 2021/2022:

- Deteriorating child or young person
- Medication Safety
- Parity of Esteem for physical and mental health in an acute and community setting

Given the overlap with the national priorities the work streams will be combined and utilise improvement methodologies to demonstrate progress. The project plans, monitoring metrics and outcomes will be agreed and monitored through the Trust Safety and Quality Assurance Committee (SQAC)

Preventing deterioration and sepsis

Our work will continue to focus on avoiding harm or death caused by unrecognised or untreated deterioration in a child or young person's condition wherever they are being cared for. The work of the DETECT study has shown the importance of early identification, escalation and intervention in children and young people who show signs of deterioration. The national Paediatric Early Warning Score is being developed and will be embedded across the organisation.

There will be continued focus on improving compliance with the associated interventions for children and young people with suspected sepsis.

Alder Hey will:

- Reduce the number of unplanned admissions to HDU and ITU
- Improve compliance with escalation and response times when a child or young person is identified as deteriorating
- Improve compliance with the administration of IV antibiotics for child and young people with suspected sepsis

The Medicines Safety Improvement Programme

The Medicines Safety Improvement Programme (MSIP) aims to reduce medication related harm in the NHS, focusing on high risk drugs, situations and vulnerable children and young people. The programme will contribute to the WHO Challenge target to reduce severe avoidable medication-related harm globally by 50% over five years.

An estimated 237 million medication errors occur in England every year, 71 66 million of which are clinically significant. The third WHO Global Patient Safety Challenge: Medication Without Harm has set a global challenge which aims to reduce severe avoidable medication-related harm by 50%, globally by 2022.

Medicines in children and young people is complex and complicated. The approach to medicines safety will focus on common areas of error in prescribing, dispensing and administering medication to children and young people. Technology will be embraced and used to support decision making in the clinical environment.

To improve medication safety, Alder Hey will

- Focus on reduction of 10x medication errors
- Identify the top 10 high risk medications and work specifically to reduce risk in each
- Embed Bedside Medication Verification across the organisation
- Optimise the Electronic Patient Medication Administration system to improve safety functions
- Could we have something in here regarding STOMP and STAMP which focuses on over medication in children and young people

There will also need to be a focus on human factors and education specifically in relation to medication for the staff involved in all aspects of the process.

Mental Health Safety

Children and young people with a mental health need may be admitted to any part of the organisation and are not only seen through our community-based specialist mental health services. There has been a steady increase in the number of children and young people who present with mental health or emotional needs.

The Trust will ensure that there is a cultural change in the attitude of staff, ensuring that all children and young people have consideration given to their emotional and mental health, alongside any physical health care reasons for admission or treatment. A program of work focusing on parity of esteem will include a range of workstreams that will address this gap.

Alder Hey will:

- Deliver suicide prevention training to all staff across the organisation
- Provide relevant education and training to all staff regarding mental health
- Embrace positive behavioural support as a method of working with children and young people
- Develop a workforce approach that best supports children and young people who are admitted with a mental health need to the acute services
- Undertake comprehensive work related to restrictive interventions, rapid tranquilisation and clinical holding which will include improved training, reporting, recording and a restraint reduction programme

Maternal and Neonatal Safety

Recent years have seen a focus on improving safety in maternity and neonatal units driven by public enquiries into failings in care and the implementation of a range of national priorities to improve the safety and quality of care. As a stand-alone level 3 surgical neonatal unit Alder Hey has had a limited role to play in the safety initiatives with many of the key metrics being applicable to the maternity unit and initial stabilisation of the preterm infant.

Alder Hey will continue to work in partnership with Liverpool Women's Hospital as part of the Liverpool Neonatal Partnership, and will jointly review quality and safety initiatives, adopting these where relevant.

The focus for the organisation will be on

- Developing and delivery of the new purpose built NICU, embracing technology to improve safety and quality of care
- Working towards becoming BAPM compliant in staffing levels
- Achieving BFI accreditation for the NICU

Safety and learning disabilities

There has rightly been a recent focus on the quality of care provided to children and young people with a learning disability in care. The NHS Long Term Plan emphasises the approach

that is needed to address the longstanding health inequalities and inequities that have led to poorer outcomes, harm and premature deaths. This includes ensuring children and young people with a learning disability are more visible; that they are listened to; and that reasonable adjustments are made to ensure they have better access to healthcare.

The Learning Disabilities Mortality Review programme (LeDeR) provides insight about the care provided to those with a learning disability who die and has already shown they experience more respiratory problems, diagnostic overshadowing and under-recognition of early deterioration. LeDeR is being accelerated and will be supported and aligned with the medical examiner system. Greater understanding of the safety issues experienced by children and young people with a learning disability supports our improvement work

Diagnostic overshadowing is the tendency, once a diagnosis is made of a major condition, all other problems are attributed to that diagnosis. In the context of people with a learning disability, the STAMP (Supporting Treatment and Appropriate Medication in Paediatrics), launched in December 2018, supports children and young people to be involved in decisions about their medication and avoid inappropriate psychotropic medication.

Ask Listen Do: too often the voices of those with learning disabilities are not heard, even when they or their relatives raise concerns about the safety of services. Ask Listen Do supports organisations to learn from and improve the experiences of children and young people with a learning disability and their families and carers when they raise a concern or give feedback. It also makes it easier for children, young people, families and carers to give feedback, raise concerns and complain. Alder Hey will work to design and embed this process into our culture, supported by the patient experience team.

Care, Education and treatment reviews (CETRs): hospitals can be risky places, so encouraging staff and agencies to find alternatives to hospital admissions where appropriate is important. Children and young people with a learning disability may present with behaviours that staff can find challenging. Being admitted to hospital, particularly when the environment is inappropriate, can escalate those behaviours, increasing the likelihood the child or young person stays longer and may experience restrictive physical practices including rapid tranquilisation. A child or young person-centred approach and support from people who know them best often leads to better outcomes. Alder Hey is developing new models of care, including virtual to reduce the stress of attendance at hospital.

By 2023/24 we will fully meet the learning disability improvement standards. There are four standards, each supported by a range of metrics which providers are expected to measure themselves against. As a world first, the process for assuring delivery of the standards is facilitated via a triangulated approach. This requires the input of board-level representation, clinical representation and direct feedback (provided anonymously) from children, young people, carers and families who have accessed a particular service. It is expected that over time the standards will help create new benchmarks and enable providers of NHS-funded care

to consistently identify where challenges exist, alongside highlighting exemplars in service delivery and provision.

Antimicrobial resistance and healthcare-associated infections

The Annual Report of the Chief Medical Officer (2011) brought the threat of antimicrobial resistance (AMR) to the fore.

Where we are now?

AMR is driven by several complex, interwoven factors and compounded by a lack of industry innovation with no new classes of antibiotic discovered since the 1980s. The number of drug-resistant infections continues to rise, threatening the provision of safe and effective patient care and increasing treatment costs. Efforts to tackle AMR in healthcare involve prevention of infection, diagnostic stewardship and optimisation of antibiotic use to reduce the emergence and spread of resistant infections.

What next?

A new UK National Action Plan for AMR was published alongside a 20-year vision in January 2019. It has a focus on reducing healthcare-associated infection (HCAI), aiming to reduce healthcare-associated Gram-negative blood stream infections (GNBSIs) by 50% by 2023/24.

The GIRFT surgical site infection survey started in 2017 seeks to complement the work of PHE by engaging frontline clinicians in exploring variation in surgical practice and infection outcomes for a wider range of procedures and specialties.

The promotion of vaccination against, for example, influenza remains a priority to prevent the development of secondary respiratory tract infections, and therefore avoid the need for antibiotic use. Alder Hey is at the forefront of research, hosting a study on opportunistic immunisation of children and young people against influenza at outpatient and emergency attendances.

Research and innovation

Safety improvement relies on innovation, be that incremental or disruptive, and innovation relies on research to generate and test new ideas. An obvious example relates to Never Events – incidents that are considered wholly preventable because national safety recommendations that provide strong systemic protective barriers should have been implemented by all local systems. Never Events are rare but still occur. CQC found that prevention of the most common Never Events relies on repeated completion of procedural safety requirements like checklists and training programmes. Never Events that are prevented by a one-off technical solution are much rarer. Technical innovations that act as barriers to people getting things

wrong can have a greater impact on Never Event prevention and move us away from expecting people to try hard to compensate for systems that do not always support them.

Adoption of evidence-based tools to support safety priorities as well as developing innovative solutions to pre-empt emerging threats is therefore a priority.

Alder Hey will

- Continue to work in collaboration with the innovation centre and industry partners to develop and pilot solutions to improve the safety of care
- Embrace new and emerging technology such as AI and exploit its role in patient safety
- Seek solutions to issues from front line staff, and sharing learning through the wider NHS

Conclusion

The implementation of this strategy will align the range of work relating to improving patient safety with better use of data, education, training and will ensure that the systems and processes we use are developed in partnership with children, young people, carers, families and our staff.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 29th July 2021

Paper Title:	Serious Incident Board Report (1st June 2021 – 30th June 2021
Report of:	Nathan Askew, Chief Nursing Officer
Paper Prepared by:	Cathy Umbers Associate Director of Nursing and Governance

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

1. Purpose.

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

2. Summary

Table 1 (appendix 1) provides the performance position for StEIS reported incidents including Serious Incidents and Never Events for this financial year. There were two serious incidents reported in June 2021 and zero 'Never Events' reported.

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

Table 3 (Appendix 1) provides an overview of the two closed investigations in reporting period.

Alder Hey Children's NHS
NHS Foundation Trust

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

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

Note: 5 open investigations carried forward 2020/21

Table 2 Open ongoing StEIS reported investigations

StEIS Reference	Date reported	Incident	Agreed date of completion
2021/1899	24/01/2021	Unexpected death of a patient (HDU). Joint Perinatal review (PMRT) with Warrington and Halton Hospitals underway. (Warrington leading)	31/07/2021
2021/1919	02/01/2020	Patient treatment pathway issues	23/07/2021

2021/10050	07/05/2021	Cardiac arrest transferred to PICU. Complex medical history.	05/08/2021
2021/12203	27/06/2021	Delay in treatment, delay in transfer to HDU. Transferred to PICU shortly following transfer to HDU	03/09/2021
2021/12387	12/06/2021	Patient ingested large overdoes of tablets at home, including Omeprazole and Colchicine. Patient brought to ED and was admitted to PICU. Unfortunately, patient died due to impact of Colchicine toxicity.	07/09/2021

Table 3 closed investigations

StEIS Reference	Date reported	Investigation completion date		Comment
2021/7300	31/03/2021	29/06/2021	Wrong site block	Final report completed and submitted within agreed timeframe. Report shared with family. On 21st July 2021 Investigation report, including findings and actions for improvement presented to Clinical Quality Assurance Committee (SQAC)
2020/23828	09/12/2020	25/06/2021	Waiting list data quality issues	Final report completed and submitted within agreed timeframe. Actions for improvement progressing in line with expected timeframes.

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th July 2021

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing
Subject/Title:	Nursing Workforce Report 2020/21
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Hard Truths: The Journey to Putting Patients First: Department of Health, 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Safe staffing for nursing in adult inpatient wards in acute hospitals: National Institute for Clinical Excellence July 2014 • Safer Staffing: A Guide to Care Contact Time: NHS England 2014 • Single Oversight Framework: NHS Improvement September 2016 • Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals: Department of Health and Social Care, February 2016 • Standards of Proficiency for Registered Nurses: Nursing and Midwifery Council, May 2018 • Supporting Nurses, Midwives and Nursing Associates (England) in the event of a COVID-19 epidemic in the UK, March 2020 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • Stepping Forward to 2020/21: The mental health workforce plan for England: Health Education England, July 2017

	• NMC Emergency Standards: NHSE January 2021 • Advice on acute sector workforce models during COVID-19: NHSE, December 2020 • Joint statement on developing immediate critical care nursing capacity: NHSE, March 2020 • Deploying the healthcare science workforce to support the NHS clinical delivery plan for COVID-19: NHSE, May 2020 • Covid-19: Deploying our people safely: NHSE, April 2020
Purpose of Paper:	This paper provides the required assurance that Alder Hey Children's Hospital has safe nurse staffing levels across all in-patient and day case wards and appropriate systems in place to manage the demand for nursing staff To inform the Board of proposed workforce improvements in 2021/22
Action/Decision Required:	PAWC asked to note: • The content of the report and assurance that appropriate information is being provided to meet national and local requirements • The information on safe staffing and the impact on quality of care
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	

CONTENTS

1. EXECUTIVE SUMMARY

The aim of this paper is to provide assurance to PAWC that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff.

Since the previous annual Nurse Staffing Board report for 2019/20, the senior nursing leadership team have continued to work on the recommendations that were agreed. This report contains an updated position with regard to the nursing workforce and makes further recommendations for continued improvement.

The recruitment action plan has continued in order to maintain safe staffing levels. Alder Hey has demonstrated continued success in this highly competitive regional and national market, and the attrition rate of nurses offered employment at Alder Hey has reduced from 30-35% to 0% following highly successful recruitment of all Extended Placement Students (ECP) who evaluated their experience at Alder Hey positively.

In the last financial year of 2020/21, 122 WTE Band 5 Registered Nurses have been recruited through local, national and international campaigns. In addition, the Trust has successfully externally recruited to key senior nursing leadership posts namely the Chief Nurse; Associate Chief Nurse Surgical Division; Oncology Matron; new role of Complex Care Matron; and new role of Surgical Matron in the Surgical Division

The average monthly number of front line staff leaving the organisation has decreased significantly to 2.5 WTE.

A review against the RCN standards was repeated which has demonstrated an improvement following the full implementation of the ACT team and the Trust is now compliant with 15 of the 16 core standards with an improved position in the standard rated partial compliance

The Trust's mandated monthly submission of staffing levels to NHS website presented was consistently higher than 90% throughout the year against the nationally accepted level of 90%.

In response to the Covid-19 pandemic, a temporary model of nursing was devised for the Trust for the emergency period. The staffing guidelines devised at the time of the first wave (Amber and Red staffing levels) were for that point in time and were subsequently stood down back to the usual Green staffing levels in line with national guidance. In preparation for the second wave and more sustained staffing challenges over the winter period, the staffing model was reviewed and revised. The Amber and Red models were devised in collaboration with senior nursing staff. it is important to note that at no time during either wave were the Amber or Red staffing levels invoked and staffing remained at Green and in line with national standards at all times.

A significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust, came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed to critical care, wards and as health care support workers. During the second wave of the pandemic, based on learning from the first wave, staff redeployment was undertaken on a voluntary basis. The Trust also supported the Nightingale Hospital during the second wave and provided short term mutual staffing aid to local Trusts. This was done on a voluntary basis and the staff shared the learning of their positive experience with the Senior Nurse / AHP Forum.

2. NATIONAL CONTEXT AND REGULATION

There are a number of tools available to determine safe staffing levels. The tools currently used at Alder Hey are Royal College of Nursing standards nurse to patient ratio, skill mix review, patient acuity and dependency assessment through the SCAMP Safer Nursing Care Tool, professional judgement and triangulation with nurse sensitive indicators.

Specific guidance for safe staffing levels in neonatal and paediatric settings is set in the main by the Royal College of Nursing (2013). A review of the Trust's compliance against the 16 core standards for 2020/21 can be found in section 4.3, with the Trust fully compliant with 15 standards and partially compliant with 1 standard. This is an improvement on the position reported in 2019/20 when the Trust was compliant with 14 standards.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine set standards for care of neonates (BAPM, 2011). The Royal College of Psychiatrists set out CAMHS standards (RCP, 2020).

In November 2017, the National Quality Board (NQB) published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. The improvement resources are based on the NQB's expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time. The Trust undertook specific reviews of staffing requirements in 2020/21 in response to the potential unique staffing challenges resulting from the advent of the covid-19 pandemic. Annual establishment reviews are scheduled for June to August 2021.

In October 2018, NHSI published the Developing Workforce safeguards document to build on the NQB tools by helping Trusts manage common workforce problems, providing recommendations to support making informed, safe and sustainable workforce decisions. The document sets out that Trusts compliance with the triangulated approach to staffing will be assessed, combining evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time based on patients' needs, acuity, dependency and risks, and the requirement for ward to board monitoring. A specific workforce statement is provided in the annual governance statement which is monitored by NHSI. Implementing the recommendations and strong, effective governance, provides Trust Board assurance that workforce decisions promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards, NHSI compliance and the Board's statutory duties.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are required to submit monthly staffing data. The Trust is compliant with submitting data to the public through NHS website and on the Alder Hey website (Section 4.2 and Appendix 1)

In 2000, the Department of Health proposed that every hospital should have Matrons who are accountable for a group of wards and are easily identifiable to patients, in order to improve the delivery of patient care, patient experience, and to provide strong clinical leadership and authority at ward and departmental level. In 2020, the Matron structure was reviewed and it was identified that due to the increase in patient acuity, and breadth of the role, the structure needed to be strengthened to provide increased clinical leadership and expertise in the Medical Division and Surgical Division and as such a new Matron role was introduced in both Divisions

The Nursing and Midwifery Council (NMC) implemented Nurse Revalidation from April 2016, which requires all registered nurses to revalidate every 3 years to maintain their professional registration. The purpose of revalidation is to improve public protection ensuring nurses remain fit to practise

throughout their careers. To date, all registered nurses due to revalidate have done so successfully.

The RCN's Principles of Nursing Practice states that 'Nurses and nursing staff must have up to date knowledge and skills and use these with intelligence, insight and understanding in line with the needs of each individual in their care'. In May 2018, the Nursing and Midwifery Council (NMC) launched new standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. The Standards of Proficiency for Registered Nurses represents the skills, knowledge and attributes all nurses must demonstrate. Practice Educators play an essential role in the development of a workforce that is able to deliver high quality, effective and safe care. The clinical education team, expanded in 2018/19, has proved invaluable in supporting students, new registered nurses and existing staff with support and education throughout the year and specifically during the Covid-19 pandemic, providing induction to new staff, supporting the Extended Clinical Placement (ECP) students (section 4.4) and providing PPE training.

During 2020/21, as the consequences and impact of the Covid-19 pandemic became apparent, a multitude of associated new national guidance was set out by NHSE/I and professional bodies (referenced in background papers). In 2020, the Chief Nursing Officer (CNO) for England recognised that the pandemic would require temporary changes to practice, requiring health and care professionals to be flexible, working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole whilst practicing in line with the NMC code and using judgement in applying the principles to situations that you may face, and using professional judgement to assess risk and to make sure people receive safe care. The CNO acknowledged this included a rational approach to varying practice in an emergency as part of that professional response.

In response to the national crisis, a temporary model of nursing was devised by the Trust for the first wave of the pandemic in March / April 2020. The staffing guidelines devised at the time of the crisis (Amber and Red staffing levels) were for that point in time and were stood down back to the usual Green staffing levels in line with national guidance in summer 2020. In preparation for the second wave and more sustained staffing challenges over the winter period, the staffing model was reviewed and revised Amber and Red models were devised in collaboration with senior nursing staff. It is important to note that at no time during the Covid crisis period were either the Amber or Red staffing levels invoked, and staffing remained at Green and in line with national standards at all times. The Director of Nursing worked in collaboration locally with the Ward Managers, Matrons and Associate Chief Nurses; and at regional and national level with the Association of Chief Children's Nurses, the RCN and the C&M Directors of Nursing in order to ensure safe staffing levels were set to cope with the Covid crisis. The risk was recorded on the Risk Register (risk 2138) and has subsequently been closed.

A significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed to critical care, wards and as health care support workers. During the second wave of the pandemic, based on learning from the first wave, staff redeployment was undertaken on a voluntary basis. The Trust also supported the Nightingale Hospital during the second wave and provided short term mutual staffing aid to local Trusts. This was done on a voluntary basis and the staff shared the learning of their positive experience with the Senior Nurse / AHP Forum.

3. SUMMARY OF ACHIEVEMENTS

The overall impact of the success of the recruitment, reduction in vacancies, response to the pandemic and other developments to support safe nurse staffing is as follows:

3.1: Recruitment

i. 122 WTE front line nursing staff recruited in 2020/21
ii. Successfully recruited all Student Nurses who opted into the national ECP scheme
iii. From the successful international recruitment programme in 2019/20, 50 of the 105 nurses given a conditional offer have successfully commenced employment at Alder Hey in 2020/21 and all have passed the OSCE enabling them to register with the NMC
iv. Trust has 5 qualified Nurse Associates and 3 Trainee Nurse Associates across the Trust and are planning to recruit 8 per year across 2 intakes
v. Vacancy rates less than 2%
vi. A responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days and a comprehensive induction and preceptorship programme for new nursing staff. Ongoing recruitment work also continues via the virtual recruitment programme
vii. Recruitment strategy partnership working with Higher Education Institutes to attract potential student nurses from diverse backgrounds
viii. Successful bid awarded for funding from NHSE/I to support international recruitment
ix. Successful bid awarded from NHSE/I to support national strategy for zero Health Care Assistant (HCA) vacancies. Funding being used to deliver the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is a HCA vacancy
x. Appointment of one overseas nurse through the NW refugee program, with other potential refugees being recruited as part of cohort 4 in January 2022

3.2: Safe staffing levels

i. Staffing levels consistently higher than 90% throughout the year for open beds
ii. Daily Safer Staffing Huddle operational and fully embedded
iii. Covid-19 staffing plan set out for the emergency phase 1 covid period and the winter / phase 2 covid period including specific staffing model for PICU when caring for adult patients

3.3: Strong and effective leadership structure

i. External recruitment to the Chief Nurse role commenced in post November 2020
ii. Director of Nursing undertook Acting Chief Nurse role April to October 2020
iii. Internal recruitment to the Associate Chief Nurse Surgical Division
iv. The Trust is now fully compliant with RCN core standard 14 and has a paediatric nurse of at least Band 8A on duty 24 hours per day following successful recruitment and implementation of the Acute Care Team (ACT)
v. External recruitment to the Oncology Matron in the Medical Division
vi. External recruitment to the new Complex Care Matron role in the Medical Division
vii. Internal recruitment to the new Surgical Matron in the Surgical Division
viii. Internal recruitment to Burns Unit and Ward 4A Ward Manager posts
ix. Internal rotation with LWH for Neonatal Unit Ward Manager post
x. Secondment opportunity for Ward 4C Ward Manager post
xi. Internal promotion to Band 6 Ward Sister / Charge Nurse positions
xii. Safer Staffing Huddle Chaired by a senior nurse
xiii. Senior nurse oversight and involvement at all stages of the redeployment process due to Covid-19 pandemic

xiv. Successful bid awarded for funding to employ a pastoral support lead for international recruitment

3.4: Educational developments

i. Bespoke Staff Nurse preceptorship and rotation programme continues for all newly qualified nurses; facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
ii. Supported all 2nd year and 3rd year students who opted into the national ECP scheme
iii. Successful bid awarded for 10 places on the Registered Nurse Degree Apprenticeship (RNDA) September programme. Funds awarded will support backfill arrangements for trainees and / or support externally appointed applicants
iv. Successful bid awarded from Health Education England for the Clinical Placement Expansion programme to increase the number of student nurses nationally and thus the future number of Registered Nurses. An additional 27 Student Nurses have been offered placement at Alder Hey with the funding awarded supporting their education
v. Review and evaluation of the Clinical Educator programme undertaken to ensure the most effective model utilised which produces the best outcomes for both our staff and the educators
vi. Eight nurses predominantly from the Education team were successfully offered places on the NHSE/I Professional Nurse Advocate programme. This will help build a team who can support our nurses both educationally and across a pastoral and supervision capacity
vii. Continued to support senior nurses and aspiring nurse leaders to undertake the MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
viii. Practice Education Facilitators and Clinical Practice Educators continues to address organisational education requirements and provides a streamlined approach to a wide variety of staff development opportunities. A workforce development flow chart has been devised to outline the workforce programmes available and the access criteria
ix. In response to the Covid-19 pandemic, in March 2020 a significant training and redeployment process was set up by staff from across the Trust to address anticipated staffing challenges. This saw a large number of staff trained and available to be redeployed:
    a. Critical care orientation training: 246
    b. Ward orientation training: 121
    c. HCA orientation training: 112

3.5: Quality metrics

i. Review of Infection Control audits and now undertaken through the Perfect Ward audit tool
ii. Following initial covid period (Q1 2019/20), Perfect Ward audit quality metrics measured and monitored in Divisions. Exceptions reported to CQSG
iii. Challenge boards introduced for each ward within Divisions and assurance regarding key performance indicators reported to CQSG, SQAC and executive performance reviews
iv. With the support and expertise of the IT team and the Communication team, we have improved the electronic safety screens outside all wards to include public facing information regarding cleanliness scores, hand hygiene compliance, medication errors, and complaints.
v. Collaborative working with the IT team and Pharmacy to roll out Bedside Medication Verification to enhance and improve the safety of medicines administration, blood sampling and the administration of expressed breast milk.

4. HOSPITAL NURSE STAFFING MODEL

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with the national requirements as described in section 2. Due to the Covid-19 pandemic, some formal establishment were postponed. All establishment reviews have been arranged to take place between June to August 2021. Establishment review and subsequent business case resulted in increased staffing in ED and EDU, and Ward 3A

Staffing models and associated requirements, including agreement on minimum staffing levels, was undertaken at least twice with each Ward Manager, Matron and Associate Chief Nurse in 2020/21 in line with planning and agreeing phase 1 and winter / phase 2 Covid staffing models. This included compliance with any national Covid staffing guidance agreed predominantly in relation to critical care staffing.

4.2: Safer staffing levels

In line with Department of Health Hard Truths Commitments (2013), all Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level and make the information available to the public. The Trust is compliant with submitting data to the public through NHS website, the Alder Hey website, and at ward level. The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2020/21 demonstrated that the overall staffing level was consistently higher than 90% throughout the year.

In 2020/21 there were occasions where the average fill rate for Health Care Assistants was 83% to 89% fill rate, and one occasion where the fill rate was 84%, however the Registered Nurse requirement, who are the largest number of staff per shift, was never less than 90%. For context, typically a shift will be staffed with an average of 9 nurses with 2 Health Care Assistants. Where the fill rate for HCA's was lower than the expected risk assessments were undertaken by the safer staffing group to ensure safety across the organisation was maintained.

Appendix 1 provides a full break down of staffing levels by ward for 2020/21.

4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, a review against the RCN standards has been repeated in 2020/21 by the Director of Nursing (Appendix 2; Table 1; Table 2). This will be repeated as an audit in 2021/22 as part of annual establishment reviews involving the Ward Managers, Matrons and Associate Chief Nurses across in patient and day case wards.

4.3.1: RCN Core Standards

The thermometer below demonstrates year on year improvements against the RCN core standards since the first audit was undertaken in 2014.

July 2014	2	4	6	7	8	10	11	15	16	1	3	5	9	12	13	14
Feb 2017	2	4	6	7	8	9	10	11	12	13	15	16	1	3	5	14
Feb 2018	2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14
Mar 2019	2	3	4	5↑	6	7	8	9	10	11	12	13	15	16	1↑	14↑
Mar 2020	2	3	4	5	6	7	8	9	10	11	12↑	13↑	15	16	1	14↑
Mar 2021	2	3	4	5	6	7	8	9	10↑	11↑	12	13	15	16	14↑	1

The audit last year demonstrated the Trust was Green (full compliance) with 14 standards and Amber (partial compliance) with 2 standards.

The recent review has demonstrated a further improvement resulting in Green (full compliance) with 15 standards and Amber (partial compliance) with 1 standard within which there has been an improvement.

This improved position is due to the implementation of the ACT team (Acute Care Team) which provides senior nurse cover at Band 8a or above 24 hours per day 7 days a week in line with core standard 14. The ACT team provides early response and intervention for patients showing early signs of deterioration and responding to concerns raised by staff. This is a significant patient safety improvement in ensuring the safety of our patients 24 hours a day.

Although core standard 1 (all clinical areas are required to have a supernumerary shift supervisor) has remained at Amber (partially compliant), there has been significant improvement with an increase of an additional Matron in both the Medical Division and the Surgical Division to support the wards.

Further improvement has been made in line with core standards 10 (HCA training) and 11 (student nurse placement) as the Deputy Director of Nursing has been successful in being awarded bids to support the Trust to deliver the HCA Care Certificate and to increase the number of student nurses placements offered and supported at Alder Hey.

Table 1 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to improve compliance:

Table 1: Core standards to be applied in services providing health care for children and young people		
Standard		**Compliance**
1	The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff	**Partial ↑**
	10 out of 15 areas have a supranumery clinical co-ordinator however there has been an improvement following an increase in nurse staffing in ED ensuring appropriate staffing across ED and EDU Gaps exist on Wards 3C, 4B (nights), Burns Unit, and Medical Day Case. However, all Ward Managers are supernumery; all wards benefit from presence of a supernumery Matron; and all wards benefit from the support of a Clinical Educator. An additional Matron role has been introduced in both Medicine and Surgical Divisions in 2020/21. A significant number of wards	

	benefit from a supernumery Advanced Nurse Practitioner (ANP) and / or Trainee ANP (see core standard 2) and whilst ANP's should not be counted in the bedside establishment, they provide key clinical leadership, skill, experience and knowledge that benefit the ward teams All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward Review of this standard is a key component within the establishment reviews and ED / EDU have submitted a business case to address	
2	Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff	**Compliant**
	Fully compliant In March 2020 in response to the Covid-19 pandemic, a significant training and redeployment process was undertaken which saw a large number of Clinical Nurse Specialists undertake training and redeployment to wards and departments. This was very successful and forms a key part of the wider Training Needs Analysis and education strategy going forward to build on the skill set and ensure a flexible workforce as required	
3	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need	**Compliant**
	100% compliance with the Trust resuscitation policy for areas identified to have APLS or PLS trained staff on each shift	
4	There will be a minimum of 70:30 per cent registered to unregistered staff	**Compliant**
	Fully compliant. Ward 4B has a ratio of 50: 50 however that is a deliberate workforce configuration as the support staff are trained to care for children requiring long term ventilation	
5	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave	**Compliant**
	The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce. In addition, 6 WTE nurse Clinical Educator's in post	
6	There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas	**Compliant**
	Fully compliant	
7	Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles	**Compliant**
	Fully compliant	
8	Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's oncology,	**Compliant**

	children's neurosurgery	
	Fully compliant. Specialist wards have locally or regionally delivered programmes to support staff development and expertise in their field as identified in their local Training Needs Analysis	
9	Support roles should be used to ensure that registered nurses are used effectively. Support roles are defined in the standards as a minimum of the following:	**Compliant**
	Supernumery Ward Manager: Fully compliant	
	Ward receptionist / ward clerk / admin support for ward staff: Fully compliant	
	Play Specialist: Fully compliant apart from PICU however they can make a referral to the Play Specialists as required which will then be reviewed and actioned appropriately. Prior to Covid restrictions, all areas had access to the significant Arts for Health programme which includes musicians attending the wards and departments	
	Housekeeper: Fully compliant. Burns Unit access PICU / HDU housekeeper	
10	Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks	**Compliant ↑**
	Successful bid awarded from NHSE/I to support national strategy for zero Health Care Assistant (HCA) vacancies. Funding being used to deliver the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is a HCA vacancy. All new Health Care Assistants signed up to NHSP undertake Advanced Clinical Skills training. All HCA's on wards have assessment of competency in assigned skills.	
11	The number of students on a shift should not exceed that agreed with the university for individual clinical areas	**Compliant ↑**
	Fully compliant Successful bid awarded from Health Education England for the Clinical Placement Expansion programme to increase the number of student nurses nationally and thus the future number of Registered Nurses. An additional 27 Student Nurses have been offered placement at Alder Hey with the funding awarded supporting their education	
12	Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels	**Compliant**
	SCAMPS tool in place. Workstream established pre Covid pandemic to review the tool and will now be progressed further. Workstream led by a Ward Manager. Safer Nursing Care Tool being evaluated following implementation of the e-roster system	
13	Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.	**Compliant**
	Ward Managers / Senior Nurses attend daily Safer Staffing Huddle to inform of ward level patient acuity and requirement for additional staff; staffing plan is agreed, implemented and reported in to the Bed Meeting	

	Perfect Ward audits undertaken monthly, temporarily suspended during the first wave of the covid-19 pandemic. Infection Control audits and covid audits regularly conducted and ward dashboards completed. Ward Accreditation process temporarily suspended during the pandemic and have now resumed. Challenge boards introduced for each ward within Divisions and assurance regarding key performance indicators reported to CQSG, SQAC and executive performance reviews In line with Hard Truths Commitments daily staffing information displayed electronically to the public via screens.	
14	Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification	**Compliant ↑**
	The Trust is now fully compliant with this standard following successful recruitment to the Acute Care Team (ACT) to support ward staff 24 hours per day and respond to patients showing early signs of deterioration. Therefore there is now a minimum of a Band 8a ANP's on duty at all times. The ACT ANPs commenced in post in August 2020	
15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day	**Compliant**
	Fully compliant. Nursing and Medical staff on call	
16	Children, young people and young adults must receive age appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs	**Compliant**
	Appropriately trained workforce and specially designed Children's Hospital Clinical educators have played a key and essential role in supporting newly qualified staff, internationally recruited staff, and redeployed staff	

4.3.2: RCN Specific Guidance

Analysis has taken place to review front line staffing against the relevant specific staffing guidance sections of the RCN guidelines not captured within the core principles.

The review demonstrated that the Trust remains fully compliant with 2 standards and partially compliant with 2 standards, with an improved position in standards 7 and 8. Majority of wards (12 out of 15 for standard 7; 6 out of 9 for standard 8) are fully compliant in the standards rated Amber and a staffing plan is in place to mitigate any gaps as outlined in Table 2 below and Appendix 2.

The thermometer below demonstrates sustained improvements against the relevant RCN specific standards since the first audit was undertaken in 2017.

Feb 2017	5	6	7	8
Feb 2018	5	6	7	8

Mar 2019	5	6	7↑	8↑
Mar 2020	5↑	6	7	8
Mar 2021	5	6	7↑	8↑

Table 2 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to mitigate and improve compliance:

Table 2: Staffing principles within "Defining staffing levels for children and young people's services"		
Section		**Compliance**
Section 5: Neonatal services	Bedside, deliverable hands-on care: Special care 1:4 nurse: infant High dependency care 1:2 nurse: infant Intensive care 1:1 nurse: infant	**Compliant**
	Fully compliant. Neonates requiring intensive care are nursed on PICU, surgical and cardiac neonates requiring high dependency care are nursed on Ward 1C. Neonates on other wards are nursed 1:3 in line with standards in Section 7 below. The Trust is part of a single neonatal service with LWH. Rotation of ANPs and nursing staff in place and a new Ward Manager has joined the team from LWH	
Section 6: Designated children's intensive care and children's high dependency services	PICU 6.7-7.06 WTE per bed dependent upon maternity leave included in calculation Bedside, deliverable hands-on care: Level 1: HDU 1:2 nurse: child Level 2: PICU or HDU cubicle patient: 1:1 nurse: child Level 3: PICU: 1:1.5 nurse: patient Level 4: 2:1 PICU: nurse: patient (ECMO)	**Compliant**
	Current ratio now at 6.6 WTE per PICU bed. HDU compliant with 4.4 WTE per bed. Full nursing ECMO team established in PICU. All patients are nursed as per ratios set above unless not required for example a patient who is being transferred from PICU to a ward. HDU care provided on general HDU, Ward 4A and Ward 1C Cardiac all provide 1:2 care PICU cared for adult patients during both wave 1 and wave 2 of the covid-19 pandemic supported by staff redeployed from other areas of the Trust following a training programme	
Section 7: General children's wards	Bedside, deliverable hands-on care: Children < 2 years of age 1:3 registered nurse: child, day and night Children > 2 years of age 1:4 registered nurse: child, day and night	**Partial ↑**
	12 out of 15 areas fully compliant: All wards compliant except Wards 3B, 4B, 4C and EDU on night duty however additional temporary staff are sourced where acuity is high and necessitates the need to increase the night nurse to patient ratio. Staffing levels and patient acuity are monitored and appropriate action taken to ensure safe staffing at the daily Safer Staffing Huddle	

	This staffing plan continues to be monitored and evaluated and all wards have annual establishment review undertaken as per best practice guidelines.	
Section 8: Specialist children's wards	At least a third of patients on specialist wards (such as oncology, cardiac, neurosurgery) should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent. The relevant standards must be followed (1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child	**Partial ↑**
	6 out of 9 areas fully complaint There is a case to say that almost all of the in-patient wards at Alder Hey are specialist in nature Wards with dedicated HDU beds (Ward 1C and Ward 4A) are established for 1:2 ratio for commissioned HDU beds, and in addition Ward 4A provides 1:2 ratio for orthopaedic patients requiring a higher intensity of care Ward 3C regularly has high acuity patients requiring a HCA 1:1 and this is always supported and facilitated through temporary staffing as required Wards are not established for 1:3 ratio for remainder of patients. Achieving compliance with this standard would require significant additional financial investment However, staffing levels and patient acuity are monitored and appropriate action taken to ensure safe staffing at the daily Safer Staffing Huddle	

4.4: Recruitment and Resilience

The senior nursing team have continued to undertake recruitment activities throughout 2020/21 and have recruited 122 WTE front line registered nurses. In year nursing vacancy rates are below 2%, which is significantly lower than the national average of 10%.

As a result of the pandemic, the Nursing and Midwifery Council (NMC) offered revised education programmes for nursing students. In the first wave of the pandemic, 2nd year and 3rd year student nurses were able to opt in to undertake paid placements which allowed the students to remain on their programme while undertaking paid work to support the NHS at this crucial time. Alder Hey supported 63 2nd year students and 97 3rd year students. During the first and second wave of the pandemic, 3rd year students in the final six months of their training were able to opt into Extended Clinical Placement (ECP) full time paid work. The ECP students evaluated their experiences positively and were subsequently all recruited as Staff Nurses. This is a highly significant and positive outcome as in previous years the Trust has experienced a 30% attrition rate in respect of recruiting student nurses as Staff Nurses.

A highly successful recruitment campaign was undertaken in November 2019 and the Trust welcomed a further 25 highly skilled and experienced nurses from India in September 2020 and January 2021 once the lifting of Covid restrictions enabled their safe passage to the UK. A comprehensive induction and OSCE programme was put in place however in response to the

Covid-19 pandemic, the national guidance regarding overseas nurses changed to enable the staff to join a temporary register sooner with the NMC to then work at Band 5 rather than the intended six month Band 4 period. All of the nurses, including the 25 nurses who joined Alder Hey in February 2020, have successfully passed their OSCE examination.

The Trust has 5 qualified Nurse Associates and 3 Trainee Nurse Associates across the Trust and are planning to recruit 8 per year across 2 intakes

Table 3 and Figure 1 shows actual number of starters per quarter in 2018/19 in comparison to the previous 2 financial years which demonstrates continued successful recruitment supported by the previous international recruitment campaign.

Table 3: Front line registered nurses recruited in WTE

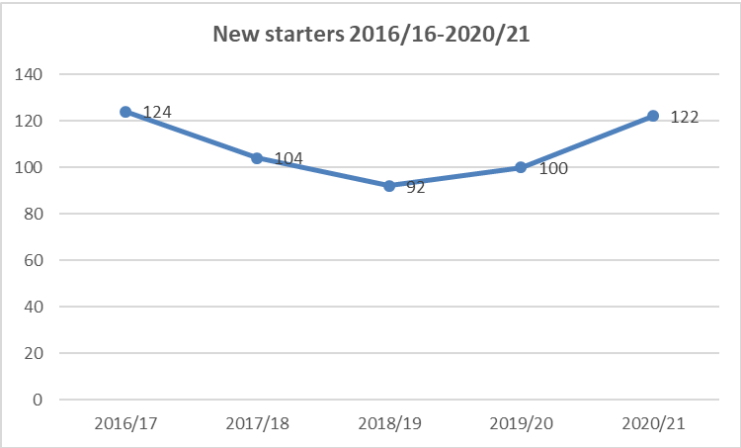
Q1 2016/17			Q2 2016/17			Q3 2016/17			Q4 2016/17			Total
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	25	5.8	6		65.6		2		5.45	12.22	2.8	124.87

Q1 2017/18			Q2 2017/18			Q3 2017/18			Q4 2017/18			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
2	22.35	2.61	2.51	1	49.67	10.15	3.92	0	5.96	3.46	1	104.63

Q1 2018/19			Q2 2018/19			Q3 2018/19			Q4 2018/19			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
4	26.21	3	1.22	0.76	4	48.53	2.22	0	1.31	0	1.39	92.64

Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
0.92	16.9	5.41	1.61	1	2	34.75	1.5	0.43	6.5	3.51	26	100.53

Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
20.52	0	0	0	0	19.72	52.26	3	0	11	10.92	4.52	121.94



There has been rise back up in the curve again for the number of staff who have commenced employment in the Trust since 2016/17 following addressing this strategically through the

international recruitment campaign in 2019. It is anticipated that with the increased placement capacity for student nurses introduced in 2020/21 that this high level of recruitment will be sustained

The senior leadership team worked closely with HR and the Communications Team to ensure a robust recruitment drive; advertising on social media as well as traditional routes such as NHS Jobs, for both registered and non-registered nurses

The senior nursing leadership team have implemented and embedded a formalised process, including a "One Stop Shop" recruitment day, incorporating a clearly articulated offer to new staff including the Staff Nurse Rotation Programme. This has now been in place for two years and has been evaluated positively by new starters. Throughout the pandemic the Trust continued to support the training requirements of ECP students and enabled fast track completion to expedite their recruitment process.

The senior nurse leadership team, together with HR and the BAME Task Force, recognise that our nursing staff are not representative of our local population. Only 6% of student nurses who have had placement at Alder Hey in the last 5 years are from black, Asian and minority ethnic backgrounds. The nursing workforce is also predominantly female. The senior nursing leadership team, HR and Communications team have been working in partnership with the local HEI's to take positive action to increase the diversity of future student nurses and working to align recruitment strategies. This is a continued priority for 2021/22

Appendix 3 provides analysis of all new Band 5 nurses in 2020/21 by ward.

4.5: Workforce developments in 2020/21

i. **Training and Redeployment process and RotAHub:** In response to the Covid-19 pandemic, a significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust, including (but not exhaustive to) Critical Care, Finance, HR, OD, IT, DMO, Nurse Education, Divisions came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed:

   a. Critical care orientation training: 246 (104 ward staff / 108 Theatre staff / 34 Nurse Specialists)
   b. Ward orientation training: 121
   c. HCA orientation training: 112

   A RotAHub was set up to assist in the co-ordination of ward rotas.

   During the second wave of the pandemic staff volunteered to be redeployed to PICU and this was positively evaluated

ii. **E-roste**r: In line with NHSI&E requirements the Trust have procured and implemented an e-roster system. Ward Managers worked with the lead to build staffing profiles for all acute nursing areas.

iii. **Successful bids for external funding awarded to support workforce developments:**
   a. To support international recruitment and employ a pastoral support lead
   b. To support national strategy for zero Health Care Assistant (HCA) vacancies. Funding being used to deliver the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is a HCA vacancy

c. To support 10 places on the Registered Nurse Degree Apprenticeship (RNDA) programme. Funds awarded will support backfill arrangements for trainees and / or support externally appointed applicants
d. To support the national Clinical Placement Expansion programme; an additional 27 Student Nurses have been offered placement at Alder Hey with the funding awarded supporting their education

xv. **Enhanced nurse leadership:** Two new Matron roles were established following a workforce review in Medical and Surgical Division; both roles successfully appointed to following external recruitment. External recruitment to the Chief Nurse role commenced in post November 2020

iv. **Professional Nurse Advocate:** Eight nurses predominantly from the Education team were successfully offered places on the NHSE/I Professional Nurse Advocate programme. This will help build a team who can support our nurses both educationally and across a pastoral and supervision capacity

v. **Safer Staffing Huddle:** A Safer Staffing Huddle is embedded and takes place every day before the Bed Meeting. The huddle is Chaired by a senior nurse and there is representation from the Divisions. Staffing is reviewed for the day and the next 24-48 hours and a plan is put in place which is then shared at the Bed Meeting. This has resulted in shared and agreed oversight of the Trust staffing position and increased efficiency within the Bed Meeting.

vi. **Acute Care Team (ACT):** In 2018/19, a business case was devised and approved to establish an ACT team to support staff 24 hours per day in responding to patients showing early signs of deterioration. This is a significant and vital development in ensuring the safety of our patients 24 hours a day. All postholders have now commenced employment in the Trust and the Trust is compliant with RCN core standard 14

4.6: Proposed workforce developments for 2021-2025

i. **Continue and commence implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025 with focus on:**
   a. Compliance with Regulatory guidance and safe staffing
   b. Education, Training and routes of entry
      i. HCA's
      ii. Degree entry student nurses
      iii. RNDA
      iv. Associate Practitioners
      v. Nurse Associates
   c. Education and development pathways
   d. Establishment reviews and moving to a sustainable model of care
   e. Mental health and learning disabilities
   f. Extended scope and advanced practice roles
   g. Equality, Diversity and Inclusion
   h. Clinical Academic Careers

ii. **Reduce use of temporary staffing**

iii. **Implement Children and Young People Safer Nursing Care Tool (SNCT):** This will form the next phase following the introduction of the e-roster system and will replace the SCAMPS acuity and dependency tool. The SNCT is an evidence based measurement tool which facilitates comprehensive establishment reviews as part of triangulated approach

5. WORKFORCE CHALLENGES

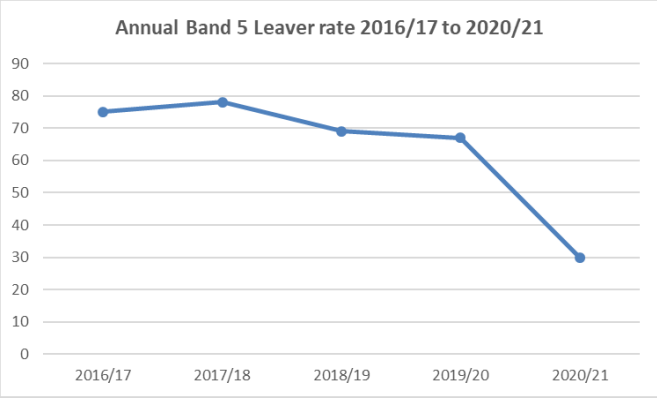
5.1: Leavers

The average leaver rate per month in 2020/21 decreased significantly to 2.5 WTE per month which is the lowest leaver rate in more than 5 years. This equates to a turnover of 4.8% compared to 8.5% in the previous year. The main reasons for leaving have been voluntary resignation and relocation, along with retirement and retire and return, accounting for 78% of leavers. 14 staff left the organisation citing the reason for leaving as promotion suggesting that there was a lack of opportunity for progression within Alder Hey, primarily from Band 5 to Band 6. There has been a large reduction in the number of staff citing work life balance as their reason for leaving down from 9 three years ago

As part of the nursing retention programme, based on national best evidence, Alder Hey offers a transfer window, allowing staff to move between departments as well as applying for promotion to Band 6 in any area of the Trust. This allows staff to easily transfer to learn new skills and explore areas of interest, not just in the acute environment, but also within team such as research education and community services. Over the last 3 years 202 nurses have moved between departments

Table 5: Actual and average Band 5 leavers in WTE per Quarter

	Q1		Q2		Q3		Q4		Total	
Year	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Total**	**Mean for year**
2016/17	**20.6**	(6.8)	**12.3**	(4.1)	**22.5**	(7.5)	**19.2**	(6.6)	**75.4**	(6.2)
2017/18	**20.5**	(6.8)	**14.5**	(4.8)	**24.7**	(8.2)	**18**	(6)	**78.4**	(6.5)
2018/19	**10.9**	(3.6)	**21**	(7)	**15**	(5)	**22.4**	(7.4)	**69.4**	(5.7)
2019/20	**15.7**	(5.2)	**13.9**	(4.6)	**15.6**	(5.2)	**21.9**	(7.3)	**67.2**	(5.6)
2020/21	**5**	(1.6)	**4**	(1.3)	**14.6**	(4.8)	**6.4**	(2.1)	**30**	(2.5)



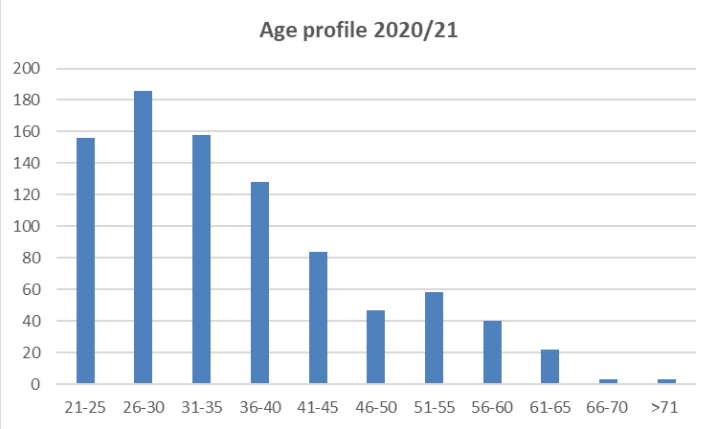
Appendix 4 provides analysis of Band 5 nurses who left in 2020/21 by ward.

5.2: Age profile of nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

Any registered nurse in the pre-1995 NHS pension scheme is eligible for full retirement at the age of 55 and actuarially reduced retirement from the age of 50. The nursing age profile in Table 6 and the graph below identifies 68 WTE (72 WTE in 2019/20) front line nursing staff aged 55 and over who could retire with immediate effect. There are a further 58 WTE (aged 51-55) (77 WTE in 2019/20) achieving retirement age in the next 5 years. Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years.

Table 6: Age profile of front line nursing staff in WTE											
Age range	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**>71**
WTE 2020/21	156	186	158	128	84	47	58	40	22	3	3



Effective succession planning is key, and there has been successful internal promotion to front line Band 6 and Band 7 nursing roles, including Ward Manager roles.

Analysis by ward is provided in Appendix 5

5.3: Maternity leave

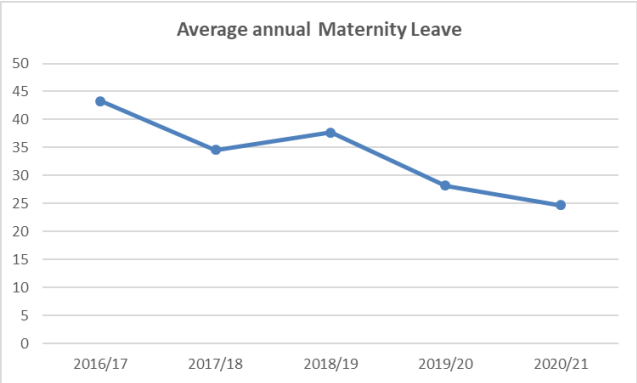
Maternity leave cover is not currently included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the funded "nursing pool" to 40 WTE in order to further improve resilience and optimise bed occupancy.

Table 7 and the graph below demonstrates that there has been a decline in the average maternity leave in the last 2 years however it is recognised that the frontline nursing workforce is predominantly female and the age profile demonstrates that a large number of our staff could be considered of childbearing age therefore this rate can increase as well as decrease. (The 'nursing pool' is also utilised to provide cover for long term sickness outlined in section 5.4.)

60% of maternity costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the

region of £480,000 per annum. Appendix 7 provides analysis of all maternity leave in 2020/21 by ward.

Table 7: Average maternity leave in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average in year**
2016/17	42.6	41.6	44.3	45	43.3
2017/18	36.8	35	31	35.6	34.6
2018/19	36.4	36.6	39.6	38.4	37.7
2019/20	27	26.8	30	29	28.2
2020/21	28.7	23.3	23	24	24.7



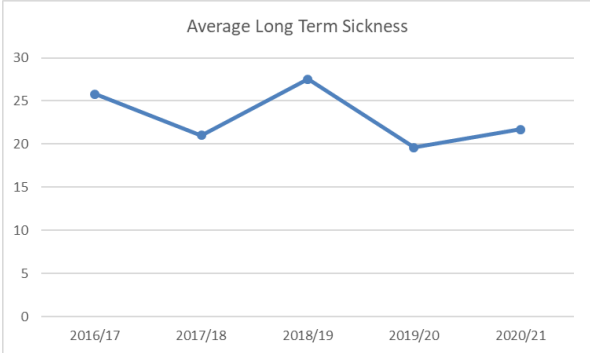
Analysis by ward is provided in Appendix 6

5.4: Sickness

Long term sickness (LTS) has remained high, with a slight increased average of 21.7 WTE compared to the previous year when the average was 19.6. Ward Managers are supported by the HR team to ensure all staff on LTS are appropriately supported and managed.

Table 8a and the graph below demonstrate the trend in long term sickness. This supports the need for the nursing pool with 40 WTE above funded establishment due to staff availability to work

Table 8a: Average LTS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	30.9	21	27	24.6	25.8
2017/18	15.7	14.7	24.4	29.4	21
2018/19	22.5	30.5	25	32	27.5
2019/20	22.2	17.2	18.5	20.5	19.6
2020/21	22.4	21.2	22.2	21	21.7

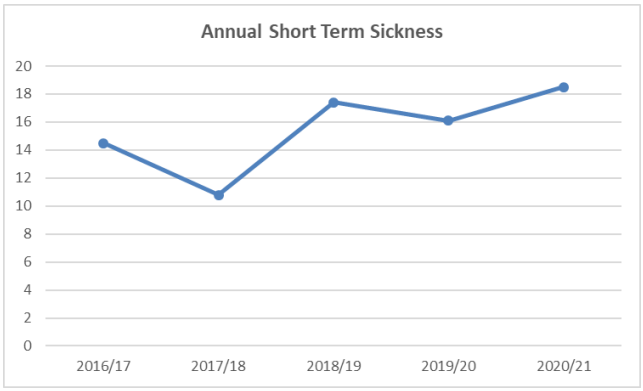


Short term sickness increased slightly from last year. 2020/21 was a unique year with the advent of the Covid-19 pandemic; the staff absence position was closely monitored and reviewed daily relating to staff off sick for both Covid and non-Covid reasons was provided by HR throughout the pandemic and reviewed and monitored by local and divisional teams which assisted managers with management and staff support. In addition, some staff were required to isolate at times and a number of frontline nursing staff were required to shield. Shielding staff were supported to work from home as appropriate supporting new services such as Track and Trace.

Ward Managers continued to work in collaboration with HR to support the physical and mental health and wellbeing of staff; it is well recognised both within the Trust and at regional and national level the impact that the pandemic has had on both the mental and physical wellbeing of staff, with staff reported to be exhausted and burnt out. The Staff Advice and Liaison Service (SALS) has been a vital support service for all staff, and Ward Managers signpost staff to SALS as well as referring to Occupational Health and the Alder Centre, in addition to staff accessing SALS support directly.

Table 8b and the graph below demonstrate the trend in short term sickness.

Table 8b: Average STS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	20.8	12.5	14.2	10.8	14.5
2017/18	6.8	8	13	15.7	10.8
2018/19	14	15	18.9	21.7	17.4
2019/20	13.7	13	17.4	20.5	16.1
2020/21	11	24	22	17	18.5



Staff health and wellbeing, particularly mental health, is a key priority for the senior nursing team and will continue throughout 2020/21 in close partnership working with HR and SALS

Analysis by ward is provided in Appendix 7

5.5: Attrition rates of recruited staff

In 2020/21 the Trust saw a zero attrition rate amongst new recruits taking up employment elsewhere. This has previously been 30-35% compared to a nationally reported figure of 50%. The reason attributed to zero attrition is that the majority of new nurses from national recruitment are student nurses from the local HEI's who evaluated their experiences as ECP students during the pandemic so favourably that they all chose to come and work at Alder Hey as registered nurses. The learning therefore from the ECP students is being taken forward into practice to ensure that future student nurses upon qualification chose to work at Alder hey; the learning is in particular respect to how the ECP students were allocated to care for patients under the supervision of a registered nurse

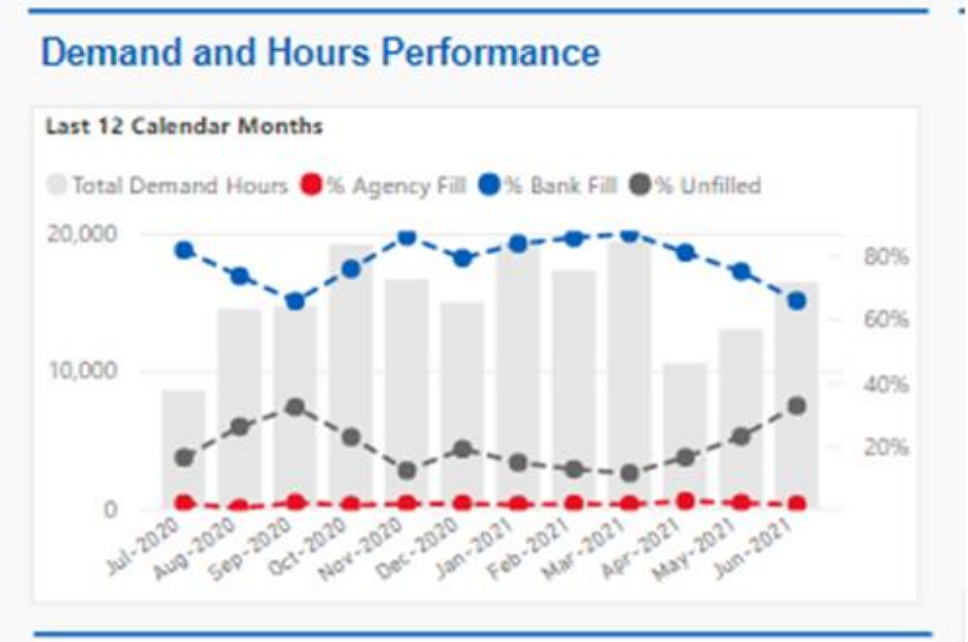
5.6: Increasing patient acuity

'Specialling' refers to patients' acuity requiring 1:1 nurse to patient ratio of care, which is over and above all acute inpatient ward normal rostered shift pattern and funded establishment (excluding PICU and HDU). The vast majority of special shifts are utilised on surgical wards (3A and 4A), and medical wards (3C, 4C and 4B). An example of a typical patient requiring "special" 1:1 care for a period of time would be a child requiring non-invasive ventilation stepping down from HDU to Ward 4B. The Trust has also cared for an increased number of children and young people with complex and challenging behaviours who require a full risk assessment of their care and increased staffing needs

The SCAMP acuity and dependency measurement tool enables the nurse to categorise the patient against pre-determined levels and criteria which determines the level of care required. This is an evidence based tool. Professional judgement is also applied and by ward Managers indicating increasing patient acuity, together with information from the DETECT study indicating where the sickest patients and highest numbers of sick patients outside of critical care. The CYP SNCT will be implemented in 2021/22; the tool is similar to SCAMPS as it is evidence based however the tool is also linked to outcomes which SCAMPS is not therefore this will provide an enhanced measure

5.7: Temporary staffing: NHSP and agency

There has been a continued drive to reduce the use of bank and agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly by the Trust. This remains a priority for 2020/21



However as part of the winter staffing plan, in anticipation of staff sickness and unavailability to work coupled with increased pressures associated with Covid-19 recovery plans and caring for adult patients, the Trust increased NHSP rates for all nursing staff (registered and non registered) to incentivise shifts and increase the temporary staffing availability; this was undertaken following a comprehensive benchmarking exercise across the region to ensure parity and competitive.

5.8: Covid-19 pandemic

The importance and guidance surrounding safe and sustainable staffing levels is enshrined in national professional nursing and regulatory standards. At Alder Hey, the senior nursing team have worked to ensure compliance with national standards (RCN / BAPM / PICS / QNIC / NQB / Hard Truths). However, with the advent of COVID-19, and the predicted rate of 20% of staff across all groups being unable to work, this presented a significant impact on the ability of the Trust and the UK to be able to comply with these standards. Coupled with this, was the intention to significantly increase the number of critical care beds available which further significantly challenge the Trust's ability to meet and maintain national staffing standards.

In response to the national crisis, a temporary model of nursing was devised for the emergency period. The staffing guidelines devised at the time of the crisis (Amber and Red staffing levels) were for that point in time and have since been stood down, reverting to the usual Green staffing levels in line with national guidance. In preparation for the second wave and more sustained staffing challenges over the winter period, the staffing model was reviewed, and revised Amber and Red models were devised in collaboration with senior nursing staff. It is important to note that at no time during the Covid crisis period were either the Amber or Red staffing levels invoked, and staffing remained at Green and in line with national standards at all times. The Director of Nursing worked in collaboration locally with the Ward Managers, Matrons and Associate Chief Nurses; and at regional and national level with the Association of Chief Children's Nurses, the RCN and the C&M Directors of Nursing in order to ensure safe staffing levels were set to cope with the Covid crisis. The risk was recorded on the Risk Register (risk 2138) and has subsequently been closed.

A significant training and redeployment process was established and implemented in recognition of the anticipated spike in patients requiring critical care and up to 20% staff absence for Covid related reasons. Staff from across the Trust came together and worked collaboratively to set up and implement a successful process which saw a large number of staff trained and available to be redeployed to critical care, wards and as health care support workers. During the second wave of the pandemic, based on learning from the first wave, staff redeployment was undertaken on a voluntary basis. The Trust also supported the Nightingale Hospital during the second wave and provided short term mutual staffing aid to local Trusts. This was done on a voluntary basis and the staff shared the learning of their positive experience with the Senior Nurse / AHP Forum.

5.9: Staffing risks and incidents reported

There were a total of 125 staffing related incidents and near misses reported in 2020/21. Where staffing related incidents were a theme within a week, this was reported to and discussed at the weekly Patient Safety Meeting. Staff are actively encouraged to report incidents, concerns and near misses via the Ulysses Incident reporting system and a high level of reporting is a positive indicator of a Trust with an open, transparent and learning culture. The downward trend in 2020/21, despite the challenging year for staff, is associated with predominantly Green staffing levels during the year.

The main reported themes relate to staffing issues due to sickness or absence due to shielding, concerns regarding skill mix, and concerns due to staff moves. All incidents are investigated by the relevant Division and escalated appropriately. Examples of action taken are as follows:

- The Safer Staffing Huddle has been embedded to ensure a clear and agreed daily staffing plan each day; appropriate redeployment of staff from other areas following assessment and review
- Use of temporary staffing including agreement for agency nurses
- Weekly staffing overview meeting overseen by Associate Chief Nurse
- Weekly forward look of TCIs to plan staffing requirement
- Clinical Educator working alongside new nurses and student nurses
- Recruitment strategy
- Retention strategy in collaboration with HR
- Education strategy for nursing staff including induction, preceptorship, clinical supervision, CPD.

There are currently 11 open risks on the Risk Register relating to staffing (not all associated with wards) with risk scores in the main ranging from 6 to 9 and one risk scored at 12 relating to the Diabetic service. All have appropriate control measures, associated actions and are regularly reviewed. 11 risks were closed on the Risk register in 2020/21.

6. RECOMMENDATIONS

A positive foundation has been built to support ongoing workforce management and further development. The senior nursing team will continue to implement planned developments, recruitment strategies, workforce reviews, and educational strategies in line with the Nursing and Health Care Support Worker Workforce Plan 2021-2025. In addition, the team will continue to respond to the national picture, including emerging risks such as Covid-19 pandemic and predicted RSV surge this winter, national and local developments and changes, and identify opportunities to transform and enable effective new ways of working.

PAWC is asked to support the following recommendations for further development:

a) Support the improvements and developments as detailed in section 4.6.

b) Continue to monitor and evaluate staffing levels and review safety and effectiveness

c) Continue to work in partnership with HEI's in the evaluation and further development of new nursing and support roles including through the apprenticeship route.

d) Continue to work with HEI's to promote nursing as a career choice with people from all backgrounds and ethnic groups.

e) Continue recruitment activities to ensure low levels of nursing vacancies.

Appendix 1: Staffing Availability Report 2020/21

Ward Safer Staffing 2018/19	Day registered	Day HCA	Night registered	Night HCA	Overall staffing
April	98%	97%	97%	99%	97%
May	99%	93%	97%	100%	97%
June	97%	88%	96%	97%	95%
July	91%	96%	86%	100%	90%
August	92%	90%	90%	98%	91%
September	95%	91%	93%	98%	94%
October	96%	90%	95%	89%	94%
November	97%	88%	94%	84%	94%
December	96%	86%	94%	91%	91%
January	92%	87%	90%	83%	90%
February	95%	98%	93%	99%	94%
March	96%	87%	94%	89%	94%

Appendix 2: RCN review of compliance by ward 2020/21

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sec 5	Sec 6	Sec 7	Sec 8
1C Card														↑						
1C Neo														↑						
3A														↑						
3B														↑						
3C														↑						
4A														↑						
4B														↑						
4C														↑						
PICU														↑						
HDU														↑						
Burns														↑						
EDU														↑						
MDC																				
SDC/ SAL																				
Renal																				
Trust overall RAG rating	=	=	=	=	=	=	=	=	=	=	=	↑	↑	↑	=	=	↑	=	=	=

Key

Green:	Compliant	↑:	Improved position compared to 2017/18
Amber:	Partial compliance	↓:	Deteriorating position compared to 2017/18
Red:	Non compliant	=:	Static position compared to 2017/18
Blue:	Trust agreed workforce requirement		
Grey:	Not applicable		

Appendix 3: New Band 5 staff commenced in post in 2020/21

Starters WTE 2020/21	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac						2	4.6			2	2	1	**11.6**
1C Neo	1					2	3						**5**
3A	3					1.92	5			1	1	1	**9.92**
3B						3							**3**
3C							5.8			1	1		**7.8**
4A	5					2	5	1			2		**10**
4B	1					1	7.6			1	0.92		**10.52**
4C	3					1	4				2		**6**
BU							1				1	0.92	**2.92**
PICU	1.92						11.26	1		4			**16.26**
HDU	4						4	1		2			**11**
SDC	1											1	**2**
MDC													**0**
DJU											1		**0**
OPD	0.6												**0**
ED						6.8	1					0.6	**8.4**
Total	**20.52**	**0**	**0**	**0**	**0**	**19.72**	**52.26**	**3**	**0**	**11**	**10.92**	**4.52**	**121.94**
Q total	**Q1: 20.52**			**Q2: 19.72**			**Q3: 55.26**			**Q4: 26.44**			

Appendix 4: Band 5 leavers in 2020/21

Leavers WTE 2020/21	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac		1						0.61	0.92				**2.53**
1C Neo						1.61			2				**3.61**
3A									0.31				**0.31**
3B				0.75			2.33		0.8				**3.88**
3C													**0**
4A			0.92										**0.92**
4B								1.46					**1.46**
4C			0.31			1			0.92	0.92			**3.15**
BU			0.43										**0.43**
PICU		0.92	1		0.31	0.31	0.61	1	0.4	1.84	1	1.31	**8.7**
HDU			0.46										**0.46**
SDC							0.51			0.76			**1.27**
MDC										0.61			**0**
DJU									1				**1**
OPD									1.72				**1.72**
ED													**0**
Total	**0**	**1.92**	**3.12**	**0.75**	**0.31**	**2.92**	**3.45**	**3.07**	**8.07**	**4.13**	**1**	**1.31**	**30.05**
Q total	**Q1: 5.04**			**Q2: 3.98**			**Q3: 14.59**			**Q4: 6.44**			av WTE

Appendix 5: Band 5 maternity leave in 2020/21

ML 2020/21	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	2.92	2	2	1	0	1	0	0	0	0	0	1	0.8
1C Neo	1	1	1	1	1	0	1	0	0	1	1	1	0.7
3A	1	1.77	1.77	1.77	0.77	0.77	1.92	1.92	2.61	2.61	2.61	2.61	1.8
3B	0.6	0.6	0.6	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.21	1.1
3C	2.84	2.84	2.84	2.84	2.84	1.92	1.92	1.8	1.8	1.8	0.8	0.8	2.1
4A	4.52	4.52	3.92	2.92	2.92	2	2	3	3	3.92	2.92	2.92	3.2
4B	0.92	0.92	0.92	0.92	0.92	1.61	1.61	1.61	1.61	1.61	3.61	3	1.6
4C	0.92	1.23	1.23	1.23	1.23	1.23	1.23	1.23	0.31	1.07	2.07	2.07	1.3
BU	0.61	0.61	0.61	0.61	0.61	0.61	0	0.61	0	0	0	0	0.4
PICU	5.92	5.92	5.92	5.92	4.92	3.92	3.92	4	4	2	2	1	4.1
HDU	6.83	4.83	4.91	4.91	3.91	5.83	5.21	6.21	4.92	4.92	4.92	4.92	5.2
SDC	1.76	0.76	0.76	0.76	0.76	0.76	0	0	0.76	0.76	0.76	0.76	0.7
MDC													
DJU	0	0	0	0	0	0	0	0	0	0	0	1	0.1
OPD													
ED / EDU	1	1	1	1	1	1	2	2.99	1.99	1.99	1.99	2.99	1.7
Total	**30.84**	**28**	**27.48**	**26.09**	**22.09**	**21.86**	**22.02**	**24.58**	**22.21**	**22.89**	**23.89**	**25.28**	
Q average	**Q1: 28.7**			**Q2: 23.3**			**Q3: 22.9**			**Q4: 24**			**20/21: 24.7**

Appendix 6: Band 5 long term sickness in 2020/21

LTS 20/21	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	0.38	0.38	0.38	0.45	0.39	1.33	2.61	0.88	2.57	3.86	3.03	1.79	1.5
1C Neo	0.48	1.38	0.38	0.07	0	0	1	0.03	0	0	0	0	0.3
3A	3.03	2.87	0.85	0.85	1	3.66	2	1.8	0.85	1.94	1.87	1.25	1.8
3B	0	1	1	1.29	1.38	0.21	0	0.38	0.42	0.75	0.05	0.94	0.6
3C	2.38	2.38	2.18	2	1.45	1	1	1	1.49	1.33	1.22	1.82	1.6
4A	2.55	3.82	2.48	1.79	1.69	1.69	3.54	5.17	4.2	2.01	1.45	3.46	2.8
4B	0	1.06	0.58	0.44	1.37	0.36	1.06	0.85	0.85	0.85	0.63	0.38	0.7
4C	1.98	0.85	1.63	1.39	2.02	1.72	1.7	0.88	1.53	2.36	1.99	1.33	1.6
BU	0	0	0	0	0	0	0	1.04		0	0	0	0.01
PICU	1.96	3.84	2.97	3.84	3.46	3.18	2.85	3.49	2.27	2.78	3.26	1.85	3
HDU	3	3.21	2.24	2.22	2.95	4.14	3.79	3.72	4.35	4.53	4.87	2.75	3.5
SDC	0.58	1.86	1.66	1.84	1	0.37	0	0.52	0.58	0.58	0.1	0.58	0.8
MDC													0
DJU													0
OPD	1.09	0.55	0	0	0	1.48	1.45	0	0	0	0	0	0.4
ED / EDU	3.82	2.58	3.79	4.5	3.13	4.02	2.29	1.63	2.73	2.43	2.16	2.5	3
Total	**21.25**	**25.78**	**20.14**	**20.68**	**19.84**	**23.16**	**23.29**	**21.39**	**21.84**	**23.42**	**20.63**	**18.65**	
Q average	**Q1: 22.4**			**Q2: 21.2**			**Q3: 22.2**			**Q4: 21**			**20/21: 21.7**

Appendix 7: Age profile of ward / departmental registered nursing staff (Band 5-7)

Age profile 20/21	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>71 years
1C cardiac	19	19	9	10	4	1	3	2	2		
1C Neo	6	4	4	2	2		4	1	2		1
3A	11	7	14	8	8	3	7		1		
3B	4	9	15	8	6	4	2	2	2		
3C	8	12	2	19	2	4	7	3	2		
4A	21	18	12	12	3	4	7	3	1		
4B	15	9	10	5	3	2	5	1	1		
4C	14	15	10	10	4	1	1	1			
BU	2	2	4	6	3			1			
PICU	21	36	36	17	18	13	11	14	6	1	
HDU	20	29	21	7	11	4	2		1	1	
SDC		3	5	3	2	3	2	2			
MDC	1		2	2	1		2				
DJU	3	3		3	3			1	1		1
OPD		2	3	1	3	1	3	4	1		
ED / EDU	11	18	11	15	11	7	2	5	2	1	1
Total	**156**	**186**	**158**	**128**	**84**	**47**	**58**	**40**	**22**	**3**	**3**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th July 2021

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

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

Digital and Information Technology Update

1. Introduction

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

2. Executive Summary

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

- Excellent visit from NHSX Executive colleagues
- Good progress with internal digital transformation programme delivery
- Go live of iDigital on the 1st of June with great engagement from staff and a service development programme underway
- Maintaining a high level of performance against key performance metrics including 95% of all tickets resolved within the target
- Key Programmes including HIMSS 7 accreditation remain on track for their respective delivery dates
- Progress to commence strategically looking at the next phase of Digital Futures from 22/23

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

3. National Digital Update

3.1 ICS Framework – Data and Digital

The Integrated Care System (ICS) Framework published in June 2021 includes a dedicated section on data and digital. The standards and requirements for digital and data are centered around the What Good Looks Like framework. There is a national expectation that digital and data experts will have a pivotal role in Integrated Care Systems, supporting transformation and ensuring health and care partners provide a modern operating environment to support workforce, citizens and populations.

There are a range of actions for ICS NHS bodies including a renewed digital and data plan, clear accountability with a named ICS SRO, a shared care record, a focus on citizen channels including digital inequalities, system intelligence function and embedding of population health management capabilities.

Within C&M, work is underway with a reset of the system digital strategy and the appointment of a substantive Digital Director within the ICS Leadership team.

2.2 NHSX

NHSX is the organisation nationally with integrated teams from the Department of Health and Social Care and NHS England / Improvement. The remit of NHSX is to drive the digital transformation of care. NHSX work closely with national policy setters to ensure that the digital agenda is represented clearly in health and care policy and priorities.

The NHSX strategy focusses on a strategic narrative based around three themes: Digitise, Connect, Transform. These themes should guide Integrated Care Systems in their local digital plans.

To support this, NHSX have a range of publications in train including:

- Digital Transformation (to be published imminently)

- ‘What Good Looks Like’ (to be published imminently)
- ‘Who Pays for What’ (to be published imminently)
- NHS Data Strategy (published July 2021)

The interlinked publications aim to provide a clear vision for good digital practice across health and care. They include the ‘levelling up’ of organisations and the empowerment of frontline leaders to support digital and data transformation.

NHSX aims to create a vibrant community for sharing good practice that enables acceleration of transformation.

The What Good Looks Like framework will provide a set of standards for provider organisations to assess themselves against seven domains:

1. Well Led – confident leadership which inspires a culture of transformation and data literacy with a clear digital strategy
2. Ensure Smart Foundations - safe modern, reliable and resilient infrastructure and data capabilities. Continuous improvement of core IT and digital services
3. Safe Practice - systems and technology maintain high quality safety and service standards
4. Supported People - digitally literate and empowered workforce
5. Empower Citizens - citizens at centre of design
6. Healthy Populations - effective strategy to encourage innovative thinking, models of care informed by data insights and digital capabilities
7. Improve Care - make best use of technology and data to improve care across pathways and Integrated Care Systems

The Who Pays for What framework is intended to signal a shift of the role of NHSX to one of supporting investment. The unified tech fund within this framework is a single fund of eight legacy national funds totalling £700M. It is understood that the framework will set out an ambition to enable better financial planning of digital investments linked to local strategy with allocation of funding investment in line with What Good Looks Like. It is understood that implementation will be staged.

The NHS Data Strategy sets out an aim to build on the flexibilities in place during Covid, particularly in relation to Population Health Management and information sharing. Additionally it references a shift to using data for research purposes in a more accessible way than historically.

Locally, a visit from members of the NHSX Executive Team including the national Chief Information Officer was hosted at Alder Hey in June 2021. The visit included a number of visits and a showcase of the digital partnership work with Liverpool Heart and Chest. The visit was hugely successful including Alder Hey being the first Trust nationally to formally receive the Global Digital Exemplar accreditation award.

3. Digital Futures Progress

Internally, progress with Digital Futures implementation is good. Key delivery programmes continue to progress and benefits realised and tracked.

Alder Hey is now into the third year of the three year Digital Futures strategy. Delivery has been hugely successful across a range of areas. Some areas have accelerated significantly with the adoption of digital during the pandemic and others have had more challenges with a shift in dates.

Engagement work is due to commence on the shape of the next phase of digital for Alder Hey from 22/23 onwards.

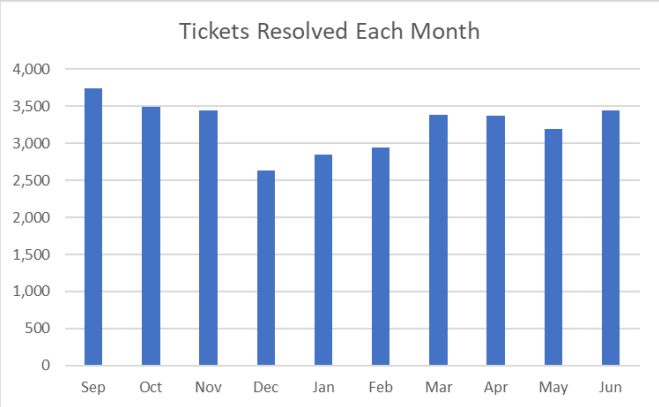
In terms of current progress to date, headlines include:

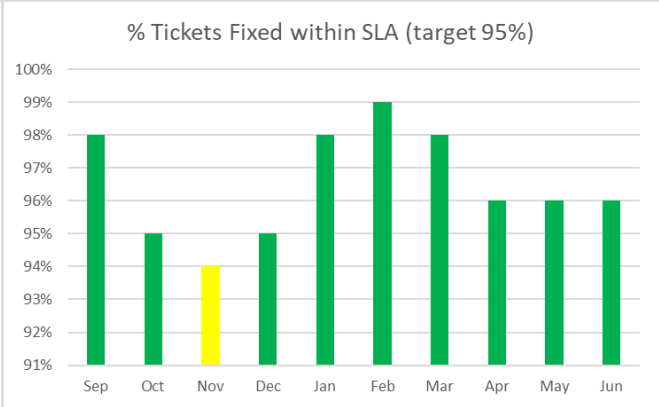
- Projects within the Digital Safety Programme remain on track, to achieve HIMSS Stage 7 accreditation during 2021
- Alderc@re programme continues to progress. A significant amount of the system has been built, challenges in relation to prescribing and pharmacy continue to make progress including support from other Meditech sites, NHS Digital and external assurance. Discussions are progressing to assess whether implementation should include a further release of the software to enable further benefits for staff
- Islacare has been implemented in a number of services in Acute and Community to securely receive, review and store images and videos directly from patients. This enables the capture of photos and videos as part of clinical consultations and remote patient monitoring. During June, 128 patients were added to the pilot, with 186 submissions captured
- New neonatal 'soft wristbands' have been launched which include bar coding technology for bedside verification of neonates

4. Operational IT Performance and Technology Roadmap

Key highlights include:

- Consistently achieving the resolution Service Level Agreement (SLA) target of 95% following the introduction of improved processes and monitoring
- Maintenance of average ticket volume and SLA even with some large project deliveries to all staff including OneDrive and Office Application upgrades





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

- Extension of the Alder Hey and Clatterbridge Electronic Patient Record (EPR) data centre to support Liverpool Womens Hospital
- Completion of the migration of all staff home drive data to One Drive and completion due in July for the upgrade of all PCs/Devices to the latest versions of Microsoft Office applications
- Implementation of mobile phone coverage boost technology into the Emergency Department to improve signal coverage for both patients, families and staff, positive feedback received
- Collaboration work commenced with Liverpool Heart and Chest regarding shared infrastructure

5. Digital Partnership

Following engagement with staff, a new name and branding, 'iDigital' have been developed for the LHCH and Alder Hey Integrated Digital Service.

Since the go live of the service and coming together of staff, progress has been excellent. Staff have embraced working together and a staff forum has been established. Following an away day with senior leaders, a number of ideas were developed and a service development programme established.

The partnership governance group held its inaugural meeting in July 2021.

Key developments concerning the partnership to date include extensive collaboration on infrastructure, data centres, digital transformation and resources to ensure good value for money, sharing of scarce skills and resilience of services.

7. Summary and Recommendations

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

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

The Board of Directors is asked to:

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

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report June 2021

How Did We Do?

Executive Summary **Month: June** **Year: 2021**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Continued high rates of incident reporting across the organisation. 1 clinical incident resulting in death was reported in month; reported to STEIS and will be subject to a serious case review. The relevant external organisations have been notified and we await the outcome of the review.
- There has been a reduction in medication errors resulting in harm, and zero pressure ulcers reported in month: over 200 days without any Category 3 pressure ulcers and over 1100 days without any category 4 pressure ulcer.
- ED sepsis score was slightly below target but the in patients score was above 90%.
- There has been continued improvement across the range of IPC metrics.

Highlight

- Excellent compliance with IPC and pressure score metrics.
- In patient sepsis score achieved 100%.

Challenges

- ED sepsis score below target; update on plan regarding management of sepsis presented at SQAC.

The Best People Doing their Best Work

Caring

- Powerful patient story presented at the Patient Experience Group; learning will be used to improve breastfeeding support
- There has been a decline in the patient satisfaction scores for FFT in both the inpatient environment and the ED, which can be attributable to the increasing pressures. Response rates where available are low compared to the national average and increasing the number of completed responses is a key focus for the patient experience team.
- 100% of complaints have been responded to consistently for the last 2 months within 25 working days which is a significant improvement, and there continues to be a positive improvement in PALS responsiveness.
- Recruitment to a new post as part of the 'Volunteer to Career' scheme to support play service.

Highlight

- Improved position of 100% compliance with 25 day complaint metric for 2 months.

Challenges

- Continued challenges in response rate and satisfaction score for FFT.
- Play continues to require improvement on the patient surveys; improvement plan in place. Plan to undertake a specific Quality Round to gain deeper understanding of the views of children and young people.

Delivery of Outstanding Care

Effective

The extreme pressures on urgent and emergency care have continued. 86% of patients were treated within 4 hours in June. Pressures on staff are high and staff availability is decreasing as Covid-19 prevalence increases. These factors, plus the advent of RSV admissions, has increased the risk to timely care and we are working hard to test new intra-hospital ways of working, and increasing levels of support to staff in the Department. We have also secured agreement for additional external support from partners in the community.

Highlight

- Zero 28 day breaches
- Low number of cancelled operations

Challenges

- Emergency Department attendance levels

Delivery of Outstanding Care

Responsive

There has been a reduction in the number of children waiting over 52 weeks for treatment from 235 in May to 204 in June. The number of children on an open pathway receiving treatment within 18 weeks has increased to 74.7%.

The improvements in access to planned care have been driven by high levels of service recovery, relative to 2019, in outpatients (102%) and elective care (113 %).

There was one patient on the 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) pathway and they did not receive treatment within this timescale due to a delayed appointment from the referring centre.

Highlight

- Improvement in access to planned care with a higher % of patients treated within 18 weeks and fewer patients waiting greater than 52 weeks for treatment

Challenges

- Two complex cancer patient pathways (not a systemic issue with access to cancer care)

The Best People Doing their Best Work

Well Led

Finance

For the Month of June (Month 3), the Trust is reporting a year to date deficit of £0.6m which is largely in line with plan for quarter 1.

This deficit is largely due to reduced car parking and catering income plus historical cost pressures within pay for the surgical division.

The trust is still awaiting the finalisation of the funding arrangements for additional activity associated with ERF and confirmation of arrangements for the H2 finance regime.

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

The overall capital expenditure in month for June was £1.8m (£4.0m year to date) against a plan of £1.8m in month (£4.1m year to date). This demonstrates spend is in line with plan and relates to Community Cluster & Dewi Jones development.

The external audit for 2020/21 is now successfully complete and accounts have been submitted in line with the associated deadline.

Sickness update

Sickness increased by 0.22% from 5.24% to 5.46%. Within this, short term absence increased from 1.35% to 1.62%, however the Trust saw a slight decline in long term absence from 3.88% to 3.85%. The HR team continue to support managers across the Trust to facilitate a return to work for employees when possible, and ensure appropriate support mechanisms are in place whilst colleagues are absent from the workplace. The team have also refreshed the attendance management training support available and this will be rolled out over the next few months.

Highlight

- Long term sickness rates falling
- Mandatory Training

Challenges

- Number of patients waiting over 52 weeks for treatment.
- Continue to work with NHSI re clarification of funding arrangements for 2021/22 in particular implications of ERF funding.

Mandatory Training

Overall Mandatory Training has remained at 88% for this month, but is still steadily returning back to the target of 90% based on recent trajectory. As per previous updates our key areas of focus are practical topics with frequent refreshers that require face to face training to take place and our Estates and Ancillary staff as a wider staff group.

PDR

We're starting to see people completing their staff appraisals and recording them into ESR with nearly 20% of appraisals having been completed up until this point.
We've ran further PDR Workshops for reviewers to ensure that managers are best equipped to have meaningful appraisal conversations and are prepared for the new addition of the wellbeing conversation.
Regular reporting and updates will start to be seen at Organisational level as we move through the window to ensure that the appraisal process and deadlines are promoted throughout the Trust.

Mandatory Training:

Overall Mandatory Training has remained at 88% again this month, 2% below the target of 90%. As per the previous updates our key areas of low compliance are still within our annual topics that require face to face training including: Basic Life Support, PLS/APLS Annual Update and Moving and Handling Level 2.
Our Estates and Ancillary Staff group continue to be our area of concern around mandatory training compliance but have increased again this month and are now up to 69% overall.

Appraisals With 1 month left of the appraisal window, we're starting to see an increase in people completing their staff appraisals and recording them into ESR with 20% of all staff now having had their PDR. We've now run 7 workshops and have 1 more due to run next week to ensure that all of our managers are best equipped to have supportive wellbeing conversations as well as meaningful appraisal discussions. Regular divisional reports are being sent out to leaders for encouraging their staff to complete their appraisals before the close of the window on the 31st of July 2021.	

Game Changing Research and Innovation

Research and Development

Month 3 Research Activity: • 146 research studies currently open • 896 patients recruited to research studies (2990 in 21/22) Divisional Participation: • Division of Medicine – 122 open studies • Division of Surgical Care – 22 open studies • Division of Community & Mental Health – 2 open studies Research Assurance: • GCP training compliance – 97% • Research SOP compliance – 98%	**Highlight** • Recovery plan remains on track **Challenges** • Financial uncertainty • Clinical support bandwidth

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
1	0	0	2	0	91.67 %
Jun 2021	Jun 2021	Jun 2021	Jun 2021	Jun 2021	Jun 2021

Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
87.88 %
Jun 2021

CARING

Friends & Family: Overall Percentage Recommended Trust
90.96 %
Jun 2021

EFFECTIVE

ED: 95% Treated within 4 Hours
85.48 %
Jun 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
0 %	100 %	95.65 %	98.46 %
Jun 2021	Jun 2021	Jun 2021	Jun 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 %	74.74 %	204	11420
Jun 2021	Jun 2021	Jun 2021	Jun 2021

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
82001	391.21	88.13 %	97.64 %	5.48 %
Jun 2021	Jun 2021	Jun 2021	Jun 2021	Jun 2021

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	100.0%	98.9%	99.1%	100.0%	100.0%	100.0%	99.8%	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	59	85	52	50	75	100	74	53	64	97	80	83	83		No Threshold	
Clinical Incidents resulting in No Harm	D	286	382	323	341	328	410	314	288	332	401	393	360	330		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	D	88	91	83	70	67	83	75	81	76	96	92	81	70		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	D	0	6	1	0	0	0	1	1	1	1	1	4	1		No Threshold	
Clinical Incidents resulting in severe, permanent harm	D	0	0	2	0	0	0	0	1	0	0	0	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	1		0 N/A >0	✔
Medication errors resulting in harm	D	7	6	2	8	1	11	0	6	3	4	4	2	2		<=4 N/A >4	✔
Pressure Ulcers (Category 3)	W	0	2	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events	W	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	D P	96.2%	79.2%	77.3%	85.2%	74.1%	79.2%	73.7%	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	90.9%	88.5%	85.2%	86.1%	94.3%	80.8%	70.8%	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%		>=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	1	1	0	0	0	0	0	0	1	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	1	4	1	0	1	0	3	1	0	0	1	0		No Threshold	

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	94.9%	94.6%	93.8%	90.6%	94.7%	93.7%	91.5%	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	92.3%	90.7%	91.5%	84.4%	92.1%	89.2%	91.5%	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	95.2%	95.2%	92.3%	89.1%	94.7%	98.8%	100.0%	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	93.3%	97.0%	95.1%	92.4%	94.5%	95.5%	93.4%	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	100.0%	100.0%	82.4%	92.3%	89.7%	91.3%	100.0%	96.3%	90.3%	87.9%	90.6%	85.7%	95.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	96.6%	96.0%	95.7%	94.1%	95.5%	93.9%	90.4%	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%		>=95 % >=90 % <90 %	✔
Complaints	W	10	5	20	11	19	15	10	15	11	23	7	9	15		No Threshold	
PALS	W	86	105	105	77	100	74	65	68	88	110	100	119	148		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	W	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%		No Threshold	
ED: 95% Treated within 4 Hours	D	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%		>=95 % N/A <95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	3	7	18	17	19	16	10	5	7	12	13	7	13		<=20 N/A >20	✔
28 Day Breaches	W	2	0	0	8	2	1	3	3	1	2	4	3	0		0 N/A >0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	94.1%	99.3%	95.9%	95.4%	95.4%	95.7%	97.5%	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	94.1%	98.5%	97.9%	96.0%	98.3%	98.6%	97.5%	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	95.8%	98.5%	93.2%	97.1%	96.7%	97.8%	95.0%	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	90.8%	91.1%	99.3%	98.3%	100.0%	99.3%	91.7%	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	64.7%	72.6%	81.5%	82.3%	83.3%	84.9%	76.7%	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	84.0%	83.0%	78.1%	75.4%	88.3%	71.9%	81.6%	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	45.9%	39.6%	43.1%	48.2%	54.2%	59.0%	60.8%	61.3%	63.4%	68.3%	68.6%	71.9%	74.7%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	11,248	11,022	11,402	11,000	10,939	10,832	10,520	10,722	11,535	11,979	11,111	11,565	11,420		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	W	82	149	127	145	145	148	184	222	307	361	283	235	204		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	81.9%	82.9%	78.9%	91.8%	96.4%	97.1%	92.3%	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%		>=99 % N/A <99 %	
PFI: PPM%		100.0%	100.0%	99.0%	99.0%	100.0%	98.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG			Comments Available
Control Total In Month Variance (£'000s)	W	0	-1	-1	-1	-359	331	686	242	590	3,824	-955	592	391		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	3,503	936	-483	4,518	187	-1,733	1,610	-1,979	-3,207	-5,794	-910	974	13		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	107,221	107,221	107,763	108,756	109,084	110,503	110,776	110,776	110,871	92,708	92,708	88,440	82,001		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	1,341	1,825	1,076	2,492	-793	748	234	227	2,309	18,172	-494	715	1,597		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-312	-340	-291	-1,160	20	492	-192	-373	-387	-13,171	-308	-370	-545		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,029	-1,485	-786	-1,333	414	-909	644	387	-1,333	-1,176	-153	247	-661		>=-5%	>=-20%	<-20%	✔
AvP: IP - Non-Elective	W	770	838	817	971	961	950	929	747	731	1,066	-98	-102	1,289		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W	263	379	357	366	400	411	390	340	353	455	-89	-63	448		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W	1,340	1,547	1,452	1,511	1,660	1,772	1,713	1,508	1,598	2,075	183	-8	2,101		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W	18,214	20,419	17,765	22,055	22,785	23,876	20,853	22,271	22,281	26,566	1,302	3,552	25,561		>=0	N/A	<0	✔
PDR	W	5.4%	13.4%	20.7%	29.5%	62.6%	72.4%	74.6%	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%		No Threshold			✔
Medical Appraisal	W	95.6%	95.6%	95.6%	95.6%	95.6%	95.6%	95.9%	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%		No Threshold			✔
Mandatory Training	W	91.0%	90.5%	90.6%	89.3%	88.6%	85.8%	85.0%	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.0%	5.1%	5.0%	5.2%	6.0%	5.4%	5.6%	7.2%	5.7%	4.7%	4.6%	5.2%	5.5%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	0.9%	1.0%	1.1%	1.4%	1.9%	1.3%	1.1%	2.3%	1.2%	1.2%	1.1%	1.3%	1.5%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	4.0%	4.1%	3.9%	3.9%	4.1%	4.2%	4.5%	4.9%	4.5%	3.6%	3.5%	3.9%	4.0%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	564	934	946	1,015	1,062	1,365	1,404	1,378	1,279	2,272	1,073	1,044	968		No Threshold			✔
Staff Turnover	D	10.0%	9.6%	10.1%	9.8%	9.5%	9.3%	9.2%	9.2%	9.1%	9.1%	9.9%	10.8%	10.5%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	95.6%	90.3%	91.3%	94.2%	94.2%	94.9%	93.6%	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	100.0%	85.6%	97.0%	93.8%	90.0%	87.5%	90.4%	94.4%	97.7%	97.7%	97.7%				>=85 %	N/A	<85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	43	47	50	61	66	71	76	80	80	90	100	103	108		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	20	25	27	28	34	37	36	36	36	36	34	36	38		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	3	1	3	4	1	4	4	1	0	6	7	2	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	1	2	0	2	1	0	0	0	2	0	3	1		>=1	N/A	<1	✔
Number of patients recruited	W	560	134	508	413	665	832	182	504	403	105	1,055	1,039	896		>=100	>=86	<86	✔

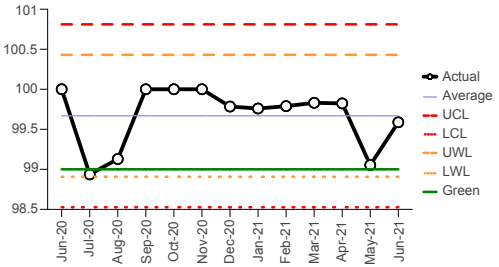
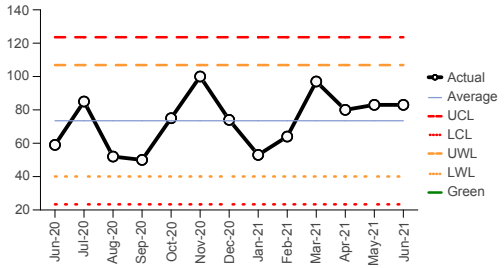
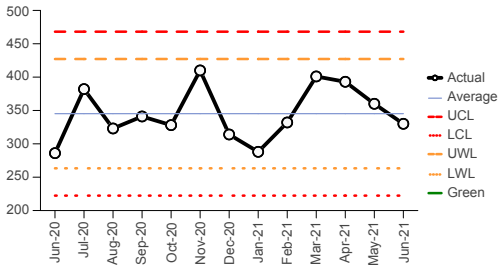
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

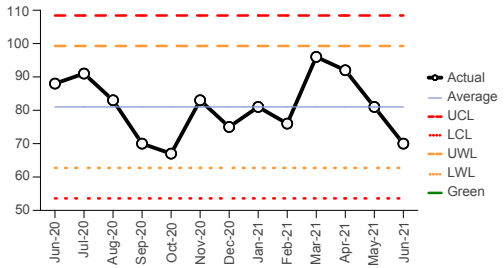
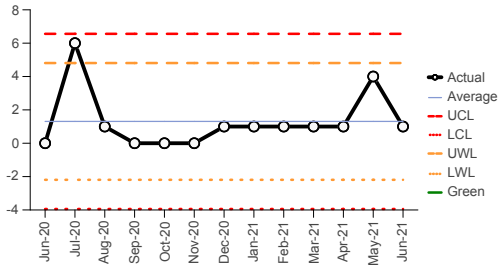
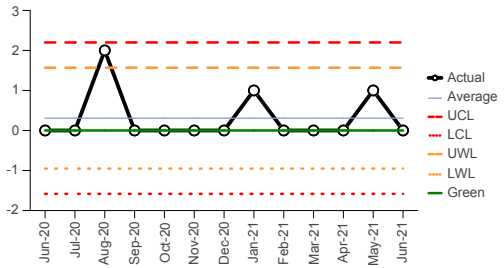
	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nicki Murdock **Committee:** SQAC	99.59 %	R <99 % A N/A G >=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	83	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	330	No Threshold		

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

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

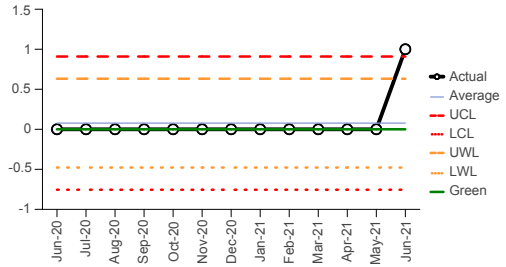
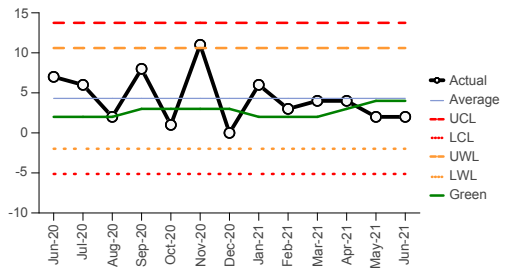
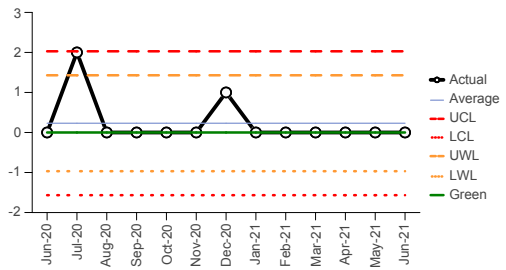
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

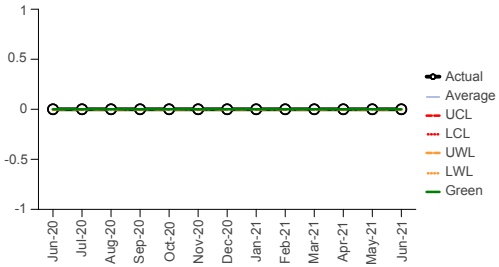
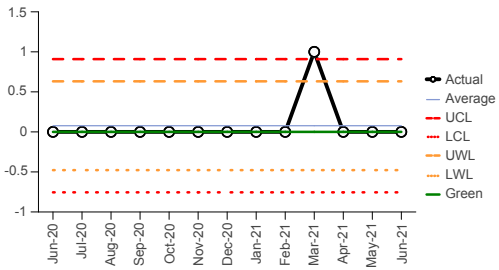
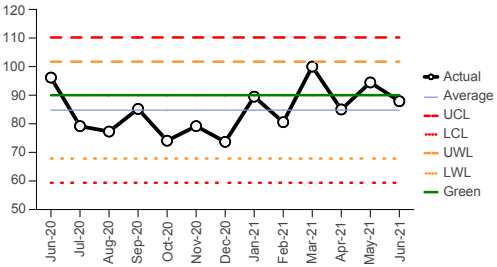
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	1	R >0 A N/A G 0		Patient brought to ED following ingestion of overdose of tablets. Transferred to PICU. Patient died 3 days later. Incident StEIS reported. Duty of candour completed in line with regulation 20. 72 hour review completed. RCA comenced following identification of lead investigator. Support for patients family identified and ongoing.
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	2	R >4 A N/A G <=4		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

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	87.88 %	R <90 % A N/A G >=90 %		4 patients did not receive antibiotics within 60 minutes. 2 received antibiotics by 65 minutes and were delayed due to difficult intravenous access; 1 also had difficult intravenous access and received antibiotics intramuscularly; the final patient required stabilisation of seizures in resus initially. All were treated within 90 minutes.

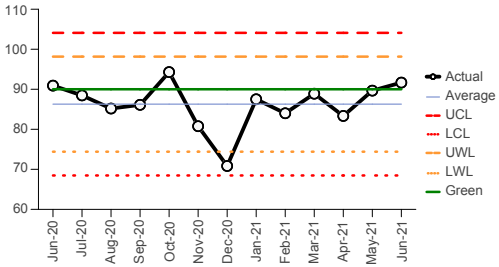
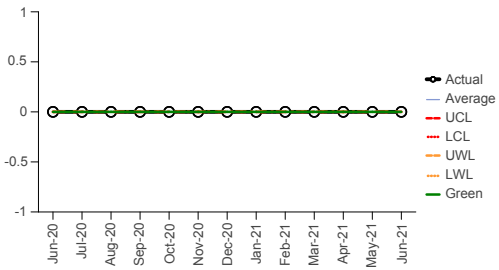
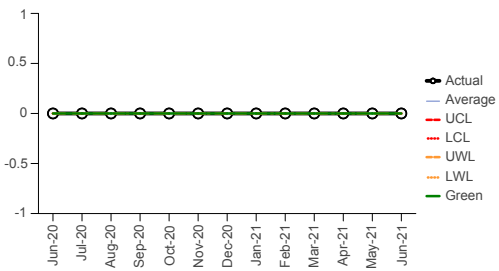
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

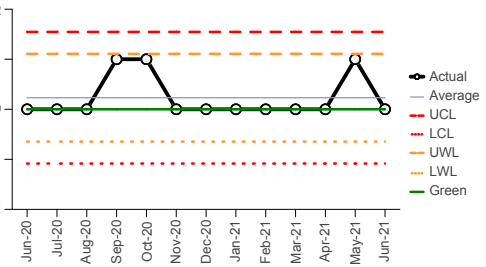
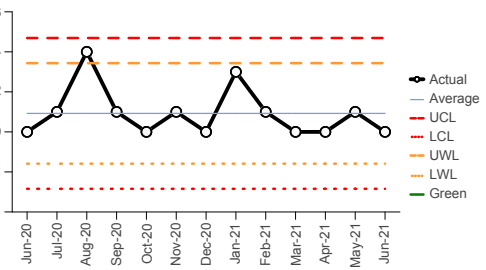
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%. **Exec Lead:** Nicki Murdock **Committee:** SQAC	91.67 %	R <90 % A N/A G >=90 %		No Action Required
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 21/22 is zero. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nicki Murdock **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

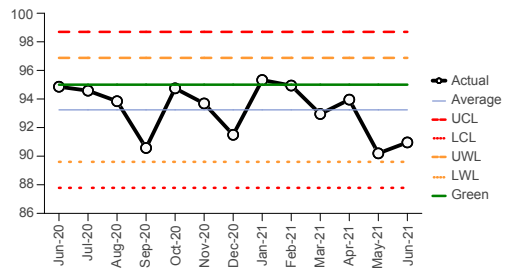
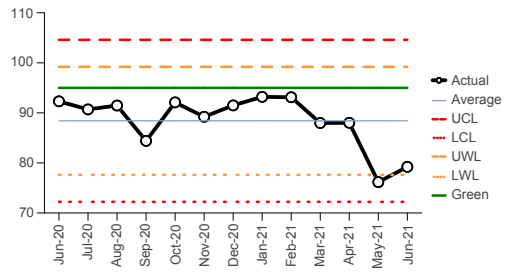
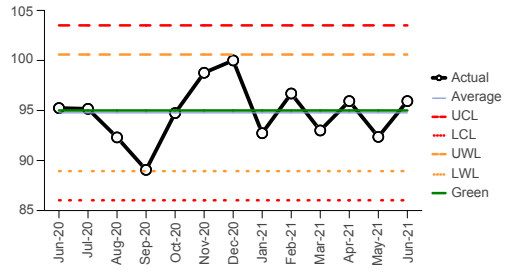
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W 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	90.96 %	R <90 % A >=90 % G >=95 %		Overall percentage of those who recommend the Trust has increased from 90.20% to 90.88% from May 2021 to June 2021. There were 1,844 responses for June 2021 which is the highest number of responses since pre-COVID. 5.91% (109) of the total responses were either poor or very poor. Medicine had a total of 922 responses with 64 negatives (6.96%), Surgery had a total of 638 responses with 27 negatives (4.23%), and Community had a total of 249 responses with 13 negatives (5.2%).
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	79.21 %	R <90 % A >=90 % G >=95 %		Overall percentage has increased by 3.05% from May 2021. There were 380 responses for June 2021, with 49 (12.89%) either poor or very poor. This is the second consecutive that A&E has been below 80%. Waiting times remains an issue with 59.2% of respondents waiting over 2 hours. There were high number of attendances in June which impacted on patient experience due to long waits. When respondents were asked how we could have improved, 89 out of 273 comments (32.6%) mentioned waiting times as an issue; 18 (7%) mentioned the attitude of triage staff.
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	95.94 %	R <90 % A >=90 % G >=95 %		No Action Required

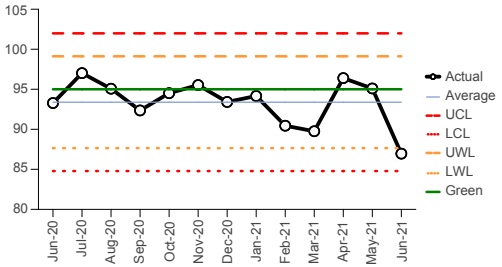
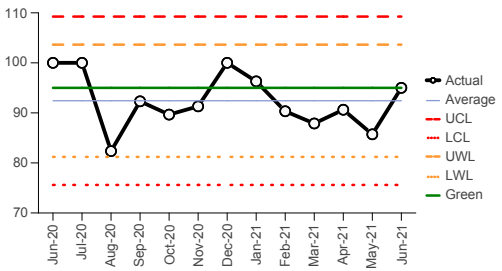
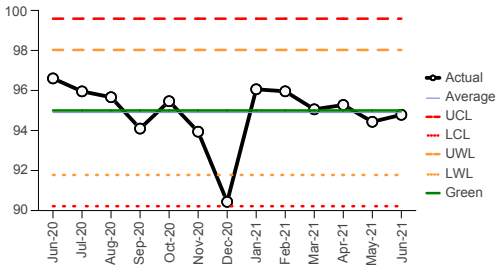
The Best People doing their best Work

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	86.96 %	R <90 % A >=90 % G >=95 %		Overall percentage has decreased by 8.14% since May 2021. There were 140 responses for June 2021, 64 less than the May 2021 but in line with figures seen in 2020/21. 10 (7.1%) respondents said their experience was neither good nor poor which has significantly impacted on the overall FFT score in this area. Through comment analysis, there was a clear theme surrounding the sleeping arrangements for parents with comments highlighting comfort as an issue. There were also comments surrounding communication between staff during their handover, and also comments surrounding the attitude of staff.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	95 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nicki Murdock **Committee:** SQAC	94.78 %	R <90 % A >=90 % G >=95 %		The percentage has increased by 0.38% since May 2021 to 94.78%. There were 1,145 completed surveys, with 41 (3.58%) poor or very poor responses in this area. 16 (1.4%) of respondents said their experience was neither good nor poor, which when combined with the negative responses took the overall FFT percentage below the internal threshold of 95%. Waiting time was highlighted as a major issue in May 2021, however, the percentage in this area has increased from 74% to 80%. When asked 'How could we have improved' there was a trend surrounding directions and signage and also the attitude of staff.

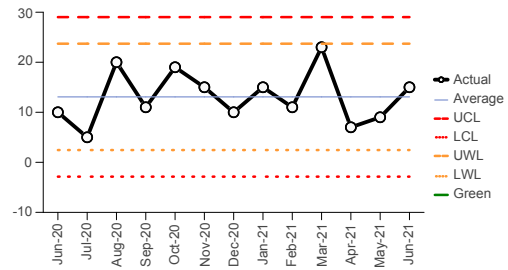
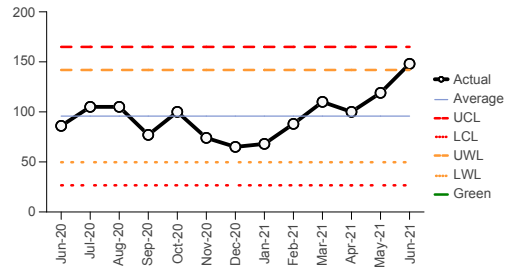
The Best People doing their best Work

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	15	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nicki Murdock **Committee:** SQAC	148	No Threshold		

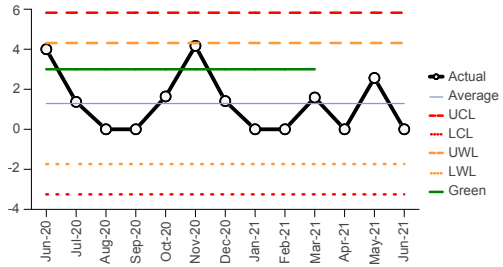
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

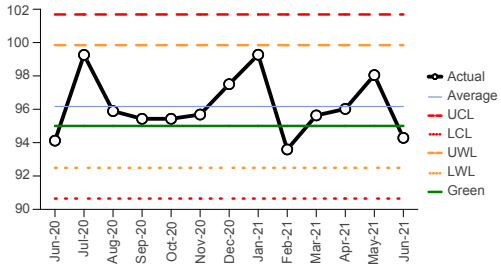
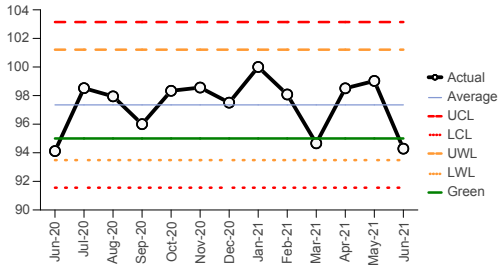
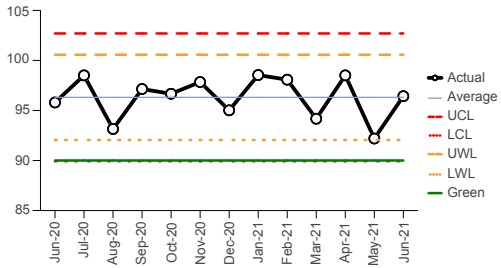
Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

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: 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	94.29 %	R <90 % A >=90 % G >=95 %		The percentage has decreased by 3.75 from 98.04% in May 2021 to 94.29% in June 2021. 132 out of 140 of respondents claimed that the received enough information about their care. No comment analysis attributed to this question to provide further qualitative feedback. Of the 8 negative responses, 2 were from Ward 3C, 2 from Ward 4A, 2 from Ward 3A, 1 from SDC, and 1 from Ward 4C.
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	94.29 %	R <90 % A >=90 % G >=95 %		132 out of 140 (94.29%) respondents reported that they have been treated with respect. Out of the 8 negative responses, 5 were from Medical Division. More specifically, there were 3 negatives responses from Ward 3C, 1 negative response in Ward 4c, and 1 negative response in EDU. There were also 3 negative responses in Surgical division (2 in SDC and 1 in Ward 3A). Although there are no recurring themes, one comment highlighted a parent feeling judged because they were unable to breastfeed and another comment regarding alleged bullying and intimidation to a parent on Ward 3C.
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	96.43 %	R <85 % A >=85 % G >=90 %		No Action Required

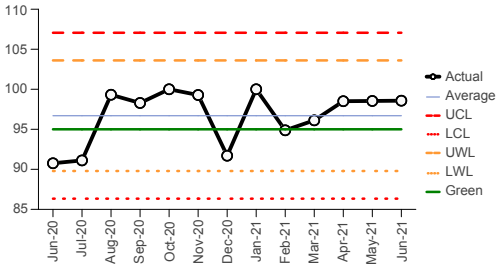
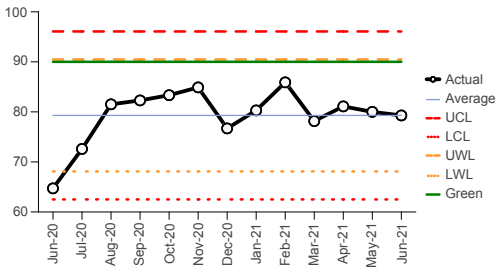
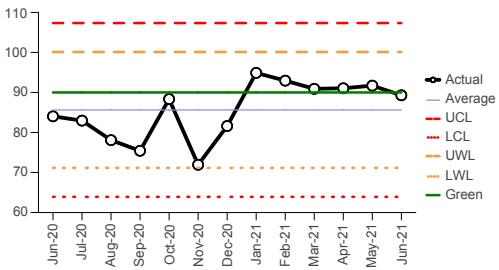
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	98.57 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	79.29 %	R <85 % A >=85 % G >=90 %		The percentage of patients that reported engagement with play this month was 79.29%, a decrease of 0.71% from May 2021. There were 140 responses during June 2021. 28 of those responses said that they did not have access to play/activities. Of the 28 responses, 43% (12) came via Surgical Daycare, 32% (9) came via Ward 4C. Major improvement in Ward 4A with only 1 negative response compared to 8 in the previous month. Actions are taking place to improve Play performance with discussions regarding additional volunteer support and the recruitment of Play support currently ongoing.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nicki Murdock **Committee:** SQAC	89.29 %	R <85 % A >=85 % G >=90 %		Overall percentage for those who reported that they engaged in learning was 89.29% for June 2021. Out of 140 responses, 15 people responded that they were not involved in learning. Medicine had a divisional percentage of 80.43% in this area, in comparison to 93.62% for Surgery. This has seen Medicine drop from 89.3% in the previous month. As a result, investigations are underway and meetings between the Associate Chief Nurse of Medicine and the Headmaster of Sandfield has been scheduled to establish cause for percentage reduction.

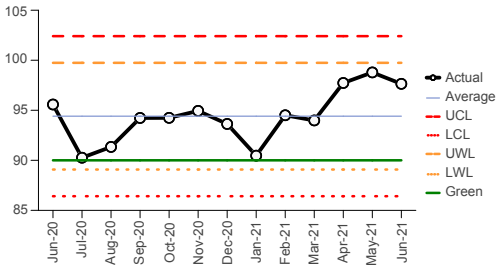
The Best People doing their best Work

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	97.64 %	R <90 % A N/A G >=90 %		No Action Required

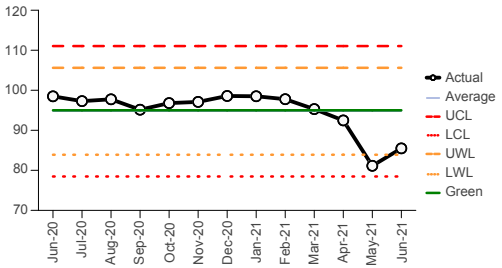
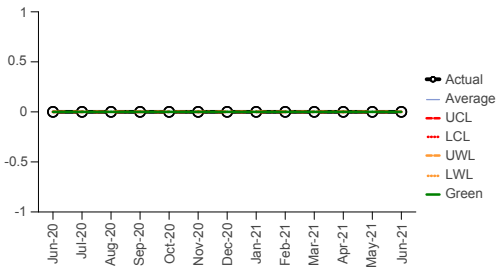
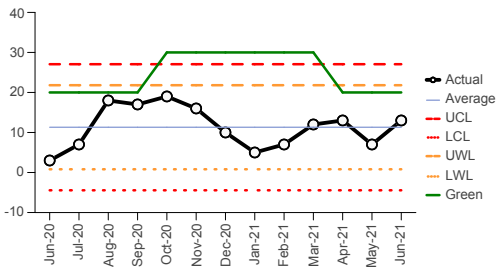
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

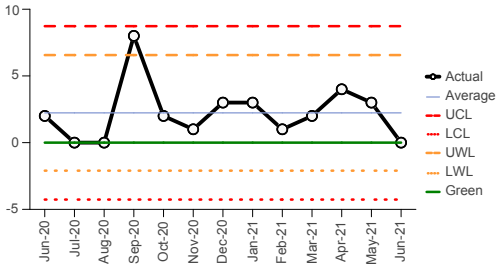
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	85.48 %	R <95 % A N/A G >=95 %		There is a significantly higher amount of attendances than usual for this time of year placing huge pressure on the dept. Attributing this to easing of lockdown restrictions, limited patient access to P/C, other healthcare providers and a lack of F2F appts. We are placing high priority on ensuring the dept is well staffed and staff's well-being. High-med acuity patients continue to be priority, however we are looking at deflection of certain patients were appropriate to access providers/treatments most suitable. Comms about ED have also been stepped up with the aim relieve pressure within ED.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	13	R >20 A N/A G <=20		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required

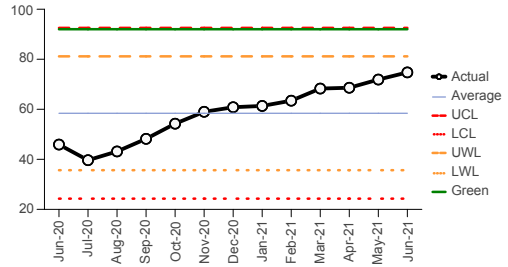
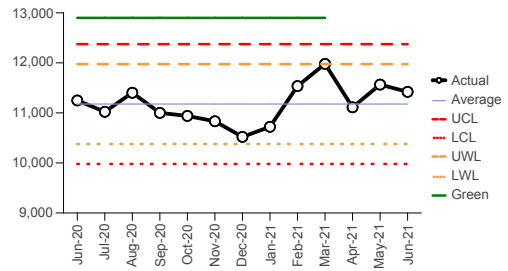
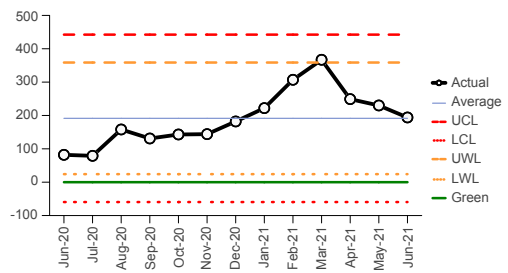
Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	74.74 %	R <90 % A >=90 % G >=92 %		Performance continues to improve with notable progress against our restoration targets. Continued challenges remain primarily within surgical specialities however the most challenges specialities have made significant progress over recent weeks. Each speciality below 95% RTT has an individual delivery plan to support their achievement of RTT pathways within coming weeks or months.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	11420	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	204	R >0 A N/A G 0		Third consecutive month there has been a reduction in the number of C&YP waiting over 52wks to receive treatment. Majority of patients are waiting surgical treatment. All have received a clinical review with plans to treat asap. Challenging specialities have made significant progress by creating more capacity to accommodate as many of these C&YP. Some of the C&YP have also been established via additional validation associated with the Safe WL Programme.

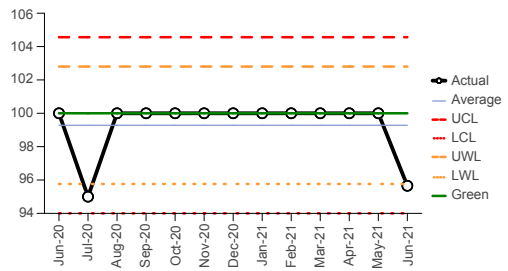
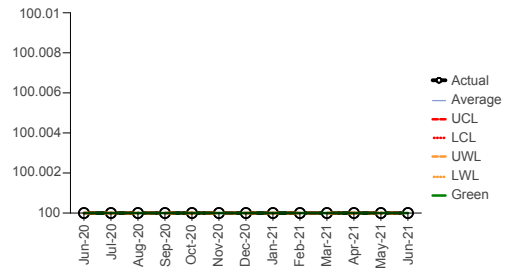
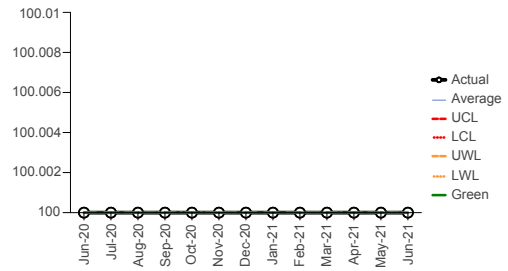
Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	95.65 %	R <100 % A N/A G 100 %		Patient breached due to complexity of patient pathway, a transfer between 2 providers starting with delays early on with first appointment at external provider. The 2 week wait breach is attributable to the Linda McCartney Centre.
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

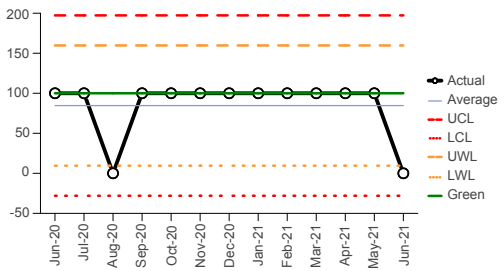
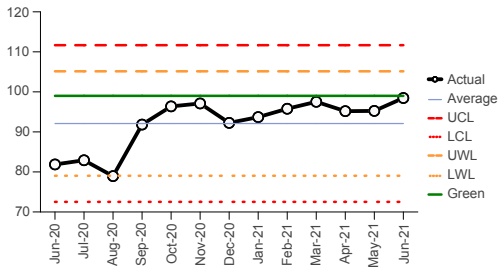
Delivery of Outstanding Care

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	0 %	R <100 % A N/A G 100 %		31 day target was breached due to complexity of patient pathway, a transfer between 2 providers starting with delays early on with first appointment at external provider. Then once transferred back, patient was required to be informed of this from external provider which caused delay, then they needed investigations once back at Alder Hey.
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	98.46 %	R <99 % A N/A G >=99 %		We're glad to see the improvement that's been made as we're recovering from capacity challenges in endoscopy and MRI. MRI remains at capacity and there are some patients who continue to wait longer than the 6 week standard for routine scans due to the volume of urgent requests coming through.

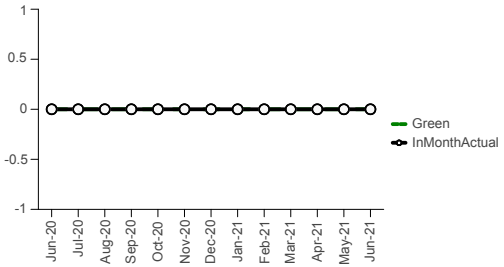
The Best People doing their best Work

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

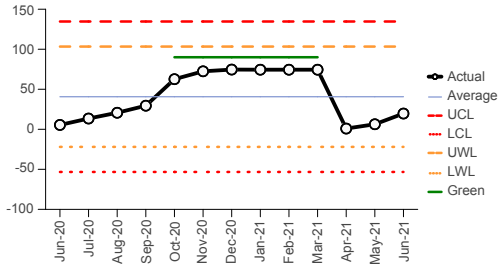
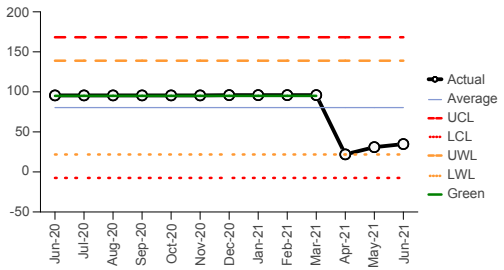
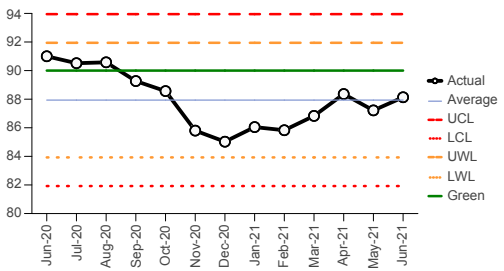
The Best People doing their best Work

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	19.66 %	No Threshold		We're starting to see people completing their staff appraisals and recording them into ESR with nearly 20% of appraisals having been completed up until this point. We've ran further PDR Workshops for reviewers to ensure that managers are best equipped to have meaningful appraisal conversations and are prepared for the new addition of the wellbeing conversation. Regular reporting and updates will start to be seen at Organisational level as we move through the window to ensure that the appraisal process and deadlines are promoted throughout the Trust.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	34.77 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	88.13 %	R <80 % A >=80 % G >=90 %		Overall Mandatory Training has remained at 88% for this month, but is still steadily returning back to the target of 90% based on recent trajectory. As per previous updates our key areas of focus are practical topics with frequent refreshers that require face to face training to take place and our Estates and Ancillary staff as a wider staff group.

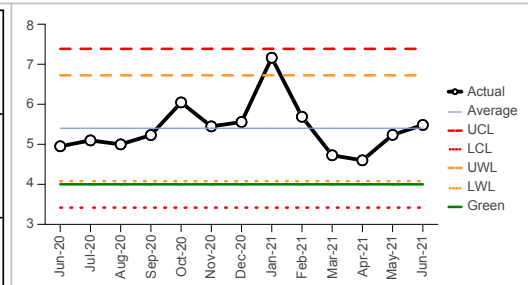
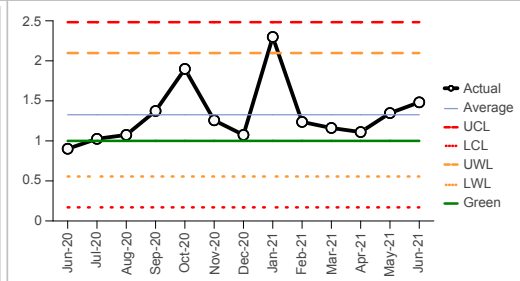
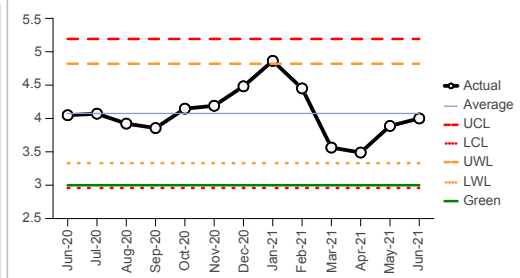
The Best People doing their best Work

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	5.48 %	R >4.5 % A <=4.5 % G <=4 %		sickness increased by 0.22% from 5.24% to 5.46%. Within this, short term absence increased from 1.35% to 1.62%, however the Trust saw a slight decline in long term absence from 3.88% to 3.85%. The HR team continue to support managers across the Trust to facilitate a return to work for employees when possible, and ensure appropriate support mechanisms are in place whilst colleagues are absent from the workplace. The team have also refreshed the attendance management training support available and this will be rolled out over the next few months.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** PAWC	1.48 %	R >1 % A N/A G <=1 %		as above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	4.00 %	R >3 % A N/A G <=3 %		as above

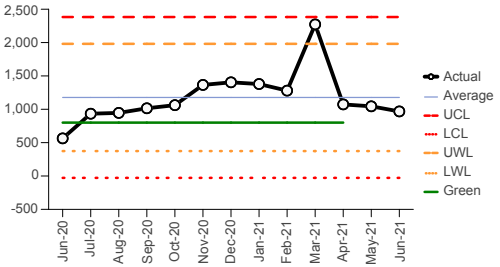
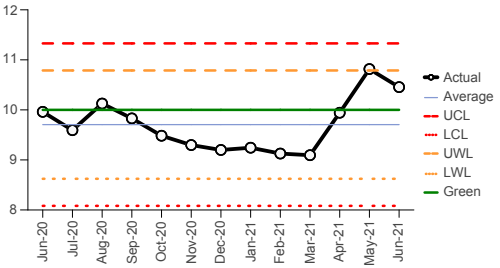
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	967.78	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	10.45 %	R >11 % A <=11 % G <=10 %		Turnover has started to show a decline after a number of our temporary staff contracts ended

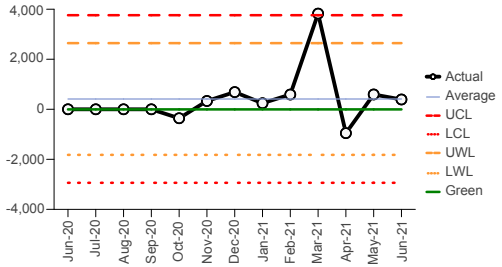
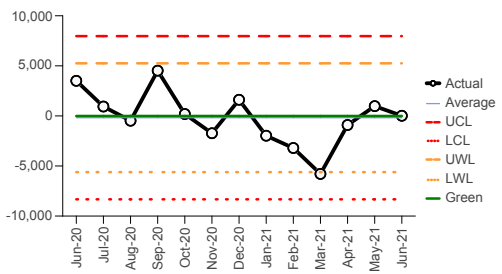
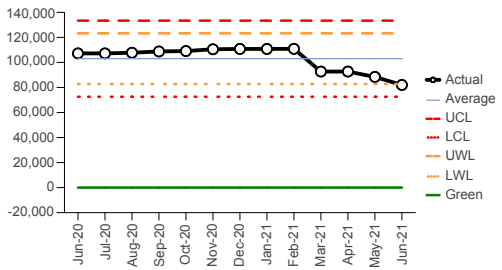
The Best People doing their best Work

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	391	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	13	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	82,001	R <-20% A >=-20% G >=-5%		No Action Required

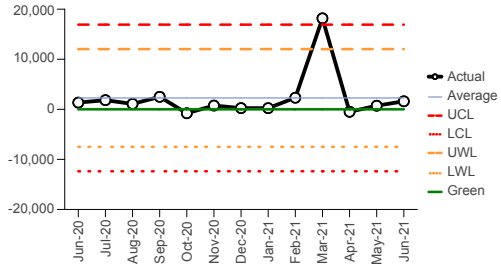
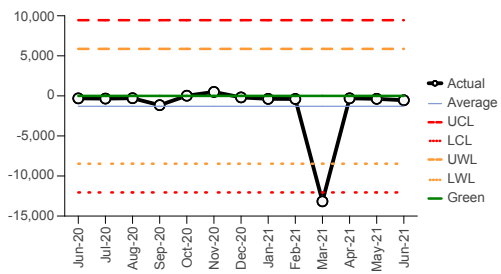
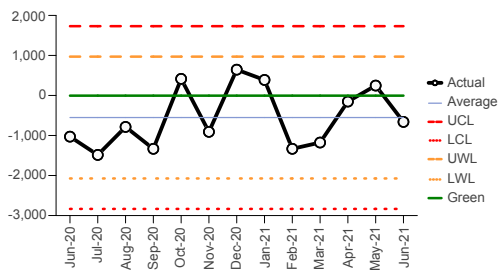
The Best People doing their best Work

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	1,597	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	-545	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	-661	R <-20% A >=-20% G >=-5%		

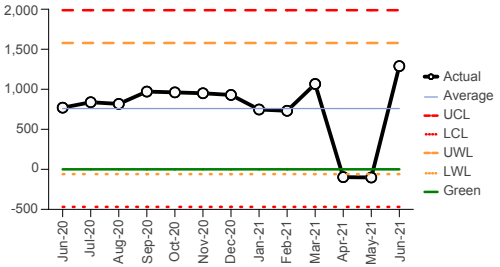
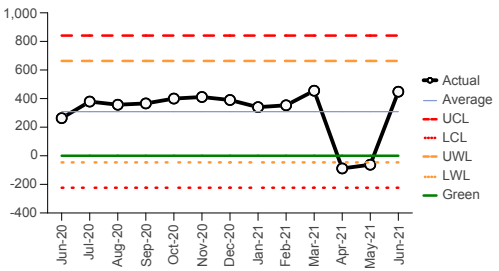
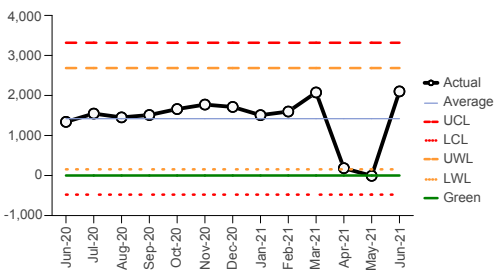
The Best People doing their best Work

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	1289	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	448	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	2101	R <0 A N/A G >=0		No Action Required

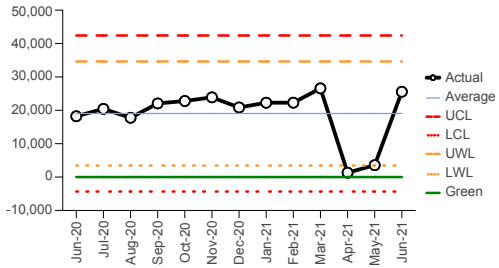
The Best People doing their best Work

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	25561	R <0 A N/A G >=0		No Action Required

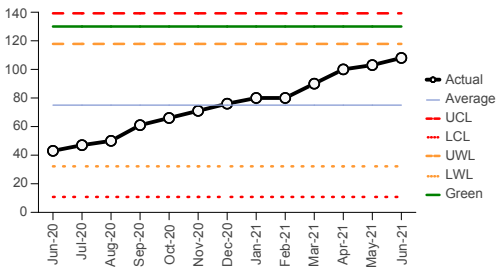
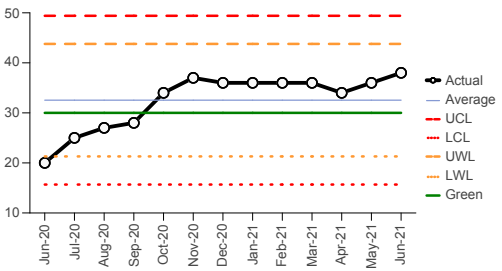
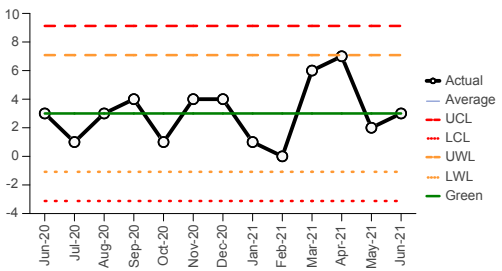
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS 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	108	R <111 A >=111 G >=130		On track with the planned increase in the number of open academic studies.
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	38	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	3	R <2 A >=2 G >=3		No Action Required

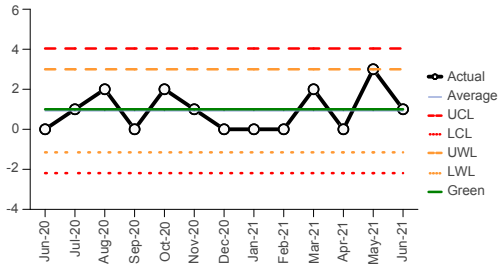
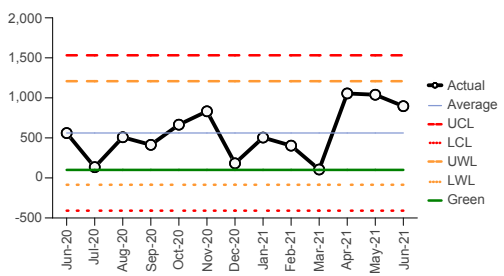
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

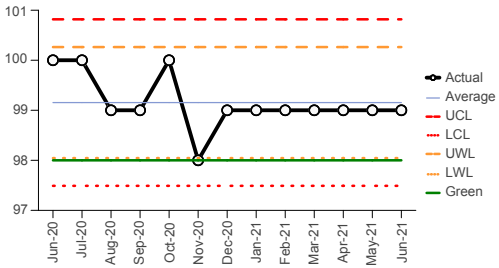
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	1	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	896	R <86 A >=86 G >=100		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

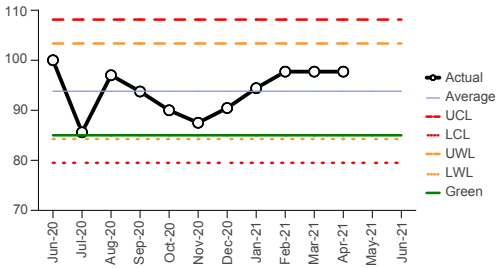
The Best People doing their best Work

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		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	8	34	38	No Threshold
Clinical Incidents resulting in No Harm	D	48	91	172	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	11	16	37	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	1	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	1	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	1	1	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		93.3%	88.9%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	0	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	8	2	5	No Threshold
PALS	W	55	41	43	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	No Threshold
ED: 95% Treated within 4 Hours	D		85.5%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	1	12	No Threshold		
28 Day Breaches	W	0	0	0	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		93.5%	94.7%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		89.1%	96.8%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		95.7%	96.8%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		97.8%	98.9%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		71.7%	83.0%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		80.4%	93.6%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	69.6%	92.5%	67.9%	>=92 %	>=90 %	<90 %
Waiting List Size	W	808	3,122	7,484	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	6	197	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		95.7%		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		98.4%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		0.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	-11	-1,036	90	No Threshold
Income In Month Variance (£'000s)	W	50	-1	209	No Threshold
Pay In Month Variance (£'000s)	W	-87	-150	-124	No Threshold
Non Pay In Month Variance (£'000s)	W	25	-886	5	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	0	807	482	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	158	289	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,312	788	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	3,926	7,766	11,826	>=0	N/A	<0
PDR	W	21.5%	18.5%	20.3%	No Threshold		
Medical Appraisal	W	24.0%	33.9%	37.8%	No Threshold		
Mandatory Training	W	92.3%	87.9%	87.8%	>=90 %	>=80 %	<80 %
Sickness	D	4.7%	5.2%	5.8%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.5%	1.5%	1.5%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.2%	3.7%	4.3%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	229	230	334	No Threshold		
Staff Turnover	D	9.8%	8.3%	9.9%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W		96.0%	98.4%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Improvement in sepsis recognition and treatment evident in June 2021 C. Difficile – RCA 1 Key findings: unusual case of unresolving Typhilitis with limited consideration of alternative diagnosis, documentation of bowel pattern difficult to determine dates, time and consistency, Bristol stool chart not used, lack of clarity over when to take sto	**Highlight** • Weekly divisional incident review meeting for rapid learning and sharing • Weekly monitoring of investigations and action log • Number of excellence reports increasing • DIG reporting schedule aligned to CQSG work plan **Challenges** • Medication errors remain the top reported incident category – Update on actions led by Pharmacy to DIG August 2021 meeting
CARING	Formal complaints decreased from 5 to 2. Increase in PALS going from mid 20's in previous months to 41 in June.	**Highlight** • 100% acknowledgement of formal complaints within 3 working days • 100% compliance with response to formal complaints within 25 working days in May 2021 • Increase to 79% compliance with responses to PALS within 5 working days in June 2021 • 'Governance Hour' dedicated to Patient Experience in May and June 2021 **Challenges** • Formal complaints - 1 breach in June 2021 due to availability of staff member to respond to the complaint
EFFECTIVE	Deflection policy for ED and low acuity patient streams set up away from ED. Recruitment for dermatology to in house consultant post and neurology expanding physiotherapy treatment pathway. OPD transformation team to attend Divisional Board on 20th July to expand scope of PIFU workstream.	**Highlight** • RTT performance above 94% for June 2021 • Continued improvements to follow up backlog position with programs of work in endocrinology and neurology **Challenges** • ED performance remains below 95% target • Dermatology and Neurology RTT performance challenged due to capacity
RESPONSIVE	DM01 to be added to risk register Trajectory for delivery of 6 week standard on all diagnostics to be managed through SLWM and Access to Care. Last of the backlog for reporting was sent to Medica in June. Now sending any reports that will failed 2 week standard for outsourcing.	**Highlight** ▪ Outpatient imaging waits now at 2 weeks following outsourcing to Medica ▪ Cancer standards being met consistently including new Faster Diagnosis standard being delivered well above national standard of 75% - data errors on report for June to be corrected. **Challenges** ▪ Diagnostic standard of 6 weeks below compliance for MRI due to equipment failures. Some additional capacity put on to mitigate but not fully. ▪ Several tests not currently being reported against DM01 (polysomnography and urodynamics) will significantly impact on DM01 performance.

WELL LED

Mental health related absences are treated as a high priority – relaunching Mental Health First Aid offering and reviewing all mental health cases

Budget vs Actual	In Month			Year To Date		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000
Income	9,934	9,934	0			
Pay	-5,872	-6,229	-357	-58,227	-59,683	-1,457
Non Pay	-1,381	-1,263	119	-13,057	-12,949	108
Total	**2,681**	**2,443**	**-238**	**-71,283**	**-72,632**	**-1,349**

Highlight

- 6 risks closed in month and only 4 new ones added
- Absence continues to reduce with a short peak in May 2021 which is to be kept under review
- Mental ill health accounts for **36.3%** of sickness absence in Medicine Division which is a reduction of 3.7% since April 2021
- High percentage of case work continues to be resolved at informal stage
- Compliance is below the 90% target. There was an increase with Mandatory training in March and April 2021. The data shown in the Corporate Report is up to May 2021 at 87.6%
- COVID related absence for the Division of as 8 July 2021 is at 1.58% (includes absence and self isolation)
- PDR running at completion level of 20.63%
- OP Over achievement mainly in OP Follow ups at > 3000 compared to plan and 5000 compared to 2019
- Significant attendance figures to ED as expected compared to under performance on non-elective reflects low acuity attenders not converting to admission

Challenges

- 7 risks over due a review and 5 with overdue actions
- Due to level of engagement at informal stage for cases, formal cases tends to be high in complexity
- COVID – we do not record staff who are self isolating and working from home on ESR. Particular impact on some service areas e.g. ED has **13.8%** of staff as of 8 July 2021
- In person mandatory training was on hold for a period of time
- Some managers unable to update ESR with PDR information once review undertaken

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Medicine

D Drive W Watch P Programme

SAFE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	18	29	19	17	28	34	22	18	24	33	42	33	34		No Threshold
Clinical Incidents resulting in No Harm (D)	76	104	76	94	70	126	99	90	96	125	121	122	91		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	18	26	20	16	11	18	19	21	17	19	23	23	16		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	2	0	0	0	0	0	0	1	1	0	2	1		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	1	0	0	0	0	1	0	0	0	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)	3	2	0	4	0	0	0	4	1	2	0	0	1		No Threshold
Medication Errors (Incidents)	29	26	23	19	24	32	36	34	28	39	28	41	28		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	0	2	2	0	0	1	0	2	4	0	3	1		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)	92.3%	100.0%	84.6%	91.7%	100.0%	75.0%	90.9%	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%		>=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	1	0	0	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	0	2	0	0	0	2	2	2	1	5	0	0		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	1	1	0	0	0	0		No Threshold
Cleanliness Scores	98.5%	97.7%	97.8%	98.0%	98.0%	96.0%	95.1%	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%		No Threshold
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.	99.6%	99.8%	99.8%	99.8%	99.8%	99.7%									>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	60.0%	63.8%	63.8%	63.8%	49.3%	64.6%	71.3%	53.9%	68.2%						>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	64.0%	78.5%	84.0%	77.3%	85.0%	85.0%	85.0%	85.0%	84.0%						>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	100.0%	100.0%	100.0%	100.0%	100.0%	77.0%		100.0%	100.0%						>=90 % N/A <90 %

CARING

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Complaints (W)	6	1	11	7	8	7	6	8	3	12	5	5	2		No Threshold
PALS (W)	21	32	49	27	24	28	27	25	20	37	24	23	41		No Threshold

EFFECTIVE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Referrals Received (Total)	1,437	1,669	1,571	2,284	2,023	2,096	1,697	2,078	1,673	2,217	2,115	2,211	2,359		No Threshold
ED: 95% Treated within 4 Hours (D)	98.5%	97.3%	97.7%	95.1%	96.8%	97.1%	98.6%	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	1.1%	1.5%	0.8%	2.0%	0.8%	1.0%	0.6%	0.5%	0.7%	2.2%	3.8%	7.4%	4.9%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0			0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W)	0	0	0	0	0	0	0	0	0	0	0	0			0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	7.5%	7.8%	8.3%	7.0%	7.9%	7.8%	7.9%	9.0%	7.9%	7.5%	8.3%	9.4%	8.6%		No Threshold

Medicine

D Drive W Watch P Programme

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	75.4%	82.0%	82.1%	81.3%	83.6%	82.2%	84.7%	84.0%	87.0%	82.6%	84.6%	80.3%	77.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	0	0	3	2	1	1	2	0	0	1	2	0	1		No Threshold
28 Day Breaches W	2	0	0	3	2	0	0	1	0	0	0	0	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	2	12	55	20	33	20	47	16	14	18	21	19	21		No Threshold
OP Appointments Cancelled by Hospital %	15.6%	13.1%	11.4%	12.3%	11.2%	12.4%	13.7%	12.1%	12.1%	11.8%	9.8%	10.1%	11.2%		<=5 % N/A >10 %
Was Not Brought Rate W P	11.5%	11.4%	11.8%	11.7%	11.2%	9.6%	10.4%	9.8%	9.5%	8.9%	9.7%	10.1%	10.6%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	14.4%	14.8%	13.1%	15.8%	12.3%	11.3%	11.4%	12.0%	10.9%	9.4%	12.6%	10.8%	11.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	10.7%	10.7%	11.5%	10.9%	10.9%	9.1%	10.2%	9.3%	9.2%	8.8%	9.0%	9.9%	10.4%		<=14 % <=16 % >16 %
Coding average comorbidities	5.40	5.33	5.27	5.17	5.32	5.44	5.50	5.45	5.53	5.41	5.13	5.20	5.57		No Threshold

RESPONSIVE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care W	81.5%	100.0%	95.6%	92.9%	92.9%	96.9%	95.8%	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	88.9%	96.8%	97.8%	100.0%	97.2%	100.0%	95.8%	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	85.2%	100.0%	93.3%	95.2%	88.9%	100.0%	91.7%	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	85.2%	90.3%	100.0%	97.6%	100.0%	100.0%	87.5%	100.0%	92.9%	95.2%	94.3%	100.0%	97.8%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D	63.0%	77.4%	80.0%	88.1%	77.8%	84.4%	81.2%	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	77.8%	87.1%	82.2%	76.2%	63.9%	62.5%	81.2%	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	46.3%	40.6%	45.0%	55.5%	68.0%	81.0%	86.1%	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%		>=92 % >=90 % <90 %
Waiting List Size W	2,791	2,484	2,420	2,151	1,916	1,778	1,785	1,731	2,110	2,280	2,509	2,819	3,122		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	0	0	0	0	0	0	0	1	16	4	4	3	6		0 N/A >0
Waiting Times - 40 weeks and above	127	147	181	137	81	63	24	9	37	10	24	12	15		No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%		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	82.1%	84.6%	77.9%	91.4%	96.2%	97.7%	91.7%	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	90.0%	90.4%	92.7%	89.7%	90.0%	90.6%	90.4%	90.4%	90.4%	91.9%	91.1%	92.6%	91.1%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	99.9%	100.0%	100.0%	100.0%	99.8%	100.0%	99.9%	100.0%	100.0%	100.0%	99.5%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	100.0%	100.0%	98.0%	100.0%	100.0%	97.0%	95.0%	99.0%	99.0%	100.0%	89.0%	96.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	98.0%	97.0%	97.0%	98.0%	93.0%	98.0%	92.0%	99.0%	98.0%	99.0%	89.0%	96.0%	95.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	97.0%	81.0%	69.0%	71.0%	74.0%	72.0%	51.0%	75.0%	77.0%	58.0%	65.0%	57.0%	52.9%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	62.6%	82.4%	59.1%	98.0%	98.8%	100.0%	94.2%	100.0%	95.0%	98.0%	98.7%	100.0%	91.9%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	35.4%	88.2%	77.8%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	83.8%	86.4%	95.0%	92.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%	100.0%	100.0%		>=99 % N/A <99 %

Medicine

D Drive W Watch P Programme

WELL LED

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,048	278	-1,111	-1,201	-264	153	41	189	160	-586	263	200	-1,036		No Threshold
Income In Month Variance (£'000s)	W	-1,103	347	-1,170	-622	-647	561	142	10	36	170	37	-26	-1		No Threshold
Pay In Month Variance (£'000s)	W	92	196	62	-211	-143	338	30	-61	-52	-148	-64	60	-150		No Threshold
AvP: IP - Non-Elective	W	407	489	484	640	595	596	586	405	416	676	-153	-76	807		>=0 N/A <0
AvP: IP Elective vs Plan	W	78	114	99	119	121	147	136	123	138	154	-16	-10	158		>=0 N/A <0
AvP: OP New		1,088.00	998.00	842.00	1,000.00	1,334.00	1,392.00	1,034.00	1,120.00	1,081.00	1,223.00	-388.97	-412.28	1,286.00		>=0 N/A <0
AvP: OP FollowUp		4,207.00	4,559.00	3,853.00	5,044.00	4,858.00	4,922.00	4,446.00	4,953.00	4,586.00	5,405.00	929.17	501.80	5,485.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	888	917	897	915	1,051	1,092	1,071	1,003	1,030	1,264	244	186	1,312		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	5,988	6,397	5,439	6,931	7,173	7,387	6,450	6,917	6,765	7,784	94	-209	7,766		>=0 N/A <0
PDR	W	10.7%	12.1%	23.0%	21.8%	60.2%	69.1%	74.6%	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%		No Threshold
Medical Appraisal	W	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	94.1%	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%		No Threshold
Mandatory Training	W	91.6%	91.3%	91.3%	89.9%	90.2%	88.9%	86.7%	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%		>=90 % >=80 % <80 %
Sickness	D	5.4%	5.6%	5.1%	5.0%	5.8%	4.7%	4.9%	6.3%	5.1%	4.1%	4.4%	5.4%	5.2%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.0%	0.9%	1.1%	1.4%	2.2%	1.5%	1.2%	2.0%	1.4%	1.1%	1.2%	1.4%	1.5%		<=1 % N/A >1 %
Long Term Sickness	D	4.4%	4.7%	4.1%	3.6%	3.6%	3.3%	3.7%	4.3%	3.7%	3.0%	3.3%	3.9%	3.7%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	108	167	217	266	235	239	213	247	267	261	210	262	230		No Threshold
Staff Turnover	D	8.2%	7.5%	7.5%	6.6%	6.6%	7.0%	7.3%	6.8%	6.7%	6.2%	6.7%	7.8%	8.3%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	97.7%	96.4%	94.9%	94.9%	93.2%	93.6%	93.2%	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%		>=90 % >=80 % <90 %

Surgery Division

SAFE	• Continued increase in clinical incidents resulting in near miss 45>26<34<39 • Number of clinical incidents resulting in No harm 175>168>167<172 • Increase in Clinical Incidents resulting in minor, non-permanent harm 34<35>39<37 • Reduction in clinical incidents resulting in moderate, semi-permanent harm, 0<1<2>0 • No Clinical Incidents resulting in severe, permanent harm, 10 consecutive months • No Clinical incidents resulting in catastrophic, death • Overall reduction in all medication errors 46>44>36>35 • No never events • Patients treated for sepsis within 60 mins 76.9%<91.7%>88.9% • No hospital acquired organisms	**Highlight** • Further reduction in medication errors that result in harm 4>2>1 • No pressure ulcers, cat 3 & 4 since Dec 2020 • Cleanliness scores 99%>98%:98% **Challenges** • Ward Staffing levels as patient acuity increases

CARING	• Increase in formal complaints received 3<7>0<4<5
	• Increase in PALS 27<34<42<43
	  ○ Themes include team working across multiples specialities
	  ○ Communications
	  ○ Waiting time for treatment
		Highlight
		• Improvements made to Vitreo-retinal pathway, patient who receive the op at LUFT
		Challenges
		• Providing access within a timely manner for elective patients

EFFECTIVE	• No patients readmitted to PICU within 48 hours 0<2>0 • Slight decrease in WNB rate increased 6.7%<8.2%>8% • Reduction in patients waited over 28 days from their cancelled procedure to be rescheduled 2<4>3>0 • Increase in the number of patients cancelled on the day of their procedure 11>7<13 • Theatre Utilisation 84.1%<88.8%>85.2%	**Highlight** • Increase in CCAD cases 34:34>31<39 **Challenges** • Continued increase in referrals received 3885<4016<4185 • Increase in short notice cancelations for theatre owing to families isolating / COVID positive
RESPONSIVE	• Decrease % Received information enabling choices about their care 96%<98%>95% • Patients who noted that they were treated with respect 94%<98%:98%>97% • Patients knew their planned date of discharge 95%<99%>93%<97% • Patients noted that they knew who was in charge of their care 97%<100%>98%<99% • Increase in patients noted they were involved in learning 96%>91%<93%<94%	**Highlight** • Continued improvement in RTT%, 62%<64%<68% • Reduction in patients waiting over 52 weeks to commence treatment 357>276>232>197 • Reduction in patients waiting to commence treatment (Waiting list size) 7,773> 7,980>7,484 **Challenges** • Increase OP and IP capacity required to recover waiting time position
WELL LED	• Increase in PDRs completed 0.1%<9%<20% • Increase Medical appraisals 24%<35%<38% • Mandatory training maintained at 88% • Slight increase in staff turnover7.8%<8%<9.8%<9.9% • Slight increase in Sickness rates 5.2%<5.7%<5.9% • Long term sickness 3.7%<4.1%<4.2% • Short term sickness 1.5%<1.6%<1.7%	**Highlight** • Delivery of IP and OP activity plan against 2019/20 baseline • Significant reduction in patients waiting over 52 weeks to commence treatment in most cancelled specialities **Challenges** • Establishing increased capacity which is sustainable for all staff groups – theatre ODP staffing

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	29	40	23	21	27	46	31	24	25	45	26	34	38		No Threshold
Clinical Incidents resulting in No Harm D	114	176	151	140	154	190	143	107	140	175	168	165	172		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	48	47	52	38	37	45	42	38	27	34	35	30	37		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	0	4	1	0	0	0	1	1	0	0	1	2	0		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm D	4	4	1	4	1	11	0	1	2	2	4	2	1		No Threshold
Medication Errors (Incidents)	34	62	36	37	38	68	44	23	40	46	44	36	35		No Threshold
Pressure Ulcers (Category 3) W	0	2	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events W	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	88.9%	83.3%	85.7%	75.0%	86.7%	90.0%	53.8%	91.7%	83.3%	90.9%	76.9%	91.7%	88.9%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	2	0	0	0	0	1	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	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA D	0	1	4	1	0	1	0	2	0	0	0	1	0		No Threshold
Cleanliness Scores	97.9%	98.4%	96.0%	98.2%	98.0%	96.0%	97.9%	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%		No Threshold

CARING

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Complaints W	2	0	7	2	10	4	2	2	3	7	0	4	5		No Threshold
PALS W	37	39	33	22	29	22	23	16	23	27	34	42	43		No Threshold

EFFECTIVE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Readmissions to PICU within 48 hrs D	2	1	0	0	1	2	1	0	0	1	0	2	0		No Threshold
% Readmissions to PICU within 48 hrs W	4.0%	1.4%	0.0%	0.0%	1.6%	4.2%	1.4%	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%		No Threshold
Referrals Received (Total)	2,261	2,847	2,611	3,206	3,040	2,974	2,807	2,678	2,886	3,986	3,886	4,025	4,250		No Threshold
Theatre Utilisation - % of Session Utilised W	86.6%	88.6%	89.1%	88.8%	89.2%	88.6%	85.0%	87.6%	90.3%	89.5%	84.1%	88.8%	85.2%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	3	7	15	15	18	15	8	5	7	11	11	7	12		No Threshold
28 Day Breaches W	0	0	0	5	0	1	3	2	1	2	4	3	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	0	16	70	52	58	38	45	38	50	37	47	46	59		No Threshold
OP Appointments Cancelled by Hospital %	17.4%	15.0%	12.1%	11.4%	11.1%	11.9%	10.6%	10.6%	10.8%	11.8%	10.0%	10.1%	11.5%		<=5 % <=10 % >10 %
Was Not Brought Rate W P	7.6%	8.8%	9.0%	9.4%	8.9%	8.7%	10.0%	10.4%	7.9%	7.2%	6.6%	8.1%	7.9%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	8.7%	10.3%	10.5%	11.5%	9.4%	9.5%	11.7%	11.5%	10.5%	8.4%	7.3%	9.7%	8.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	7.1%	8.3%	8.5%	8.7%	8.8%	8.4%	9.5%	10.0%	7.0%	6.7%	6.4%	7.4%	7.6%		<=14 % <=16 % >16 %
Coding average comorbidities	4.19	4.06	4.48	4.45	4.39	4.39	4.48	4.40	4.43	4.53	4.61	4.37	4.40		No Threshold
CCAD Cases	27	30	32	31	31	27	28	25	29	34	34	31	39		No Threshold

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Surgery

D Drive W Watch P Programme

RESPONSIVE

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	97.8%	99.0%	96.0%	96.2%	96.2%	95.3%	99.2%	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	95.7%	99.0%	98.0%	94.7%	98.8%	98.1%	99.2%	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	98.9%	98.1%	93.1%	97.7%	100.0%	97.2%	98.4%	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	92.4%	91.3%	99.0%	98.5%	100.0%	99.1%	95.9%	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D	65.2%	71.2%	82.2%	80.5%	85.7%	85.0%	72.1%	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D	85.9%	81.7%	76.2%	75.2%	98.8%	74.8%	82.0%	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	47.8%	40.3%	43.2%	46.8%	50.9%	53.4%	54.3%	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%		>=92 % >=90 % <90 %
Waiting List Size	W	7,186	7,431	7,840	7,737	8,127	8,221	7,858	8,132	8,432	8,701	7,773	7,980	7,484		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	60	137	121	135	143	147	183	221	291	357	276	232	197		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	W	66.7%	53.3%	100.0%	100.0%	100.0%	87.5%	100.0%	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-1,773	-1,983	-1,540	-1,990	-487	54	-502	-245	11	-857	-734	199	90		No Threshold
Income In Month Variance (£'000s)	W	-1,908	-1,964	-1,428	-1,460	15	1	34	0	83	152	47	49	209		No Threshold
Pay In Month Variance (£'000s)	W	32	67	35	-457	-68	-67	-398	-364	-169	-549	-608	21	-124		No Threshold
AvP: IP - Non-Elective	W	363	349	333	331	366	354	343	341	308	390	56	-24	482		>=0 N/A <0
AvP: IP Elective vs Plan	W	185	265	258	247	279	262	254	217	215	300	-74	-52	289		>=0 N/A <0
AvP: OP New		1,694.00	1,822.00	1,712.00	1,951.00	1,808.00	2,084.00	1,911.00	1,951.00	2,059.00	2,591.00	355.54	-98.15	2,817.00		>=0 N/A <0
AvP: OP FollowUp		4,897.00	6,077.00	5,115.00	6,634.00	6,804.00	6,819.00	5,813.00	6,159.00	6,387.00	7,842.00	-2,495.10	425.79	7,470.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	W	451	629	555	595	609	680	642	503	568	808	-62	-193	788		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	7,286	8,838	7,794	9,658	9,810	10,138	8,974	9,305	9,715	12,007	-2,092	347	11,826		>=0 N/A <0
PDR	W	1.1%	17.1%	24.7%	35.5%	57.8%	67.5%	67.6%	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%		No Threshold
Medical Appraisal	W	94.1%	94.1%	94.1%	94.1%	94.1%	94.1%	96.8%	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%		No Threshold
Mandatory Training	W	89.6%	89.1%	89.3%	88.0%	87.1%	84.8%	85.6%	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%		>=90 % >=80 % <80 %
Sickness	D	5.6%	5.6%	5.9%	6.1%	6.8%	5.8%	6.2%	8.3%	6.5%	5.4%	5.2%	5.7%	5.8%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.1%	1.4%	1.4%	1.7%	2.1%	1.2%	1.3%	3.2%	1.6%	1.5%	1.5%	1.6%	1.5%		<=1 % N/A >1 %
Long Term Sickness	D	4.6%	4.2%	4.5%	4.4%	4.8%	4.6%	4.9%	5.1%	5.0%	3.9%	3.7%	4.1%	4.3%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	204	310	332	286	446	505	415	434	382	560	518	459	334		No Threshold
Staff Turnover	D	9.4%	9.6%	9.5%	9.4%	8.7%	8.3%	7.9%	8.2%	8.1%	7.8%	8.0%	9.8%	9.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	94.4%	86.8%	89.1%	93.6%	94.4%	95.3%	93.5%	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	One catastrophic incident reported relating to death of young person access Sefton Mental Health Services. Internal RCA and external multi-agency safeguarding review underway Reduction in incidents relating to medication errors (9 in June). Lessons learnt/actions from incidents in June include: • Equipment used by services must always have a visual and physical check prior to use, to reduce risk of accidents occurring. • Process implemented to ensure referrals are redirected quickly and seamlessly between Liverpool and Sefton Speech Therapy.	**Highlight** • 102 incidents reported in June 2021 • Zero incidents reporting moderate, semi-permanent harm • Zero incidents reporting severe, permanent harm • Zero pressure ulcers grade 3 or above **Challenges** • Increase in incidents reported late (> 24 hours) after the incident occurred. Divisional Governance meeting addressing this with specific leads to understand rationale for this increase and delays • Lack of dedicated Infection Control support to Division
CARING	Successful support provided to complex children accessing acute outpatient services using CALM techniques (restrictive intervention) Learning/actions from complaints over the past month includes ensure young person's history is reviewed in advance of appointments to avoid families repeating their stories	**Highlight** • 13 excellence reports received • 12 compliments received • 95% FFT scores for Community & Mental Health **Challenges** • 8 x formal complaints received in June. Main themes relate to delays in access and communication. • 54 x PALs received in June deep dive underway to identify areas for improvement
EFFECTIVE	Significant increase in referrals for services within the division, including: • 105 % increase in referrals to Mental Health services (June 2021 vs June 2019) • 73% higher than expected referrals to the ASD service • 51% higher than expected referrals to the ADHD service • Crisis Care continue to receive a high number of calls into the service (716 calls in June).	**Highlight** • Continued reduction in number of outpatient clinics cancelled by hospital (9.66% in June) **Challenges** • Referral logging turnaround has increased to 7 days. Booking & Scheduling Team are converting all referrals received via NHS e-RS to paper and logging into Meditech as direct booking remains switched off in most specialties.
RESPONSIVE	Zero children & young people waiting to start ASD and ADHD assessments from original pre-April 2020 cohorts. However, referral rates remain significantly higher than predicted and access times for the new ASD pathway are greater than the 30-week target. Discussions are ongoing with commissioners and other partners to understand potential impact of high referrals, ensuring support is available for children and young people whilst waiting for a diagnosis.	**Highlight** • 5 x Speech & Language Therapists recruited to provide additional capacity and reduce waiting times **Challenges** • Access times remain challenging for services within the division (Mental Health, EDYS, ASD & SALT) • Waiting time for Primary Care Paediatric Phlebotomy (routine request) is 12 weeks

WELL LED	Princes Trust BAME "Get into the NHS" scheme commenced in June providing eight-week placements for 8 young people.	**Highlight** • PDR target on track for completion by end of July deadline • Mandatory training above Trust target at 91% • COVID related absence for the Division is at 0.14% (includes absence and self-isolation) **Challenges** • Recruitment times in the division remain challenging (16 weeks) due to absence in the recruitment team • Sickness absence has increased to 4.6%, after being within the Trust target for three consecutive months.

Alder Hey Children's NHS
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Community

D Drive W Watch P Programme

SAFE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	6	8	5	8	16	10	16	5	5	9	8	12	8		No Threshold
Clinical Incidents resulting in No Harm (D)	84	83	73	88	84	76	53	63	75	84	74	54	48		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	10	6	5	9	11	12	9	11	21	35	29	20	11		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Medication Errors (Incidents)	6	11	10	20	33	26	16	19	17	23	17	9	9		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	78.3%	100.0%		98.8%	98.8%					100.0%		99.0%	97.5%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Supported early discharges from hospital care	100.0%														No Threshold
CCNS: Prescriptions	15														No Threshold

CARING

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Complaints (W)	2	4	2	2	1	4	2	5	4	3	2	0	8		No Threshold
PALS (W)	26	29	22	26	32	17	15	14	38	41	40	49	55		No Threshold

EFFECTIVE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Referrals Received (Total)	652	876	636	857	978	1,048	847	774	880	1,101	907	1,310	1,308		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	0	4	25	25	18	2	5	7	10	7	11	5	9		No Threshold
OP Appointments Cancelled by Hospital %	6.2%	6.3%	10.5%	10.1%	10.0%	11.5%	8.2%	12.8%	9.8%	12.4%	11.5%	8.7%	9.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	11.5%	10.8%	10.5%	7.0%	11.6%	8.2%	7.5%	9.1%	11.2%	17.3%	18.6%	25.9%	29.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	14.7%	15.3%	13.6%	13.9%	13.3%	11.0%	12.9%	12.4%	11.6%	13.9%	16.1%	16.6%	25.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	11.5%	9.0%	12.3%	9.2%	14.7%	10.0%	9.3%	9.0%	14.9%	22.6%	26.5%	33.7%	41.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	11.9%	15.1%	14.1%	17.5%	14.9%	12.0%	14.7%	15.6%	15.0%	18.5%	21.2%	23.9%	46.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	28.3%	25.7%	23.6%	9.7%	12.8%	13.3%	13.6%	19.7%	11.5%	15.1%	6.9%	15.8%	13.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	16.2%	15.9%	13.9%	13.1%	13.3%	11.6%	13.2%	12.0%	10.9%	12.9%	14.0%	13.4%	13.1%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	85.7%	82.5%	61.3%	77.1%	93.5%	48.6%	44.7%	38.7%	28.6%	28.6%	19.5%	14.3%	14.3%		No Threshold
CAMHS: Tier 4 DJU Bed Days	360	356	266	324	408	202	196	166	112	124	82	62	54		No Threshold
Coding average comorbidities		2.00	6.00		4.50	3.33	3.00	3.00		4.00	9.00		2.00		No Threshold
CCNS: Number of commissioned packages	9														No Threshold

RESPONSIVE

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1	1	1		2	2		1		1				No Threshold
CAMHS: Referrals Received	259	262	257	357	348	417	340	268	352	470	395	535	638		No Threshold

Community

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	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
CAMHS: Referrals Accepted By The Service	144	154	146	269	193	232	198	158	182	252	198	254	315		No Threshold
CAMHS: % Referrals Accepted By The Service	55.6%	58.8%	56.8%	75.4%	55.5%	55.6%	58.2%	59.0%	51.7%	53.6%	50.1%	47.5%	49.4%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks (W)	34.0%	32.3%	38.1%	40.2%	49.2%	64.3%	64.4%	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%		>=92 % >=90 % <90 %
Waiting List Size (W)	1,184	1,032	1,109	1,051	795	756	800	785	911	911	828	765	808		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways (W)	22	12	6	10	2	1	1	0	0	0	3	0	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity	448	550	494	517	598	720	698	650	804	807	744	756	716		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks (W)	49.3%	44.0%	53.2%	59.1%	68.8%	70.0%	69.9%	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%		>=92 % >=90 % <88 %
ASD: Completed Pathways	78	123	138	122	126	108	52	70	69	99	87	118	92		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	55.1%	65.0%	74.6%	77.9%	93.7%	88.0%	82.7%	62.9%	82.6%	70.7%	28.7%	20.3%	13.0%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P)			100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	46.2%	16.7%	23.5%	28.6%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P)			100.0%	100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	25.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals (W)	149	188	122	144	146	151	127	119	139	169	120	135	150		No Threshold
CCNS: Number of Contacts (D)	812	1,083	803	1,035	1,038	877	844	783	826	896	791	821	835		No Threshold

WELL LED

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Last 12 Months	RAG
Control Total In Month Variance (£'000s) (W)	175	-26	0	-70	369	270	45	321	221	-41	14	212	-11		No Threshold
Income In Month Variance (£'000s) (W)	139	-49	-44	96	397	155	75	148	996	150	94	88	50		No Threshold
Pay In Month Variance (£'000s) (W)	-29	-64	-98	-31	-81	30	12	65	-81	137	5	-49	-87		No Threshold
AvP: OP New	621.00	687.00	457.00	690.00	753.00	776.00	585.00	637.00	515.00	587.00	65.50	228.95	476.00		>=0 N/A <0
AvP: OP FollowUp	3,327.00	3,189.00	2,804.00	3,291.00	3,543.00	3,781.00	3,357.00	3,774.00	3,719.00	4,010.00	1,283.90	1,200.84	3,450.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan (W)	3,948	3,877	3,263	3,981	4,296	4,557	3,942	4,413	4,234	4,597	1,350	1,430	3,926		>=0 N/A <0
PDR (W)	9.8%	16.6%	23.1%	41.3%	73.4%	81.9%	81.9%	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%		No Threshold
Medical Appraisal (W)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%		No Threshold
Mandatory Training (W)	92.8%	92.1%	92.0%	91.4%	91.7%	89.2%	88.4%	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%		>=90 % >=80 % <80 %
Sickness (D)	2.7%	2.5%	2.7%	3.8%	4.0%	4.3%	4.5%	5.7%	4.7%	3.9%	3.3%	3.9%	4.7%		<=4 % <=4.5 % >4.5 %
Short Term Sickness (D)	0.5%	0.7%	0.9%	1.3%	1.6%	1.2%	0.9%	1.9%	1.0%	1.0%	0.8%	1.2%	1.5%		<=1 % N/A >1 %
Long Term Sickness (D)	2.2%	1.8%	1.9%	2.5%	2.5%	3.2%	3.6%	3.8%	3.7%	2.9%	2.4%	2.7%	3.2%		<=3 % N/A >3 %
Temporary Spend ('000s) (D)	21	189	194	169	173	212	355	226	169	141	183	192	229		No Threshold
Staff Turnover (D)	11.4%	10.7%	10.6%	10.4%	9.7%	9.0%	8.7%	9.3%	9.5%	9.8%	10.6%	9.5%	9.8%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) (W)	96.2%	99.5%	99.8%	99.8%	100.1%	98.5%	98.6%	99.9%	99.4%	100.2%	97.2%	99.1%			No Threshold

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF ICP (compliant) • All patients continue to be screened for potential COVID 19 prior to hospital visit using telephone triage • CRF will part of ward accreditation • All Areas have been certified Covid Secure (all actions completed) • SIREN STUDY nominated as good catch to weekly safety meeting	**Highlight** • Mandatory Training > 94% • GCP training 97% • SOP compliance 98% • ANTT compliance 100%-CRF Ward • CRD ICP compliant • Research continues with SIREN study • CRD involved in Trust Quality Rounds • X1 good catch reported with Siren Study **Challenges** • Trust PDR Target of 90% -aiming to achieve this year • Limited storage space on CRF causing H&S risk • Research blood samples for multiple trials • Delays with recruitment to children's vaccine study • 0 incidents reported • CRD report for SQUAC needs review
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience • Plans underway to capture experience patient experience data • Patient compliments received for CRF	**Highlight** • X 0 Complaints or PALS concerns • New Children's PRES developed for 21/22 ongoing • Big conversation events completed • Positive patient story for research celebrated via International Clinical Trials Day **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system
EFFECTIVE	• Studies stratified and selected based on best possible outcomes for children and young people. • Current portfolio regularly reviewed with monthly performance meetings • No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients. • Clinicians encourage children and young people to make informed decisions about participating in studies. • CRD performance reports and meetings restarted to review portfolio • Essential skills training approved for Division	**Highlight** • Important Covid 19 studies remain open within Trust • Site selected for LAVA 2 study and recruited 10% of RTT despite IT challenges (Crit Care) • Siren Study has received NIHR certificate **Challenges** • CRF housekeeping • PHE has reduced LAVA 2 study RT significantly • Trust space for extension of Siren study • Significant issues with recruitment process has delayed backfilling a number of vacancies affecting timely opening of new studies
RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • H&S Covid RA's completed for all areas of research • Coordinated and partnership working with local	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners • Successful applicant from CRF to NIHR CPD course

	providers to offer joint training programmes.	**Challenges** • Storage for site files and equipment is insufficient for research department • Children's vaccines studies have been pulled by sponsor due to safety data
WELL LED	• LTS absence rates have increased, • staff are supported through line managers and staff support. • Engagement with partners in relation to upcoming starting well initiatives. • Recruitment programme was successful with a number of staff appointed to vacancies • Formal one to ones in progress within service re-org • A number of bids submitted from Trust to CRN under contingency funding to support performance with recovery plan.	**Highlight** • Division supporting staff with Flexible working (hybrid model) • Big Conversation event completed with action plan in place • Reduction in CRN funding for 21/22 corrected **Challenges** • Service Re-organisation commenced • LTS numbers increased but SSS has reduced. • CRD overall financial deficit to be reduced following recovery from pandemic

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 29th July 2021

Paper Title:	**Wellbeing Guardian: Dashboard**
Report of:	**Wellbeing Guardian**
Paper Prepared by:	Fiona Marston. Jeanette Chamberlain, Jo Potier and Sarah Robertson

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Slides presented to the Board on 27th May 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

This paper is a follow up as proposed in the presentation to the Board by the Wellbeing Guardian on 27th May 2021, providing an action plan for approval by the Board

2. Background

The Wellbeing Guardian WBG) is a Non-Executive Director who:

There are nine Board principles supported by the WBG and the recommended approach to implementation is:

Phase 1: Health and wellbeing has limited coverage at board level	Phase 2: Principles of wellbeing guardian role are largely embedded	Phase 3: Health and wellbeing is routinely considered and included in board activity
• Undertake NHS Health and Wellbeing Diagnostic to assess current health and wellbeing performance and identify priority activities (Principle 1) • Identify a wellbeing guardian • Agree the priority actions to be included in the wellbeing guardian role description and how the nine principles will be phased in	• Wellbeing guardian role is established and functioning well within the board. • Most of the nine principles are routinely evidenced at board meetings, including reference to supporting equality and inclusion in the workplace. • A holistic health and wellbeing strategy is in place (either standalone or as part of a wider people strategy) and being delivered. • Staff experience measures indicate a compassionate culture is in place or being created.	• All board members routinely consider the holistic health and wellbeing of our NHS people in their strategic and operational plans and performance reporting • The board regularly hears feedback, including in the form of staff stories • All nine principles are being delivered • The NHS Health and Wellbeing Diagnostic Tool dashboard is green

Alder Hey's appointed WBG (Fiona Marston) is working with SALS, Organisational Development and HR to advance the implementation. The Board was advised at the May 2021 meeting that the NHS Health & Wellbeing Diagnostic had been completed and for Alder Hey to formally move to Phase 2 of implementation, priority actions are to be approved by the Board. The Wellbeing Steering Group has created a Dashboard to summarise the action plan for the nine principles supported by the WBG:

ALDER HEY WELLBEING GUARDIAN DASHBOARD					
	WELLBEING GUARDIAN TO SUPPORT	**LEAD**	**PROGRESS**	**STATUS**	**ACTIONS**
Principle One	The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.	SALS	• Burn Out Briefing in June 2021 to raise awareness. • Work to address 'hygiene' factors • Sharing themes and hotspots with Wellbeing Guardian in SALs meetings.		Working to ensure this is embedded: • Development of SALs PALs • Targeted work on Burn Out • Offering SALS sessions to teams • Offering SALS drop-in sessions to hard to reach areas, e.g. facilities & community locations
Principle Two	Where an individual or team is exposed to a particularly distressing clinical event, board time should be made available to assure the board and the wellbeing guardian that the wellbeing impact on those NHS staff and learners has been checked.	SALS	• Ground TRUTH feedback slot agreed with Execs in June • Support for organisation wide debriefing from September • Listening events with leads in each division being arranged		Delivering this through: • Listening events • Ground TRUTH feedback to Execs • Team by team debriefing • Debriefing after traumatic clinical incidents. • Reflective practice spaces
Principle Three	Regular assurance will be provided to the wellbeing guardian to ensure that wellness induction (previously wellbeing 'check-in') is being provided to all new NHS people on appointment and to all learners on placement in the NHS, as outlined in the 2019 NHS Staff and Learners' Mental Wellbeing Review's recommendations.	Jeanette Chamberlain /SALS	JC & SALS to action		Delivering this through: Health & Wellbeing conversations offered to all new staff and learners as part of their induction (first 100 days)
Principle Four	The wellbeing guardian will receive assurance that all our NHS people and those learning in the NHS have ready access to a self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.	• SALS • Alder Centre • Occ. Health • Clin. Health Psychology • Care First	• Wellbeing. Guardian a member of the Wellbeing Steering Group and • Attends alternate SALs meeting		Delivering this through: • Wellbeing Steering Group • SALS. Meetings • Continue to offer attendance at departmental and team meetings when asked to do so

Principle Five	The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian	Executive (Operations & HR)	Under discussion		• Establish the appropriate processes • Understand who will be involved and their roles
Principle Six	The NHS will ensure that all our NHS people and learners have an environment that is both safe and supportive of their mental and psychological wellbeing, as well as their physical wellbeing	• SALS • Wellbeing Steering Group • Academy links	Delegated authority from the Board and encompasses: - Physical safety and - Psychological safety		Requires further discussion to assess from: • Staff survey and • People Pulse data • Doctors in Training outcomes from listening events. • HWB diagnostic and gaps in physical health • Bespoke listening events e.g. Menopause, Disability:Seen and Unseen • Other (TBC)
Principle Seven	The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.	• EDI lead • Supported by Chaplaincy, Comms	To be developed by the EDI lead		EDI lead with SALS/Wellbeing Steering Group • Bespoke listening events for staff with disabilities both seen and unseen already taking place to support EDI lead when they come into role
Principle Eight	The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).	• EDI lead • Supported by HR/SALS	• BAME Taskforce events • Disability listening event (29th June 2021)		• EDI lead to input on appointment • BAME taskforce outputs and establishment of networks. • Outputs of Disability listening event • Listening events for others of the nine groups
Principle Nine	The wellbeing guardian will provide suitable challenge to the board to be assured that the organisation is working with system leaders and regulators, to ensure that wellbeing is given the same weight as other aspects in organisational performance assessment	Wellbeing Guardian	Board review July 2021		Board approval of actions and progress review timetable

The action plan will result in progressive implementation of the nine principles of the Wellbeing Guardian and the Board is asked to:

(i) Review and provide feedback on the format of the Dashboard
(ii) Approve the actions planned described in the Dashboard
(iii) Consider and approve the proposed frequency of formal presentation by the Wellbeing Guardian to:
   a. People & Wellbeing Committee quarterly and
   b. The Board annually

These reviews will be a formal opportunity for the PAWC and Board to review, discuss and influence the ongoing activities of the Wellbeing Guardian. It is assumed this will be alongside less formal ongoing review of progress towards full implementation of the nine principles

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

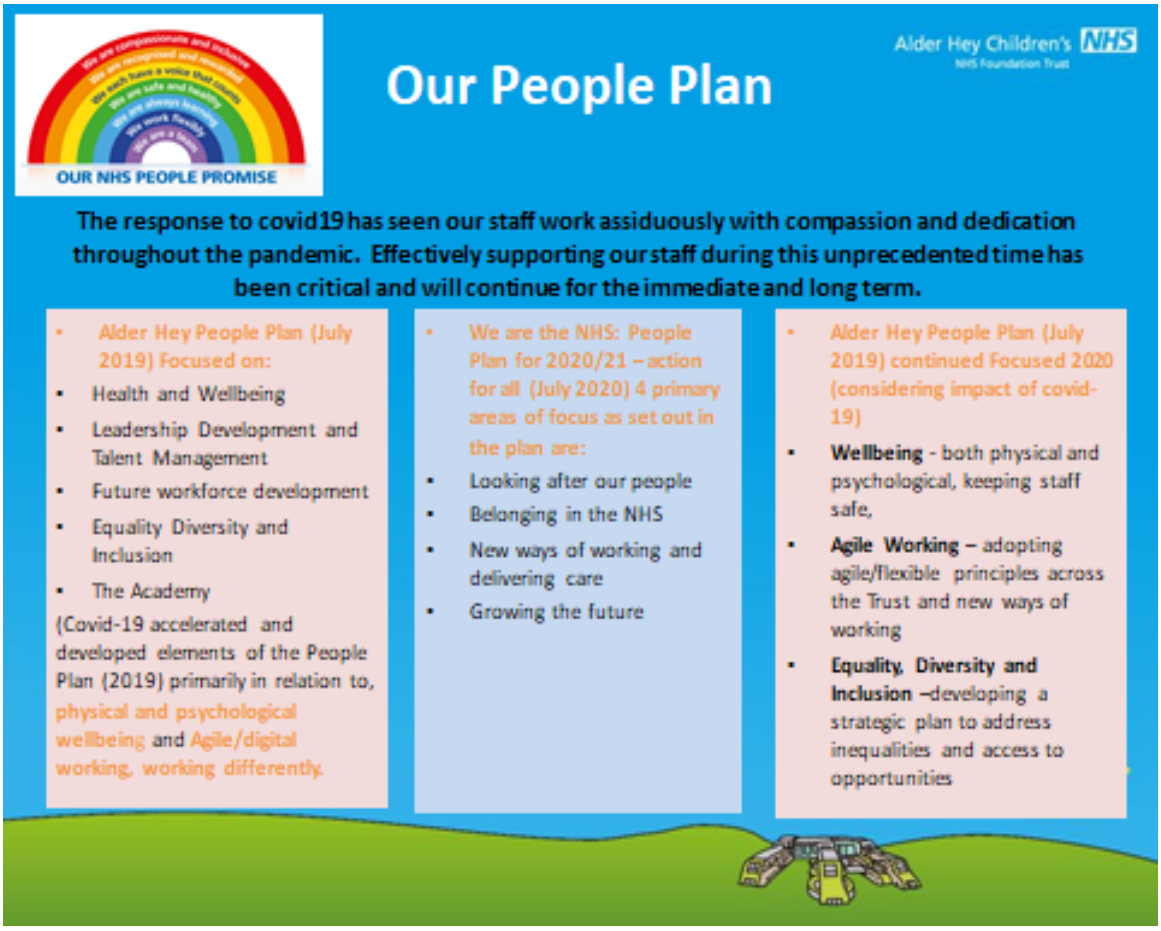
Thursday 29th July 2021

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

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

1. Purpose

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



1. Wellbeing

1.1 Staff Advice and Liaison Service

The Staff Advice and Liaison service has continued to remain busy and we have had over 1515 contacts to the service. Whilst really busy the team are still able to respond quickly (within 24 hours) to any new referral which comes via e mail, phone call or drop in. For information purposes the main themes that staff are experiencing are:

- Burnout
- Staff in Crisis (Presenting with suicidal ideation)
- Development or management of OCD
- Long Covid symptoms
- Trauma
- Workplace Issues
- Relationship issues within workplace
- Isolation due to COVID and lockdown
- Bereavement
- Supporting staff on Long Term sick and facilitating a return to work and often undertaking Stress Risk Assessments
- Supporting staff through formal employment processes
- Domestic Abuse

There has been a significant increase in contacts to the service regarding burnout which lead to the team delivering a session at the Trust briefing on the topic. We are also now a research site for a burnout intervention for staff and are working on developing evidence-based interventions that we can offer out to the organisation. Having an active and growing wellbeing and general coaching group connected to SALS has been crucial in being to offer a range of support to staff who are concerned about burnout. Our Strong Foundations programme also provides additional opportunities for us to discuss this amongst our leaders and managers and offer support to those who may need it.

The team have also been providing additional support to ED given the additional pressures on them and the impact on staff health and wellbeing. This has included SALS drop ins in ED, virtual support sessions for consultants and senior leads, facilitating Wingman on Wheels and a massage van for staff. The team are also supporting the development of a Pastoral Care Volunteer team who will be offering additional support to staff via additional drop ins to facilitate the use of the Ground TRUTH tool (as per the model developed during the third wave in ICU).

The team have also been responding to requests from groups of staff or service areas to provide listening events. A number of listening events have been delivered over the past month including an event for staff with seen and unseen disabilities, an event for operational managers in the Medicine Division, a menopause event, a listening event for the Booking and Scheduling Team and two sessions for redeployed theatres staff. Outcomes of these events are being collated for feedback to relevant areas and via the new monthly Ground TRUTH sessions at the execs team meetings.

SALS also offers debriefs following clinical incidents and have provided several over the past month following particularly traumatic incidents which have occurred in ED and CAMHS. This has led to the development of a debrief model with NWAS who are keen to develop a closer partnership with Alder Hey staff support following traumatic incidents.

In addition to these core activities, SALS will be providing team based debriefs for the whole organisation starting the autumn and using the Ground TRUTH tool as a framework, enabling feedback of core themes and focus on actions at the monthly Ground TRUTH session at execs, and communication to the wider organisation via a Ground TRUTH bulletin. The first team to be debriefed using this model will be the executive team.

In terms of external facing activity, the team facilitated and very successful session at the recent Cheshire and Merseyside Partnership People Summit in June titled '*Flourishing in adversity; A showcase of staff engagement at Alder Hey'.* We also presented to the judges as finalists in the HPMA Browne Jacobson staff engagement award and are awaiting the outcome. The team have also been invited to present the work around staff engagement as part of a national NHS Employers webinar on 15th July.

1.2 Health Wellbeing Steering Group

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

- Financial wellbeing
- Staff Survey and the Big Conversations
- Health and Wellbeing conversations
- Menopause support
- Wellbeing Guardian role
- Health & Wellbeing Champions/SALS Pals

- Schwartz Rounds and Team Time

A smaller Wellbeing Action Group, comprising SALS, comms and the Wellbeing Guardian, has now also been established to develop and monitor action plans and work on specific tasks. Work is underway to agree priority areas around the Wellbeing Guardian 9 principles, including a focus on HWB conversations at induction, and ensuring that the needs of underrepresented groups are understood and attended to.

In terms of the Schwartz programme, the Schwartz steering group continues to meet monthly and has established a 12-month calendar of organisation wide Rounds. We are also in the process of identifying 30 additional facilitators (focussing on Nurses and AHPs) to join the 11 staff already trained to join the wider team and also enable the roll out of Team Time across the Trust. The Schwartz lead for Alder Hey is also in the process of being trained as a Schwartz Mentor to support the development of Schwartz both regionally and nationally.

Equality, Diversity & Inclusion

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

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

2. Flexible Working

The Trust continues with its roll-out of hybrid working; a policy framework in in development with staff side colleagues, and training and awareness sessions will be held with managers in July to support the management of hybrid teams.

3. Staff Availability

Table 1- Sickness position as of 14th July 2021

	Trust		Community		Corporate		Medicine		Research		Surgery	
Reason	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff
Non Covid Related Sickness	4.96%	197	3.75%	26	6.16%	44	4.49%	54	6.35%	4	5.33%	69
Covid Related Sickness	0.35%	14	0.14%	1	0.56%	4	0.42%	5	0.00%	0	0.31%	4
Absence Related to Covid - not inc sickness	0.68%	27	0.14%	1	0.42%	3	0.91%	11	0.00%	0	0.93%	12
Absence Related to Covid Inc Sickness	1.03%	41	0.29%	2	0.98%	7	1.33%	16	0.00%	0	1.24%	16
All Absence (total of above)	6.00%	238	4.03%	28	7.14%	51	5.82%	70	6.35%	4	6.56%	85

Compared to the same time last month, overall sickness has continued to increase slightly with the numbers of staff absent with COVID related absence doubling, which is reflective of the increasing rate of infections in the North West. Staff have been reminded to be vigilant and we will continue to follow all safety measures across the organisation. Absence will be monitored closely for any emerging trends/hotspots.

The workforce availability meeting that was launched during the pandemic will be re-launched in July, the purpose of which is to ensure immediate organizational oversight of staffing pressures, to be able to readily respond to meet activity needs.

Governance and Ongoing Business

3.1 Case Management

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

In July 2021 there are 17 cases currently ongoing. This is a decrease of 8 cases since June 2021.

Table 1- Employee Relations Activity Per Division as of 16th July 2021

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery H/C 1326	1	2	5	1	2	0	0	**11**
Medicine H/C 1223	1	1	1	0	0	0	0	**3**
Community H/C 687	1	1	0	0	0	1	0	**3**
Corporate & Research H/C 695/65	0	0	0	0	0	0	0	**0**
Grand Total	**3**	**4**	**6**	**1**	**2**	**1**	**0**	**17**

3.2 Training

As of the 15th July 2021, Mandatory Training was at 88% overall, 2% below the Trust target of 90% where it has remained for the last 2 months. We continue to work with staff, managers and SMEs to encourage improvements in compliance.

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

Since the last update we have seen our Estates and Ancillary staff group compliance increase by a further 8%, taking them to 68% overall and are working with our subject matter experts to continue to identify ways we can support this staff group in particular to improve compliance as they struggle to utilise the e-Learning offerings available. Some of the ways we are addressing this include bespoke recorded sessions and support for managers to facilitate

topics as well as socially distanced bespoke face to face sessions for staff delivered by our subject matter experts.

In terms of Resuscitation training there has been a small increase in compliance in the PLS/APLS Annual update but a small decrease in the Basic Life Support compliance. The Resuscitation team are working closely with the Nursing leads across the organisation to improve compliance and ensure staff are booked into the appropriate sessions.

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

Table 3- Mandatory Training compliance 15th July 2021

Trust	Overall Mandatory Training	Change (Since Last Report)
Trust	88.02%	-0.06%
Division	**Overall Mandatory Training**	**Change (Since Last Report)**
411 Alder Hey in the Park	86.49%	+10.55%
411 Community	92.37%	+0.64%
411 Corporate Other Department	87.33%	+0.48%
411 Facilities	67.96%	+8.16%
411 Finance	89.58%	+1.38%
411 Human Resources	89.13%	+0.32%
411 IM&T	93.70%	-0.67%
411 Innovation	96.74%	+19.29%
411 Medicine	87.74%	-1.01%
411 Nursing & Quality	91.19%	+1.42%
411 Research & Development	94.14%	-2.02%
411 Surgery	87.69%	-0.88%

Table 4 – PDR Compliance as of 15th July 2021

There are just over 2 weeks left of this year's appraisal window which is due to close on the **31st of July 2021**. The current Trust completion rate is just over 30% (as below) significantly below target. Managers and teams have been forwarded regular reminders to ensure that not only are these undertaken but recorded in ESR before the end of July.

Org L2	Assignment Count	Reviews Completed	Reviews Completed %
411 Alder Hey in the Park	22	0	0.00%
411 Community	628	217	34.55%
411 Corporate Other Department	55	16	29.09%
411 Facilities	199	10	5.03%
411 Finance	77	7	9.09%
411 Human Resources	72	39	54.17%
411 IM&T	114	33	28.95%
411 Innovation	9	0	0.00%

411 Medicine	1,009	297	**29.44%**
411 Nursing & Quality	81	12	**14.81%**
411 Research & Development	61	42	**68.85%**
411 Surgery	1,047	314	**29.99%**
Grand Total	**3,374**	**987**	**29.25%**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 29th July 2021

Paper Title:	**Appraisal and Revalidation Update July 2021**
Paper Prepared by:	Helen Blackburn, Medical Appraisal & Revalidation Manager

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☒ ☒ ☐
Background Papers and/or supporting information:	N/A	
Action/Decision Required:	To note To approve	☒ ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	☐ ☒ ☐ ☐ ☒
Resource Impact:		
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.	

1. Introduction

The purpose of this paper is to provide an update to Board on the uptake / current status of appraisal and revalidation for medical staff.

A total of 339 clinicians require an appraisal during 2021.

2. Background

The Trust implemented a new appraisal system L2P in January 2021. Following discussions with the Responsible Officer and Appraisal Lead the decision was made to move appraisal dates to clinician's birth months.

The benefit of this approach is it allows appraisers to spread the number of appraisals across the year rather than undertaking them all between September and January, as was our previous practice.

(For reference, a sample audit of the appraisals will take place throughout the year to ensure quality and consistency).

3. Position (as at mid-July 21):

Appraisals for Consultants and SAS Drs

Month	Total number	Completed	Outstanding	% completed
Jan-21	21	19	2	90
Feb-21	23	20	3	86
Mar-21	31	30	1	97
Apr-21	21	17	4	79
May-21	30	25	5	84
Jun-21	26	12	14	53
Jul-21	50	12	38	24
Aug-21	21	0		
Sep-21	36	0		
Oct-21	31	0		
Nov-21	29	0		
Dec-21	20	0		
	n=339			

Revalidation Overview:

Year	Numbers due	Submitted	Pending	Deferred
Due 2021	94[1]	34	60	9[2]
Due 2022	43			
Due 2023	61			

[1] *noting that many of these were deferred from last year
[2] due to insufficient evidence, number of appraisals or MSF. 1 due to on-going process

3. Discussion / To note

The new appraisal system has been well received. The change from the previous appraisal window to birth months has been challenging for some clinicians due to workload/capacity.

Although there appears to be a high number of incomplete appraisals, most meetings have taken place and they are awaiting sign-off.

There have been five GMC letters sent to consultants, four of which have been acknowledged. The outstanding respondent is being pursued.

Two second GMC letters have been sent and both parties now have plans in place to undertake their appraisals soon.

Recently there has been several resignations from appraisers due to lack of time, not in their job plan, or illness. An appraiser's course will take place on 7th October. Emails have been sent to clinical service leads to identify team members to undertake the training.

4. Recommendations

Consideration needs to be given to consistently including the role of appraiser in job plans as there appears to be variance in this respect across the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 29th July 2021

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

The development and support of the FTSU Champions, is underpinned by the new guidance published by the National Guardians Office

https://nationalguardian.org.uk/wp-content/uploads/2021/04/Guidance-on-Champions-and-Ambassador-Networks-2021.pdf

This new guidance sets out principles for the development and support for FTSU Champions networks and for the first time specifically recommends a clear distinction between the roles of champion and guardian and that **'only FTSUG's having received NGO training and registered on the NGO's public directory, should handle cases'.** Where Champions have been handling cases organisations are required to implement refreshed arrangements within a year of publication of the guidance. In Alderhey, FTSU Champions have never handled cases and therefore no change is required.

We are committed to developing a FTSU Champion network that is diverse and representative of our organisation .During the last recruitment drive we have had some success with the recruitment of staff who are reflective of our diverse organisation, however in order to ensure that we are fully representative, we are creating a confidential FTSU Champion profile, in order to review and monitor this data to identify gaps and recruit accordingly.

4. Communication Plan

With the introduction of the newly appointed FTSU Champions within the Trust, working with the Internal Communication team, we are looking to promote the champions by doing a small biography on each of them, with a picture, so that staff recognize them and know who to go to should they need too.

Whilst staff are going to continue to work from home completely or partially, we are looking to promote the role of the FTSU Guardian/Champions, so that staff, whether working from home or on site, know that there is someone there who will listen to their concerns and raise them, should that be required and that we, as the FTSU team, will be as flexible as our new ways of working are.

During the pandemic it has been difficult for the FTSU Guardian to be visible, this however this needs to change, as their visibility is an excellent way to promote FTSU. The ability to 'floor

walk' cannot be underestimated, not only does it give the FTSUG the ability to see 'what's really going on' and promote the role of the guardian and the champions, but, most importantly, it allows staff to approach them, without leaving their ward/department, time is often a blockage to raising concerns, by going to them, we remove the obstacle.

October is Speak Up Month, the focus this year is on the National Guardians Office, E-Learning modules, Speak Up, Listen Up, Follow Up. It is the proposal of the FTSUG that we link with the Quality Hub and internal communications, to promote throughout the organisation, further in order to further understand what barriers staff feel get in the way of them raising concerns and to also understand what quality improvements could be made to aid the principles of FTSU and embed the concepts of a Just Culture

5. FTSU TRAINING

Uptake of the NGO E-Learning modules, Speak Up, Listen Up, remains low within the organisation and should therefore remain an area of concern. Feedback from staff that have completed the FTSU modules, has been positive, see below

Regarding the Speak Up training, I thought it was brilliant, pitched at the right level so that it's easily accessible for everyone. And again, the Listen Up, pitched well for managers. It just gets you thinking, makes you reflect on your own values and behaviour's.

I think these eLearning packages should be mandatory because while they're voluntary, it will always be the people who are more inclined to already have these values, who will want to access it and the ones that don't believe in it, won't think it's for them.

Vivienne Irwin
Specialist Speech and Language Therapist
Alder Hey Children's NHS Foundation Trust

In terms of promoting the NGO modules, the FTSUG would like to propose that the first module be included in the Induction programme, which would ensure that all new starters were given the opportunity to complete the Speak Up training.

Further promotion of the training will continue via the FTSU Guardian and Champions, through their regular contact with staff.

6. FTSU INDEX

The Freedom to Speak Up (FTSU) Index can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

This year, a new question (18f) was included in the NHS Staff Survey, asking workers if they feel safe to speak up about anything that concerns them within their organisation, however, this question has not been included in the FTSU Index scores to enable comparability to previous years

Alderhey was in the top 10 trusts with the greatest overall increase in their FTSU Index, being the 4th highest with a result of 81.7% an increase of 4.4 %, we were also above average in our response to question 18f, with 72.8%, the national average being 65.6%.

This increase would suggest an increased strength in the positive culture of speaking up.

7. Guardian Report content

There were 4 cases submitted to the NGO for Q1, numbers reported for this period are low, however consideration should be given to the absence of the FTSUG for a period of 6 weeks. Whilst this absence was covered by the champions, it could possibly indicate that there is a need to ensure that staff are aware of who the FTSU Champions are and that staff are safe to reach out to them, should they require, this need has been taken into consideration when reviewing our communication plan and role of the champion.

All 4 cases were raised with the right to anonymity wavered, 3 were related to process and 1 to patient safety, there 3 relating to safety have been closed, with learning identified, the 1 relating to patient safety remains open however there is a follow meeting scheduled with the potential to close this case.

Feedback to the FTSUG from those raising concerns is that they would use the service again and have scored the process high.

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Kerry Turner
July 2021

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday 29th July 2021

Report of	Director of Corporate Affairs
Paper prepared by	Governance Manager
Subject/Title	Directors' Register of Interests 2020/21
Background papers	Managing Conflicts of Interest in the NHS - K:\Executive Team\Declarations of Interests and Gifts and Hospitality Registers\NHSE guidance-managing-conflicts-of-interest-nhs[1].pdf
Purpose of Paper	The purpose of this paper is to provide the Board with the Register of Directors' Interests 2020/21
Action/Decision required	The Board is requested to receive and note the Register of Directors' Interests 2020/21
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Robust corporate governance arrangements support the achievement of all Trust Strategic Objectives: ➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

1. Executive Summary

This paper provides the current Register of Directors Interests. Updates to the register are provided to the Board at annual intervals, and in line with the Trusts Declaring Conflicts of Interest and Gifts and Hospitality Policy. Directors have a responsibility to inform the Director of Corporate Affairs when a new interest arises.

2. Current position

The Codes of Conduct and Accountability for NHS Boards, require the declaration of Board Members' and Directors' interests and the maintenance of a register of interests. This is reinforced through the Trusts Standing Orders.

The Board has a clear view that it aspires to the highest standards of probity and governance. Setting out publicly its Declarations of Interests makes it clear to key stakeholders, commissioners and the public that the Board aims to meet these standards and ensure good conduct in public business.

3. Recommendation

The Board is requested to note the Directors Register of Interests attached at appendix A.

Alder Hey Children's NHS
NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS
2020/21

	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Fiona Beveridge (Non-Executive Director)	**Name of organisation**: University of Liverpool **Relationship:** Pro Vice Chancellor **When did business interest begin:** **How is this relevant to the Trust:** University	
Kerry Byrne (Non-Executive Director)	**Name of organisation**: South Lakes Housing. **Relationship:** Non-Executive Director. **When did business interest begin:** **How is this relevant to the Trust:** No conflicts of interest.	
Lisa Cooper (Director of Community and Mental Health Services)	**Name of organisation**: Empower the Invisible Project. **Relationship:** Ambassador for the project. **When did business interest begin:** **How is this relevant to the Trust:** Supports adults who have had experience of abuse.	
John Grinnell (Director of Finance/Deputy Chief Executive)	**Name of organisation:** Play World Ltd. **Relationship:** Company Secretary (no dealings with hospital) **When did business interest begin:** 2007 **How is this relevant to the Trust:** Indoor Children's Play Centre	
Anita Marsland (Non-Executive Director)	**Name of organisation:** Unique Health Solutions. **Relationship:** Director and Owner.	

	When did business interest begin: May 2012. **How is this relevant to the Trust:** Healthcare Consultancy. **Name of organisation:** The Reader. **Relationship:** Chair of the Board of Trustees at the Reader. **When did business interest begin:** **How is this relevant to the Trust:** No conflicts of interest. **Name of organisation:** Public Health England. **Relationship:** Local Government Advisor. **When did business interest begin:** September 2012. **How is this relevant to the Trust:** Executive agency of the Department of Health and Social Care. **Name of organisation:** South Sefton CCG. **Relationship:** Independent Chair of Sefton Transformation Board. **When did business interest begin:** September 2018. **How is this relevant to the Trust:** NHS organisation. **Name of organisation:** Sefton ICP. **Relationship:** Independent Chair of the Programme Delivery Group. **When did business interest begin:** **How is this relevant to the Trust:** Integrated care partnership. **Name of organisation:** Calderstones Mansion Community Interest Company. **Relationship:** Director and Chair.	

	When did business interest begin: **How is this relevant to the Trust:** No conflicts of interest.	
Fiona Marston (Non-Executive Director)	**Name of organisation**: Liverpool School of Tropical Medicine **Relationship:** Independent Business Development Consultant. **When did business interest begin:** **How is this relevant to the Trust:** University. **Name of organisation**: Liverpool School of Tropical Medicine. **Relationship:** Royal Society Entrepreneur in Residence at Liverpool School of Tropical Medicine. **When did business interest begin:** **How is this relevant to the Trust:** University **Name of organisation**: CEIDR Innovation **Relationship:** Director **When did business interest begin:** **How is this relevant to the Trust:** CEIDR Innovation is a partnership between LSTM and the University of Liverpool. **Name of organisation**: RFM Associates **Relationship:** Partnership for consultancy work. **When did business interest begin:** **How is this relevant to the Trust:** **Name of organisation**: UK12S **Relationship:** Advisor **When did business interest begin:**	

	How is this relevant to the Trust: Investment company.	
Nicki Murdock (Medical Director)	**Name of organisation**: Health Leaders Australia. **Relationship:** Chair of Health Leaders Australia. **When did business interest begin:** 2021. **How is this relevant to the Trust:** This organisation works in health education.	
Shalni Arora (Non-Executive Director)		✓
Nathan Askew (Chief Nurse)		✓
Adam Bateman (Chief Operating Officer)		✓
Alfie Bass (Director of Surgery)		✓
Urmi Das (Director of Medicine)		✓
Claire Dove (Non-Executive Director)		✓
Mark Flannagan (Director of Communications)		✓
Adrian Hughes (Deputy Medical Director)		✓
Dani Jones (Director of Strategy and Partnerships)		✓

Claire Liddy (Managing Director of Innovation)		✓
David Powell (Development Director)		✓
Ian Quinlan (Vice Chair/Non-Executive Director)		✓
Erica Saunders (Director of Corporate Affairs)		✓
Louise Shepherd (Chief Executive)		✓
Melissa Swindell (Director of HR and OD)		✓
Dame Jo Williams (Trust Chair)		✓
Kate Warriner (Chief Digital and Information Officer)		✓

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 29th July 2021

Paper Title:	**Board Assurance Framework 2020/21 (June)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

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

Board Assurance Framework 2020/21

1. Purpose

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

A properly used BAF will drive the agendas for the Board and its Committees.
The board assurance committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.
The newly formed Care Delivery Board (monthly Risk Management Meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

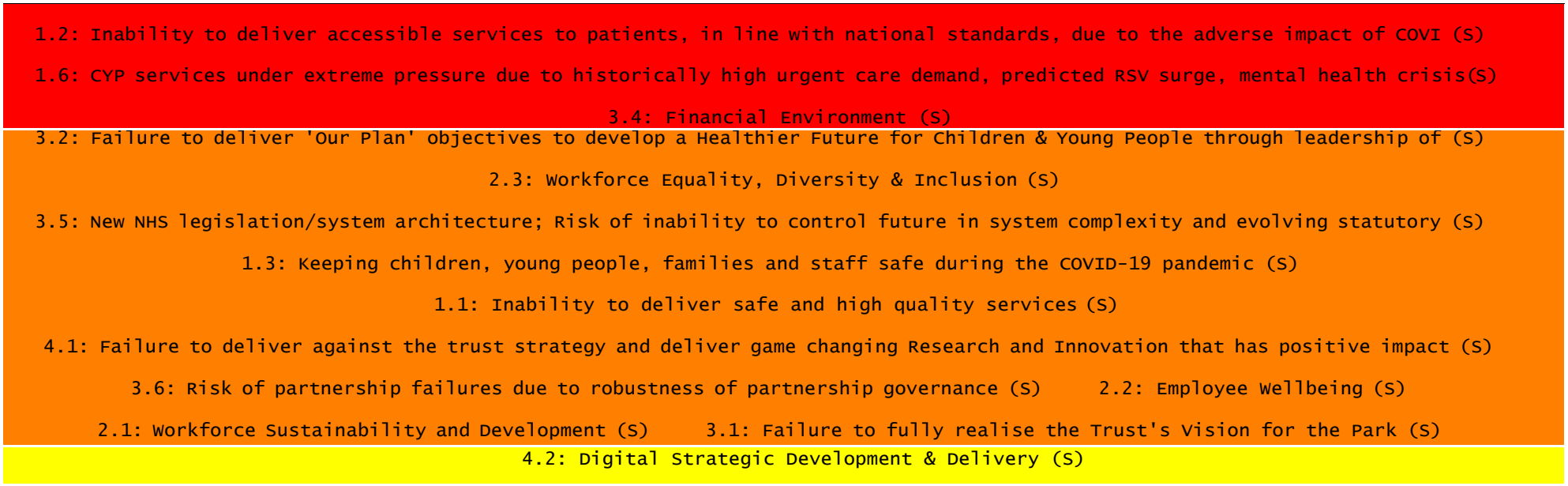
2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high quality services	Safety & Quality Assurance Committee
1.2	Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic	Safety & Quality Assurance Committee
1.6	CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID.	Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.	Resources and Business Development Committee
3.6	Risk of partnership failures due to robustness of partnership governance	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Innovation Committee
1.3	Keeping children, young people, families and staff safe during COVID-19 ***Risk 1.3 has been superseded by BAF risk 1.6 and therefore will be removed from the next iteration of the Board Assurance Framework Report.***	Trust Board

3. Overview at 14th July 2021

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



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

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

4. Summary of BAF - at 14th July 2021

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

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

5. Summary of June updates:

External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ).***
  Risk reviewed; no change to score in month. Progressing implementation of C&M CYP programme. System-wide RSV surge plan under finalisation.

- ***New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  *New risk.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  *New risk.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Actions progressing against plans. EDI Lead appointed.

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB).***
  In June recovery has continued at high levels: 105% for outpatients and 112% for elective care. The number of patients waiting over 52 weeks is stable. In June we have observed an increase in staff isolating and pressures on staff availability in some teams, such as ODAs in theatres. We have subsequently reduced our planned levels of additional sessions in July and August to support staff rest. There remains very high pressure in the ED. A number of operational and clinical actions have been taken. In the short-term we have changed our triage process, allocated a member of the ACT team to the department and prioritised nurse staff allocation to the ED. In the medium term we have agreed investment in consultant general paediatrics and additional junior doctors to support an increase in staffing levels to help manage current demand plus RSV surge.

- ***Keeping children, young people, families and staff safe during COVID-19 (JG).***
  BAF risk 1.3 has been superseded by BAF risk 1.6. This risk will be closed in the following iteration of the BAF.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (JG).***
  *New risk. Urgent care is under significant pressure and RSV levels are rising, coupled with some staffing areas of fragility. Gold Command structure has been triggered both internally and via Cheshire and Merseyside.

- ***Inability to deliver safe and high quality services (NA).***
  This risk has been reviewed and completed actions updated. The quality hub has developed robust plans for each of the projects associated with gaps in assurance, the work on these will commence from July and the BAF will be updated accordingly to reflect progress

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

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Cost estimates are under review ahead of the RABD meeting which takes place on the 26.7.21.

- ***Digital Strategic Development and Delivery (KW).***
  BAF reviewed, good progress.

- ***Workforce Sustainability and Development (MS).***
  Action plans progressing. Some actions amended in light of the need to respond to current pressures (COVID, accelerator, RSV)

- ***Employee Wellbeing (MS).***
  Risk reviewed and updated to reflect updated ED support plan, Ground TRUTH sessions @execs and establishment of Wellbeing Action group. No change in risk rating due to ongoing impact of Covid, increased risk of burnout and ongoing uncertainty around likely future impacts of this pandemic.

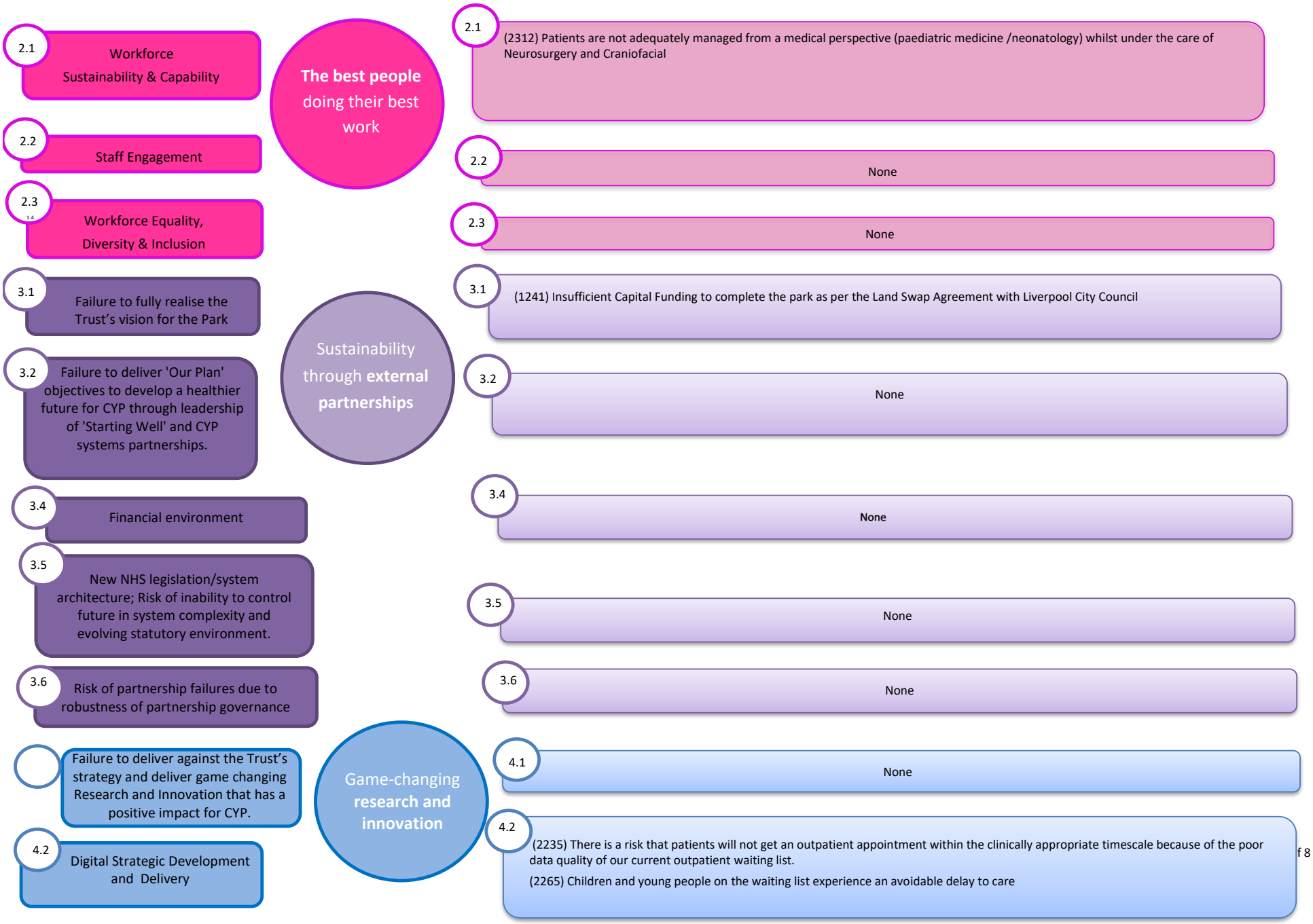
- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  JULY 21 - Risk review static.

Erica Saunders
Director of Corporate Affairs

Appendix A

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

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	1.1 (1560) New patients referred to CAMHS Liverpool may breach 18 week referral to treatment target. (2183) Staff, patients and the public will not be able socially distance whilst waiting in ED. (2230) Ten-fold medication errors resulting in serious harm to patients. (2233) Failure to meet QST Major Trauma peer review standards. (2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list. (2265) Children and young people on the waiting list experience an avoidable delay to care (2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial (2326) Delayed diagnosis and treatment for children and young people. (2332) Inadequate provision of service delivery if agreement cannot be reached by two main providers of paediatric cardiology care over how best to provide a 'joint approach' to service provision. (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Risk of negative impact on the mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation. (2384) Infection Control Risk – Risk of infection from spores to the children post op cardiac surgery. (2410) : Limited access to primary care and community based services for patients, which results in attendance to the Emergency Department. This means that we are unable to deliver the standard of care to our patients that is required. (2414) New referrals not being triaged timely, non-complaint with RTT pathway. Follow up patients not receiving appointments in detailed time frame, cohorts being lost to follow up due to lack of oversite. Patients not able to receive Laser treatment due to lack of training and knowledge of current team. Patients not able to receive Laser treatment timely due to availability and capacity of current team. Changed from Divisional level on the 19.5.21. (2434) Failure to meet the 90% target compliance for Trust wide Resuscitation Training in line with Mandatory Training Policy - E21. (2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available Monday to Friday. Patients may not receive the treatment they require or may experience a significant delay based on service availability. (2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval.
1.2 Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19, a surge in urgent care and an RSV epidemic.		1.2 (2233) Failure to meet QST Major Trauma peer review standards.
1.3 Keeping children, young people, families and staff safe during COVID-19		1.3 None
1.6 CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of Covid.		1.6 None


2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
2.2
None
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships.
3.4
Financial environment
3.5
New NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.
3.6
Risk of partnership failures due to robustness of partnership governance
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
None
3.4
None
3.5
None
3.6
None
Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP.
4.2
Digital Strategic Development and Delivery
Game-changing research and innovation
4.1
None
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: 2235, 2233, 2183, 2332, 2312, 2265, 2384, 2414, 2383, 1560, 2434, 2230, 2436, 2441, 2326, 2410		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alignment of workforce plans across the system	31/03/2021	Action captured within BAF risk 2.1
The 72hr review process will be followed for all patients who do not receive their antibiotics within the timeframe to identify themes, trends and any trust wide learning which will lead to improvement in compliance with this standard	01/07/2021	
The Trust will form a complex children programme board to improve the safety and experience of mental health patients within the Trust. Workstreams will be directed by service need and monitored through CQSG	02/08/2021	
The Quality Hub will work with the Trust Medication Safety Group to identify areas for improvement across a range of areas relating to prescribing, dispensing and administration	01/09/2021	

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

Executive Leads Assessment

June 2021 - Nathan Askew
This risk has been reviewed and completed actions updated. The quality hub has developed robust plans for each of the projects associated with gaps in assurance, the work on these will commence from July and the BAF will be updated accordingly to reflect progress

May 2021 - Nathan Askew
Risk reviewed and updated to include progress on the roll out of the DMS and compliance with policy and guideline documents which will be completed by the end of May.
Recent issues relating to correct site surgery, marking and pre operative checking procedures have been captured as gaps in assurance. Work continues through the quality priorities to address the other gaps in assurance and reporting processes developed through CQSG and SQAC in relation to these programs of work.

April 2021 - Nathan Askew
Risk has been reviewed. Control updated and gaps in assurance articulated. Risk has been updated following SQAC review

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

4. Provide additional capacity by sourcing capacity from the independent sector

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Alder Hey is one of five children's hospitals forming part of the "accelerator" programme, which aims to clear NHS backlogs at pace. The programme aspires to short-term delivery of 120% pre-Covid activity levels coupled with a legacy that will offer long-lasting sustainable benefits. Delivery in the 5 priority specialties to commence from July 2021.	30/09/2021	The Trust completed and submitted a data collection template detailing its accelerator schemes and costings and included activity projections/trajectories. The central accelerator team have submitted the full business case to NHS England using the trusts' completed data collection templates as a basis, which is currently awaiting final approval. The Trust prepared a position paper outlining the financial and activity impact of the elective recovery fund (ERF) and accelerator. The paper included details of the proposed accelerator schemes and their costs. Approval was given to proceed with the schemes with immediate effect.
Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training.	09/07/2021	The IP RTT, planned, watchful wait and non-RTT waiting lists have been successfully implemented under release 2.1 and provides full visibility of patients waiting for treatment. The feedback from the operational teams has been very positive regarding the new waiting list, which is deemed to have a very high degree of integrity. The new OP waiting lists (RTT, follow-up, non-RTT) are in development and are due to be tested the last week in June with a view to implementation at the end of June or early July 2021. A clinical harm SOP has been signed off and is currently being used to ensure that all long waiters have a clinical review undertaken (and a full harm review where indicated). The national outcome codes have been implemented on Meditech and the ePPF updated with the new codes. Training has been rolled out to all staff and compliance is currently being monitored. A data quality dashboard has been developed and the high priority indicators have been populated on the dashboard and are currently undergoing testing.
12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce	07/12/2020	All specialties provided with backlog recovery data as part of the 2021-22 annual planning process
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.	30/07/2021	
RSV preparedness plan to be finalised with comprehensive arrangements and analysis that covers demand, escalation, staffing and resources	30/06/2021	

Executive Leads Assessment

0 - No Reviewer Entered

July 2021 - Adam Bateman
In June recovery has continued at high levels: 105% for outpatients and 112% for elective care. The number of patients waiting over 52 weeks is stable.

In June we have observed an increase in staff isolating and pressures on staff availability in some teams, such as ODAs in theaters. We have subsequently reduced our planned levels of additional sessions in July and August to support staff rest.

There remains very high pressure in the ED. A number of operational and clinical actions have been taken. In the short-term we have changed our triage process, allocated a member of the ACT team to the department and prioritised nurse staff allocation to the ED. In the medium term we have agreed investment in consultant general pediatrics and additional junior doctors to support an increase in staffing levels to help manage current demand plus RSV surge.

June 2021 - Adam Bateman
There has been a reduction in the number of children waiting over 52 weeks for treatment from 283 in April to 230 in May. This improvement has been driven by high levels of recovery in outpatients (113%) and elective care (107%).

The national accelerator programme will provide additional capacity through investment in equipment and staffing levels and additional sessions. We expect an additional 4,000 patients to receive treatment through this programme.

There is a threat to elective capacity in Q3 and Q4 as an RSV epidemic would see a surge in attendances and hospitalisations that would put pressure on hospital capacity and contract elective care.

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Keeping children, young people, families and staff safe during the COVID-19 pandemic		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: 2170		
Exec Lead: John Grinnell	Type: External,	Current IxL: 4x3	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Trust Board

Risk Description

There are risks to the physical and psychology safety and wellbeing of children and young people, and staff as a result of the effects of COVID-19.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19/ Winter Plan agreed and being deployed	Winter 2020 Plans
Work programme on keeping our staff safe enacted	
Track record of implementing adult intensive care.	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
24/7 CAMHS crisis line in-situ	Staff rota
Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative	
Continued to update vulnerable shielding patients with guidance and support as per government advice	
Face masks introduced for staff and visitors	
New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC	
PPE suppliers and innovations strategy to ensure adequate supply	PPE predictor 4 week forward look
Operational plan to increase restoration of capacity	Tracked weekly though Communication Cell Metric Report in Operational Delivery Board
Covid-19 testing service	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Staff-Testing.aspx
Covid-19 test and trace policy	Covid-19 test and trace policy
Cheshire & Mersey Gold Command in place.	Notes of meeting shared weekly
Vaccine deployment programme completed.	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Covid-Vaccine.aspx
Enhanced staff welfare programme	https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Support%20%26%20Well-Being.aspx

Gaps in Controls / Assurance

Summer/Winter 2021 Plan to be finalised.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment	31/05/2021	
This is active and ongoing.	15/08/2021	

Executive Leads Assessment

July 2021 - John Grinnell
BAF risk 1.3 superseded by BAF risk 1.6. This risk will be closed in the following iteration.

June 2021 - John Grinnell
Recovery continues to progress well. Continual focus on latest IPC guidance and impact on our environment. Focus ahead of the summer on a Summer/Winter Plan which is captured in BAF action 1.2.

May 2021 - John Grinnell
Progress remains positive with a focus on working environments after 21.6.21. Easing of lockdown, plans being formed to mitigate any further wave and potential RSV surge for CYP. Overall risk profile reduced.

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Regional incident response triggered.	
C & M GOLD oversight.	
C & M Urgent Care Board oversight.	
C & M Paediatric Gold Instigated with AH COO leadership.	
AH triggered GOLD response with resources re prioritised.	
Detailed plans in place for Urgent Care, RSV Surge and MH response.	
Previous COVID response mechanisms in place.	
IPC oversight through CAG.	
Wellbeing programme in place.	
Governance Lite approach enacted to free up time and resources.	
Board and Sub-Committee oversight in place.	

Gaps in Controls / Assurance

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Urgent Care Action Plan to be finalised.	23/07/2021	
RSV response to be finalised.	26/07/2021	RSV working groups in place across a range of areas, tactical command meeting in place and first meeting held. Actions from meeting to drive forward preparedness and RSV response to be reviewed at the next meeting
Develop Mitigation Strategy for areas of workforce fragility.	30/07/2021	
Finalise IPC arrangements post lockdown easing.	21/07/2021	
Revised Communication Strategy.	30/09/2021	

Executive Leads Assessment

July 2021 - John Grinnell
Urgent care is under significant pressure and RSV levels are rising, coupled with some staffing areas of fragility. Gold Command structure has been triggered both internally and via Cheshire and Merseyside.

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work		Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led			Link to Corporate risk/s: 2312		
Exec Lead: Melissa Swindell	Type: Internal, Known		Current IxL: 3x3	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 WOD
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	-Monthly reporting to the Board via the Corporate Report -Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
Permanent nurse staffing pool to support nurse staffing numbers	Large-scale nurse recruitment event 4 times per year
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	75 skilled nurses to join the organisation across 2020/21
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to WOD OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to WOD
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/09/2021	Mandatory training continues to increase - focused recovery plans in place
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/09/2021	Delayed as a result of needing to respond to covid. workforce planning happening in response to backlog and nre pressures (accelerator and RSV)
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/07/2021	Recruitment actions progressing against action plan

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

Executive Leads Assessment
July 2021 - Melissa Swindell Action plans progressing. Some actions amended in light of the need to respond to current pressures (COVID, accelerator, RSV)
June 2021 - Sharon Owen Action plans progressing. Workforce planning methodology needs to be revisited.
May 2021 - Sharon Owen Actions reviewed all are progressing against plan, gaps in controls identified to mitigate risk.

Board Assurance Framework 2021-22

NHS 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
Staff Temperature Check Reports to Board (quarterly)	Board 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
Recovery task force established and operational	Recovery taskforce action plan
Health and Wellbeing Conversations launched	
Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin	Minutes of exec meetings

Gaps in Controls / Assurance

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

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

Wellbeing Action Group to be established from 29.6.21 to include SALS, comms and WB Guardian initially. To be held once every 2 weeks and feed into WB Steering Group. Group to also progress programme of whole organisation debriefing as part of recovery planning.	28/09/2021	
Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external counselling provision.	31/08/2021	Staff support proposal still in draft form. Meeting on 5th July to continue work with Alder Centre. Discuss incorporating this proposal into wider Wellbeing proposal to include increased resource for SALS/OD as part of wider staff support offer. Confirm with Director of HR and agree next steps
Paper to be presented on 2.3.21 to execs outlining proposal for helping staff with their Recovery from impacts of Covid. Proposal to develop Recovery working group to develop and monitor action plan to include whole organisation debriefing programme	30/06/2021	Recovery task group now closed and actions fed back to execs via new monthly Ground TRUTH slot on 1st July. Email sent to recovery group thanking them for their contribution and inviting ongoing attendance at WB Steering Group. First Wellbeing Action Group meeting to be held on 6th July so this action now closed. Ongoing actions to be captured against debriefing programme and Wellbeing Action Group.
Meeting with ED leads on 18.05.21 to discuss issues and develop an acute support plan for staff. Agreed to offer SALS drop ins daily to ED w/c 24.05.21 plus 2 virtual drop ins. Department to support release of staff on shift to attend if needed. Ground TRUTH to be rolled out to department to help to build resilience and monitor anxiety and morale. SALS to explore feasibility of providing a Wingman on wheels service to the department and also access to brief massages (via an external service). Nicola Evans to email senior executive leads to ask if the department could be supported in the medium term by a Pastoral Support Volunteer service (as was set up to support redeployed staff during the cCovid-19 second wave). Team to regroup to discussing medium term support after next week.	31/08/2021	Updated support plan following meeting with Divisional Director on 18 June. Agreement to offer 6 hours of Pastoral Care support (paid time) for ED. SALS to support PC team as per model developing during third wave (and support to ICU). Ongoing provision of Wingman on Wheels and massage van. Staff to access SALS as required

Executive Leads Assessment
July 2021 - Jo Potier Risk reviewed and updated to reflect updated ED support plan, Ground TRUTH sessions @execs and establishment of Wellbeing Action group. No change in risk rating due to ongoing impact of Covid, increased risk of burnout and ongoing uncertainty around likely future impacts of this pandemic.
June 2021 - Jo Potier Risk reviewed. Actions updated to reflect ongoing support for staff in ED, changes to recovery task group and current areas of focus in staff wellbeing. No change to risk score given ongoing impact on staff of the Covid pandemic.
May 2021 - Jo Potier Risk reviewed. Actions updated following progress in Recovery task group and staff support pathways. No change to risk rating given ongoing uncertainty in likely impacts of Covid on workforce.

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Specialist Trusts discussion to explore implementing an EDI team across all four Trusts.	30/06/2021	Appointment made June 2021

Executive Leads Assessment

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

June 2021 - Sharon Owen
Actions progressing against plan - EDI post interviews taking place 8th June 2021

May 2021 - Sharon Owen
Actions progressing against plan

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: 1241		
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 or budget and in partnership with the local community and other key stakeholders as a legacy for future generations

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Review and update Space Strategy	31/07/2021	
Prepare Action Plan for NE plot development	31/10/2021	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust
Create opportunities analysis for Park/campus	31/10/2021	

Executive Leads Assessment

July 2021 - Russell Gates
Cost estimates are under review ahead of the RABD meeting which takes place on the 26.7.21.

June 2021 - David Powell
Review prior to June Board

May 2021 - No Reviewer Entered
Prior to May 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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	30/09/2021	Plan for Private Patients & International reviewed at Exec strategy away day 23.4.21. Continued commitment to developing the business model, define the plan & include in the proposal to Clinicians as part of future planning assurance of Trust

		commitment to achieve this long-term goal.
1. Strengthening the paediatric workforce	30/09/2021	Strengthened work across paediatric network continues; current focus on developing C&M RSV surge plan with embedded mutual aid arrangements, connected into NW RSV surge plan (submitted June 2021)
Full programme proposal implementation; Funding flows into AH from C&M/NHSE Recruit to all key programme roles - beginning with Programme Director Establish C&M CYP Transformation Board	30/09/2021	CYP Programme Director recruited to - starts 1st July. Further PMO roles agreed and to proceed recruitment. Notification received of 21/22 programme allocations from NHSE.
Executive Leads Assessment		
June 2021 - Dani Jones Risk reviewed; no change to score in month. Progressing implementation of C&M CYP programme. System-wide RSV surge plan under finalisation.		
May 2021 - Dani Jones Risk reviewed; no change to score in month, though rapid system developments following White Paper and Covid; CYP increasingly prioritised & aligned work ongoing to sustain this, which will support mitigation of this risk in medium term. Progress with C&M CYP and Strategic planning at Exec & Board during April.		
April 2021 - Dani Jones Risk reviewed; no change to score in month. Progress in C&M CYP - evidence attached.		

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/07/2021	Work ongoing on financial strategy for H2 and beyond for both capital and I&E. Updates are being provided through RABD and Trust Board.
2. Five Year capital plan	31/07/2021	Update provided at May RABD on 5 year capital programme with further work underway and to be represented to RABD in July.
1. Uncertainty of H2 21/22 framework and beyond	30/09/2021	Revised guidance issued for Q2 of H1 reducing the Elective Incentive Fund payments which places a significant risk on the delivery of a breakeven for H1. This has been flagged with C&M and a revised trajectory in development to mitigate this risk. Further updates to be provided at Trust Board and RABD.

Executive Leads Assessment

July 2021 - Rachel Lea
Risk reviewed and actions updated

June 2021 - Rachel Lea
Risk reviewed and actions updated to reflect latest position.

May 2021 - Rachel Lea
Risk reviewed and updated to reflect 21/22 risks and actions, controls being taken

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

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

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

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

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

Executive Leads Assessment

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	

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Develop the Alder Hey Partnership Framework - for approvals in Alder Hey. Assess core pre-existing and new partnerships against the framework and address any gaps through individual partnership governance groups.	29/10/2021	

Executive Leads Assessment

Board Assurance Framework 2021-22

NHS
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: No Risks Linked		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Operationalise new strategy including programme and project prioritisation and associated resource requirement and planning.	31/08/2021	
Work with new dedicated finance resource to prepare financial forecast and investment/growth strategy.	31/08/2021	
LCR/BOOM engagement and collaboration for public funding and investment.	31/08/2021	

Executive Leads Assessment

July 2021 - Claire Liddy
JULY 21 - Risk review static

June 2021 - Claire Liddy
JUNE 21 - Risk review and updated for data risks.

May 2021 - Claire Liddy
MAY 21 - risk review and update to include data / AI. no change to score

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

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

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

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of Alder Care Programme	01/10/2021	Programme progressing, a number of work streams with challenges being progressed.

Executive Leads Assessment
July 2021 - Kate Warriner BAF reviewed, good progress
June 2021 - Kate Warriner BAF reviewed, good progress against actions.
May 2021 - Kate Warriner BAF reviewed, progress being made. 21/22 plans in place. Refresh of strategy scheduled towards the end of 21/22 to be in place for 22/23 onwards.

Alder Hey Children's NHS
NHS Foundation Trust

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

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

20/21/238 **Apologies:**
Apologies were received from Adam Bateman and Claire Liddy.

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

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

20/21/240 **Matters Arising and Action log**
Capacity Lab – confirmed to attend July meeting

20/21/241 **Declarations of Interest**
There were no declarations of interest.

20/21/242 **Finance Report – Month 2**
CS gave an update on the position at the end of Month 2. The Financial Plan for H1 has now been finalised and included a £3.6m deficit. However, since that submission we have been required to submit a further iteration which shows a break-even position due to an assumed contribution of £4m from the accelerator programme and further efficiency savings of requested by C&M ICS and was a requirement across the board for all organisations.

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

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

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

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

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

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

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

Resolved:
RABD received and noted the M2 Finance report.

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

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

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

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

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

20/21/244 **Commercial Governance SOP**

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

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

20/21/245 **Capital & Cash Updates**

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

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

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

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

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

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

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

20/21/246 **Campus & Park Updates**

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

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

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

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

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

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

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

.**20/21/247** **Marketing and Communications Update**
MF gave a verbal Marketing & Communications update, noting that the Volunteer Team have been awarded The Queen's Award for Voluntary Service, for which a celebration is planned. Future papers will include the Green Agenda update, an update on Marketing with Strathouse and Staff Engagement.

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

20/21/248 **Accelerator Bid Update**
RV presented an update on the Paediatric Accelerator programme, noting the increased activity requirements and the financial impact of this upon expected Elective Recovery Funding. The bid has been predicated upon transformational

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

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

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

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

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

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

Resolved:
RABD received and noted the Accelerator Bid update.

20/21/249 **Month 2 Corporate Report**

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

Resolved:

RABD received and noted the M2 Corporate report.

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

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

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

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

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

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

20/21/251 **PFI Report**

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

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

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

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

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

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

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

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

Resolved:
RABD received and noted the M2 PFI report.

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

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

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

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

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

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

29th July 2021

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	21st July 2021 – Summary 23rd June 2021 – Approved Minutes
Report of:	Fiona Beveridge, Chair, Safety Quality Assurance Committee
Paper Prepared by:	Julie Creevy, CQAC Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 21st July 2021, along with the approved minutes from the 23rd June 2021 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

The Safety Quality Assurance Committee **i**s a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting at the meeting held on 21st July 2021

- Quality Priorities Monthly update was received, which highlighted good progress made by teams in all three areas, with strong engagement of teams, detailed plans and targets, and strong momentum on the many different workstreams. Quality Leads requested support in terms of a previously submitted Business Case for Education Governance 8A post in terms of financial approval for the Business Case. Quality Lead requested support from NM re Medical Leadership on Care Flow Implementation.
- Sepsis update received, which demonstrated progress to date with the introduction of 'Sepsis Status', with a real understanding of improved data, new dashboards, better documentation, and a consequent capacity to focus also on Antimicrobial stewardship. Support was required in terms of adapting and improving Sepsis training for the hybrid environment and ensuring recovery of a high level of training compliance
- Never Event RCA report was received, which highlighted a clear process and included lessons learned for colleagues within the Trust, JG agreed to follow up offline with C Talbot regarding the importance of identifying audit leads on one particular 'Stop Before you Block' action.
- Transition Update was received, SQAC NOTED the requirement for Transition leads within Medicine and Surgery Division, agreed offline discussion with JG, NA & A Bass , with a further discussion required at Executive Team meeting. Meeting was reminded that this is a NICE compliance issue.
- Safety Strategy was received and endorsed by SQAC
- CQSG Update
- CQC Action Plan
- DIPC Exception Report
- Aggregated Analysis Reporting including management of high-profile inquests, complaints, incidents, including lessons learned or near misses and improvement actions, legal cases and clinical claims - report demonstrated clear governance process in place, with a sense of a clear reporting culture. The new combined approach enabled the identification of themes and areas of higher risk and activity. Key themes overall are Communication, Documentation, Human Factors and Escalation.
- Safeguarding Annual Report
- Children with Complex Behavior Update

- Assurance ED Activity Monthly Update
- ED MH Attendance – report to be amended, updated and circulated as appropriate
- Quality Account was endorsed and NOTED
- Board Assurance Framework received, SQAC NOTED access to care in terms of planning for potential RSV/Surge and NOTED the threat level in terms of service recovery.
- Divisional updates regarding highlights and challenges were NOTED

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

Board Assurance Framework – Access/Delivery of Care relating to potential RSV/Surge

4. Positive highlights of note

Positive updates were received regarding: -

- Quality Improvement Programme
- Sepsis Update
- Aggregated Analysis Reporting including management of high-profile inquests, complaints, incidents, including lessons learned or near misses and improvement actions, legal cases and clinical claims
- Safety Strategy
- Issues within Divisional highlight updates

5. Issues for other committees

Executive Team to discuss Transition with regards to Transition Leads for Medicine and Surgery Division, to ensure that there is appropriate progress made in terms of Transition.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on
Wednesday 23rd June 2021
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Chair of SQAC)	(FB)
	Kerry Byrne	Non-Executive Director	(KB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Interim Divisional Director for Medicine	(UD)
	John Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Adrian Hughes	Deputy Medical Director	(AH)
	Lisa Cooper	Director - Community & Mental Health Division	(LC)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Nicki Murdock	Medical Director	(NM)
	Jacqui Pointon	Associate Chief Nurse/Safety Lead	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Christopher Talbot	Safety Lead, Surgery Division	(CT)
In attendance:			
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Mark Campbell	Inspector, Care Quality Commission	(MC)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
	Ian Gilbertson	Associate Director – Digital Transformation	(IG)
	Jennie Williams	Head of Quality Hub	(JW)
	Kerry Turner	Senior Quality Improvement Practitioner Freedom to Speak Up Guardian	(KT)
21/22/45	Harry Sutton	Volunteer Co-ordinator	(HS)
21/22/52	Ronnie Viner		
21/22/54	Liz Edwards	Head of Clinical Audit & NICE Guidance	(LE)
21/22/56	Raman Chhokar	Chief Operating Officer, Medicine Division	(RC)
21/22/59	Cath Creed	Named Nurse for Safeguarding Children, Young People & Adults	(CC)

21/21/41	**Apologies:**		
	Adam Bateman	Chief Operating Officer	(AB)
	Robin Clout	Interim Deputy CIO	(RC)
	Alfie Bass	Divisional Director, Division of Surgery	(AB)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Cathy Wardell	Associate Chief Nurse, Medicine Division	(CW)
	Kate Warriner	Chief Digital & Information Officer	(KW)

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

21/22/42 **Declarations of Interest**
SQAC noted that there were no items to declare.

21/21/43 **Minutes of the previous meeting held on 19th May 2021 –**
Resolved: Committee members were content to **APPROVE** the minutes of the meeting held on 19th May 2021.

21/21/44 **Matters Arising and Action Log**
Action Log
The action log was updated accordingly.

Matters Arising
SQAC Annual Report 2020-21
SQAC received and **NOTED** the amended SQAC Annual Report.

Quality Improvement Progress Reports

21/22/45 **Patient & Family Feedback Report**
HS presented the Quarter 4 Patient & Family Feedback Report, which provided an overview regarding Children & Young People 2020 CQC survey, Children & Young People 2018 survey, Patient Led Assessment Care Environment, (PLACE), Friends & Family Test, FFT themes and actions, NHS Staff Survey, Under 16 Cancer Patient Experience Survey, and Healthwatch, key issues as follows:-

- In Quarter 4 2020/21 key themes and actions identified related to waiting times, communication, parking, one parent per child policy, staff wearing face masks correctly and lack of play provision in certain areas. There has been a significant increase in the FFT score for learning, however Play had maintained a poor FFT performance.
- The Children & Young Person survey is currently going through the fieldwork process which is due to conclude at the end of June 2021,
- Patient Led Assessment of the Care environment (PLACE) 2020 was postponed due to COVID 19 pandemic, with no information regarding the dates of the next national programme published to date.
- Fieldwork for the Cancer Under 16 survey was due to conclude on 28th May 2021. The Trust is expecting analysis of reports from Picker in June 2021.
- Healthwatch Liverpool are part of the Trusts Patient Experience Group and CQSG meetings.

KB referred to the assurance process and queried how the samples are made, HS confirmed that 250 patients had been selected, and that there had been no bias, patients had been validated to ascertain that no deceased patients had been included.

KB queried whether there was an overarching detailed action plan in order to ensure appropriate ongoing monitoring, HS advised that he would need to obtain feedback/clarity from PB and VS in order to clarify this further.

LC queried whether FFT scores included virtual and Attend Anywhere data, HS confirmed that this data had been included. Committee agreed it would be helpful to include methods of data sample collection in future Patient & Family Report updates to SQAC.

Committee requested supporting detail with regards to actions taken to address play issues, clarification was also required for future reports regarding what support is being offered to the various ages/age groups i.e. what is being provided to teenagers whilst in hospital. FB advised that it is really important to receive distinction of data collection.

JG stated that it would be helpful to consider ED, and queried whether any support is required for ED, in order to improve/enhance patient experience within ED.

NA advised that he provide feedback to colleagues, to enable the future Patient & Family Feedback report to be enhanced, in terms of including clarity of actions taken to improve play support. NA confirmed that the process for selection is fully anonymised, and advised that a dip sample is made from the Information Team, with NA signing this off, in his role as Caldicott Guardian.

FB thanked HS for Patient & Family Feedback update.
SQAC **RECEIVED** and **NOTED** the Patient & Family Feedback update.

Safe

21/22/46 Never Event Report Action Plan updates and RCA

NA presented the Never Event Action Plan; Key issues as follows:-

- NA advised that the report had a slight error and confirmed that Actions 8 and 9 should be shown as completed. NA confirmed that the RCA is currently in final draft and would be presented to July SQAC meeting, this would also be shared with CCG, this had been completed on time.
- Action 3 – '*Amend stop before you block' process*, CT confirmed that there is an updated Standard Operating Procedure which is ready to be signed off? with regular weekly audit of compliance, which feedback to CQSG
- Action 5 – '*Update the sign in process to reflect the sign out processes of the WHO checklist*- new process is in place, with ongoing audits, with updates to Divisional Integrated Governance meetings, with update to SQAC and CQSG scheduled in July 2021. Plan for full Afpp audit of department added to the annual audit plan.
- Action 6 – '*Creation of new Safety Day' induction for all juniors'* - CT advised that 2 sessions had been provided for juniors within the service, the first session focussed on Safety Strategy, Civility, just culture, Risk, Clinical incidents, and medication safety, with the 2nd session focusing on theatre safety. Positive feedback from colleagues who had attended the sessions had been received.
- Action 7 – '*The Theatre list will contain all intended procedures in clear terminology*' - CT advised that there had been a slight delay with regards to Digital solution in terms of Expanse, AB and CT had met with the Digital Team, and are currently working to create an interim solution in lieu of meditech expanse launch.

NA advised that the Action Plan would be amended and reissued, in order reflect that Actions 8 and 9 are completed. NA acknowledged that there is a requirement for final route map relating to Digital Standard Operating Procedures which would require sign off.

CT advised that he would liaise offline with Neil Herbert with regards to the

observation work required, once the detail is finalised, SQAC agreed that this should be discussed at Executive Team meeting, ahead of updating SQAC at July SQAC meeting.

Resolved: Executive Team to receive update, ahead of update to SQAC at July 2021 meeting.

FB thanked NA & CT for update.

21/22/47 CQC Action Plan

ES presented CQC Action Plan. ES proposed that the CQC Action Plan be closed, and the remaining action point being addressed through a stand alone report on Consent. ES advised that ongoing work is taking place with regards to Consent and that the Consent Audit is now on the draft Division Audit Plan (Q1-Quarter 3).

A discussion was held regarding the complexities of demonstrating the involvement of under 16's with capacity taking part in the consent process. This will be picked up through the regular audit.

Resolved: SQAC to receive an update in July following CQC Engagement Meeting.

SQAC **RECEIVED** and **NOTED** CQC Action Plan

21/22/48 DIPC Exception Report

BL presented the report, key highlights were:

- 1 case of D Difficile – which related to an oncology patient, following review, no lapse of care had been identified .
- The Trust continue to see improved monitoring of CLABSI's.
- Covid 19 Vaccination – 3097 have had the 2nd Dose Administered – equating to 80% of staff. There had been data quality concerns with the NIMC/BI system which had been investigated nationally in order to obtain accurate information. Once this information has been cleansed; it is envisaged that this would reflect an increase in numbers who had received the second dose.
- Fit Testing – all Divisions are over 80% compliant, with a strategic in place for 12 monthly updates of all staff
- Self-testing – the Trust had transitioned to the LAMP asymptomatic programme, and had completed over 6,000 tests had been undertaken with 2 positive cases. BL advised that the uptake of LAMP testing is a universal Trust's issue with regards to improving compliance. BL advised that this issue had been raised at the weekly staff briefing by LS and IPC team continue lead ona rnage of interventions to increase compliance

21/22/49 Neurology Action plan update

UD presented a comprehensive detailed overview of the progress to date relating to each of the the 11 actions within the Neurology Action Plan; key issues as follows:-

- SQAC noted that the progress had been made against the 11 actions within the Action plan, and NOTED the robust governance processes in place.
- LC referred to ticks and Tourette and advised that a Business Case had been submitted to the CCG in November 2020, to provide this service at Alder Hey, Business Case had been rejected due to a lack of funding. LC advised that within Community MH Service, had seen an increase in Liverpool and

Sefton patients being referred with ticks and Tourette's.

SQAC were content with the update and happy to close this item.

FB thanked UD for Neurology Action Plan update and extended thanks to colleauges involved in progress to date

Resolved: SQAC received and NOTED Neurology Action Plan update, Action Plan closed

21/22/50 Mandatory Safeguarding Training Compliance

LC presented Mandatory Safeguarding Training Compliance update, key issues as follows: -

- LC advised that Safeguarding training compliance had decreased to below 90% throughout the past year, and that due to the Covid-19 pandemic working arrangements the delivery of face to face training had ceased for a 10-month period. During this time, staff were still able to access e-learning modules and the safeguarding team facilitated 'Spotlight On' sessions which supported the delivery of key safeguarding topics via Microsoft teams. Prior to March 2020, compliance for mandatory safeguarding training was 97%. The following two areas were below the trust requirement for 90% compliance:

  - Safeguarding Children & Young People (including LAC) Level 2 - 88.02%
  - Safeguarding Children & Young People (including LAC) Level 3 – 85.95%

- Actions taken to improve compliance included, compliance data being regularly shared with divisions to enable them to identify non complianct staff and work to imrpve the current position.
- LC identified that the Facilities team had additional challenges in terms of compliance and there had been bespoke and specific training organized for the service.

FB advised that given the Safeguarding Compliance figures that this should be discussed at Executive Team meeting in order to highlight current position and continue to raise awareness throughout the organisation.

RESOLVED: SQAC RECEIVED and NOTED the Mandatory Training Compliance report and considered additional actions required within divisions and services, in order to improve compliance with mandatory safeguarding training. Mandatory Training Safeguarding Compliance to be discussed at Executive team meeting, with a progress updated to be received at SQAC at September 2021 meeting

FB thanked LC for update.

21/22//51 Reflective Practice Review Young Person A

LC presented the Reflective Practice Review Young Person A which provided background, summary report, action plan and summary of key findings, update, key issues as follows:-

- Summary of key findings had been provided of key actions required within 30 days, 60 days and 90 days. There were a number of actions relating to AH which were in progress.

- Action plan is monitored through Community Mental Health Divisional Governance Group.

FB thanked LC for Reflective Practice Review Young Person A update.

RESOLVED: SQAC RECEIVED and NOTED the Reflective Practice Review Regarding Young Person A.

21/22/52 Safe Waiting List Update

RV presented the Safe Waiting List update; key issues as follows:-

- Inpatient validation had been completed, with Outpatient validation due to be completed by end of July – 2,000 records remain to be validated
- 134* patients waiting >52 weeks had been added to the waiting list (from validation of approximately 45,000 records), 94 patients had been treated, 22 patients scheduled to receive treatment within 6 weeks; 18 patients awaiting a date for treatment, with 3 xP5 patients choosing to delay treatment.
- *242 additional patients potentially > 52 weeks are subject to senior review
- Harm Review status – 47,597 records had been validated, 134 long waiters, with 40 patients awaiting treatment.
- One minor harm had been identified due to delay in treatment in ophthalmology,

FB thanked RV for Safe Waiting List update.

Resolved: SQAC received and NOTED the Safe Waiting List update

Clinical Governance Effectiveness

21/22/53 CQSG Key Issues Report

NM provided a verbal update on CQSG Key issues Report, following CQSG meeting held on 8th June 2021, key issues as follows:-

- NM advised that significant progress had been made with regards to policies/leaflets and that only 18 policies remained out of date, this is a significant improvement in the position.
- Discussion had taken place at CQSG regarding reducing interuptions during prescribing and administration of medicaitons. The Trust had seen a slight reduction since new system piloted on the wards, however the reduction in interruptions was not statistically significant, CQSG agreed that it would be beneficial to further review and concentrate on one ward in order to review whether there would be a significant reduction and if so this would be rolled out across other wards.
- Discussion at CQSG took place regarding a number of changes regarding policies that recognised Mental Health Act and the need ensure that those policies that related to C&YP were appropriate for C&YP as most related to Adults and that wording etc is appropriately reflected in such policies.

FB welcomed the significant progress made in order to ensure guidelines are current and up to date, and requested timeline on those outstanding guidelines/policies. NM advised that she anticipated that these would be in date by the end of July 2021, 6 policies are drug related and are awaiting ratification at Medication Management Committee, NM confirmed that she was confident that these would be completed.

FB thanked NM for CQSG update and welcomed receiving an update in due course from NM with regards to which ward would commence a pilot system regarding interruptions/medication dispensing.

SQAC **RECEIVED** the CQSG verbal update.

21/22/54 Clinical Audit & Effectiveness Report incorporating Clinical Audit Action Plan

LE presented the Clinical Audit & Effectiveness Report incorporating Clinical Audit Action Plan. Key issues as follows:-

- Between 1st January and 31st March 2021 79 clinical audits were registered, of the 79 audits, 12 had been completed, 65 audits are ongoing: of which 0 remain outside the estimated completion date, 1 audit had not yet commenced, however an amended start date had been confirmed and 1 audit had been cancelled.
- Process for ensuring all audits are completed was initiated during the past year.
- The Committee **NOTED** the Trust audit plan for 2021-2022 which had been approved at Clinical Quality Steering Group
- Discussion had taken place with Divisional Governance leads and clinical audit team had developed an action plan for each division which incorporates actions identified from April 2021.
- Clinical Audit Processes Review – MIAA review presented to the Trust Audit & Risk Committee in January 2021, provided substantial assurance that the Trust has an established and effective system for Clinical Audit and thee is compliance with the Trust's policy, 4 recommendations were made, LE advised that an updated would be provided on progress at September 2021 meeting.

FB welcomed significant progress made in terms of assurance, oversight and review. KB stated that there had been significant changes during the last few months and requested that it would be helpful to show how areas had been prioritised and selected. KB thanked LE for ongoing support and looked forward to receiving further update at September 2021 SQAC mtg.

SQAC agreed on the importance of Divisional ownership and the requirement for careful thought in terms of prioritisation which would be captured and included within the next Report.
FB thanked all for good progress made to date.

RESOLVED: SQAC RECEIVED and NOTED the Clinical Audit & Effectiveness Report incorporating Clinical Audit Action Plan

Well Led

21/22/55 Board Assurance Framework

ES presented the Board Assurance Framework; key issues as follows:-.

- The Sepsis Update is due to be received at July 2021 SQAC meeting.
- Complex Children Board report due in July -a meeting had taken place week commencing 14th June 2021 with ongoing work in terms of metrics.
    - Medication focus from Quality Hub. Improvement Board had Inaugural meeting on 22nd June 2021, ES envisaged this would improve agenda going forward.

SQAC **RECEIVED** and **NOTED** the Board Assurance Framework update.
FB thanked ES for update.

21/22/56 Assurance Report regarding ED activity

RC presented the Assurance Report regarding ED activity, presentation provided an overview of challenges, actions taken to address issues, system support requested, and details on next steps, key issues as follows:-

- Alder Hey Emergency Care Department is experiencing sustained pressure & this is largely an influx of low acuity patients that are largely suitable for management in primary care.
- ED attendances for May are 32% higher than our most challenging year (2019) with record daily attendances of 282.
- Monitoring of our acuity also shows that on average 65% of attendances were minor illnesses and ailments, most of which can be managed in the community.
- Data collected from patients in our ED at the start of April 2021 shows that a majority of attenders to ED have attempted to access alternative services prior to attending ED (52%)
- Actions taken to address current issue including request for the reintroduction of GP which had not been supported, participation in weekly system calls to escalate in real time, request for direct access to primary care slots, reinforced staffing, escalation of senior staffing rates to mitigate gaps and support skill mix, Rapid assessment triage by consultant, summer/winter planning sessions to commence to gain specialty agreement and initiate resilience plan going forward.
- RC provided an overview of next steps required to address current issues which included the proposal to deflect patients to more appropriate parts of the system.
- Division have been working with colleagues within SALS team and Jo Pottier in order to support ED staff and provide pastoral support at this difficult period.

FB referred to managing the immediate pressures. NA stated that as part of robust governance process that it is not acceptable to receive this presentation on the day, and highlighted the importance of receiving written reports in a timely manner, prior to SQAC meetings in order to ensure that Committee members have sufficient time to review. RC confirmed that going forward the reports would be submitted in a timely manner ahead of SQAC meeting.

JG advised that there is weekly Executive Team oversight with weekly discussion at Executive Team regarding ED. JG advised that over the coming weeks that the Trust is looking to move to an 'incident model' in terms of RSV and recovery/Mental health challenges.

SQAC **RECEIVED** and **NOTED** the Assurance Report regarding ED activity and agreed that a monthly update would be provided by SQAC, with SQAC receiving a monthly report by no later than 2-3 days prior to SQAC meeting.

FB thanked RC for Assurance Report regarding ED activity

21/22/57 Divisional Reports by exception/Quality Metrics

The divisions presented an overview of their quality metrics, some key highlights were:

Community & Mental Health Division

- Division had formally escalated to Health and Safety Committee the lack of access for manual handling training for staff and parents and carers based within a community

setting to ensure staff receive appropriate manual handling training and ensuring parents are supported.

- The Division had received an increase in the number of compliments and excellence reports and Family and Friends scores continue to remain at 95%
- Launch of CYP platform on 6th May 2021 - single referral form, with positive feedback received to date.
- During mental health week, Alder Hey mental health service was features on BBC North West, with positive feedback received, the team are working with BBC for a follow up in 12 months' time.

FB thanked LC for update.

Medicine Division

- ED remained a challenge regarding performance 81% due to high number of attendance without the necessary support from primary care.
- Outsourcing of cross section of Radiology in May 2021 had resulted in significant reduction in reporting waits, Division continue to maintain this through continued outsourcing and additional sessions.
- Maintained excellence performance against cancer standards including new faster diagnosis standard, RTT remains above 92%
- EPPF completion on the day of attendance remains a challenge, the Division are reviewing how this could be improved.
- PDR and Big Conversation remain a key focus for the Division, the division continue to engage with teams through monthly presentations, with mini service reviews within the Division to review any support required and celebrate highlights.

Surgery Division

- Significant improvement regarding patients treated Sepsis - 91%,
- Since January 2021 no Category 3 or Category 4 pressure ulcers
- Challenges regarding formal complaints in May 2021 – with a slight increase in PALS also.
- Continued focus on Patient information leaflets
- RTT improved to 64%, with some departments around 88%.
- Reduction in patients waiting over 52 weeks, over the 52 weeks at the peak the Division had 59 patients, currently 4 patients.
- Significant reduction in waiting times, ENT, Dental, Orthopaedics
- Challenge establishing and ensuring all staff groups are fully protected and not Overworked

FB welcomed Divisional updates and thanked colleagues for updates.
SQAC **RECEIVED** and **NOTED** Divisional updates.

21/22/58 Quarter 4/Year end 2020/21 Complaints, PALS and Compliments Report

PB presented combined report which included Quarter 4 and Year end report.

- Compliance 3 day working acknowledgement – 100 % for Quarter 4
- Increase in 25 working day time – 35%, but May 100% response rate
- 22 2nd stage complaints, 14% reopen rate which is in line with national trends
- 1 complaint is ongoing with PHSO, with 1 new complaint submitted to PHSO in Quarter 4
- Thematic review related to treatment and procedure are the main reason for formal complaints, action regarding ensuring that the Trust have the robust first response. With ongoing work required over the coming year to ensure training regarding assisting staff to locally resolve wherever possible.

- PALS 5 days response increased performance in Q4 56%, currently 74%

  Actions and next steps, Complaint improvement plan had been presented at SQAC in May, which is being monitored by CQSG and Patient Experience Group. SQAC to receive Report in Quarter 1.

FB thanked PB for update and for continued support.

SQAC RECEIVED and NOTED the Quarter 4/Year end 2020/21 Complaints, PALS and Compliments Report

21/22/59 Policy Approval
PREVENT Policy
The prevent policy was presented to the group for ratification

SQAC RECEIVED & RATIFIED the PREVENT Policy
KB referred to Integrated Governance Committee and asked for this to be amended.

SQAC RECEIVED & RATIFIED the PREVENT Policy, subject to minor changes.

FB thanked CC for update.

21/22/60 Any other business
None

21/22/61 Review of meeting

- FB advised that the committee had reviewed comprehensive agenda items.
- FB welcomed positive update regarding Patient Experience/FFT Survey
- FB welcomed the Never Event Report & Action plan Report with ongoing progress made.
- FB welcomed the CQC Action plan update
- FB welcomed the good progress made in terms of the Neurology Action plan update
- Safeguarding Compliance report – noted concerns raised and further actions required
- Safe Waiting List Management report – noted current position and progress to date
- Clinical Audit & Effectiveness report - SQAC noted ongoing work regarding NICE compliance in order to ensure an improved position and noted current position and progress to date.
- FB welcomed ED report update.
- Adoption of PREVENT policy – SQAC RATIFIED policy subject to minor change.
- FB welcomed BAF update.
- Ongoing work required regarding NICE compliance in order to ensure an improved position

20/21/40 Date and Time of Next meeting
21st July 2021 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

29.07.2021

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	20th July 2021 – Summary 18th May 2021 - Approved Minutes
Report of:	Fiona Beveridge, Committee Deputy Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 20th July 2021 along with the approved minutes from the 18th May 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 July 2021 (overview)
   - Wellbeing Plan
   - Corporate Metrics – June 2021
   - Board Assurance Framework – June 2021
   - CQC Action Plan – June 2021
   - DBS Programme Update
   - Nurse Workforce Report – Year-end 20-21
   - Policies reviewed and ratified
     - Medical Revalidation and Appraisals Guidelines
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 23.02.21
     - JCNC – 28.04.2021
     - Health & Safety Committee – 22.04.21
     - BAME Task Force – Action Log 12.07.21

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - People plan highlighted the burnout issue within the divisions, development of the wellbeing guardian. Hotspots identified – keep risks under review. Operational Managers – think about how we can support.

4. **Positive highlights of note**
   - Roll out of DBS
   - Welcomed to the Committee - Katherine Birch – Director of Academy
   - Comprehensive Nursing Workforce Year- end 20-21 report – very encouraging signs. Success of ECP on the newly qualified retention issue, along with the development and helping nurses move around the departments.
   - Medical Revalidation and Appraisals Guidelines – important piece of work – look forward to seeing the process developed.
   - Race Equality Action Plan - recognised that the development of an action plan with clear targets was an important step forward.

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

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on 18th May 2021
Via Microsoft Teams

Present:	Claire Dove	Non-Executive Director (Chair)
	Melissa Swindell	Director of HR & OD
	Adam Bateman	Chief Operating Officer (Part attendance)
	Nathan Askew	Chief Nurse
	Nicki Murdock	Medical Director
	Erica Saunders	Director of Corporate Affairs
In attendance:		
	Sharon Owen	Deputy Director of HR&OD
	Jo Potier	Associate Director of Organisational Development
	Jacqui Pointon	Associate Chief Nurse – Community
	Jackie Friday	Executive Assistant (Minutes)
Apologies:	Mark Flannagan	Director of Communications & Marketing
	Ian Quinlan	Non-Executive Director
	Fiona Beveridge	Non-Executive Director
	Catherine Wardell	Associate Chief Nurse – Medicine
	Lisa Cooper	Director C&YP – Community
	Dot Brannigan	Public Governor (Observing)
	Kate Warriner	Chief Digital & Information Officer
	Robin Clout	Deputy Chief Information Officer
	Raman Chhokar	ACOO - Medicine

21/22/01 **Declarations of Interest**

No declarations of Interest.

Committee Quorum

The Committee noted that in the absence of two Non-Executive Directors the Committee was not quorate.

21/22/02 **Minutes of the previous meeting held on 23rd March 2021**

Resolved : The minutes of the last meeting were approved as an accurate record.

21/22/03 **Matters Arising and Action Log**

Matters Arising

MKS advised that the following items, previously discussed at Executive or Board level, have been raised as a formal record to the Committee members.

21/22/04 **Annual Report 2020-2021**

The annual report was approved by the Committee.

Resolved : PAWC received and approved the Annual Plan subject to virtual approval by Non-Executive Directors

21/22/05 Partnership Agreement

The Draft Partnership Agreement is currently with our Trade Union colleagues and still under the process of review, it is hoped to receive feedback in the coming weeks.

Resolved : PAWC received and noted the update on Partnership Agreement

21/22/06 Nursery

Formally written to the Trade Unions with the Trust position. Subsequently met with nursery staff a week ago and overall the meetings were positive. A commitment has been given to engage with staff about what employment opportunities might be available and to work with staff to find alternative employment when the nursery closes. Shadowing opportunities will be offered in September (nursery quiet period). Shared with the nursery staff that we were working with the Developer, who have pulled together a draft specification, this will need to be taken forward. Consideration is required as to how we keep the parents of children engaged going forward.

CD asked what is the timetable that we are working to on this? MKS advised that the new nursery will be built and operational at end of 2022 beginning 2023. There is no timescale for the procurement of the new provider. This request has been put forward to the developer.

Resolved : PAWC received and noted the update on the Nursery

Trust People Plan 2019-2024

21/22/07 People Plan Report

The Committee received the People Plan Update Report, this report is a regular report presented to Trust Board and is noted as read by the Committee. MKS highlighted the following outlined in the report:

21/22/08 Flexible working

There is a multi-professional bi-weekly Flexible Working Steering Group. Focus at the moment is on the staff who are moving from Alder Hey site to the Innovation Park. Comprehensive programme in place, keeping staff informed, liaising with staff about design and how it will work. Work has commenced on the Home Working Guidance, Clear guidance has been shared with the Steering Group, prior to going to ratification this week, on how infection prevention control rules will work in relation to how we use space post June.

CD asked if consultation takes place with the unions and with the staff as a whole in relation to flexible working. MKS confirmed we have talked to staff throughout the process. A couple of surveys have taken place with the overwhelming feedback being that staff want an element of homeworking to continue. Trade Unions are represented at the Steering Group.

21/22/09 BAME Inclusion Taskforce Plan

The latest draft version was shared on screen. The Plan outlines the ambition/focus of the Taskforce i.e. Data, Listening, tackling overt and convert racism, recruitment, training – development and progression, governance, communications. The plan outlines the outcomes to be achieved; actions to be taken and metrics to be reached.

The Chair noted focus on procurement and strategic partners has not been included on this draft version, this is another area where the Taskforce can make an impact.

MKS added that the Board had asked for clear metrics on this programme so we can easily measure performance. Some of the metrics we use will be from the national Workforce Race Equality Scheme, and some will be local measures.

ES referred to the metrics relating to board diversity and queried why it was focussed on voting members only? MKS confirmed that this is a specific measure required in the WRES, but we can expand this to include all Board Directors.

MKS/CD advised in order to be clear on the metrics, updates will be made and issued to the Committee for any questions/suggestions to be raised prior to review.

Action: 21/22/09 Circulate the updated BAME InclusionTaskforce to PAWC and questions/suggestions to be fed back to MKS, for review by MKS/Chair

21/22/10 **People Recovery Plan**

JP shared an overview of progress to date and advised that they continue to have a weekly Task & Finish Group. There are a range of developments taking place, highlighted as follows:

- Listening events focusing initially on operational teams – who seemed to be feeling the burden of tension about the recovery of services versus the need to rest and recover.
- Recovery survey closes this week and will be analysing that data.
- Health & Wellbeing conversations have launched, feedback so far is really positive.
- Wellbeing Guardian has been appointed – so that is establishing itself. Regular meetings taking place to think about that role and how it can be most helpful.
- Looking to scale up and rollout Team Time, awaiting feedback. Focussing training on nursing and HP's.
- Looking to continue to rollout the Groundtruth feedback tool as the format for our listening activities. Looking at a systematic approach to feedback to Execs.
- Focussing on the social elements of recovery, plan in development with the Comms Team around how we start to connect with each other safely but socially.

JP raised a concern about the recovery in ED and advised they are on their radar. The Chair asked JP to elaborate. The numbers coming through the door has increased, SALS have reached out for any support that they can have in terms of their wellbeing. Reporting high levels of anxiety, feeling sick going into work, struggling to switch off, with no respite. Really tired. Looking at ways to support them immediately through drop-ins; base some SALS activities in ED, looking at what we can do to support them.

NM updated the Committee on latest development in ED to manage the physical impact on staff i.e. respiratory and gastro locums to work on presentations. Along with the support offered by SALS psychological it is hoped in the next couple of weeks, ED will be in a much better place.

CD instigated a strategic discussion about there not being enough services to support children in the City, this impacts on the hospital through referrals, ultimately leading to staff exhaustion, sickness etc. Not every child needs to be seen in an ED setting and this needs addressing. The Committee referred to conversations taking place just now to tackle this issue. NM advised that NWAS ran a pilot of paediatrics specific 111

(divert children to appropriate support). More funds are now available, they are going to meet with ED & CCG to talk about how we can take this forward, hopefully it will be up and running in 4 weeks time.

JP thanked NM and advised that from a wellbeing perspective we have an immediate plan, do what we can right now. Then probably need to look at a longer-term plan, CD concurred. NA raised that point that it does need a complete change in the way that we work i.e. practices need modernising in terms of the way that we stream and deal with patients and agreed with the short term solutions, but acknowledged a longer term solution is required on streaming the work. If you build a hospital in a city everyone is going to want to see a paediatrician rather than their GP.

NM referred to the Trust previously having a GP in place in ED prior to Covid. CL referred to walk-in centres such as Smithdown Lane struggling with the number of patients presenting themselves and referring them on to Alder Hey and suggested an intervention is required. NM/NA advised that a contract meeting is taking place later in the week to support those points for children and young people - (provision of appointments at Walk in Centres/GP Services also where the support is needed on site for that type of activity)

Resolved : PAWC received and noted the content of the People Plan.

Governance

22/22/11 **Corporate Report Metrics – April 2021**

The paper is noted as read, this paper contains an overview of workforce KPI's along with divisional updates. MKS noted there was no representation at the Committee from Medicine or Surgery. Highlights as follows:

Trust Metrics - SO gave an overview of the Trust's metrics position – Sickness absence, starting to see an overall reduction, just over 4.5%. Slight increase in short term sickness, but overall the long-term sickness is reducing. Interventions to support managers, in particular ward managers, by removing some administration process has helped. In a healthy position in comparison to comparator Trusts. Post pandemic in a good position but will continue to manage those processes. Working with Occupational Health (OH) in terms of improved support services. Currently looking at the OH contract. Some further conversations are required with the Teams around how we can ensure that Return to Work (RTW) can be completed quicker and swifter.

PDR window has commenced, closes end July, currently low, to be picked up by the Learning & Development Team and HRBP's to ensure the message goes out at Divisional Meetings. Important they take place as the health & wellbeing conversations are happening at the beginning of the PDR process. Mandatory Training slightly below 90%, but in a healthy position given what we have been through. L&D team are doing a lot of work to get this back up again, so confident we will get that over 90% threshold in not too distant future. Other areas, staff turnover is below target of 10%. Payroll over 99% accuracy, seen significant improvements. SO flagged an anomaly in terms of disciplinary and grievance information contained in the report, it is slightly higher at about 15 and has been picked up with the team.

Questions raised: CD referred to RTW and highlighted the importance of this process, particularly for staff returning following long-term sickness. How is the Trust dealing with this? SO agreed the RTW is one of the most important processes in terms of managing staff returning. If not completed effectively individuals will go off

sick again. SO added we know the impact of what an effective RTW is, it is going to subsequently reduce our overall sickness absence and embed that individual back into the organisation. It is a conversation being picked up with HRBP's to ensure they are helping/coaching/ supporting managers when the staff actually return. Recent focus has been on managing the return of shielding staff, this was managed well. The issue with RTW is not that it is not being completed, but it is not been recorded onto the system quick enough so we can see accurate data. The key concern is to ensure the RTW has taken place. JP added with SALS they are also capturing data in support of the system in place around individuals with complex mental health problems. Individuals can refer themselves or be referred by management for support in complex returns.

NA highlighted a compliance concern with Mandatory Training to the Chair, this came to light recently and will be discussed further at the weekly Executive meeting today . In relation to BLS training, currently at 71%. Only 65% of available spaces are being booked and used and of that 35% of those spaces are being cancelled or DNA'd. A real focus to maximise bookings for this needs to be raised with the Divisions. ES concurred and advised it had previously been raised by CQC inspection back in 2017/18. ES added for information of the Chair, that SQAC have asked for a review of all the previous CQC action plans to ensure we are still focused on some of those previous issues that the regulators have raised. (Report to go to SQAC in June). ES advised that there needs to be some cross over with PAWC, just around those risks that will emerge. ES acknowledged it was a real concern. SO to pick up conversation with the Learning & Development Manager.

CD referred to the Induction and PDR processes, and asked if the Trust had considered not signing off these processes if mandatory training had not been completed. SO advised that this had been stitched into Induction/PDR processes. It has been stipulated via coaching and training for managers to raise awareness of the requirement to complete mandatory training, particularly before any other training can be authorised for individuals. SO referred to the link of PDR's in relation to incremental progression of pay and noted that this year incremental pay was allowed to go through automatically because of the pandemic. It is hoped in the coming year that if staff don't satisfactorily complete their PDRs in terms of performance plus completion of mandatory training, the caveat will be put back in place to defer increments. CD agreed that managers have to manage individual processes but should also lead by example. CD acknowledged the importance of PDR/Mandatory Training process/compliance and asked SO to share an update at a future committee to keep sight of developments.

Action : 21/22/11-01 SO to share an update on PDR/Mandatory Training process/compliance at a future Committee

Community Division Metrics - JP shared an overview of the Community Division metrics. Sickness stats are looking good. In contrast to that, RTW's are not hitting the target (approx. 1 in 6 not receiving the interview on time). This links into the recovery taskforce work taking place. There is a big push in the division to highlight how important RTW's are i.e. to be aware of what people are struggling with at the moment. It is hoped to see increased compliance by the next Committee. Mandatory Training is looking healthy. Picking up on BLS mentioned earlier, the L&D Team have been really responsive and really supportive in coming out to put on training in Sefton and Southport for staff. Across the board a lot of focus has been placed with BLS/safeguarding, we need to ensure we hold onto that green position going forward. In terms of the number of Apprenticeships, we are starting a piece of work offering work experience placements through the Prince's Trust with the focus around

increasing the diversity of the workforce across age, gender, ethnic and cultural presentation. In the future, that work will generate other opportunities for people coming to do apprenticeships as well. The Community Division are looking at where we have vacancies and where they can be to support apprenticeships in those roles.

CD congratulated JP and the Community Team for last week's spotlight on mental health featured on BBC that highlighted the work that Alder Hey is doing (eating disorders filling up beds). In reference to the work experience placements, CD advised that we now have a database of organisations of black and ethic minorities in the Liverpool area who we will be sharing vacancy information with and this information will be shared and monitored by the BAME Taskforce.

Action : 21/22/11-02 MKS to issue a reminder note to the Divisional 3 at the top from MKS/CD of the importance of representation at the Committee going forward.

Resolved: PAWC received and noted the update on the content of the Corporate Report & Workforce KPI's.

20/22/12 **Board Assurance Framework - April**

The Committee received a full BAF report for April, noted as read. Going forward, following strategic discussions with Execs and the Board, the Director of Strategy & Partnerships and ES need to agree what the strategic risks look like for the coming year. Some adjustments will be around the people risks based on the presentation MKS gave on 23rd April. For today's purposes, ES highlighted that the main area to explicitly address is the pressure on staff in ED (in particular under that element 2.2 recovery piece). Also some of the mitigations that NM referenced too. Everything else is up to date. EDI resource is key and will be addressed at a future Board.

Questions raised: CD referred to the variant currently in Bolton and asked if we brought any children in from outlying areas (for specialities) and if so, what are they associated risks i.e. ensuring parents have had a Covid test. The Committee deliberated and confirmed that in terms of risk, testing for Covid still takes place for 'elective pathways' so risk is minimal. Testing for 'emergency transfers' - patients would have been through another ED so would have had a test on arrival before transfer to Alder Hey. The Committee reflected 'research' and super subspecialties where probably a reminder about ensuring we follow the correct pathway around testing would be helpful.

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

21/22/13 **CQC Action Plan - April**

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. The report outlines the action required and the progress made for 1 recommendation, Mandatory Training – Progress at April 2021 is 92% - the Practice Educator continues to work with the Resus team to prioritise staff for the limited PLS and APLS places. The required outcome is for Mandatory Training compliance for ED and EDU nursing workforce to be achieved - consistently above 95%. ES advised that this recommendation is recorded as ongoing maintenance. Refocus is required in order to demonstrate and supply evidence for this recommendation.

CD concurred and advised different options have been discussed and that it is high on the workforce agenda. CD acknowledged a plan should be firmly in place to ensure that training happens.

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

21/22/14 **DBS Update**

The Committee received an update on the report previously received at the last Committee in March 2021, prepared by the Deputy Director of HR. SO advised the March 2021 paper confirmed what we were doing as an organisation in terms of prioritising staff who have never had a DBS or have had a DBS previously and it has expired. As explained previously, due to the pandemic and the fact that no face to face meetings with staff for ID checks were taking place, the project was behind plan. It was initially hoped to get back on plan and be completed by end of April, but this is still some way off, despite involvement of the HR Team and additional specific resource from NHSP. There seems to be a lack of engagement in terms of some staff. Priority group 1 (staff who have never had a DBS as they were recruited prior to DBS) and priority 2 group have all been contacted more than once and supplied the information required to get in touch with HR and complete a DBS (over 2700 staff). Unfortunately there still remains a number of staff who have made no contact whatsoever with the HR dept. This has been escalated to the Divisions (3 at the top). SO outlined the outstanding current position of staff who have not engaged with HR (Priority Group 1 – 56, Priority Group 2 – 715) and acknowledged the requirement to ensure we relay how important it is for staff to complete their DBS as a contractual requirement. It remains on the risk register. The recovery plan continues. SO advised that information is being prepared so each of the Divisions can see what it means for their Division. SO suggested meeting with NA and NM to agree how this is managed going forward, as it is important we have staff with current DBS's in the organisation. .

NA/NM agreed. NA thanked SO and the HR Team for all the hard work. The Committee discussed the different ways staff have been contacted i.e. phone/email/text and escalation via Divisions (3 at the top). SO shared the next steps for consideration, to formally write to individuals (as breach of contract if not compliant). NA agreed to this (inclusive of deadlines for completion). Followed by a formal process across the board, regardless of role or grade, as the Trust as an employer can't allow this situation to continue. NA/NM/SO to discuss the detail further outside of this meeting.

CD concurred and suggested we would have no alternative but to go down that route as in breach of contract. MKS extended her thanks to SO and the team and welcomed the support of CD/NA/NM. MKS pointed out that everyone in the HR operational team has been involved in this process and acknowledged it has been a challenge and very labour intensive. MKS noted some thought/planning is required prior to DBS expiry in three years time. Following guidance from the regulators/CQC the focus on this occasion was role out the DBS process throughout the NHS.

Resolved: PAWC received and noted the content of the DBS Update

21/22/15 **Policies**

The Committee received the following policies and Equality Assessments for formal ratification/approval. The Committee noted that in the absence of IQ/FB the policies will be sent virtually for ratification/approval.

Health & Safety Policies

MKS advised that the Health & Safety policies have been through the Health & Safety Committee and shared with the Safety Reps as is process and are ready for ratification, no significant changes to existing policies, just updated titles/legislation.

- *Slips Trips and Falls*
- *Latex*
- *COSHH*
- *PPE*
- *PUWER*
- *Fire*
- *Transport*
- *Asbestos*

Workforce Policies
SO outlined high level changes to all three workforce policies and advised all policies had previously been approved, following consultations with Staff Side colleagues, at the Policy Review Group with the support of Staff Side colleagues.

Disciplinary
There is a requirement to publicly publish this policy by the end of June. This will also be presented to the next Trust Board. A complete review has taken place and it has been through Staff Side at several meetings for consultation. All recommendations from the Dido Harding review have been considered and we have incorporated a lot of information from the 'Just Culture' guidance. we have separated the Investigation Policy from the Disciplinary Policy. Legal input from our solicitors has been received. Some additional practices have been put in to ensure that an Executive has got oversight of each case. An Executive lead will oversee anything that is subject to suspension/disciplinary complexities. Further information around staff support (SALS etc) has been added. Policy has been reviewed and was well received by Staff Side colleagues and management who have been on the Employment Review Group.

CD brought attention to the wording in the Disciplinary policy section 4.8 – 'just culture' recommendations and advised one of the areas discussed at the BAME Taskforce is a 'just and safe culture'. SO to address adjustment to ensure this is reflected within the policy.

E-Roster
This is a new policy to support the electronic rostering system. To ensure we have the guide and principles to effectively embed and monitor our rotas, ensuring that we do that in the most appropriate way. Sets out the rules and responsibilities in there and how we do that. Thisd policy has been discussed with Staff Side colleagues at PRG for final agreement.

NA added that he fully supported the E-roster policy (thorough and designed really well). NA brought attention to the Committee that going forward the KPI's will evolve, so that will probably be the 'living part' of the document. Also the NMC and RCN have just released workforce standards for nursing and midwifery. Whilst the policy is in line with current best practice, once the workforce standards have been reviewed the policy will probably need tweaking in the future. NA supported it being approved today.

Organisational Change
Minor changes – adding additional support (SALS etc.), also some terminology updates, simplify some of the language, no significant change.

CD noted thanks for the considerable amount of work to update the Disciplinary Policy.

Action: 21/22/15 – A note to be sent out to IQ/FB for virtual formal ratification of policies by the end of the week (Friday 21st May)

Resolved: PAWC ratified the policies and the equality analysis was approved, subject to virtual formal ratification of IQ/FB.

21/22/16 Board of Directors Summary

Assurance - Key risks at today's Committee to be noted:

- Recovery plan ED and health & wellbeing of staff, look at interventions in that area to support staff
- Mandatory Training
- DBS checks

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

21/22/17 The Committee received the minutes for the following for information.

- Local Negotiating Committee – None to report
- Health & Safety Committee – 10.2.21
- JCNC – 24.2.21 & 29.3.21
- Education Governance – 20.04.21
- BAME Task Force Action Plan – 13.05.21

No questions raised.

Resolved: PAWC noted the content of the minutes

21/22/18 Any other business

CD is looking to implement a Policy on Modern Slavery – impacts on subcontracts we have in the hospital. (key issue with central government at the moment – strategic supplies in government). ES offered her services to help on the modern slavery policy. CD to send information through to MKS and ES ahead of a meeting to progress.

JP to liaise with FM further – in relation to the Wellbeing Guardian role and determine what the role will entail, along with agreeing how often it will report into PAWC. ES advised that FM will verbally update the Board at end of May.

Action : 19/51 – Modern Slavery Policy – CD to send information through to MKS/ES ahead of a meeting to progress.

PAWC received and noted the items raised under AOB.

21/22/19 Review of Meeting

CD thanked everyone for great meeting and for all the work that has been discussed today.

21/22/20 **Date and Time of Next meeting**
20th July 2021, 10am-12noon, via Teams

Minute Reference	Action	Who	When	Status
Trust People Plan 2019-24				
21/22/09	• Circulate (when ready) the updated BAME Inclusion Taskforce (Plan on a Page) to PAWC for review.	MKS/CD	May 2021	
21/89	• To review provision to support disabled staff in the absence of Networks	JP/MKS	March 2021	
Health & Wellbeing				
20/28	Sickness Absence/Shielding/Agile Working • Working from home – update on review	MKS	March 2020	
Equality, Diversity & Inclusion				
20/29	EDS2 & Workforce EDI Annual Report • Share Procurement strategic government guidelines for sourcing suppliers/services with ES/MKS • Revisit Procurement statement to get a sense of what further action is required.	CD/MKS ES/MKS	November 2020 November 2020	Noted on 23.03.2021 CD/MKS to review EDI – overall action plan off-line.
20/42	• Present at future Board the Government Framework for Social Value (as part of the Government covid recovery plan to be rolled out in January 2021). Raise with CEO & Chair of Board. Noted on 25.01.2021 to be progressed outside of this Committee	CD/MKS	January 2021	Noted on 25.01.2021 CD/MKS to be progressed outside of this Committee.
Governance				
21/22/11-01	• Share an update on PDR/Mandatory Training process and compliance at a future PAWC	SO	May 2021	
21/22/11-02	• Issue a reminder note to the Divisional 3 at the top re the importance of representation at the Committee going forward.	MKS	May 2021	
21/22/15	• A note to be sent out to IQ/FB for virtual formal ratification of policies to be received by the end of the week (Friday 21st May 2021)	MKS	May 2021	

21/77	Policies to Review & Ratify • Security Policy – MKS to ask Security/Emergency Planning how often the Trust received advice on security measures.	MKS	March 2021	
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	• Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed. Noted on 18.05.2021 - Modern Slavery Policy – CD to send information through to MKS/ES ahead of a meeting to progress.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values-based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing
Equality & Diversity				
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD SM	TBC 1/4ly Update 6 monthly Review	Noted on 23.03.2021 CD/MKS to review EDI – overall action plan off-line
Education Governance Update				
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Ongoing
Nurse Associate Recruitment				
19/69	Develop a wider plan – to be reviewed	Vikki Hughes	April 2020	