Alder Hey Children's NHS Foundation Trust

# BOARD OF DIRECTORS PUBLIC MEETING

## Thursday 31st March, commencing at 9:00am

## via Microsoft Teams

## AGENDA

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| **PATIENT STORY (9:00am-9:15am)** | | | | | | | |
| **1.** | **22/23/294** | **9:15 (1 min)** | **Apologies.** | Chair | To note apologies. | **N** | For noting |
| **2.** | **21/22/295** | **9:16 (1 min)** | **Declarations of Interest.** | All | Board members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **21/22/296** | **9:17 (3 min)** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **Thursday 24th February 2022.** | **D** | Read enclosure |
| **4.** | **21/22/297** | **9:20 (5 mins)** | **Matters Arising and Action Log.** | Chair | To discuss any matters arising from previous meetings and provide updates and review where appropriate. | **A** | Read enclosure |
| **5.** | **21/22/298** | **9:25 (10 mins)** | **Chair/CEO's Update.** | Chair/ L. Shepherd | To provide an update on key issues and discuss any queries from information items. | **N** | Verbal |
| **Year-end Review and Forward Look for 2022/23** | | | | | | | |
| **6.** | **21/22/299** | **9:35 (20 mins)** | **Operational Plan for 2022/23; including an Update on Activity, Finance and the Workforce.** | A Bateman/ R. Lea/ M Swindell | To provide an update on the Operational Plan for 2022/23, activity, finance and the workforce. | **A** | Report |
| **Strategic Update** | | | | | | | |
| **7.** | **22/23/300** | **9:55 (10 mins)** | **ICS Development Update.** | L. Shepherd | To receive an update on the development of ICSs. | **A** | This item was deferred |
| **8.** | **22/23/301** | **10:05 (10 mins)** | **Next Steps in Developing the Trust Strategy.** | L. Shepherd/ J. Grinnell | To launch the proposed evidence based approach to strategic planning towards the Trust's 2030 vision. | **N** | This item was deferred |

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|---|---|---|---|---|---|---|---|
| **9.** | **21/22/302** | **10:15 (10 mins)** | **Alder Hey in the Park Campus Development Update.** | D. Powell | To provide an update on key outstanding issues/risks and plans for mitigation. | **A** | Read report |
| **Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led** | | | | | | | |
| **10.** | **21/22/303** | **10:25 (10 mins)** | **Serious Incident Report.** | N. Askew | To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. | **A** | Read report |
| **11.** | **21/22/304** | **10:35 (10 mins)** | **Q3 DIPC Report:**<br>• **Next steps for living with Covid-19 at Alder Hey - staying safe in 2022/23.** | B. Larru | To receive the DIPC report for Q3.<br>To receive a briefing with regard to the proposed approach to remaining Covid safe. | **A** | Presentation |
| **12.** | **21/22/305** | **10:45 (15 mins)** | **Corporate Report – Divisional updates:**<br>- **Medicine.**<br>- **Community & Mental Health.**<br>- **Surgery.** | U. Das<br>L. Cooper<br>R. Craig | To receive a report on the Trust's performance for scrutiny and discussion, highlighting any critical issues. | **A** | Read report |
| **Sustainability through External Partnerships** | | | | | | | |
| **13.** | **21/22/306** | **11:00 (10 mins)** | **Liverpool Neonatal Partnership Update.** | LNP Team | To receive an update on progress. | **A** | Verbal |
| **The Best People Doing Their Best Work** | | | | | | | |
| **14.** | **21/22/307** | **11:10 (10 mins)** | **2021 Staff Survey Results.** | M. Swindell | To receive the published results of the 2021 NHS Staff Survey. | **A** | Presentation |
| **15.** | **21/22/308** | **11:20 (15 mins)** | **People and Wellbeing Update; including:**<br>• **BAME Inclusion Taskforce report on achievement and next steps.** | M. Swindell<br>C. Dove | To receive the People and Wellbeing Report.<br>To report on the achievements of the BAME Inclusion Taskforce and to advise of the next steps. | **A**<br>**A** | Read report<br>Read report |

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|---|---|---|---|---|---|---|---|
| **16.** | **21/22/309** | **11:35 (5 mins)** | **Gender Pay Gap.** | M. Swindell | To provide an update on the gender pay gap. | **A** | Presentation |
| **Strong Foundations (Board Assurance)** | | | | | | | |
| **17.** | **21/22/310** | **11:40 (10 mins)** | **Board Assurance Framework Report; including Corporate Risk Register.** | 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 |
| **18.** | **21/22/311** | **11:50 (15 mins)** | **Board Assurance Committees; report by exception:**<br>• **Resources and Business Development Committee:**<br>- **Chair's verbal update from the meeting held on the 28.3.22.**<br>- **Approved minutes from the meeting held on the 24.1.22.**<br>- **Approved minutes from the meeting held on the 18.2.22.**<br>• **Safety and Quality Assurance Committee:**<br>- **Chair's Highlight Report from the meeting held on the 23.3.22.**<br>- **Approved minutes from the meeting held on the 16.2.22.**<br>• **People and Wellbeing Committee:**<br>- **Chair's Highlight Report from the meeting held on the 22.3.22.** | I Quinlan<br><br>F. Beveridge<br><br>F. Marston | To escalate any key risks, receive updates and note approved minutes. | **A** | Verbal/ read approved minutes |

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|---|---|---|---|---|---|---|---|
| | | | - **Approved minutes from the meeting held on the 15.2.22.** | | | | |
| **Items for information** | | | | | | | |
| **19.** | **22/22/312** | **12:05 (4 mins)** | **Any Other Business.** | All | To discuss any further business before the close of the meeting. | **N** | Verbal |
| **20.** | **21/22/313** | **12:09 (1 min)** | **Review of meeting.** | All | To review the effectiveness of the meeting and agree items for communication to staff in team brief. | **N** | Verbal |
| **Date and Time of Next Meeting:** Thursday 28th April 2022, 9:00am-1:00pm, via Microsoft Teams. | | | | | | | |

| REGISTER OF TRUST SEAL |
|---|
| **The Trust Seal was used in March 2022** |
| 382: Springfield Park Landscaping Project Contract Deed – Huntley Cartwright |

| SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION | |
|---|---|
| Financial Metrics, M11, 2021/22 | R. Lea |
| DIPC Q3 Report | B. Larru |
| NHS Staff Survey: Directorate Report/Benchmark Report | M. Swindell |

# PUBLIC MEETING OF THE BOARD OF DIRECTORS

**Confirmed** Minutes of the meeting held on **Thursday 24th February 2022 at 9:00am**
via Microsoft Teams

| | | | |
|---|---|---|---|
| **Present:** | Dame Jo Williams | Chair | (DJW) |
| | Mr. N. Askew | Chief Nurse | (NA) |
| | Mrs. S. Arora | Non-Executive Director | (SA) |
| | Mr. A. Bass | Interim Chief Medical Officer | (ABASS) |
| | Mr. A. Bateman | Chief Operating Officer | (AB) |
| | Prof. F. Beveridge | Non-Executive Director | (FB) |
| | Mrs. K. Byrne | Non-Executive Director | (KB) |
| | Mr. G. Dallas | Non-Executive Director | (GD) |
| | Mrs. A. Marsland | Non-Executive Director | (AM) |
| | Dr. F. Marston | Non-Executive Director | (FM) |
| | Mr. I. Quinlan | Vice Chair/Non-Executive Director | (IQ) |
| | Mrs. L. Shepherd | Chief Executive | (LS) |
| | Mrs. M. Swindell | Chief People Officer | (MS) |
| **In Attendance** | Dr. J. Chester | Director of Research and Innovation | (JC) |
| | Ms. L. Cooper | Director of Community Services | (LC) |
| | Mr. R. Craig | Interim Director of Surgery | (RC) |
| | Dr. U. Das | Director of Medicine | (UD) |
| | Mr. M. Flannagan | Director of Communications | (MF) |
| | Mrs. D. Jones | Director of Strategy and Partnerships | (DJ) |
| | Mrs. R. Lea | Acting Director of Operational Finance | (RL) |
| | Mrs. K. McKeown | Committee Administrator (minutes) | (KMC) |
| | Mr. D. Powell | Development Director | (DP) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Mrs. K. Warriner | Chief Digital and Information Officer | (KW) |
| **Observing** | Prof. J. Jankowski | Member of the public. | (JJ) |
| | Ms. J. Williams | | (JW) |
| **Apologies:** | Prof. M. Beresford | Assoc. Director of the Board | (PMB) |
| | Mr. J. Grinnell | Deputy Chief Executive | (JG) |
| | Dr. A. Hughes | Deputy Medical Director | (AH) |
| | Mrs. C. Liddy | Managing Director of Innovation | (CL) |
| **Patient Story** | Ms. A. Smart | Parent | (AS) |

**Patient Story**

The Chair welcomed Anna Smart, who had been invited to February's Trust Board to share her son's journey with the Trust. Anna provided an overview of James' medical history and the treatment that he received to combat a life threatening diagnosis.

The Board was advised that James had a number of traumatic experiences as a result of having to have blood taken, cannulas inserted, MRI scans, general anaesthesia and frequent hospitalisation. Given James' intense experience of procedures he was referred to the Play Therapy service at Alder Hey in 2017 which made an immense difference to him and his family. Anna advised of James' success in undertaking an MRI scan without a general anaesthetic and being able to cope with a cannula insertion as a result of the support he received from the Senior Play Therapist, Phillipa Bradshaw, and being able to access holistic support. Anna pointed out that play therapy normalised hospital visits for James and has equipped him to

accept his vulnerabilities. Anna highlighted the importance of ensuring access to this service for all patients.

The Chair thanked Anna for sharing James' story and drawing attention to the important role that play therapy has in supporting patients.

**21/22/262 Welcome and Apologies**

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

**21/22/263 Declarations of Interest**

The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine. This declaration also applies specifically to agenda item 21/22/275.

**21/22/264 Minutes of the previous meetings held on Thursday 27th January 2022**
**Resolved:**
The minutes from the meeting held on the 27th of January were agreed as an accurate record of the meeting.

**21/22/265 Matters Arising and Action Log**

*Matter Arising*

There was no matters to discuss.

*Action Log*

All actions for February have been completed.

**21/22/266 Chair's and CEO's Update**

The Chair pointed out that the changes across Cheshire and Merseyside are being progressed and a number of appointments to the ICS have been made, which will be announced in the coming weeks. From a Trust perspective, as the organisation heads towards the end of the financial year the Chair felt that the Board can be pleased with Alder Hey's achievements despite the difficulties and pressures that have been experienced. It was reported that moving into 2022/23 the emphasis will be on restoration, productivity and long-term planning. As the Trust moves forward there will also be opportunities for strategic discussions and development for the Board.

Louise Shepherd drew attention to the three areas that thought needs to be given to in context of today's Board meeting;

1. *The NHS pivoting towards recovery and what that means* – It was reported that the National Recovery Plan focusses on elective work, therefore it is imperative to keep children and young people (CYP) at the forefront locally and nationally as there is a real danger that CYP will be overlooked due to the sheer volume of adult services. Attention was drawn to the work that is taking place with the National Children's Alliance to develop the accelerator to ensure CYP remain at the top of the agenda nationally. It was pointed out that the work that has been conducted by the Trust over the last five months during a very difficult period has put Alder Hey in a position to be a major influencer.

The Board was advised that provision for mental health hasn't been included in the National Recovery Plan but there is a Mental Health Plan therefore it is important to progress the actions in the plan and look at how Alder Hey works in partnership with colleagues across C&M to tackle the issue of mental health for CYP. Attention was drawn to the innovative approaches that have been used to support the delivery of care along with the digital work that is taking place which colleagues and clinicians have embraced.

2. *Framing of the National Recovery Plan* – The Board was advised of the ambiguity of the funding at the present time which makes it difficult to plan ahead. Partnerships will be key going forward as this will be the route that funds will flow through in the future. It was reported that a number of important appointments have been made in the region with the current Chair and CEO indicating that they would like Alder Hey to be the lead organisation in terms of developing a children's network and driving the agenda forward.

   In terms of research, the Liverpool system is looking towards developing a compelling research offer in partnership. An important meeting has been scheduled for the end of March 2022 to look at how this offer will be progressed. It was reported that Alder Hey is still seen as a key partner and the system still sees children's research as a major part of the whole effort going forward.

   Local discussions are taking place around partnership working across Cheshire and Merseyside (C&M) and within the region more generally. The Trust is involved with the group that is looking at how acute hospitals in Liverpool should work together to improve pathway working and research. It was reported that the Specialist Trust Alliance initiative has brought LUFT and the Liverpool Women's Hospital into the wider discussions that focus on the main issues that are important to health services and the recovery of the city going forward.

3. *People* – It was pointed out that people are at the heart of everything the Trust does, and it is a big ask to continue driving forward the necessary agendas but having a fantastic team of forward thinking people in all levels of the organisation is helping hugely. A key part of this is the Chief Medical Officer role. Last month saw the Trust go through a process to try and appoint a new Chief Medical Officer which was unsuccessful. Following discussions, the interim Chief Medical Officer, Alfie Bass, agreed to remain in this role for a further twelve months. Louise Shepherd thanked Alfie Bass for his leadership and dedication in supporting the Trust with its vision and direction of work.

The Chair felt that the update sets the context for February's Board and the next steps that need to be taken. The Chair formally welcomed Alfie Bass in his role as interim Chief Medical Officer.

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

**21/22/267 Recovery Plan 2021/22**

*National Recovery Plan*

The Board received a briefing on the national Delivery Plan for tackling the Covid-19 backlog of elective care. A number of slides were shared which provided information on the following areas:

- An overview of the plan;
  - Increasing health services capacity.
  - Prioritising diagnosis and treatment.
  - Transforming the way in which elective care is provided.
  - Providing better information and support to patients.
- Ambitions of the plan;
  - Reduce long waits for elective care.
  - Diagnostic tests within 6 weeks.
  - Urgent cancer diagnosis within 28 days.
  - Transform the outpatient model of care.
- Capital funding.
- Increasing capacity;
  - Safely adapting infection prevention control measures.
  - Using digital technology and data systems to free up capacity.
- Transforming the way in which the Trust provides elective care;
  - Making outpatient care more personalised.
  - Alder Hey Anywhere digital platform vision.
- Prioritising diagnosis and treatment;
  - Reducing long waits.
  - Diagnostics.

The Chair asked as to whether it is possible to incorporate data into a dashboard to monitor the Trust's progress against the National Delivery Plan and highlighted the importance of reporting into C&M and the region to demonstrate progress and the consequences of the investment. It was confirmed that these standards will be included in the Corporate Report.

**21/22/267.1 Action: AB**

*Update on People Issues*

The Board was informed of the pause of the vaccine as a condition of deployment.

It was reported that as of the 24.2.22 sickness absence is 7%. The general sickness absence position is on a downward trajectory, with the current position at 5.3%. Sickness absence will continue to be monitored, especially in light of the Government's announcement this week on the lifting of Covid restrictions.

The Chair thanked everyone for the updates and pointed out that further clarity on restrictions at Alder Hey will be provided over the coming weeks.

**Resolved:**
The Board noted the updates provided under the Recovery Plan for 2021/22.

**21/22/268 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:

- *Schemes* – The Trust is awaiting approval from NHSI following the release of new guidance around Treasury approval when including additional buildings in a PFI. Subject to approval, work will commence on the construction of the new Neonatal scheme as soon as possible.

  A revised completion date has been issued by Galliford Try stating that the

construction of Sunflower House will be completed by the 29th of April 2022. The analysis of the revised programme and claim for prolongation costs are underway.

- *Park Reinstatement* – Phase 2 is nearing completion and phase 3A is planned to commence in April/May with a completion date of 2024. Discussions are taking place to agree a plan that will help bring the completion date of the park forward so that it can be handed over to Liverpool City Council and the community as soon as possible. A further update on this matter will be provided in March.

- *North East Plot Development* - The Trust is in the process of compiling a business case that will support the buy-back land option on the North East plot development.

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

**21/22/269 Serious Incident Report**

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.1.22 to the 31.1.22. The following points were highlighted:

- There were eight incidents reported to StEIS, which included one Never Event.
- There were zero serious incidents closed in January.
- The Trust declared one StEIS reportable incident requiring an investigation that related to a Grade 4 pressure ulcer.
- It was reported that the Division of Surgery has completed their overdue action plans for the Division. The Division of Medicine has six action plans outstanding which will be completed by March 2022.

**Resolved:**
The Board received and noted the contents of the Serious Incident report for January 2022.

**21/22/270 Q3 PALS and Complaints Report**

The Board was provided with an overview of formal complaints, informal concerns (PALS) and compliments received and closed between October to December 2021/22 (Q3). The following points were highlighted:

- The Trust has seen an improvement in compliance of acknowledging complaints within a three day period with 97% of formal complaints being within 3 working days during Q3 and with 33 (85%) being acknowledged on the same day.
- There were no new referrals to the Parliamentary and Health Service Ombudsman during this period. However, there are two ongoing investigations.
- There were 395 informal concerns received during Q3 2021/22, compared to 236 in Q3 2020/21. The main theme was around communication.
- The Board was advised that an action plan for the improvement of complaints has been submitted to the Safety and Quality Assurance Committee.
- It was reported that compliance has improved in terms of responding to complaints within a twenty-five day period; 27 of 39 first stage complaints

received in Q3 were responded to during the same quarter; 12 (44%) were responded to within 25 working days, however 3 of these complaints have subsequently been re-opened.

- The current format of the Complaints and PALS report is to be amended and from Q1 onwards will provide a monthly update and a quarterly summary to identify the improvements that are being made.

**Resolved:**
The Board received and noted the PALS and Complaints report for Q3.

**21/22/271 SARC Accreditation**

A proposal was submitted to the Board to request approval with regard to Alder Hey becoming the Legal Entity for the Paediatric Sexual Assault Referral Centre (SARC).

The Board was provided with an overview of the current arrangements for the SARC service, and the contract that is in place with St. Mary's Hospital in Manchester who provide the forensic element of this service.

From October 2023 it is a legal requirement that all SARCs achieve accreditation via the UK Accreditation Service (UKAS), with a key requirement for accreditation being the identification of the 'Legal Entity'. It was pointed out that the organisation that is awarded the UKAS accreditation is legally responsible for all aspects of the SARC provision which will include the forensic element. If the Board agrees that the Trust is to become the legal entity for the SARC service, the organisation will commence the accreditation process to achieve accreditation. In the event the proposal is declined, St. Mary's may choose to apply for legal entity and run the SARC service that is situated on the Alder Hey site.

Erica Saunders felt that from a governance perspective the accreditation would strengthen the Trust's position and enable it to demonstrate compliance with national requirements. It was pointed out that the costs of the accreditation are paid for by Merseyside Police and support is being provided by a number of the force's Quality Officers who are helping the Trust with the process for gaining accreditation.

Louise Shepherd queried as to whether the Trust needs to put anything in place to reflect the change to the arrangements, if the proposal is approved by the Board. It was reported that Alder Hey will work alongside St. Mary's Hospital once it commences the accreditation process in order to transfer responsibility and employ the respective Forensic Physicians. The Board was advised that the Trust will align the accreditation process with the changes that it wants to make to the SARC service and will provide an update on the outcome in terms of what the whole process will entail.

**21/22/271.1 Action: LC**

Fiona Marston queried as to whether the risks related to the SARC service will be included in the BAF. It was confirmed that they will if the proposal is approved. Fiona Marston advised that she was unable to access the embedded documents in the report. It was confirmed that the three documents embedded in the report had been circulated separately to Board members.

Following discussion, the Board agreed to approve the proposal for Alder Hey to accept the role of the legal entity for the SARC.

**Resolved:**
The Board noted the contents of the report and approved the decision for Alder Hey to accept the role of legal entity

**21/22/272 Q3 Mortality Report**

The Board received the Mortality Report for Q3, 2021/22. The following points were highlighted:

- It was reported that there has been a focus on two areas during Q3; review of deaths and HRMG compliance.
- There were five sudden unexpected deaths during October and November of which two were traumatic; one stabbing and one accident. It was confirmed that two of the trauma deaths are undergoing RCAs.
- Attention was drawn to the challenges being experienced in terms of HMRG being able to review deaths in line with the timeframe that is set out.
- One of the most significant changes will be the introduction of the Medical Examiner (ME) process. This will be a legal requirement by April 2022 in terms of providing scrutiny for all deaths. It was reported that discussions have taken place with colleagues at LHCH to see if Alder Hey is able to share LHCH's Medical Examiner resource from April 2022 onwards. The Trust is still awaiting a response.

A suggestion was made with regard to liaising with the Children's Alliance to see if they can offer any support on the new ME process.

**21/22/272.1 Action: ABASS**

Kerry Byrne drew attention to page 2 and 3 of the report and pointed out that there is no plan in place to address the concerns that have been raised about the alerts on the Meditech system, and asked that assurance be provided to confirm that these actions have been captured and are being tracked.

**21/22/272.2 Action: ABASS**

**Resolved:**
The Board received and noted the content of the Q3 Mortality Report.

**21/22/273 Digital Information and Technology Update; including an update on Alder Care**

The Board received an update on national digital developments, Alder Hey Digital and Information Technology progress and key areas of digital transformation. The following points were highlighted:

- Nationally, there have been some significant developments with structures and ways of working. This includes the abolition of NHSX and the lift and shift of NHSX and NHS Digital colleagues into NHS England & Improvement. The move includes a much closer link to transformation activities and includes the establishment of the 'Office of the CIO'.
- Due to some of the national changes HIMMS accreditation is back in the spotlight.
- Discussions are taking place around electronic patient records, and the Trust is in the process of refreshing its Digital Strategy.
- The Board was advised of the areas of work that have gone live;
  - HIMSS 7 accreditation.

- A Board Development session for data and digital is in the process of being scheduled.
- It was reported that progress is being made with the Alder Care programme which is one of the key priority programmes for 2022. Alder Care is the programme which will see a major upgrade to the Trust's core electronic patient record system on Meditech. This upgrade will impact all staff who utilise Meditech and is a major change programme for Alder Hey.
- Alder Hey is looking to go live in September/October 2022 with the ePPR upgrade. It was reported that the Trust has had a number of challenges which has subsequently delayed the go live date.

The Chair queried as to whether the Trust is in a position to attract the right members of staff. It was reported that there is a lot of change in terms of the digital world and therefore recruitment is a real challenge for the profession at the present time.

**Resolved:**
The Board received and noted the Digital Information and Technology Update.

**21/22/274 Corporate Report**

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. The following points were raised:

*Medicine*

Attention was drawn to the thirty-nine outstanding NICE guidelines for the Division of Medicine and it was confirmed that there is now an action in place for each guideline. It was reported that the Division's Governance Lead is monitoring this area of work going forward.

*Mandatory training for medical colleagues Trust wide* – Having gained feedback from other trusts across the region in terms of how they are dealing with the issue of mandatory training, it was confirmed that a letter will be sent to clinicians Trust wide advising them that revalidation won't take place unless they have completed their mandatory training remit.

*Surgery*

The Board was advised that theatres will return to a full schedule w/c the 28.2.22, which will consist of a 139 lists per week.

It was reported that there were 18 on the day theatre cancellations for non-clinical reasons in January 2022 which compares with 23 in December and 51 in November. In terms of 28 day breaches, they have reduced to 7 for January 2022 from 23 in December 2021.

The waiting list for the Division of Surgery has remained fairly static since October and stands at 11,567 for January. There are 231 patients who have waited over 52 weeks for treatment but again these figures have remained level since September 2021.

Louise Shepherd thanked Richard Craig for stepping into the Director of Surgery role on an interim basis and leading the Division.

*Community*

During the month of January there were two young people who remained in an acute inpatient bed but required a specialist eating disorder bed. One of these patients was detained under Section 3 of the Mental Health Act. It was pointed out that this is the forth young person who has been detained in the last twelve months. It was confirmed that one patient has since been allocated an eating disorder bed, and the other patient is still waiting as there are none nationally.

On behalf of the Board, the Chair acknowledged the pressures on the Trust as a result of the overwhelming rate of referrals.

**Resolved:**
The Board received and noted the Corporate Report for January 2022 which included updates from each of the Divisions.

**21/22/275 Memorandum of Understanding (MoU) with iiCON (LSTM)**

It was reported that iiCON is a leading global centre for infectious diseases hosted by the Liverpool School of Tropical Medicine and brings together industry, academia and the NHS in a collaborative programme.

The Trust's Innovation Centre has previously engaged with iiCON on areas of mutual interest. This particular MoU brings together new areas of potential collaboration in clinical evaluation of innovative products, and trial designs are under discussion which may provide opportunities for international collaboration which align with the Trust's Department of International Child Health thereby enhancing the international profile.

The Board was asked to approve the draft MoU with iiCON which it is felt will facilitate further discussion and development of collaborative opportunities in Research and Innovation.

**Resolved:**
The Board approved the MoU with iiCON.

**21/22/276 People and Wellbeing Update**
**Resolved:**
The Board received and noted the contents of the People and Wellbeing report.

*BAME Inclusion Taskforce update*

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

- The Board was advised of the short-term 'Paper Free' project that the Trust has been working on and it was confirmed that ten people have been recruited as a result of this project, with the majority of successful candidates coming from BAME backgrounds.
- *Apprenticeships* – There were a total of 173 apprenticeships but only 9 BAME candidates were successful. Attention was drawn to the Government

initiative that took place in 2021 around nurse apprenticeships. It was reported that the Trust received 484 applications with 91% received from candidates from a white background and 5% from a BAME background. The Board was advised that the initiative took place so quickly that it didn't allow the Trust to establish a diverse interview panel. It was confirmed that none of the BAME candidates made it to the final stage of the interviews. Nathan Askew advised that the learning following this initiative is to be more explicit when addressing the application process in terms of progressing applications that meet the relative criteria. It was also pointed out that a piece of work is taking place to help people obtain the appropriate qualifications required to access apprenticeships.

- *Universities* – The Board was advised that John Moores University had a plan for upscaling their programme working with refugees who were successful in gaining medical qualifications from their country of origin. It was reported that Alder Hey received one candidate from this initiative. Attention was drawn to the importance of writing to the Vice Chancellors of Universities to highlight the issues that are being experienced from a student diversity perspective. It was felt that the Trust should look towards gathering diversity data from local universities on an annual basis and providing feedback via a diversity lens. Garth Dallas advised that contact has been made with Liverpool John Moores at Vice Chancellor level and work is taking place to progress discussions on this matter.
- Work is ongoing around recruitment practices.
- *Volunteers* – It was reported that since work has taken place with this team there are now over 25% of volunteers from a BAME background. It was suggested that a letter of congratulations should be sent to the team.

**21/22/276.1 Action: LS/DJW**

- Claire Dove advised that her time as Chair of the BAME Taskforce is coming to a close and the taskforce will be disbanded in its current form. It was confirmed that a transition plan is in the process of being compiled.

The Board had a discussion around the contents of the report that has been published by the NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'. Shalni Arora advised that the Trust is looking for Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and queried as to whether this could be included as part of a proposal to look at health inequalities and child health across the BAME communities. Claire Dove agreed to discuss this matter outside of the meeting.

**21/22/276.2 Action: CD/SA**

Dani Jones drew attention to the piece of work that has been commissioned that will look at reducing waiting lists for patients from a BAME background.

The Chair and Louise Shepherd thanked Claire Dove for the progress that has been made as a result of her leadership.

**Resolved:**
The Board noted BAME Inclusion Taskforce update.

**21/22/277 2021/22 H2 Plan; including Financial Update, M8 2021/22.**

*M10 YTD position:*

The Trust has achieved an in-month surplus of £2.1m surplus against a breakeven plan. The YTD position is a surplus of £1.7m and the cash in bank the is £87.8m. Capital spend YTD is £18.2m in line with plan YTD.

Key drivers relate to:

- Following activity baseline changes, C&M achieved the ERF threshold between M7 and M9 with a backdated income payment of £1.3m in M10 for the Trust.
- There have been Divisional improvements in month due to non-recurrent vacancies, reduced activity in month and an improvement in depreciation.
- The Trust still has a shortfall in its recurrent CIP with 61% now achieved.

*Latest H2 Position*

It was reported that C&M are now likely to achieve a breakeven position overall due to:

- Achievement of the ERF threshold; £18m already earned with the potential for further ERF in Q4.
- Surge funding to offset costs incurred due the Omicron wave.
- Mitigations from most providers due to reduced spend.

The Board received an updated H2 scenario analysis for Alder Hey showing the breakeven position as most likely to be achieved by the end of March subject to no further deterioration in run rate spend. This includes the achievement of the ERF income. It was reported that work will continue in terms of securing capital funding.

The Chair thanked all those involved in helping the Trust achieve its current financial position for 2021/22.

**Resolved:**
The Board noted the latest position for H2 and the update for M10.

**21/22/278 Leader Standard Work – Supporting Performance and Improvement**

The Board received a report on the Leader Standard Work that the Executive team has been progressing over a period of time. The report provided information on the scope of the work, the reason for action, recommendations and benefits of new routines, the Trust's commitments and aims along with the conclusion/next steps.

It was reported that 'Standard Work' related to how processes and systems operate is vital to the consistent delivery of effective performance and improvement. As part of the Leadership Behaviours workstream in Brilliant Basics, this paper sets out specific recommendations for Standard Work and new routines for the Executive team.

Erica Saunders asked NED colleagues to provide comments on the proposed changes to the Execs way of working which will have an impact on the way Execs interact with NEDs via the Assurance Committees. The following feedback was provided:

- Fiona Marston felt that the Executives should take stock of the meetings that they presently attend with the view to reducing participation in unnecessary meetings. It was also pointed out that making better use of summaries in reports may help to reduce reading time and free up capacity.

- Fiona Beveridge highlighted the importance of adopting a different culture in terms of delegating responsibility and feeling comfortable with a colleague providing an update. It was also suggested that a process be implemented to monitor/ensure that the recommendations in the paper are being adhered to.
- Kerry Byrne pointed out that the half day reflection time is really important but tends to be lost when people are busy.
- Shalni Arora felt that the standardisation of reports and presentations will save time and confirmed her support of the half day reflection time. Erica Saunders advised that there is an outline proposal for the refresh and rebranding of paperwork.
- Ian Quinlan suggested introducing time management courses as they provide people with the tools to make the most of their workday.

The Chair pointed out that the challenge will be to hold each other to account. In the wider context it will be necessary to think carefully about who the best person is to be the voice of Alder Hey in external meetings, especially as particular meetings become increasingly critical.

**Resolved:**
The Board confirmed their support for the implementation of the Leader Standard Work.

**21/22/279 2022 Review of Risk Appetite Statement and Proposed Risk Tolerances**

The Board received a report on the 2022 review of the Risk Appetite Statement and proposed risk tolerances for discussion and approval purposes.

It was reported that discussions have been taking place over a period of time in terms of introducing this concept of tolerances and thresholds. There have been a number of changes to how the organisation manages its risk with discussions taking place Trust wide via a risk lens which the pandemic has accelerated. Board members were invited to share their views on progressing this approach.

Kerry Byrne advised the Board that it is important to set parameters for each type of risk in terms of what is acceptable and what isn't so this process can be implemented across the organisation to provide consistency. It is important for the Board to agree the proposed risk tolerance because in effect it means that when a risk reaches its tolerance level it will be closed with no further action required. It was reported that there are a number of risks that aren't at target but will be if risk tolerances are introduced, this is a significant change that will cascade down through the organisation via the Corporate Risk Register and individual risks. The Board was advised that in the event the proposal is approved work will take place with the Divisions to look at the impact of the changes and to see if change are required to the tolerances.

The Chair drew attention to the importance of the Board having a full understanding of the organisation's risk appetite and felt that in order to reach agreement members should ask themselves as to whether the proposed risk appetite feels appropriate.

Shalni Arora queried as to whether there is the possibility that divisions will have different risk appetites. It was reported that it is the role of the Board to set the risk appetite, and this will be cascaded to the Divisions/Corporate functions to ensure consistency.

Fiona Marston raised two points; 1. The risk relating to ICS is included from a regulatory and compliance perspective and yet it has a big financial impact to the Trust which is a major concern. 2. The risk appetite in the summary is minimal for diversity and inclusion and yet the organisation is challenging itself in terms of wanting a diverse workforce.

Fiona Beveridge queried the process for dealing with a combination of targets and tolerance when risk factors are outside the organisation's remit. It was reported that current targets are to be replaced by thresholds and in terms of dealing with risks outside of the organisation's control the Trust will continue to address this in the way it does currently. Fiona Beveridge raised concerns about potential gaps that won't be mitigated, referring to the access risk as an example.

Louise Shepherd commented that she was comfortable with the approach and felt that a lot of progress has been made on this area of work and supported the comments made by Fiona Marston and Fiona Beveridge. Attention was drawn to the regulatory element of risks and it was pointed out that there are times when the organisation has no control over external wider factors, but Alder Hey still has a responsibility to try and tackle these risks.

Nathan Askew highlighted that agreeing a nil risk appetite for risks relating to quality and safety could potentially cause difficulty particularly at clinical/ divisional level to mitigate risks as far as possible and close them down. It was agreed to discuss this matter further during an Executive team meeting.

**21/22/279.1 Action: NA/ES**

Following discussion, Board members endorsed the Risk Appetite Statement and proposed risk tolerances, taking into account the comments made during the meeting.

**Resolved:**
The Board endorsed the approach for the Risk Appetite Statement and proposed risk tolerances, taking into account the caveats detailed in the minutes.

**21/22/280 Board Assurance Framework (BAF)**

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:

- The Board was advised of the closure of risk 1.6. It was felt that it was the appropriate time in which to close this risk as it was originally set in the context of the pandemic and the organisation has moved beyond this.
- It was confirmed that a risk relating to buildings will be included in February's version of the BAF.

**Resolved:**
The Board noted the contents of the BAF report as at the end of January 2021 and endorsed the closure of risk 1.6.

**21/22/281 Board Assurance Committees**

*RABD* – During February's meeting the Committee focussed on the financial workstreams and the ongoing projects. Attention was drawn to the complex environment that the finance team is working in and how well they are doing in terms of addressing issues.

*SQAC* – The approved minutes from the meeting that took place on the 19.1.22 were submitted to the Board for information and assurance purposes. During February's meeting the Committee focussed on the transition for children with complex needs and received an update on NICE guidelines. The Committee also received confirmation that the Section 31 Notice issued to the Trust in December 2020 has been closed.

*PAWC* – The approved minutes from the meeting that took place on the 18.1.22 were submitted to the Board for information and assurance purposes. During February's meeting the Committee focussed on the People Plan, the Staff Survey, and the review of the process for the recording and monitoring of staff turnover. It was reported that the Trust is starting to see a downward trend in sickness absence figures. The Committee has also commenced to review the wellbeing risks that are on the BAF.

*Innovation Committee* – The approved minutes from the meetings that took place on the 11.10.21 and the 24.1.22 were submitted to the Board for information and assurance purposes. During February's meeting the Committee focussed on the draft Innovation Strategy and Operational Plan for the delivery of the strategy. It was confirmed that a small working group is to be established to address the governance element of the strategy. The Committee also received a presentation on the current position of the partnership for transparent masks.

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

**21/22/282 Any Other Business**

The Board was advised that Alex Pitman is progressing the Green Plan, and an interim report will be submitted during April's Trust Board.

**21/22/82.1 Action: AP**

**21/22/283 Review of the Meeting**

The Chair felt that enough time had been allocated during the meeting to discuss key items and receive an update on the work that is taking place to prepare for the national agenda. During March the Board will set some time aside to discuss the system, and there will be a focus on the strategies for research and innovation in the new financial year.

**Date and Time of Next Meeting:** Thursday the 31st March 2022 at 9:00am via Teams.

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

Alder Hey Children's NHS
NHS Foundation Trust

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Actions for March 2022** | | | | | | | |
| 16.12.21 | 21/22/218.1 | Q2 Mortality Report | Follow-up on the meeting that took place between Nicki Murdock and the CEO of LHCH to confirm as to whether Alder Hey is able to share LHCH's Medical Examiner resource from April 2022 onwards. | J. Grinnell | 31.3.22 | Dec-21 | **22.2.22** - An update will be provided on the 31.3.22 |
| 24.2.22 | 21/22/267.1 | Recovery Plan 2021/22 | Include data/standards in the Corporate Report to monitor and demonstrate the Trust's progress against the National Delivery Plan. | A Bateman | 31.3.22 | On track Mar-22 | |
| 24.2.22 | 21/22/272.1 | Q3 Mortality Report | *New Medical Examiner Process* - Liaise with the Children's Alliance to see if they can offer any support on the new ME process. | A. Bass | 31.3.22 | On track Mar-22 | |
| 24.2.22 | 21/22/272.2 | Q3 Mortality Report | *Concerns raised about alerts on the Meditech System (refer to page 3 of the M&M report)* - Provide assurance that the alerts that have been raised as difficult to achieve on the current system have been captured, have actions against them and are being tracked. | A. Bass | 31.3.22 | On track Mar-22 | |
| 24.2.22 | 21/22/276.1 | BAME Inclusion Taskforce Update | Send a letter of thanks to the team who are responsible for volunteers to congratulate them on the successful work that has taken place to encourage volunteers from a BAME background to join the Trust. | Dame Jo Williams/ L. Shepherd | 31.3.22 | On track Mar-22 | |
| 24.2.22 | 21/22/279.1 | 2022 Review of Risk Appetite Statement and Proposed Risk Tolerances | Discuss the implications in greater detail of having a nil risk appetite for risks relating to quality and safety, during an Exec team meeting in March. | N. Askew/ E. Saunders | 31.3.22 | On track Mar-22 | |
| **Actions for April 2022** | | | | | | | |
| 16.12.21 | 21/22/214.1 | Chair's/CEO's Update | Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes. | K. McKeown | 28.4.22 | On track Apr-22 | |
| 24.2.22 | 21/22/271.1 | SARC Accreditation | Align the accreditation process with the changes that the Trust wants to make to the SARC service and provide an update on the outcome in terms of what the whole process will entail. | L. Cooper | 28.4.22 | On track Apr-22 | |
| 24.2.22 | 21/22/276.2 | BAME Inclusion Taskforce Update | *NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.* - Discuss the possibility of Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and child health across the BAME communities | S. Arora/ C. Dove | 28.4.22 | On track Apr-22 | |
| 24.2.22 | 21/22/282.1 | Any Other Business | *Green Plan* - Submit an interim report during April's Trust Board meeting. | A. Pitman | 28.4.22 | On track Apr-22 | |
| **Actions for June 2022** | | | | | | | |

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

Alder Hey Children's NHS
NHS Foundation Trust

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 24.6.21 | 21/22/65.2 | Approach to End of Life Care when there is a dispute | Provide a progress update on the Trust's process that supports end of life discussions and agreements. | Nicki Murdock/ Adrian Hughes | 30.6.22 | On track | |
| | | | | | | | |
| | | | | | | | |
| **Status** | | | | | | | |
| Overdue | | | | | | | |
| On Track | | | | | | | |
| Closed | | | | | | | |
| | | | | | | | |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

## Thursday 31st March 2022

| | |
|---|---|
| **Paper Title:** | **Operational Update: Omicron, winter pressures and recovery of services** |
| **Report of:** | **Adam Bateman, Chief Operating Officer** |
| **Paper Prepared by:** | Adam Bateman, Chief Operating Officer<br>Karl Edwardson, Head of Information<br>Kate Holian, General Manager<br>Mark Carmichael, Associate Chief Operating Officer |

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

## 1. Introduction

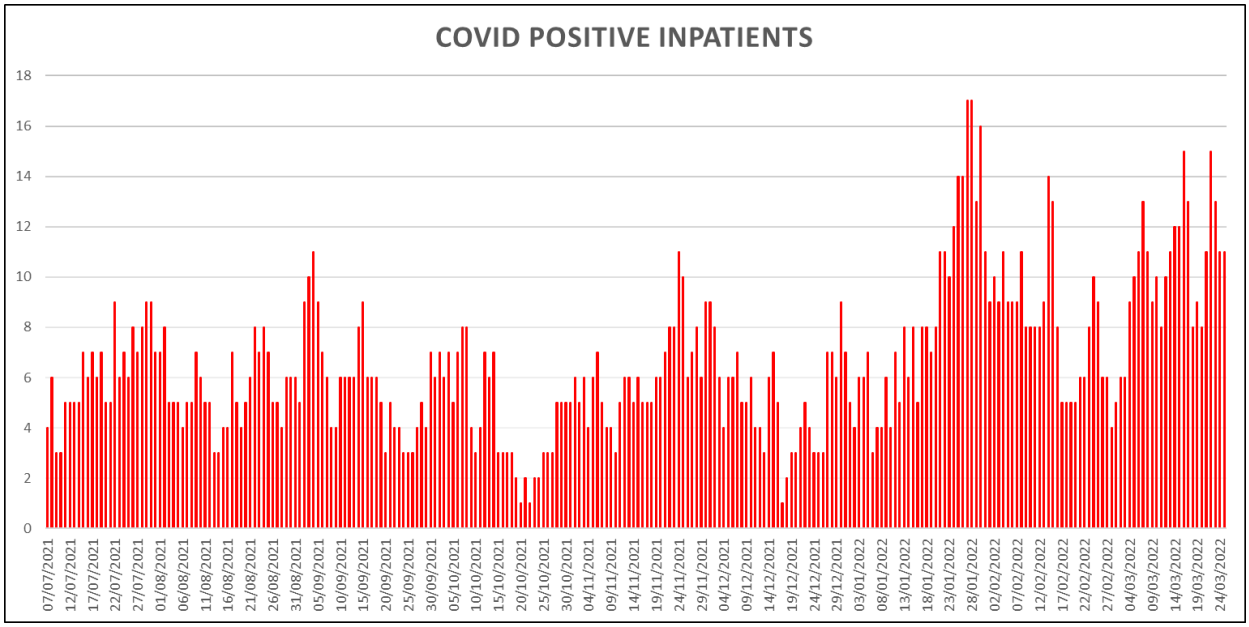
In February, the high community prevalence of Omicron and the persistence of high staff absence levels is placing additional pressures on staff and reducing the level of capacity we have available in our clinical services. Moreover, the daily numbers of non-Covid emergency admissions are rising. In the Emergency Department there has been a corresponding increase in waiting times.

The confluence of rising daily emergency admissions and high staff absence is causing a drag effect on our recovery plan, with elective waiting times projected to get slightly worse in March, before they get better.

## 2. Omicron

### 2.1 Covid-19 admissions

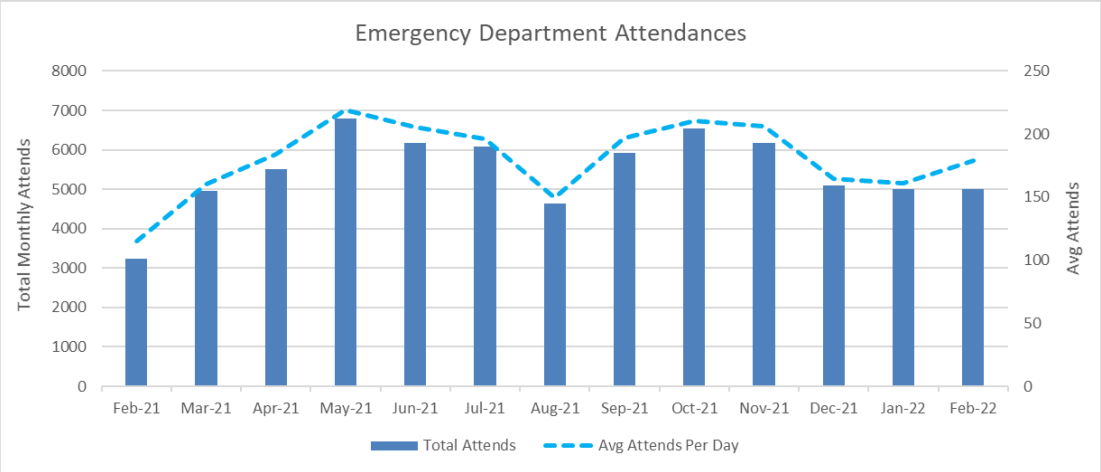
In February the number of children and young people in hospital with Covid-19 has been reducing. However, our latest data for March shows this trend reversing and a rise in C&YP in hospital and testing positive for Covid-19.



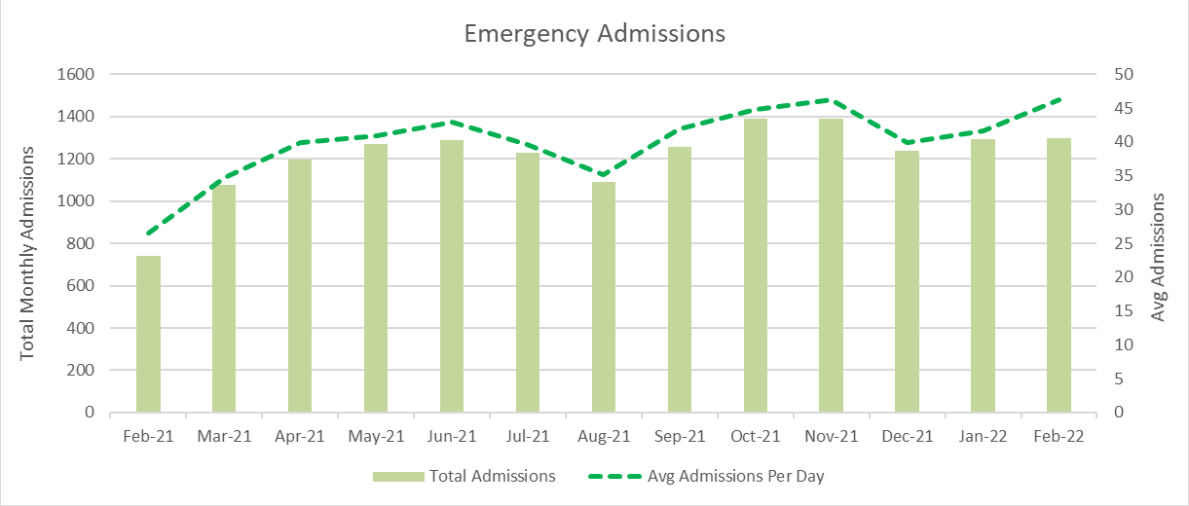
## 3. Emergency and urgent care admissions and attendances

### 3.1 Emergency Department attendances to hospital

In February, there was an increase in the number of daily attendances to the Emergency Department, and a 9.6% increase in attendances relative to 2019.




### 3.2 Emergency admissions to hospital




The acuity of presentations to the Emergency Department has increased as evidence by the rise in daily emergency admissions to the hospital, which is comparable to our peak in emergency admissions November 2021.

### 3.3 Emergency Department Clinical Quality Standards

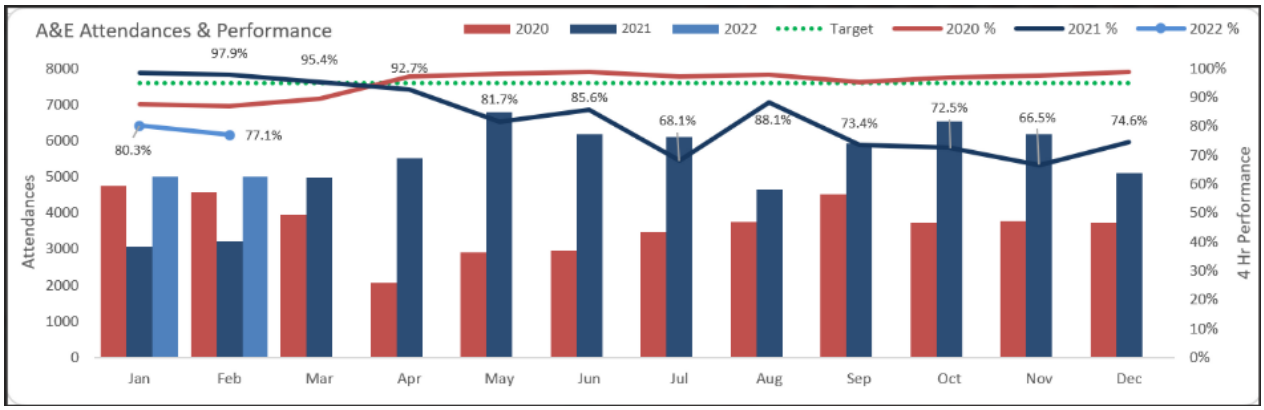
#### 3.3.1 4-hour standard

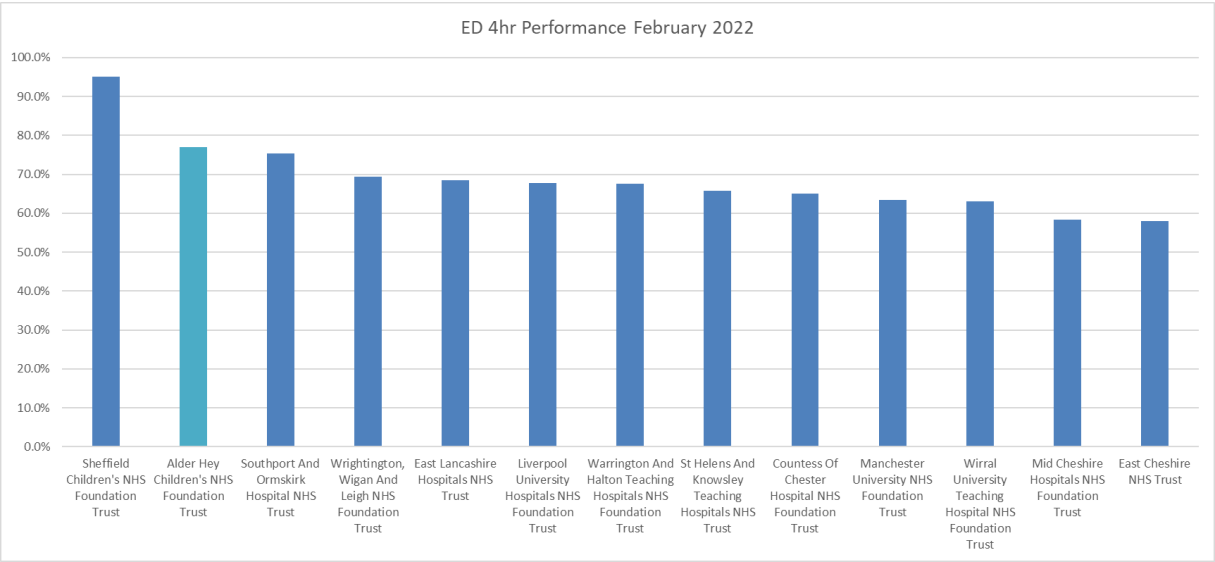
We treated 77.1% of patients within 4 hours, a decline relative to January, but the highest level of performance in Cheshire & Merseyside. There are significant challenges relating to staff availability,

caused by COVID and non-COVID absences; the clinical management teams continue to respond with creative scheduling and additional shifts.

We have an urgent care improvement plan which is focused on:

- **Launch of 'ED at its Best':** staff engagement programme jointly delivered by OD and Transformation focused on wellbeing, psychological safety and improvement engagement, launches 4th April
- **Review of ED footprint**: analysis of activity changes signals a significant shift in number of children in the urgent and very urgent category in comparison to 19/20; we are focus in on identifying alternative space on AH site for minor injuries/ailments and GP stream
- **Partnerships:** a planning meeting is scheduled with the CCG to explore the system approach to Paediatric Urgent Care

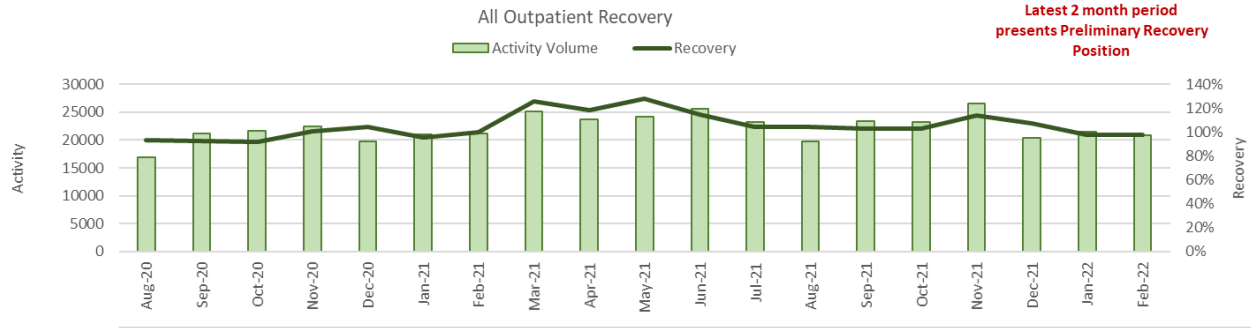


## 4. Elective care services

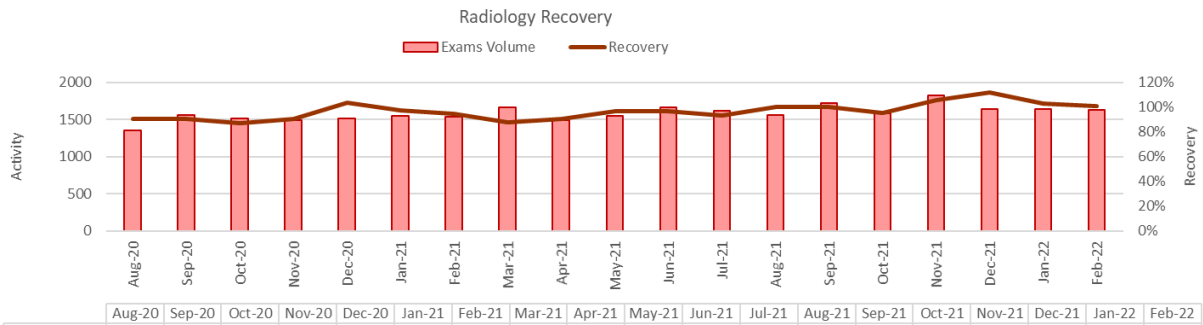
Our levels of planned care in February were good in the context of Omicron and staff absence levels that were just under 8%. We achieved 93% recovery of elective and day case services, 98% for outpatient services and 101% in Radiology. Nonetheless, this is lower than pre-Omicron levels and the reduction has stalled our progress in reducing the number of children and young people waiting over 52 weeks for treatment; this fell only slightly from 237 patients to 232. We are now working to fully restore the theatre schedule and review improvement plans for workforce expansion and productivity.

Outpatient recovery




| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity Volume | 16897 | 21115 | 21676 | 22484 | 19749 | 20987 | 21217 | 25050 | 23727 | 24151 | 25610 | 23250 | 19736 | 23432 | 23200 | 26547 | 20296 | 21431 | 20853 |
| Recovery | 94% | 92% | 92% | 101% | 104% | 95% | 100% | 126% | 118% | 128% | 115% | 104% | 104% | 103% | 103% | 114% | 107% | 97% | 98% |

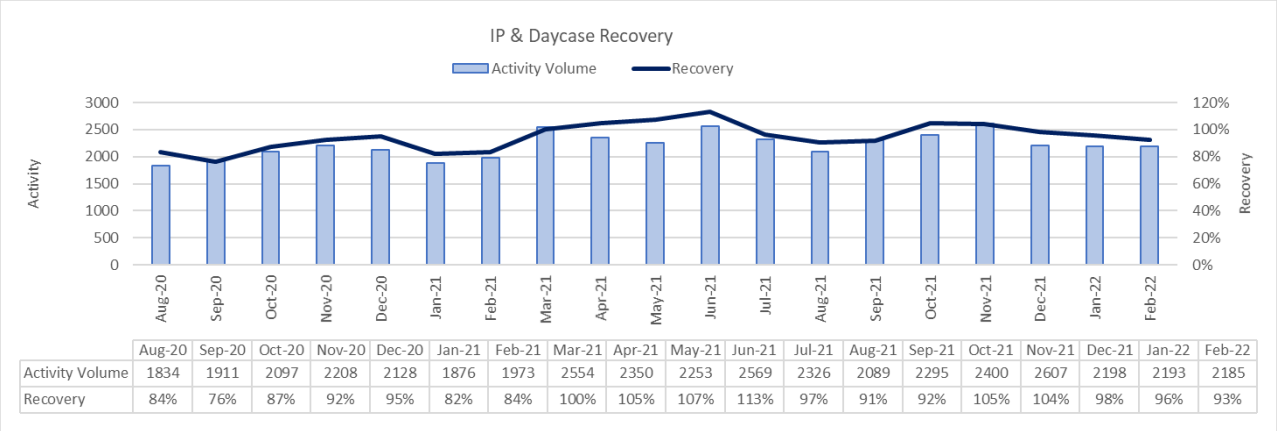
Radiology recovery




| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Exams Volume | 1353 | 1561 | 1510 | 1488 | 1510 | 1549 | 1531 | 1667 | 1496 | 1547 | 1663 | 1616 | 1563 | 1726 | 1582 | 1822 | 1637 | 1641 | 1626 |
| Recovery | 91% | 90% | 87% | 91% | 103% | 97% | 95% | 87% | 91% | 97% | 96% | 93% | 100% | 100% | 95% | 106% | 112% | 103% | 101% |

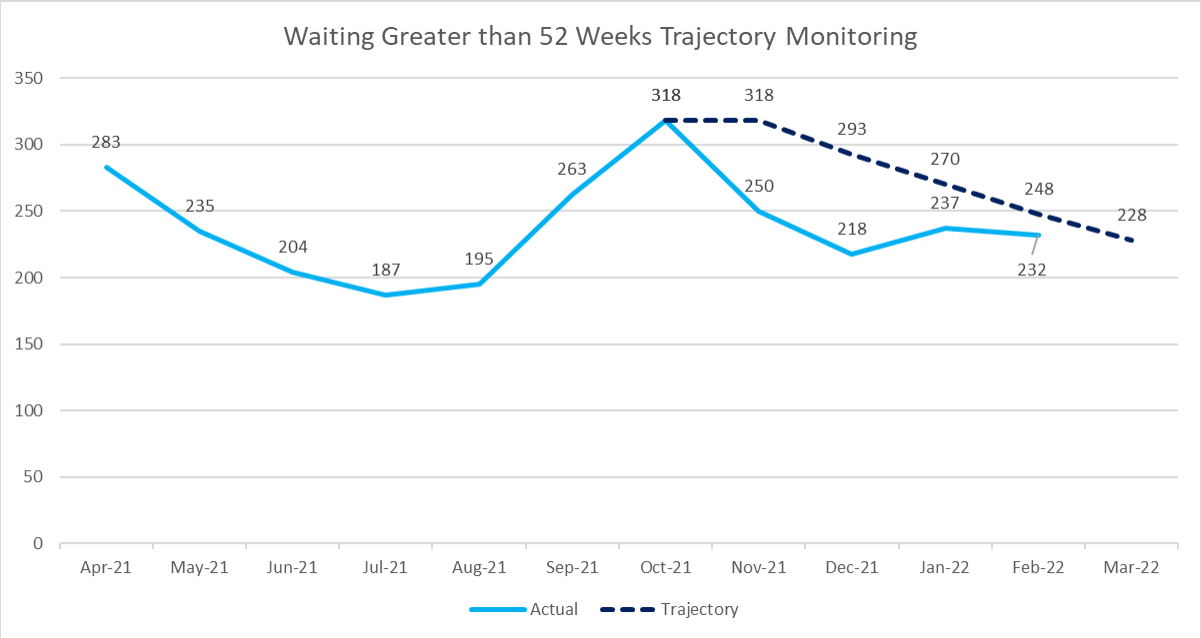
Whilst overall recovery is excellent, there are residual challenges in certain modalities. In MRI there has been a decline in the percentage of patients receiving a scan within 6 weeks, to 72.5%. The team are reviewing temporary staffing support and working patterns to realise an increase in scanning capacity. We also have an equipment failure in the DEXA service affecting service provision and we are in discussion with neighbouring paediatric Trusts to secure support pending the supply of new equipment.  affected the

Elective recovery




| | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Activity Volume | 1834 | 1911 | 2097 | 2208 | 2128 | 1876 | 1973 | 2554 | 2350 | 2253 | 2569 | 2326 | 2089 | 2295 | 2400 | 2607 | 2198 | 2193 | 2185 |
| Recovery | 84% | 76% | 87% | 92% | 95% | 82% | 84% | 100% | 105% | 107% | 113% | 97% | 91% | 92% | 105% | 104% | 98% | 96% | 93% |

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




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

Specialist CAMHS

Alder Hey Specialist Mental Health Services continue to experience high demand for services with a 37% increase in referrals in February 2022 when compared with the same period in 2019. Waiting times for treatment has remained static between January and February 2022. The service has continued to focus on recruitment to teams and we are in discussion with commissioners and NHSE to confirm available mental health investment for 22/23. In addition, we have also:

- Short term recruitment options are being explored, including fixed term contract, agency providers and overtime
- Introduced recruitment incentive scheme
- Review of caseload management and discharge processes launched to increase capacity in existing resource as much as possible

Eating Disorder Service

The Eating Disorder service is also experiencing unprecedented demand for support and has experience a **35%** increase in referrals in February 2022 compared to 2021 and **147%** compared to 2019. These pressures are also being faced nationally across community eating disorder and inpatient mental health services.

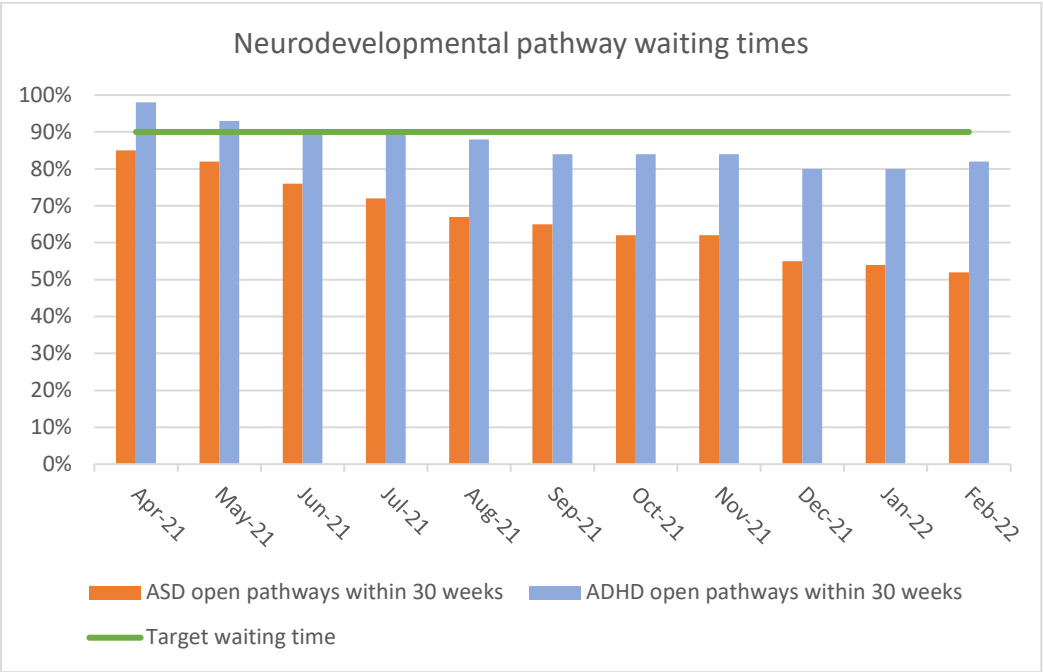
Waiting times for first assessment have reduced to a maximum of six weeks (against a national target of 4 weeks). This increase in demand as well as the increased number of acute paediatric admissions for eating disorders is significantly impacting on capacity within the service. Actions to support improvements include:

- Agency doctor and NHSP staff member in post to provide additional capacity
- Recruitment to vacancies ongoing, including utilisation of recruitment incentives to promote roles to out of area candidates
- Automatic direct booking of appointments using the Sefton and Liverpool CAMHS referral platform due to go live on 25 March 2022

## 4.4 Waiting times for Neurodevelopmental Pathways

There continues to be a sustained increase in referrals to the ASD and ADHD pathways in Liverpool and Sefton. This increase is impacting on the overall waiting time for completed assessments. At the end of February 2022, 52% of children waiting on the ASD pathway had waited 30 weeks or less and 82% for ADHD, this represents a slight improvement on the previous months position for ADHD. The services have developed improvement plans which include:

- Continued use of independent sector providers to support assessments for new ASD pathway.
- Commenced the recruitment to additional posts following commissioner agreement to invest further in capacity within the pathways
- Agreed improvements to the data dashboards used to support management of pathways



# BOARD OF DIRECTORS

**Thursday, 31st March 2022**

| | |
|---|---|
| **Report of** | Development Director |
| **Paper prepared by** | Associate Development Director- (23/03/2022)<br>Russell Gates |
| **Subject/Title** | Development Directorate<br><br>Campus Development report on the Programme for Delivery |
| **Background papers** | Nil |
| **Purpose of Paper** | The purpose of this report is to update the Trust Board on the Campus delivery. |
| **Action/Decision required** | The Board is asked to acknowledge the content of the report, the current status, risks and actions. |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | ➢ Delivery of outstanding care<br>➢ Sustainability through external partnerships |
| **Resource Impact** | Capital projects budget. |

# Campus Development report on the Programme for Delivery

## March 2022

### 1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.

As of Month 3 in Quarter 4 of 2021/22 the programme Delivery Timetable RAG rates projects against planned commencement date.

### 2. Programme Delivery Timetable

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

| Table 1. | 19/20 | 20/21 | | | | 21/22 | | | | 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Scheme** | **Qtr. 4** | **Qtr.1** | **Qtr.2** | **Qtr.3** | **Qtr.4** | **Qtr.1** | **Qtr.2** | **Qtr.3** | **Qtr.4** | **Year** |
| Initial Park Reinstatement (Phase 1) **COMPLETE** | | | | | | | | | | |
| Alder Centre occupation **COMPLETE** | | | | | | | | | | |
| Acquired buildings occupation Future use under review | | | | | | | | | | |
| Police station (Lower Floor) occupation **PROGRAMME TO BE REVISED** | | | | | | | | | | |
| Commence relocations from retained estate. | | | | | | | * | | | Final phase Q1 22/23 |
| Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks) **COMPLETE** | | | | | | | | | | Final phase |
| Main Park Reinstatement (Phase 2/100%) **COMPLETE** | | | | | | | | | | |
| Mini Master plan (Eaton Rd Frontage) 2 phases to plan | | | | | | | | | | |
| Infrastructure works & commissioning | | | | | | | | | | |
| Catkin Centre Construction | | | | | | | | | | |
| Catkin Centre Occupation | | | | | | | | | | |
| Sunflower House Construction | | | | | | | | | | |
| Sunflower House Occupation | | | | | | | | | | |
| Demolition Phase 4 (Final) | | | | | | | | | | Q2 22/23 |
| Final Park Reinstatement (Phase 3A) | | | | | | | | | | Q3 22/23 |
| Neonatal Development Tendering and Design **COMPLETE** | | | | | | | | | | |
| Neonatal Construction | | | | | | | | | | |
| Neonatal Occupation | | | | | | | | | | 23/24 |
| Orthotics move | | | | | | | | | | |
| Innovation Park 2 | | | | | | | | | | Q1 22/23 |

## 3. Project updates

### Park Reinstatement Phase 1

| Current status | Risks & Issues | Actions/next steps |
|---|---|---|
| Phase 1 of the park is now operational.<br><br>A planning application for the Multi-Use Games Area (MUGA) has now been submitted. The application is set to be determined by delegated powers in April. | Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9) | Planning decision expected mid-April. |

### Acquired Buildings Occupation (neighbouring sites)

| Current Status- on hold | Risks/issues | Action/next steps |
|---|---|---|
| **Knotty Ash Nursing Home**<br>**Under review following fire on 10th May.** | Delays to insurance pay out delays rebuild | Loss adjusters have increased their offer<br><br>A claim for temporary accommodation costs is ongoing. |

## Police Station (lower floor) occupation

| Current status | Risks/issues | Actions/next steps |
|---|---|---|
| Documents with lawyers for checking. Signature expected in April 2022<br><br>Costs to refurbish the ground floor are high so a plan to only refurbish part of the ground floor and move medical records off site is under review. | Police do not release the space while decisions are made in regard to additional police funding and its use. (Risk 2088, risk rating 12)<br><br>Refurbishment of the ground floor exceeds budget due to the state of the building. | Complete legal agreements.<br><br>Review of scope/requirements and seek alternative for medical records off site |

## Relocations

| Current status (Complete) | Risks/issues | Actions |
|---|---|---|
| Occupation of Innovation Park offices is complete. | | |

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

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

## Park reinstatement Phase 2/3

| Current status | Risks/issues | Actions |
|---|---|---|
| Landscaping has commenced. Phase 2 is complete, phase 3A is planned to start in May.<br><br>Capacity Lab have two major parties interested in supporting enhancement to the park through provision of a café/changing area. | Delays to demolition of old Catkin delays completion of phase 3A | Vacation of old Catkin into various locations is planned to complete in spring ready for decommissioning and demolition. Phase 3A will commence in May ahead of demolition.<br><br>Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress. |

## NEW Mini Master Plan for Eaton Rd frontage

| Current status- | Risks/issues | Actions |
|---|---|---|
| *No further progress required at the moment*<br>Design is now complete, taking in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Part of the scope will be funded by the 2 development sites as and when these are brought forward. | If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8)<br>Insufficient budget to complete the work | Plan the appropriate start date for the works to coincide with other works on site. |

## Infrastructure works & commissioning

| Current status | Risks/issues | Actions |
|---|---|---|
| Infrastructure changes to clear the neonatal site have been removed from the critical path and are due to commence in April.<br><br>Site power has been reconfigured to connect the Sunflower House.<br><br>A plan has been developed to allow the new Neonatal project to proceed whilst the remaining infrastructure is reconfigured. | Early indication is that to complete all of the work will exceed budget. Development team and finance are reviewing the outstanding work v budget<br><br>Delays to the infrastructure installation causes delays to the Neo and cluster projects. | The works remain on programme but close monitoring is being continued to watch for slippage.<br><br>Must maintain programme to avoid delays to the cluster and neonates projects |

## Catkin Centre and Sunflower House Construction

| Current status | Risks/issues | Actions |
|---|---|---|
| A further revised completion date has been issued by GT stating completion as 15th May 2022. The analysis of the revised programme and claim for prolongation costs have been refuted. Consideration of next steps is being discussed.<br><br>Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates. Contracts at Alder Park have been extended in line with the new planned occupation date<br><br>Furniture and interiors discussions have concluded and so furniture ordering has commenced. | Prolongation claim leads to additional costs.<br><br>Budget for furniture is inadequate | Revised programme along with cause and affect are being analysed.<br><br>Costed schedules to be produced to ensure affordability and then order furniture. |

## Demolition Phase 4 (Final)

| Current status | Risks/issues | Actions |
|---|---|---|
| N/A at current time, planned for Qtr. 1. 2/23 | Cost may exceed current allocated budget. | Monitor demolition budget management on a monthly basis and work up contingency plan. |

## Neonatal Development

| Current status | Risks/issues | Actions |
|---|---|---|
| Enabling works have commenced to create a temporary ED car park and realign the Blue Light road.<br><br>Deed of variation to be signed in April due to delays in Mitie's contribution to the legal document. Concerns that Project Co's poor performance could lead to delays and that NHSE/I could be required to give an approval due to the PFI variation which could delay the start. Liaising with NHSE/I and Private Finance Unit to avoid delays. | Project Co engagement extending the programme and increasing costs.<br><br>NHSEI delay start by Trust requiring a separate approval for the PFI variation. | Continue working with Project Co to mitigate impact.<br><br>Liaising with NHSE/I and PFU to avoid delays |

## North East Plot Development

| Current status | Risks/ Issues | Actions/next steps |
|---|---|---|
| *Status unchanged*<br>Papers issued to exercise land option.<br><br>. | Value of option increases in short term<br><br>Timescales to deliver and cost of any lease being high. | Agree value through independent, jointly appointed valuer.<br><br>Confirm scope and requirements of each service to be confirmed before approaching StepPlaces |

| | | |
|---|---|---|
| | | |

## Communications

| Current status- | Risks / issues | Actions/next steps |
|---|---|---|
| Regular dialogue between development team and Communications department are now in place to cover the park development.<br>Fortnightly meetings established to discuss wider campus development progress. | Loss of reputation, locally and regionally.<br>Lack of engagement internally and externally | Maintain links with community and support their development work. |

## Car Parking

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| *Status unchanged*<br>The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday.<br><br>Staff parking to be re-allocated across multi storey and Thomas Lane. Requires the new car parking under the new Sunflower House to support car park numbers. Facilities looking at options with the development team. | Staff resistance to change and work to coordinate with external public transport providers/council/highways needs a dedicated Green Travel Plan co-ordinator<br><br>Travel plan from Mott MacDonald does not provide realistic and evidenced solution.<br><br>Temporary shortfall of numbers between May and June. | Review car parking requirements in view of the home working and off-site office building.<br><br>Recruit a travel plan co-ordinator.<br><br>Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan.<br><br>Reviewing early access to Sunflower car park |

**Orthotics move to Outpatients**

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| Moving Orthotics service into space in the lower ground floor of outpatients is moving forward.<br><br>Project Co and Mitie has delayed the start by poor management of the contractual interface. Trust has temporarily 'stepped in' to push the project forward. This could have delayed the end date by 2-3 weeks. | Delays to works delays the move from Histopathology.<br><br>Project Co and sub-contractors do not manage the works efficiently | Works started on site<br><br>Regular site meetings to monitor progress. |

**Innovation Park 2 for CAMHs**

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| Lease has been signed and work commenced on site for completion in June to enable last teams to vacate old Catkin. | Delays to works delays the move from Catkin.<br><br>Late changes increase costs | Regular site meetings to monitor progress. |

## 4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 23rd March 2022.

Alder Hey Children's NHS
NHS Foundation Trust

**BOARD OF DIRECTORS**
**Thursday, 31st March 2022**

| | |
|---|---|
| **Paper Title:** | Serious Incident, Learning and Improvement report 1st February 2022 – 28th February 2022 |
| **Report of:** | Chief Nursing Officer |
| **Paper Prepared by:** | Chief Nursing Officer & Associate Director of Nursing and Governance |

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

## 1 Introduction

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

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

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

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

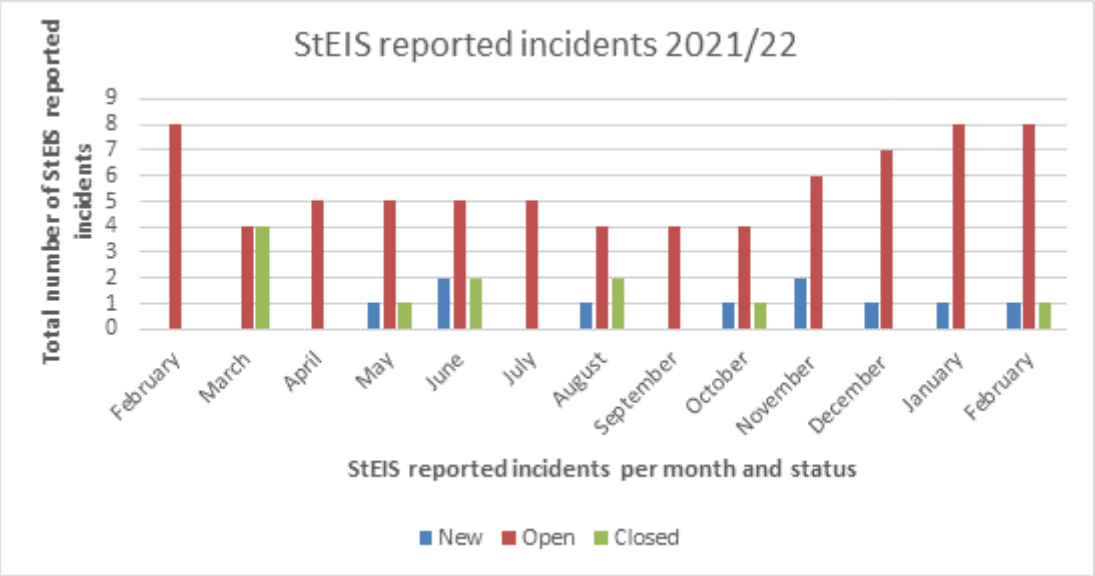
Serious incidents that do not meet the StEIS criteria are discussed at the weekly patient safety meeting and where appropriate an RCA level 2 is instigated.

## 2. Serious Incidents activity February 2021 – February 2022

During 1ST February 2021 – 28th February 2022, the Trust reported as follows

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

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




*Graph 1 – StEIS reported incident status by month*

3. **Serious Incident declared in February 2022**

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

| Division | Speciality | Ref | Brief Description |
|---|---|---|---|
| Division of Medicine | ED | 2020/2634 | Treatment delay meeting SI criteria - Missed opportunity to diagnose patient ( refer to appendix 1) |

**Table 1:** StEIS reported serious incident February 2022

**4. Never Events**

Zero 'never events' were declared in February 2022.

**5. Serious incident reports completed in February 2022**

One serious incident' investigations were closed in February 2022

**6. Learning from serious incidents**

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

6.1. Serious Incident action plans

The RCA methodology seeks to identify the causal factors associated with each event; an action plan is developed to address these factors. Action plan

completion is monitored by Clinical Quality Steering Group (CQSG) to ensure barriers to completion are addressed and change is introduced across the organisation (when required). At the time of writing there are Five SI. action plans that have passed their expected due date.

**Table 2** below provides and overview of progress position of open action plans past expected date of completion. The Division of Surgery currently have three action plans past expected date of completion. Two of the action plans have one action each that require developments via Meditec 'expanse', i.e., ref. 46313: 'inclusion of care plan for patients in Halo traction', to minimise the risk currently an RCN paper-based care plan is being used until electronic solution in place, ref. 23917: 'discharge information for dental patients needs to be available for general dental practitioners', waiting for 'expanse' to add general dental details to discharge summaries. The third action plan, ref: 49559, is an outstanding action relates to documentation audit, the expectation is that this will be completed by 31st March 2022. The Division of Medicine have two action plans past expected date of completion. The first action plan, ref: 29858, has one outstanding action relating to sharing lessons learned and recommendations for improvement with two Trusts who were involved in the patients care, expected to be completed in month. The second plan, ref: 46716, has five outstanding actions. However, progress has been made including MDT meetings being held regularly to aid decision making and minimise risk to patient safety.

| Division | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Surgery | 11 | 4 | 4 | 5 | 5 | 5 | 3 | 6 | 6 | 0 | 3 | 52 |
| Medicine | 3 | 1 | 3 | 1 | 1 | 1 | 3 | 4 | 4 | 6 | 2 | 29 |
| CMH | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Corporate | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 14 | 5 | 7 | 6 | 6 | 6 | 6 | 10 | 10 | 6 | 5 | 81 |

**Table 2:** *SI action plans past expected date of completion*

6.2 Measuring the effectiveness of serious incident actions

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

All action plans are expected to be specific, measurable, achievable, realistic, timebound (SMART) in their design. Although the Trust monitors the effectiveness of actions, in many cases via audit, in addition the actions plans are monitored for potential risk, particularly where actions have gone past expected date of completion, to ensure mitigations are in place and minimise risk. There is evidence of positive changes in practice that have led to improvements and will minimise risk of same or similar 'harm' incidents recurring, for example:

- Haematology and Oncology department developed and implemented Standard Operating Procedure (SOP) for consultant's roles and

responsibilities for the management of patients with malignant and non-malignant diagnosis.

- Blood Transfusion policy updated to include indications for the use of Riastap with the additional instruction for the ordering, preparation, and administration of the agent.
- Mandatory transfusion eLearning programme completed at induction and every 3 years thereafter has had the additional information added of alternatives to cryoprecipitate (Riastap, Fibryga, Fibrinogen Concentrate) and this will be completed by all nurses and doctors.
- Separate fibrinogen concentrate has been created including administration details. Safety bulleting sent out to all staff

## 7. Quality Improvement

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

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

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

## 8. Thematic Review

Serious incident investigations explore problems in care (Why?). the contributory factors to such problems (how?) and the root causes /fundamental issues (Why?). To support understanding a process of theming across these areas has been undertaken to identify commonalities across StEIS reported incidents submitted to commissioners since April 2021. There is no change to the themes section for this reporting period, however work continues to address the themes.

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

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

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

- Escalation processes not followed (3/6)

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

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

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

## 9. Conclusion

Patient safety incidents can have a devastating impact on our patients and staff; the Trust is committed to delivering a just, open and transparent approach to investigation that reduces the risk and consequence of recurrence. Correctable causes and themes are tracked by the Clinical Quality Steering Group (CQSG) and escalated by exception to Safety and Quality Assurance Committee (SQAC), to assure the board that changes for improvement is embedded in practice.

**Appendix 1 - Precise StEIS reported incidents in months and completed StEIS investigation reports.**

1. StEIS 2022/2634 (Ulysses ref: 54938) reported in month

**Background**

Patient brought to Emergency Department with neck pain and unable to move. Patient was taken out of the department before being seen. Left before seen proforma was completed and this was sent to GP. Patient presented again to Emergency Department with similar presentation but was discharged following investigations for a dental abscess, on antibiotics

Patient sent to neighbouring Trust for an urgent CT head and neck by the GP eight months later for ongoing torticollis. Then recalled presenting to Alder Hey Neurosurgical team as an emergency following formal reporting when a C1/2 subluxation was identified.

**Immediate lessons learned and actions for improvement**

- Reason for initial investigations unclear – c-spine tenderness and torticollis not indicators of dental abscess in the absence of fever, dental pain, facial swelling
- Reason for initial diagnosis unclear (cervical lymphangitis), as no recorded fever or cervical lymphadenopathy on examination
- In view of documented examination findings and history of trauma the patient should have received imaging of the cervical spine +/- neurosurgical consultation depending on the result.
- Consideration for a question to be asked in triage regarding any trauma, rather than relying on parents. Use of the word "trauma" may not be appropriate.
- Manchester triage for neck does ask about trauma to neck – consider rewording this to ask for any trauma as child/parent may not realise related trauma.
- Walk in Centre (WIC) do not always send letters with parents, but nursing staff do not ask for this – to consider adding this in case letter has been forgotten by parent.
- Duty of candour in line with regulation 20 applied.

**Further actions**

- Consider standard tick box on triage form – Was this trauma related? Yes/No, to allow for audit purposes.
- RCA investigation commenced
- Mother/family/patient to be asked to contribute to the investigation.
- Investigation lead and medical Lead agreed
- External expert to be sources to be on panel

2. StEIS 2021/12387 (Ulysses reference: 12387). investigation completed in month

**Background**

Patient ingested large overdoes of tablets in her home, including Omeprazole and Colchicine, transferred to Alder Hey Emergency Department. Patient died due to impact of Colchicine toxicity.

**Root Cause**

The investigation identified that the patient was part of a caseload and was reviewed adequately in line with care plans. There were no triggers to identify that the patient had suicidal ideation.

**Recommendations**

1. Review format and structure of assessments and tools used by the CAMHS team within the electronic medical record to ensure that they flow with patient care and facilitate a clear Helicopter view of patient care provided within a timeline.
2. Escalation for capacity issues with face-to-face availability should be in place if a child/young person specifies this as a specific preference for engagement.
3. Review current application of safeguarding referral process within community services and ensure that digital pathways are fit for purpose.
4. Consider if there is a threshold, or minimum number of times practitioners should engage directly with patients and if they are unable to see and speak with the patient directly, when a referral for safeguarding support be considered.
5. Review documentation standards in relation to record keeping, and appropriateness and timeliness of documentation within the CAMHS team.
6. Review communication standards between community, local authority teams and trust safeguarding teams for patients with active safeguarding concerns.
7. Consider with MHRA if national alerting can take place in relation to this medication.
8. Review cardiac surgery record keeping practice in line with trust and GMC record keeping standards and alter practice accordingly.
9. Refresh communication to teams to ensure awareness of timeliness of incident.

Comprehensive action plan in place to ensure actions for improvement are implemented.

**END**

Alder Hey Children's
NHS Foundation Trust

# TRUST BOARD Report  February 2022

How Did We Do?

**Executive Summary** **Month: February** **Year: 2022**


Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

## Safe

- 1 severe harm relating to a patient with a missed diagnosis. Reported as a SI and an RCA underway
- 1 moderate harm relating to a patient not being monitored continuously. Their condition deteriorated and the patient was admitted to HDU.
- The weekly patient safety meeting continues to provide assurance that all clinical incidents are properly documented and investigated, with all learning from RCA's/AAR's etc shared across the Divisions.

### Highlight

- Improved performance in relation to sepsis patients being treated within an hour in AED
- Continued excellent performance around IPC with 0 HAIs
- Lowest number of medication errors resulting in harm

### Challenges

- 2 medication errors resulting in harm. 1 related to a drug being given as a bolus rather than an infusion. Subsequent blood test to check for any harm was normal. Second one was related to a 10 times overdose error. A rapid review has been undertaken to establish cause. No harm established.

The Best People Doing their Best Work

## Caring

- High numbers of PALS and complaints in February
- Friends and Family score in AED relating to recommending the Trust is below 70% reflecting the continued activity challenges. Work is ongoing to address this with the Divisional team

### Highlight

- Friends and Family scores continue to be above 90% in the Community Division.

### Challenges

- The high number of PALS and complaints in February reflect seasonal pressures; Divisional Governance teams continue to process the enquiries as per guidelines to ensure responses meet the standard timeline requirements.

Delivery of Outstanding Care

## Effective

The Emergency Department dealt with a 9.6% increase in attendances relative to 2019. We treated 77.1% of patients within 4 hrs, a decline relative to January, but the highest level of performance in Cheshire & Merseyside. We have an urgent care improvement plan which is focused on increasing out-of-hours cover, increasing physical assessment space and re-establishing the primary care stream with an external partner.

### Highlight

- Notable reduction in elective cancelled operations
- Majority of patients who experienced a cancelled operation subsequently receive treatment within 28 days

### Challenges

- Further surge in Emergency Department attendances
- Emergency Department waiting times
- Staff availability affecting operational performance

Delivery of Outstanding Care

## Responsive

Our levels of planned care in February were good in the context of Omicron and staff absence levels approaching 7%. We achieved 93% recovery of elective and day case services, 98% for outpatient services and 101% in Radiology. Nonetheless, this is lower than pre-Omicron levels and the reduction has stalled our progress in reducing the number of children and young people waiting over 52 weeks for treatment; this fell only slightly from 237 patients to 232. We are now working to fully restore the theatre schedule and review improvement plans for workforce expansion and productivity.

In diagnostics we have extended waiting times in urodynamics and sleep studies. Both services have action plans which will increase capacity through the number of sessions undertaken (urodynamics) and to commence home studies (in the sleep service).

### Highlight

- Small decline in patients waiting over 52 weeks for treatment
- Access to cancer care

### Challenges

- Waiting list size increase (driven in January by referrals being significantly higher than pathways completed)
- Access to diagnostics

The Best People Doing their Best Work

## Well Led

**Finance**

The month 11 year to date position is showing a surplus of £1.0m. This is a slight deterioration from last month, but the Trust are on track to deliver the break-even position by the end of the financial year in line with the financial plan requirements.

Cash in the bank at the end of February was £92.9m.

The overall capital expenditure year to date to February was £21.2m.

### Highlight

### Challenges

- Maintain spend levels at Trust level to meet the required break-even control total by the end of the financial year.
- Delivery of recurrent CIP through remainder of 2021/22 with increasing operational pressures.

| | |
|---|---|
| **Mandatory Training**<br>As of the 28th of February, Mandatory Training was at 88% overall, 2% below the Trust target of 90%. We continue to work with staff, managers, and SMEs to encourage improvements in compliance. Our three key areas of focus recently have been Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen significant compliance drops due largely to the impact of COVID on face-to-face training restrictions.<br><br>**PDR**<br>As of the 28th of February 2022, our Trust appraisal rate was 72%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. These figures will continue to flux as staff move around the organisation. The Trust is currently doing a full review of the PDR process including timing, documentation and system.<br><br>**Sickness**<br>Sickness levels continue to fluctuate daily and remain an area of significant focus across all divisions. activity highlighted during previous months continues including enhanced reporting for managers, close monitoring of COVID related absence and supporting people to return to work were possible, taking into account reasonable adjustments to facilitate this.<br>In addition, managers training has been developed and will launch April 22, utilising a blended learning approach. Feedback on the HR Well-being Officers has highlighted the value managers are finding their support including timely occupational health referrals and supporting managers to conclude the reporting or return to work activity into the electronic reporting systems e.g. ESR.<br><br>**Turnover**<br>As we are aware turnover is increasing and Sharon Owen presented a paper to PAWC last month to highlight this in more detail. Understanding the reasons why individuals are leaving the trust remains a key requirement, linked to a robust exit interview process; alongside clear business continuity planning including workforce and succession planning. | |

Game Changing Research and Innovation

## Research and Development

**Month 11 Research Activity:**

- 194 research studies currently open
- 943 patients recruited to research studies (11,968 in 21/22)

**Divisional Participation:**

- Division of Medicine – 157 open studies
- Division of Surgical Care – 33 open studies
- Division of Community & Mental Health – 4 open studies

**Research Assurance:**

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

**Highlight**

**NIHR Clinical Research Facility**
£2M award to support Alder Hey's internationally leading facility for experimental medicine (EM) and early phase (EP) research for children and young people

**Challenges**

Capacity for additional research activity

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Alder Hey Children's NHS
NHS Foundation Trust

# Leading Metrics

## SAFE

| Clinical Incidents resulting in catastrophic, death | Hospital Acquired Organisms - C.difficile | Hospital Acquired Organisms - MRSA (BSI) | Medication errors resulting in harm | Never Events | Sepsis: Patients treated for Sepsis within 60 mins - Inpatients |
|---|---|---|---|---|---|
| 0 | 0 | 0 | 2 | 0 | |
| Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 |

| Sepsis: Patients treated for Sepsis within 60 Minutes - A&E |
|---|
| 83.72 % |
| Feb 2022 |

## CARING

| Friends & Family: Overall Percentage Recommended Trust |
|---|
| 89.17 % |
| Feb 2022 |

## EFFECTIVE

| ED: 95% Treated within 4 Hours |
|---|
| 77.14 % |
| Feb 2022 |

## RESPONSIVE

| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | All Cancers: 31 day wait until subsequent treatments | Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | Diagnostics: % Completed Within 6 Weeks |
|---|---|---|---|
| 100 % | 100 % | 100 % | 63.26 % |
| Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 |

| 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 % | 61.46 % | 232 | 19731 |
| Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 |

## WELL LED

| Cash in Bank (£'000s) | Control Total In Month Variance (£'000s) | Mandatory Training | Safer Staffing (Shift Fill Rate) | Sickness |
|---|---|---|---|---|
| 92978 | -725.23 | 88.35 % | 84.02 % | 6.74 % |
| Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 | Feb 2022 |

Delivery of Outstanding Care

# SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of Near Miss, No Harm & Minor Harm | D | 99.8% | 99.8% | 99.8% | 99.1% | 99.6% | 99.6% | 99.8% | 100.0% | 99.6% | 98.8% | 100.0% | 99.5% | 99.6% | | >=99 % N/A <99 % | ✔ |
| Clinical Incidents resulting in Near Miss | D | 63 | 98 | 79 | 81 | 90 | 73 | 62 | 91 | 89 | 65 | 77 | 75 | 78 | | No Threshold | |
| Clinical Incidents resulting in No Harm | D | 332 | 401 | 395 | 363 | 321 | 332 | 298 | 313 | 276 | 272 | 250 | 235 | 276 | | No Threshold | |
| Clinical Incidents resulting in minor, non permanent harm | D | 76 | 95 | 91 | 80 | 72 | 94 | 88 | 74 | 86 | 136 | 75 | 99 | 93 | | No Threshold | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 1 | 1 | 1 | 4 | 1 | 1 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | | No Threshold | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | | 0 N/A >0 | ✔ |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Medication errors resulting in harm | D | 3 | 4 | 4 | 2 | 2 | 2 | 6 | 4 | 2 | 4 | 5 | 3 | 2 | | <=4 N/A >4 | ✔ |
| Pressure Ulcers (Category 3) | W | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 N/A >0 | ✔ |
| Never Events | W | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Sepsis: Patients treated for Sepsis within 60 Minutes - A&E | D P | 80.6% | 100.0% | 85.0% | 94.4% | 87.9% | 88.9% | 90.2% | 76.6% | 85.9% | 85.7% | 77.4% | 78.0% | 83.7% | | >=90 % N/A <90 % | ✔ |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 84.0% | 88.9% | 83.3% | 89.7% | 91.7% | 88.9% | 86.4% | 81.1% | 87.0% | 82.9% | 75.9% | | | | >=90 % N/A <90 % | ✔ |
| Number of children that have experienced avoidable factors causing death - Internal | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 | ✔ |
| Hospital Acquired Organisms - MSSA | D | 1 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 1 | 3 | 1 | 0 | 0 | | No Threshold | |

The Best People doing their best Work

# CARING

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family: Overall Percentage Recommended Trust | W | 94.9% | 92.9% | 94.0% | 90.2% | 91.0% | 87.6% | 92.3% | 88.4% | 84.9% | 88.4% | 90.7% | 90.5% | 89.2% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family A&E - % Recommend the Trust | D | 93.1% | 88.0% | 88.0% | 76.2% | 79.2% | 59.8% | 79.6% | 64.3% | 61.1% | 64.2% | 71.7% | 74.4% | 69.5% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Community - % Recommend the Trust | D | 96.7% | 93.0% | 95.9% | 92.4% | 95.9% | 97.1% | 96.2% | 92.7% | 93.4% | 93.6% | 95.8% | 96.2% | 90.5% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Inpatients - % Recommend the Trust | D | 90.4% | 89.8% | 96.4% | 95.1% | 87.0% | 88.8% | 91.4% | 92.9% | 94.2% | 92.1% | 92.4% | 92.7% | 93.9% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Mental Health - % Recommend the Trust | D | 90.3% | 87.9% | 90.6% | 85.7% | 95.0% | 94.7% | 95.8% | 96.3% | 90.6% | 96.4% | 100.0% | 96.2% | 95.5% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Outpatients - % Recommend the Trust | D P | 96.0% | 95.1% | 95.3% | 94.4% | 94.8% | 95.5% | 95.4% | 94.7% | 91.8% | 94.2% | 95.9% | 94.7% | 94.1% | | >=95 % >=90 % <90 % | ✔ |
| Complaints | W | 11 | 23 | 5 | 9 | 15 | 10 | 12 | 13 | 13 | 14 | 9 | 16 | 20 | | No Threshold | |
| PALS | W | 88 | 110 | 101 | 119 | 150 | 122 | 88 | 148 | 136 | 141 | 106 | 99 | 133 | | No Threshold | |


D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | 0.0% | 1.6% | 0.0% | 2.6% | 0.0% | 1.4% | 2.7% | 0.0% | 0.0% | 0.0% | 1.3% | 1.7% | 1.1% | | No Threshold | |
| ED: 95% Treated within 4 Hours | D | 97.8% | 95.3% | 92.5% | 81.1% | 85.5% | 67.9% | 87.7% | 73.4% | 72.5% | 66.4% | 74.9% | 80.2% | 77.1% | | >=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 | 7 | 12 | 13 | 7 | 13 | 13 | 12 | 32 | 23 | 56 | 23 | 22 | 15 | | <=20 N/A >20 | ✔ |
| 28 Day Breaches | W | 1 | 2 | 4 | 3 | 0 | 3 | 8 | 5 | 11 | 12 | 25 | 7 | 3 | | 0 N/A >0 | ✔ |

Delivery of Outstanding Care

# RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 93.6% | 95.6% | 96.0% | 98.0% | 94.3% | 94.4% | 96.2% | 97.5% | 95.8% | 99.1% | 92.6% | 96.1% | 93.0% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Treated with respect | W | 98.1% | 94.7% | 98.5% | 99.0% | 94.3% | 94.4% | 97.8% | 96.8% | 97.6% | 99.1% | 96.6% | 98.1% | 96.7% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Know their planned date of discharge | D P | 98.1% | 94.2% | 98.5% | 92.2% | 96.4% | 93.9% | 93.0% | 95.5% | 93.3% | 87.2% | 71.1% | 72.3% | 67.6% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Know who is in charge of their care | W | 94.9% | 96.1% | 98.5% | 98.5% | 98.6% | 97.0% | 96.2% | 96.8% | 98.8% | 98.3% | 97.3% | 98.1% | 97.1% | | >=95 % >=90 % <90 % | ✔ |
| IP Survey: % Patients involved in Play | D | 85.9% | 78.2% | 81.1% | 80.0% | 79.3% | 82.7% | 77.4% | 75.2% | 78.8% | 79.5% | 78.5% | 71.4% | 80.9% | | >=90 % >=85 % <85 % | ✔ |
| IP Survey: % Patients involved in Learning | D | 92.9% | 90.9% | 91.0% | 91.7% | 89.3% | 91.9% | 87.6% | 89.2% | 92.7% | 95.7% | 89.9% | 91.7% | 91.9% | | >=90 % >=85 % <85 % | ✔ |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 63.2% | 68.1% | 68.6% | 71.9% | 74.8% | 72.7% | 71.1% | 66.5% | 62.1% | 63.2% | 64.2% | 62.0% | 61.5% | | >=92 % >=90 % <90 % | ✔ |
| Waiting List Size | W | 11,453 | 11,892 | 11,110 | 11,564 | 11,414 | 12,096 | 13,286 | 13,092 | 18,495 | 18,976 | 19,127 | 19,098 | 19,731 | | No Threshold | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 307 | 361 | 283 | 235 | 204 | 187 | 195 | 263 | 318 | 250 | 218 | 237 | 232 | | 0 N/A >0 | ✔ |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% | 100.0% | 100.0% | 96.4% | 95.2% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| All Cancers: 31 day wait until subsequent treatments | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | 100.0% | 100.0% | | 100 % N/A <100 % | ✔ |
| Diagnostics: % Completed Within 6 Weeks | W | 95.8% | 97.5% | 95.2% | 95.2% | 98.5% | 95.5% | 94.7% | 97.2% | 96.3% | 88.5% | 92.1% | 87.9% | 63.3% | | >=99 % N/A <99 % | ✔ |
| PFI: PPM% | | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 97.0% | 99.0% | 99.0% | 96.0% | | | >=98 % N/A <98 % | ✔ |

The Best People doing their best Work

# WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 591 | 3,825 | -954 | 593 | 392 | -588 | -50 | 836 | -853 | 382 | 166 | 2,123 | -725 | | >=-5% >=-20% <-20% | ✔ |
| Capital Expenditure In Month Variance (£'000s) | W | -3,207 | -5,794 | -910 | 974 | 13 | 162 | 234 | -339 | -221 | -159 | 406 | 964 | 403 | | >=-5% >=-10% <-10% | ✔ |
| Cash in Bank (£'000s) | W | 110,871 | 92,708 | 92,708 | 88,440 | 82,001 | 82,006 | 82,121 | 88,514 | 94,111 | 91,971 | 90,450 | 87,781 | 92,978 | | >=-5% >=-20% <-20% | ✔ |
| Income In Month Variance (£'000s) | W | 2,310 | 18,172 | -494 | 716 | 1,598 | 2,981 | -1,713 | 2,767 | -2,609 | 149 | 1,475 | 1,048 | 274 | | >=-5% >=-20% <-20% | ✔ |
| Pay In Month Variance (£'000s) | W | -387 | -13,171 | -308 | -370 | -545 | 553 | 71 | -2,466 | 2,477 | 676 | -16 | 6 | 9 | | >=-5% >=-20% <-20% | ✔ |
| Non Pay In Month Variance (£'000s) | W | -1,333 | -1,176 | -153 | 247 | -661 | -4,122 | 1,591 | 534 | -720 | -443 | -1,293 | 1,068 | -1,008 | | >=-5% >=-20% <-20% | ✔ |
| AvP: IP - Non-Elective | W | 731 | 1,066 | -97 | -100 | 1,292 | -184 | -141 | -66 | 1,374 | 1,365 | 1,259 | 1,272 | 1,293 | | >=0 N/A <0 | ✔ |
| AvP: IP Elective vs Plan | W | 358 | 455 | -88 | -61 | 453 | -20 | -113 | -79 | 402 | 387 | 323 | 320 | 357 | | >=0 N/A <0 | ✔ |
| AvP: Daycase Activity vs Plan | W | 1,614 | 2,098 | 208 | 31 | 2,152 | 316 | -83 | 231 | 1,985 | 2,185 | 1,849 | 1,852 | 1,808 | | >=0 N/A <0 | ✔ |
| AvP: Outpatient Activity vs Plan | W | 23,061 | 27,550 | 2,384 | 5,038 | 28,171 | 6,170 | 1,879 | 6,738 | 26,031 | 29,592 | 23,652 | 24,781 | 23,636 | | >=0 N/A <0 | ✔ |
| PDR | W | 74.4% | 74.4% | 0.9% | 6.3% | 19.7% | 56.3% | 65.0% | 67.3% | 71.2% | 72.3% | 72.0% | 72.5% | 72.2% | | No Threshold | ✔ |
| Medical Appraisal | W | 95.9% | 95.9% | 21.9% | 30.9% | 34.8% | 42.4% | 70.8% | 55.2% | 83.9% | 80.2% | 85.7% | 0.4% | 0.4% | | No Threshold | ✔ |
| Mandatory Training | W | 85.8% | 86.8% | 88.4% | 87.2% | 88.1% | 88.0% | 87.4% | 87.3% | 87.3% | 87.3% | 87.5% | 85.7% | 88.4% | | >=90 % >=80 % <80 % | ✔ |
| Sickness | D | 5.7% | 4.7% | 4.6% | 5.3% | 5.6% | 6.3% | 6.5% | 6.3% | 6.4% | 6.2% | 7.4% | 8.2% | 6.7% | | <=4 % <=4.5 % >4.5 % | ✔ |
| Short Term Sickness | D | 1.2% | 1.2% | 1.1% | 1.4% | 1.5% | 1.8% | 1.6% | 1.8% | 2.2% | 1.9% | 2.7% | 3.7% | 2.2% | | <=1 % N/A >1 % | ✔ |
| Long Term Sickness | D | 4.5% | 3.6% | 3.5% | 3.9% | 4.1% | 4.5% | 4.9% | 4.5% | 4.2% | 4.4% | 4.7% | 4.5% | 4.5% | | <=3 % N/A >3 % | ✔ |
| Temporary Spend ('000s) | D | 1,279 | 2,272 | 1,071 | 1,040 | 960 | 1,130 | 1,096 | 1,368 | 1,137 | 1,590 | 1,521 | 1,385 | 1,620 | | No Threshold | ✔ |
| Staff Turnover | D | 8.8% | 8.7% | 9.3% | 9.7% | 9.3% | 9.6% | 9.7% | 10.2% | 10.8% | 11.3% | 11.0% | 11.4% | 12.1% | | <=10 % <=11 % >11 % | ✔ |
| Safer Staffing (Shift Fill Rate) | W | 94.5% | 94.0% | 97.7% | 98.8% | 97.6% | 89.6% | 92.2% | 94.5% | 91.6% | 87.7% | 84.5% | 81.3% | 84.0% | | >=90 % N/A <90 % | ✔ |
| Domestic Cleaning Audit Compliance | W | 97.7% | 97.7% | 97.7% | 88.6% | 100.0% | 97.7% | 100.0% | 97.7% | 100.0% | 95.4% | 97.8% | 98.9% | 100.0% | | >=85 % N/A <85 % | ✔ |
| NHS Oversight Framework | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 <=1 >1 | ✔ |

Game Changing Research & Innovation

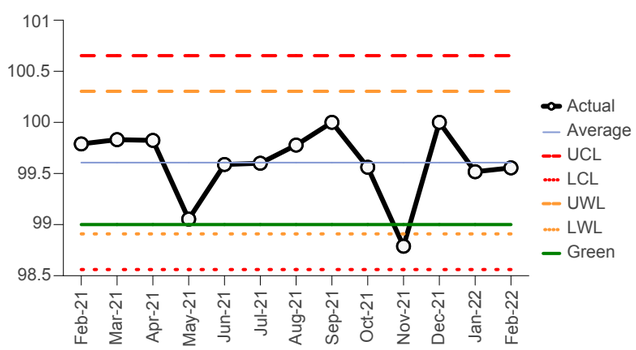
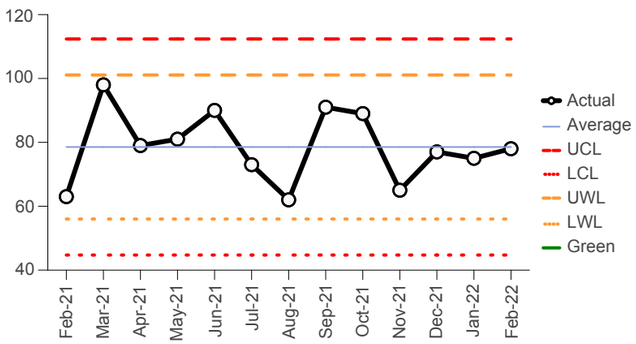
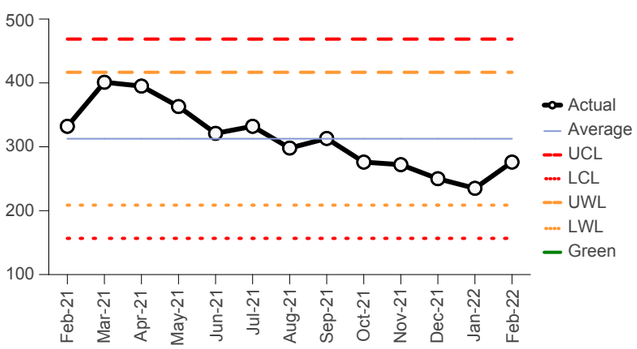
# R&D

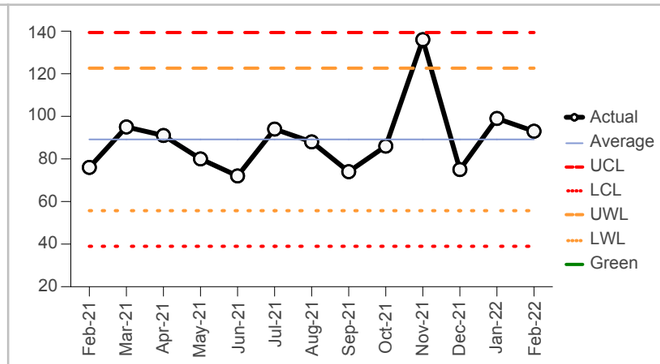
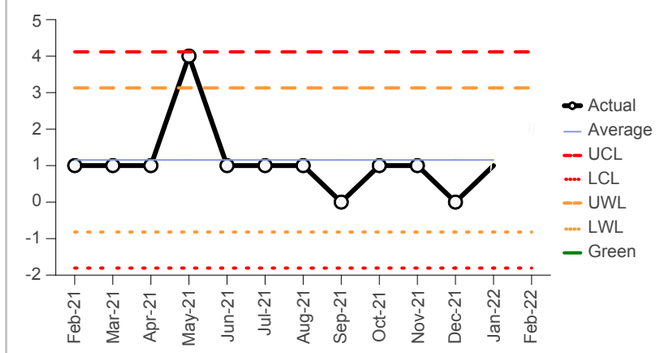
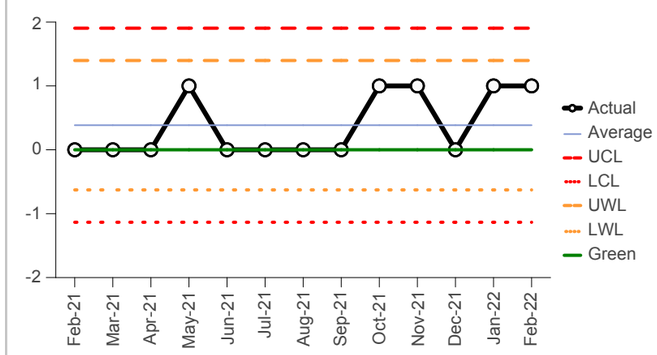
Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Open Studies - Academic | W | 80 | 90 | 100 | 103 | 108 | 117 | 125 | 132 | 139 | 142 | 145 | 148 | 150 | | >=130 | >=111 | <111 | ✔ |
| Number of Open Studies - Commercial | W | 36 | 36 | 34 | 36 | 38 | 37 | 38 | 40 | 43 | 44 | 42 | 43 | 44 | | >=30 | >=21 | <21 | ✔ |
| Number of New Studies Opened - Academic | W | 0 | 6 | 7 | 2 | 3 | 7 | 3 | 7 | 7 | 4 | 1 | 3 | 0 | | >=3 | >=2 | <2 | |
| Number of New Studies Opened - Commercial | W | 0 | 2 | 0 | 3 | 1 | 1 | 0 | 2 | 3 | 3 | 0 | 3 | 0 | | >=1 | N/A | <1 | |
| Number of patients recruited | W | 403 | 105 | 1,055 | 1,039 | 896 | 439 | 1,060 | 983 | 931 | 1,038 | 816 | 978 | 937 | | >=100 | >=86 | <86 | ✔ |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Proprtion of Incidents | **Proportion of Near Miss, No Harm & Minor Harm** D<br>Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 99.55 % | R <99 %<br>A N/A<br>G >=99 % |  | No Action Required |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in Near Miss** D<br>Total number of Near Miss Incidents reported<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 78 | No Threshold |  | |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in No Harm** D<br>Total number of No Harm Incidents reported.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 276 | No Threshold |  | |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in minor, non permanent harm** D<br>Total number of Minor Harm Incidents reported.<br><br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 93 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in moderate, semi permanent harm** D<br>Incidents reported resulting in moderate harm.<br><br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 1 | No Threshold |  | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in severe, permanent harm** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br><br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 1 | R >0<br>A N/A<br>G 0 |  | Missed opportunity to diagnosis clinical condition, patient will require complex neurosurgery to improve condition. 72 hour review complete, lessons learned identified and actions for improvement in progress. Comprehensive level 2 investigation commenced. |

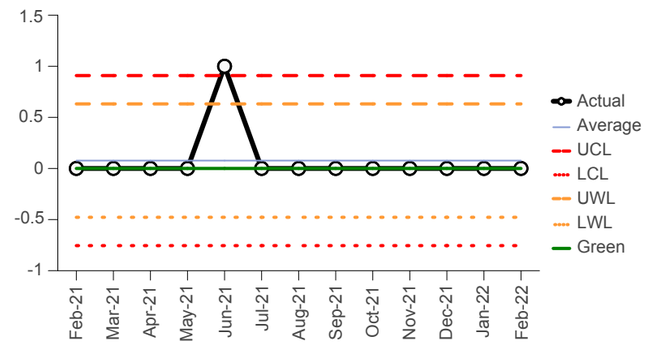
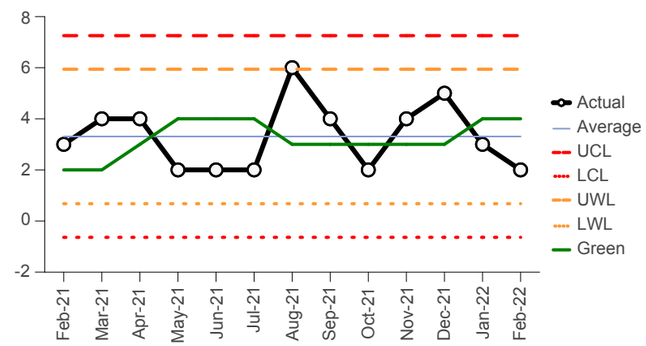
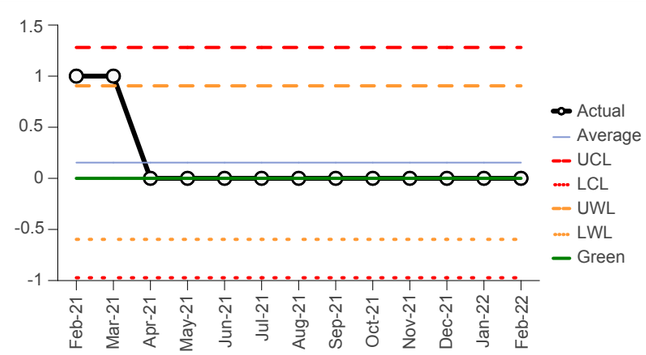
Delivery of Outstanding Care

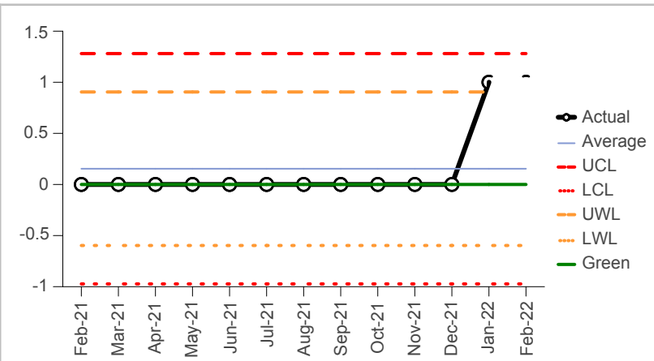
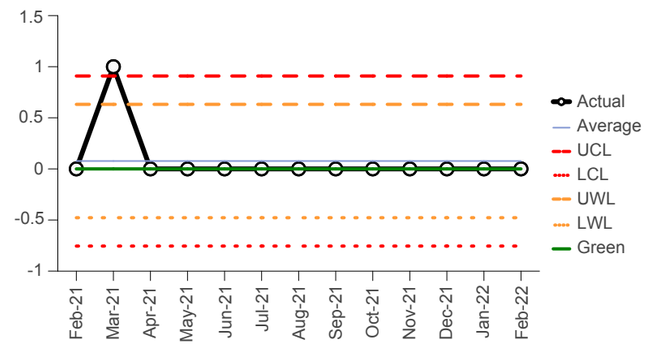
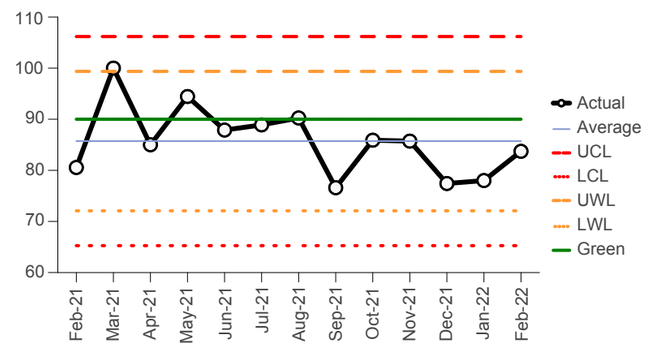
# 7.3 - QUALITY - SAFE

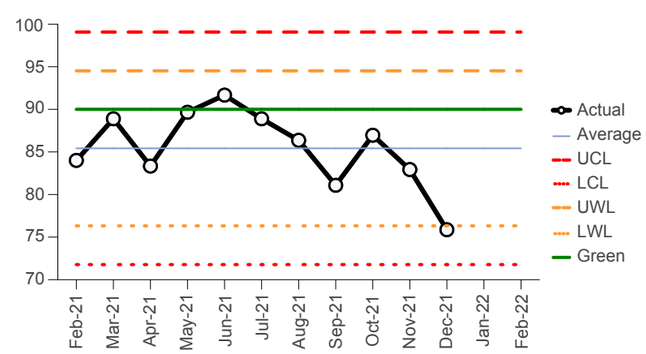
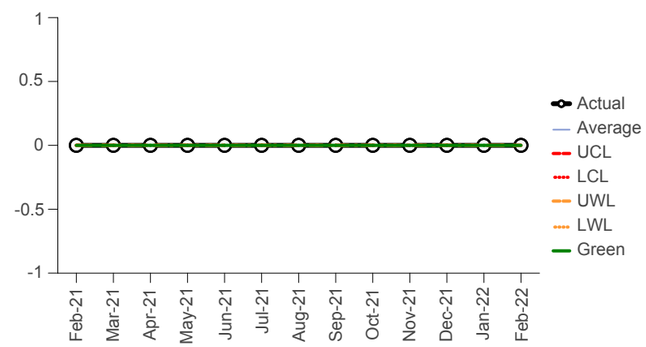
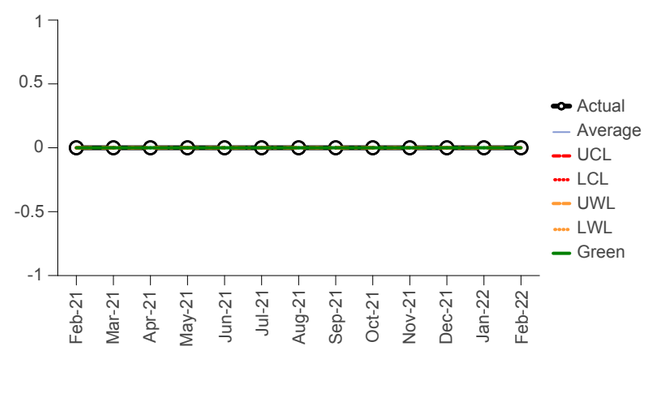
BRILLIANT BASICS

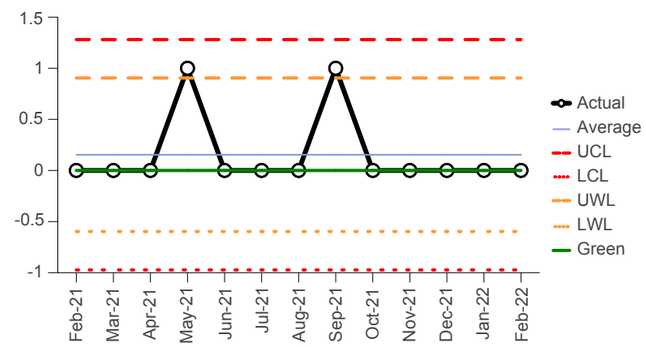
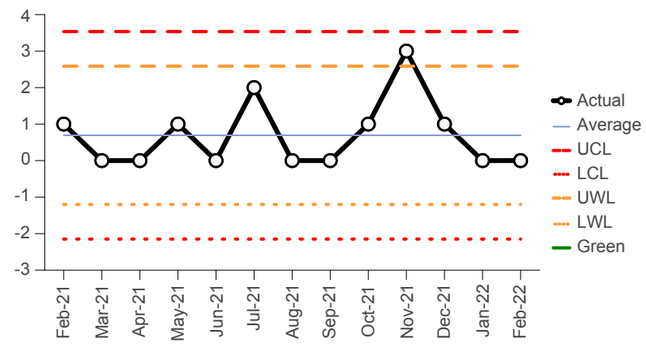
Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in catastrophic, death** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Medication Errors | **Medication errors resulting in harm** D<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 2 | R >4<br>A N/A<br>G <=4 |  | Ceftriaxone prescribed 100mg/kg as a bolus for a neonate and given as prescribed. Dose should have been 50mg/kg as an intravenous infusion. Harm level attributed to an extra bilirubin blood test that was checked due to risk of bilirubin encephalopathy - this result was normal. Patient discharged on 80mg/kg dose as per ID advice. |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 3)** W<br>Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 4)** W<br>Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Never Events | **Never Events** W<br>Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 83.72 % | R <90 %<br>A N/A<br>G >=90 % |  | 7 patients did not receive antibiotics within 60 minutes and 2 of those not within 90 minutes; 2 were just over both within 10 minutes, 2 had no obvious reason for delay and were incidented for further investigation, 1 due to difficult intravenous access and 2 due to requiring stabilisation initially. |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 21/22 aim is 90%.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | | R <90 %<br>A N/A<br>G >=90 % |  | No Action Required |
| Mortality | **Number of children that have experienced avoidable factors causing death - Internal** W<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MRSA (BSI)** D<br>The threshold is based on this event never occuring. 21/22 Aim is zero annually.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |

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

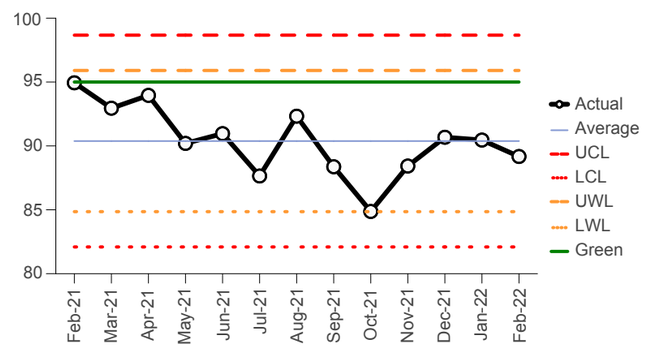
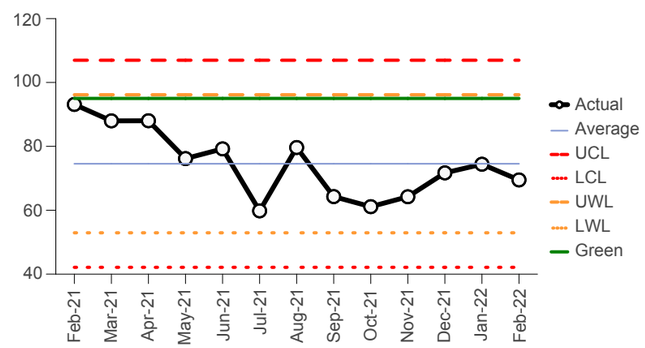
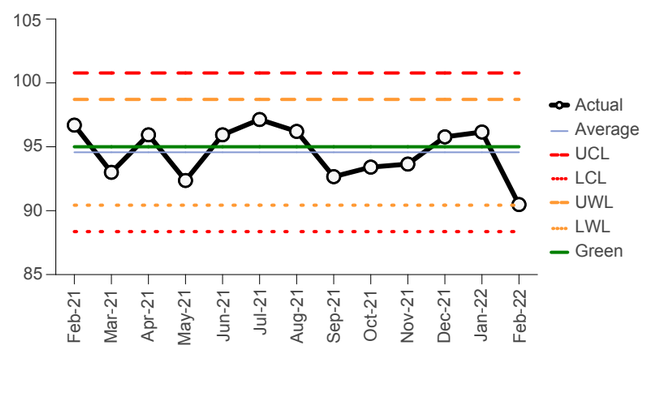
The Best People doing their best Work

# 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<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 89.17 % | R <90 %<br>A >=90 %<br>G >=95 % |  | February has 1,348 responses from a possible 31,968 (Feb 2022). This gave an overall Trust FFT percentage of 89.1% who found their experience to be either good or very good. This is a 1.03% decrease compared to January. By division – Medicine reports a 2.5% decrease, Surgery a 0.75% increase and Community a 3.5% decrease. 78% of responses came via SMS message. Face to face collection has been resumed before discharge within inpatient wards. This has resulted in a 74% increase of responses within these areas. |
| Friends & Family | **Friends & Family A&E - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 69.48 % | R <90 %<br>A >=90 %<br>G >=95 % |  | During February A&E has 249 responses from a possible 5008 (Feb 2022), this provided a response rate of 5%. From these responses 173 found their experience to be either good or very good, giving a FFT percentage of 69.5%. This is a 4.9% decrease compared to January. 24.9% responded their experience was very poor or very poor (62). From these 62 responses there were 4 main themes, waiting times, covid restriction (1 parent rule), poor communication and staff attitude. |
| Friends & Family | **Friends & Family Community - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 90.48 % | R <90 %<br>A >=90 %<br>G >=95 % |  | During February, Community division has 152 responses. From these responses 137 found their experience to be either good or very good, giving a FFT percentage of 90.48%. This is a 5.7% decrease compared to January. All responses of very poor were from Phlebotomy Clinic, which also reflects concerns raised via Healthwatch. Ongoing within this area is an improvement work, catch up clinics and the department lead has met directly with Healthwatch to address concerns |

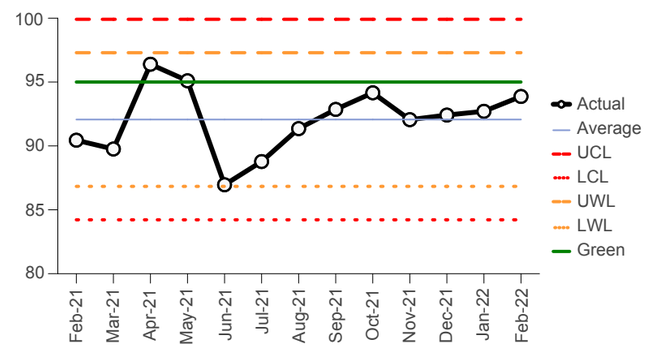
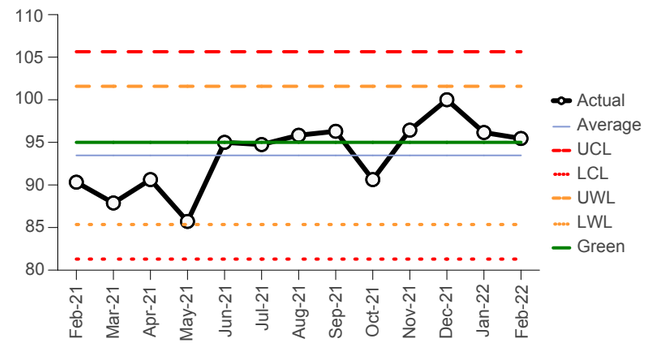
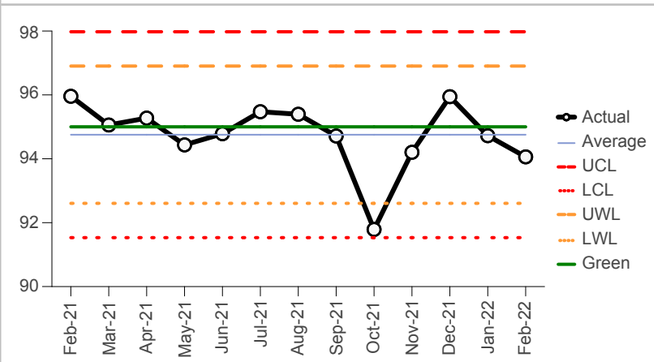
The Best People doing their best Work

# 8.2 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family Inpatients - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 93.87 % | R <90 %<br>A >=90 %<br>G >=95 % |  | During February 261 responses were received for Inpatient surveys. From these responses 245 found their experience to be either good/very good, giving a FFT score of 93.9%. This is a 1.2% increase compared to January. With the resumption of face-to-face collection of inpatient surveys there has been a 6.78% increase to response rates. This has provided the highest response since March 2020 (343) Further increase of collection is in ongoing with volunteers receiving training to visit wards, ED and OPD daily. Responses for poor/very poor raised lack of communication as common theme |
| Friends & Family | **Friends & Family Mental Health - % Recommend the Trust** D<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 95.45 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Friends & Family | **Friends & Family Outpatients - % Recommend the Trust** D P<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 94.06 % | R <90 %<br>A >=90 %<br>G >=95 % |  | During February 707 responses were received. From these responses 665 found their experience to be either good/very good, giving a FFT score of 94%. This is a 0.7% decrease compared to January. 26 responses were poor/very poor. Increase of collection within OPD to start via volunteers. |

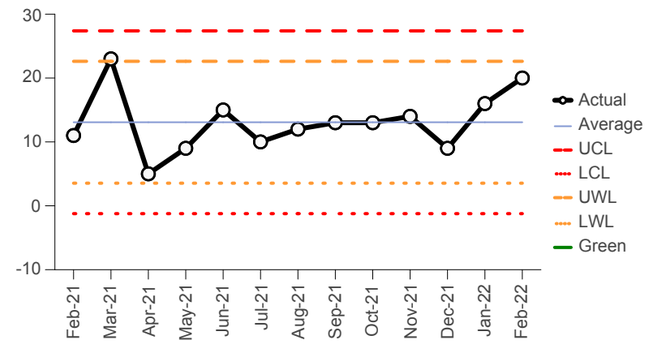
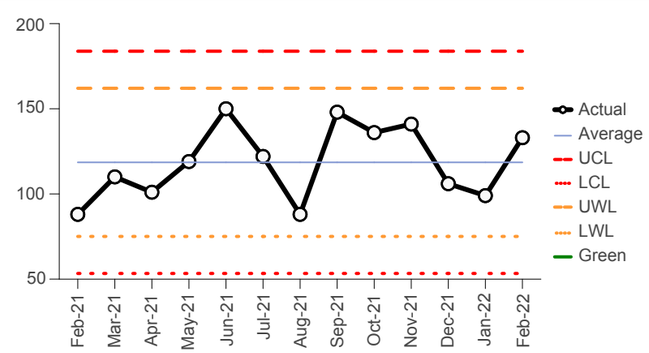
The Best People doing their best Work

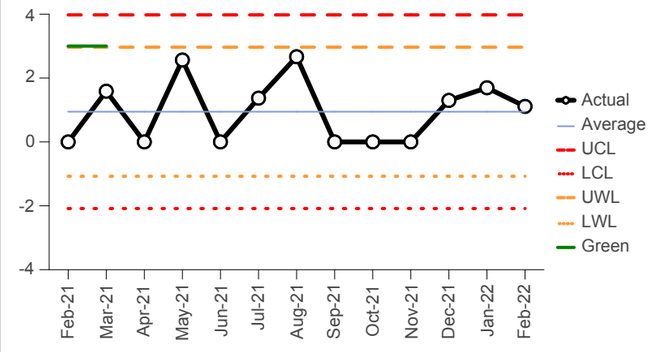
# 8.3 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Complaints | **Complaints** W<br>Total complaints received.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 20 | No Threshold |  | |
| PALS | **PALS** W<br>Total number of PALS contacts.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 133 | No Threshold |  | |

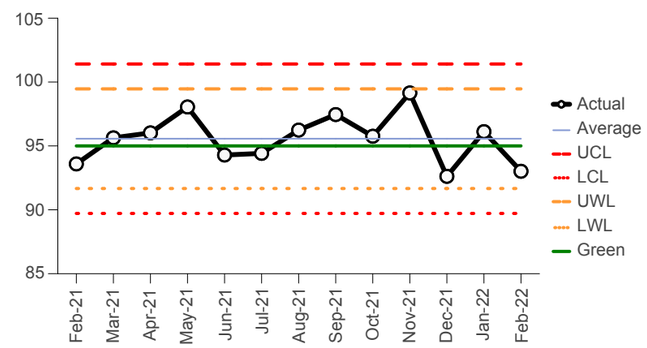
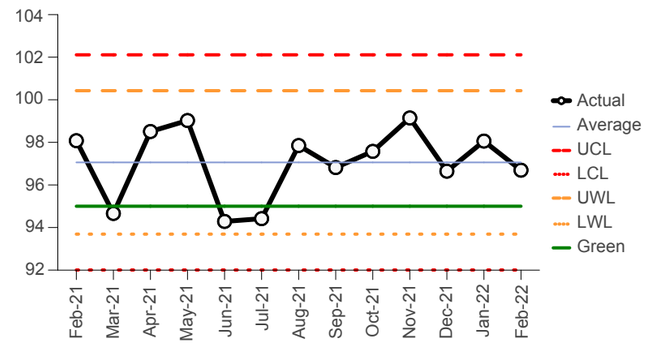
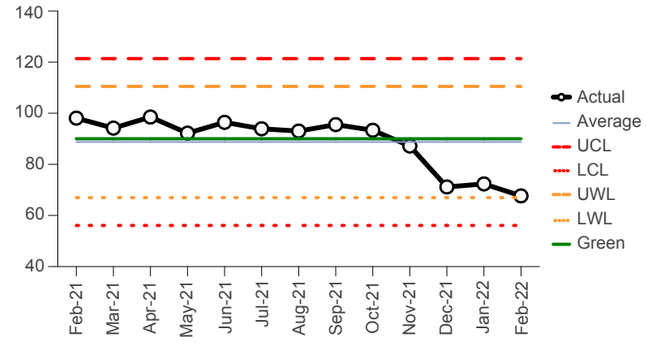
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| PICU Re-admissions | **% Readmissions to PICU within 48 hrs** W<br><br>% of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold 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%<br><br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 1.11 % | No Threshold |  | |

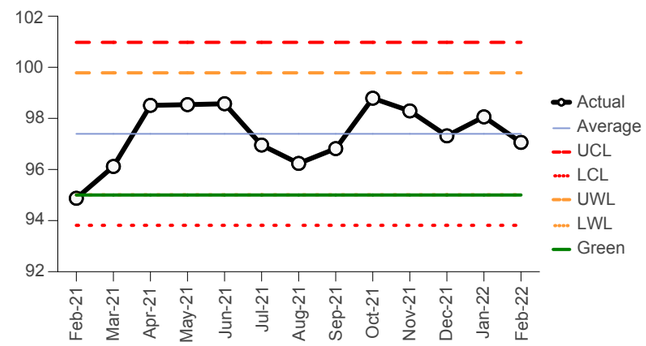
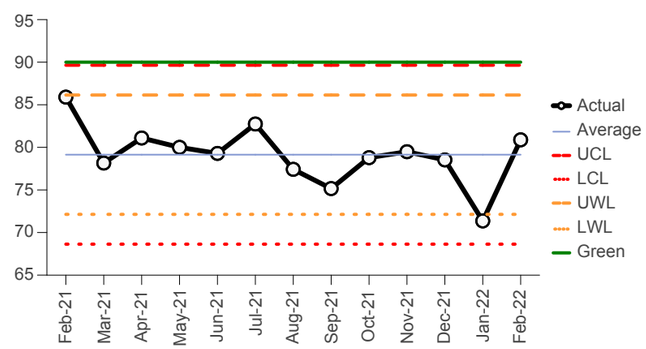
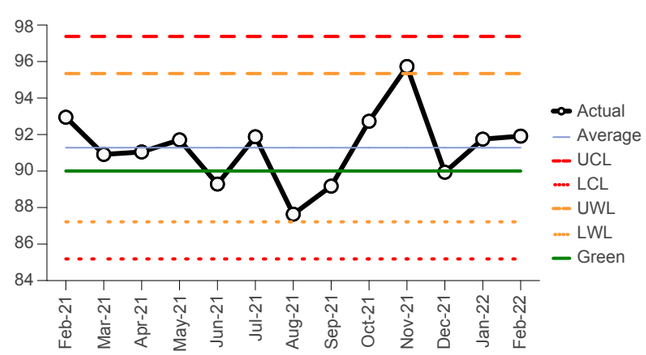
Delivery of Outstanding Care

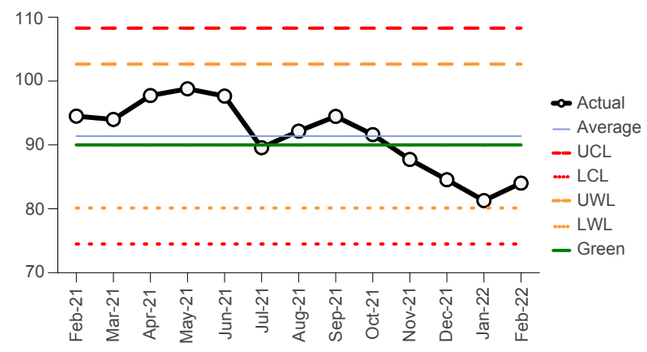
# 10.1 - QUALITY - RESPONSIVE

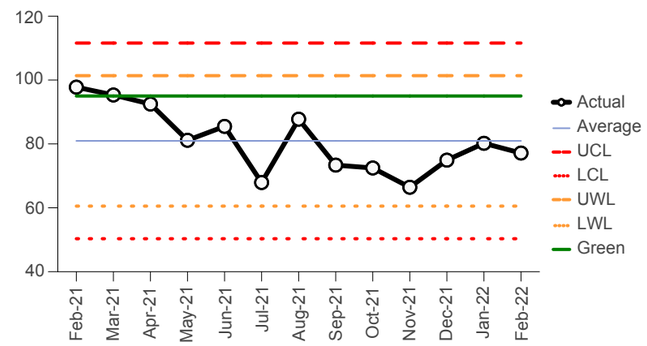
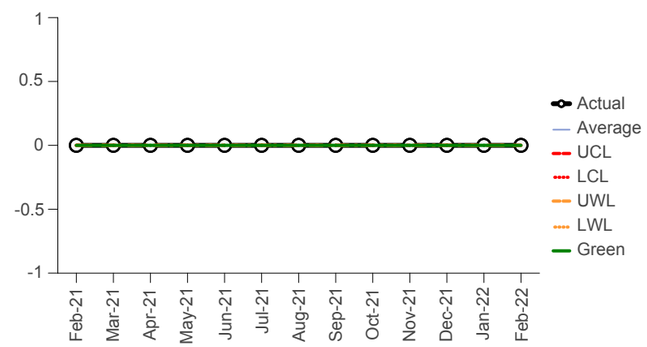
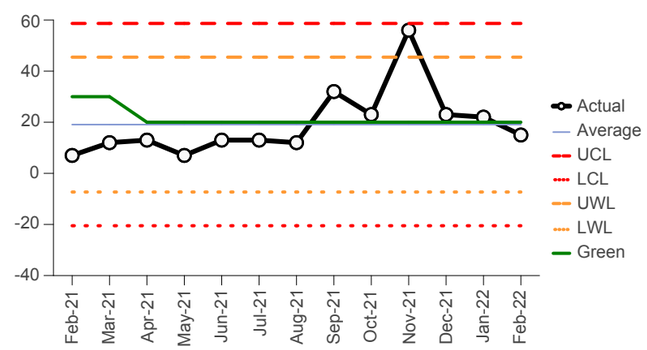
Alder Hey Children's NHS Foundation Trust

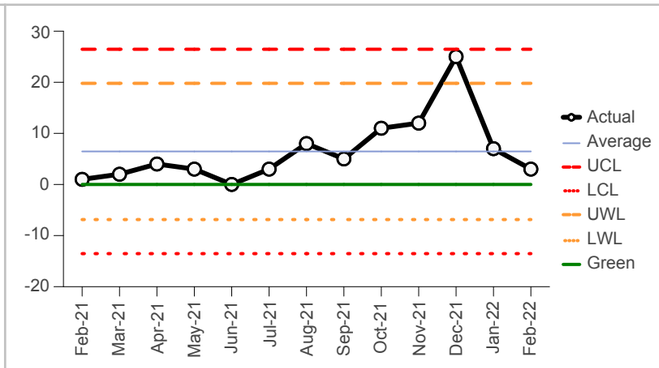
D Drive W Watch P Programme

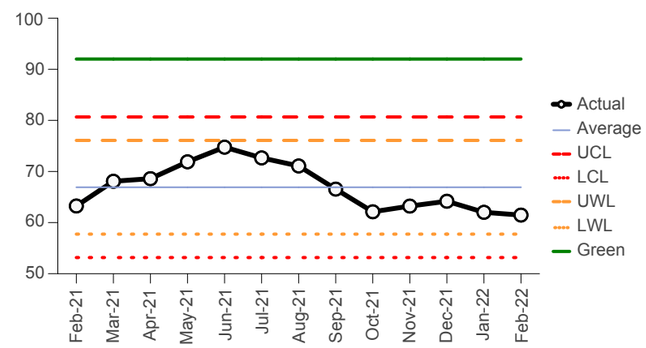
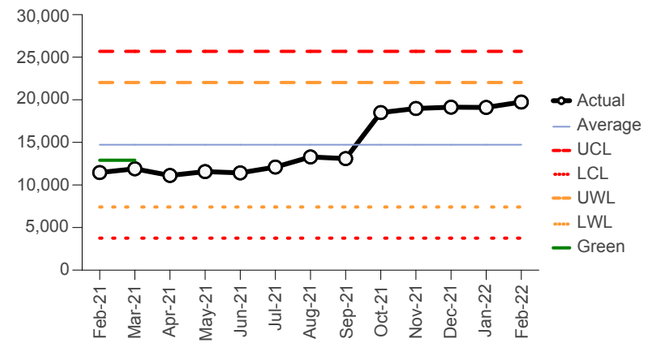
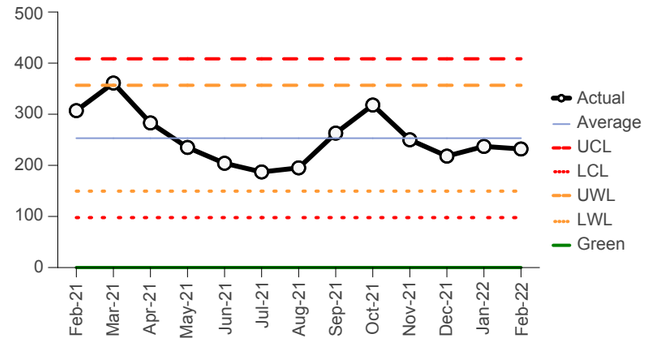
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: Choices | **IP Survey: % Received information enabling choices about their care** W<br>Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 93.01 % | R <90 %<br>A >=90 %<br>G >=95 % |  | During February 272 inpatient survey responses were received. From these responses 253 answered yes to they had received information enabling choices about their care This is a 3.10% decrease compared to January. Further analysis of responses shows from the 3 surveys (parent/carer, child, young person) identified that children 6-11 within medicine had the lowest response at 76% and young people 12-16 responded 90%, parents/carers however scored 96% medicine and 93% surgery. |
| Inpatient Survey: Respect | **IP Survey: % Treated with respect** W<br>Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 96.69 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Date of Discharge | **IP Survey: % Know their planned date of discharge** D P<br>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.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 67.65 % | R <85 %<br>A >=85 %<br>G >=90 % |  | During February there was a 4.7% decrease in the number of responses that knew their expected date of discharge – 67.7%. Improvement work continues through the Emergency Care and collaborative programme to improve timely discharges and information to children, young people and families. |

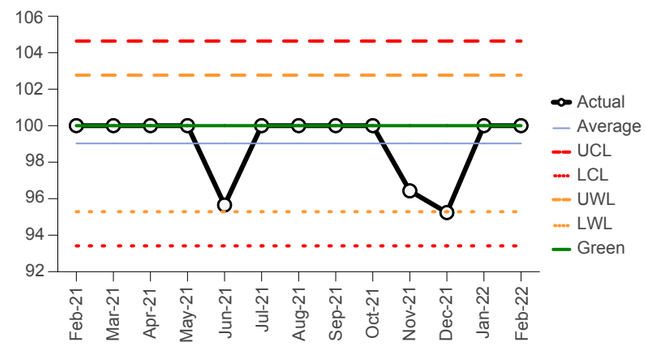
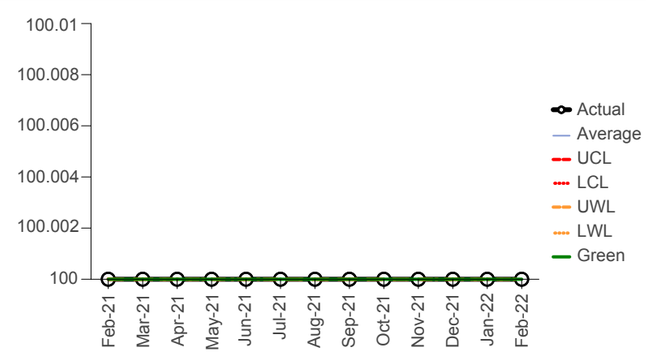
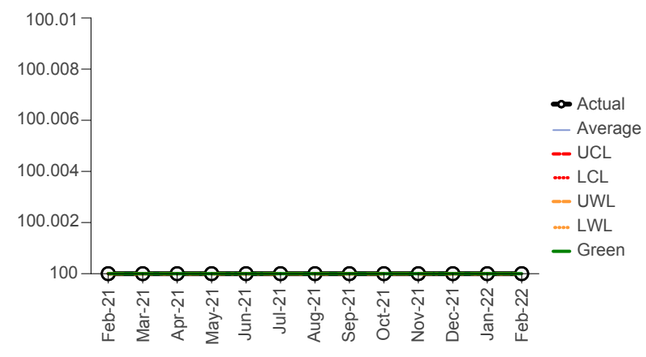
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: In Charge of Care | **IP Survey: % Know who is in charge of their care** W<br>% of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 97.06 % | R <90 %<br>A >=90 %<br>G >=95 % |  | No Action Required |
| Inpatient Survey: Play | **IP Survey: % Patients involved in Play** D<br>% of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 80.88 % | R <85 %<br>A >=85 %<br>G >=90 % |  | 80.9% responded that they had engaged with play during February an increase of 9.5% since January. There has been further provision of play due to recruitment and volunteer support in these areas and return of staff following COVID isolation and sickness absence. Play resources have increased due to donations at Christmas and through funding from the charity to enable distraction toys to be ordered through NEP. |
| Inpatient Survey: Learning | **IP Survey: % Patients involved in Learning** D<br>% of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above.<br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 91.91 % | R <85 %<br>A >=85 %<br>G >=90 % |  | No Action Required |

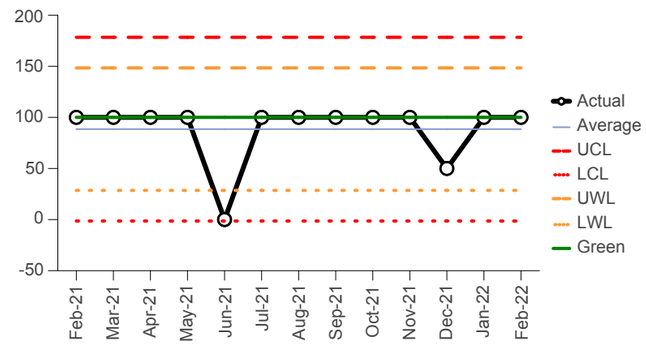
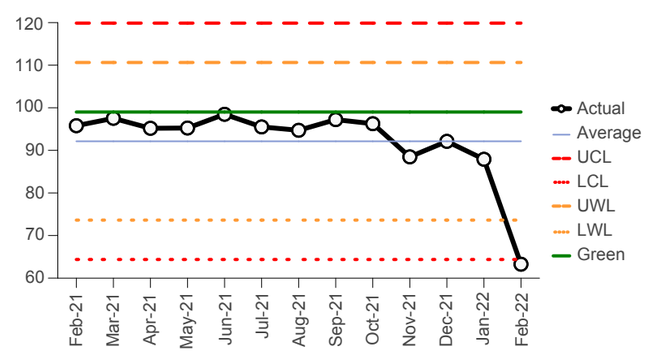
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Staffing | **Safer Staffing (Shift Fill Rate)** W<br>Safer Staffing. Threshold is based on National Target of 90% or above.<br><br>**Exec Lead:** Pauline Brown<br>**Committee:** SQAC | 84.02 % | R <90 %<br>A N/A<br>G >=90 % |  | |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| ED 4 Hour Standard | **ED: 95% Treated within 4 Hours** D<br>Threshold is based on National Guidance set by NHS England at 95%.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 77.14 % | R <95 %<br>A N/A<br>G >=95 % |  | ED performance is still deteriorating against the 95% target. We have had increased acuity and the number of sick children has increased. We have started Go to doc which has taken awhile to get off the ground, but we have seen an increase of shifts being covered. Staff sickness from medics and nurses has been hit badly and we have also had a changeover of Drs which also impacts on the pace of the department. |
| ED 12 Hr Waits | **ED: Number of patients spending >12 hours from decision to admit to admission** W<br>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.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 0 | R >0<br>A N/A<br>G 0 |  | No Action Required |
| Cancelled Operations | **On the day Elective Cancelled Operations for Non Clinical Reasons** D<br>Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 15 | R >20<br>A N/A<br>G <=20 |  | No Action Required |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Operation Breaches | **28 Day Breaches** W<br>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.<br><br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 3 | R >0<br>A N/A<br>G 0 |  | As the division has been operating on a reduced theatre schedule and fewer capacity pressures, this has led to reduced on the day cancelled operations due to bed which has resulted in reduced 28 day breaches. |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| RTT | **RTT: Open Pathway: % Waiting within 18 Weeks** W<br>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.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 61.46 % | R <90 %<br>A >=90 %<br>G >=92 % |  | Continues to be challenging due to the reduced theatre schedule. From March 22, this is now back up to the normal schedule but challenges remain with the RTT open pathway. |
| Waiting Times | **Waiting List Size** W<br>Total waiting list size of Inpatient and Outpatient RTT incomplete pathways<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 19731 | No Threshold |  | |
| Waiting Times | **Waiting Greater than 52 weeks - Incomplete Pathways** W<br>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.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 232 | R >0<br>A N/A<br>G 0 |  | This has slightly increased as expected due to a reduced theatre schedule. The Division is working towards clearing the 52 week backlog for outpatients by end of May 22 and April 2023 for the inpatients. A trajectory has been developed for inpatients to support the delivery of this. |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Cancer RTT | **Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Cancer RTT | **Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Cancer RTT | **All Cancers: 31 day wait until subsequent treatments** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Cancer RTT | **31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br><br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 100 % | R <100 %<br>A N/A<br>G 100 % |  | No Action Required |
| Diagnostics | **Diagnostics: % Completed Within 6 Weeks** W<br>Threshold is based on National Guidance set by NHS England at 99%.<br><br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 63.26 % | R <99 %<br>A N/A<br>G >=99 % |  | Reporting against DM01 has changed from February 2022 to include a range of tests that had previously been excluded; RABD received a detailed report In February and approved moving to the revised reporting process; this change is a result of the Safe Waiting List project which was established to ensure all children receive timely access to care. |

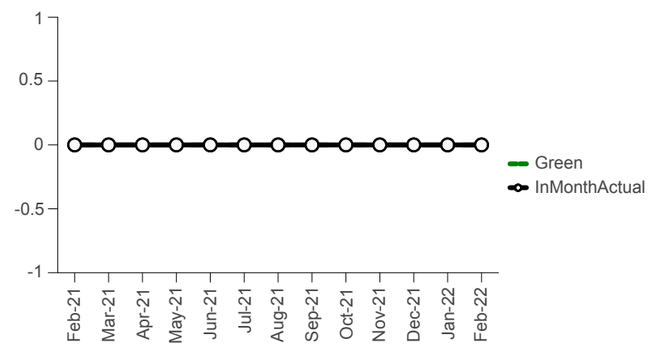
The Best People doing their best Work

# 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<br>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).<br><br>**Exec Lead:** Erica Saunders<br>**Committee:** SQAC | 0 | R >1<br>A <=1<br>G 0 |  | No Action Required |

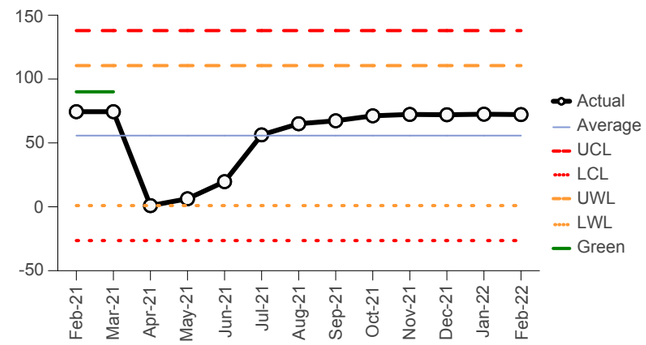
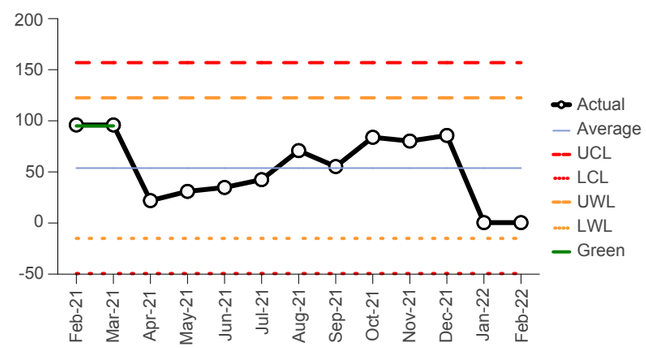
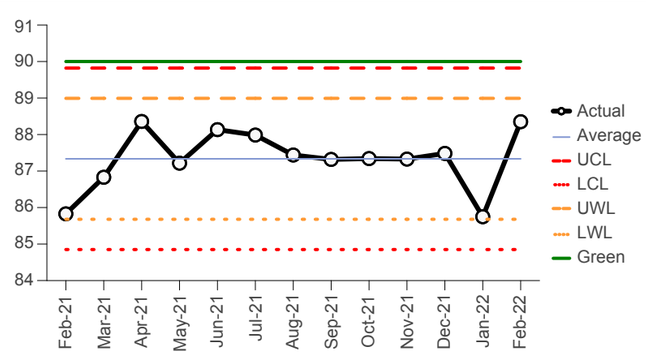
The Best People doing their best Work

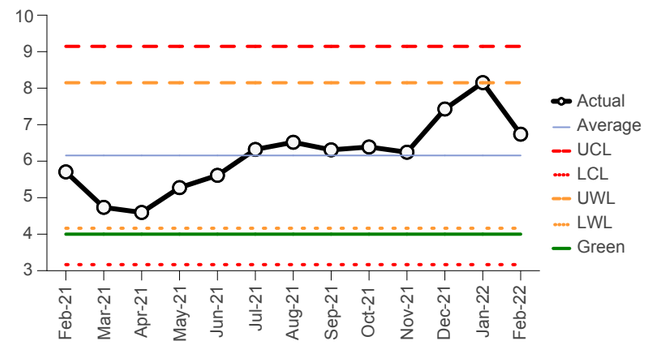
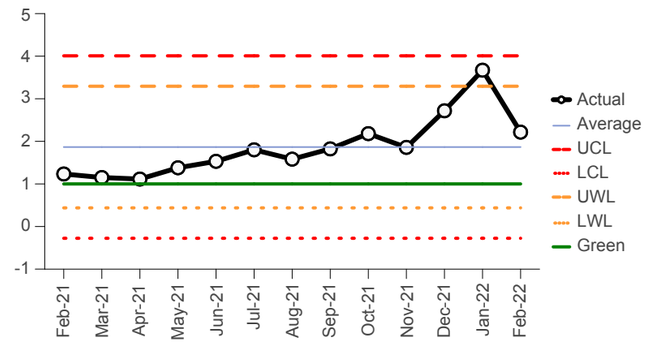
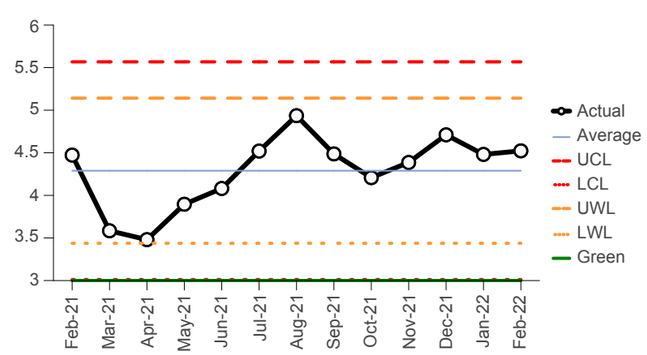
# 15.1 - PEOPLE - WELL LED

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<br>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).<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 72.17 % | No Threshold |  | As of the 28th of February 2022, our Trust appraisal rate was 72%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. These figures will continue to flux as staff move around the organisation. The Trust is currently doing a full review of the PDR process including timing, documentation and system. |
| Appraisal | **Medical Appraisal** W<br>Trust Target for compliance for medical staff, which is on a rolling 12mth period.<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 0.38 % | No Threshold |  | The Medical Appraisal process has reset as of January 22 |
| Training | **Mandatory Training** W<br>This is a Trust target that measures all required training including Resuscitation.<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 88.35 % | R <80 %<br>A >=80 %<br>G >=90 % |  | As of the 28th of February, Mandatory Training was at 88% overall, 2% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance. Our three key areas of focus recently have been Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen significant compliance drops due largely to the impact of COVID on face to face training restrictions. |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sickness | **Sickness** D<br>% of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 6.74 % | R >4.5 %<br>A <=4.5 %<br>G <=4 % |  | Sickness levels continue to fluctuate daily and remain an area of significant focus across all divisions. activity highlighted during previous months continues including enhanced reporting for managers, close monitoring of COVID related absence and supporting people to return to work were possible, taking into account reasonable adjustments to facilitate this. (Continued below) |
| Sickness | **Short Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting less than 28 days<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 2.22 % | R >1 %<br>A N/A<br>G <=1 % |  | In addition, managers training has been developed and will launch April 22, utilising a blended learning approach. Feedback on the HR Well-being Officers has highlighted the value managers are finding their support including timely occupational health referrals and supporting managers to conclude the reporting or return to work activity into the electronic reporting systems e.g. ESR. |
| Sickness | **Long Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting 28 days or more<br><br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 4.52 % | R >3 %<br>A N/A<br>G <=3 % |  | See above comments |

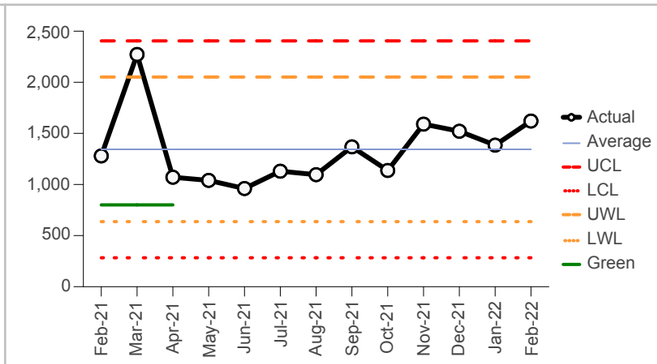
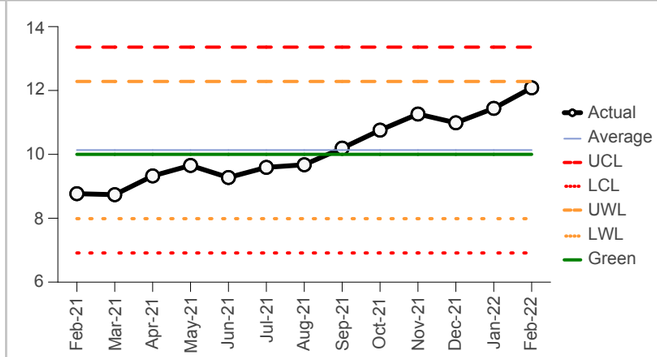
The Best People doing their best Work

# 15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

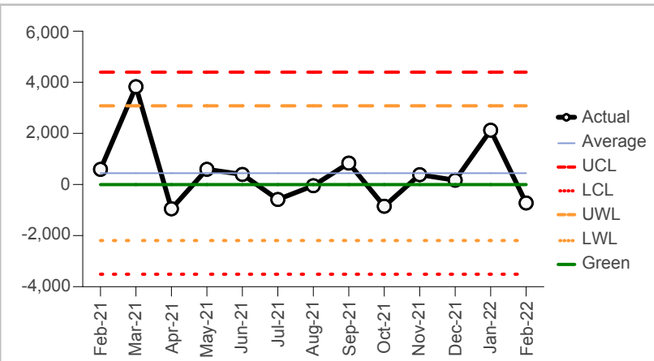
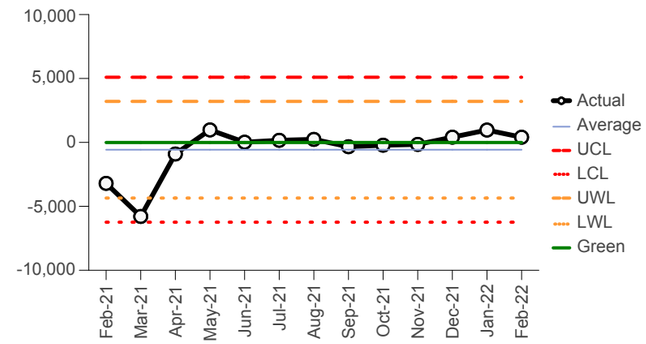
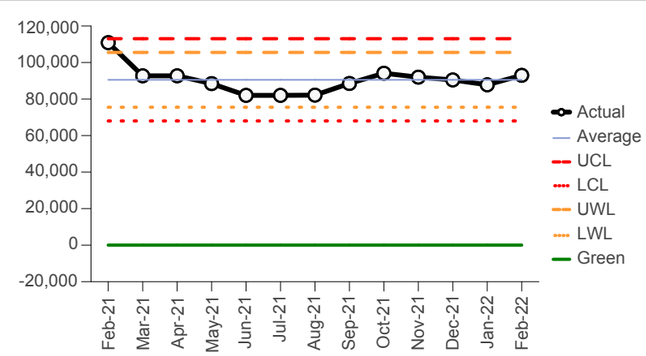
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Temporary Spend | **Temporary Spend ('000s)** D<br>Indicates the expenditure on premium temporary pay spend and monitors the reduction.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 1620.28 | No Threshold |  | |
| Staff Turnover | **Staff Turnover** D<br>Trust Target which is based on a rolling 12mth period<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 12.08 % | R >11 %<br>A <=11 %<br>G <=10 % |  | As we are aware turnover is increasing and Sharon Owen presented a paper to PAWC last month to highlight this in more detail. Understanding the reasons why individuals are leaving the trust remains a key requirement, linked to a robust exit interview process; alongside clear business continuity planning including workforce and succession planning. |

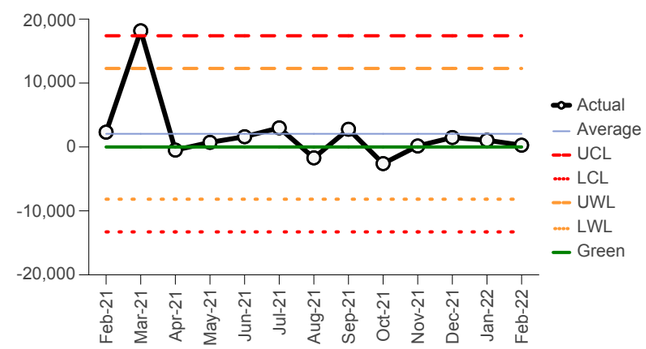
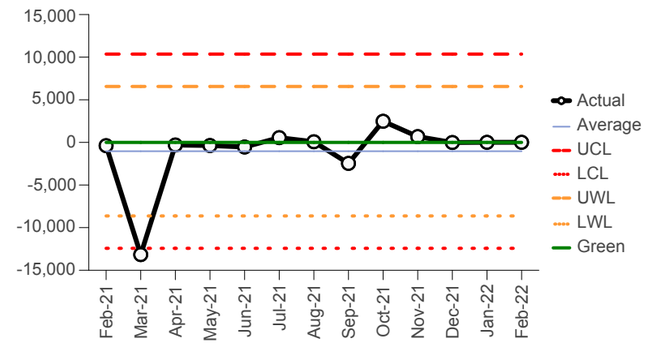
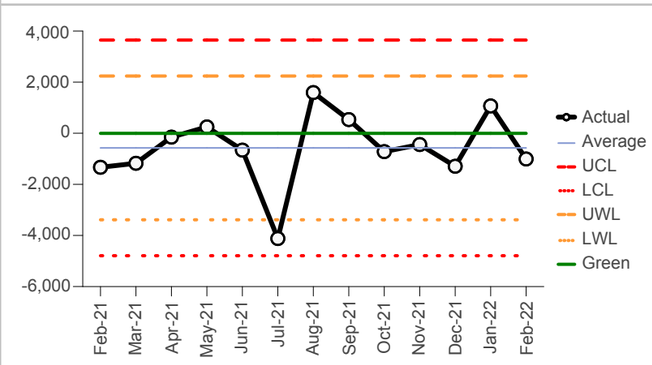
The Best People doing their best Work

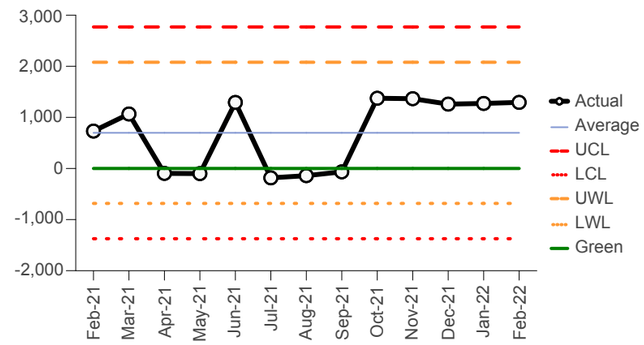
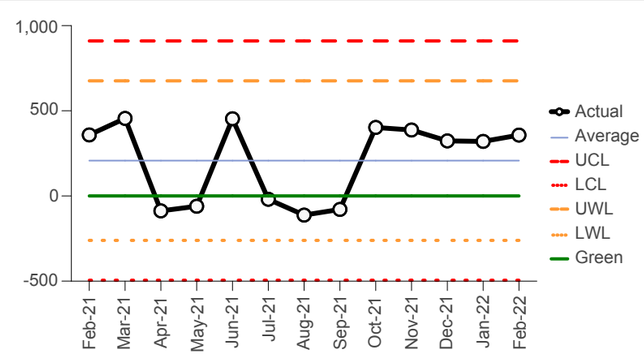
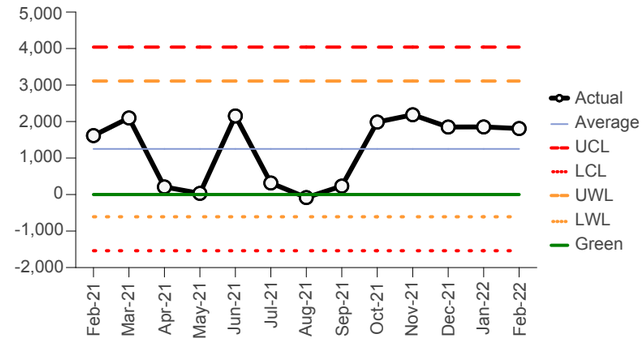
# 16.1 - FINANCE - WELL LED

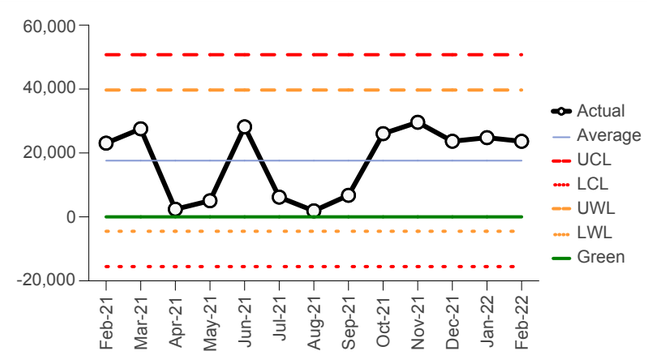
Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Control Total In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | -725 | R <-20%<br>A >=-20%<br>G >=-5% |  | |
| Finance | **Capital Expenditure In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | 403 | R <-10%<br>A >=-10%<br>G >=-5% |  | No Action Required |
| Finance | **Cash in Bank (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | 92,978 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Income In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 274 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Pay In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 9 | R <-20%<br>A >=-20%<br>G >=-5% |  | No Action Required |
| Finance | **Non Pay In Month Variance (£'000s)** W<br>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<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -1,008 | R <-20%<br>A >=-20%<br>G >=-5% |  | |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **AvP: IP - Non-Elective** W<br>Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 1293 | R <0<br>A N/A<br>G >=0 |  | No Action Required |
| Finance | **AvP: IP Elective vs Plan** W<br>Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 357 | R <0<br>A N/A<br>G >=0 |  | No Action Required |
| Finance | **AvP: Daycase Activity vs Plan** W<br>Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 1808 | R <0<br>A N/A<br>G >=0 |  | No Action Required |

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **AvP: Outpatient Activity vs Plan** W<br>Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher.<br><br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 23636 | R <0<br>A N/A<br>G >=0 |  | No Action Required |

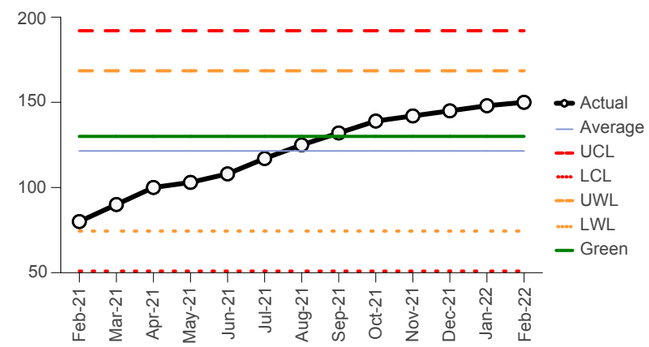
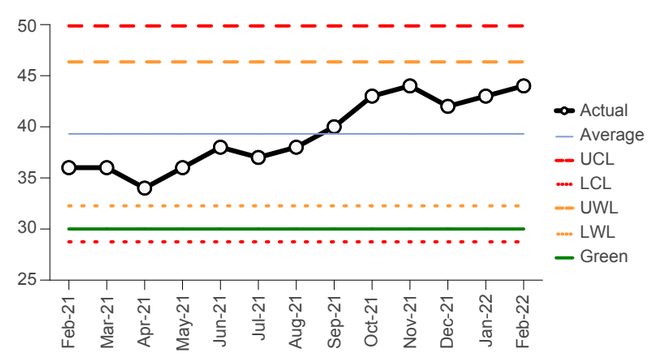
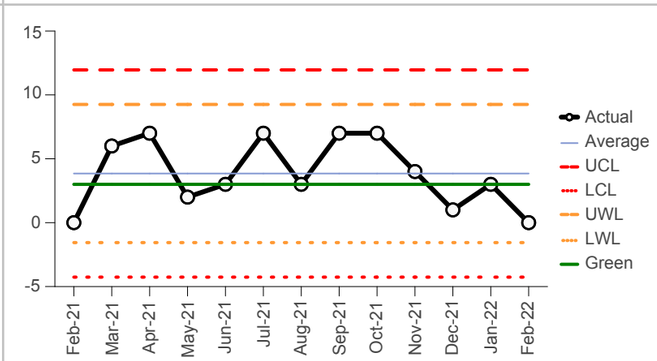
Game Changing Research & Innovation

# 17.1 - 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 Open Studies - Academic** W<br>Number of academic studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 150 | R <111<br>A >=111<br>G >=130 |  | No Action Required |
| Clinical Research | **Number of Open Studies - Commercial** W<br>Number of commercial studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 44 | R <21<br>A >=21<br>G >=30 |  | No Action Required |
| Clinical Research | **Number of New Studies Opened - Academic** W<br>Number of new academic studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 0 | R <2<br>A >=2<br>G >=3 |  | |

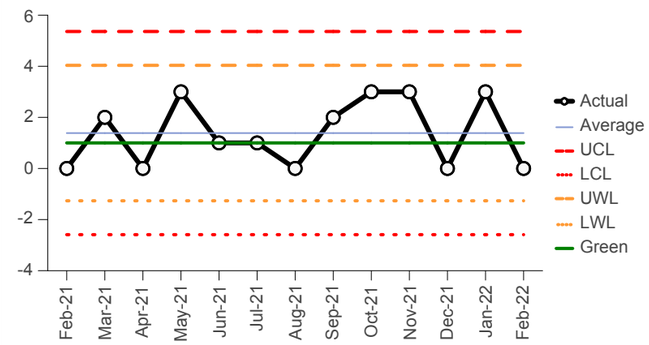
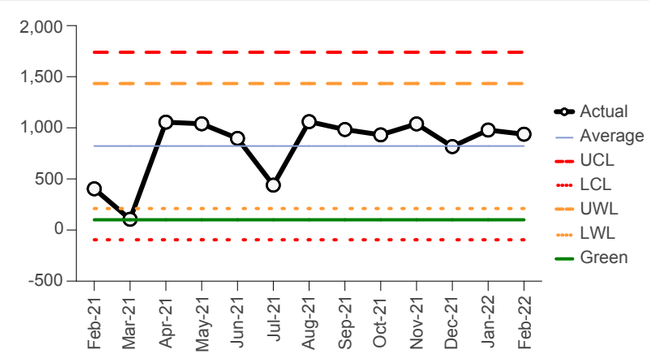
Game Changing Research & Innovation

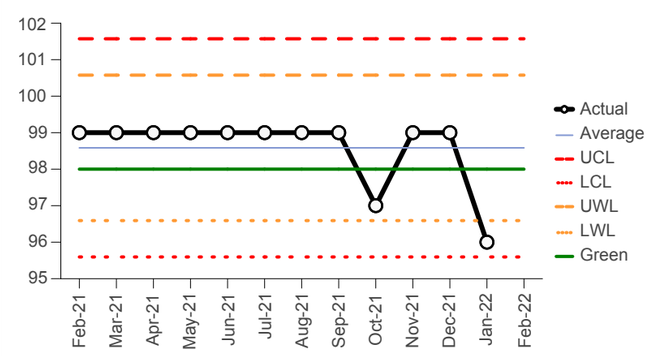
# 17.2 - RESEARCH & DEVELOPMENT - WELL LED

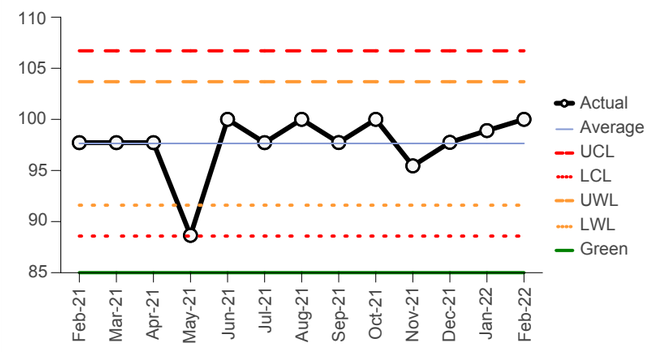
Alder Hey Children's NHS
NHS Foundation Trust

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<br>Number of new commercial studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 0 | R <1<br>A N/A<br>G >=1 |  | |
| Clinical Research | **Number of patients recruited** W<br>Number of patients recruited to NIHR portfolio studies in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 937 | R <86<br>A >=86<br>G >=100 |  | No Action Required |

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

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Facilities | **Domestic Cleaning Audit Compliance** W<br><br>Auditing for Domestic Services, aim is to ensure National Cleaning Standards.<br><br>**Exec Lead:** Nathan Askew<br>**Committee:** SQAC | 100 % | R <85 %<br>A N/A<br>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 | 13 | 37 | 22 | No Threshold | | |
| Clinical Incidents resulting in No Harm | D | 50 | 103 | 116 | No Threshold | | |
| Clinical Incidents resulting in minor, non permanent harm | D | 17 | 18 | 43 | No Threshold | | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 1 | No Threshold | | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 1 | 0 | 0 | N/A | >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Medication errors resulting in harm | D | 0 | 0 | 2 | No Threshold | | |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Never Events | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | | 83.3% | 75.0% | >=90 % | N/A | <90 % |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Hospital Acquired Organisms - MSSA | D | 0 | 0 | 0 | No Threshold | | |

## CARING

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Complaints | W | 4 | 5 | 10 | No Threshold |
| PALS | W | 29 | 50 | 45 | No Threshold |

## EFFECTIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | | | 1.1% | No Threshold | | |
| ED: 95% Treated within 4 Hours | D | | 77.1% | | >=95 % | N/A | <95 % |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | | 0 | | 0 | N/A | >0 |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 0 | 0 | 15 | No Threshold |
| 28 Day Breaches | W | 0 | 0 | 3 | 0 / N/A / >0 |

## RESPONSIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | | 92.1% | 93.6% | >=95 % / >=90 % / <90 % |
| IP Survey: % Treated with respect | W | | 97.0% | 96.5% | >=95 % / >=90 % / <90 % |
| IP Survey: % Know their planned date of discharge | D P | | 58.4% | 73.1% | >=90 % / >=85 % / <85 % |
| IP Survey: % Know who is in charge of their care | W | | 95.0% | 98.2% | >=95 % / >=90 % / <90 % |
| IP Survey: % Patients involved in Play | D | | 80.2% | 81.3% | >=90 % / >=85 % / <85 % |
| IP Survey: % Patients involved in Learning | D | | 92.1% | 91.8% | >=90 % / >=85 % / <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 54.1% | 63.4% | 61.5% | >=92 % / >=90 % / <90 % |
| Waiting List Size | W | 1,646 | 6,136 | 11,949 | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 2 | 230 | 0 / N/A / >0 |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | | 100.0% | | 100 % / N/A / <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | | 100.0% | | 100 % / N/A / <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | | 100.0% | | 100 % / N/A / <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | | 66.7% | 32.5% | >=99 % / N/A / <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | | 100.0% | | 100 % / N/A / <100 % |

## WELL LED

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -77 | -261 | -232 | No Threshold |
| Income In Month Variance (£'000s) | W | -106 | 135 | 23 | No Threshold |
| Pay In Month Variance (£'000s) | W | 228 | -218 | -358 | No Threshold |
| Non Pay In Month Variance (£'000s) | W | -199 | -177 | 103 | No Threshold |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| AvP: IP - Non-Elective | W | 0 | 908 | 385 | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 0 | 132 | 225 | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | 1,199 | 609 | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 4,139 | 7,133 | 10,247 | >=0 | N/A | <0 |
| PDR | W | 82.5% | 74.2% | 61.3% | No Threshold | | |
| Medical Appraisal | W | 0.0% | 0.0% | 0.8% | No Threshold | | |
| Mandatory Training | W | 92.4% | 87.0% | 88.5% | >=90 % | >=80 % | <80 % |
| Sickness | D | 5.8% | 8.2% | 6.1% | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 1.5% | 2.6% | 2.6% | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 4.3% | 5.6% | 3.5% | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 278 | 495 | 535 | No Threshold | | |
| Staff Turnover | D | 10.9% | 12.3% | 12.2% | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 99.1% | 77.0% | 86.6% | >=90 % | >=80 % | <90 % |

# Medicine Division

| | | |
|---|---|---|
| **SAFE** | Open historic incidents are being addressed and ongoing weekly monitoring will be developed to ensure incidents are closed in a timely manner.<br><br>3 ongoing RCAs<br><br>Locum Interventional radiology consultant started in post allowing us to close one of our highest scored risks. | **Highlight**<br>• The teams have completed a large piece of work to close the majority of historic incidents.<br>**Challenges**<br>• National shortages of ventilation equipment is delaying set up of patients for NIV. Currently have 16 patients waiting set up. Regional discussions taking place through ODN to assess managing waiting list and potential to suspend routine services. |
| **CARING** | All complaints received in February on track to be responded to within 25 working days. | **Highlight**<br>• All historic complaints have been closed.<br>• All Medicine lead January complaints responded to within 25 working days.<br>**Challenges**<br>• PALS process has points of failure of admin procedures – trust wide review required to make process lean and effective. |
| **EFFECTIVE** | ED Performance has deteriorated in month; the department is still impacted by absenteeism in nursing and medicine; recruitment is underway to fill outstanding vacancies. | **Highlight**<br>• No breaches of 28-day standard for rebooking cancelled surgery.<br>**Challenges**<br>• Theatre Utilisation under 85% for 3rd month running. Review undertaken within medicine to identify areas for improvement in Rheum and Respiratory where performance lowest.<br>• WNB rate increased across the board. Gen Paediatrics taking part in pilot using WNB predictor tool in March and April.<br>• Appointments cancelled < 6 weeks for non-clinical reasons are under review.<br>• NICE position reporting due to unplanned leave. |
| **RESPONSIVE** | Locum consultants appointed for Gen Paediatrics as part of plans to reduce waiting times. Starting in April and July.<br><br>Work progressing on BI reports for Radiology and Cancer waiting lists to improve visibility for specialty teams.<br><br>Reporting against DM01 has changed from February 2022 to include a range of tests that had previously been excluded; RABD received a detailed report In February and approved moving to the revised reporting process; this change is a result of the Safe Waiting List project which was established to ensure all children | **Highlight**<br>• Cancer targets all achieved.<br>• All patients over 52 weeks have planned appointment dates and teams now working to resolve for all patients over 40 weeks.<br>**Challenges**<br>▪ Reporting of Cross-Sectional Imaging remains a challenge in meeting the 2-week target. 2nd outsourcing company identified that is in use across NW and with procurement for sign off.<br>▪ DM01 performance for MRI lower due to backlog of cancelled patients from unexpected system downtime. |

| | | |
|---|---|---|
| | receive timely access to care. The Division of Medicine have several tests that continue to experience long waits in excess of the 6 week standard:<br><br>• MRI: referrals have increased during 2021/22, in response the Radiology department are extending the working day to 8pm Fridays and from 8am each weekday; the department are also reviewing longer term options including weekend working and the potential for a 3rd MRI scanner to reduce long waits.<br>• DEXA: this service was suspended in January 2022 due to issues with the replacement equipment; this equipment is now being removed and replaced via new supplier; once installed and training complete a recovery plan will be instigated.<br>• Respiratory Physiology: the serviced continues to suffer the impact of the pandemic including the post pandemic increase in referrals; the service has approval for additional equipment to establish home testing, this is expected to be available from late spring. In the meantime additional inpatient session are being arranged to mitigate the long waits. | |
| **WELL LED** | Overall Sickness absence rates have improved but remain high at 8.5% with a concerning increase in long term sickness; HR teams are actively supporting case reviews. | **Highlight**<br>• Risk awareness sessions being held by R&GL.<br><br>**Challenges**<br>• Maintain monthly risk reviews in all areas.<br>• There are a significant number of staff who are in the red for mandatory training compliance, the Division are actively contacting individuals to remind them of the requirement to comply.<br>• PDR compliance is not improving, managers are being encouraged to undertake PDRs ahead of the formal PDR window in April. |

# Medicine

D Drive W Watch P Programme

## SAFE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss (D) | 23 | 33 | 42 | 32 | 36 | 29 | 28 | 33 | 39 | 24 | 49 | 32 | 37 | | No Threshold |
| Clinical Incidents resulting in No Harm (D) | 97 | 125 | 123 | 125 | 90 | 101 | 99 | 133 | 93 | 87 | 100 | 105 | 103 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm (D) | 17 | 19 | 23 | 24 | 17 | 18 | 17 | 14 | 28 | 25 | 18 | 19 | 18 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm (D) | 1 | 1 | 0 | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm (D) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death (D) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm (D) | 1 | 2 | 0 | 0 | 1 | 0 | 2 | 3 | 1 | 0 | 1 | 1 | 0 | | No Threshold |
| Medication Errors (Incidents) | 28 | 39 | 29 | 42 | 26 | 14 | 20 | 35 | 24 | 20 | 30 | 29 | 18 | | No Threshold |
| Pressure Ulcers (Category 3) (W) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) (W) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Acute readmissions of patients with long term conditions within 28 days | 2 | 4 | 1 | 3 | 2 | 0 | 2 | 1 | 6 | 7 | 4 | 1 | 3 | | No Threshold |
| Never Events (W) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P) | 84.6% | 87.5% | 90.9% | 88.2% | 93.3% | 96.2% | 75.0% | 85.7% | 91.3% | 83.3% | 83.3% | | | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) (D) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile (D) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - CLABSI | 2 | 1 | 5 | 0 | 0 | 2 | 3 | 3 | 4 | 2 | 1 | 0 | 1 | | No Threshold |
| Hospital Acquired Organisms - MSSA (D) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | | No Threshold |
| Cleanliness Scores | 97.2% | 98.6% | 98.7% | 98.2% | 98.6% | 98.6% | 98.7% | 98.8% | 99.4% | 98.5% | 98.4% | 99.2% | 98.8% | | No Threshold |
| Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed. | 68.2% | | | | | | | | | | | | | | >=50 % N/A <50 % |
| Pharmacy - Dispensing for Out Patients - Routine within 30 minutes | 84.0% | | | | | | | | | | | | | | >=90 % N/A <90 % |
| Pharmacy - Dispensing for Out Patients - Complex within 60 minutes | 100.0% | | | | | | | | | | | | | | >=90 % N/A <90 % |

## CARING

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints (W) | 3 | 12 | 4 | 5 | 2 | 4 | 4 | 3 | 5 | 7 | 2 | 5 | 5 | | No Threshold |
| PALS (W) | 19 | 37 | 24 | 23 | 40 | 41 | 25 | 48 | 50 | 45 | 42 | 34 | 50 | | No Threshold |

## EFFECTIVE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | 1,699 | 2,246 | 2,147 | 2,251 | 2,425 | 2,264 | 1,928 | 2,475 | 2,621 | 2,689 | 3,055 | 2,887 | 2,478 | | No Threshold |
| ED: 95% Treated within 4 Hours (D) | 97.8% | 95.3% | 92.5% | 81.1% | 85.5% | 67.9% | 87.7% | 73.4% | 72.5% | 66.4% | 74.9% | 80.2% | 77.1% | | >=95 % N/A <95 % |
| ED: Percentage Left without being seen (W) | 0.7% | 2.2% | 3.8% | 7.4% | 4.9% | 12.5% | 4.3% | 9.1% | 9.5% | 8.7% | 6.1% | 4.0% | 5.9% | | <=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 | 1 | 0 | 1 | 4 | 0 | 1 | | 0 N/A >0 |
| ED: All handovers between ambulance and A & E - Waiting more than 60 minutes (W) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 3 | 0 | 0 | | 0 N/A >0 |
| ED: Re-attendance within 7 days of original attendance (%) (W) | 7.9% | 7.5% | 8.3% | 9.5% | 8.6% | 9.8% | 9.7% | 8.4% | 9.1% | 9.6% | 9.9% | 9.1% | 8.8% | | No Threshold |
| ED: Number of patients spending >12 hours from decision to admit to admission (W) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |

# Medicine

D Drive W Watch P Programme

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Theatre Utilisation - % of Session Utilised W | 87.8% | 86.3% | 74.7% | 76.9% | 73.9% | 74.2% | 72.2% | 78.5% | 76.6% | 76.7% | 73.7% | 70.8% | 74.9% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 0 | 1 | 2 | 0 | 1 | 0 | 3 | 2 | 3 | 5 | 0 | 4 | 0 | | No Threshold |
| 28 Day Breaches W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 2 | 2 | 0 | 0 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 14 | 18 | 21 | 19 | 21 | 37 | 42 | 30 | 43 | 45 | 40 | 33 | 37 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 12.5% | 11.6% | 10.0% | 10.7% | 11.6% | 14.9% | 14.6% | 13.7% | 15.3% | 12.2% | 12.0% | 12.2% | 13.3% | | <=5 % N/A >10 % |
| Was Not Brought Rate W P | 9.2% | 8.6% | 9.0% | 8.6% | 9.5% | 10.4% | 11.0% | 9.7% | 9.4% | 9.1% | 9.1% | 8.8% | 9.1% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 10.9% | 9.3% | 12.3% | 9.8% | 11.1% | 10.4% | 11.2% | 9.1% | 9.4% | 8.6% | 8.9% | 10.3% | 8.1% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 8.9% | 8.5% | 8.4% | 8.4% | 9.2% | 10.4% | 11.0% | 9.9% | 9.4% | 9.2% | 9.1% | 8.5% | 9.3% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 5.54 | 5.41 | 5.14 | 5.17 | 5.58 | 5.47 | 5.58 | 5.50 | 5.68 | 5.57 | 5.49 | 5.50 | 5.41 | | No Threshold |

## RESPONSIVE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care W | 96.4% | 95.2% | 96.2% | 98.3% | 93.5% | 87.9% | 100.0% | 92.7% | 88.7% | 100.0% | 92.5% | 93.3% | 92.1% | | >=95 % >=90 % <90 % |
| IP Survey: % Treated with respect W | 100.0% | 95.2% | 98.1% | 100.0% | 89.1% | 87.9% | 97.9% | 92.7% | 94.3% | 100.0% | 98.1% | 98.7% | 97.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Know their planned date of discharge D P | 98.2% | 91.9% | 96.2% | 91.5% | 95.7% | 86.2% | 91.5% | 92.7% | 86.8% | 89.7% | 58.5% | 57.3% | 58.4% | | >=90 % >=85 % <85 % |
| IP Survey: % Know who is in charge of their care W | 92.9% | 95.2% | 94.3% | 100.0% | 97.8% | 93.1% | 87.2% | 90.2% | 100.0% | 94.9% | 96.2% | 97.3% | 95.0% | | >=95 % >=90 % <90 % |
| IP Survey: % Patients involved in Play D | 89.3% | 85.5% | 84.9% | 88.1% | 71.7% | 81.0% | 72.3% | 75.6% | 73.6% | 84.6% | 73.6% | 58.7% | 80.2% | | >=90 % >=85 % <85 % |
| IP Survey: % Patients involved in Learning D | 94.6% | 80.0% | 90.6% | 89.8% | 80.4% | 87.9% | 74.5% | 85.4% | 86.8% | 97.4% | 92.5% | 92.0% | 92.1% | | >=90 % >=85 % <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks W | 90.8% | 92.9% | 92.0% | 93.1% | 92.5% | 86.8% | 83.3% | 77.5% | 65.4% | 65.9% | 67.4% | 64.1% | 63.4% | | >=92 % >=90 % <90 % |
| Waiting List Size W | 2,110 | 2,280 | 2,509 | 2,819 | 3,122 | 3,338 | 3,507 | 3,565 | 5,605 | 5,842 | 5,943 | 5,955 | 6,136 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways W | 16 | 4 | 4 | 3 | 6 | 11 | 7 | 13 | 23 | 10 | 15 | 5 | 2 | | 0 N/A >0 |
| Waiting Times - 40 weeks and above | 37 | 10 | 24 | 12 | 15 | | | | | | | | | | No Threshold |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W | 100.0% | 100.0% | 100.0% | 100.0% | 95.7% | 100.0% | 100.0% | 100.0% | 100.0% | 96.4% | 95.2% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| All Cancers: 31 day wait until subsequent treatments W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Diagnostics: % Completed Within 6 Weeks W | 96.0% | 97.7% | 95.5% | 95.1% | 98.4% | 95.6% | 94.4% | 97.1% | 96.4% | 88.7% | 92.3% | 88.5% | 66.7% | | >=99 % N/A <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 50.0% | 100.0% | 100.0% | | 100 % N/A <100 % |
| Pathology - % Turnaround times for urgent requests < 1 hr | 90.4% | 91.9% | 91.1% | 92.6% | 91.1% | 91.6% | 91.9% | 89.8% | 89.8% | 90.0% | 88.2% | 89.8% | 90.4% | | >=90 % >=85 % <90 % |
| Pathology - % Turnaround times for non-urgent requests < 24hrs | 100.0% | 100.0% | 100.0% | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% | 100.0% | 100.0% | | >=90 % >=85 % <90 % |
| Imaging - % Report Turnaround times GP referrals < 24 hrs | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=95 % >=90 % <95 % |
| Imaging - % Reporting Turnaround Times - ED | 99.0% | 100.0% | 89.0% | 96.0% | 100.0% | 99.0% | 100.0% | 96.0% | 91.0% | 98.0% | 94.0% | 100.0% | 99.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Inpatients | 98.0% | 99.0% | 89.0% | 96.0% | 95.0% | 92.0% | 93.0% | 79.0% | 73.0% | 81.0% | 84.0% | 93.0% | 82.0% | | >=90 % >=85 % <90 % |
| Imaging - % Reporting Turnaround Times - Outpatients | 77.0% | 58.0% | 65.0% | 57.0% | 52.9% | 54.0% | 61.0% | 57.0% | 51.0% | 66.0% | 54.0% | 72.0% | 64.0% | | >=85 % N/A <85 % |
| Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks | 95.0% | 98.0% | 98.7% | 100.0% | 91.9% | 89.4% | 83.1% | 86.7% | 100.0% | 84.5% | 90.2% | 74.8% | 72.5% | | >=99 % N/A <99 % |
| Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 93.5% | 91.7% | 100.0% | 97.1% | 94.3% | 93.6% | 89.7% | 93.5% | | >=99 % N/A <99 % |
| Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks | 100.0% | 100.0% | 98.9% | 100.0% | 100.0% | 99.3% | 100.0% | 100.0% | 98.0% | 98.7% | 100.0% | 98.7% | 100.0% | | >=99 % N/A <99 % |

# Medicine

D Drive W Watch P Programme

## WELL LED

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 160 | -586 | 263 | 200 | -1,036 | -347 | -58 | 253 | -127 | -199 | 87 | 144 | -261 | | | | |
| Income In Month Variance (£'000s) | W | 36 | 170 | 37 | -26 | -1 | 209 | -490 | 201 | -184 | 1,138 | 829 | -308 | 135 | | | | |
| Pay In Month Variance (£'000s) | W | -52 | -148 | -64 | 60 | -150 | 48 | 47 | 121 | -35 | 15 | 70 | -96 | -218 | | | | |
| AvP: IP - Non-Elective | W | 416 | 676 | -153 | -78 | 807 | -82 | -19 | -42 | 1,003 | 954 | 857 | 887 | 908 | | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 139 | 154 | -16 | -10 | 161 | -25 | -58 | -25 | 119 | 122 | 91 | 116 | 132 | | >=0 | N/A | <0 |
| AvP: OP New | | 1,087.00 | 1,229.00 | -383.97 | -404.28 | 1,295.00 | -506.93 | -566.20 | -319.45 | 1,326.00 | 1,378.00 | 1,030.00 | 1,093.00 | 1,055.00 | | >=0 | N/A | <0 |
| AvP: OP FollowUp | | 5,229.00 | 6,176.00 | 1,674.17 | 1,403.80 | 6,498.00 | 1,256.46 | 1,210.03 | 1,734.47 | 5,685.00 | 6,367.00 | 5,742.00 | 6,338.00 | 5,196.00 | | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | 1,044 | 1,283 | 265 | 222 | 1,356 | 268 | 117 | 422 | 1,252 | 1,348 | 1,153 | 1,180 | 1,199 | | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 7,416 | 8,563 | 845 | 706 | 8,800 | 343 | 381 | 1,207 | 7,992 | 8,838 | 7,756 | 8,299 | 7,133 | | >=0 | N/A | <0 |
| PDR | W | 74.2% | 74.2% | 2.6% | 6.8% | 18.5% | 50.2% | 61.7% | 65.8% | 72.8% | 74.0% | 73.7% | 74.5% | 74.2% | | | | |
| Medical Appraisal | W | 94.1% | 94.1% | 23.4% | 28.6% | 33.9% | 42.0% | 75.9% | 52.2% | 81.8% | 75.7% | 80.3% | 0.0% | 0.0% | | | | |
| Mandatory Training | W | 87.1% | 88.5% | 89.1% | 87.6% | 87.9% | 87.2% | 86.9% | 87.0% | 86.1% | 86.6% | 86.7% | 85.9% | 87.0% | | >=90 % | >=80 % | <80 % |
| Sickness | D | 5.2% | 4.2% | 4.5% | 5.5% | 5.3% | 6.4% | 7.1% | 6.3% | 6.5% | 7.4% | 9.3% | 9.9% | 8.2% | | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 1.4% | 1.1% | 1.2% | 1.5% | 1.5% | 2.0% | 1.9% | 1.8% | 2.3% | 2.2% | 3.5% | 4.4% | 2.6% | | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 3.8% | 3.1% | 3.4% | 4.0% | 3.7% | 4.4% | 5.2% | 4.5% | 4.3% | 5.2% | 5.8% | 5.5% | 5.6% | | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 267 | 261 | 210 | 262 | 230 | 265 | 263 | 292 | 311 | 373 | 370 | 452 | 495 | | | | |
| Staff Turnover | D | 6.5% | 6.0% | 6.5% | 6.8% | 7.3% | 7.5% | 8.3% | 9.4% | 9.6% | 10.0% | 10.1% | 11.3% | 12.3% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 97.8% | 93.9% | 101.7% | 97.9% | 96.0% | 87.2% | 90.6% | 95.0% | 83.8% | 83.7% | 79.3% | 75.2% | 77.0% | | >=90 % | >=80 % | <90 % |

# Surgery Division

| | | |
|---|---|---|
| **SAFE** | • Clinical incidents resulting in new miss reduced.<br>• Incidents resulting in no harm have increased in line with trend over the year.<br>• Another semi permanent harm<br>• No pressure ulcers in Feb<br>• No hospital acquired infections. | **Highlight**<br>• No hospital acquired infections.<br>• No pressure ulcers in Feb<br>**Challenges**<br>• 1 semi permanent harm. Under going concise investigation process.<br>• Increased incidents resulting in no harm. |
| **CARING** | • Increased number of PALs and complaints | **Highlight**<br>•<br>**Challenges**<br>• Increased number of complaints and PALs. |
| **EFFECTIVE** | • Increased referrals<br>• Increased theatre utilisation<br>• Reduced on the day cancellations<br>• Reduced 28 day breaches<br>• Increased hospital initiated clinic cancellations<br>• Reduced WNB | **Highlight**<br>• Increased theatre utilisation.<br>• Reduced on the day cancellations<br>• Reduced 28 day breaches.<br>**Challenges**<br>• Increased hospital initiated clinic cancellations. |
| **RESPONSIVE** | • Reduced choice<br>• Reduced awareness of planned discharge date<br>• RTT remains same<br>• Increased waiting list size<br>• Volume of 52 week patients remains static | **Highlight**<br>• Overall volume of 52 week patients remains static<br>**Challenges**<br>• Increased waiting list size. |
| **WELL LED** | • Strong income position<br>• No movement on PDRs<br>• Increased mandatory training<br>• Reduced sickness | **Highlight**<br>• Strong income position<br>• Reduced sickness<br>**Challenges**<br>• Static position on mandatory training. Raised at Divisional Board. |

# Surgery

D Drive W Watch P Programme

## SAFE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss D | 25 | 46 | 23 | 32 | 43 | 27 | 25 | 42 | 33 | 33 | 22 | 26 | 22 | | No Threshold |
| Clinical Incidents resulting in No Harm D | 139 | 174 | 166 | 165 | 163 | 120 | 114 | 107 | 103 | 116 | 117 | 77 | 116 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm D | 27 | 33 | 35 | 28 | 38 | 31 | 49 | 39 | 43 | 82 | 39 | 40 | 43 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm D | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 1 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 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 | 2 | 2 | 4 | 2 | 1 | 2 | 3 | 1 | 1 | 3 | 4 | 1 | 2 | | No Threshold |
| Medication Errors (Incidents) | 39 | 45 | 43 | 36 | 29 | 24 | 27 | 26 | 20 | 28 | 29 | 20 | 21 | | 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 | 1 | 0 | | 0 N/A >0 |
| Never Events W | 0 | 1 | 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 | 83.3% | 90.9% | 76.9% | 91.7% | 88.9% | 66.7% | 100.0% | 75.0% | 82.6% | 82.4% | 75.0% | | | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MSSA D | 0 | 0 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 1 | 0 | 0 | | No Threshold |
| Cleanliness Scores | 97.0% | 97.9% | 98.9% | 98.4% | 98.2% | 98.7% | 98.2% | 98.6% | 98.5% | 97.4% | 99.3% | 98.7% | 98.7% | | No Threshold |

## CARING

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints W | 3 | 7 | 0 | 4 | 5 | 3 | 4 | 6 | 4 | 5 | 4 | 4 | 10 | | No Threshold |
| PALS W | 23 | 27 | 34 | 42 | 43 | 33 | 25 | 30 | 29 | 42 | 33 | 28 | 45 | | No Threshold |

## EFFECTIVE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions to PICU within 48 hrs D | 0 | 1 | 0 | 2 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 1 | 1 | | No Threshold |
| % Readmissions to PICU within 48 hrs W | 0.0% | 1.6% | 0.0% | 2.6% | 0.0% | 1.4% | 2.7% | 0.0% | 0.0% | 0.0% | 1.3% | 1.7% | 1.1% | | No Threshold |
| Referrals Received (Total) | 2,905 | 4,047 | 3,965 | 4,120 | 4,376 | 3,766 | 3,238 | 3,930 | 3,570 | 3,918 | 3,111 | 3,268 | 3,397 | | No Threshold |
| Theatre Utilisation - % of Session Utilised W | 90.3% | 89.5% | 77.0% | 83.0% | 78.4% | 79.5% | 81.0% | 83.8% | 86.7% | 79.4% | 81.5% | 77.2% | 85.9% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons D | 7 | 11 | 11 | 7 | 12 | 13 | 9 | 30 | 20 | 51 | 23 | 18 | 15 | | No Threshold |
| 28 Day Breaches W | 1 | 2 | 4 | 3 | 0 | 3 | 8 | 4 | 10 | 10 | 23 | 7 | 3 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 50 | 37 | 47 | 46 | 59 | 63 | 74 | 54 | 78 | 43 | 51 | 48 | 34 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 10.9% | 11.8% | 10.1% | 10.2% | 11.3% | 9.7% | 11.5% | 11.4% | 10.8% | 9.0% | 10.5% | 12.3% | 12.4% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate W P | 7.8% | 7.1% | 6.0% | 6.8% | 7.0% | 8.6% | 9.5% | 8.3% | 7.8% | 8.2% | 8.8% | 8.8% | 7.8% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) W | 10.4% | 8.3% | 7.0% | 8.9% | 8.3% | 11.1% | 11.6% | 9.6% | 9.5% | 10.0% | 10.6% | 11.0% | 9.2% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 6.8% | 6.6% | 5.6% | 6.0% | 6.5% | 7.6% | 8.7% | 7.7% | 7.2% | 7.7% | 8.2% | 8.0% | 7.3% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | 4.43 | 4.54 | 4.63 | 4.40 | 4.49 | 4.62 | 4.57 | 4.51 | 4.50 | 4.28 | 4.51 | 4.57 | 4.61 | | No Threshold |
| CCAD Cases | 29 | 34 | 34 | 31 | 39 | 28 | 19 | 23 | 29 | 24 | 33 | 20 | 22 | | No Threshold |

# Surgery

D Drive W Watch P Programme

## RESPONSIVE

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 92.0% | 95.8% | 95.9% | 97.9% | 94.7% | 97.1% | 95.0% | 99.1% | 99.1% | 98.7% | 92.7% | 97.7% | 93.6% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | 97.0% | 94.4% | 98.6% | 98.6% | 96.8% | 97.1% | 97.8% | 98.3% | 99.1% | 98.7% | 95.8% | 97.7% | 96.5% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | 98.0% | 95.1% | 99.3% | 92.5% | 96.8% | 97.1% | 93.5% | 96.6% | 96.4% | 85.9% | 78.1% | 80.9% | 73.1% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | 96.0% | 96.5% | 100.0% | 97.9% | 98.9% | 98.6% | 99.3% | 99.1% | 98.2% | 100.0% | 97.9% | 98.5% | 98.2% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | 84.0% | 75.0% | 79.7% | 76.7% | 83.0% | 83.5% | 79.1% | 75.0% | 81.2% | 76.9% | 81.2% | 78.6% | 81.3% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | 92.0% | 95.8% | 91.2% | 92.5% | 93.6% | 93.5% | 92.1% | 90.5% | 95.5% | 94.9% | 88.5% | 91.6% | 91.8% | | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 56.2% | 61.8% | 61.6% | 64.2% | 67.9% | 68.5% | 67.4% | 63.8% | 61.7% | 63.1% | 63.5% | 61.9% | 61.5% | | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 8,432 | 8,701 | 7,773 | 7,980 | 7,484 | 7,787 | 8,632 | 8,319 | 11,360 | 11,505 | 11,621 | 11,567 | 11,949 | | No Threshold | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 291 | 357 | 276 | 232 | 197 | 174 | 186 | 249 | 294 | 239 | 202 | 231 | 230 | | 0 | N/A | >0 |
| Diagnostics: % Completed Within 6 Weeks | W | 90.0% | 94.1% | 91.3% | 100.0% | 100.0% | 93.8% | 100.0% | 100.0% | 88.9% | 80.0% | 83.3% | 66.7% | 32.5% | | >=99 % | N/A | <99 % |

## WELL LED

| | | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 57 | -708 | -716 | 217 | 108 | 583 | -5 | -137 | -349 | -598 | -657 | -130 | -232 | | | | |
| Income In Month Variance (£'000s) | W | 83 | 152 | 47 | 49 | 209 | 223 | 28 | -144 | -43 | 68 | 59 | -16 | 23 | | | | |
| Pay In Month Variance (£'000s) | W | -157 | -526 | -599 | 28 | -116 | 541 | -64 | -158 | -82 | -452 | -331 | -85 | -358 | | | | |
| AvP: IP - Non-Elective | W | 308 | 390 | 57 | -20 | 485 | -101 | -121 | -23 | 371 | 411 | 402 | 385 | 385 | | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 219 | 300 | -73 | -50 | 291 | 4 | -55 | -55 | 281 | 265 | 232 | 204 | 225 | | >=0 | N/A | <0 |
| AvP: OP New | | 2,065.00 | 2,600.00 | 369.54 | -64.15 | 2,827.00 | 711.90 | -107.72 | 404.80 | 2,778.00 | 2,889.00 | 2,166.00 | 2,286.00 | 2,133.00 | | >=0 | N/A | <0 |
| AvP: OP FollowUp | | 6,426.00 | 7,896.00 | -2,404.10 | 599.79 | 8,059.00 | 1,780.00 | -1,011.90 | 1,307.00 | 7,686.00 | 8,979.00 | 6,491.00 | 6,815.00 | 6,855.00 | | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | 570 | 812 | -58 | -190 | 795 | 46 | -201 | -192 | 731 | 836 | 696 | 672 | 609 | | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 9,760 | 12,070 | -1,987 | 558 | 12,428 | 2,881 | -1,121 | 2,197 | 11,949 | 13,618 | 9,951 | 10,216 | 10,247 | | >=0 | N/A | <0 |
| PDR | W | 66.1% | 66.1% | 0.1% | 9.0% | 20.3% | 47.2% | 52.8% | 54.2% | 60.0% | 61.6% | 60.9% | 61.4% | 61.3% | | | | |
| Medical Appraisal | W | 96.8% | 96.8% | 24.0% | 34.8% | 37.8% | 44.2% | 66.7% | 59.5% | 87.0% | 89.3% | 91.0% | 0.8% | 0.8% | | | | |
| Mandatory Training | W | 86.9% | 87.8% | 89.0% | 87.1% | 87.8% | 88.2% | 88.4% | 88.9% | 88.4% | 87.4% | 87.6% | 87.0% | 88.5% | | >=90 % | >=80 % | <80 % |
| Sickness | D | 6.5% | 5.4% | 5.2% | 5.7% | 5.8% | 6.7% | 6.2% | 6.3% | 5.9% | 5.5% | 7.2% | 8.4% | 6.1% | | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 1.6% | 1.5% | 1.5% | 1.6% | 1.6% | 2.2% | 1.6% | 2.3% | 2.5% | 1.8% | 3.1% | 4.5% | 2.6% | | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 5.0% | 3.9% | 3.7% | 4.1% | 4.2% | 4.5% | 4.5% | 4.1% | 3.4% | 3.7% | 4.1% | 3.9% | 3.5% | | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 382 | 542 | 515 | 457 | 332 | 445 | 469 | 532 | 363 | 631 | 535 | 474 | 535 | | | | |
| Staff Turnover | D | 7.9% | 7.5% | 7.9% | 9.0% | 9.0% | 9.7% | 10.3% | 10.5% | 11.2% | 11.4% | 11.3% | 11.8% | 12.2% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 92.7% | 93.7% | 95.8% | 99.2% | 98.4% | 90.0% | 92.5% | 94.1% | 94.8% | 89.0% | 87.0% | 83.4% | 86.6% | | >=90 % | >=80 % | <90 % |

# Community & Mental Health Division

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|---|---|---|
| **SAFE** | Improvement changes from incidents:<br><br>**Incident 55275** (ASD/ADHD) Interpreter not booked for a joint assessment. **Improvement** – Administrators to ensure interpreter details are added at the initial triage stage so that the need for an interpreter is identified for each appointment<br><br>**Incident 55315** (Liverpool CAMHS) Prescription pad left on a desk in an unlocked area. **Improvement –** Communication shared reminding staff to ensure prescription pads are always stored securely.<br><br>**Incident 55535** (Children's Community Nursing) – Patient admitted from Whiston DGH with Category 4 Pressure Ulcer on sacral area. **Improvement** – All staff to ensure they follow guidance to complete mandatory documentation and incident forms for all skin breakdowns<br><br>**Incident 55529** (Community Physiotherapy & OT) – Text message sent to child's parent, but text message received back to say that text message had been sent to the wrong person. **Improvement –** Reminder shared for staff to remain vigilant in checking patient identifiable information prior to communicating with a family. | **Highlight**<br>• Zero clinical incidents resulting in moderate harm, severe harm or death<br>• Zero grade 3 or 4 pressure ulcers<br>• 119 incidents reported (80 clinical, 39 non-clinical)<br>• Zero grade 3 or 4 pressure ulcers<br>•<br>**Challenges**<br>• Spotlight session held in February's Integrated Governance Meeting focussed on information governance with a highlight on sharing of information with external partners<br>• Continued admissions to acute medical bed for young people with an eating disorder who are medically compromised |
| **CARING** | Improvement changes from complaints includes:<br><br>**SO19576** – Complaint related to experience in the phlebotomy clinic. **Improvement** – Staff to request for another team member to support when undertaking a clinical procedure if needed.<br><br>**SO19770/SO19783** – Complaint related to wait for prescriptions, communication regarding appointments and response to previous concerns. **Improvement** - when concerns are logged with the PALS and Complaints Team, care is needed to ensure all aspects of the concern are fully addressed before closing the case on the Ulysses system | **Highlight**<br>• 17 Excellent Reports submitted in February<br>• 23 Compliments submitted in February<br>• 95% FFT Scores for Mental Health<br>• 94% FFT Scores for Outpatients<br>• 90% FFT Scores for Community<br>**Challenges**<br>• 32 PALS recorded in February; this is a slight decrease from January. The main theme is waiting times for appointment/assessment.<br>• 3 formal complaints logged in February (decrease compared to January). Complaints relate to waiting times for assessments and communication. |
| **EFFECTIVE** | Divisional Training and Education Sub-Committee launched to ensure our staff have the skills, knowledge and experience to deliver safe and effective care. | **Highlight**<br>• WNB rates for follow up appointments in the division at 13.9% and remain below the Trust target of 14%<br>• Reduction in hospital-initiated clinic cancellations with less than 6 weeks' notice. |

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| | | **Challenges**<br>• Continued increase in referrals received across all services in the division significantly above 2019/20 referral rates. |
| **RESPONSIVE** | Access times remain challenging in the division, particularly for Mental Health Services, SALT and ASD.<br><br>Improvement plans and recovery trajectories for Community SALT and ASD/ADHD diagnostic pathways were shared with Liverpool and Sefton CCGs in February, outlining the expected timeframe to return to the agreed waiting time standards. | **Highlight**<br>• Zero patients waiting over 52 weeks for an appointment in Community Paediatrics at the end of February.<br>**Challenges**<br>• One urgent breach of eating disorders urgent waiting time standard in February due to no engagement from the young person or family. |
| **WELL LED** | Two Consultant Developmental (Community) Paediatricians recruited substantively in February 2022. | **Highlight**<br>• Mandatory training remains above Trust target at 92.4%<br>• The Division continues to be on track to achieve all financial objectives for 2021/2022, forecasting to end the year in a £2m surplus.<br>**Challenges**<br>• Reduction in staff absence from 6.2% to 5.4% however this remains above the Trust target. Short term sickness has reduced in month and HR continue to work with managers to support with long term absence, including weekly drop-in sessions. |

# Community

D Drive W Watch P Programme

## SAFE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss D | 5 | 9 | 7 | 12 | 7 | 11 | 4 | 8 | 4 | 2 | 4 | 13 | 13 | | No Threshold |
| Clinical Incidents resulting in No Harm D | 75 | 84 | 74 | 54 | 51 | 92 | 65 | 50 | 63 | 56 | 29 | 38 | 50 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm D | 21 | 35 | 28 | 19 | 11 | 20 | 10 | 14 | 8 | 9 | 4 | 7 | 17 | | 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 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication Errors (Incidents) | 17 | 23 | 17 | 9 | 9 | 10 | 8 | 12 | 18 | 13 | 5 | 6 | 5 | | No Threshold |
| Pressure Ulcers (Category 3) W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 3 and above) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Cleanliness Scores | | 100.0% | | 99.0% | 97.5% | | 86.8% | | | | 98.6% | 98.5% | 98.2% | | No Threshold |
| CCNS: Advanced Care Plan for children with life limiting condition | 0 | | | | | | | | | | | | | | No Threshold |
| CCNS: Prescriptions | 0 | | | | | | | | | | | | | | No Threshold |

## CARING

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints W | 4 | 3 | 1 | 0 | 8 | 0 | 3 | 4 | 2 | 2 | 3 | 7 | 4 | | No Threshold |
| PALS W | 39 | 41 | 40 | 50 | 55 | 39 | 34 | 62 | 51 | 48 | 25 | 31 | 29 | | No Threshold |

## EFFECTIVE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | 885 | 1,108 | 911 | 1,318 | 1,325 | 1,063 | 728 | 1,022 | 1,116 | 1,230 | 1,055 | 1,111 | 1,106 | | No Threshold |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | 10 | 7 | 11 | 5 | 9 | 21 | 22 | 17 | 25 | 41 | 17 | 12 | 8 | | No Threshold |
| OP Appointments Cancelled by Hospital % | 9.9% | 12.2% | 11.5% | 9.2% | 10.6% | 11.9% | 13.6% | 10.9% | 15.2% | 8.8% | 12.2% | 12.1% | 12.5% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate (New Appts) W | 10.4% | 14.0% | 13.0% | 15.6% | 11.4% | 16.1% | 10.8% | 15.3% | 17.3% | 15.6% | 13.6% | 17.1% | 13.0% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) W | 10.8% | 12.8% | 13.6% | 13.0% | 12.1% | 15.1% | 15.4% | 13.0% | 12.5% | 13.7% | 12.9% | 12.7% | 13.9% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (New Appts) - Community Paediatrics | 16.1% | 18.8% | 18.2% | 22.7% | 17.1% | 19.8% | 17.1% | 19.9% | 16.9% | 16.9% | 18.0% | 18.5% | 11.1% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) - Community Paediatrics | 14.4% | 17.7% | 17.4% | 16.9% | 18.5% | 21.9% | 24.3% | 24.0% | 20.2% | 19.7% | 17.6% | 17.1% | 16.2% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (CHOICE Appts) - CAMHS | 11.5% | 15.1% | 6.9% | 15.8% | 11.7% | 23.4% | 19.7% | 12.6% | 16.2% | 21.1% | 17.5% | 18.7% | 16.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (All Other Appts) - CAMHS | 10.8% | 12.7% | 14.0% | 13.3% | 12.0% | 15.8% | 15.3% | 10.9% | 12.0% | 13.8% | 13.9% | 12.4% | 14.7% | | <=14 % <=16 % >16 % |
| CAMHS: Tier 4 DJU % Bed Occupancy At Midday | 106.6% | 114.3% | 113.3% | 114.3% | 112.9% | 100.0% | 99.5% | 101.4% | 122.6% | 103.8% | 91.2% | 100.5% | 128.6% | | No Threshold |
| CAMHS: Tier 4 DJU Bed Days | 210 | 248 | 239 | 248 | 237 | 217 | 216 | 214 | 267 | 217 | 198 | 219 | 252 | | No Threshold |
| Coding average comorbidities | | 4.00 | 9.00 | | 2.00 | | 8.00 | | | 4.50 | 7.00 | 3.50 | | | No Threshold |
| CCNS: Number of commissioned packages | 0 | | | | | | | | | | | | | | No Threshold |

## RESPONSIVE

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Tier 4 Admissions To DJU | 1 | | 1 | | | | | 1 | 1 | 1 | | 4 | | | No Threshold |
| CAMHS: Referrals Received | 351 | 469 | 396 | 536 | 638 | 374 | 297 | 475 | 526 | 567 | 433 | 534 | 483 | | No Threshold |
| CAMHS: Referrals Accepted By The Service | 182 | 251 | 197 | 254 | 316 | 173 | 141 | 233 | 302 | 308 | 219 | 274 | 233 | | No Threshold |

# Community

D Drive W Watch P Programme

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: % Referrals Accepted By The Service | 51.9% | 53.5% | 49.7% | 47.4% | 49.5% | 46.3% | 47.5% | 49.1% | 57.4% | 54.3% | 50.6% | 51.3% | 48.2% | | No Threshold |
| RTT: Open Pathway: % Waiting within 18 Weeks (W) | 64.5% | 66.0% | 63.3% | 74.0% | 69.6% | 57.1% | 61.2% | 52.8% | 53.3% | 54.5% | 56.9% | 55.0% | 54.1% | | >=92 % / >=90 % / <90 % |
| Waiting List Size (W) | 911 | 911 | 828 | 765 | 808 | 971 | 1,147 | 1,208 | 1,530 | 1,629 | 1,563 | 1,576 | 1,646 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways (W) | 0 | 0 | 3 | 0 | 1 | 2 | 2 | 1 | 1 | 1 | 1 | 1 | 0 | | 0 / N/A / >0 |
| CAMHS: Crisis / Duty Call Activity | 806 | 808 | 744 | 757 | 718 | 573 | 367 | 675 | 563 | 766 | 629 | 687 | 618 | | No Threshold |
| CAMHS: RTT (First Partnership) % waiting within 18 weeks (W) | 67.9% | 67.3% | 65.6% | 68.0% | 70.1% | 69.3% | 68.3% | 63.8% | 63.9% | 68.2% | 68.7% | 67.7% | 67.2% | | >=92 % / >=90 % / <88 % |
| ASD: Completed Pathways | 99 | 112 | 107 | 143 | 132 | 91 | 224 | 45 | 60 | 74 | 58 | 76 | 48 | | No Threshold |
| ASD: Completed Pathway Compliance (% within 18wks) | 76.8% | 66.1% | 24.3% | 25.2% | 15.2% | 9.9% | 4.5% | 13.3% | 6.7% | 6.8% | 15.5% | 10.5% | 8.3% | | >=92 % / >=90 % / <90 % |
| EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P) | | | 16.7% | 23.5% | 28.6% | 6.7% | 21.4% | 10.5% | 23.8% | 21.7% | 25.0% | 16.7% | 14.3% | | No Threshold |
| EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P) | | | 100.0% | 25.0% | 100.0% | 50.0% | 100.0% | 66.7% | 100.0% | 100.0% | 50.0% | 100.0% | 50.0% | | >=95 % / >=92 % / <92 % |
| CCNS: Number of Referrals (W) | 139 | 169 | 120 | 135 | 150 | 582 | 144 | 143 | 165 | 168 | 177 | 150 | 140 | | No Threshold |
| CCNS: Number of Contacts (D) | 826 | 896 | 791 | 821 | 835 | 959 | 809 | 736 | 931 | 959 | 951 | 740 | 823 | | No Threshold |

## WELL LED

| | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) (W) | 221 | -41 | 14 | 212 | -11 | 287 | 250 | 540 | 16 | 60 | 185 | 346 | -77 | | |
| Income In Month Variance (£'000s) (W) | 996 | 150 | 94 | 88 | 50 | 154 | 75 | 118 | -78 | 59 | 118 | -112 | -106 | | |
| Pay In Month Variance (£'000s) (W) | -81 | 137 | 5 | -49 | -87 | 260 | 167 | 15 | 142 | 319 | -9 | 248 | 228 | | |
| AvP: OP New | 505.00 | 588.00 | 79.50 | 236.95 | 561.00 | -130.00 | -42.30 | -178.00 | 527.00 | 629.00 | 483.00 | 491.00 | 566.00 | | >=0 / N/A / <0 |
| AvP: OP FollowUp | 3,794.00 | 4,116.00 | 1,448.90 | 1,416.84 | 4,230.00 | 1,014.00 | 688.30 | 1,238.00 | 3,423.00 | 4,160.00 | 3,410.00 | 3,738.00 | 3,561.00 | | >=0 / N/A / <0 |
| AvP: Outpatient Activity vs Plan (W) | 4,299 | 4,704 | 1,529 | 1,654 | 4,791 | 884 | 646 | 1,061 | 3,950 | 4,795 | 3,907 | 4,242 | 4,139 | | >=0 / N/A / <0 |
| PDR (W) | 83.1% | 83.1% | 0.0% | 1.5% | 21.5% | 71.5% | 78.8% | 81.0% | 80.9% | 83.4% | 83.6% | 83.0% | 82.5% | | |
| Medical Appraisal (W) | 100.0% | 100.0% | 6.2% | 24.0% | 24.0% | 36.0% | 68.0% | 48.0% | 80.0% | 60.0% | 84.6% | 0.0% | 0.0% | | |
| Mandatory Training (W) | 88.6% | 89.3% | 91.8% | 91.0% | 92.3% | 92.1% | 91.9% | 91.4% | 91.6% | 91.5% | 91.1% | 91.5% | 92.4% | | >=90 % / >=80 % / <80 % |
| Sickness (D) | 4.7% | 3.9% | 3.1% | 3.9% | 4.9% | 5.6% | 6.4% | 5.8% | 5.9% | 5.5% | 5.8% | 6.3% | 5.8% | | <=4 % / <=4.5 % / >4.5 % |
| Short Term Sickness (D) | 1.0% | 1.0% | 0.9% | 1.2% | 1.5% | 1.4% | 1.5% | 1.6% | 2.1% | 1.7% | 1.8% | 2.6% | 1.5% | | <=1 % / N/A / >1 % |
| Long Term Sickness (D) | 3.7% | 2.9% | 2.2% | 2.7% | 3.5% | 4.2% | 4.9% | 4.3% | 3.8% | 3.7% | 4.0% | 3.8% | 4.3% | | <=3 % / N/A / >3 % |
| Temporary Spend ('000s) (D) | 169 | 141 | 183 | 192 | 229 | 171 | 127 | 168 | 192 | 166 | 273 | 168 | 278 | | |
| Staff Turnover (D) | 9.5% | 9.8% | 10.7% | 9.6% | 9.8% | 9.8% | 9.9% | 10.1% | 10.9% | 12.1% | 11.1% | 10.4% | 10.9% | | <=10 % / <=11 % / >11 % |
| Safer Staffing (Shift Fill Rate) (W) | 99.4% | 100.2% | 97.2% | 99.1% | | 99.2% | 98.9% | 96.3% | 108.0% | 98.2% | 96.8% | 99.1% | 99.1% | | >=90 % / >=80 % / <90 % |

# Research Division

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|---|---|---|
| **SAFE** | • Divisional Mandatory training demonstrates good compliance<br>• CRF working at Gold accreditation on the perfect ward inspection, action plan being reviewed.<br>• All Incidents reported onto Ulysees system and thematic reviews conducted periodically.<br>• Trust metrics discussed at monthly 121's with staff to encourage compliance.<br>• PDR metric will improve within next PDR window | **Highlight**<br>• Mandatory Training > 90%<br>• GCP training 97%<br>• SOP compliance 98%<br>• ANTT compliance 100%<br>• CRD ICP compliant<br>• Risk and incidents all actioned<br>**Challenges**<br>• PDR Target of has reduced to under TT due to an increase in leavers<br>• X1 outstanding risk review<br>• Out of hours research blood samples for oncology trials<br>• X1 incidents reported in month |
| **CARING** | • 0 complaints received<br>• Patient centred follow up care for patients on clinical trials.<br>• Patient feedback used to improve quality of patient care and experience<br>• Plans underway to capture patient experience data<br>• R&D metrics for PALS and complaints are recorded separately from corporate data (action completed)<br>• Staff survey completed under people plan | **Highlight**<br>• X 0 Complaints or PALS concerns<br>• Collaborative working with local services and teams are being established<br>• Research participating in Trust PEG.<br>• Research attended CYP forum (regular invite established)<br>• Research Patient stories included on agenda<br>• PRES link live on Twitter and has been shared wider via comms<br>**Challenges**<br>• More work to do on local patient internal audits<br>• Low numbers of electronic survey questionnaires from patients on system.<br>• Compliments to be added to Ulysses as standard practice. |
| **EFFECTIVE** | • Commenced review of Current portfolio to review study performance and utilise capacity and resource more effectively. Will be an ongoing task within recovery programme<br>• Clinicians encourage children and young people to make informed decisions about participating in studies.<br>• Research skills training continues with excellent feedback from staff.<br>• Clinical skills days are well attended and has improved some MT compliance.<br>• Opened out to other departmental staff with a research interest.<br>• Systems and processes are being reviewed as part of effective and efficient ways of working | **Highlight**<br>• Important Covid 19 studies remain open within Trust AH one of chosen sites nationally to continue with UPH studies (Recovery)<br>• Trust participating in extension COV09 vaccine study with LSTM.<br>• AH sponsoring flagship Asymptomatic Study<br>• Stop RSV trial. (one of two national sites) now actively recruiting.<br>• Portfolio growth in line with plans |

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| | | **Challenges**<br>• CRD working with local system partners to improve research participation.<br>• Significant issues with recruitment process has delayed backfilling a number of vacancies affecting timely opening of new studies<br>• RSV recruitment has been affected through HR recruitment challenges.<br>• Annual Planning guidance v meeting staff expectations and capacity and demand, |
| **RESPONSIVE** | • 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.<br>• Coordinated and partnership working with local providers to offer joint training programmes.<br>• Targeted training TBA for new managers in the department for risk reporting. | **Highlight**<br>• Agile working implemented to reduce footfall<br>• Collaborative working with external partners continues<br>• Team fund has been utilised and is on track<br>**Challenges**<br>• Storage for site files and equipment is insufficient for research department<br>• Research team supporting Trust vaccine programme.<br>• Trust has been accepted as Pic for new RSV vaccine trial |
| **WELL LED** | • Staff are supported through line managers and staff support.<br>• LTS numbers are now reducing as staff RTW<br>• Engagement with partners in relation to upcoming starting well initiatives.<br>• Service Re-organisation undergoing data collection for audit and review<br>• Internal staff survey results have been collated and shared<br>• Confirmation of new CRF grant for Two Million awarded from NIHR | **Highlight**<br>• Division supporting staff with Flexible working (hybrid model)<br>• CRD engaging staff with SALS<br>• Core business hours established through recent service re-org (audit ongoing)<br>• Extra-ordinary team brief planned for March to revisit big conversation actions<br>**Challenges**<br>• Correct model for the future working to be established<br>• Some staff will experience changes to working patterns period of adjustment needed<br>• Recruitment and retention being monitored carefully due to increase in leavers<br>• F2F exit interviews established with leavers with key questions focussed on retention |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday, 31st of March 2022**

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

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

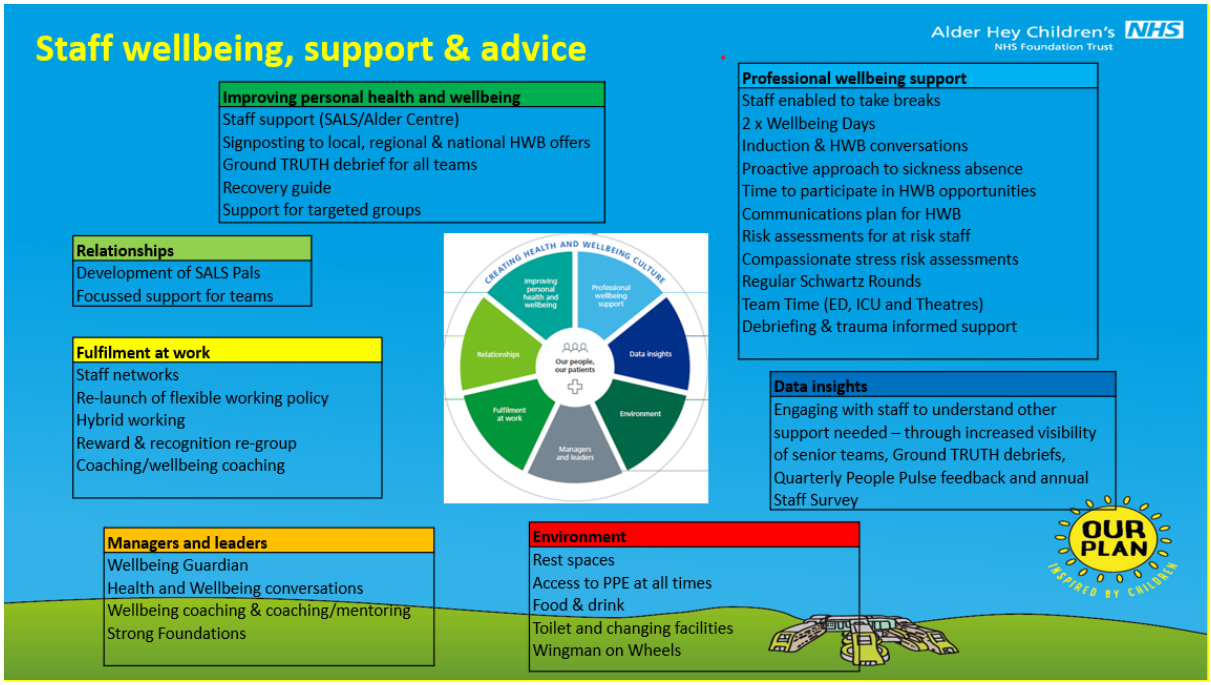
## 1. Purpose

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


## 2 Health & Wellbeing

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

At Alder Hey, we are using this checklist to understand what is most needed for our staff and what key aspects of health and wellbeing support will be needed through the coming months. The diagram below outlines the organisational approach:




Work is progressing on all of the key areas of work highlighted in the Organisational Health & Wellbeing Plan outlined above. Of note since the last report to the committee are the following updates:

*Improving personal health and wellbeing*

There is significant work underway around menopause incorporating a monthly menopause support group which is well attended and highly valued and there is also work underway on a new menopause policy. The support group is now focussed on widening participation to appeal to younger women who may be perimenopausal to raise awareness by focussing more broadly on women's health.

SALS also held a listening event designed to support admin and clerical staff within the organisation. Themes discussed related to staff feeling invisible, lonely and undervalued within teams. There was a shared sense that admin staff can feel more like a role than an individual. To combat some of these feelings, staff decided they would like to keep these events going as a forum to connect and support one another. Themes will also be shared through workstreams focusing on improving the experience of new starters and retention of experienced staff. Staff reported that they were "Very grateful for this empathetic and caring space, and feeling heard", saying that "it was very helpful to connect with other people in other departments".

SALS continues to be extremely busy seeing a significant rise in contacts in February. From the 1 February until the 28 February the service received 333 contacts in comparison to 247 contacts in January and 199 in December. 82 of those contacts were Nursing, 63 Admin & Clerical, 16 Medics, and 23 AHPs. Key themes arising are around Relationships/Teams, Workplace Stress, Physical illness (Long Covid/Cancers), Trauma, & Domestic Abuse. Within SALS we have seen a high number of cases where we are supporting staff experiencing domestic abuse. We are working with our HR partners to develop a policy focused on supporting staff with domestic abuse and are improving our relationships with external services to better support our staff at Alder Hey.

Feedback about the staff support service offered through SALS continues to be very positive with staff valuing the ease of access and compassionate approach as highlighted in the feedback below:

*"I've currently been on the waiting list for counselling/CBT for over 15months now. When I got in touch with SALS I was given an appointment within a few weeks. The appointments were carried out via telephone/MS Teams which is ideal as I did not have to take time from my working day in order to attend appointments in the hospital …ensuring I could still effectively do my job without having to take time from my working day. The staff were all extremely friendly and compassionate; I never once felt as though I was a 'number' on the list to be seen, and the staff (from the initial phone call with a member of the admin team through to the staff member I had sessions with) all treated me with compassion. I feel that the support I gained from SALS has had a huge beneficial impact to my daily life both at home and in work. The work of the entire SALS team is astonishing and I strongly believe that having this service available is one of many reasons why Alder Hey is a great organisation to work for."*

The new Staff Support pathway is now in operation (since 1st February) with SALS being the point of contact for all new referrals. The Alder Centre will no longer accept any new referrals for counselling and will direct all new referrals via SALS who will offer an initial triage, listening session and intervention where indicated. The waiting list for counselling at the Alder Centre has reduced from 20 weeks to 8 weeks.

*Professional wellbeing support*

The Health and Wellbeing Steering group has recently been paused to enable a refocus and refresh of the agenda. Attendance had been reducing at the meeting so membership is under review and there is also work underway aligning the action plan with the organisational health and wellbeing plan outlined above. The task and finish groups focussing on the themes below continue to meet and will report into the steering group when the meeting resumes in April:

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

SALS are working with partners at the University of Liverpool to conduct a service evaluation focused on the experiences of staff who have accessed debriefs after critical incidents within Alder Hey. The evidence about debriefing is mixed. We want to better understand what works well for our staff and continue to develop evidence-based practice. We plan to use the

insights gained from this project to shape and influence a debriefing pathway within the Trust.

*Data insights*

Although the staff survey 2021 is still officially under embargo until 30th March, we have now received our benchmark reports (see separate presentation for details). We have also now received our Q4 People Pulse data which is included in the Staff Survey presentation attached.

## 3 Equality, Diversity & Inclusion

The Trust Black, Asian and Minority Inclusion Taskforce led by Claire Dove OBE, will hold its final meeting in March 2022. This will then take on the form of the networks for the following groups, BAME, LGBTQIA+ and Disabled staff reporting into a newly formed EDI steering group.

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.

## 4 Staff Availability

### Table 4.1- Sickness position as of 15th March 2022

| Division | Total Workforce | Total Absent | Total Covid Related | Total Non Covid Related | Covid Related (Sickness) | Non Covid Related (Sickness) | Covid Related (Special Leave) | Non Covid Related (Special Leave) | Total Absent % | Covid Related % | Non Covid Related % | Covid Sickness % | Non Covid Sickness % |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Community | 767 | 48 | 13 | 35 | 11 | 35 | 2 | 0 | 6.26% | 1.69% | 4.56% | 1.43% | 4.56% |
| Corporate | 758 | 64 | 11 | 53 | 10 | 51 | 1 | 2 | 8.44% | 1.45% | 6.99% | 1.32% | 6.73% |
| Medicine | 1219 | 102 | 31 | 71 | 31 | 69 | 0 | 2 | 8.37% | 2.54% | 5.82% | 2.54% | 5.66% |
| Research | 65 | 5 | 1 | 4 | 1 | 4 | 0 | 0 | 7.69% | 1.54% | 6.15% | 1.54% | 6.15% |
| Surgery | 1303 | 91 | 25 | 66 | 20 | 61 | 5 | 5 | 6.98% | 1.92% | 5.07% | 1.53% | 4.68% |
| **Total** | **4112** | **310** | **81** | **229** | **73** | **220** | **8** | **9** | **7.54%** | **1.97%** | **5.57%** | **1.78%** | **5.35%** |

Total sickness absence as of 15th March 2022 (7.54%), has started to plateau around 7.5% for total sickness absence (5.35% general sickness absence and 1.78% for Covid related sickness absence). The number of staff with covid related sickness absence has increased, to 73 staff currently absent with covid related symptoms, compared to the previous reporting period, of 56 staff off absent with covid related symptoms.

The general sickness absence position has slighted reduced at 5.35%, compared to the previous months of February (5.55%) and January (5.62%)

The number one reason for Non-Covid related sickness absence remains mental health. All mental health related absences are referred to Occupational Health and the SALS team, as part of our suite of support to staff. Sickness absence continues to be monitored and reported daily.

## 5. Governance and Ongoing Business

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

**Table 5.1- Employee Relations Activity and Stage 3 Sickness Management Per Division as of the 15th March 2022**

| Division | MHPS | Disciplinary | Grievance | B&H | Appeal | ET | Stage 3 | Total |
|---|---|---|---|---|---|---|---|---|
| Surgery H/C 1326 | 1 | 4 | 1 | 0 | 1 | 2 | 8 | **17** |
| Medicine H/C 1223 | 1 | 2 | 0 | 0 | 0 | 0 | 3 | **6** |
| Community H/C 687 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | **6** |
| Corporate & Research H/C 695/65 | 0 | 2 | 1 | 0 | 0 | 0 | 2 | **5** |
| Grand Total | **2** | **8** | **3** | **0** | **1** | **3** | **17** | **34** |

Activity in terms of MHPS, disciplinary, Grievance, B&H, Appeal and ET have all remained static compared to last months reporting period, however there has been an increase in stage 3 sickness absence cases this month compared to last month where there were 13 stage 3 sickness cases active.

## 6. Training

As of the 28th of February, Mandatory Training was at 88% overall, 2% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance.

Our three key areas of focus recently have been Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen significant compliance drops due largely to the impact of COVID on face to face training restrictions.

In terms of Resuscitation training, we have worked closely with the Resus team who have rolled out Basic Life Support via e-Learning on ESR and allocated additional resources to Paediatric Life Support update sessions. This has seen a consistent improvement in Resus compliance overall and has maintained at 80% overall this month.

In terms of Estates and Ancillary staff we have worked closely with the department managers to identify ways we can deliver training to a staff group who were previously heavily reliant on face to face training and don't engage with e-Learning. This work has seen Estates and

Ancillary staff group improve from 58% in October to 77% as of today. We will continue to push mandatory training within this staff group.

In terms of Moving & Handling, we co-ordinated a focused week of Moving and Handling Level 2 training in February with over 120 staff completing training during this period taking compliance from 59% to 72% in February. We will continue to work with Moving and Handling leads to further improve this figure.

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 6.1- Mandatory Training compliance – 28th February 2022**

| Trust | Overall Mandatory Training | Change (Since Last Report) |
|---|---|---|
| **Trust** | **88.35%** | **+0.46%** |
| **Division** | **Overall Mandatory Training** | **Change (Since Last Report)** |
| **411 Alder Hey in the Park** | **78.48%** | **-5.90%** |
| **411 Capital** | **63.64%** | **-** |
| **411 Community** | **92.41%** | **+0.67%** |
| **411 Corporate Other Department** | **75.76%** | **-5.70%** |
| **411 Executive** | **89.59%** | **-3.10%** |
| **411 Facilities** | **77.03%** | **+0.63%** |
| **411 Finance** | **86.99%** | **+0.35%** |
| **411 Human Resources** | **93.53%** | **+1.11%** |
| **411 IM&T** | **87.86%** | **+1.49%** |
| **411 Innovation** | **85.63%** | **+1.20%** |
| **411 Medicine** | **87.00%** | **+0.27%** |
| **411 Nursing & Quality** | **90.16%** | **+1.61%** |
| **411 Research & Development** | **93.02%** | **+1.15%** |
| **411 Surgery** | **88.51%** | **+0.24%** |

**Table 6.2 – PDR Compliance as of 28th February 2022**

As of the 28th of February 2022, our Trust appraisal rate was 72%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. These figures will continue to flux as staff move around the organisation.

The Trust is currently doing a full review of the PDR process including timing, documentation and system.

| Org L2 | Reviews Completed % |
|---|---|
| 411 Alder Hey in the Park L2 | 60.00 |
| 411 Capital L2 | 100.00 |
| 411 Community L2 | 82.53 |
| 411 Corporate Other Department L2 | 50 |
| 411 Executive L2 | 55.43 |
| 411 Facilities L2 | 71.58 |
| 411 Finance L2 | 91.84 |
| 411 Human Resources L2 | 77.55 |
| 411 IM&T L2 | 82.56 |
| 411 Innovation L2 | 77.78 |
| 411 Medicine L2 | 74.15 |
| 411 Nursing & Quality L2 | 86.36 |
| 411 Research & Development L2 | 79.66 |
| 411 Surgical Care L2 | 61.27 |
| **Grand Total** | 72.19 |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday, 31st March 2022**

| | |
|---|---|
| **Paper Title:** | **BAME Inclusion Taskforce Report** |
| **Report of:** | **Chair of the BAME Inclusion Taskforce** |
| **Paper Prepared by:** | Chief People Officer |

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

# Black, Asian and Ethnic Minority (BAME) Taskforce

## *'Reflections, achievements and a blueprint for the future'*

### 1. Purpose of the report

The purpose of this report is to provide the Board with an overview of the activities of the Black, Asian and Ethnic Minority (BAME) Taskforce since its inception in October 2020, to recognise its achievements and challenges, and to outline the proposals for how we continue to progress the Equality, Diversity and Inclusion (EDI) agenda using the learning from this Taskforce as a 'blueprint' to help shape the Trust's future EDI priorities and focus.

(Whilst there is active debate within the NHS currently with regard the use of the term 'BAME', it has been used throughout this report, given that this was the nomenclature used at the start of the Taskforce project. The Trust will take advice about the most appropriate language to use moving forward from this report.)

### 2. Background

In 2020, the Black Lives Matter movement highlighted the devastating impact of racism and racial inequality on our society and communities. At the same time, data was emerging about the experiences of NHS staff from black and minority ethnic backgrounds in respect of COVID-19, which reinforced what we already knew about the poorer experience of BAME colleagues in every part of the NHS[1].

In response to these emerging issues, Dame Jo Williams, Trust Chair, wrote an open letter to staff in October 2020 on behalf of the Trust Board, which coincided with the start of Black History Month, sharing the Board's commitment to addressing racism and inequality across the Alder Hey community.

In her letter, Dame Jo outlined her commitment to Alder Hey being an anti-racist organisation, with a zero-tolerance approach to racism and discriminatory behaviour. She described the five commitments the Trust Board were making to take the first steps to making positive changes:

1. To commission Claire Dove CBE, Non-Executive Director, to chair a special taskforce to agree the steps we need to take to remove processes and barriers in the organisation that sustain systemic racism. This taskforce will work to ensure that we support staff from all backgrounds to have a positive experience of working at Alder Hey, and that our plans specifically support opportunity for education and employment for under-represented groups.

2. Create the space for us to have open conversations with our staff

3. Commit to being transparent as to how we're delivering change and holding ourselves accountable for these changes. We will communicate openly with you how we're doing this and share with you the action plans from the taskforce

4. Commit to increasing ethnic minority, and particularly black, representation across our workforce

5. Equip ourselves with more knowledge; learning and growing together so that we can remove processes and barriers that sustain systemic racism

[1] https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

The BAME Taskforce was established in October 2020 and has been the 'engine room' for moving this agenda forward and making positive change.

## 3. The BAME Taskforce

Chaired by Claire Dove MBE, Non-Executive Director, membership of the taskforce was limited to, at first, a small number of senior attendees, tasked with progressing the actions agreed by the group. In addition to focusing on the overarching aims as set out in Dame Jo's letter to staff (as referenced above), the Taskforce identified a number of other priorities and actions, as detailed in Appendix 1. Latterly, the membership was expanded to include staff from the BAME workforce. (Appendix 3)

**It started with listening….**

Many of the actions from the Taskforce were identified as a direct result of the feedback we received from BAME staff via the listening events. The most significant step we took at the very start of this process was to create a space to listen to our BAME colleagues and hear, for the first time from many, their experiences of working in the NHS at Alder Hey. These listening events, hosted by Claire Dove, and followed up by Claire personally for those colleagues who preferred to share their stories confidentially, provided us with valuable insight into their experiences, and their ideas for change and progression. We had an overwhelming, emotional and challenging response to these events, with people sharing their very personal stories and experiences. We are so grateful to all those who gave their time to take part and to share their stories.

These listening events were repeated in 2021, and again, colleagues generously shared their experiences, and also their ideas for engaging with this agenda going forward.

## 4. Achievements

The Taskforce is proud of what it has achieved in the 18 months since its inception. The Trust has made some amazing progress in areas which have, and will continue to, change the experience of, and dialogue with, colleagues from black, Asian and minority ethnic backgrounds. We have started to open opportunities for members of the community who would never have considered volunteering or working in the NHS and have started to change the language and focus of our communications.

### 4.1.1 Tackling overt racism, prejudicial or discriminatory behaviour – a 'Zero Tolerance' approach

A key priority for the Trust is ensuring a safe working environment for all staff. We have a 'zero tolerance' approach to verbal and physical abuse, with a clear focus on challenging negative discriminatory behaviours. We have, through extensive research, collaboration and consultation devised a specific Zero Tolerance policy against any racist, homophobic, prejudicial or discriminatory behaviour. This policy aligns to the Trust's existing Zero Tolerance Policy and associated Zero Tolerance Process however specifically addresses discriminatory behaviour.

The policy supports staff to report any incidents they experience or witness with a clear emphasis of believing what staff tell the Trust about their experience as unfortunately this is not always the experience of individuals in our society. As well as addressing discriminatory behaviour exhibited by parents and visitors, the policy also addresses such behaviour exhibited by children and young people, which whilst this behaviour may be learned, must not be tolerated. It is understood that this is the first policy in a children's healthcare setting to specifically address this issue. The policy was launched on the United Nations International

Day for the Elimination of Racial Discrimination on 21st March 2022 and a plan to implement the policy and address the training needs of all staff, including staff who may be part of Expert Panels, is being established. We are working on how we come together to create the change for us to become the beacon of diversity and a safe place for all.

### 4.1.2 Improving access to volunteering opportunities

In response to a challenge from the Taskforce about the lack of BAME volunteers, and an acknowledgement that we needed to increase our relationships and connections with local community groups and organisations, the volunteering service reviewed their recruitment practises with the aim of increase diversity and increase the numbers of all under-represented groups. Those from BAME backgrounds were particularly under-represented.

The Trust worked with organisations such as Blackburne House and linked with Imagine Independence and South Liverpool Homes to increase awareness and promote volunteering opportunities. As a result, this review of practises has seen an increase of almost 11% more volunteers from BAME backgrounds over the last two years, a fantastic achievement. The volunteering service have plans to work with a wider range of community groups to continue this work, and we hope to continue to see an even greater number of candidates from diverse backgrounds volunteering, and hopefully then employed by, Alder Hey.

### 4.1.3 More diverse and inclusive communications

The Deputy Director of Communications, Colin Beaver, was instrumental in working with Claire Dove and the Taskforce to create a comprehensive communications campaign, using different methods of communicating with staff:

- **Blogs**

We published a series of blogs from Claire Dove, speaking directly to BAME colleagues and addressing the issues that affect us. Initially running under the banner of Black History Month 2021, the highly celebrated blogs morphed into a regular BAME Taskforce blog, updating colleagues on the progress that was being made. In turn, the blog became a quarterly BAME Newsletter which continues to be popular with staff, having just published its second issue.

After the great success of our Black History Month 2021 campaign, we started 2022 with a series of pen-portraits of leading figures from BAME communities throughout history. With a different profile being shared with staff daily throughout the month, the 2022 campaign received much praise as a fantastic means of sharing black history.

- **Communicating inclusivity – and opportunity**

We developed a campaign that features on our website called '**A Face Like Mine**'. The campaign gets its name from Claire's assertion that every child that comes through the doors at Alder Hey should feel the comfort of seeing a face like their own. Who could possibly not want that for the children and young people that we treat, and their worried families? It's this that drives the campaign. It includes stories of our BAME colleagues' professional (and personal) journeys from childhood, to inspire children with what's possible.

- **Better reflecting diversity in Alder Hey**

We need to better reflect – in fact, positively reinforce – diversity in all our external communications engagement, whether it is on our website, on social media, or in marketing material that we use to promote Alder Hey and its services. We need to celebrate our cultural

differences within the organisation too. Initially, messages about Diwali and Islamophobia Awareness Month generated warm and heartfelt responses from BAME staff. One of our Consultant Paediatric Surgeons sent this message in response:

*"Wow! This is impressive! Hi guys - I am one of the new Consultant surgeons here in Alder Hey - started on the 1st of November - I trained in Alder Hey over a decade ago and spent 7 years as a Consultant in Manchester followed by a three-year stint in the Gulf and back to Alder Hey! I am a Muslim - and this is my first time in over 16 years' working in the NHS that I received such a communication - well done guys - well done. And thank you."*

This response illustrates the huge difference just a small step towards a more inclusive approach can make to how someone feels in the workplace. To this end, we developed a monthly faith celebration calendar that acknowledges holy days and celebration events for all faiths, and we commissioned a photoshoot of BAME staff to be used in our marketing and communications material.

### 4.1.4 BAME Network

The listening events were a catalyst for establishing the BAME Staff Network. Claire worked alongside two outstanding colleagues who had volunteered their time and energy to help with the work of the Taskforce, Charlee Martin and Rushownara Miah, to develop the terms of reference and to get the group established. The Network is now chaired by Charlee, who is doing an outstanding job of bringing staff together through the network and who will provide a safe space for staff to share learning, support each other and challenge the organisation.

### 4.1.5 Established Trust Equality, Diversity and Inclusion (EDI) Resources

Alder Hey, Clatterbridge Cancer Centre and the Walton Neurological Centre have developed a model for a single EDI team to support the work of all three Trusts. This model was championed by the Taskforce. Angie Ditchfield joined the Trust as the interim EDI lead in September 21, completing a range of activities including the production of an improved Workforce Race Equality Scheme (WRES) Report, support for the emerging BAME Staff Network and worked with the Chaplaincy on developing inter-faith relationships; of particular note Angie helped secure the services of an out of hours Imam to support Muslim families in ED, a specific request from staff who were responding to what families needed at such emotional and difficult times.

Ayo Barley joined as the Head of Equality, Diversity and Inclusion in January 2022 and since her appointment has helped progress the work of the Taskforce, including the ongoing development of the staff network. She will play a key role in the future development of the EDI agenda.

### 4.1.6 Improvements in Trust data

There are several nationally mandated areas of focus within the area of race and race equality for Trusts in England. NHS England have defined 'Model Employer' goals, which Trusts are expected to achieve by 2028[2]. These focus on increasing representation of black, Asian and ethnic minority staff in senior leadership roles, and across the breadth of the workforce. The national Workforce Race Equality Scheme (WRES) also defines a range of measures that Trusts are assessed against annually.

[2] https://www.england.nhs.uk/wp-content/uploads/2019/01/wres-leadership-strategy.pdf

In addition, the Trust has signalled its aspiration to reflect the ethnicity of the local population of Liverpool (2011 Census indicates the non-white population in Liverpool is 11% BAME, however more recent data from ONS and DfE suggests this could be as high as 15.5%[3]).

### i. Representation on Trust Board

In response to a vacancy in 2021 for a Non-Executive Director, the Trust engaged with a new search agency, Green Park, known for its success in helping organisations secure appointments from candidates from diverse backgrounds who may not have traditionally considered senior NHS appointments. The recruitment campaign was very successful and enabled the Trust to appoint an excellent individual who has brought a wealth of skills, experience and knowledge to the Trust Board. We have committed to working with Green Park for future Board level appointments.

The figures below show the percentage difference between the organisation's board voting membership and its overall workforce, one of the metrics contained within the WRES. The data below shows a positive picture for the Trust against the national position. Our aim is to maintain, if not improve, this position going forward, with a particular focus on Executive Director appointments going forward.

**Voting Board (March 22)**

| White | BAME | Not Stated | National |
|---|---|---|---|
| **78.6%** | 21.4% | 0% | 10% |

### ii. Representation within the wider workforce

Since October 2020, we have grown our workforce by 248 staff; 66 of these colleagues, just over 25% of all new starters, were from a black, Asian or ethnic minority background. These are small, but positive, steps in the right direction, and we must keep our focus on ensuring we keep on increasing diversity by being an attractive place to work for everyone.

| Grade | October 20 | | | March 22 | | |
|---|---|---|---|---|---|---|
| | Ethnicity | | | | | |
| Band | Unknown | BME | White | Unknown | BME | White |
| Band 1 | 0.00% | 5.56% | 94.44% | 0.00% | 0.00% | 100.00% |
| Band 2 | 0.23% | 2.30% | 97.47% | 0.72% | 2.65% | 96.63% |
| Band 3 | 0.73% | 3.15% | 96.13% | 2.37% | 3.23% | 94.41% |
| Band 4 | 1.16% | 5.49% | 93.35% | 5.03% | 4.52% | 90.45% |
| Band 5 | 0.80% | 7.11% | 92.09% | 1.93% | 10.76% | 87.32% |
| Band 6 | 0.16% | 5.85% | 94.00% | 0.76% | 5.60% | 93.65% |
| Band 7 | 0.44% | 2.65% | 96.91% | 1.03% | 3.09% | 95.88% |
| Band 8A | 2.52% | 5.04% | 92.44% | 2.78% | 3.82% | 93.40% |
| Band 8B | 0.00% | 2.00% | 98.00% | 0.00% | 5.71% | 94.29% |
| Band 8C | 0.00% | 0.00% | 100.00% | 0.00% | 0.00% | 100.00% |
| Band 8D | 0.00% | 0.00% | 100.00% | 7.69% | 7.69% | 84.62% |
| Band 9 | 0.00% | 0.00% | 100.00% | 0.00% | 20.00% | 80.00% |

[3] https://www.cheshireandmerseysidepartnership.co.uk/wp-content/uploads/2021/02/Ethnicity-profiles-in-Cheshire-Merseyside.pdf

| | | | | | | |
|---|---|---|---|---|---|---|
| **Medic** | 3.01% | 35.24% | 61.75% | 0.00% | 25.00% | 75.00% |
| **Other** | 0.00% | 11.11% | 88.89% | 4.47% | 39.94% | 55.59% |
| **Senior Manager** | 3.57% | 14.29% | 82.14% | 6.90% | 10.34% | 82.76% |
| **Grand Total** | **0.90%** | **7.47%** | **91.63%** | **2.14%** | **8.62%** | **89.24%** |
| **Headcount** | **35** | **289** | **3545** | **88** | **355** | **3674** |

### iii. Staff Experience Data (Staff Survey)

The four questions below are from the annual NHS Staff Survey and are the 'staff experience' metrics from the WRES. Encouragingly, three of the four responses for 20-21 show an improvement in responses from BAME colleagues; the first question sees a decline; however this was from both white and BAME staff.

| Staff Survey Question | 2020 | 2021 | Movement |
|---|---|---|---|
| % staff experiencing harassment, bullying or abuse from families/public in last 12 months | White: 18.4%<br>BAME: 13.4% | White: 20.7%<br>BAME: 16.9% | ⬇ |
| % staff experiencing harassment, bullying or abuse from staff in last 12 months | White: 16.2%<br>BAME: 27.5% | White: 16.9%<br>BAME: 20.1% | ⬆ |
| % staff believing that trust provides equal opportunities for progression or promotion | White: 64.5%<br>BAME: 48.8% | White: 63.9%<br>BAME: 51% | ⬆ |
| % staff experiencing discrimination from a manager, team leader or other colleagues | White: 4.8%<br>BAME: 12.4% | White: 5.6%<br>BAME: 10.5% | ⬆ |

### 4.1.7 Educational Opportunities

For the Academy, the past 12 months has seen a heightened focus on inclusivity, and the ways in which we, as an organisation, seek to be more diverse (reflecting our local populations and those who use our services). Given the priorities set by the BAME Taskforce, much attention has been focused on BAME metrics (for example seeking to increase the % of nursing students from BAME backgrounds - in discussion with our local HEIs as part of their Access and Participation plans - and in respect of attracting more staff from BAME backgrounds into apprenticeships).

During the year specific projects / initiatives have yielded greater insight into key matters. For example, the detailed data analysis in respect of the nearly 500 applications received for the Registered Nurse Development Apprenticeship (RNDA) highlighted that the situation in respect of supporting those from BAME (and other) backgrounds into degree level apprenticeships employment with us is complex and multifaceted.

A significant proportion of applicants for the RNDA, including the significant majority of BAME applicants, did not hold the necessary minimum qualifications (including maths and English) to quality for entry to a degree level apprenticeship. Socio-economic factors, ethnic background and place of residence in the city all had a bearing on the ability of these individuals to progress, and this is what we will be continuing to work with HEI's, FE and the third sector on, ensuring we play our part in providing opportunities and widen participation in employment for the whole community.

Our local Universities and other HE providers have a plethora of innovative programmes in place to support achievement of specific APP targets (under the broad banner of widening participation and closing the attainment gap) and we are now working closely with them in order to:

- explore how we can support and enhance their existing programmes, blending expertise and capabilities (for example, supporting the UoL's Destination Medicine programme)
- identify gaps / opportunities for us to augment this, given our role and profile across the City (for example offering a one day Aspiring Medics programme, Prepare to Succeed Days and working with local schools and colleges in terms of careers in the health sector)
- consider whether there are opportunities for us to contribute at course level to support those wishing to pursue specific careers / courses

## 5. Challenges

The Taskforce came together during a global pandemic, one of the most challenging periods in the history of Alder Hey, and indeed the NHS. During this time, the Trust's focus was on three key areas; keeping our children, young people and their families safe, keeping our staff safe, and ensuring continued to provide clinical services to those who needed them.

We are immensely proud of what the Taskforce managed to achieve, however there were actions we were unable to progress due to operational and resource pressures as a result of the management of the pandemic, and these will be priority areas of focus going forward:

- **Recruitment**

A complete overhaul of our recruitment strategy, including processes, systems, training, approach, materials etc was one of the key actions identified by the Taskforce. Operational pressures with the HR team, coupled with the need to implement a new automated recruitment system, TRAC, has delayed the strategy review. This lack of progress was frustrating for us all, however, the Deputy Chief People Officer, Sharon Owen, has now commenced this project, which will be one of the significant projects undertaken by HR in 2022.

- **Community engagement, education and opportunity**

Whilst not as extensive as we would have liked, the volunteer team have made an excellent start engaging with local community groups and the education sector, with positive results, and the Academy have set out their plans for community, school and third sector engagement.

There is more work to be done to understand the impact of intersectionality when supporting those from our communities into employment with us. People belong to many categories and categories overlap. African Caribbeans and Bangladeshis in Britain, for instance, are disproportionately working class, compared not just with white people but with other minority groups, such as Indians, Chinese and black Africans.

To provide further insight as to the complexity then consider school exclusions. Black pupils are disproportionately excluded from school. Look more closely and you see the problem is in particular with those of Caribbean descent. Pupils of black African descent are less likely to be excluded than their white peers. Figures also show that pupils claiming free school meals

(FSM) – a proxy for poverty – are three times more likely to be excluded than the average pupil; 40% of all school exclusions are of FSM pupils.

In developing inclusive approaches therefore, it is vital that we focus on metrics / measures relating to the following noting (for the Academy and when considering wider recruitment ambitions) that intersections of disadvantage are particularly relevant when looking at access to education and employment.

- those from low participation neighbourhoods, typically categorised according to the participation of local areas (POLAR) classification groups together with

- the Index of Multiple Deprivation (IMD)
    - BAME
    - Mature students
    - Those with a disability
    - Care Leavers
    - Gender

It will be vital that we review our approach and develop wider collaborations which support those from the most disadvantaged into work with us. We have established relationships / collaborations which will see us working with the Princes Trust on pre-employment programmes, offering Supported Internships, widening our apprenticeship offer and targeting our schools and college programmes on those from POLAR / IMD classification areas.

- **Training & Development**

A pause on the delivery of national leadership programmes during the pandemic stalled our ambition to support and encourage BAME colleagues to access these targeted development opportunities, and we hope these are re-established in 2022. There has not been the movement we would have hoped to have seen for BAME staff in leadership positions; again this has to remain one of our targets.

A training provider has been identified to deliver Board level and Trust wide training. Ayo Barley is now leading on this, with the aim to have this training commence in 2022.

- **Positive Action**

More work is needed on our approach to positive action, focusing on those areas and professions with lower numbers of BAME staff. This also applies for leadership roles.

## 6. Taskforce legacy and the future

The Taskforce has set the ‘blueprint’ for how, when we come together with strong leadership, a shared purpose, and the right team alongside this we can achieve so much. It has given a voice to staff who told us that they have never felt listened to, but that they have now through this work, and they have seen the Taskforce identify actions in response to their feedback. We developed a sensitive and thought-provoking communications plan which has been brilliantly received by colleagues, and we have taken small, but very positive, steps to improve the ethnic diversity of our workforce and the experience of BAME colleagues.

The learning from the Taskforce is already being applied; Nathan Askew, Chief Nurse, and the SALS team have both used the listening model championed through the Taskforce to hold events with our LGBTQIA+ and disabled colleagues respectively. They have been hugely

welcomed and two staff networks are emerging from these events. These staff groups have told us that they are keen to ensure their issues can also be the focus of the kind of energy, drive and dedication we have within the BAME Taskforce.

With Claire Dove's tenure as lead for the BAME Taskforce sadly ending at the end of March 22, and with Garth Dallas, Non-Executive Director, having agreed to step forward and lead this agenda on behalf of the Board, it is timely to consider next steps, and how we take forward the learning and best practice from the Taskforce into the next phase of the Trust's approach to improving Equality, Diversity and Inclusion. We must not lose the momentum of the Taskforce, and so the recommendations below outline the proposals for moving swiftly forward.

## 7. Recommendations

- Trust Board to agree to close the BAME Taskforce, and to support the establishment of the Equality, Diversity and Inclusion (EDI) Steering Group, to be chaired by Garth Dallas, Non-Executive Director. This will ensure dedicated time and space to progress the full EDI agenda and take forward the learning from the Taskforce. The remit of this group will be to identify actions to improve the opportunities and experiences of people from all groups including, but not limited to, BAME, LGBTQIA+, and disabled staff.

- All outstanding actions from the Taskforce are taken forward into the EDI Steering Group as key priorities and refreshed to consider the wider remit of the new group.

- To support the continued development of the BAME Staff Network, and the establishment of the Disability and LGBTQIA+ Staff Networks, supporting the nominated chairs with one paid day per month to chair and prepare for the network meeting.

- To agree that each network will have a nominated Executive Director lead, who will work with the Network Chair to support and champion the agenda

**Appendix 1 - BAME Taskforce Ambition and Actions**

**OUR AMBITION:**

- **To remove processes and barriers in Alder Hey that could sustain systemic racism**
- **To support opportunity for education and employment for under-represented groups**
- **To have a diverse and inclusive workforce which truly represents the local population, and will be a place where all staff feel their contribution as an individual is recognised and valued, and the care we provide reflects this.**
- **To define and create the cultural and behavioural changes we want to see**

| Our Focus: | Our overarching actions: |
|---|---|
| • Listening to staff through open conversations and feedback | Listening Events, 1-1 sessions, continuous learning/feedback loop |
| • Recruitment (Attraction/Recruitment/Retention) - Increasing ethnic minority, and particularly black, representation across our workforce | Develop a new recruitment strategy; publications, links with local community groups, apprenticeships, advertising methods |
| • Tackling overt and covert racism | Developing a 'Zero Tolerance' approach. Policy, training, awareness, communications |
| • Training, Development and Progression - supporting the confidence and professional development of BAME colleagues in order for them to progress into more senior roles | Review of access to national programmes. A positive action approach for access to leadership development for BAME colleagues. |
| • Governance –increased BAME representation on the Trust Board, Council of Governors and at all levels within Alder Hey | Review current recruitment methods, including use of agencies. |
| • More diverse and inclusive communications | Developing a diverse communications plan. Launch a refocused BAME Network, and use this as a blueprint for other networks that require support |
| • Understanding the data –what is it telling us? | Analysis of the WRES and other workforce metrics to assess current position and areas for focus |
| • Equip ourselves with more knowledge; learning and growing together | Review of training and awareness sessions for all levels of staff, with a particular focus on the Board |
| • Develop strategic alliances with communities and organisations that support our ambitions | Developing an engagement plan with local community groups, including schools, to build relationships, connections and trust |

**Appendix 2 – BAME Taskforce Metrics**

| | BAME Inclusion Taskforce – Metrics | 2020 | Future State |
|---|---|---|---|
| **WRES Metrics** | % staff in AfC Bands 1-9/VSM by ethnicity vs. % staff in overall workforce | Not representative | Meet Model Employer goals 2028 |
| | % difference between the Board voting membership and its overall workforce | 15.8% BAME | Remain higher than Trust representation |
| | BAME applicants appointed vs. white applicants | White: 17.47%<br>BAME: 18.73% | Retain no disparity |
| | BAME staff entering formal disciplinary process vs. white staff | Negligible | Retain no disparity |
| | BAME staff accessing non-mandatory training/CPD vs. white staff | Negligible | Retain no disparity |
| | % staff experiencing harassment, bullying or abuse from families/public in last 12 months | White: 18.4%<br>BAME: 13.4% | For there to be no difference in experience between white and BAME staff |
| | % staff experiencing harassment, bullying or abuse from staff in last 12 months | White: 16.2%<br>BAME: 27.5% | |
| | % staff believing that trust provides equal opportunities for progression or promotion | White: 90.8%<br>BAME: 76.6% | |
| | % staff experiencing discrimination from a manager, team leader or other colleagues | White: 4.8%<br>BAME: 12.4% | |
| **Local Metrics** | Ethnicity of organisation vs. ethnicity of area | 7.4% | 11% |
| | BAME university students (nursing) per year | 6% | tbc |
| | BAME staff accessing leadership programmes vs. white staff | tbc | tbc |
| | BAME applicants for board/Governor roles | | |
| | Board Level Training and Awareness | None | Trust Board trained by Dec 21 |
| | Refreshed Training & Awareness for all Trust staff | None | Programme rolled out by July 22 |

## Appendix 3 – BAME Taskforce Terms of Reference

**BAME TASKFORCE**

**TERMS OF REFERENCE**

| | |
|---|---|
| **Constitution** | The Board has requested a Task Force be established, set up for a 6 month period initially, which will be responsible for a focused review of process and practice relating to EDI, with a view to recommending and implementing specific actions to improve EDI across the organisation. |
| **Membership** | Claire Dove, Non-Executive Director [Chair]<br><br>Anita Marsland, Non-Executive Director<br><br>Shalni Arora, Non-Executive Director<br><br>Melissa Swindell, Director of HR & DO<br><br>Mark Flannagan, Director of Marketing and Communications<br><br>Pauline Brown, Acting Chief Nurse<br><br>Raman Chhokar, Associate COO, Medical Division<br><br>Annemarie Davies, Senior Project Manager, Community Division<br><br>Sharon Owen, Deputy Director of HR & OD<br><br>Jo Potier, Associate Director of OD |
| **Attendance/Quorum** | Given the focused nature of this Taskforce, all members will be asked to attend each meeting, with others co-opted in as and where necessary. Virtual participation in meetings through the use of video conferencing or other virtual means shall count towards the quorum. |
| **Frequency** | Meetings shall normally take place on a monthly basis.<br><br>The Chair may at any time convene additional meetings of the Taskforce to consider business that requires urgent attention. |
| **Authority** | The Taskforce is responsible for providing strategic direction and board assurance in relation to workforce EDI matters, and making recommendations, as appropriate, on EDI matters to the Board of Directors, in support of the stated aim of 'looking after our people' and making Alder Hey the Best Place to Work. |
| **Duties** | The Taskforce has been delegated authority by the Trust Board to carry out the following duties:<br><br>• Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey, and that our plans specifically support opportunity for education and employment for under-represented groups. There will be specific focus on:<br>• Establishing a programme of Positive Action |

| | |
|---|---|
| | • Use of careful listening through networks to monitor and challenge progress<br>• Review of recruitment practices<br><br>**Performance Indicators**<br><br>To monitor progress on achieving workforce standards and targets. To ensure timely and appropriate information is provided to the Trust Board to fulfil governance and monitoring duties, including:<br><br>• WRES<br>• WDES<br>• EDS2 |
| **Reporting** | The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the People and Wellbeing Committee along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action. |
| **Conduct** | The committee will develop a work plan with specific time-focused objectives.<br><br>Members and attendees are selected for their specific role or because they are representative of a professional group/speciality/service line or division. As a result members are expected to:<br>• Ensure that they read papers prior to meetings<br>• Contribute fully to discussion and decision-making<br>• If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress<br>• Represent their professional group or their speciality/directorate/division as appropriate in discussions and decision making<br>• Disseminate and feedback on the content of meetings to colleagues in their speciality/service line/division via governance structures and processes.<br><br>Agendas, papers and minutes to be distributed not less than 2 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance. |
| **Monitoring** | The committee will assess its own performance and effectiveness by ensuring actions and activities are monitored and |
| **Review** | Committee Terms of Reference to be reviewed following 6 months of operation to determine if there is a requirement for the Taskforce to continue beyond 6 months. |

Alder Hey Children's NHS Foundation Trust

**BOARD OF DIRECTORS**

**Thursday, 31st March 2022**

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

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | Monthly BAF Reports |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**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 2021/22

## 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 13 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 Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

## 2. Review of the BAF

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

| BAF Risk | | Reviewed By |
|---|---|---|
| 1.1 | Inability to deliver safe and high quality services | Safety & Quality Assurance Committee |
| 1.2 | Children and young people waiting beyond the national standard to access planned care and urgent care | Resources and Business Development Committee |
| 1.3 | Failure to address building deficits with Project Co. | Resources and Business Development Committee |
| 2.1 | Workforce Sustainability and Development | People & Wellbeing Committee |
| 2.2 | Employee Wellbeing | People & Wellbeing Committee |
| 2.3 | Workforce Equality, Diversity & Inclusion | People & Wellbeing Committee |
| 3.1 | Failure to fully realise the Trust's Vision for the Park | Resources and Business Development Committee |
| 3.2 | Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. | Resources and Business Development Committee |
| 3.4 | Financial Environment | Resources and Business Development Committee |
| 3.5 | ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment | Trust Board |
| 3.6 | Risk of partnership failures due to robustness of partnership governance | Resources and Business Development Committee |
| 4.2 | Digital Strategic Development and Delivery | Resources and Business Development Committee |
| 4.1 | Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People. | Innovation Committee |

### 3. Overview at 14th March 2022

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


**Trend of risk rating indicated by: 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 March 2022

The diagram below shows that all risks remained static in-month except for risk 2.1 which has improved.

| 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 | **Children and young people waiting beyond the national standard to access planned care and urgent care** | RABD | **3x5** | 3x3 | IMPROVED | STATIC |
| 1.3 DP | **Failure to address building deficits with Project Co.** | RABD | 4x3 | 2x3 | - | **NEW** |
| **STRATEGIC PILLAR: The Best People Doing Their Best Work** | | | | | | |
| 2.1 MS | **Workforce Sustainability and Development.** | PAWC | 3x4 | 3x2 | STATIC | IMPROVED |
| 2.2 MS | **Employee Wellbeing.** | PAWC | 3x3 | 3x2 | STATIC | STATIC |
| 2.3 MS | **Workforce Equality, Diversity & Inclusion.** | PAWC | 4x3 | 3x2 | STATIC | STATIC |
| **STRATEGIC PILLAR: Sustainability Through External Partnerships** | | | | | | |
| 3.1 DP | **Failure to fully realise the Trust's Vision for the Park.** | RABD | 3x3 | 3x2 | STATIC | STATIC |
| 3.2 DJ | **Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.** | RABD | 4x3 | 4x2 | STATIC | STATIC |
| 3.4 JG | **Financial Environment.** | RABD | **4x4** | 4x3 | STATIC | STATIC |
| 3.5 DJ | **ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.** | Board | **4x4** | 3 x3 | STATIC | STATIC |
| 3.6 DJ | **Risk of partnership failures due to robustness of partnership governance.** | RABD | 3x3 | 3x2 | STATIC | STATIC |
| **STRATEGIC PILLAR: Game-Changing Research and Innovation** | | | | | | |
| 4.1 CL | **Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.** | Innovation | 3x3 | 3x2 | STATIC | STATIC |
| 4.2 KW | **Digital Strategic Development & Delivery.** | RABD | 4x1 | 4x1 | STATIC | STATIC |

## 5. Summary of February's updates:

### External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Significant transition ongoing at system level, though progress made in both Alder Hey's 2030 vision (aligned to system priorities) and C&M CYP Programme leadership. First draft of Healthier Futures governance presented to Execs for consideration.

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

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. LNP plan detailed previously still stands - scheduled for April

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed, all actions on track.

- ***Failure to address building deficits with Project Co. (DP)***
  New risk.

### Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  Our levels of planned care in February were good in the context of Omicron and staff absence levels in excess of 7%. We achieved 93% recovery of elective and day case services, 98% for outpatient services and 101% in Radiology. Nonetheless, this is lower than pre-Omicron levels and the reduction has stalled our progress in reducing the number of children and young people waiting over 52 weeks for treatment; this fell only slightly from 237 patients to 232.

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

- ***Inability to deliver safe and high-quality services (NA).***
  Risk has been reviewed and current controls remain in place.

- ***Financial Environment (JG).***
  Risk has been reviewed and actions updated. The current 22/23 plan remains uncertain at this stage however mitigations are in progress with clarity expected before final submissions due mid-April.

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

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed. Strategy in development for Board in Q1 22/23. Alderc@are revised dates and approach supported by Trust Executive.

- ***Workforce Sustainability and Development (MS).***
  Whilst staff availability issues have continued coupled with high levels of sickness absence, this has continued to drop in the last two months. This has therefore allowed for a reduction in the risk score from 16 to 12.

- ***Employee Wellbeing (MS).***
  Risk reviewed; all actions on track.

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

**Erica Saunders**
**Director of Corporate Affairs**

## Links between high scored risks & BAF

BAF Risk

1.1

Inability to deliver
safe and high-quality services

(3x3=9)

Strategic Aim

Delivery of **outstanding care**

### Related Corporate Risk(s)

(2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity. * (linked to 2.1)
(2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors
(2233) Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies
(2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available Monday to Friday, caused by significant staffing gaps due to sickness.
(2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval caused by UNHM and Alder Hey are served by two different transport services (KIDS & NWTS) meaning neither will transport non-time critical patients between trusts. Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours.
(2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs * (Linked to 1.2 &1.6)
(2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. *(Linked to 2.1)
(2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.* (Linked to 2.1)
(2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.6 &2.1.)
(2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.* (linked to 1.2 & 2.1)
(2501). Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic *( linked to 1.2. & 2.1)
(2327) Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence
(2332) : Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients (Linked to 1.1)
(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.2 & 2.1)
(2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.2 & 2.1)
(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 2.1)
(2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.2 & 2.1)
(2578) Insufficient funding to provide Porter's service (Linked to 2.1)
(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.2)
(2434) Failure to meet the 90% target compliance for Trust wide Resuscitation Training in line with Mandatory Training Policy - E21
(2570) Inadequate provision of inherited cardiac conditions (ICC) service for Children within the North West.

| BAF Risk | Strategic Aim | Related Corporate Risk(s) |
| --- | --- | --- |
| 1.2 Inability to deliver accessible services to patients, in line with national standards, due to a surge in urgent care demand, respiratory infections and the impact of COVID-19 (3x5=15) | Delivery of **outstanding care** | (2233) Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies (linked to 1.1)<br>(2501) Risk of inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 10 pandemic leading to a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments (linked to 1.1 & 1.6)<br>(2463) Risk that Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals during 2020 (linked to 1.1 & 1.6)<br>(2517) Risk of Children & Young People coming to harm whilst waiting for urgent treatment episodes, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS (linked to 1.1 & 2.1)<br>(2501) Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic (Linked to 1.1 & 2.1)<br>(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1 and 2.1)<br>(2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.1 and 2.1)<br>(2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 2.1)<br>(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.1) |
| 1.3 Failure to address ongoing building defects with Project Co. (4x3=12) | | None |

| BAF Risk | Strategic Aim | Related Corporate Risk(s) |
|---|---|---|
| 2.1 Workforce Sustainability & Capability (4x4=16) | **The best people** doing their best work | (1910) Risk of being unable to provide interventional Radiology service caused by only one consultant radiologist being in post (linked to 1.1)<br><br>(2100) Risk of inability to provide safe staffing levels.( Linked to 1.1)<br>(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients( Linked to 1.1)<br>(2340) Risk in the amount of training delivered will suffer due to the inability of resuscitation staff providing it, equally with holding the cardia arrest bleep, caused by insufficient staff in resuscitation team. ( linked to 1.1)<br>(2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. (linked to 1.1)<br>(2517) “Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes”, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. (linked to 1.1)<br>(2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately. (linked to 1.1)<br>(2497) Delayed diagnosis and treatment for children and young people”, caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.1 & 1.6)<br>(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1)<br>(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 1.1)<br>(2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 1.2)<br>(2578) Insufficient funding to provide Porter's service (Linked to 1.1) |

| BAF Risk | Strategic Aim | Related Corporate Risk(s) |
| --- | --- | --- |
| 2.2 Employee Wellbeing (3x3=9) | **The best people** doing their best work | None |
| 2.3 Workforce Equality, Diversity & Inclusion (4x3=12) | **The best people** doing their best work | None |

| BAF Risk | Strategic Aim | Related Corporate Risk(s) |
| --- | --- | --- |
| 3.1 Failure to fully realise the Trust's vision for the Park (3x3=9) | Sustainability through **external partnerships** | None |
| 3.2 Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships (4x3=12) | | None |
| 3.4 Financial Environment (5x4=20) | | None |
| 3.5 ICS: New Integrated Care System NHS legislation/system architecture; risk of inability to control future in system complexity and evolving statutory environment (4x4=16) | | None |
| 3.6 Risk of partnership failures due to robustness of partnership governance (3x3=9) | | None |

| BAF Risk | Strategic Aim | Related Corporate Risk(s) |
| --- | --- | --- |
| 4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP (3x3=9) | Game-changing **research and innovation** | None |
| 4.2 Digital Strategic Development and Delivery (4x1=4) | | None |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 1.1 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Inability to deliver safe and high quality services | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | Link to Corporate risk/s: 2383, 2436, 2332, 2441, 2461, 2265, 2427, 2326, 2501, 2514, 2384, 2233, 2434, 2340, 2463, 2516, 2312, 2229, 2230, 2332, 2383, 2536, 2570, 2528, 2246, 2578, 2497, 2434, 2100, 2415 | | |
| Exec Lead: Nathan Askew | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 2x2 | Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 3. SQAC will receive on going monthly updates on this program of work and improvements will be monitored through this process. | 01/04/2022 | Refer to SQAC reports for most up to date progress |
| 1. Continue to monitor KPI's at SQAC and within divisional governance structures. | 01/04/2022 | Refer to corporate report to SQAC and associated conversations |
| 2. The Trust will deliver the Parity of esteem work program addressing this issue | 01/04/2022 | Please note most recent report to SQAC. Due to increased COVID response the working group was paused. |

**Executive Leads Assessment**

March 2022 - Nathan Askew
this risk has been reviewed and current control remain in place.

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

| |
|---|
| November 2021 - Nathan Askew<br>The risk has been reviewed. Current control in place remain on track with particular improvement in all 3 quality priorities. Quality work across the organisation continues to recover following covid 19 and will provide additional assurance against the gaps detailed |
| October 2021 - Nathan Askew<br>This risk has been reviewed, controls for haps in assurance continue. There has been progress with all 3 safety priority workstreams with clear plans in place across medication safety, deterioration and parity of esteem. |
| September 2021 - Nathan Askew<br>the risk as been reviewed and updates undertaken of some control actions. Work continues in relation to gaps in assurance relating to medication safety. Other controls remain in place |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 1.2 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective | | Link to Corporate risk/s: 2233, 2501, 2463, 2517, 2501, 2383, 2528, 2246, 2497, 2578 | | |
| Exec Lead: Adam Bateman | Type: Internal, Known | Current IxL: 3x5 | Target IxL: 3x3 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Rising urgent care demand has increased the wait for clinical assessment and reduced the number of patients treated within 4 hours. A loss of capacity during COVID-19 has made access to planned care extremely challenging.

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

**Gaps in Controls / Assurance**

1. Reduce to zero the number of C&YP waiting over 52 weeks for treatment to clear the long-wait backlog for planned care
2. In urgent and emergency care, improve to 95% the number of patients treated within 4 hours and a time to clinical assessment of 60 minutes
3. Patients with an urgent referral to the eating disorder service to be seen within 7 days and routine referrals within 4 weeks

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

| | | |
|---|---|---|
| Specialty-based recovery plans to be developed for ENT, paediatric dentistry, spinal, paediatric surgery and long-term ventilation.<br>This will include a) a timescale/ trajectory for clearing the backlog in 2022 b) the high-impact interventions to support delivery of this goal | 28/02/2022 | Weekly specialty meetings to focus on booking IP TCI dates.<br>Provision of additional capacity - including Accelerator Bid.<br>Chronological booking.<br>Theatre transformation to focus on Day Case and start times with expectation to increase number of patients per list. |
| see attachment for 'standard workstream update'. Actions include:<br>1. symptom checker go-live 2. additional medical and clinical support to manage the urgent care workstream, via Go2doc 3. new out-of-hours cover for APNPs +/- other staff groups | 31/03/2022 | Go 2 doc now covering shifts<br>Symptom checker has gone live |
| Increase eating disorder service capacity<br>Detailed action plan contained in risk 2497 | 31/03/2022 | |

**Executive Leads Assessment**

0 - No Reviewer Entered

In October we have seen a positive increase in the level of service recovery: elective care was 103% and outpatient services 94% (provisional data) relative to 2019. The increase was driven in part by an increase in weekend sessions.. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

March 2022 - Adam Bateman

Our levels of planned care in February were good in the context of Omicron and staff absence levels in excess of 7%. We achieved 93% recovery of elective and day case services, 98% for outpatient services and 101% in Radiology. Nonetheless, this is lower than pre-Omicron levels and the reduction has stalled our progress in reducing the number of children and young people waiting over 52 weeks for treatment; this fell only slightly from 237 patients to 232. We are now working to fully restore the theatre schedule and review improvement plans for workforce expansion and productivity.

Our Emergency Department dealt with a 9.6% increase in attendances relative to 2019. We treated 77.1% of patients within 4 hrs, a decline on January, but the highest level of performance in Cheshire & Merseyside. We have an urgent care improvement plan which is focused on increasing out-of-hours cover and re-establishing the primary care stream with an external partner.

February 2022 - Adam Bateman

The risk score has been reduced following the embedding of the new outpatients and inpatient waiting list, which are available in real-time and supporting enhanced patient tracking.

On planned care, there are 248 patients waiting over 52 weeks for treatment. There are 9 patients waiting over 104 weeks and all have treatment dates scheduled before the end of March 2022. Progress with reducing long waiting times has been curtailed by the impact of Omicron on staff absence and in turn a reduced theatre schedule.

In urgent and emergency care, the percentage of patients treated within 4 hrs increased to 79.4%. Gold Command tracks the urgent care improvement plan, as one of our priority areas to support.

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

| BAF 1.3 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Failure to address ongoing building defects with Project Co. | | |
|---|---|---|---|---|
| Related CQC Themes: Safe | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: David Powell | Type: External, Resource And Business Development Committee | Current IxL: 4x3 | Target IxL: 2x3 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Failure to address the ongoing building defects with Project Co resulting in impact to the operational services and running of the hospital and potential contractual dispute.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Detailed action plan agreed by both parties in place which reduces the risk of failure. Review of the action plan takes place monthly to ensure all remains on track. | |
| Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact. | |

**Gaps in Controls / Assurance**

Remedial Works not yet completed:
1. Detailed action plan agreed by both parties in place which reduces the risk of failure. Review of the action plan takes place monthly to ensure all remains on track.
2. Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Monthly report to Trust Board on mitigation and remedial works | 31/03/2023 | |
| Board to board meeting to take place on a regular basis and escalation of any issues | 31/03/2023 | |
| Regular inspections on known issues/defects | 31/03/2023 | |
| Monthly report to RABD on progress of remedial works | 31/03/2023 | |

**Executive Leads Assessment**

# 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: 2340, 1910, 2312, 2501, 2517, 2516, 2497, 2383, 2528, 2536, 2246, 2578, 2497, 2100 | | |
| Exec Lead: Melissa Swindell | Type: Internal, Known | Current IxL: 3x4 | Target IxL: 3x2 | Trend: IMPROVED |

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Continue with regular reporting of data<br>target hotspot areas and staff groups<br>review methodology of accessing training | 28/04/2022 | Overall Mandatory Training still at 88% overall as of 1st March 2022.<br><br>Key hot spots are vastly improved from the start of the focus:<br>Resus: 81%<br>Estates: 77%<br>M&H Level 2: 72% |

| | | |
|---|---|---|
| | | We will continue to promote and work with SMEs to further improve compliance across all topics and staff groups. |
| 3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019 | 28/02/2022 | Workforce planning discussions and a framework to support these was presented to SDG as part of this years operational planning. |
| 5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan | 31/03/2022 | A project/action is in draft supported by the DMO |

| **Executive Leads Assessment** |
|---|
| March 2022 - Sharon Owen<br>Whilst staff availability issues have continued coupled with high levels of sickness absence, this has continued to drop in the last two months. This has therefore allowed for a reduction in the risk score from 16 to 12. |
| February 2022 - Sharon Owen<br>Risk scores remains high. Absence rates remain high across the Trust, recruitment activity also remains high. Action plans in place to address and the situation is monitored through gold command weekly. Absence position reported on daily |
| January 2022 - Sharon Owen<br>This risk is monitored through the gold command structure. Daily reports and key actions are in place in respect of staff availability. Staff availability will be further impacted as a result of the legislative changes in respect of the Covid19 vaccine as a condition of employment. Working group identifying those in scope. |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| The People Plan Implementation | Monthly Board reports |
| Wellbeing Strategy implementation | Wellbeing Strategy. Wellbeing Steering Group ToRs |
| Action Plans for Staff Survey | Monitored through PAWC (agendas and minutes) |
| Values and Behaviours Framework | Stored on the Trust intranet for staff to readily access |
| People Pulse results to People and Wellbeing Committee quarterly | PAWC reports and mintues |
| Values based PDR process | New template implemented and available on intranet. Training for managers (appraisers) delivered. |
| Staff surveys analysed and followed up (shows improvement) | 2021 Staff Survey Report - main report, divisional reports and team level reports |
| Reward and Recognition Group relaunched after being on hold during the peak of the pandemic | 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 |
| Staff advice and Liaison Service (SALS) - staff support service | Referral data, key themes and outcomes reported to PAWC as part of the People Paper |
| Care first - online Employees Assistance programme | |
| Counselling and Psychological support - Alder Centre | |
| Trust Briefs - keeping staff informed | |
| Spiritual Care Support | |
| 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 | Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly |
| Health and Wellbeing Conversations launched | HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse |
| Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin | Minutes of exec meetings |

**Gaps in Controls / Assurance**

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of this pandemic
2. Increase in mental health crises in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and corresponding decrease in availability of emergency mental health provision
3. Increase in self-reported rates of burnout as assessed via 2021 Staff Survey and consistent with national picture for NHS staff

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

| | | |
|---|---|---|
| After Action Review to be coordinated to inform learning from incident. Director of Nursing to ask for member of Governance team to lead the review. Risk management plan in place to ensure member of staff is safe and receiving appropriate interventions. | 31/03/2022 | Learning review ongoing. Expected outcome end of March |
| Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model | 31/03/2022 | Assistant psychologist recruited and starting in post mid March. SALS Pals model ongoing in ED, in development in Theatres and to be developed in ward areas and a community site - yet to be decided. Task and finish group established to work on this project |
| Business case to be written and taken to IRG to secure funding for proposed staff support model combining SALS and Staff counselling. Interim plan to operationalise new pathway from 1st February with current funding to ensure equity of provision for staff and to minimise waiting times. | 31/03/2022 | New process agreed with Alder Centre. All new referrals for staff support from 1st Feb to be directed to SALS for initial triage and intervention where appropriate. All staff counselling to be accessed via SALS. Communications plan drawn up to be sent to all staff w/c 24th January. Current Alder Centre waiting list being reviewed and all staff contacted to review need and offer support from SALS or other services as appropriate. |

| **Executive Leads Assessment** |
|---|
| March 2022 - Melissa Swindell<br>risk reviewed, actions on track |
| February 2022 - Jo Potier<br>Actions reviewed and updated and controls reviewed and updated to include 2021 staff survey results. No change to risk rating |
| January 2022 - Jo Potier<br>Risk review and all controls and actions reviewed and updated. No change to risk rating |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

Staff Networks still in development stage, requires further support, resource and input

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| New Head of EDI will be develpping an action plan as a result of her audit of EDI, as part of her induction to the role | 31/03/2022 | |

**Executive Leads Assessment**

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

March 2022 - Melissa Swindell
risk reviewed, actions updated

February 2022 - Melissa Swindell
risk reviewed, actions updated for Head of EDI

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Business Cases developed for various elements of the Park & Campus | Approved business cases for various elements of the Park & Campus |
| Monitoring reports on progress | Monthly report to Board<br>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<br>SLA |
| Exec Design Group | Minutes of Exec Design Reviews to Campus Steering Group |
| We are working with a designer and a QS to review the Remediation Strategy which has now been submitted to LCC. This should lead to a reduction in estimated costs, if approved. In addition we are looking at alternative suppliers that meet the LCC specification. | Planning submission and the estimated costs. Estimated costs provided by Landscape Contractor and QS. |

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Appoint PM and legal team to review NE plot and produce Business Cases/Board papers. Revised to summary report of costs and benefits. | 31/03/2022 | Paper re option exercise to January Board. Options paper for science building in Feb Board. |
| Create oversight group with staff governor and LCC input | 01/04/2022 | |
| Round table working session with CoG | 01/04/2022 | |
| Set up a campus review | 31/03/2022 | |
| Create acceleration plan | 31/03/2022 | |

**Executive Leads Assessment**

| |
|---|
| March 2022 - David Powell<br>Prior to March Board |
| February 2022 - David Powell<br>Review prior to February Board |
| January 2022 - David Powell<br>Review prior to January Board |

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver | Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached) |
| Compliance with All Age ACHD Standard | ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey |
| Capacity Plan identifies beds and theatres required to deliver BD plan | Daily activity tracker and forecast monitoring performance for all activity. |
| Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board | Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board. |
| Internal review of service specification as part of Specialist Commissioning review | Compliance with final national specifications |
| Compliance with Neonatal Standards | Single Neonatal Services Business Case approved by NHS England. |
| Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda | MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly). Partnership update & refresh of North West Paediatric Partnership Board schedule and arrangements undertaken Feb 22 |
| 'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs | 'Our Plan' approved at Trust Board October 2019 |
| 'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services | Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within. |
| Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board |
| Gap / risk analysis against all draft national service specification undertaken and action plans developed | Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance |
| Involvement of Trust Executives in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year) |
| Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed. | |
| C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan | C&M C&YP Recovery Plan Narrative |
| One Liverpool - Provider Alliance action plan | Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. |
| C&M Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under implementation | Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS)<br><br>4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway.<br><br>9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received.<br><br>25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed.<br><br>27.1.22 - Presentation of Beyond programme to HCP Programme |

| | |
|---|---|
| | Board. ICS CEO in attendance. Programme progress accepted. |
| Coordinated system-wide action planning for predicted RSV surge | NW & C&M Surge Plans |
| ICPG led Refreshed One Liverpool Delivery Plan - under development | |
| 2030 Vision: Alder Hey vision and strategic objectives refresh - Q4 21/22 | -Trust Board Strategy / 2030 Vision session scheduled Jan 22<br>- Refreshed Draft 2030 Vision (to be attached following Jan Board session)<br>- Final 2030 Vision & objectives to Trust Board for sign off Feb 22<br>- Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention |

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 6.Develop Operational and Business Model to support International and Private Patients | 31/03/2022 | Refresh of Trust Strategic plan scheduled for Q4 21/22 - planning for non-NHS income to form part of this refresh |
| 1. Strengthening the paediatric workforce | 31/03/2022 | Alder Hey making strong strides re: Physicians Associates as the largest employer of PA's in England - demonstrating new approaches to staffing skill mix. Requirement for system-based workforce planning outlined in new Gov't guidance 'Build Back Better' in September; local implementation timelines as yet unknown but Alder Hey will ensure positioning for CYP workforce played in. |

**Executive Leads Assessment**

March 2022 - Abigail Prendergast
Risk reviewed; no change to score in month. Significant transition ongoing at system level, though progress made in both Alder Hey's 2030 vision (aligned to system priorities) and C&M CYP Programme leadership. First draft of Healthier Futures governance presented to Execs for consideration.

February 2022 - Dani Jones
Risk reviewed; no change to score in month. Significant transition ongoing at system level, though progress made in both Alder Hey's 2030 vision (aligned to system priorities) and C&M CYP Programme leadership

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

# 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: 5x4 | Target IxL: 4x3 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

Failure to meet NHSI/E target, impact of changing NHS finance regime and inability to meet the Trust ongoing Capital requirements.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Organisation-wide financial plan. | Monitored through Corporate Report and the monthly financial report that is shared with RABD and Trust Board. |
| NHSi financial regime, regulatory and ICS system. | Specific Reports submitted monthly and anually as part of business plan process (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<br>- Full electronic access to budgets & specialty performance results<br>- Finance reports shared with each division/department monthly<br>- Financial in-month and forecast position reported through SDG, Exec Team, RABD, and Trust Board<br>- Financial recovery plans reported through SDG and RABD<br>- Internal and External Audit reporting through Audit Committee. |
| Capital Planning Review Group | Capital management group chaired by Exec lead to regularly review schemes and spend<br>5 Year capital plan ratified by Trust Board |
| Quarterly performance review meetings with Divisional Clinical/Management Team and the Executive | Quarterly Performance Management Reporting with divisional leads ('3 at the Top') |
| Fortnightly Sustainability Delivery Group overseeing efficiency programme and financial controls | Fortnightly Financial Sustainability delivery meeting papers |
| CIP subject to programme assessment and sub-committee performance management | Tracked through Execs / RABD and improvement board for the relevant transformation schemes |
| RABD deep dive into any areas or departments that are off track with regards to performance and high financial risk area | RABD Agendas, Reports & Minutes |

**Gaps in Controls / Assurance**

1. Changing financial regime and uncertainty regarding income allocations and overall position for 22/23 and beyond
2. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
3. Long Term Plan shows £3-5m shortfall against breakeven
4. Long Term tariff arrangements for complex children shows underfunding c£3m for Alder Hey.
5. Devolved specialised commissioning and uncertainty impact to specialist trusts.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 4. Long Term Financial Plan | 30/04/2022 | Part of business planning for 22/23 will be to develop an internal 3-5 year LTFM for Alder Hey.<br>First draft to be presented alongside plans to RABD and Trust Board |
| 2. Five Year capital plan | 31/03/2022 | CDEL allocation methodology now agreed by ICS and initial allocation for 22/23 for AH is significantly lower than the current plans. Number options being explored jointly with ICS to manage the risk this provides, expected to be in position to assess any residual risk after these mitigations at the end of March. |
| 1. Uncertainty of income for 22/23 and beyond | 31/03/2022 | Draft plans submitted to ICS showing deficit position whilst awaiting clarity on final income allocations. Delivery of financial plan will be reliant on robust activity plans and delivery of 3% CIP programme which is high risk. |

**Executive Leads Assessment**

March 2022 - Rachel Lea
Risk has been reviewed and actions updated. The current 22/23 plan remains uncertain at this stage however mitigations are in progress with clarity expected before final submissions due mid April.

February 2022 - Rachel Lea
Risk reviewed and updated with latest position and actions.

January 2022 - Rachel Lea
Risk reviewed and actions updated.

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** Trust Board

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda | Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21)<br><br>CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21)<br><br>Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan |
| Specialist Trust Alliance membership of C&M ICS (HCP) Board - to ensure Specialist Trusts have a voice to influence | |
| C&M CYP Transformation Programme hosted at Alder Hey | ICS Programme Highlight Report<br>Further evidence attached to BAF 3.2 |
| Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4) | See BAF 3.4 (financial environment) |
| Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning | Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete |
| C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence | |
| C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services | TOR & System Finance Principles in development (to be attached once finalised) |
| Maintain effective existing relationships with key system leaders and regulators | |
| Lead Provider and partnership arrangements; development of new models of care | ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans |

**Gaps in Controls / Assurance**

1. NHS Bill not yet read in Parliament; final statutory arrangements cannot take place until this is completed (clarity will follow)
2. H2 Planning Guidance landed October 21: Review of impact and associated action plan for Alder Hey to be undertaken early Oct 21
3. Uncertainty over future commissioning intentions (see BAF 3.4)
4. National delay to transition into ICB's announced over Christmas 21 - projected transfer date now July 22 - meaning continued uncertainly in the interim

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services | 28/04/2022 | |
| 4. Continue to develop collaborative arrangements with key partners and shape the service offering | 31/03/2022 | |

**Executive Leads Assessment**

March 2022 - Abigail Prendergast
Risk reviewed; no change to score in month. National delay to transition into ICB's noted - now July 22 - current action plans remain appropriate

February 2022 - Dani Jones
Risk reviewed; no change to score in month. National delay to ICB transition by 3mths, along with Omicron variant wave has focused system efforts on mutual aid for Dec/Jan.

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

# Board Assurance Framework 2021-22

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

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group | |
| Escalation process for risks and issues pertaining to ODNs and Joint Services | |
| Partnership Quality Assurance Framework | P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement) |
| Identification of 'pilot' partner to co-design the Framework | Pilot of Partnership Quality Assurance Round approach agreed with LWH MD - to be piloted via Liverpool Neonatal Partnership and presented to LNP Board in April 22 |
| Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership | RMF agendas and minutes |

**Gaps in Controls / Assurance**

1. Partnership Governance Framework to be devised and approved through Alder Hey governance.
2. 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 |
|---|---|---|
| Agreement to pilot Pship Assurance Round approach with LWH and Liverpool Neonatal Partnership. Pack development to be undertaken during Feb & March, for presentation to LNP Board in April. Learning to be shared and co-design to pack to be incorporated | 28/04/2022 | |

**Executive Leads Assessment**

March 2022 - Abigail Prendergast
Risk reviewed; no change to score in month. LNP plan detailed previously still stands - scheduled for April

February 2022 - Dani Jones
Risk reviewed; no change to score in month. LNP plan detailed previously still stands - scheduled for April

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

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** Innovation Committee

**Risk Description**

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

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

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 3. Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation | 08/11/2023 | |
| 2. Board approval of a joint R&I strategy with encompasses the new 2030 innovation Strategy and promotes a growth plan and brings inward investment. | 31/03/2022 | |
| Agree an MoU to outline the partnership - value based shared purpose and also commercial upside sharing | 31/03/2022 | |
| 1. Agree IP policy to cover whole Trust and include incentivisation | 31/03/2022 | |

**Executive Leads Assessment**

March 2022 - Claire Liddy
Risk remains static - no change in month

February 2022 - Claire Liddy
February review - no change

January 2022 - Claire Liddy
Jan review - - no change

# Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Development of new strategy from 22/23 | 01/04/2022 | |
| Implementation of Alder Care Programme | 03/10/2022 | Some issues highlighted with programme, risking dates to delivery. Review underway |

**Executive Leads Assessment**

March 2022 - Kate Warriner
Risk reviewed. Strategy in development for Board in Q1 22/23. Alderc@are revised dates and approach supported by Trust Executive.

February 2022 - Kate Warriner
Risk reviewed. New digital strategy in development with feedback from stakeholders underway. Executive decision with regards to revised dates for Aldercare programme

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

Alder Hey Children's NHS Foundation Trust

# BOARD OF DIRECTORS

## Thursday, 31st March 2022

| | |
|---|---|
| **Paper Title:** | Corporate Risk Register Report (CRR)<br>1st January 2022 – 21st March 2022 |
| **Report of:** | Erica Saunders, Director of Corporate Affairs |
| **Paper Prepared by:** | Cathy Umbers, Associate Director of Nursing and Governance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ■ |
| **Background Papers and/or supporting information:** | Risk Strategy & Risk Management Policy & Procedure and supporting policy documents<br><br>Board Assurance Framework<br><br>CQC standards |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**Strong Foundations** |
| **Resource Impact:** | Supports resource identification |
| **Associated risk (s)** | NA |

## 1. Purpose

This paper provides the Trust Board with the opportunity to scrutinise and discuss the current Corporate Risk Register (CRR). The reporting period covered is 1st January – 21st March 2022.

## 2. Summary CRR:

Total number of open high risks = **20** (excluding 3 network risks, ref: 2332, 2383, 2536)
Number of new high risks identified since 1st January 2022 = **2** (ref: 2570, 2578)
Number of high risks with an overdue review date = **3** (ref: 2528, 2570, 2312 )
Number of high risks with actions past expected date of completion = **3** (ref: 2246x2, 2528 x2, 2312x1)
Number of high risks closed = **2** (ref: 2235, 1910)
Number of high risks with reduced risk scores = **1** (ref: 2415)
Number of risks with increased risk scores to high = **2** (ref: 2246, 2327)
Number of high risks with static risk scores = **13** (ref. 2229, 2230, 2233, 2312, 2326, 2340, 2436, 2441, 2463, 2497, 2501, 2516, 2517)

Table 1 - Risks with reduced risk score
Table 2 - Closed risks
Table 3 – New high risks
Table 4 - Risks with increased risk scores
Table 5 – Long-standing risks (greater than 12 months since identification)

## 3. Themes

There are currently five themes identified on the CRR, including access to services (8 risks), people (8 risks), major trauma (2 risks), medicines management (1 risk) and governance (1 risk).

### 3.1. Access to services

Risk **2528 (4x4=16)** *Risk of extensive delays for treatment and care* caused by recently waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with RTT compliance decreasing significantly. Capacity and demand and workforce review with recommendations in progress. Consultant job planning in General Paediatrics to be finalised to give clear picture for capacity and demand modelling. New locum consultant posts progressing.

**Risk 2312 (5x3 =15).** *''Risk of Patients not being adequately managed from a medical perspective (paediatric medicine / neonatology) whilst under the care of Neurosurgery and Craniofacial".* Business case has been submitted that includes 2 WTE General Paediatrician. The increase in establishment would enable the provision of medical cover for neurosurgical patients on the ward. Meeting has taken place to agree 8.15 - 9.30am (weekday) - ward round 1 - 3pm (Monday) – Neurosurgery Multidisciplinary Team (MDT). Medical Division have advertised for 2.0 Consultant positions who will provide cover to the neurosurgical patients, recruitment process commenced.

**Risk 2436 (3x5=15).** "*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 experience a significant delay based on service availability*". Review of demand and capacity, staff training, risk assessment of current room and provisions, consideration of the storage of images completed. 3D service is now available as part of the workflow, more staff have

had training. Action underway to secure an HCA to support in the photography clinic to act as a chaperone and play specialist.

**Risk 2441 (5x3=15).** *"Risk of patients deteriorating whilst transport services and hospitals agree who is going to undertake the retrieval",* caused by Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours. Service Manager met with Paediatric Intensivist (PI) from NWTS. Confirmed they have a surge transport team which is funded until 31st March 2022. Business case submitted to Commissioners which requests recurrent funding to retain the surge team. The surge team has enabled non time critical patients to be retrieved from UHNM and brought to Alder Hey. This is one of approximately 10 cohorts of patients that the surge team hopes to continue serving. Interim Standard Operating Procedure (SOP) / flowchart for transfer of patients to be created.

**Risk 2463 (4x4=16).** "*Risk that children and young people will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard)".* Improvements agreed to ASD and ADHD dashboards with BI to support monitoring of pathway and reporting of waiting times and dashboard updates will be implemented during March 2022.

**Risk 2326 (3x5=15).** '*Delayed diagnosis and treatment for children and young people'*, caused by Lack of paediatric phlebotomy provision in the local area for children and young people requiring blood tests requested from primary care providers. Work is ongoing with CCGs and Mersey care to develop a phlebotomy service for appropriate GP referrals (patients aged 12 years and over with no complex/ongoing medical needs). Plans have been agreed to implement a Merseyside-wide ICE system. Currently Mersey care have agreed that their phlebotomy service will go live in April 22. Next available routine phlebotomy appointment is June 22; therefore, the following actions have been taken :- - Currently planning WLI lists for April 22

- Appointments on the GP stream have been reduced from 30minutes to 15minutes with the aim of increasing capacity.

**Risk 2497 (3x5=15). "***Delayed diagnosis and treatment for children and young people",* caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service has increased. Ongoing challenges with recruitment – asst psychologists have been appointed but unable to recruit to band 6 post. Readvertising with recruitment incentives & sponsored adverts.

**Risk 2517 (3x5 = 15). "***Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes",* caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. One agency staff member has left, still one in post (off framework) - extended until May 2022. Recruitment team reducing time to hire. Ongoing review and discussion with recruitment team. Move to 'Trac' complete - more oversight of delays/point in process.

### 3.2. People

**Risk 2246 (4X4 = 16). INCREASED "***The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered"* caused by if the Trust does not have adequate Specialist Palliative Care consultants. Controls include Specialist Palliative Care consultants service in hours, nursing on call partnership with Claire House Hospice. Requires recruitment – business case for 1 Consultant WTE being developed to provide the on-call rota 24/7. Finalising job plans for the Consultants within the Specialist Palliative Care Team. Scoring reviewed alongside risk matrix and adjusted to align with current situation.

**Risk 1910 (5x3 =15).** *"Risk of being unable to provide interventional Radiology service"* caused by only one consultant radiologist being in post. Business case is due to go in financial year 2023/2024. Discussions ongoing regarding a proposed pathway with LUFT. Risk now closed as locum has started meaning IR Consultant's job plan has been reduced to 10PAs and cover during annual leave

periods is in place.

**Risk 2340 (3x5=15).** "*Risk of not meeting Resuscitation Council (UK) Acute Care Quality Standards, including training, and leading on cardiac arrest calls".* Successful appointment at interview.
3 WTE resus officers appointed, two not qualified currently as Resuscitation Officers. awaiting GIC qualification before able to teach. 1 WTE booked GIC March 2022. 1WTE to retake APLS.
Resus officer started 14th February 2022 - is still on 4-week preceptorship within the role. Currently only one staff member ALS trained. Vacancy of head of resuscitation. Continue to employ external agency in the short term to increase capacity for mandatory training delivery with a review date of April 2022.

**Risk 2501 (4x4=16). "***Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD",* caused by COVID 19 pandemic, there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. Draft workforce review completed, business case to be developed. Two band 5 staff have had the opportunity to work a Nurse in Charge shift to gain experience. The E-Rostering system has gone live within the OPD; however, some issues have been identified - these are currently being reviewed. Recruitment process of new HCAs is ongoing and start dates yet to be confirmed.

**Risk 2100 (4x4=16).** "*Risk of inability to provide safe staffing levels",* caused by high level of sickness and absence. The Trust target is no more than 4%. Controls in place include, sickness and absence policy, monthly reporting to divisions, Bank Resource via NHSP, Occupational Health Service, early intervention service, Staff Advice and Liaison Service (SALS), early Intervention service, Staff Advice and Liaison Service, Health and Wellbeing conversations, Resilience hub, Appointment of wellbeing guardian reporting to board. Further actions include Occupational Health revised contract under consideration. Pay as you go arrangement in place and agreed until new contract is in place on 1st April 2022 and training and e-learning tool to be rolled out to managers. Draft training programme presented to Senior HR team for Sign off - expected to be rolled out in April. Absence rates remain high; however, they have reduced in the last month, it is anticipated that rates will continue to reduce. Full support plan in place across the organisation to support absence and the Trust position continues to be monitored via gold command and daily ops meeting.

**Risk 2516 (4x4 =16).** "*There is a risk that patients will not be managed appropriately, including appointments not being pended or booked correctly, potential for patient care and treatment being compromised",* caused by lack of ward clerk administrative cover. A business case has been completed for a robust ward clerk staffing structure to be recruited and implemented across the Trust. Business case to be shared with key internal stakeholders for final comments before progressing internal processes for final sign off and possible Trust investment. Ward Clerk review is in progress. Ward discharge process supporting new ward clerk processes has been rolled out across W1C. W3A is currently in scope for roll out. Training is required for all ward clerks and PCO's to ensure processes are followed correctly for improved outcomes. W4A is suspected to be April 2022 and medical wards will follow.

**Risk 2570 (5x3 =15). NEW *"****Inadequate provision of inherited cardiac conditions (ICC) service for Children within the Northwest"*** caused by a lack of funding to support a defined inherited cardiac condition (ICC) within the following staff groups: Genetics, Nurse specialist, Psychology, Admin. Controls in place include monthly ICC clinics to see new and follow up patients, however this is only one clinic per month. Monthly visit from adult geneticist to support clinic but there is currently no cover due to maternity leave and cardiac nurse specialist team provide advice, but this is on an ad-hoc basis. Further actions include scoping permanent dedicated nurse specialist time, additional support from genetic counsellors from LHCH and increased clinics.

**Risk 2578 (4x4 =16). NEW** *"Insufficient funding to provide Porter's service"* caused by insufficient roster agreed 2018. Controls in place include daily labour reporting and overtime, however there is currently no funding for overtime provision. Further actions being taken include an organisational

change paper with agreed minimum working levels and request funding to bridge gap of £140k.

### 3.3. Major Trauma

**Risk 2233 (4x4 =16*).** *"Risk of failure to meet QST Major Trauma peer review standards.*" Additional resource required to support increase in compliance with expected standards. Recruitment ongoing. Timeframes for successful candidates to be in post March 2022. New NICE guidelines have been published. The team are currently reviewing these to identify position.

**Risk 2229 (4x4 =16*).** *"Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, substandard care and prolonged stay / inappropriate discharge".* Evidence that current major trauma pathways do not have consensus across all relevant specialties tied to that specific pathway leading to risk of non-standardised approach. Controls include Rehab Coordinators, Hospital Trauma Lead, and support of Northwest Children's Major Trauma Network. Increase in capacity required - two posts have been advertised 8A Clinical leader for Major Trauma (1.00wte) and Band 7 rehab coordinator (1.00wte). Interviews imminent. Hoping to have new staff members in post March 2022. Team to create a 7 day a week service provision model for testing. Exercise completed now for summer and autumn/ winter periods. The feedback from both pieces of work led by the team will be used to inform a 7-day service once recruitment to 2 posts has been completed (i.e., end March 2022). Team now consists of 3 x full time and 1 part time coordinators.

### 3.4. Medicines Management

**Risk 2230 (5x3=15).** *"Risk of Ten-fold medication errors resulting in serious harm to patients"* Outcome of business case to support medication safety quality improvement project (QIP) approved – to be presented at IRG in March 2022. Ongoing actions include 10x error working group in place and roll out of reducing interruptions bundle to all wards.

### 3.5. Governance

**Risk 2327 (4X4 =16). INCREASED *"***Losing Cardiac data which can impact on the full AH Cardiac service and national submission"* caused by database corruption resulting in the database crashing on a regular occurrence and having to use a backup system to generate previous work which can result in more current work being lost. Controls include backups and manual submission of the data however backups are taking place around 3 days which can result in a loss of data collation and the database is exceeding maximum capacity which means the inability to export data currently. A business case has been developed to seek resource and cost, to be presented at IRG in March 2022.

**Table 1 RISK WITH REDUCED RISK SCORES**

| Division | Ref. | Risk | Prior Score / New Score | Reason reduced / comment |
|---|---|---|---|---|
| **Corporate Service Human Resources** | 2415 | "*Risk of significant vacancies in key services across the Trust*", | 4x4 =16<br>3x3 = 9 | Time to hire KPI now met. TRAC implemented. Processes amended. Ongoing training still required with both recruitment team and recruitment managers. |

**Table 2: RISKS CLOSED**

| DIVISION | Ref | Risk | Risk Owner | Date Identified |
|---|---|---|---|---|
| Surgery | 2235 | *"There is a risk that patients will not get an outpatient (OP) appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list".*<br><br>Duplicate risk linked to risk 2265 =3x3=9, therefore risk 2235 closed | Chief Operating Officer | 13/07/2020 |

| | | | | |
|---|---|---|---|---|
| Division of Medicine | 1910 | *"Risk of being unable to provide interventional Radiology service caused by only one consultant radiologist being in post. "*<br><br>Risk now closed as locum has started meaning IR Consultant's job plan has been reduced to 10PAs and cover during annual leave periods is in place. | Umi Das<br>Director of Medical Division | 10/06/2019 |

**Table 3: NEW HIGH RISKS**

| DIVISION | Ref / Score CxL | Risk | Reason/ comment | Risk Owner | Date Identified |
|---|---|---|---|---|---|
| **Division of Surgery (Cardiology)** | 2570<br><br>5x3=15 | Inadequate provision of inherited cardiac conditions (ICC) service for Children within the Northwest. | Lack of funding to support a defined inherited cardiac condition (ICC) within the following staff groups:<br><br>- Genetics<br>- Nurse specialist<br>- Psychology<br>- Admin<br>We are currently not delivering the national service specification for an ICC service.<br><br>New risk, discussed with rapid review panel and added to risk register. Actions in place to support risk and mitigate risk. | Michael Bowes, Paediatric Cardiology Consultant | 10/02/2022 |
| **Corporate Services (Facilities)** | 2578 | Insufficient funding to provide Porter's | Insufficient roster agreed 2018. | Lachlan Stark, Associate Chief Operating Officer, | 18/02/2022 |

| DIVISION | Ref / Score CxL | Risk | Reason/ comment | Risk Owner | Date Identified |
|---|---|---|---|---|---|
| | 4x4=16 | service. | | Corporate Services | |

**Table 4: RISKS WITH INCREASED SCORES**

| DIVISION | Ref | Risk | Prior Score / New Score | Reason for increase in score |
|---|---|---|---|---|
| **Medicine (Palliative Care Team)** | 2246 | The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered. | 3x3 = 9<br><br>4x4 =16 | Risk reviewed with team and reworded to allow more effective management of the risk. Controls revisited and reworded. Scoring reviewed alongside risk matrix and adjusted to align with current situation. |
| **Surgery (Cardiac Surgery)** | 2327 | Losing Cardiac data which can impact on the full AH Cardiac service and national submission. | 4x3 = 12<br><br>4x4 = 16 | There is a difference of opinion regarding which is the best system to use. Updated at divisional risk meeting 3/2/22. 14896. Action extended by one month. |

**Table 5: LONG-STANDING RISKS (identified more than 12 months on the register)**

| DIVISION | Ref | Risk Owner | Risk | Date identified |
|---|---|---|---|---|
| **CORPORATE SERVICES:**<br><br>HR | 2100 | Melissa Swindell<br>Director of People | Risk of inability to provide safe staffing levels<br><br>**Summary**<br>Risk has fluctuated between a 9 and a score of 6, increased to a score of 9 in January 2021. Increased to a score of 16 in August 2021, where it remained static until further increase to a score of 20 in January 2022. | **January 2020** |

| | | | | |
|---|---|---|---|---|
| **DIVISION OF SURGERY:**<br><br>Major Trauma | 2229 | Alf Bass<br>Director for Division of Surgery | Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, substandard care, and prolonged stay / inappropriate discharge.<br><br>**Summary:**<br>Risk has remained a high risk, fluctuating between a risk score of 20 and 16. Risk score decreased in March 2021 (moderate) and re-escalated in July 2021 and has remained at that level since. | **July 2020** |
| **DIVISION OF MEDICINE:**<br><br>Medicines Management | 2230 | Pauline Brown<br>Director of Nursing | Risk of Ten-fold medication errors resulting in serious harm to patients<br><br>**Summary:**<br>Risk identified in July 2020 as a high risk (risk score 20). Risk decreased to 10 in July 2020 and re-escalated to a high risk in June 2021. Risk deescalated to a score of 10 in October 2021 but re-escalated the same month and has remained static since that time. | **July 2020** |
| **DIVISION OF SURGERY:**<br><br>Major Trauma | 2233 | Pauline Brown<br>Director of Nursing | Risk of failure to meet QST Major Trauma peer review standards<br><br>**Summary:**<br>Risk identified in July 2020 as a high risk (risk score 20). Risk score decreased to a score of 16 in November 2020 and has remained static since that time. | **July 2020** |

| | | | | |
|---|---|---|---|---|
| **DIVISION OF SURGERY:**<br><br>Neurosurgery | 2312 | Alf Bass, Divisional Director | Risk of patients not being adequately managed from a medical perspective (paediatric medicine / neonatology) whilst under the care of Neurosurgery and Craniofacial<br><br>**Summary**<br>Risk has remained at the same level since first identified 5x3=15. | **November 2020** |
| **DIVISION OF COMMUNITY AND MENTAL HEALTH:**<br><br>Phlebotomy | 2326 | Lisa Cooper, Divisional Director | Delayed diagnosis and treatment for children and young people<br><br>**Summary**<br>Risk added at a risk score of 8 (2x4) in December 2020. Risk increased to a score of 15 in July 2021 and has remained at this score since. | **December 2020** |
| **CORPORATE SERVICES:**<br><br>Resuscitation Department | 2340 | Philip O'Connor, Deputy Director of Nursing | Risk of not meeting Resuscitation Council (UK) Acute Care Quality Standards, including training, and leading on cardiac arrest calls<br><br>**Summary**<br>Risk added at a risk score of 9 (3x3) in January 2021. Escalated to a risk score of 15 in August 2021 and has remained at this score since. | **January 2021** |

**END**

**Resources and Business Development Committee**
**Confirmed Minutes of the meeting held on Monday 24th January at 13:00, via Teams**

| | | | |
|---|---|---|---|
| **Present:** | Shalni Arora | Non-Executive Director **(Chair)** | (SA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Rachel Lea | Acting Director of Finance | (RL) |
| | Anita Marsland | Non-Executive Director | (AM) |
| | Melissa Swindell | Director of HR & OD **Left at 2pm** | (MS) |
| **In attendance:** | Nathan Askew | Chief Nursing Officer | (NA) |
| | Robin Clout | Deputy Chief Digital Information Officer | (RC) |
| | Mark Flannagan | Director of Communications | (MF) |
| | Emily Kirkpatrick | Associate Director Commercial Finance | (EK) |
| | Russell Gates | Associate Commercial Director Development | (RG) |
| | Ken Jones | Acting Director of Operational Finance | (KJ) |
| | Claire Liddy | Managing Director of Innovation | (CL) |
| | Erica Saunders | Director of Corporate Affairs **Left at 2pm** | (ES) |
| | Clare Shelley | Associate Director Operational Finance | (CS) |
| | Jason Taylor | Acting Associate Chief Operating Officer Research | (JPT) |
| | Julie Tsao | Executive Assistant (*minutes*) | (JT) |
| **Agenda item:** | Jason Dean | Costing Accountant | |
| | Mark Carmichael | Associate Chief Operating Officer | |
| | Andy McColl | Associate Chief Operating Officer | |
| | Jim O'Brien | Senior Capital Programme Manager | |

**20/21/3347** **Apologies:**

Apologies were received from:

| | | |
|---|---|---|
| Ian Quinlan | Non-Executive Director | (IQ) |
| John Grinnell | Acting CEO | (JG) |
| Graeme Dixon | Head of Building Services | (GD) |
| Dani Jones | Director of Strategy and Partnerships | (DJ) |
| Kate Warriner | Chief Digital & Information Officer | (KW) |

**20/21/348** **Minutes from the meeting held on 15th December 2021.**

The minutes were approved as a true and accurate record.

**20/21/349** **Matters Arising and Action log**

**Terms of Reference to be adjusted for both Innovation Committee & RABD**

The Chair queried the governance of the companies. ES agreed to monitor this through the Audit and Risk Committee Workplan.

The Managing Director of Innovation has been added as a member and the Deputy Director of Business Development, Commercial has been included as an attendee.

**Resolved:**
**RABD APPROVED the above changes to the TOR.**

The Chair welcomed Anita Marsland, NED as a member of the RABD Committee.

All other actions have been updated in the log or are included as an agenda item.

**20/21/350** **Declarations of Interest**

There were no declarations of interest.

**20/21/351** **Finance Report**

**Month 9 Financial Position**

The in-month position for December is a £152k surplus which is marginally ahead of the break-even plan position however the year to date position is showing a deficit of £352k. This is adverse to the break-even plan trajectory to the end of the year but as noted above an improvement on the £3.4m risk identified at the start of H2.

As at month 9, the in-year forecast is currently a £6.0m achievement through budget and run rate savings with a further opportunity of £0.1m to be achieved. It should be noted that only 47% of schemes in year have been achieved recurrently. Further work is underway to establish if these schemes can become recurrent and will feed into the 22/23 budget setting process.

An update on the divisional positions was received and had been included with the report.

**Further details on the mitigation plan and benefit realisation for the Medicine Division**

MC presented the financial plan noting a deep dive to understand cost pressures had been completed and presented to RABD in November 21. A number of actions are being implemented including the tightening of approval processes and uploading consultant job plans to L2P, this will provide an accurate cost base.

CIP and service reviews for 2022/23 was shared with RABD.

MC agreed to provide a further update to RABD in April and circulate the slides presented.
**Action: MC**

**Resolved:**
RABD received and noted the M9 Finance report and the mitigation plan and benefit realisation for Medicine Division.

**20/21/352** **2022-23 Plan**

A system plan is to be finalised and submitted by the end of April 2022. The draft will be presented at the March RABD prior to Board approval.

AMc went through the main 3 themes:
Further planning ahead 3-5 years
Tackling Health inequalities
Pre pandemic access and productivity

Robust internal strategic plans have commenced this morning with divisions focusing on 4 key elements: Activity, Financial, Workforce and Digital.

AMc shared a slide on the transformation and governance of the 10 priorities.

CS went through the Finance and Budget setting highlighting risks, opportunities and efficiencies.

AM and AB discussed inequalities of access to care and for this is to be reported on going forward through RABD. The first update would be received at the March meeting.
**Action: AB**

**Resolved:**
RABD received details of the 2022-23 Financial Plan with further updates to be presented in February and March.

**20/21/353** **Service Line Report Month 6**
JD went through patient level costing and how the data is captured and used to benefit both patients and the Trust. JD gave a number of examples and shared future plans.

CL noted the trail blazer Health Inequalities project and was keen to see the developments from it. The Chair queried if this would include adult hospitals. JD said currently as the main gaps are children the project will focus on the data from Alder Hey.

**Resolved:**
RABD received and noted the Service Line Report.

**20/21/354** **Capital & Cash Updates**
KJ bridging cap in forecast shared at the November RABD. Gap was around £17m.

Working more strategically with Alder Hey Charity.
Trying to be more specific with funding, more joined approach in applying for bids.
Hoped further £4m of PDC gain in 2023-2025.
£2.2m has come out of the spend mainly from the Capital reserve.
Capital allocation will be challenging.

AB as well as being affordable needs to be balanced and to include carbon reduction. RABD agreed to include a placeholder for a zero carbon footprint to be included once developed. Plans would also include tracking of grant funding performance.

The Chair queried if Alder Hey Charity are aware of the plans for them to support the Capital plan. KJ said there had been discussions once approved plans would be shared with the AH Charity.

**Resolved:**
RABD APPROVED the revised plan noting the placeholder to be included on Carbon reduction.

**20/21/355** **Campus & Park update (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the Campus and Park report included in the pack.

**20/21/356** **Neonatal Tender**
JO'B gave an overview of the plans. £1.2m has been saved in relation to the building bringing the project back on track to £19.6m. In relation to the additional £1m RABD had requested, AH Charity have agreed to provide £500k.RL reported on a number of opportunities on the outstanding £500k that Alder Hey would bid for.

Risks include planning, service diversions, service connections and SPV/funder approval. RABD received assurance on the weekly planning meetings to track progress.

**Resolved:**

RABD APPROVED the project to proceed to Trust Board for agreement on the construction of the Neonatal/EDU/PAU/UC project.

**20/21/357 Land Buy Back**

RL gave an overview of the paper that had been circulated to RABD members.

The Trust had sold a piece of land to Step Places in 2019. Part of the sale agreement provided a condition to buy back the land, to enable the Trust to consider options for future growth. The expiry date for this clause is 8th February 2022. RABD was asked to support the process to buy back the land.

AM queried access to areas of the grounds for all parties. RL confirmed this would be included in the process.

**Resolved:**
RABD gave support for the proposal to buy back the land to be presented at the Trust Board Thursday 27th January 2022.

**20/21/358 Innovation and Commercial Activity**

**Resolved:**
CL introduced the first commercial activity report to RABD providing an overview of grants, inward investment and revenue generation schemes for 2021/22.

**20/21/359 Innovation Strategy**

EH presented the draft Innovation Strategy ahead of the Innovation Committee on 7th February 2022 for approval. It was noted that the strategy would be used as a tracking tool to monitor progress with regular updates being presented to RABD.

A discussion took place with regard to the process for handling the commercial aspects of the strategy. RABD noted this would need to be developed going forward and asked that an annual or bi-annual review was added. Regular reports would be presented to RABD tracking both the financial and benefit realisation of Innovation.
**Action: CL/EH**

EK highlighted the link with the Transformation team and Innovation projects.

RABD noted the aim of the Strategy is to support Alder Hey in delivering innovative solutions that will advance child health and have measurable global impact for all Children and Young People, any commercial results are an additional benefit.

**Resolved:**
RABD supported the Innovation Strategy to be put forward to the Innovation Committee on 7th February for approval, noting regular reports tracking the benefits against the strategy will be presented to RABD.

**20/21/360 Recovery & Urgent Care October Update**

AB updated RABD on Omicron, winter pressures. Inpatient admissions decreased slightly in December. Staff sickness did spike as well as the number of staff isolating.

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

**20/21/361** **Month 9 Corporate Report (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the M9 Corporate report.

**20/21/362** **Communications update (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the communications paper.

**20/21/363** **PFI Report**
**Update on Commercial position**
RL discussions continue another meeting with Project Co Board is due to take place this week. Further updated will be provided next month.

**Resolved:**
RABD received and noted the M9 PFI report as well as the current commercial position.

**20/21/364** **Board Assurance Framework**
RL highlighted the risk in relation to the park. The planning guidance for the financial environment has now come through.
**Resolved:**
RABD received and noted the BAF update for January 2022.

**20/21/365** **Any Other Business**
No other business was reported.

**20/21/366** **Review of Meeting**
The Chair noted the through updates that had been received including:
Neonatal Tender
Innovation Strategy, how surplus is managed.

**Date and Time of Next Meeting: Monday 14th February 2022, 1300, via Teams. NB: moved to Friday 18th February 2022.**

**Resources and Business Development Committee**
**Confirmed Minutes of the meeting held on Friday 18th February 2022 at 09:30, via Teams**

| | | | |
|---|---|---|---|
| **Present:** | Ian Quinlan | Non-Executive Director (Chair) | (IQ) |
| | Shalni Arora | Non-Executive Director | (SA) |
| | Anita Marsland | Non-Executive Director | (AM) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Claire Liddy | Managing Director of Innovation | (CL) |
| | John Grinnell | Director of Finance | (JG) |
| | Kate Warriner | Chief Digital & Information Officer | (KW) |
| **In attendance:** | Nathan Askew | Chief Nursing Officer | (NA) |
| | Mark Carmichael | Associate Chief Operating Officer | |
| | Mark Flannagan | Director of Communications | (MF) |
| | Ken Jones | Associate Director Financial Control & Assurance | (KJ) |
| | Clare Shelley | Associate Director Operational Finance | (CS) |
| | David Powell | Development Director | (DP) |
| | Abby Prendergast | Associate Director of Strategy and Partnerships | (AP) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Julie Tsao | Executive Assistant (*minutes*) | (JT) |
| | Kath Stott | Merseyside Internal Audit Agency | |
| **Agenda item: 372** | Andy McColl | Associate Chief Operating Officer | |

**20/21/367 Apologies:**
Apologies were received from:

| | | |
|---|---|---|
| Adam Bateman | Chief Operating Officer | (AB) |
| Rachel Lea | Acting Director of Finance | (RL) |
| Emily Kirkpatrick | Associate Director Commercial Finance | (EK) |
| Dani Jones | Director of Strategy and Partnerships | (DJ) |

**20/21/368 Minutes from the meeting held on 24th January 2022**
The minutes were approved as a true and accurate record.

**20/21/369 Matters Arising and Action log**
MF noted the post for the Project Manager of the Green plan had now commenced post and an update would be presented next month.

All other actions have been updated in the log or are included as an agenda item.

**20/21/370 Declarations of Interest**
There were no declarations of interest.

**20/21/371 Finance Report**
**Month 10 Financial Position**
CS reported £2.1m surplus a significant improvement in month due to ERF monies received following a successful challenge to NHSEI to rebase 19/20 activity levels. Alder Hey continues to work towards a end of year breakeven position.

A divisional update was received. SA asked for details on outsourcing within the Aseptic Unit. MC said part of the current business case is to purchase some of the equipment within the unit by March 2022. A recruitment plan is underway to return the rota to working time equivalent. Both actions will support the Medicine Division reduce the financial position.

**Resolved:**
RABD received and noted the M10 Finance report.

**20/21/372** **2022-23 Plan**
CS shared slides that will be sent to RABD members after the meeting.
**Action: CS Completed.**

Initial draft activity plans was submitted to the Cheshire & Merseyside Integrated Care Systems on Monday 14th February 2022. Financial plans were submitted yesterday, Workforce plans will be submitted on 21st February. An update was received on Mental Health Service plans due to be submitted this month. CS highlighted 8 national assumptions.

Activity plans: AMc went through pre pandemic performance against the 2022/23 plans. In relation to Outpatients follow ups (personalised care) AH would work towards the reduction however it was unlikely this target would be met for a pediatric service.

CL noted a number of Innovation and Digital projects that are in progress to reduce follow up outpatient appointments and asked going forward that the work from these projects is captured.

RABD received details on the divisional position noting this was a first draft and refinement on some of the target standards would be required. KW queried the outcome this will have on the system as a whole once there had been refinement of targets set. AMc said there had already been communication on the targets being systematic and will not be met by specialists Trusts.

Financial plans have been submitted based on H2X2 excluding Elective Recovery Funding, Covid funding and system top up. This would leave AH with a £23.3m deficit, this does exclude a number of income lines as outlined in the presentation pack. CL asked if opportunities for further income was likely. CS advised there would be bids AH would be able to apply for. AMc noted opportunities would also be developed through the Children's Alliance.

CS gave an overview of emerging risks and next steps.

**Resolved:**
RABD received details of the 2022-23 Financial Plan.

**20/21/373** **Capital Update**
Looking forward KJ noted a substantial gap over the 3 year plan. Allocation of cash is being worked through. Due to this actions have been agreed on must do.

**Resolved:**
RABD noted the details of the confidential paper with a further update to be received in March.

**20/21/374** **Campus & Park update (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the Campus and Park report included in the pack.

**20/21/375** **Digital Update**
KW highlighted:

- AH was re-credited HIMMS Level 7 in November 2021.

- Reviewing Digital Strategy update to presented at the April Trust Board
- (Meditech Expanse) renamed Aldercare programme internally this is the first version to be available in the UK, due to this there are a number of challenges that are being worked through. The programme is behind schedule with a go live date of late autumn early winter 2022. KW did note 2 major risks that would need to be resolved before AH went live.
- Review model in place in relation to the partnership with Liverpool Heart and Chest IDigital Service: Deputy Chief Digital Information Officer is due to leave in March 2022. Interviews for Heads of Service are taking place today. The new model will support the CIP.

**Resolved:**
RABD received and noted the digital update.

**20/21/376** **Recovery & Urgent Care October Update**

MC highlighted:

- Low staff availability due to Omicron, managed to maintain elective and non-elective services.
- Peak patient admissions was the last week in January and has now reduced.
- Reduction in patient admissions to urgent care services was seen for December and January. This improved both patients seen within 4 hours and left before seen.
- There was high levels of Junior Doctors absence in the February change over this has impacted access and performance standards. GP and ACP presence in ED has been provided by a 3rd party provider to support primary care stream.

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

**20/21/377** **Safe Waiting List Management: diagnostic reporting changes**

MC provided an overview of the paper noting a detailed validation, data quality review that has highlighted aspects of reporting and waiting list calculations that should be revised to ensure complete alignment to national guidance. A key recommendation following this review is to make some adjustments to the diagnostic waiting list calculation and the algorithm used to generate external reports.

RABD went through the number of patients affected and the recovery plans including additional sessions for the services within the 3 diagnostic groups.

**Resolved:**
RABD APPROVED the recommendations within the paper to revise the DM01 reporting from February 2022 noting the negative impact on performance against the 6 week standard.

MC agreed to provide a further update at the May RABD.
**Action: MC**

**20/21/378** **Month 10 Corporate Report (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the M9 Corporate report.

**20/21/379** **Communications update (starred item – only questions/answers will be noted)**
**Resolved:**
RABD received and noted the communications paper.

**20/21/380** **Marketing and Communications Strategy**
**Resolved:**
MF highlighted the proposals set out in the strategy, the changes to the communications structure, team champion for each division and planned events for 2022/23.

**20/21/381** **PFI Report**
**Update on Commercial position**
**Resolved:**
RABD received and noted the M10 PFI report as well as the current commercial position.

**20/21/382** **Board Assurance Framework**
ES noted the risk in relation to PFI will be added to the February BAF report.
**Resolved:**
RABD received and noted the BAF update for January 2022.

**20/21/383** **Any Other Business**
No other business was reported.

**20/21/384** **Review of Meeting**
The Chair noted the through updates that had been received.

**Date and Time of Next Meeting: Monday 28th March 2022, 1300, via Teams.**

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

**Thursday, 31st March 2022**

| | |
|---|---|
| **Paper Title:** | **Safety Quality Assurance Committee** |
| **Date of meeting:** | 23rd March 2022 – Summary<br>16th February 2022 – Approved Minutes |
| **Report of:** | Fiona Beveridge, Non Executive Director, (Chair of Safety Quality Assurance Committee) |
| **Paper Prepared by:** | Fiona Beveridge |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 23rd March 2022, along with the approved minutes from the 16th February 2022 meeting. |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ☐<br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | None |
| **Associated risk (s)** | None |

## 1. Introduction

The Safety Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

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

- Good discussion held regarding risk review, with actions agreed to review how those risks are managed, including more owner control over frequency of review, and training issues. ES agreed to take forward discussion at Risk Management Forum.
- Quality Priorities – updates received, including a deep dive on Parity of Esteem. A discussion took place regarding Medication Errors regarding the coherence in timescales between the vision and the training roll out, as reported. Update also received on Deteriorating Patients, and established that this project will not be moving to 'business as usual' and would be followed up offline outside of SQAC meeting. SQAC would receive an update in due course.
- Q3 DIPC Report received
- Monthly ED Activity Update
- Clinical Quality Steering Group verbal update
- Quarter 3 Mortality Report was received, which included an update on the Medical Examiner current position, together with the statistics.
- Safe Waiting List update received, detailing key issues from the RCA, together with current focus on follow up appointments.
- Clinical Audit and Effectiveness Report received. SQAC noted the improved presentation of this report. SQAC will now look forward to see how emerging themes are being identified and actioned, and how the audits will be aligned to strategic priorities going forward.
- Good, detailed discussion held regarding Transition Update, identifying key issues, and agreeing that a 'plan on a page', is required to capture the various strands and to aid continued progress
- Board Assurance Framework
- NICE Compliance summary report, which highlighted progress in terms of assurance with regards to NICE guidelines.
- SQAC Metrics and Divisional Reports
- SQAC 2022/23 Workplan received and supported

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

None

**4. Positive highlights of note**

Positive updates received regarding NICE compliance which highlighted progress in terms of assurance.

## 5. Issues for other committees

Discussion to take place at Risk Management Forum regarding risk review, prior to SQAC receiving an update in due course.

## 6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

# Confirmed Safety and Quality Assurance Committee
## Minutes of the meeting held on
## Wednesday 16th February 2022
## Via Microsoft Teams

| | | | |
|---|---|---|---|
| **Present:** | Kerry Byrne | Non-Executive Director (Chairing today's meeting) | (KB) |
| | Dame Jo Williams | Trust Chair | (DJW) |
| | Nathan Askew | Chief Nursing Officer | (NA) |
| | Robin Clout | Interim Deputy CIO | (RC) |
| | Lisa Cooper | Director – Community & Mental Health Division | (LC) |
| | John Grinnell | Acting Chief Executive | (JG) |
| | Adrian Hughes | Deputy Medical Director | (AH) |
| | Dani Jones | Director of Strategy, Partnerships & Transformation | (DJ) |
| | Beatrice Larru | Consultant, Infectious Diseases | (BL) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Alfie Bass | Acting Chief Medical Officer, Divisional Director For Surgery Division | (AB) |
| **In attendance:** | | | |
| | Mo Azar | Chief Pharmacist | (MA) |
| | Julie Creevy | Executive Assistant (Minutes) | (JC) |
| | Andrew Hanson | General Manager, Division of Medicine | (AH) |
| | Neil Herbert | Head of Nursing & Allied Health Professionals - Theatres, Critical Care & Cardiac Theatres | (NH) |
| | Jill Preece | Governance Manager | (JP) |
| | Kerry Turner | Senior Quality Improvement Practitioner Freedom to Speak Up Guardian | (KT) |
| | Cathy Umbers | Associate Director of Nursing & Governance | (CU) |
| **21/22/104** | Pauline Brown | Director of Nursing | (PB) |

**21/21/186** **Apologies:**

| | | |
|---|---|---|
| Fiona Beveridge | Non-Executive Director (Chair of SQAC) | (FB) |
| Adam Bateman | Chief Operating Officer | (AB) |
| Urmi Das | Director – Medicine Division | (UD) |
| Christopher Talbot | Safety Lead – Surgery Division | (CT) |

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

**21/22/187** **Declarations of Interest**
SQAC noted that there were no items to declare.

**21/21/188** **Minutes of the previous meeting held on 19th January 2022 –**
**Resolved:** Committee members were content to **APPROVE** the minutes of the meeting held on 19th January 2022.

**21/21/189** **Matters Arising and Action Log**
**Action Log**
The action log was updated accordingly.

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

**Matters Arising**

***Quality Improvement Progress Reports***

**21/22/190 Quality Priorities Monthly update**

KT presented the Quality Priorities Monthly Update , which included highlight summary progress reports on the Medication Safety Project and the Deteriorating Patient.

- Medication Errors – local quality improvement work is progressing across the organisation, focussing on key areas that have a high number of medication incidents. KT alluded to the risk in terms of progress regarding the business case which is due to be presented to the Investment Review Group in March 2022.
- Quality Improvement Team are due to work with staff on Ward 4B from week commencing 23rd February 2022, with regards to reviewing Bedside medication verification non-compliance.

DJW questioned the use of 'red aprons/tabards' not making the impact that it should and questioned how zero tolerance with regards to not disturbing colleagues would be addressed. NA echoed DJW comments and advised that it is a culture change which is required, with regards to minimising disruptions in order to empower individuals wearing the tabards to refuse to engage as appropriate. NA advised that there is good national evidence that the use of this intervention does work. NA advised that it would be helpful to revisit this and stated it would be helpful to undertake a re-trial in a different area.

NA expressed anxiety with regards to colleagues placing significant emphasis on approval of the business case and queried whether there is a need to draw out the objectives that are directly impacted by it, and those actions that could continue in the absence of the additional funding.

KT advised that she is aware that progress is being made in this regard and apologised if this was not being clearly articulated. KT confirmed that feedback would be provided to the Quality Improvement Team, and that an update would be provided at the next meeting.

JG referred to PICU, HDU and 4B, and queried if something more specific is required, noting that improvement with medication errors had been made in previous months which is now seeing a plateau.

NA supported JG's comments specifically citing the need for standardised infusions and increased use of CIVAS in PICU, which would have a significant impact on the current levels of medication errors.

KB advised that on review of the reports, it was not clearly articulated regarding whether the Trust is on trajectory/on plan with each of the improvement projects. KB suggested this information could be incorporated into March's report. SQAC agreed that this information should be clearly articulated within future reports to SQAC.

NA confirmed that a refreshed report would be shared at March SQAC meeting, to include progress made, together with detail regarding any slippage against targets, and any reset for next year.

DJW referred to the Deteriorating Patient update and advised that it was not particularly clear within the report whether there had been any progress made, and that it would be helpful to compare against plan, and whether there are any slippages.

KB referred to the specific information regarding a number of the goals and suggested that the medication errors goals needed to be more specific.

KT advised that in addition to the summary provided regarding the Deteriorating Patient, that roll out had been increased to include 4B and 3C, as well as 4C. KT stated that the risk associated with this piece of work related to the current organisational change of the ACT team.

NA stated that irrespective of future team structure there was a need now to ensure that appropriate escalation is in place to enable this to move forward.

JG questioned data relating to 'unanticipated admissions to PICU and HDU' and noted the increase in 'patient acuity', JG requested reassurance from SQAC that there was appropriate oversight, and that trends were being monitored.

NA suggested that the metrics were reviewed, and the future reports updated to address the issues raised. SQAC welcomed review of a refreshed report, in order to redefine and reflect metrics as appropriate.

SQAC **NOTED** that there was no Parity of Esteem project update, and welcomed a deep dive at March 2022 SQAC meeting. SQAC welcomed a refreshed report at March 2022 SQAC meeting.

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

KB expressed thanks to KT & Quality Improvement team.

**21/22/191 CQC Action Plan**

SQAC received and **NOTED** the CQC Action Plan, this item was starred and was not discussed. As has previously been reported, all actions have been completed and the item is now closed.

**Resolved: SQAC received CQC Action Plan, and NOTED that all actions have been completed and that this item is now closed.**

**21/22/192 Quarter 3 DIPC Report**

SQAC received and **NOTED** the Quarter 3 DIPC Report.

**21/22/193 Assurance ED Activity Monthly Update**

SQAC received and **NOTED** the ED Activity Monthly update.
KB referred to the table contained within section 2.1 of the report, which provided an update on the current position to 10th January 2021, KB requested whether the division could provide information which is more current/up to date.

AH advised that the Division had been reliant on data received from the Business Intelligence Team. AH advised that the Division are now able to access more

timely/current data following the production of a daily report which would enable SQAC to review more current and up to data.

AH advised that the ED 4 hour target had improved towards the end of January 2022, and that 80% compliance against the 4 hour target had been reached. Division had seen a reduction in the proportion of patients who were leaving, prior to being assessed, which is a correlation between the two.

KB requested that on the front sheet of the report the wording of the risks referred to be provided, rather than just the risk reference numbers.

**21/22//194 Quarter 3 ED Mental Health Attendance Quarterly Report**

LC presented the ED Mental Health Attendance Quarterly Report for the reporting period 1st October 2021 – 31st December 2021.

SQAC noted the increase in the number of CYP attending, and also the small increase in the referrals to the Crisis Care Team. Regular audits are undertaken to understand the reason CYP may not be referred to the Crisis Team.

For the reporting period, 45 (21%) children and young people were admitted to an acute inpatient ward, which is slightly lower than the previous quarter (35%). The number of children and young people with a length of stay greater than 7 days had increased from 10% in Quarter 2, to 20% in Quarter 3. This increase in length of stay is attributable to the increasing number of young people with an eating disorder that are requiring admission due to their medical needs.

SQAC **NOTED** the actions identified for Quarter 4 (2021/22)

KB thanked LC for update and questioned whether future reports could include trend graphs. KB referred to the 85% which seemed to be the "normal" level of referrals into crisis care and questioned whether this should be used as the 'standard' number of referrals. LC advised that 85% should be the standard, and that this would be monitored as appropriate, this would be incorporated into the report for Quarter 1.

DJW thanked LC for comprehensive detailed report and queried whether postcodes and ethnicity could be included in future reports, LC confirmed that this would be included within future reports. LC advised that previous year's trends would also be included in future reports as an Appendix.

**Resolved:** SQAC received and **NOTED** the Quarter 3 ED MH Attendance Quarterly Report and **NOTED** the improvement actions identified with the Report.

***Clinical Governance Effectiveness***

**22/22/195 CQSG Key issues update**

NA advised that the Clinical Quality Steering Group had met on 8th February 2022, the meeting had focussed on key issues as follows:-

- Discussion took place regarding PALS & Complaints in order to ensure Divisions continue to make progress in improving performance.
- CQSG discussed NICE Guidance, and recognised the significant amount of work completed collating evidence, resulting in improved compliance.
- Zero Tolerance of Racist, Homophobic, Prejudiced, or Discriminatory Behaviour – RM70 policy was reviewed and approved at CQSG.
- Resuscitation mandatory training compliance levels were discussed and it was

noted that Resus are providing sufficient training sessions to staff, however due to competing priorities, the training sessions were not being well attended on a regular basis. Resus compliance is being raised at the Divisional Governance Meetings, and at local meetings, in order to significantly improve compliance across all Divisions.

- NA advised on the commitment to improve the divisional governance processes had progressed, with an agreed simplified statement of roles and responsibilities within divisional and corporate teams.

KB questioned what the current plans are for updating SQAC formally on the work regarding divisional governance. NA advised that he envisaged that a monitoring plan would be presented to SQAC meeting in April 2022.This would be included on the SQAC workplan.

KB thanked NA for CQSG key issues update, and welcomed an update on progress at the March SQAC meeting.

**Resolved: SQAC received and NOTED CQSG Key issues verbal update**
**SQAC NOTED that the Monitoring Plan for the Devolved Governance Process would be presented to April 2022**
**SQAC meeting, and would be a regular monthly report for SQAC to Review, the SQAC workplan would be updated to reflect this.**

**21/22/196 NICE Compliance update on proposed plan**

CU provided an update on NICE guidance compliance for the reporting period 1st January 2022 – 31st January 2022, compared to December reporting period 1st December – 31st December 2021.

- There was a total of 60 NICE publications open during this reporting period
  The divisions and corporate functions had declared substantial progress in month, compared to the previous month.
  Progress position in month, 65.0% - (39) had made substantial progress, compared to 23% in January 2022, in addition 21% - (13) of the overall total had been completed and closed, minimal or no progress equated to just over 13%.

KB queried whether the committee would see the split between those with assessments completed, and those with actions being delivered within the next update at March 2022 SQAC meeting, CU confirmed that this was on plan to present that split in that format.

KB acknowledged the significant improvement made, and highlighted the importance of reviewing the information split.

KB questioned whether the Trust have a direct link, in terms of reviewing action plans and assessment, identifying any risks, and ensuring that any risks arising are contained on the Risk Register. CU confirmed that there are no associated risks on the Risk Register, and that this is currently being reviewed. KB advised that this is a really important step to review and address.

**Resolved:** Divisions and Services to consider whether there are any risks arising from non-compliant areas and add these to the risk registers.

**Resolved** SQAC received and **NOTED** the National Institute for Health & Care Excellence update and **NOTED** the ongoing improvements.

KB thanked CU for NICE Compliance update.

**21/22/197 Quarter 3 PALS/Complaints Report**

SQAC received and **NOTED** the Quarter 3 PALS/Complaints Report.

KB sought clarity regarding how complaints for which the timescales have been extended and agreed with complainants are recorded in the graphs / analysis.

NA stated that that if an extension is agreed and responded to within that agreed timescale that it is counted within 25 days, which is the way that this information would appear within the PALS/Complaints report, NA advised that during the last 12 month period that he had only approved 1 extension beyond timeframe.

KB commented that the quarterly report does not provide information on those complaints raised in previous quarters but closed within the quarter, and questioned if the information displayed could be represented in a different way. NA advised that he did not find the quarterly comparisons useful, and advised that the Team are currently in a process of transition to reporting continuous data, rather than quarterly comparisons.

KB acknowledged that the report is significantly improved, and **NOTED** that this is work in progress.

SQAC welcomed the improved PALS report and **NOTED** that the PALS/Complaint Report continued to be work in progress to further enhance content of the report.

DJW referred to 'template letters' and advised on the importance of personalising and customising responses. NA provided assurance and advised that all complaint letters are fully personalised, with a standardised top and tail which provides information required under the complaints regulations.

KB referenced the MIAA report on their review of the complaints process, which included good and positive responses, which is due to be monitored through CQSG and is reviewed at Audit & Risk Committee.

**Resolved: SQAC received and NOTED the Quarter 3 PALS/Complaints Report**

**21/22/198 Quarter 3 Patient & Family Feedback Report**

SQAC received and **NOTED** the Quarter 3 Patient and Family Feedback report.

**Resolved: SQAC received and NOTED the Quarter 3 Patient & Family feedback report.**

**21/22/199 Transition Update – Compliance with NICE Guideline 43: Transition from children to adults' services for young people using health or social care services**

LC presented the Transition Update regarding compliance with NICE Guideline 43, key issues as follows:-

- Compliance against the self-assessment - Community and Mental Health Division – 100% of services completed, Division of Surgery – 86% services completed, Division of Medicine – 71.5% services completed, with the remaining services to be completed by 28th February 2022.

  Following a meeting with the Chief Nurse and divisional senior leadership teams it had been agreed that each speciality/service would complete their self-assessment, and where possible the specialty/service self-assessments would be completed by the relevant Specialist Nurse.

Following completion of these self-assessments each division would compile a compliance report, and action plan for review and scrutiny via divisional governance processes. These would also be submitted to SQAC for assurance purposes.

**Cohort 1 (age 19-24 years old)**
In 2020, there were 52 young people on the Transition Exception Register (TER). 100% of these young people had transition plans, health information passports, and route into urgent care plans. There are currently 12 young people remaining from Cohort 1. Of the 12 young people, 9 live within the local areas, and all young people have had a community professionals MDT with adult service provider. Plans are in place to transition this cohort of young people during 2022, following an MDT with adult community providers, the young person, and their families.

**Cohort 2 (16-18 years old)**
There are 22 young people in this cohort, 100% of these young people have transition plans, health information passports and route into urgent care plans.

**Cohort 3 (14 -15 years old)**
There are currently 24 young people identified as meeting the criteria for this complex cohort, from a report of 300 complex young people.
A self-assessment had been undertaken against the transition standards for these complex cohorts of young people and compliance against these is 100%.

LC reiterated that these are the most complex young people, and are usually known to three or more specialties.

DJ queried whether any comparisons had been made by colleagues within the Trust to review the impact of Covid on C&YP, recognising the pressures on adult services, and questioned whether there had been any shift or changes, with regards to the number of complex C&YP. LC advised that this was not the case with the complex children and young people.

**Resolved:** SQAC received and **NOTED** the Transition Update, and welcomed Transition Report from Department of Medicine at the March SQAC meeting.

KB referred to the cohort of patients due to transition, who are not included within this current report shared at SQAC (i.e. those patients not classed as complex), and highlighted the importance of SQAC reviewing the entire transition population quarterly. SQAC **NOTED** that Divisions are required to fully contribute/input to the report, to provide service level data on transition moving forward

**Resolved: Divisions to provide their transition data to be included in future reports**

**Resolved:** SQAC to receive Quarter 4 Transition update at May 2022 meeting. SQAC workplan would be updated to reflect.

**21/22/200 Children & Young People with Complex Behaviour (inpatient programme) Closure Report**

LC presented the Children & Young People with Complex Behaviour (inpatient programme) Closure Report, which detailed background information, a summary of the outputs, feedback received from staff on Ward 4C, and audit of pathways. Key issues as follows:-

The programme had driven significant improvement:

- Guard rails had been removed from balconies within the main acute site.
- 5 ligature 'lite' rooms identified on Ward 4C, 3A and 3C, with all works completed.
- All pathways, processes, risk assessments relating to complex and challenging children and young people were reviewed and updated, including ward documentation.
- Development and implementation of mandatory training regarding Mental Health Act, Mental Capacity Act and Rapid Tranquilisation.
- Restrictive practice – 2 annual reports presented to Trust Board regarding the use of restrictive practice, with the third report to Trust Board due in May 2022.
- Contract is in place with a specialist company and during 2021, 11 young people had been supported.
- Mental Health Champion role launched as part of Parity of Esteem work.
- Successful bid for Consultant Nurse Mental Health role via regional winter monies to be recurrently funded via Director Community & Mental Health and joint post with Edge Hill University.
- Successful bid for HCA and Associate Nurse support via regional winter monies to support complex children and young people admitted to Wards 4C and 3A.
- Audit registered and commenced regarding single admission pathway, and use of specialist company, results are not available at present, LC proposed that findings would be shared with SQAC in due course.
- During November 2021 a 'temperature check' survey was completed by Point of Care Foundation with staff on Ward 4C, which demonstrated positive improvements.
- Audit of the pathway, ward process and support provided by the specialist company had been registered with the Trust Audit Team, work is due to be completed by 31st March, with results of the audit being presented to SQAC in due course.
- An annual audit of the pathway, processes and staff feedback would be undertaken as part of the medical vision's audit programme, and reported to the relevant divisional audit group.

KB acknowledged the positive improvements made, in ensuring that the Section 31 Notice was lifted rapidly. KB highlighted the importance of the annual audits, and ensuring appropriate feedback, to ensure staff continue on the ongoing/continuous improvement journey.

DJW echoed KB comments, and welcomed the positive progress made. DJW reflected on the importance of enabling colleagues to think about the place for these children within Alder Hey, and whether Covid would enable all staff to reflect on the importance of mental health support for C&YP through appropriate communication channels. LC welcomed and supported DJW comments, and referred to Parity of Esteem, in mental health services, and the organisation recognising that it provides mental health services, and having pride in its mental health services, and colleagues realising that this is a key component. LC referred to positive improvements made and stated that next steps are regarding how to support patients and colleagues within those frameworks.

JG thanked LC and colleagues for the outstanding report, which clearly detailed good practice, with good disciplines, JG commended LC for her exemplary leadership.

NA referred to Parity of Esteem, and stated that when referring to children and young people with a mental health need, those colleagues often refer to those children and young people in an acute environment, and that it is important to remember that the real cultural change within this programme is picking up the 12 year old who is admitted for physical health care, and ensuring their emotional wellbeing is also met.

SQAC received and **NOTED** the contents of the Children & Young People with Complex Behaviour (inpatient programme) Closure Report, and **NOTED** the improvements made in the care provided to complex and challenging children and young people who are admitted to the acute hospital.

***Well Led***

**21/22/201 Board Assurance Framework**

SQAC received and **NOTED** the Board Assurance Framework.
ES advised that an update would be provided by AB at the next SQAC meeting regarding the closed risk number 1.6 relating to CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of Covid.

**Resolved: SQAC received and NOTED the Board Assurance Framework, and would receive an update on closed BAF Risk 1.6 from AB at March 2022 meeting.**

**21/22/202 Divisional Reports by exception/Quality Metrics**

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

- 4 children had been detained under Section 3 of the Mental Health Act within the last 12 month period.
- PALS remain low, with 30 PALS (department have previously received numbers in high 80's/90's), previously relating to ASD/ADHD.
- Division continues to receive significant increase in referrals,(98% increase in January 2022, compared to January 2021). With calls to Crisis Care higher than in previous year.
- Division is compliant with the urgent waiting time standard for eating disorders, and the Division had received the investment for ASD/ADHD.

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

- The Division of Medicine had **NOTED** improvements in ED standards.
- Ongoing challenges regarding pressures with Radiology reporting times for cross sectional imaging scans, currently 3-4 weeks on reporting turnaround, against the standard 2 week reporting.
- Diagnostics – sleep studies, the Division are working with C Grimes to explore the use of new sleep equipment, which is coming onto the market in May 2022, which would increase sleep study provision.
- Sepsis – ED Sepsis compliance had decreased to 78% in January 2022. Regular meetings are taking place within ED to review all patients who had exceeded the 60 minute target to ascertain whether there are any contributory factors, other than clinical factors. There had been no incidents of harm recorded.
  AH advised that he is awaiting receipt of full report to see what the actions are.

  KB advised on the importance of SQAC receiving a detailed report/update on sepsis at March 2022 meeting. NA advised that the delivery of this target is frontline workforce responsibility on a day to day basis.

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

- Division had seen a decrease in PALS/complaints, and had been working hard to address timescales, in order to reduce response times for PALS/complaints.
- Challenges regarding reduction in theatre capacity, mainly driven by workforce issues and Omicron variant, which had resulted in increased waiting times.
- Division had a slight deterioration with regards to 52 week waiting times, due to the

reduced schedule in January 2022, although this is planned to go back to normal activity levels of 139 sessions per week from the end of February 2022.

- Division had 1 severe permanent harm which related to a Grade 4 pressure ulcer on PICU, RCA level 2 is currently being undertaken, patient was a PICU patient with Grade 4 pressure ulcer, extremely sick patient on ECMO and oscillator, Division have already implemented a number of key actions.

KB welcomed reviewing output from RCA through the SIRI report.

KB referred to the staff attitude in many of the FFT and PALS responses and recognised that this referred to very small members of staff. KB referred to any actions regarding staff attitude. NA stated that there is a fundamental corelation regarding staff attitude, and parents deciding to raise a PALS or complaint. NA advised that the usual process is to follow up with the staff member involved, and to carry out either verbal or written reflection.

KB referred to the 'management action' column in the report and stated that this is generally just a statement of fact rather than an action and questioned whether this could be improved upon. NA confirmed that this would be reviewed.

DJW requested that the Exec Leads information be updated as appropriate, given that the previous CMO's name is still included on the report. NA confirmed this would be actioned.

KB thanked the Divisional Leads for the Divisional updates.

Committee **NOTED** the pressures across each of the Divisions within services, resulting from high clinical workload, coupled with staffing issues.
KB welcomed Divisional updates and thanked colleagues for updates.

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

**21/22/203 Review of SQAC Terms of Reference**

ES presented SQAC Terms of Reference, ES advised that the language within the Terms of Reference had been changed within some of the sections. ES stated that SQAC require 3 Non-Executive Directors, this issue would be addressed in the future, following recruitment process. ES confirmed that the Terms of Reference had been robustly reviewed by her and NA.

KB queried whether the governance team have cross referenced from the ToR to the workplan. It was agreed that this will be undertaken with any significant findings to be updated to FB from ES.

SQAC received, **NOTED** and supported the SQAC Terms of Reference.

**21/22/204 Hospital Visiting Policy – C25**

SQAC received C25 – Hospital Visiting Policy, which had been reviewed and updated in line with Covid guidelines and Covid visiting.

**Resolved: SQAC received and RATIFIED C25 – Hospital Visiting Policy.**

**Zero Tolerance of Racist, Homophobic, prejudiced, or discriminatory behaviour – RM70 Policy**

SQAC received RM70 Policy and were asked to ratify the policy.

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DJW strongly supported the policy.
DJW referred to the VIP Policy and requested whether the term 'VIP' could be worded in a slightly different way, given that all who visit the Trust are VIPs.

KB welcomed and supported the policy, and thanked PB for such a comprehensive policy.
KB expressed the view that Trust policies are generally extremely lengthy, and questioned how realistic it was to expect such lengthy policies to be reviewed by staff, should policies comprise of 30-50 pages of narrative. PB advised that she had tried to keep the policy as short as possible, and that the quick reference guide, together with the hyperlinks would be helpful to colleagues to bookmark sections.

**Resolved: SQAC Received, NOTED and RATIFIED the Zero Tolerance of Racist, Homophobic, prejudiced, or discriminatory behaviour – RM70 policy.**

**21/22/205 Any other business**
None.

**21/22/206 Review the key assurances and highlight to report to the Board**

Positive updates were received regarding:-

- Quality Priorities, with sustained progress made in month for Medication Errors and Deteriorating Patients with good level of assurance provided. DMO report to be shared at March 2022 meeting.
- NICE compliance position
- Transition progress made with the Complex Cohort, and it was agreed to look at whole transition population
- Complex Children & Young People with Complex Behaviour Closure Report relating to Section 31 Notice
- Divisional updates, and recognition of pressures which all of the Divisions are under, with good progress being made.

**21/22/207 Date and Time of Next meeting**
23rd March 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS

## Thursday, 31st March 2022

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| **Paper Title:** | **People and Wellbeing Committee** |
| **Date of meeting:** | 22nd March 2022 – Summary<br>15th February 2022 - Approved Minutes |
| **Report of:** | Fiona Marston, Chair |
| **Paper Prepared by:** | Amanda Graham, PAW Committee Administrator |

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| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 22nd March 2022 along with the approved minutes from the 15th February 2022 meeting. |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ☐<br>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<br>BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3<br>BAF 2.2 - Employee Wellbeing – current risk IxL: 3x3<br>BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4 |

1. **Introduction**

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

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

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

- People Plan
- Staff Survey 2021
- Appraisal System
- Gender Pay Gap
- Corporate Report Metrics/Workforce KPIs – February 2021
- Board Assurance Framework/Key Workforce Risks – February 2021
- Minutes of Sub Committee/Working Groups reporting to the Committee
    - LNC – 08.12.21
    - JCNC – 25.01.2022

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

- The Trust's People Plan has highlighted a number of areas of potential risk; despite a drop in sickness absence rates, there is an increase in Covid-related sickness & underlying mental health / stress concerns; concerns around domestic violence and financial wellbeing, for which a specific Task & Finish group is being set up to review the latter with support from an external organisation – this group will report to the committee regularly.
- The Staff Survey demonstrated 32% from a response of 52% said they suffered burn-out / stress

4. **Positive highlights of note**

- Good focus is on menopause-related wellbeing concerns to support staff and managers
- Communications plans include a revision of the Intranet and website. The team were thanked for their work on the webinar for the UN Anti-Racism Day
- Staff Survey showed the Raising Concerns question had the most improved result
- Results from Staff Survey data will be cascaded through Divisional leadership teams and shared with every team of 11 or more staff, showing their team rating against the organization and outlining their action plan
- People Pulse report gives a view on what is impacting staff
- Proposed changes to the Trust's appraisal system for non-medical staff were approved, giving the go-ahead to undergo a refresh of paperwork with an extended window and consideration being given to moving to an electronic process
- Recommendations put forward from the Gender Pay Gap report were approved to be taken to Trust Board and will be reported on quarterly
- *Time to Hire* target of 40 days within the Corporate Metrics is to be reviewed for the April meeting, with possibility of being reduced in May
- Health & Safety dashboard was shared for the first time and will be shared quarterly.

5. **Issues for other committees**

Effectiveness of the new Health & Safety dashboard is to be reviewed from an SQAC perspective to ensure the data given is relevant and informative for committees.

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 15th February 2022**
**Via Microsoft Teams**

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| **Present:** | Fiona Marston | Non-Executive Director (Chair) |
| | Fiona Beveridge | Non-Executive Director (Deputy Chair) |
| | Melissa Swindell | Chief People Officer |
| | Mark Flannagan | Director of Communications & Marketing |
| | Erica Saunders | Director of Corporate Affairs |
| | Dot Brannigan | Governor |
| | Ian Quinlan | Non-Executive Director |
| | Rachel Greer | ACOO – Community & Mental Health |
| | Rachel Hanger | Associate Chief Nurse - Surgery |
| | Cath Wardell | Associate Chief Nurse – Medicine |
| | Mark Carmichael | Associate COO – Medicine |
| | Jacqui Lyons-Killey | General Manager – Research (deputy) |
| **In attendance:** | Sharon Owen | Deputy Chief People Officer |
| | Jo Potier | Associate Director of Organisational Development |
| | Ayo Barley | Head of Equality, Diversity & Inclusion |
| | Maria Salcedo | HRBP - Surgery |
| | Clare Shelley | Associate Director of Operational Finance |
| | John Chester | Director of Research & Innovation (Part Attendance) |
| | Amanda Kinsella | Head of Health & Safety |
| | Jackie Friday | Executive Assistant (Minutes) |
| **Apologies:** | Nathan Askew | Chief Nurse |
| | Jason Taylor | Acting Associate COO - Research |
| | Lisa Cooper | Director of Community & Mental Health Services |
| | Katherine Birch | Director – Alder Hey Academy |
| | Adrian Hughes | Deputy Medical Director |
| | Alfie Bass | Deputy Medical Director |
| | Pauline Brown | Director of Nursing |
| | Phil O'Connor | Deputy Director of Nursing |

**21/22/92** **Declarations of Interest**
Fiona Marston – Liverpool School of Tropical Medicine

**Introductions**
None received.

**21/22/93** **Minutes of the previous meeting held on 18th January 2022**
**Resolved :** The minutes of the last meeting were approved as an accurate record.

**21/22/94** **Matters Arising and Action Log**
No matters Arising. The action log was updated accordingly.

**Trust People Plan 2019-2024**

**21/22/95 People Plan**

The Committee received the People Plan Update Report. MKS invited JP/SO to share highlights from the report, not covered by agenda items:

JP acknowledged some of what she mentions may be picked up in other agenda items (i.e. staff turnover issues/Staff Survey results). In terms of OD, SALS are seeing an increased number of requests for support for teams where they are experiencing higher levels of tension in teams/conflict.

JP advised of a new staff support pathway that has been put in place, now operational. All referrals for staff support now come through SALS. Previously staff counselling referrals were progressed via the Alder Centre. This transition has gone through smoothly and has helped reduce waiting lists, via a more tailored offer of support.

JP shared that the SALS PALS project has moved forward (part of the winter plan to offer increased support to high pressure areas). Following a bid, NHS England who are funding the pilot, have agreed an extension. An Assistant Psychologist has been recruited to drive this work forward.

FM referred to increased workloads of the SALS team and asked what the impact of this is. JP advised that SALS have now become well known for being the first point of contact (i.e. referrals numbers for Alder Centre for January was just 11). These numbers do not represent a huge shift in SALS workload. Also SALS has access to other resources that are available i.e. the Regional Resilience Hub, this enables people to gain access to different types of psychological support as well (not just provided by SALS). JP added SALS are generally busier but not sure it's all traffic that would have gone through to the Alder Centre.

FM referred to the numbers going through SALS and suggested the Committee is kept sighted on this.

FM referred to trends, underlying breakdowns and facilitated conversations and asked if this will be explored further when we hear about the Staff Survey. JP described it as multi-faceted – i.e. anecdotal conversations, talking to other people – people feeling tired (burnout figures identified through the Staff Survey are quite high) and exacerbated by Covid. The Committee reflected on current external influences also taking place at the moment that impact on the pressures on people and acknowledged it was hard to quantify/measure this.

MF referred to the re-introduction of the Reward & Recognition piece of work in relation to wellbeing, whilst currently not funded, this is something that is being discussed at Execs and RABDC this week. It was agreed this will be discussed further by the Committee when support is put in place.

Following JP's update, in relation to the sickness absence position - SO highlighted that SALS and the HR team work quite closely together/joined up approach with the aim to triangulate the position. Sickness is seeing a downward trajectory, hovering around 7.5% for total sickness which includes Covid. Sickness absence has presented for some time now as largely attributable to stress, anxiety, depression and this links into JP's earlier points. Also seeing some additional anxieties on the back of vaccination as a condition of deployment (VCOD), whilst acknowledging the government proposal to revoke the regulations on 31st January. This has impacted on teams and created some division, with managers having to have difficult conversations

that they wouldn't necessariily have had to have. The effect of this will still be seen in the coming months. SO noted we should be mindful of this impact. HR is working quite closely with all the divisional leads to help support staff.

FM advised it is interesting to see that common theme and the reasons behind it.

**Resolved: PAWC received and noted the update of the People Plan**

**21/22/96 Staff Turnover**

MKS advised the report issued in the pack was produced as a direct result of conversations that have taken place at the last two Committees for a review of the data relating to Staff Turnover. Included in the data are the various reasons behind why people are leaving the Trust and the increases/decreases seen for staff turnover for 2020 and 2021. Highlighted as follows:

SO shared an overview with comparisons of Trust Wide Turnover for 2020 to 2021 (internal KPI is set at 10%). 2020 shows we are below 10%, with 2021 showing an upward trajectory from May-December 2021 (over the threshold of 10%). During 2020 there were 442 leavers in year, compared to 2021 with 405 leavers. SO shared that Medical & Dental, Additional Clinical Services and Nursing and Midwifery had the highest number of leavers over 2020-21.

Of the 405 leavers in 2021 only 50 of them completed an exit interview questionnaire – this represents 88% of leavers who did not provide the Trust with feedback on their experiences of their employment – a missed opportunity. SO shared the themes of the feedback received (both negative and positive).

In relation to immediate actions and 'next steps' - SO advised - as a team, there are a number of key actions that have been taken away from this that subsequently will need to be put in place. HR Manager KJ is going to lead on this piece of work on an ongoing basis and review the process of recording, monitoring and reporting of turnover. Promotion of the Exit Interview will be focussed on, with a revised and streamlined Exit Interview SOP put in place and also a more detailed analysis and sharing of data, which can also be used to inform workforce development plans. An update on this piece of work will continue to be brought back to the Committee.

FB commented that it is great to see this first report and receive insight into what is taking place and the plans to improve the quality of the data going forward. With turnover being such a significant part of work in HR it is really helpful to see this kind of focus. FB paid thanks for producing the report.

JP thanked SO for a great report. In relation to exit interviews - JP queried is there is an option in the system for leavers to hold their interviews with an alternative colleague to their line manager. SO confirmed that offer is available and has been factored into processes, the HR Business Partner can step in as an independent person to do that.

AB thanked SO for a really good report. AB referred to the report, in particular the information that was broken down by division where disproportionate issues around turnover was honed into. AB wondered if something similar around protected characteristics in terms of EDI could be produced, to enable any particular issues that could be indicators to be pulled out. SO agreed this could be done.

RH shared that it was great to see this kind of detailed level of information divisionally and suggested it would be helpful to receive a quarterly report (specific areas with specifically high turnover along with consistent feedback from leavers behind that). It

would really help the divisions to drill down into any cultural issues that may be going on in an that area or some things that we don't hear about via other routes i.e. freedom to speak up or 'raise it change it'. It would be useful to see that cross section of a wider picture. SO advised she is happy to do that.

FM thanked everyone for the really good comments/points raised. FM wondered if the report should be produced quarterly for now, for review in about 9-12 months time. Being conscious of adding to people's workloads around producing reports, FM suggested a slide deck with a breakdown of figures that we can talk to at the Committee, rather than a narrative report as this type of information lends itself to being produced visually and graphically. SO agreed.

JP referred to the Staff Survey data – the increase of people who are thinking about leaving – JP shared a reflection around the possibilities of having a 'thinking about leaving interview'. JP added often you get to an exit interview and hear lots of things that if they had been remedied potentially the member of staff would not be leaving (encourage conversations to stay).

FM commented that it was a good point and highlighted mechanisms put in place by SALS i.e. ED have their Wellbeing Wednesdays, Ground Truth Tool, where we can make sure that we incorporate those kinds of discussions.

MKS confirmed the importance of this piece of work and was happy for it to come back to this Committee on a quarterly basis and acknowledged there is lots of learning to take forward here, particularly the point raised by JP around opportunities to stop people leaving. MKS advised that turnover has never been an issue in the past, but is becoming more of an issue of late, this report is timely. Each quarter we will learn something new, so it is probably pertinent to keep reporting on a more regular basis.

ES referred to JP's point (thinking about leaving) in relation to the PDR process. ES suggested we need to remind and encourage managers to use the opportunity to chat about peoples aspirations in relation to their careers and future plans particularly in the context of what JP raised around how people are feeling at the moment.

JLK thanked SO for a great report and advised that the Research Division can certainly take some learning from this going forward. JLK wondered if this Committee would like to hear from someone who has left the Trust (staff story - similar to a patient story at other forums). Would it be helpful to hear why they made a decision to leave to inform quality data. The Committee recognised this was an interesting idea and deliberated on how this could be expanded. SO acknowledged that it would inform quality data and tell us something more meaningful and agreed to give it more thought as to how it would be incorporated within the report. FM suggested this was added to the action log to think about how the idea might be captured.

FM acknowledged it was a good report that stimulated lots of discussion and thanked SO.

**Action 21/22/96 – Staff Story – idea identified as part of Staff Turnover - think about how we may capture this going forward - SO**

**Resolved: PAWC received and noted the update on Staff Turnover**

**21/22/97 Staff Survey**

The Committee received a report from JP, along with the Trust's summary report and the Trust full report from the Survey Provider - Quality Health. An embargo is in place on sharing the results externally of any survey results from the benchmarked analysis in the reports but we are free to use this data internally until national results are published centrally. MKS asked JP to share the highlights:

JP advised that the new version of the Staff Survey is put together well and is organised around the 'seven People Promises'. The paper produced by JP shows where Alder Hey have fared against our comparators. The headlines are that there is so much there to celebrate, whilst acknowledging there have been some challenges. Alder Hey has scored above average on almost every indicator, with very few areas where Alder Hey is faring worse in the sector. Particular areas to celebrate are: 'We are compassionate and inclusive'; 'We are recognised and rewarded'; 'We each have a voice that counts'; 'We are safe and healthy', and 'We work flexibly'. The remaining two People Promises are in line with the sector scores. JP acknowledged this is a massive achievement in these times when everyone is tired – it gets harder and harder to be kind to each other. Some positive comments around diversity and equality.

In comparisons to ourselves – JP advised there is a decline in almost every area from last year, but the majority have not seen a significant decline. Apart from sharing and celebrating these results, one of the recommendations links to the piece of work taking place relating turnover and understanding the reasons behind this issue, also burnout and the need to keep the focus on health and wellbeing (add to weekly briefings). JP added that she and AB have had a helpful conversation about the higher reporting of staff who experience discrimination. It is coming out generally as an indicator, but particularly in relation to disability. There is definitely work to do around this in relation to establishing a Disability Network to take this forward (identified at the Disability Listening events run through SALS and feedback to AB). Relatively lower scores received for appraisals (not about whether they have taken place, more about whether it helps people to do their job better) – the types of conversations we're having may need to alter as so much else has changed.

FM questioned what happens with the data and how do we celebrate it.

MKS advised the data received hasn't yet been shared but will be as part of the briefing. A Trust wide action plan will be put in place with data shared with divisions, with departments being able to take some local actions. MKS referred to MF and the Comms Team to help with interpreting the data in a way that makes sense to staff and is sensitive, whilst celebrating the positives. MF confirmed this action is on the 'key message calendar' for two weeks time (planning will need to commence w/c 21st February).

MKS stated that a definite date has not been confirmed for when the national results are to be published centrally.

FM reflected that we would obviously want to celebrate all the positives. FM queried that as part of the publicity are there positive ways in which we can show that we are addressing the things that are still challenging within the Trust (acknowledging what we need to improve, but in a constructive way).

MKS agreed with that stance. MKS reported that the Trust has been really open over the last few years with those areas that need support. All of this needs to be included in the communications to staff.

ES highlighted to the Committee the importance that the regulator places on this data and how far they use it in when making their assessments in the well led domain and advised we need to be mindful of that. ES echoed MKS's sentiments about being scrupulous about developing our action plan in relation to this and making it as meaningful as we can. Once published nationally this will be discussed with our regulators at the next engagement meeting.

AB reflected on some of the feedback, particularly around discrimination in relation to disability. AB is aware of the Listening sessions (following meeting with JP and the Team). AB shared she will be meeting with the emerging disability group as well. AB advised the disability group are really calling out for some senior support and a real structure for moving that work forward. To provide assurance to this group (prior to publication nationally of the Staff Survey) AB wondered whether it would be beneficial to reach out to key members before that, to look at what structure we could provide to provide some support round that group. AB referred to the work happening with the BAME Task Force/Network and MKS's sponsorship of that group and the desire of the disability group to move in a similar direction. MKS and AB agreed to meet to discuss further, with the possibility of sharing progress at the Staff Survey Comms rollout.

**Action 21/22/97/1 – Produce overarching Staff Survey Trust wide action plan – MKS – March 2022**

**Action 21/22/97/2 – Disability Network – look establish Network and reflect in Staff Survey Comms rollout – MKS/AB – March 2022**

ES referred to the Staff Survey and inclusion of a summary of the narrative that had been included in the past and questioned if that is not included anymore. JP confirmed it wasn't included last year but thought it may be included this year (included in directorate level report, yet to be received). JP advised that the narrative was useful and informed a thematic analysis completed couple of years ago. JP to ask the question.

FB reflected on the timeline challenge of this big piece of work and suggested some of the broader conversations need to have taken place first within the divisions (breakdown of results to be discussed within the divisions and agree what actions are required more broadly) prior to agreement of high-level corporate actions. FB advised it would be good to see what those broader actions are going to look like in a way that we can track and monitor their implementation.

MKS confirmed the divisional breakdown of data had not been received as yet – expected end February, but this date may be delayed. MKS suggested signalling as an organisation what we know we want to work (high level areas of focus), with a view to building the divisional information into it once it is received.

FM confirmed that we will have to be guided by what information we currently have. FM suggested we can look at this at the next meeting in relation to how we are sharing/celebrating how we are communicating our actions around some of the key issues with staff.

**Resolved: PAWC received and noted the update on Staff Survey**

**21/22/98 Vaccine as a Condition of Deployment (VCOD)**

The Committee received a verbal update from MKS. MKS advised that the Government have signalled their intention to revoke the VCOD legislation subject to full public

consultation and new scientific evidence, The public consultation has commenced and is open until 16th February and they are encouraging health and social care staff to comment on that public consultation.

MKS advised that all activity around this has been paused, awaiting further guidance from the Government. Advice given to managers is to have a conversation with staff impacted by this and any comms to managers is being managed. MKS alluded that the last couple of months had been a difficult time for HR & the Trust. As soon as further guidance comes through it will be shared. The communication/message to staff is still to encourage uptake of the vaccine were possible. FM thanked MKS for the update.

**Resolved: PAWC received and noted the update on VCOD**

**21/22/99 Communications Update**

The Committee received the regular update report from MF. MF advised a more detailed paper will be issued to the Committee following this meeting - Marketing & Communications Delivering our Strategy/Key Delivery Items 2022. This paper pulls together all the corporate delivery strands of Marketing & Communications for this year. Highlights of this report are:

- A new cascade process has commenced – alluded to in terms of the planning of key messages – a rhythm and routine of sharing and embedding information to staff across the Trust.
- New intranet – conversations and surveys around design and functionality have commenced and will continue into the summer – to be rolled out in due course.
- Appointed a Green Project Director on a contract, joining the Trust next week and will be looking at things like a travel plan and numerous other 'green' initiatives to benefit the Trust.

Future progress will be shared with the Committee. FM thanked MF for the update and confirmed it would be good to receive future updates.

**Resolved: PAWC received and note the Communications Update**

**Governance**

**21/22/100 Corporate Report Metrics – December 2021**

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

**Trust Metrics**

**Community & Mental Health –** RG shared highlights – PDR rates remain broadly the same, more focus will come in when we move into 2022-2023 PDR year. Mandatory Training rates have been maintained above 90%, as confirmed last month this is a real focus in the division, with regular updates circulated to people who have slipped below 90%. PDR's rates are also discussed at all divisional meetings. Sickness absence rates did peak in January at 6.4% overall but pleased to report they have come back down as we move out of the Covid acute phase. Now much lower at about 4.5% across the division. Some improvements have been seen in

return-to-work rates, again this has been picked up as a focus as the division moved into the new year, encouraging teams to have those conversations regularly and also in a timely way. Turnover rates are just below where they have previously been at 10.55%. RG found the presentation earlier interesting and would be keen to see what that looks like across the division, particularly in terms of where and why people are leaving and where they go to. The division has got some areas where they would like to get underneath that data as the division continue to recruit lots of staff, so the more that is known will help support processes around this.

FM acknowledged it is really encouraging to see the change in sickness numbers.

**Corporate** – MKS referenced the position in the absence of a representative. Sickness is quite high in Corporate at 7.12%, there is work to do on returns to work at 66.67%. MKS referred to previous discussions about how we get into the rhythm of reporting on Corporate and how we may do that affectively. MKS acknowledged this is a challenge as no particular area is responsible for this and this will need to be worked through with the 'heads of' as to how this will be done going forward.

FM suggested that maybe it's a shared responsibility. Encourage people to come and report on an intermittent basis, take turns. ES shared her thoughts and advised she would probably choose to use a risk based approach in terms of Committee reporting, via exception reporting for different areas (massive range across Corporate, with some teams being quite small and with differing issues across different types of departments).

FM confirmed this will be left with Execs to decide how to move forward. FM acknowledged the way this data is presented at this Committee is really good but recognised in relation to Corporate some of the underlying themes could be missed by looking at the data in this way and some sort of verbal update would be quite helpful.

**Medicine Division –** MC shared a summary – some improvement in terms of PDR at 74.5% compliance and the division will continue to encourage that upward trend in compliance moving into the new financial year. Mandatory Training has plateaued with a slight decline, a number of actions have been taken i.e. written to every member of staff who shows red for training. Although a number of staff have just returned from maternity leave so that's given the division pause for thought in terms of how that is supported (i.e. kit days, maternity leave induction, refresh before they work clinically). Sickness was a real cause for concern in January in a number of areas i.e. four main medical wards and ED had significant absence related to coronavirus. This has improved similar to Community, have seen steady improvement particular in ED with less than 50% of what it was in January in terms of absence. There are still some pockets of concern and work continues with JP and the SALS in terms of supporting those teams and supporting individuals. Return to work has seen rapid improvement and the division will continue to push forward on this. The division is receiving weekly reports which are then shared with senior/clinical managers in the division with hope of achieving 100% and maintaining that. There is a worrying decline in turnover (which was noted at the last meeting) and would welcome a more detailed report similar to Surgery and Medicine to understand those hotspots. In terms of assurance, these metrics are now being used at a subgroup of the Divisional Board and the divisions care groups/speciality groups are reporting upwards in terms of the more drill down performance so that when hot spots occur, they can be identified. This information will go live in the divisions people group in the month of March to try and get the two-way conversations underway and performance metrics embedded in the divisional business.

FM shared that it was a good overview and highlighted that long term sickness seems to be the theme that we are seeing in a number of other reports that have been talked about so far and that could be looked into. FM wondered if the huge leap in return to works was associated with quite a few people returning from maternity leave. MKS clarified that the return to works increase were in relation to sickness returns not maternity and recognised it was a brilliant achievement by the division. FM thanked MKS for the clarification and agreed it was a great achievement.

**Research & Development Division** –PDR's have seen a reduction in year, impacted by the number of staff leaving. It is hoped to see an increase once the new PDR season comes into effect. Mandatory Training is above target at 92.1%. Sickness in month has reduced in the last couple of weeks, short term impacted by Covid, but now seeing returns. JKL assured the Committee that there are only two or three people on long term sick. Staff are kept in touch with on a regular basis to try and support them back into work as soon as possible and some return-to-work dates have been set.

In relation to return to works an education piece is needed in the Division for all managers across Research. Confident that they are being completed and staff are having supportive conversations. In terms of inputting that data onto ESR, they are not being input within the window of 72 hours, largely because some people who return to work will return to annual leave before they actually come back on shift. This will be rectified following the education piece of work around the 72-hour window, so confident this will be increased.

Staff turnover – is concerning – face to face exit interviews have been put in place for those members of staff as receive more meaningful data, rather than just an exit questionnaire. There has been only one negative exit interview, with the others being quite positive in terms of staff enjoying the time working in the divisions. Reasons for leaving range from receiving promotional roles doing a similar job in another Trust and we haven't been in a financial position to offer the same. More so in this division is the ending of fixed term contracts. With Covid, commercial studies have seen a reduction as being paused by sponsors and has impacts on finances and the ability to offer contracts. A piece of work is taking place around this. Also the division is looking at a restructure to support career progression in line with the bigger divisions. JKL acknowledged the increase in turnover in January was due promotional roles being sought within the data team/clinical team and notice periods (four weeks/eight weeks) falling in the same month. This is currently being looked at, so the division are assured that is the only reason underlying the increase.

FM thanked JKL for a helpful update. JC drew attention to the impact of fixed term contracts on turnover – suggested somehow that this figure is broken down further (a % that excludes fixed term contract ending) to support focus on the real issues. MKS deferred to SO and asked if we can do this on ESR. SO confirmed that ESR would give us the reason why every individual has left.

AB referred to her background in terms of higher education and discussions around fixed term contracts and turnover. AB commented there is some interesting insight around who is more likely to be on fixed term contract in terms of protected characteristics. AB asked if there was any opportunity for her to contribute or have a look into that side of the data particularly when you are looking at restructures and staff progression. AB advised It would be interesting to have that insight as well to see if we have any disproportionate figures that could potentially impact people's

progression based on whether they are on fixed term contracts and why they might be more likely to be on one than other people as well. JLK agreed to liaise with AB in relation to taking the restructure forward. FM referred to support in the chat. MKS commented it was a great idea for across all divisions AB.

FM referred to the missing Innovation data and recent correspondence with the Innovation Director and advised it would be good to incorporate that data in this report, to be addressed outside of this meeting. MKS/JC agreed this can be addressed.

JC alluded to previous conversations at this Committee where it was agreed to fuse Research & Innovation information metrics – JC approves this stance and referred to a bit of confusion amongst the Innovation Team about what the intention was. JC advised they will try to get onto this in time for the next Committee. FM noted that fusing the data is really a more practical solution. It has no reflection on anything else in the organisation. When you have such a small group as R&D/Innovation reporting individually, you start to get some skewed figures when you look at percentages. Actually bumping up the R&D numbers by including Innovation makes sense because we receive a truer picture of what is going on. JC agreed and thanked FM.

**Surgery Division –** RH shared a summary and referred to the PDR's window as being stuck between cycles, so if the division push forward now to increase, they would always be out of the PDR cycle. The teams are continuing with 1:1's but waiting to fall into the window again to arrive at compliance. Mandatory training, RH acknowledged a refocus was required. When you look behind the data 6 of the medical teams are below 80% (2 below 70%), so this skews the whole data. The divisional director is looking at writing to medical teams to look at resolving. In terms of assurance the only metric that is sitting below 80% compliance for the whole of the division is manual handling but recognised this was because of the gap caused by not having a key trainer. For ward managers mandatory training is looked at monthly as part of challenge board, this has seen compliance almost doubled in some areas since we have had a real focus on it. Going forward the division needs to look at how we support medical colleagues to find the time to complete their mandatory training as well.

In terms of sickness – ongoing overview – making sure that teams are really managing long term sickness and they are giving the right support in the right place and managing people through the phases appropriately. RH shared she had looked at return to works prior to Committee as to whether or not we have a weekly reporting on those areas of the lowest compliant with their return-to-work documents. Lots of conversations have taken place repeatedly with teams about increased compliance with this documentation. RH confirmed it would be good to have the data for specific areas that need more support and focus, or the reasons or blockers to getting that data to where it needs to be. Staff turnover/exit interviews referred to in the wider report it would be interesting to see that data split across departments to help in understanding if there is a specific area issue or whether it is more broadly spread throughout the division.

MS added in terms of what RH has communicated in relation to low KPI's for return to works. One of the factors has been that we have long term sickness/absences within the HR team in terms of helping and supporting with those return-to-work figures. HR are doing a piece work around working closely with managers – also sharing some support in terms of the HRO's within team. There is going to be a real targeted effort on improving that return-to-work figure going forward. MS advised some positives

coming through in terms of improved 'time to hire' KPI's and also a reduction in complex employee relations cases. MS shared that as reported at the Quarterly Performance Review Meeting – despite maintaining the elective programme on reduced theatre capacity – despite difficult times with coronavirus and a difficult Christmas and January the division were very pleased with the performance of the overall division across the quarter.

FM thanked MS/RH for sharing a helpful overview.

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

**20/22/101 Board Assurance Framework – December 2021**

The Committee received a full BAF report for December and supporting documentation , noted as read. ES shared a couple of observations – included in the report is the mapping of the risk from the corporate risk register for our people objectives – all relating to workforce sustainability. ES advised that these are the individual risks that were discussed at the Risk Management Forum and it is good for this assurance committee to have sight of this to raise any particular questions.

In relation to the main strategic risks, ES referred to conversations earlier in the meeting about the temperature in the organisation on how people are feeling coming out of the pandemic/ongoing issues and whether we need to have a look at the score around that. ES suggested her and MKS can chat outside of the Committee about that.

ES reported that she and AB had a helpful conversation about the EDI risk. AB is going to have a look at that, particularly around the gaps in assurance. This should be ready around April as AB will need to do her baseline look at what is going on in the organisation first. AB confirmed it was a useful meeting and will report back once she has had a look around what Alder Hey and the other Trusts are doing. AB looks forward to working with ES on it.

FM welcomed the work taking place particularly around the 3 areas that are relevant to this Committee and thanked ES for the update.

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

**21/22/102 Policies**

The Committee received the following policy and Equality Assessment for formal ratification/approval. In the absence of PB, MKS advised both policies have been through the relevant processes in terms of consultation.

**Smoke Free Policy- Pauline Brown**

MKS confirmed it has been through various groups and been approved at the Health & Safety Committee on 10th February 2022. The quick reference guide on the front of the policy outlines the approach to how we are managing smoking on site and the responsibilities of staff, contractors, parents etc. MF shared that he had been working with PB and the Volunteers on the Comms plan (to be rolled out March/April) to assist staff enforcing the policy at the Trust.

**Resolved: PAWC received and ratified the Smoke Free Policy**

**Zero Tolerance of Racist, Homophobic Prejudiced or Discriminatory Behaviour Policy**

MKS paid credit to PB for leading on this piece of work (complete review of policy). This has been driven by the work taking place on the BAME Taskforce and in particular feedback from staff who had shared that they had experienced racism and discrimination from members of the public and parents. A significant amount of consultation has taken place. The first two pages give you a good overview of the process that will be embedded. An implementation/training plan for staff will be put in place, to ensure everybody is clear and aware of it.

AB echoed MKS's comments and advised that she did send the policy and equality impact assessment across to the EDI lead at Walton Centre, who is highly experienced. Really positive feedback was received. AB shared that once ratified, potentially other Trusts will want to look at it.

AB referred to positive discussions that had taken place earlier in the week about how we can potentially mark the policy launch at the UN anti racism day (taking place towards end March). This will hopefully solidify the way that we want to communicate about this policy and also develop the plan around training and implementation – to ensure staff across the board are really confident about what this policy means in terms of their day to day roles.

FB commented that it is a really positive development and shows real clarity in relation to whose responsibility it is to do what and when and how matters are to be resolved (Appendix A). Really good piece of work.

In the absence of PB, FM echoed FB's comments and noted her thanks. MKS added her thanks and noted PB has been instrumental in taking a leadership role in making this happen.

**Resolved: PAWC received and ratified the Zero Tolerance Policy**

**21/22/103 Board of Directors Summary**

- Staff Survey – Trust wide action plan to be produced
- SALS – work based relationship conflict – a wide range of support available
- Staff Turnover – actions agreed and quarterly reports to be received
- Sickness – seeing a downward trend (stress/anxiety/depression)
- Vaccination as a condition of deployment – process paused pending outcome of public consultation
- Communications – Key Delivery Plan will be going to RABD for approval
- Workforce Metrics – Data for Innovation to be combined with the Research data
- BAF – reviewing wellbeing strategic risks and scores to extend and include EDI risks.
- Ratified the Zero Tolerance Policy

**Resolved: PAWC agreed the Board of Directors Summary**

**Sub Committee/ Working Groups reporting to Committee**

**21/22/104** The Committee received the approved minutes for the following for information, noted as read.

- Local Negotiating Committee – update prior to approval 08.12.21
- Health & Safety Committee – 13.12.21
- Joint Consultation & Negotiation Committee (JCNC) – 26.11.2021
- Education Governance Committee – 09.12.21
- BAME Task Force Action Plan – 08.02.22

MKS referred to Local Negotiations Committee (staff side meeting with medics and the BMA) and outlined key areas of discussion. MKS confirmed the minutes had not been approved as yet, but it was hoped to receive approval at the LNC meeting in the afternoon. MKS advised the main focus of the conversation at the last meeting was in relation to the national Clinical Excellence Awards. National negotiations have taken place with NHS Employers and the BMA and the HCSA; very protracted negotiations have not ended in any sort of agreement. CEA was discussed as was Job Planning along with a number of policies around covering colleagues gaps in service/sickness (i.e. renumeration for medics who cover that).

MKS suggested that a quick summary guide/precis be added to all notes of reporting Committees outlining what was agreed and discussed at the meeting. FM agreed with this idea.

**Action: 21/22/104 – Request Chairs of reporting Committees to provide a summary guide/precis outlining what was agreed and discussed at the meeting (1 page – bullet points) – MKS.**

MKS shared what was discussed at the last BAME Task Force, robust/discussion about education and opportunities for higher education.

FM – suggested AB be included on a future agenda for this Committee – to share her thoughts on what she is finding in her new role (inclusive of an update on the BAME Task Force).

**Resolved: PAWC noted the content of the minutes**.

**21/22/105 Any other business**

FM pointed out that a lot of the reports received at this Committee use acronyms and asked if there was a glossary. ES shared that she thought the Committee Administrator was in the process of compiling this for the Governors. ES to find out where it is up to and share if available. FM has added to the acronym list she received on joining the Trust and will share this with the Committee Administrator.

**Resolved : PAWC noted the items raised under AOB**

**21/22/106 Review of Meeting**

FM reviewed the meeting and hoped the Committee found it productive. FM reflected on the timings for the agenda and will review this with MKS/JF, particularly the time allowed for the People Plan discussions as recognised the importance of this section as it raises some really good points. FM asked the Committee to let her know of any feedback they may have. FM shared that the Committee was constructive and informative and thanked everybody.

MKS thanked everybody for their contribution and concurred with FM about agenda timings and welcomed the opportunity to review this.FM to pick up with MKS a review of April's meeting date due to clashing diary commitments.

**21/22/107 Date and Time of Next meeting**

22nd March 2022, 10am

| Minute Reference | Action | Who | When | Status |
|---|---|---|---|---|
| **Trust People Plan 2019-24** | | | | |
| **21/22/60-1**<br><br>**21/22/60-2** | Non Agenda for Change (AFC) Pay Update<br>• Deferred increase to on-call payments to be included in overall review of on-call arrangements<br>• Pay Review – small anomalies across the Trust – to also include review of approach for Non-AFC practices | NA/AB<br><br>MKS/SO | March 2022<br><br>Spring 2022 | Noted on 18.01.2022 – the review has commenced. |
| **21/22/96** | Staff Turnover<br>• Staff Story – idea identified – think about how we may capture this going forward | SO | | |
| **21/22/97/1**<br>**21/22/97/2** | Staff Survey<br>• Produce overarching Trust wide action plan<br>• Disability Network – look to establish the Network and reflect in Staff Survey Comms rollout | MKS<br>MKS/AB | April 2022<br>March 2022 | |
| **Governance** | | | | |
| 21/22/80-1 | Trust Metrics - Medicine Division<br>Increased staff turnover – feedback following review of data. | CW | April 2022 | ongoing |
| 21/22/80-2 | Trust Metrics - Staff Turnover<br>Report on findings | SO | February 2022 | Complete |
| 21/22/80-3 | Trust Metrics – Corporate Services<br>Discuss and agree the right performance framework for Corporate Services | AB | March 2022 tbc | Noted on 15.02.2022 – conversations have commenced as part of the Brilliant Basics work – for Corporate Service and performance framework - ongoing |
| 21/22/80-4 | Trust Metrics<br>Look at producing a 1/4ly report with year-on-year comparisons in the metrics in relation to turnover | SO/MKS | May 2022<br>(1st quarterly report) | |

| | | | | |
|---|---|---|---|---|
| **21/22/66** | Health & Safety<br>• To produce a current status dashboard for Health & Safety to inform the Board | MKS/AK | March 2022 | Noted on 18.01.2022 – an update will be brought back to March committee |
| **Equality, Diversity & Inclusion** | | | | |
| 21/22/58 | • Monitor 3 action Plans WRES/WDES/BAME | | Ongoing | |
| **Sub-Committee / Working Groups reporting to PAWC** | | | | |
| 21/22/104 | Request Chairs of reporting Committees to provide a summary guide/precis outlining what was agreed and discussed at the meeting (1 page – bullet points) | MKS | ASAP | |
| | | | | |