NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 24th February, 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.	**21/22/262**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**21/22/263**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**21/22/264**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 27th January 2022.**	**D**	Read enclosure
4.	**21/22/265**	**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.	**21/22/266**	**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
Recovery Plan 2021/22							
6.	**21/22/267**	**9:35 (30 mins)**	**Delivering a Safe Winter; including:** - **National Recovery Plan.** - **Operational update on Omicron, winter pressures and recovery of services.** - **Update on People Issues.**	 A. Bateman A Bateman M Swindell	 To provide an overview of the implications for Alder Hey. To provide an update on Omicron, winter pressures and recovery of services. To provide an update on people issues.	 **N** **A** **A**	 Presentation Report Slides
Strategic Update							
7.	**21/22/268**	**10:05 (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

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	**21/22/269**	**10:15 (10 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
9.	**21/22/270**	**10:25 (10 mins)**	**Q3 PALS and Complaints Report.**	N. Askew	To receive the PALS and Complaints report for Q3.	**A**	Read report
10.	**21/22/271**	**10:35 (10 mins)**	**Sexual Assault Referral Centre (SARC) Accreditation.**	L. Cooper/ E. Saunders	To give approval for the Trust to become a legal entity as part of the UKAS accreditation.	**D**	Read report
11.	**21/22/272**	**10:45 (10 mins)**	**Q3 Mortality Report.**	A. Bass	To receive the Mortality Report for Q3.	**A**	Read report
12.	**21/22/273**	**10:55 (10 mins)**	**Digital and Information Technology Update; including an update on Alder Care.**	K. Warriner	To provide an update.	**A**	Read report
13.	**21/22/274**	**11:05 (40 mins)**	**Corporate Report – Divisional updates:** - **Medicine.** - **Community & Mental Health.** - **Surgery.** **Cumulative Corporate Report Metrics – Top Line Indicators:** • **Quality/Safety.** • **Effective/Responsive.**	U. Das L. Cooper R. Craig N. Askew A. Bateman	To receive a report on the Trust's performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
Game Changing Research and Innovation							
14.	**21/22/275**	**11:45 (10 mins)**	**Memorandum of Understanding: Infection Innovation Consortium (iiCON).**	J. Chester	For discussion and approval.	**D**	To follow
The Best People Doing Their Best Work							
15.	**21/22/276**	**11:55**	**People and Wellbeing update;**	M. Swindell	To receive the People and Wellbeing Report.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
		(15 mins)	**including:** • **BAME Inclusion Taskforce update.**	C. Dove	To receive an update on the work conducted by the BAME Inclusion Taskforce.	**A**	Verbal
LUNCH (12:10pm-12:30pm)							
Strong Foundations (Board Assurance)							
16.	**21/22/277**	**12:30 (15 mins)**	**2021/22 H2 Plan; including:** • **Financial Update, M10 2021/22.** • **Five-year Capital Plan .**	R. Lea	To provide an overview of the H2 plan, the Trust's five-year Capital Plan and the position for Month 10.	**A**	Presentation
17.	**21/22/278**	**12:45 (10 mins)**	**Leader Standard Work - Supporting Performance and Improvement.**	E. Saunders	To brief the Board on proposals to support governance lite going forward.	**N**	Read report
18.	**21/22/279**	**12:55 (10 mins)**	**Risk Appetite Statement.**	E. Saunders	For discussion and approval.	**D**	Read report
19.	**21/22/280**	**13:05 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
20.	**21/22/281**	**13:10 (20 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 18.2.22.** - **Approved minutes from the meeting held on the 24.1.22 -** *(to follow).* • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on**	I Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			the 16.2.22. - **Approved minutes from the meeting held on the 19.1.22.** • **People and Wellbeing Committee:** - **Chair's Highlight Report from the meeting held on the 15.2.22.** - **Approved minutes from the meeting held on the 18.1.21.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 7.2.22.** - **Approved minutes from the meeting held on the 11.10.21.** - **Approved minutes from the meeting held on the 24.1.22.**	F. Marston S. Arora			
Items for information							
21.	**22/22/282**	**13:30 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
22.	**21/22/283**	**13:34 (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 31st March 2022, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in January 2022 - 380: Letter of Indemnity – Medical Photography - 381: Lease for Liverpool Innovation Park – Hill Dickinson

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
CQC Action Plan (*to follow*)	E. Saunders
Financial Metrics, M10, 2021/22	R. Lea
DIPC Monthly Exception Report	B. Larru
Register of Shareholders Interests	R. Lea

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 27th January 2022 at 12:00pm**
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	Acting 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)
	Mr. J. Grinnell	Acting Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Chief Medical Officer	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Observing	Prof. J. Jankowski	Member of the public.	(JJ)
Apologies:	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 21/22/243	Dr. B. Larru	Director of Infection Prevention Control	(BL)
Item 21/22/247	Ms. K. Turner	Freedom to Speak Up Guardian	(KT)

21/22/239 Welcome and Apologies

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

21/22/240 Declarations of Interest

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

21/22/241 Minutes of the previous meetings held on Thursday 27th January 2022
Resolved:
The minutes from the meeting held on the 16th December 2021 were approved as an accurate record of the meeting.

21/22/242 Matters Arising and Action Log

There was nothing to discuss.

21/22/243 Post Covid-19 Recovery Plan 2021/22

Delivering a Safe Winter:

The Board received an operational update following the urgent action in December to deploy an emergency preparedness plan to deal with the threat of Omicron. It was reported that the Trust, with the support of many teams, has managed to address the issues that Omicron brought, especially in terms of staff absence which was one of the biggest threats that the organisation has had to navigate over the past seven weeks. Alder Hey has maintained full access to urgent and emergency services and has achieved recovery levels of over 90% for elective, day cases and outpatients. Staff absences have started to fall slightly and the number of patients waiting over 52 weeks for treatment have reduced.

The Board was advised that there has been a reduction in emergency admissions and admissions for RSV have also reduced. The Trust has seen a reduction in attendances to the Emergency Department along with an improvement in the timeliness of care.

Adam Bateman paid tribute to the support services that were put in place to help staff and provide on-site access to vaccinations and boosters; Track and Trace team, staff who supported vaccination/booster clinics.

The Chair queried the reason as to why there are large numbers of patients waiting over four hours to be seen on days when attendance is low. Urmi Das advised that the acuity and amount of very sick patients presenting in the last four weeks has had an effect on the timeliness of care provided in ED. The Board was provided with an overview of the actions that have been implemented or are in the process of being implemented to support the service.

Update on People Issues

Staff Vaccine Status: **Vaccine as a Condition of Deployment**

It was reported that vaccination as a condition of deployment was made law and submitted to Parliament at the end of December 2021. In terms of the regulation, this will become law on the 1.4.22 and will apply to all health and social care workers who are deployed in respect to a CQC regulated activity, who have direct face to face contact with service users. This includes individuals working in non-clinical ancillary roles who enter areas which are utilised for the provision of a CQC regulated activity as part of their role and who may have social contact with patients, but not directly involved in patient care.

The Trust has compiled a set of principles to implement the legislation and has been working in partnership with trade union colleagues to support staff. The approach that has been taken with staff is a supportive and empathic one, with guidance and access to experts being provided. Good data is also part of the approach.

It was pointed out that the legislation comes into force on the 1.4.22 therefore staff will have to have had their first dose of vaccine by the 3.2.22 in order to comply with

the legislation.

The Chair thanked Melissa Swindell and her team for the huge piece of work that has been undertaken to address this regulation.

Following discussion is was agreed to provide the Board with a further update following the February deadline.

21/22/243.1 Action: MS

IPC Update

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

- The Board was advised that there have been two cases of C. difficile in immune-compromised patients. An RCA has been conducted for both cases but only one case was deemed as a lapse of care, as detailed in September's report
- *Fit Testing* – Overall Trust compliance at the 31.12.21 was 63.5%. It was reported that Fit testing capacity has been reduced due to staff sickness, and a large number of staff were also due to have an update at approximately the same time. Actions to improve compliance have included sessions for PICU staff and the refresher training of Fit testers. It was confirmed that Fit testing figures have increased during January.
- The Board received an update on the Omicron variant which included an overview of the strategy for the 'New Normal' of life with Covid.

The Chair thanked Beatriz Larru for her leadership and acknowledged that there are a number of challenges going forward in terms of living with Covid.

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

21/22/244 Serious Incident Report

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.12.21 to the 31.12.21. Attention was drawn to the following point:

- It was reported that the Trust has one StEIS reportable incident requiring investigation;
  - StEIS 2021/25961: Concerns were raised about the pathway of care and treatment following the relapse of a patient with leukaemia. A level 2 investigation has been instigated.

Resolved:
The Board received and noted the contents of the Serious Incident report for the period from the 1.12.21 to the 31.12.21.

21/22/245 Divisional Updates
Resolved:
The Board received and noted the Corporate Report for December 2021 which included updates from each of the Divisions.

For noting
It was confirmed that Richard Craig will be representing the Surgery Division at future Board meetings until a new CMO is appointed.

21/22/246 People and Wellbeing Update

Resolved:
The Board received and noted the contents of the People and Wellbeing report.

BAME Inclusion Taskforce update

It was reported that a meeting will take place with Claire Dove prior to her stepping down as the Chair of the BAME Inclusion Taskforce, to agree a route for any outstanding actions so that the BAME Taskforce Action Plan can continue to be progressed. The plan will be submitted to the Trust Board in due course to formalise the process for the continuation of this work.

It was pointed out that February is 'LGBT History Month' and the Trust is using this as an opportunity to socialise a series of information with staff across the Trust in a similar way that Black History Month was approached by the organisation. A programme is in the process of being compiled and will be shared more widely once complete.

Resolved:
The Board noted BAME Inclusion Taskforce update.

21/22/247 Freedom to Speak Up

The Board was provided with a summary of the progress that has been by the FTSU team in the last quarter. The following points were raised:

- *FTSU training* **–** It was pointed out that training has been impacted across the organisation due to operational pressures and staff absences, with the uptake of the NGO e-Learning models; Speak Up, Listen Up, remaining low. Discussions are taking place with Learning and Development to see how this can be addressed. The Trust is also looking to create 'subject matter experts' at local level to help promote and embed FTSU across the organisation.
- *Guardian Activity report* – There has been an increase in activity during Q2/Q3 in comparison to Q1. It was confirmed that there are no particular themes in terms of the concerns raised and it was pointed out that there are a number of routes in which staff can raise concerns.

Anita Marsland thanked Kerry for the hard work that is taking place to promote FTSU and felt that it might be more logical to synchronise the FTSU report with the Wellbeing Guardian report. Fiona Marston confirmed her agreement of this.

Resolved:
The Trust Board received and noted the FTSU Guardian Report.

For noting
It was agreed to align the submission of the FTSU report and the Wellbeing Guardian report to the Trust Board.

21/22/248 Developing the Children's Hospital Alliance (CHA) – Next Steps

The Board was advised that the CHA consists of a group of senior leaders from 11 of England's largest paediatric hospitals/units. Alder Hey co-chairs meetings with Great Ormand Street Hospital (GOSH) and is in a leadership role nationally with the Alliance. Work has been taking place on leadership in order to make the Alliance

more structured. It was reported that the Alliance fills an important gap in the national CYP space, bridging the potential to deliver impact at the frontline of care as seen through the paediatric accelerator, with the potential to develop a shared voice independent from the NHSE structure and to speak for patients and families who depend on specialist hospital care.

It was reported that each organisation is submitting the briefing pack 'Developing the Children's Alliance' to their respective Trust Board for approval. There is a high-level request in terms of shaping the Alliance into a membership organisation with a minimal fee. The Board was advised that the membership fee will be developed in consultation with CHA finance leads and will be paid to a host Trust predominantly for staffing costs. Attention was drawn to the positive feedback that has been received to date with regards to a number of the paediatric hospitals already involved in the Alliance agreeing to this request.

John Grinnell informed the Board that the Alliance has progressed immensely during the last twelve months and felt that there is a huge potential for the CHA to be the delivery arm for the CYP national agenda.

Resolved:
The Board:

- Approved the shared purpose, objectives, and core structure of the CHA.
- Supported the maintaining of a self-funded programme structure, through payment of a CHA 'membership fee'.

21/22/249 Reducing the Burden of Reporting and Releasing Capacity to Manage the Covid-19 Pandemic

The Board was advised of the correspondence that was received from NHSE/I about the measures that have been implemented to help free up resources to enable organisations prepare for the potential impact of the Omicron variant and other winter pressures.

It was reported that Alder Hey is continuing to operate and refine its 'governance lite' approach across the Trust, and latterly via a piece of work with KPMG on 'Leader Standard Work' that is being progressed to support staff to free up time to focus on what matters. A further update will be provided on the outcome of the KPMG work during February's meeting.

21/22/249.1 Action: ES

Resolved:
The Board noted the update.

21/22/250 2021/22 H2 Plan; including Financial Update, M8 2021/22

The Trust has achieved an in-month surplus of £152k against a break even plan. The YTD deficit is £352k behind plan and cash in the bank is £90m. Capital spend YTD is £16.2m in line with plan YTD.

It was reported that the CIP shortfall remains a high risk for the Trust with a gap of £1.1m. There has been an improvement in month of £0.2m, however there is a large recurrent gap as the Trust has only achieved 50% recurrently. This area of work is being addressed as part of the planning process.

Key drivers relate to:

- *Division of Medicine* - ED pressure continues but the Division achieved a balance position for M9. It was confirmed that an action plan has been submitted to the Resources and Business Development Committee (RABD) for monitoring purposes.
- *Division of Surgery* – There is a continued pressure in both pay and non-pay in month. It was confirmed that an action plan has been submitted to RABD for monitoring purposes.

Latest H2 position

The Board was advised that Cheshire and Merseyside (C&M) marginally achieved ERF in M8, with £200k of ERF earned across the C&M system. This has left the Trust with a risk of £1m in its H2 plan and it looks unlikely that it will be achieved before the end of the current financial year.

The Trust has had further success in capital bids which amount to £1.5m for digital and £1.4m for innovation schemes. It was pointed out that some of the capital schemes were part of Alder Hey's plan for the future, so this funding has assisted in bringing these schemes forward.

The Board received an overview of the updated H2 scenario analysis for Alder Hey including improvement, no ERF and possible mitigations. The most likely scenario for the Trust is a £1.1m risk but there is a session taking place on the 28.1.22 with the C&M region to discuss the financial risks appertaining to H2 and how they might be mitigated from a system perspective during Q4.

2022/23 National Planning Guidance Update

The guidance was released on the 24.12.22. The key priorities were highlighted:

- 10 priorities covered in guidance.
- System Plans are required.
- Draft plans are to be submitted mid-March, with final plans being submitted at the end of April.
- Key themes;
  - Planning is predicated on Covid returning to a low level.
  - Longer planning horizons (*whole of 2022/23 and some 3 year targets*).
  - Tackling inequalities.
  - Improving pre-pandemic access and productivity (*30% more by 2024/25*).
  - Climate change.
- Key financials;
  - Allocations based on H2 values.
  - There is a requirement for a break even.
  - Additional revenue and capital.
  - Blended payment model to continue in 2022/23.
  - CIP to be a minimum of 2.5%.

The Board was advised that internal planning is underway with a weekly focus on this area of work. It was confirmed that a more detailed report will be provided during February's Trust Board.

21/22/250.1 Action: RL

A query was raised about the risk to the Trust in 2022/23 from a Capital Plan perspective. It was reported that the Trust is looking to achieve its Capital Plan for 2021/22 but it was pointed out that C&M is oversubscribed heavily in terms of their

capital spend allocation for 2022/23, which is putting pressure on the amount of allocation that providers will receive. It was pointed out that autonomy is being removed from providers and organisations are having to submit requests for capital spend to C&M.

Attention was drawn to the extensive capital requirements that the Trust has in 2022/23. It was reported that Alder Hey has started to look at alternative options to fund these requirements, but it was pointed out that this area of work is going to be a risk for the organisation over the next couple of years. The Board was advised that a lot of work has taken place to reduce the Trust's Capital Plan and understand what the next five years look like. Recent discussions have also taken place at RABD on the five year plan and it was agreed to submit the plan to the Board during February's meeting to provide further information.

21/22/250.2 Action: RL

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

21/22/251 Board Assurance Framework

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

- The Board was advised that the principal risks have been scrutinised by the respective Assurance committees.
- It was confirmed that updates relating to financial environment, building issues and the Campus are to be included in the January version of the BAF.

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

21/22/252 Board Assurance Committees

Audit and Risk Committee – The approved minutes from the meeting that took place on the 18.11.21 were submitted to the Board for information and assurance purposes.

RABD – The approved minutes from the meeting that took place on the 22.11.21 were submitted to the Board for information and assurance purposes. During January's meeting the Committee focused on the Capital Plan, the Neonatal tender, the Innovation Strategy and approved the financial model for the Innovation Centre.

SQAC – The approved minutes from the meeting that took place on the 24.11.21 were submitted to the Board for information and assurance purposes.

PAWC – The approved minutes from the meeting that took place on the 23.11.21 were submitted to the Board for information purposes. During January's meeting the Committee focused on the Staff Survey, the new legislation relating to staff vaccination and the improvements to recruitment via the use of automated systems. One of the areas that was previously noted was the increase in staff turnover. As a

result of this a deep dive took place and the outcome is providing information to help the Committee understand why this is happening.

Innovation Committee – It was reported that the Innovation Strategy will be submitted to the Board in February.

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

21/22/253 Any Other Business

There was nothing to discuss.

21/22/254 Review of the Meeting

The Chair thanked everyone for their contribution during the meeting and for the work that went into producing the reports. It was felt that the Board had given due consideration to some important issues taking into account the reduced timing of the meeting.

Date and Time of Next Meeting: Thursday the 24th February 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 Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for February 2022							
27.1.22	21/22/243.1	Post Covid-19 Recovery Plan 2021/22	*Staff Vaccine Status* - It was agreed to provide an update on the staff vaccine status following the February deadline.	M. Swindell	24.2.22	Closed	**17.2.22** - An update has been included in the People and Wellbeing Update Report that is being submitted to the Board on the 24.2.22. A**CTION CLOSED**
27.1.22	21/22/249.1	Reducing the Burden of Reporting and Releasing Capacity to Manage the Covid-19 Pandemic	Provide an update on the work that is taking place between the Trust and KPMG on 'Lead of Standard Work' that is being progressed in terms of implementing new routines in support of governance lite	E. Saunders	24.2.22	Closed	**17.2.22** - A report is being submitted to the Trust Board on the 24.2.22 to provide an update on the'Lead of Standard Work' that is taking place with KPMG. **ACTION CLOSED**
27.1.22	21/22/250.1	2021/22 H2 Plan; including Financial Update, M8 2021/22	*2022/23 National Planning Guidance Update* - Provide a more detailed update of the internal planning work that is taking place in line with the 2022/23 National Planning Guidance.	R. Lea	24.2.22	Closed	**17.2.22** An update will be provided to the Trust Board on the 24.2.22. **ACTION CLOSED**
27.1.22	21/22/250.2	2021/22 H2 Plan; including Financial Update, M8 2021/22	*2022/23 National Planning Guidance Update* - Submit the Trust's five year Capital Plan to the Board.	R. Lea	24.2.22	Closed	**17.2.22 -** This item has been included on February's Trust Board agenda. **ACTION CLOSED**
Actions for March 2022							
16.12.21	21/22/214.1	Chair's/CEO's Update	Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.	K. McKeown	31.3.22	On track	
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
Actions for June 2022							
24.6.21	21/22/65.2	Approach to End of Life Care when there is a dispute	Provide a progress update on the Trust's process that supports end of life discussions and agreements.	Nicki Murdock/ Adrian Hughes	30.6.22	On track	

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

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

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

1. Introduction

In January we continued with our emergency planning arrangements in order to co-ordinate an effective response to Omicron. We maintained full access to urgent and emergency services and sustained a high level of access to elective services. Omicron has caused a significant increase in staff absence which peaked in early January but has subsequently reduced in mid to late January, albeit contributing to an overall absence level that is 50% higher than normal levels. We continued to provide an effective swabbing and track and trace service to minimise staff unavailability at work from positive household contacts, and regular testing to minimise transmission in the workplace.

2. Omicron preparedness and response

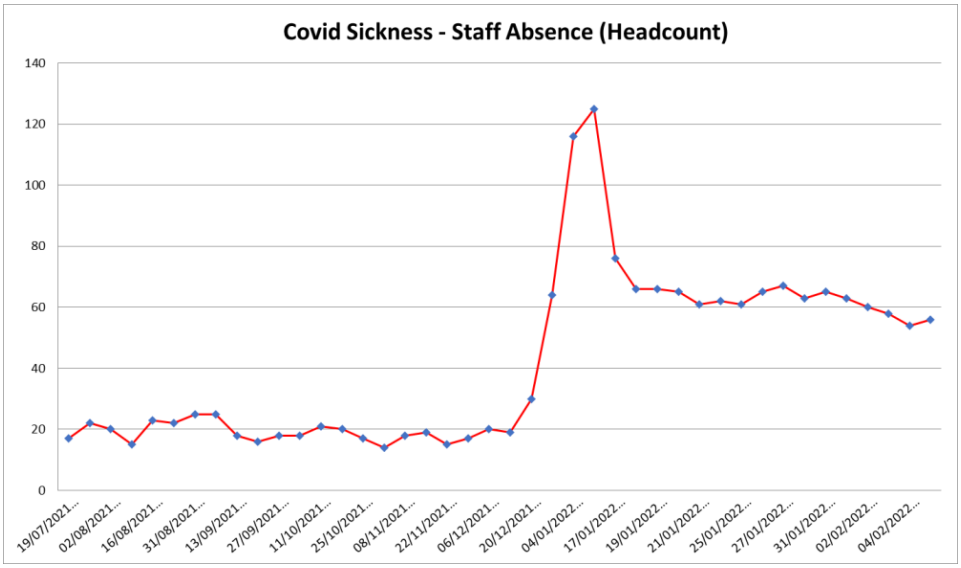
2.1 Omicron emergency response

Our emergency response structures focused on effective delivery of the following:

- Preparing for the impact of vaccine as a condition of deployment
- Business continuity plans to mitigate higher levels of absence
- Supporting PICU capacity through the ongoing deployment of staff from non-PICU clinical areas
- Shifting to higher levels of day case activities
- Track and trace

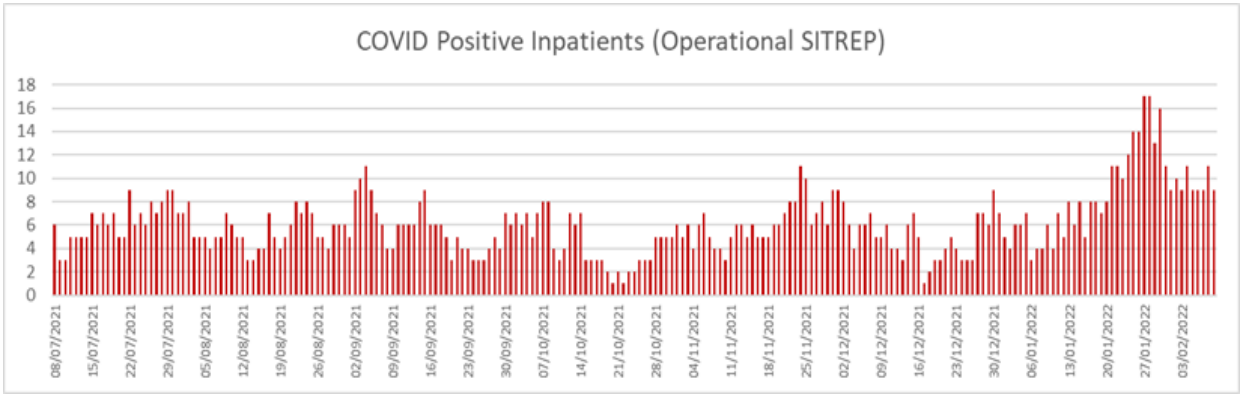
2.2 Impact of Omicron on staff absence

The Omicron variant has led to a sharp rise in staff absence (see graph below). Overall sickness absence was between 8- 11% in January. This has led to the loss of some elective activity. The effect of higher staff absence on service provision has been mitigated effectively by a range of measures taken by teams that includes amber staffing models, split team working and flexible cover arrangements. We are very grateful for the efforts made by staff to sustain their services to patients in difficult circumstances.



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

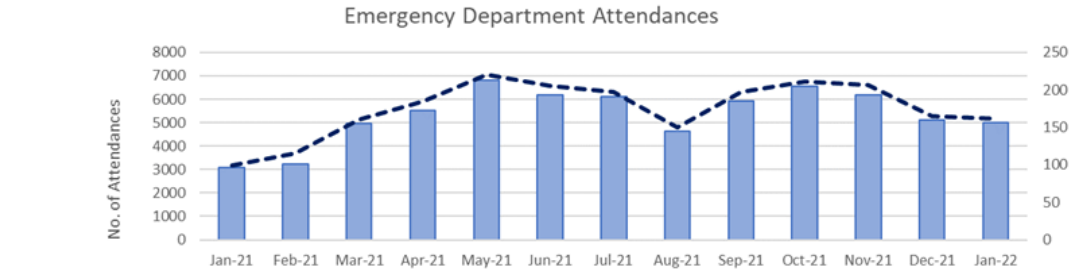
The number of children and young people who tested positive for Covid-19 upon admission and/ or during their hospital stay increased sharply during the w/c 20 January 2022. This rise is consistent with the high prevalence of covid-19 in children and young people in the community. We had a peak of 17 patients in hospital with Covid-19, some of whom were in hospital for a different primary reason. Our hospital bed occupancy levels remained optimal during this period due to a general reduction in emergency admissions.



3. Emergency and urgent care admissions and attendances

3.1 Emergency admissions to hospital

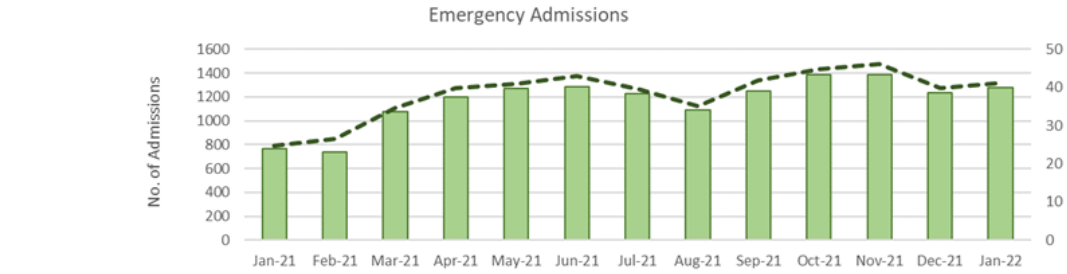
There was an average of 162 attendances per day to the Emergency Department; this is comparable to December and represents a reduction on the level of demand experienced in September to November. This reduction is associated with changes in behavioural patterns during the Omicron surge, with less mixing and presentations of minor illnesses to the Emergency Department.



	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
Attends	3069	3228	4971	5528	6819	6175	6099	4645	5917	6539	6191	5113	5018
Avg Attends Per Day	99	115	160	184	220	206	197	150	197	211	206	165	162

3.2 Emergency admissions to hospital

There was an average of 41 emergency admissions per day, this is comparable to December and represents a reduction on the level of demand experienced in October to November.

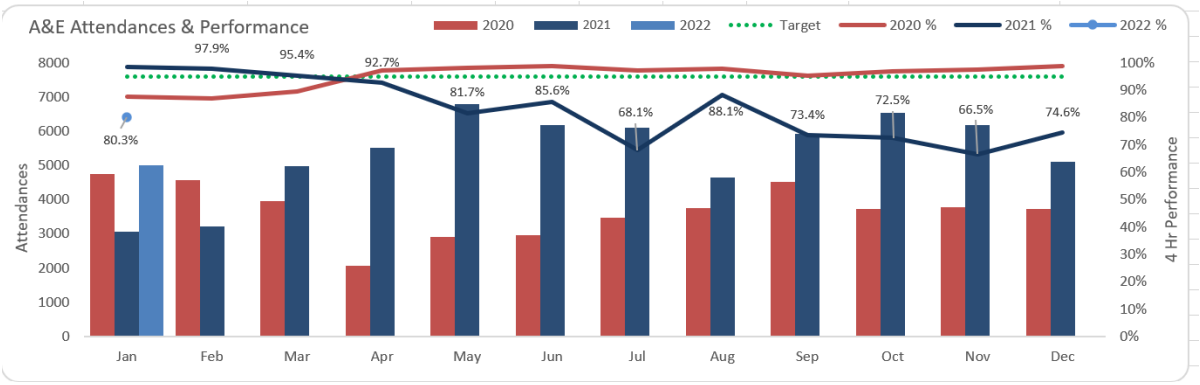


	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Emerg Admissions	766	741	1075	1198	1270	1288	1230	1089	1253	1386	1386	1235	1276
Avg Emerg Admiss. Per Day	25	26	35	40	41	43	40	35	42	45	46	40	41

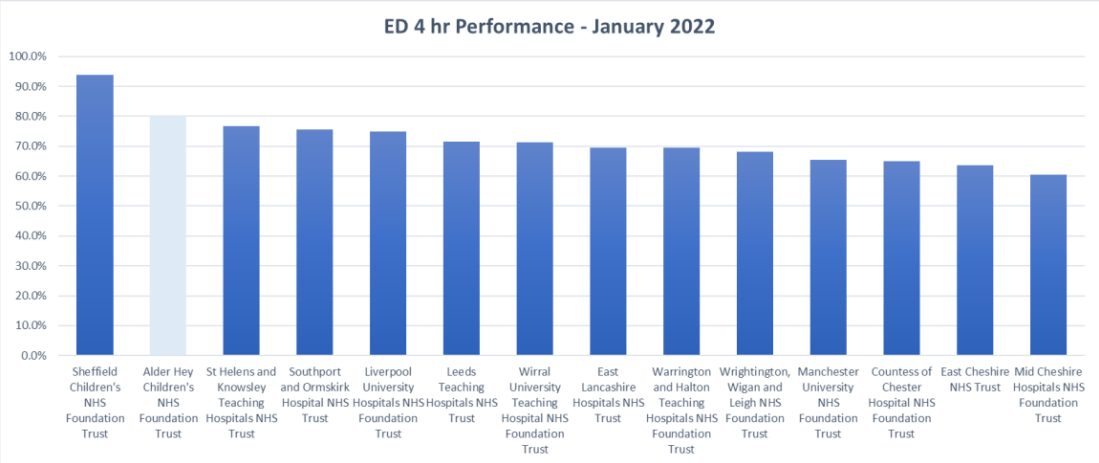
3.3 Emergency Department Clinical Quality Standards

3.3.1 4-hour standard

In January our performance improved, relative to September and December, with 80.3% of patients receiving treatment or admission within 4 hours. We have seen a total of 57,955 attendances in the ED department this financial year, this is an increase of 5,770 attendances compared to the same time in 2019/20.



We have benchmarked our performance against other centres in Cheshire & Merseyside, and two paediatric centres in the North of England:



3.3.2 other clinical indicators

Nationally, a new set of clinical standards for emergency care is proposed including a median time to clinician assessment of 60 minutes. Over the last 4 months we have been reviewing this and working to improve our time to clinical assessment. The median time to clinical assessment was 83 minutes in January 2022.

	2021									
Performance	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Time to Clinical Assessment:										
Median	101	133	117	158	76	100	108	129	87	83

The percentage of patients who 'left before being seen' in January 2022 reduced to 4%.

Performance	2021 Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Left Before Seen	14	23	110	210	507	304	761	199	536	619	539	313	202
% Left Before Seen	0.5%	0.7%	2.2%	3.8%	7.5%	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%	6.1%	4.0%

This reduction in 'left before seen' correlated to the low attendances in January. We are also trying to ensure we get additional medics on overnight to support with the activity. In January we had 14 shifts whereby we had a 3rd clinician on overnight.

Although patients leaving the department is a clinical risk, we have a robust process to capture and review this caseload. This is a consultant led pathway and each patient is clincially reviewed and appropriate action is taken to mitigate any risk. This process is managed daily.

3.4 Urgent Care Improvement Actions

Action	Impact	Status	Comment
Symptom Checker	On-line tool on AHCH Internet to support families to access the	Live	Monitoring usage and feedback

	right service or provide advice to self-care		
Health Visitor ED	Support for Families, C&YP in the community; prevention of recurring attendance	Live	Partnership with Mersey care
Go to Doc	GP and ACP presence in ED via 3rd party provider to support primary care stream	Live	Presence being stepped on week on week; tender being developed for long term provision of 3rd Party Primary Care support
Workforce and demand review	Match workforce capacity and skill mix to activity profiles and demand	In progress	Scheduled for Executive Review end of February 2022
Out-of-hours staffing levels	Proposed new rotas formulated to deliver timely clinical assessment out-of-hours	In progress	Consultation to commence February 2022

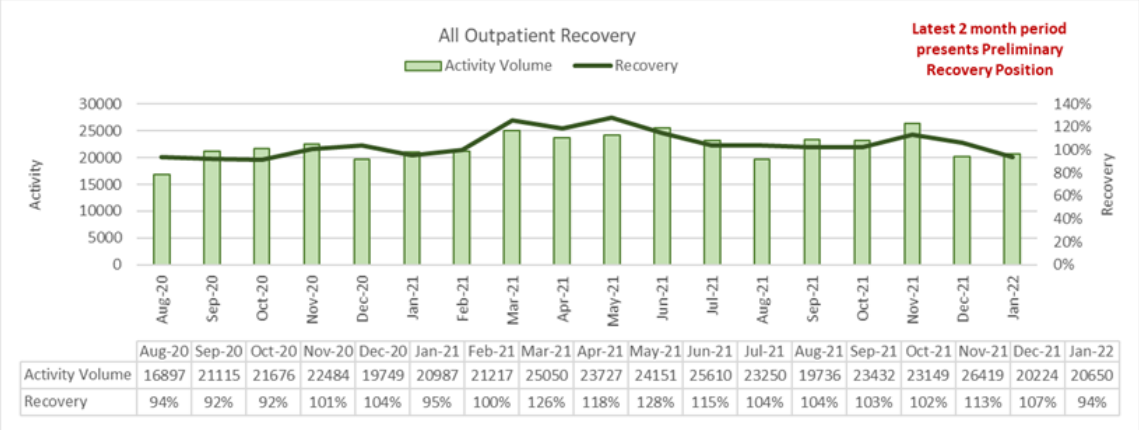
4. Elective care services

4.1 Progress in recovery of service

We continue to monitor the number of patients accessing outpatient, elective care and diagnostic procedures and investigations (against 2019 pre-covid levels).

Outpatient recovery

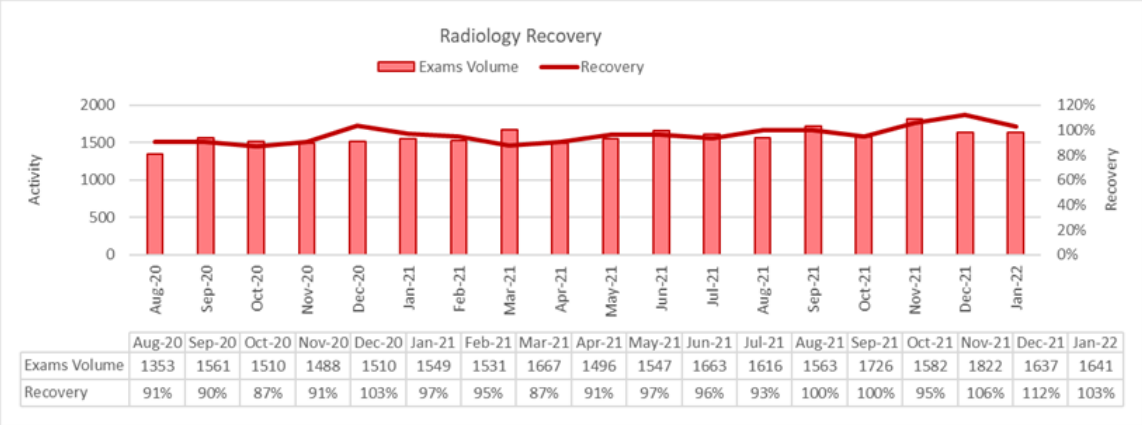
In January our provisional data indicates we delivered 94% recovery (this is expected to rise to 100%-105% following completion of coding and capture procedures).



	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
Activity Volume	16897	21115	21676	22484	19749	20987	21217	25050	23727	24151	25610	23250	19736	23432	23149	26419	20224	20650
Recovery	94%	92%	92%	101%	104%	95%	100%	126%	118%	128%	115%	104%	104%	103%	102%	113%	107%	94%

Radiology recovery

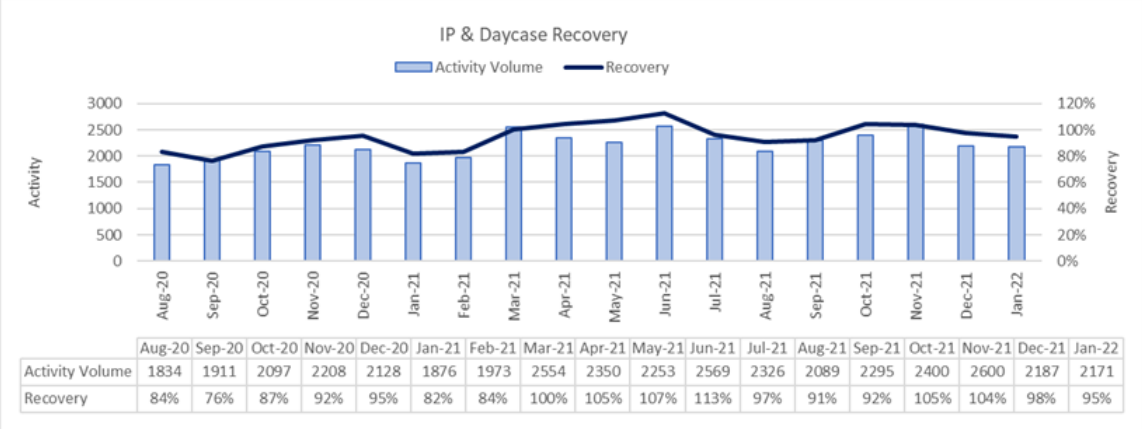
Radiology recovery was strong at 103% in January 2022.



	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
Exams Volume	1353	1561	1510	1488	1510	1549	1531	1667	1496	1547	1663	1616	1563	1726	1582	1822	1637	1641
Recovery	91%	90%	87%	91%	103%	97%	95%	87%	91%	97%	96%	93%	100%	100%	95%	106%	112%	103%

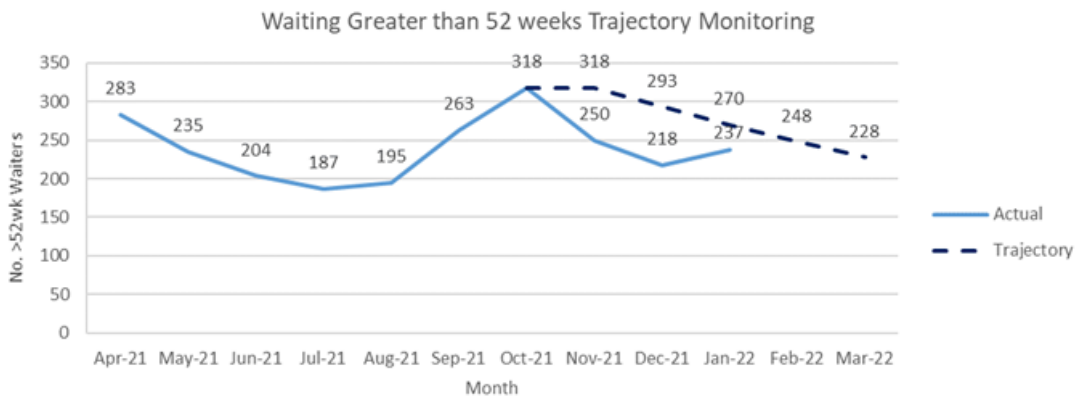
Elective recovery

We contracted our theatre schedule by 10 sessions per week which has led to elective recovery of 95% in January 2022, down on the recovery levels reached in October and November. Nonetheless, given Omircon pressures, this is good outcome aligned to our better case modelled scenario.



	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
Activity Volume	1834	1911	2097	2208	2128	1876	1973	2554	2350	2253	2569	2326	2089	2295	2400	2600	2187	2171
Recovery	84%	76%	87%	92%	95%	82%	84%	100%	105%	107%	113%	97%	91%	92%	105%	104%	98%	95%

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



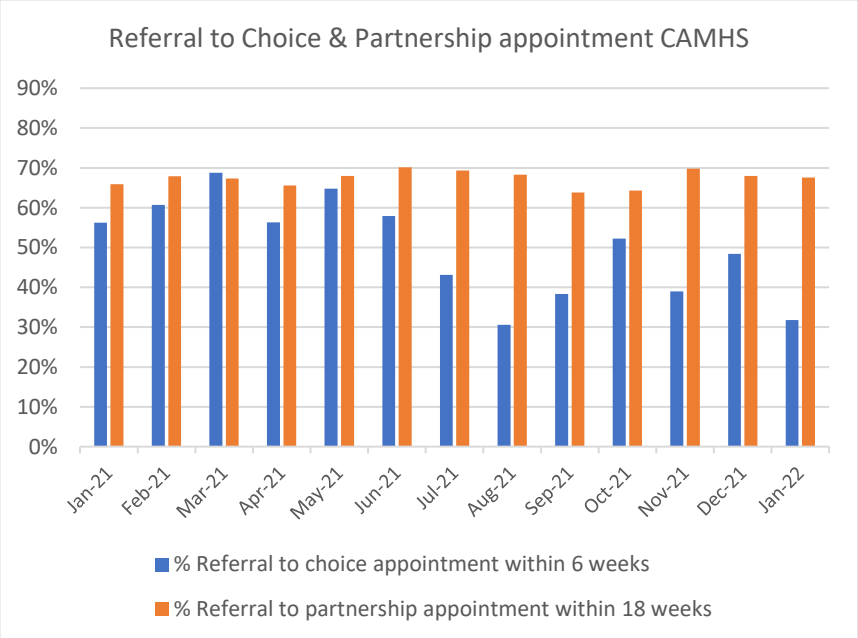
The increase in the number of children and young people waiting over 52 weeks in January is associated with the loss of elective theatre capacity. The specialties of paediatric dentistry and spinal surgery have the largest backlogs.

To make further improvements in clearing our waiting list backlogs we are progressing the following high impact changes:

- Re-instate the theatre schedule to full capacity in February 2022
- Application of the Theatre Scheduling Policy to improve theatre utilisation
- Effective pre-admission pathways to minimise on the day cancellations
- Workforce expansion and substantive recruitment in paediatric dentistry and anaesthesia
- Increase the number of day cases sessions (to reduce cancelled operations)
- Additional support provided to four specialities to achieve an increase in outpatient consultations

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

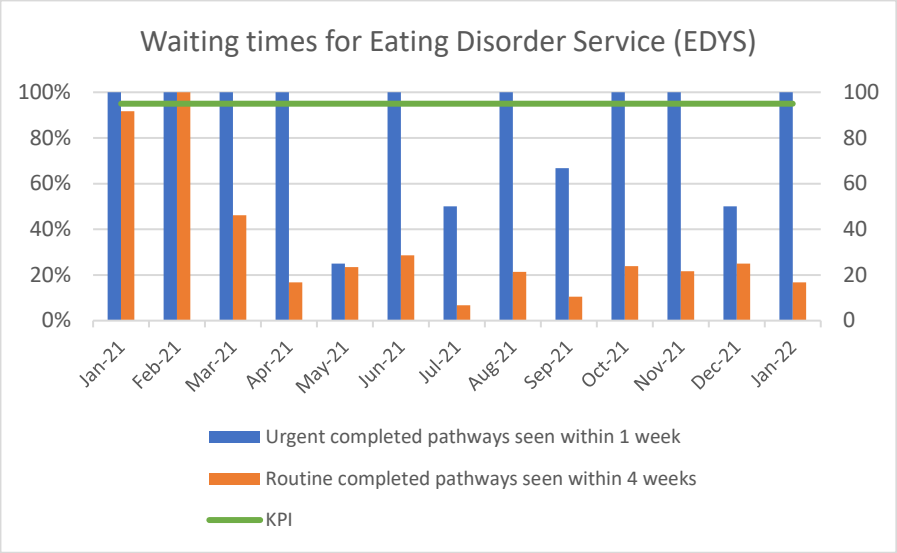
Specialist CAMHS



Alder Hey specialist mental health services continue to experience high demand for services with a 60% increase in Jan 2022 when compared with same period in 2021. The service has continued to focus on recruitment to teams and with an additional 12 staff commencing in post in January 2022. In addition, we have also:

- Engaged with additional agency staff to support capacity in service
- Introduced recruitment incentive scheme
- Reviewed clinician job plan process to ensure greater standardisation and improved notice to children and young people of appointment

Eating Disorder Service



The Eating Disorder service is also experiencing unprecedented demand for support and has experience a **58%** increase in referrals in January 2022 compared to 2021 and **192%** compared to 2019. These pressures are also being faced nationally across community eating disorder and inpatient mental health services.

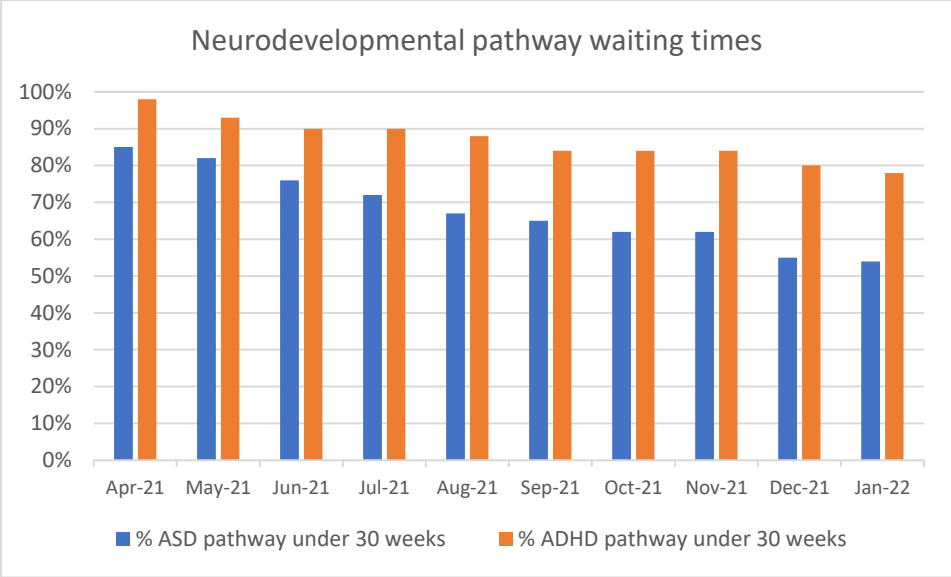
This increase in demand as well as the increased number of acute paediatric admissions for eating disorders is significantly impacting on capacity within the service. Actions to support improvements include:

- Recruitment to posts to support capacity in the service continues with further interviews planned for February.
- Agency Dr starting in post early February
- Review of automatic direct booking of appointments using the Sefton and Liverpool CAMHS referral platform undertaken in January 2022 and plan to go live now moved to mid-March following some additional development work required 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. The ASD pathway has received 125% more referrals than planned for all of 21/22 and for ADHD this is 60%. This increase is impacting on the overall waiting time for completed assessments. At the end of January 2022, 54% of children waiting on the ASD pathway had waited 30 weeks or less and 78% for ADHD. Despite this the services have:

- Continued to maintain referral to triage times within 12 weeks.
- 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
- Developed a recovery plan to support a return to a maximum 30 week pathway


Neurodevelopmental pathway waiting times
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Apr-21
May-21
Jun-21
Jul-21
Aug-21
Sep-21
Oct-21
Nov-21
Dec-21
Jan-22
% ASD pathway under 30 weeks
% ADHD pathway under 30 weeks

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday, 24th February 2022

Report of	Development Director
Paper prepared by	Associate Development Director- (10/02/2022) Russell Gates
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

January 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 2 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										
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 2/90%)										
Mini Master plan (Eaton Rd Frontage) 2 phases to plan										
Infrastructure works & commissioning										
Catkin Centre Construction										
Catkin Centre Occupation										
Sunflower House Construction										
Sunflower House Occupation										
Demolition Phase 4 (Final)										Q2 22/23
Final Park Reinstatement (Phase 3A)										Q3 22/23
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										23/24
Orthotics move										

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Phase 1 of the park is now operational. A planning application for the Multi-Use Games Area (MUGA) has now been submitted. The application is now registered but it may be March before a decision is received.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9)	Planning decision expected mid-March.

Acquired Buildings Occupation (neighbouring sites)

Current Status- on hold	Risks/issues	Action/next steps
Knotty Ash Nursing Home **Under review following fire on 10th May.**	Delays to insurance pay out delays rebuild	Loss adjusters have increased their offer to plus advisers fees, requires acceptance by the Trust to secure funds A claim for temporary accommodation costs is ongoing.

Police Station (lower floor) occupation

Current status	Risks/issues	Actions/next steps
Negotiations on the Agreement for lease and leases are progressing well. Police are content for us to move into the ground floor of the Eaton Road premises on an exchange of letters if the documents are not signed. Issue with the Police's valuation of the transaction requiring amendments to the lease documents which should be resolved over the next week. 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) Refurbishment of the ground floor exceeds budget due to the state of the building.	Complete legal agreements. 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 nearing completion, phase 3A is planned to start in April/May. Capacity Lab have two major parties interested is 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. Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress.

NEW Mini Master Plan for Eaton Rd frontage

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

Infrastructure works & commissioning

Current status	Risks/issues	Actions
The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments. Site power has been reconfigured to connect the Sunflower House.	Early indication is that to complete all of the work will exceed budget. Development team and finance are reviewing the outstanding work v budget	The works remain on programme but close monitoring is being continued to watch for slippage.
A plan has been developed to allow the new Neonatal project to proceed whilst the remaining infrastructure is reconfigured.	Delays to the infrastructure installation causes delays to the Neo and cluster projects.	Must maintain programme to avoid delays to the cluster and neonates projects

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
A revised completion date has been issued by GT stating completion as 29th April 2022. The analysis of the revised programme and claim for prolongation costs are underway, further information is awaited from GT.	Prolongation claim leads to additional costs.	Revised programme along with cause and affect are being analysed.
Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates.		
Furniture and interiors discussions have concluded and so furniture ordering has commenced.	Budget for furniture is inadequate	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. 4. 21/22	Cost may exceed current allocated budget.	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks/issues	Actions
Enabling works about to commence to create a temporary ED car park and realign the Blue Light road. Deed of variation to be signed end of March. 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. NHSEI delay start by Trust requiring a separate approval for the PFI variation.	Continue working with Project Co to mitigate impact. Liaising with NHSE/I and PFU to avoid delays

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
Status unchanged Papers issued to exercise land option. Review of options for Brain injury unit and eating disorder unit within the building allocated as a Patient Hotel.	Value of option increases in short term Timescales to deliver and cost of any lease being high.	Agree value through independent, jointly appointed valuer. 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. Fortnightly meetings established to discuss wider campus development progress.	Loss of reputation, locally and regionally. Lack of engagement internally and externally	Maintain links with community and support their development work.

Car Parking

Current status	Risks/Issues	Actions/next steps
Status unchanged The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday. The planning consent for the temporary car park expires in May. 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 Travel plan from Mott MacDonald does not provide realistic and evidenced solution. Temporary shortfall of numbers between May and June.	Review car parking requirements in view of the home working and off-site office building. Recruit a travel plan co-ordinator. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan. 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. 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. Project Co and sub-contractors do not manage the works efficiently	Works started on site Regular site meetings to monitor progress.

Innovation Park 2 for CAMHs

Current status	Risks/Issues	Actions/next steps
Lease due to be signed mid Feb. Building contractor ready to start on 14th March and complete late May to enable last teams to vacate old Catkin.	Delays to works delays the move from Catkin. Late changes increase costs	Sign lease, pre-contract meeting. 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 10th February 2022.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st January 2022 – 31st January 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Chief Nursing Officer & Associate Director of Nursing and Governance

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

1 Introduction

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

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

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

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

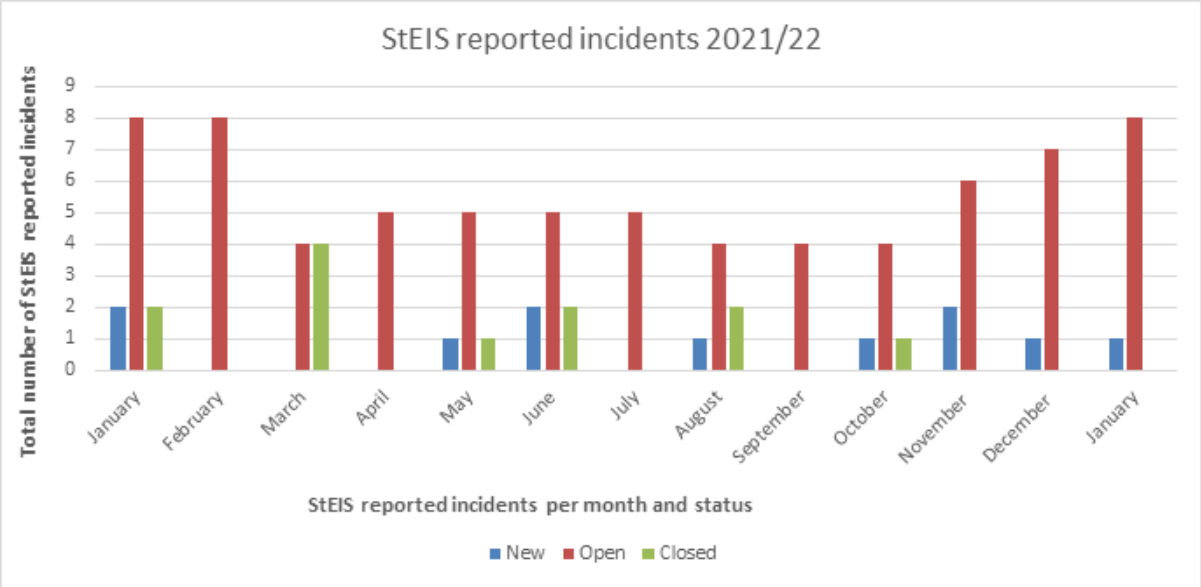
Serious incidents that do not meet the StEIS criteria are discussed at the weekly patient safety meeting and where appropriate an RCA level 2 is instigated.

2. Serious Incidents activity January 2021 – January 2022

During 1ST January 2021 - 31st January 2022, the Trust reported as follows

- 8 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 January 2022**

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

Division	Speciality	Ref	Brief Description
Division of Surgery	PICU	2022/1581	Grade 4 pressure Ulcer. (refer to appendix 1)

Table 1: StEIS reported serious incident in January 2022

4. Never Events

Zero 'never events' were declared in January 2021.

5. Serious incident reports completed in January 2022

Zero 'serious incident' investigations were closed in January 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 avoidable harm by embedding effective controls and a robust programme of quality improvement.

6.1. Serious Incident action plans

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

Table 2 below provides and overview of progress position of open action plans. The Division of Surgery have made good progress and currently have zero action plans past expected date of completion. The Division of Medicine continue to have challenges to enable completion of action plans, although many individual actions within the plans are continuing to progress to closure. There will be additional focused efforts in the division to ensure the actions are completed

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

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, there is not a current system of hierarchy of controls, therefore going forward using the risk management methodology including impact x likelihood (5x5 matrix) will be implemented. Progress with this initiative will be included in the March Board report. There is evidence of positive changes in practice that have led to improvements and reduced incidents, for example.

- Process developed and implemented ensure that no patient can leave critical care without a defined lead consultant, audit in progress to measure compliance.
- Development and implementation of standard proforma for patients undergoing oncology surgery, including all oncology surgeons to review MDT notes to ensure content accurate.
- Each stage of listing letter of consent for patients going to theatre audited daily and reported weekly to ensure compliance with expected consent standards.

- Safety alert developed and sent out to all relevant staff in respect of site marking for operative procedures. MDT quality rounds continue to focus on compliance and understanding by staff at all ward levels. Updated ward check out process for patients from ward to theatre completed and implemented, in addition to teaching session for staff, planned tom periodically repeat. Furthermore, audit of proves being undertaken daily to provide assurance with expected standards.
- Revised process implemented confirming the procedure during the sign in phase of the WHO checklist. Audits being undertaken to ensure compliance with expected standards, including independent audits by the divisional governance team.
- SOP developed and implemented for preparation of patients for Theatre, available on Trust DMS system.

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 there occurrence, the rationale being to increase insight into the most common factors associated with serious incidents and increase the opportunity to identify overarching improvement actions.

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

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

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

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

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 internal commissioned Level 2 RCA'S

1. StEIS 2022/1581 (Ulysses ref: 54938) reported in month

Background

Patient transferred via NEWTS from neighbouring Trust mid-December following collapse and admitted to PICU. Staff noted deterioration of skin integrity to outer aspect of left ear and referred to tissue viability team (TVN). Previous scab area had lifted and revealed significant damage to ear.

Immediate lessons learned and actions for improvement

- Early TVN referrals were made due to high-risk nature of patient.
- Good documentation by both PICU and TVN teams, although inconsistent re content at times.
- Known high risk patient on ECMO and some strategies in place to manage known risk.
- Communicate to all PICU staff to share incident and initial learning via safety app.
- Review with TVN team commencing daily ward/board rounds to ensure that all patients have daily oversight/support rather than using referral-based system commenced
- Exploring with Badger lead possibility of creating standardised form for daily review under Skin bundle section on Badger notes.
- Duty of candour requirements completed.

Further actions

- 72-hour review completed.
- Lead investigator agreed.
- RCA level 2 comprehensive investigation commenced
- Panel to be agreed and date of panel meeting

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	**Quarter 3 Complaints, PALS and Compliments report**
Paper of:	Chief Nurse
Paper Prepared by:	Val Shannon Patient Experience/Quality Lead Pauline Brown, Director of Nursing
Paper Presented by:	Pauline Brown, Director of Nursing

Purpose of Paper:	The purpose of this paper is to provide the Board with an update and assurance on the performance against complaints and PALS targets in Q3 2021/2022, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and proposed developments planned in 2021/2022. Decision ☐ Assurance ■ Information ■ Regulation ■
Summary and/or supporting information:	39 formal complaints received in Q3; the top reason was treatment and procedure and alleged medical failure. Compliance within the 3 working day acknowledgement for formal complaints is 97% in Q3. 27 of 39 complaints were responded to in Q3 of which 12 (44%) were compliant with 25 working day response time. Of the 12 remaining complaints opened in Q3 that have ongoing investigations, 9 (75%) were within the 25 day timeframe at the close of Q3 and 3 (25%) had exceeded the timeframe. One complaint from Q2 remains open and under investigation. 9 complaints were raised as second stage of which 5 have subsequently been closed and 4 are open and under investigation. There are 2 complaints which continue to be investigated by the PHSO. There were 384 informal PALS concerns received of which 51% were responded to within the 5 day timeframe. The main theme is regarding communication.

	67 compliments are recorded centrally in the Ulysses system for Q3 2021 of which Community Division recorded 48 MIAA conducted a complaints process review in Q3 and the Trust received limited assurance. 11 recommendations were made of which 3 are high and relate to identification, recording and sharing of lessons learned; and monitoring actions from complaints. A full and comprehensive action plan to address the recommendations has been devised and will be monitored to completion through CQSG.
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.
Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** □ **Strong Foundations** ■
Resource Impact:	Yes
Action/Decision Required:	SQAC are asked to note the content of this report and support the MIAA action plan

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our families expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate and compassionate response. Compliments, and concerns (PALS) are an important measure of the quality of care we deliver.

This report provides an overview of formal complaints, informal concerns (PALS) and compliments received and closed between October to December 2021/22 (Q3). This report aims to provide assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO; identifying and analysing themes more widely that the Trust needs to address to make service improvements; and to highlight action taken.

2. Formal Complaints

2.1 Number of formal complaints received in Q3 2021/2

The Trust has received 39 complaints in Q3, with a similar number of complaints received by month in the past 6 months (average of 10-14 per month). There has been a decrease compared to the same quarter last year (45 in Q3 2020/21); this decrease is associated with a previous specific issue in neurology.

Figure 1 shows the number of complaints by Division compared to the same period last year; Figure 2 shows the breakdown of complaints received by service

Figure 1: Number of formal complaints in Q3 2021/22 compared to same period in Q3 2020/21

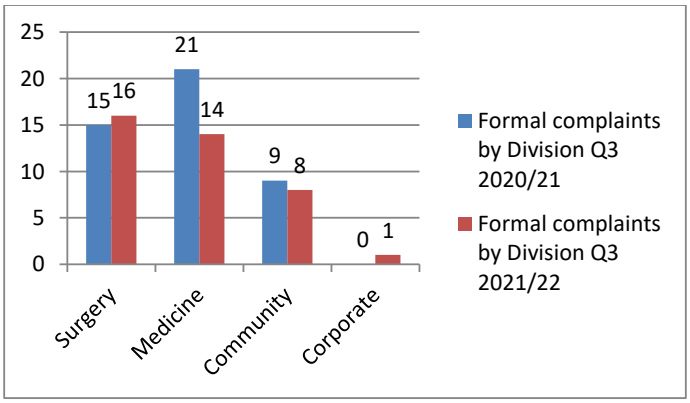
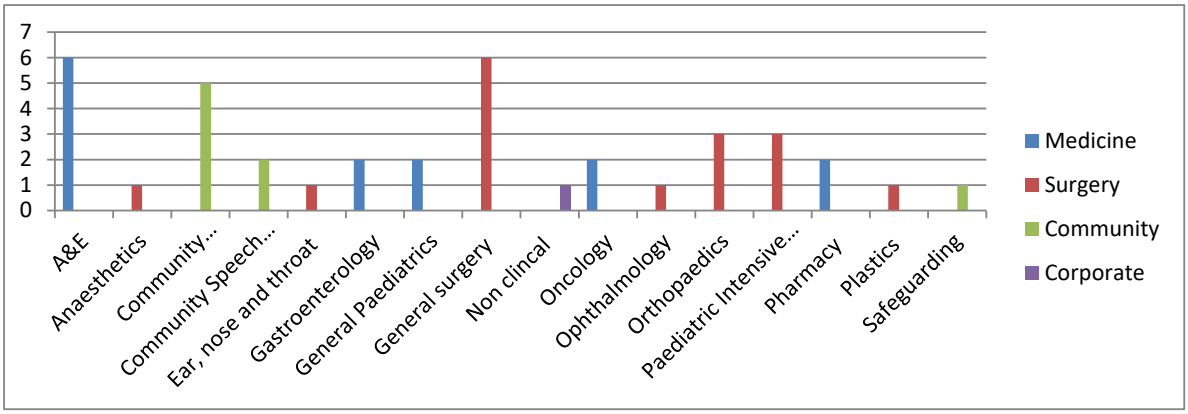


Figure 2: Number of formal complaints by service in Q3 2021/2022



There have been 112 formal complaints received so far in year as shown in Figure 3. Figure 4 shows the number of complaints by Division in year 2021/2022.

Figure 3: Number of formal complaints 2021/22

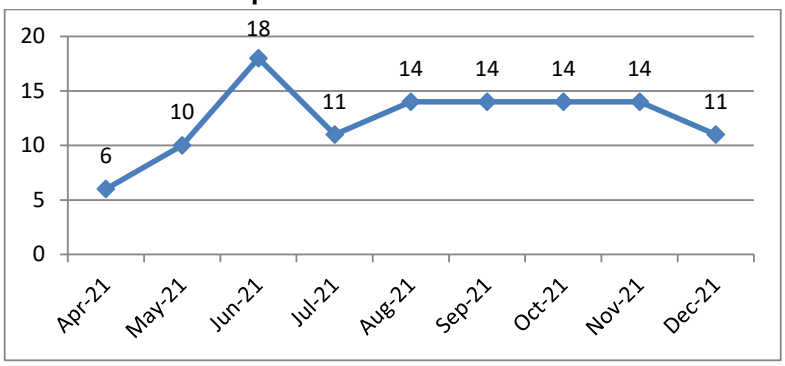
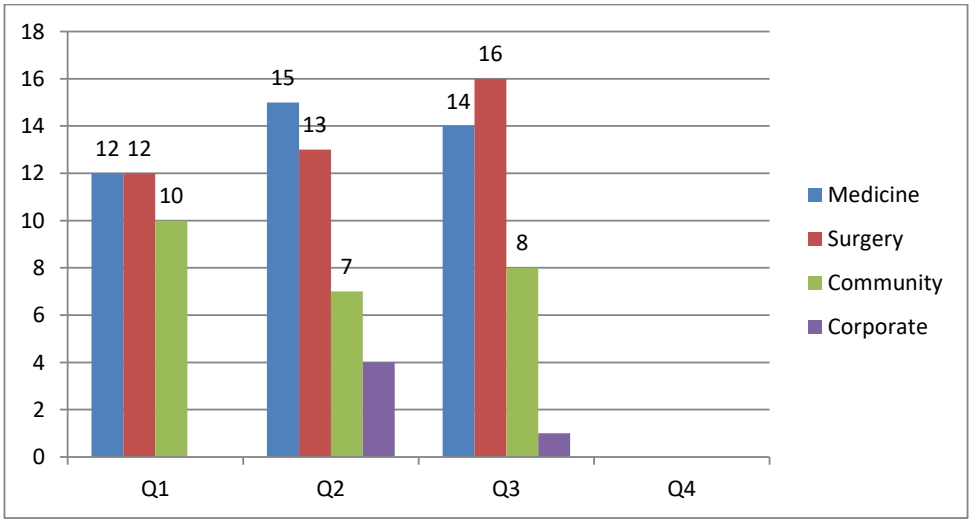


Figure 4: Number of formal complaints by Division in Q1, Q2 and Q3 2021/22



2.2 Complaints received by category Q3 2021/22

Complaints are categorised by subject as set in the Trust Ulysses complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

The main theme in this quarter is in relation to treatments and procedures as shown in Figure 5, with this theme accounting for almost half of the complaints received (19 complaints / 49%). 12 of these relate to alleged failure in medical care as shown in the sub-category thematic analysis in Figure 6.

Figure 5: Primary categories of complaints Q3 2021/22

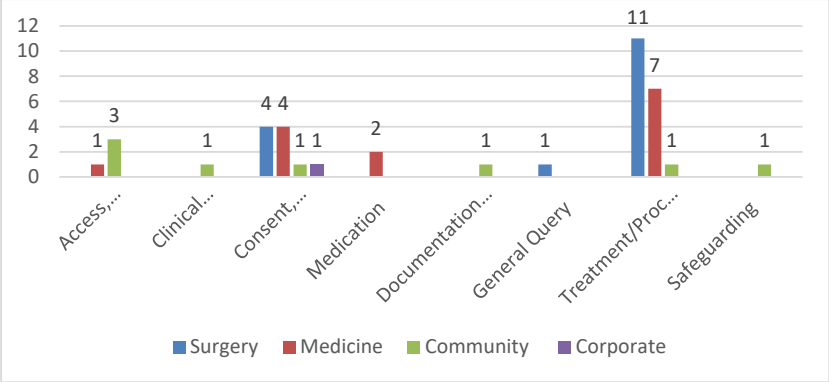
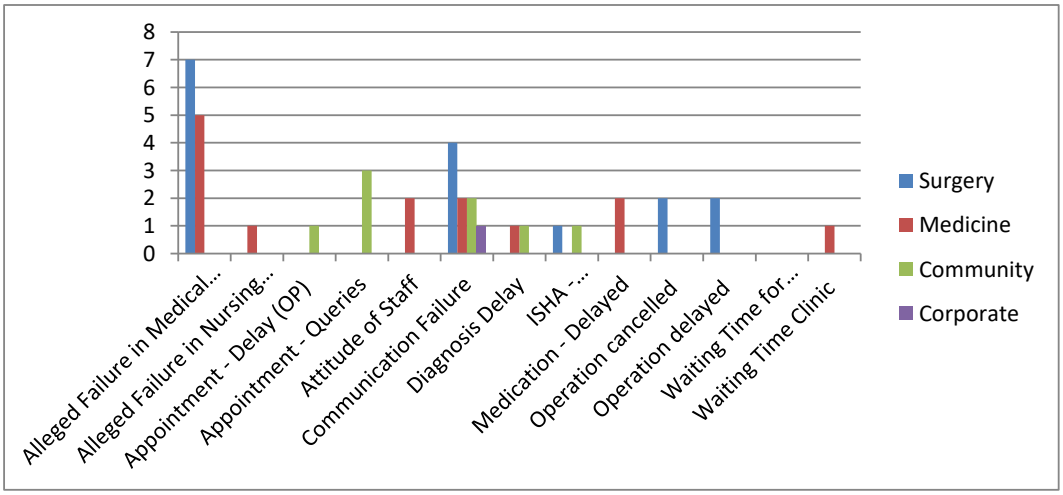


Figure 6: Subcategories of complaints Q3 2021/22



2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge that in some settings it may take longer to respond to a complaint due to the pandemic and consider it permissible for this to go beyond the usual six month maximum time period. However, organisations

should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust has continued to aim to respond to complaints in line with RM6 Complaints and Concerns policy throughout the pandemic.

2.3.2 Compliance with 3-day acknowledgement 2021/22

The NHS Complaints Guidance sets out that complaints should be formally acknowledged within 3 working days. The Trust has a generic formal complaint acknowledgement email that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The email also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q3, 97% of formal complaints received were acknowledged within 3 working days, with 33 (85%) being acknowledged on the same day as shown in Figure 7. The complaint that was not responded to within an appropriate timescale was due to an administrative oversight and a process has been put in place within the Division to ensure this does not happen again. Figure 8 and Table 1 show a journey of compliance with this standard and demonstrates the need to continue to improve and sustain improvements.

Figure 7: Compliance with of 3-day acknowledgement Q3 2021/22

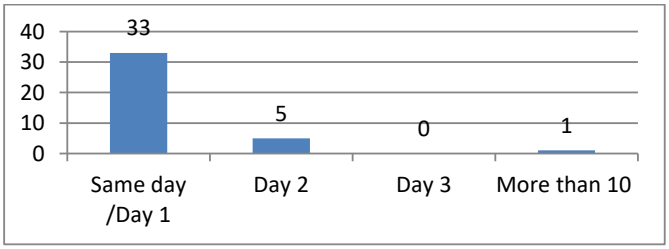


Figure 8: Compliance by month

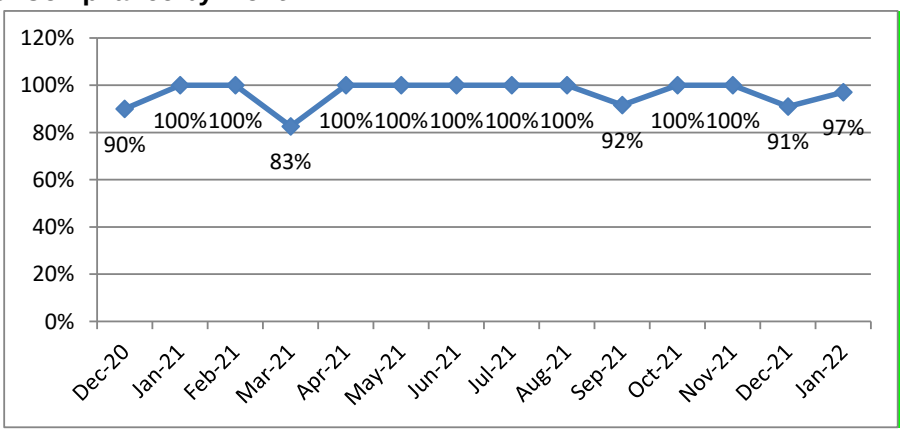


Table 1: Compliance with 3-day acknowledgement			
	Total number of complaints received in Quarter	**Total number acknowledged within 3 working days**	**% number acknowledged within 3 working days**
Q1 (2020/21)	23	19	82%
Q2 (2020/21)	35	29	83%
Q3 (2020/21)	45	44	98%
Q4 (2020/21)	53	53	100%
Q1 (2021/22)	33	33	100%
Q2 (2021/22)	39	33	85%
Q3 (2021/22)	39	38	97%

2.3.3 Complaints responded to and closed in Q2 2021/22

A total of 49 complaints were responded to and closed in Q3 of which 27 were received during Q3 (3 subsequently re-opened), 19 were received in Q2 and 5 were received in Q1.

2.3.4 Compliance with 25-day response

Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this can lead to a successful resolution of the concerns raised.

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 complaints received in Q1 and closed in Q3 took between 79-121 days to complete which not acceptable. The response times for Q3 are illustrated in Table 2 below and Figure 10 the number of complaints responded to within 25 days by month.

Table 2: Complaints received and responded to in the same Quarter (Q3 2021/22)								
Total complaints received	**Complaints responded to first stage**	**0-25 days**	**26-35 days**	**36-45 days**	**46-55 days**	**56-65 days**	**66-75 days**	**More than 75 days**
39	27	12 (44%)	12 (44%)	1 (4%)	2 (8%)			

Figure 10: Monthly compliance with 25-day response

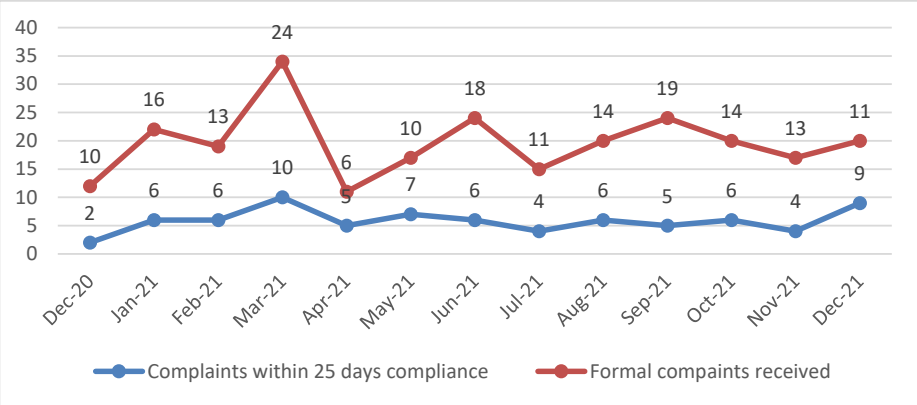


Figure 11: Compliance with 25-day response: complaints received and responded to in Q3 2021/22

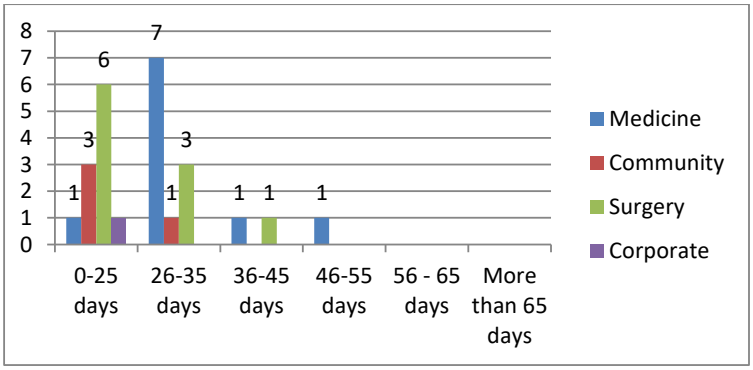
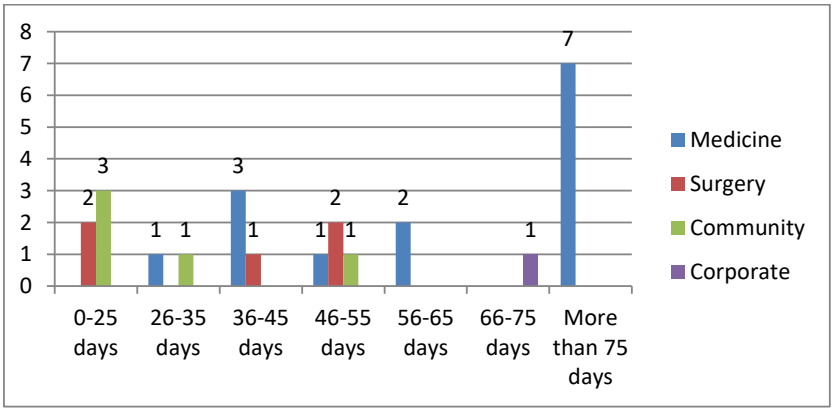


Figure 12: Compliance with 25-day response by Division: complaints received in Q1 & Q2 and responded to in Q3 2021/22



Of the 12 remaining complaints opened in Q3 that have ongoing investigations, 9 (75%) were within the 25 day timeframe at the close of Q3 and 3 (25%; 2 in Medicine and 1 in Surgery) had exceeded the timeframe. One complaint from Q2 remains open and under investigation and at Day 75 at the close of Q3.

2.3.5 Number of open and closed formal complaints by month

Table 3 shows there were 112 formal complaints opened in 2021/22 and 96 closed. The number of open complaints is inclusive of second stage complaints.

Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 3 - Formal Complaints received 2021/22													Cumulative to date
Month	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
New	6	10	18	11	14	14	14	14	11				**112**
Open	18	17	24	21	29	33	35	28	23				
Closed	25	11	8	14	9	10	12	21	16				**126**

Note 25 complaints carried over from the previous financial year 2020/21*

2.3.6 National complaint reporting: KO41a return

The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.

For assurance, Q3 data has been submitted

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse. Of the 49 complaints closed in Q3, 3 were subsequently withdrawn and closed, 13 were not upheld / resolved, 14 were partially upheld, and 19 were fully upheld.

A complaint will be partially upheld if any one concern raised is upheld irrespective of whether most concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 13 and 14 show the outcome of upheld complaints by Division.

Figure 13: Outcome of 24 complaints closed in Q3 21/22 received in Q3 21/22

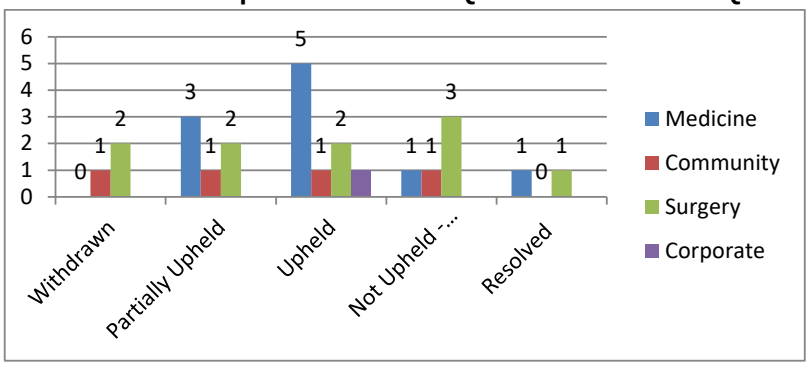
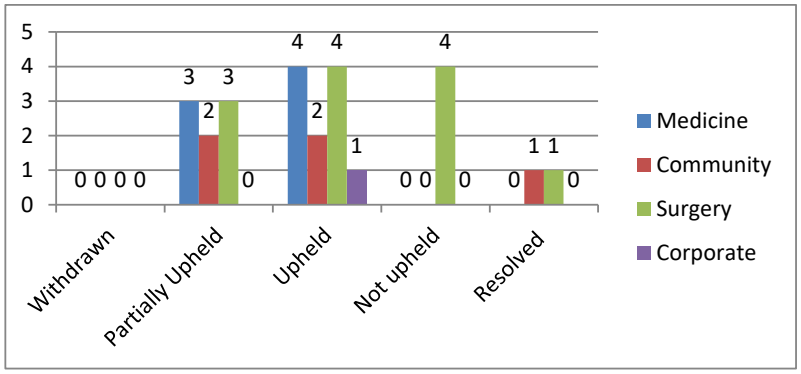


Figure 14: Outcome of 25 complaints closed in Q3 received in Q1 and Q2 2020/21



2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or requires further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

In Q3 21/22, 9 families informed us that they were not satisfied with the outcome of their initial complaint response received. Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. 5 cases have now been closed and 4 remain open and under investigation.

19 second stage complaints have been received in 2021/22 so far. Therefore, at the time of reporting 17% (19 out of 112) complaints responded to in 2021/22 have resulted in a second stage complaint. Whilst this indicates an overall high level of satisfaction with the quality and content of the initial complaint response, there is a need to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

Table 4 below shows the number of second stage complaints received and acknowledged within 25 working days in 2021/22; 8 complaints (89%) were received within 25 days working days after the initial response.

Table 4: second stage complaints received

Q	Total complaints received in Quarter	Total second stage received in Quarter	Number of days between initial response sent and second stage received (advised 25 days)					
			within 25 days	26-40 days	41-60 days	61-80 days	81-100 days	More than 100 days
Q1	33	7	2					
Q2	39	2	2					
Q3	39	9	8	1				
Q4								

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by quarter.

2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no new referrals to the Parliamentary & Health Service Ombudsman during this period. However, there are two ongoing investigations, one in the Surgical division (received April 2019) and one in Medicine (received February 2021).

2.6 Learning, action and improvements from complaints

It is essential that where things go wrong the Trust takes action to remedy any issues. Complaint response letters inform the individual complainant what action has or will be taken and the Division monitor the actions through to completion.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised are:

Surgical Division:

Concern: Patient offered surgery at short notice so some of the information in pre-op letter was not applicable
Action / improvement: Pre-admission pathway and documentation amended to ensure that all information sent to families is accurate.

Concern: Bed was not available for patient on arrival and sitting area was uncomfortable.
Action / improvement: Managers are to allocate a comfortable waiting area and offer a meal voucher to patients so that they can obtain a hot meal from the canteen or arrangements for a hot meal to be delivered to the ward

Concern: Family felt they were not given clear information on discharge.
Action / improvement: Patients are given a leaflet regarding spinal surgery in pre-op and on discharge.

Concern: Communication prior to surgery could have been improved and documentation clearer (in relation to associated risks)
Action / improvement: Anaesthetic Team are to develop an infographic aimed to improve communication of risks associated with anaesthesia and will review the information given to patients prior to surgery

Medical Division:

Concern: Poor communication
Action / improvement: Audited the screen waiting times in ED for accuracy; if staff are unable to make contact by telephone, more than one attempt should be made; parents are to be Informed of medication given to their child

Community Division:

Concern: Concerns regarding ASD assessment
Action / improvement:

- SOP for the ASD Administration Staff regarding recording all parental/carer contact to be ratified.
- SOP for the ASD Administration Staff regarding record keeping standards to ensure all clinical contact is recorded on a child's medical record as per Trust policy.
- Training to be delivered to all existing and new staff regarding record keeping standards.
- ASD referral form to capture details of parental responsibility and agreement about the referral from both parents where possible. This will include contact

details of any other parent/carer who has parental responsibility for the child/young person.

- All families whereby parents share joint parental responsibility but live separately, to be invited to contribute to assessment.
- Development to continue regarding improvements to the IT systems utilised by Alder Hey NHS Trust to allow 2 parents to automatically receive appointment letters and correspondence.

Concern: Delay in getting decision regarding ADHD diagnosis
Action / improvement: Further training to be provided particularly when the referral form and Achenbach form results do not align

Concern: Wait for appointments for two children
Action / improvement: Where possible if siblings require appointments, try to accommodate these on the same day, to avoid families making multiple trips to Alder Hey

2.7 MIAA review

The MIAA conducted an audit of complaint management during Q3 and a report was received by the Trust Audit and Research Committee in January 2022. The Trust received limited assurance and 11 recommendations have been made relating to two high risks, 6 medium risks and 3 low risks. The two high risks are in regard to identification, recording and sharing of lessons learned; and monitoring actions from complaints. A full and comprehensive action plan to address the recommendations has been devised and will be monitored to completion through CQSG.

3. PALS

3.1 Number of informal PALS concerns received Q3 2021/22

There were 395 informal concerns received during Q3 2021/22, compared to 236 in Q3 2020/21 when the Trust experienced reduced service and number of appointments during the beginning of COVID-19. In Q2 2021/22, 384 informal concerns were received.

Figure 15 below shows the number of informal PALS concerns by Division in Q3 2021/22 compared with the same period in 2020/21; showing an increase in all Divisions, and Figure 16 shows the fluctuating number by month.

Figure 15: Q3 PALS concerns by Division

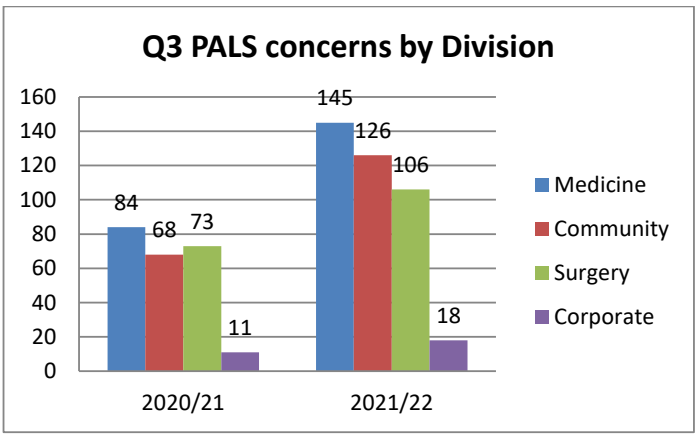
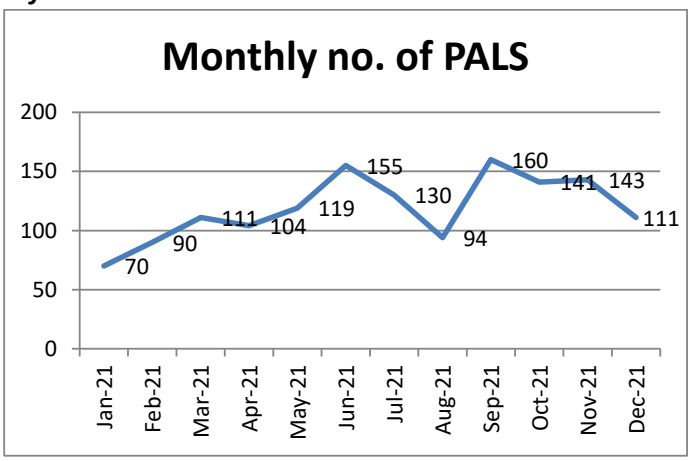


Figure 16: PALS by month



3.2 Informal PALS concerns received by category Q3 2021/22

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q3 relate to communication, appointment waiting times, and attitude of staff car parking as shown in Figure 17 in total and 18 by Division.

Figure 17: Themes of PALS concerns

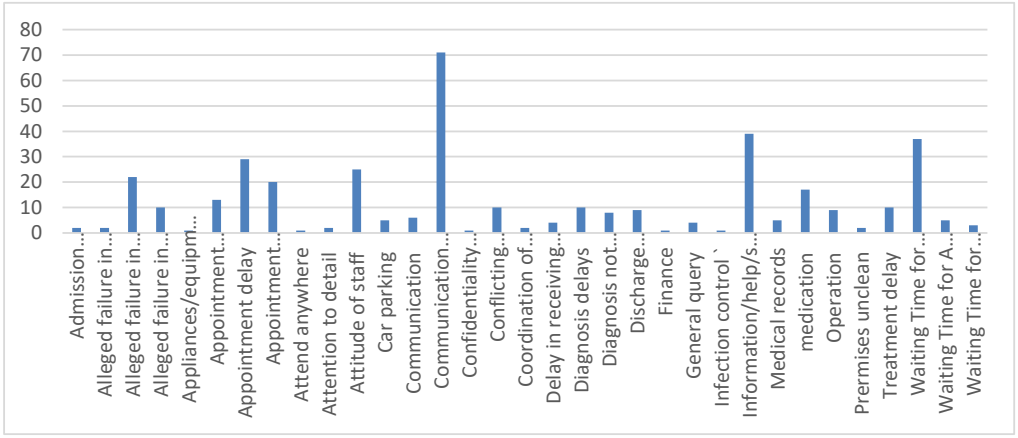
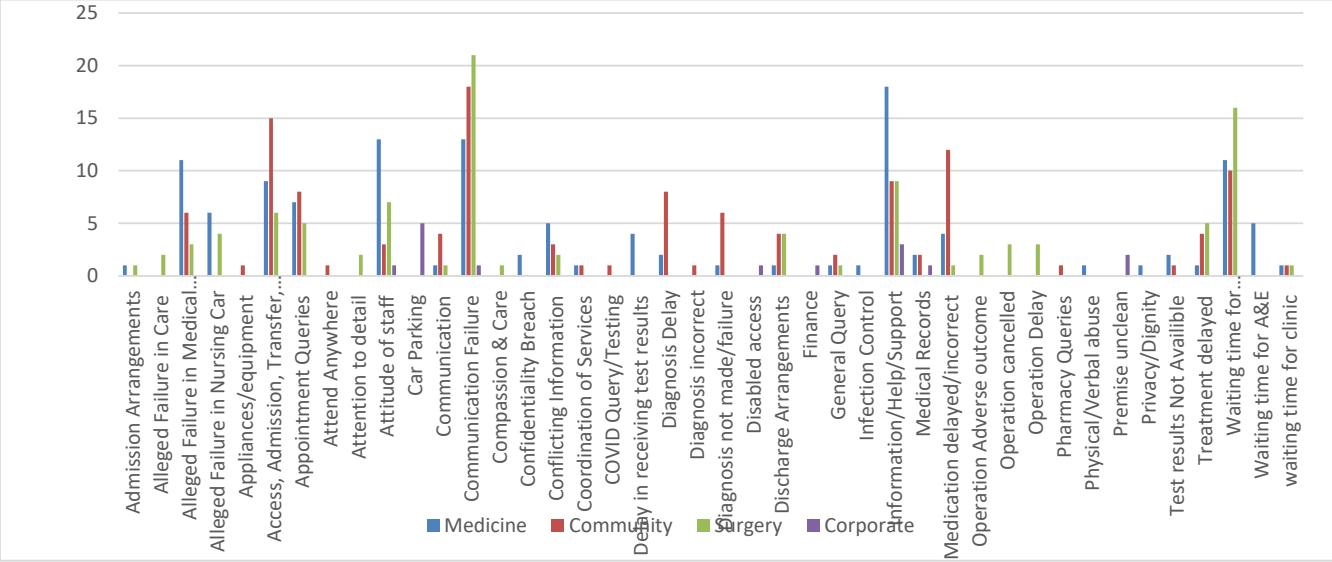


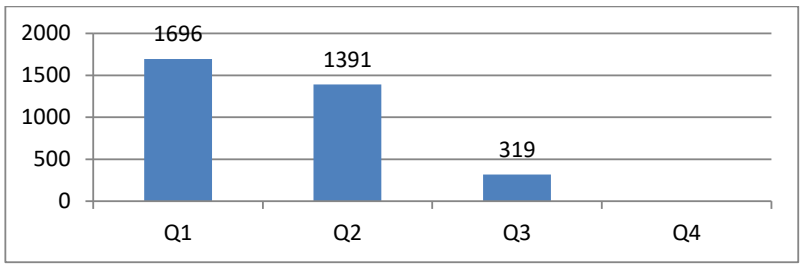
Figure 18: Themes of PALS by Division



3.3 Contacts: Customer Service/ Family Support Helpline

A significant improvement for families wishing to raise an enquiry or needing support has been through the establishment of the Family Support Helpline initially set up as a pandemic helpline. In Q3 there were 319 calls received this is a significant decrease of 1,072 compared to Q2 (1,391). This decrease is due to calls the identification of a number of calls related to appointments and Attend Anywhere therefore an improvement has been made whereby the call can be directed straight to the correct department

Figure 18: Number of calls to the helpline Q1, Q2 and Q3 2021/22



The highest numbers of activity are in regards to visiting exception forms (127), which have been introduced to assist with visiting arrangements which has been restricted due to COVID regulations. The second highest reason for calls to the helpline were made regarding help, support and advice in relation to appointments (76 regarding Attend Anywhere, and 60 appointment queries).

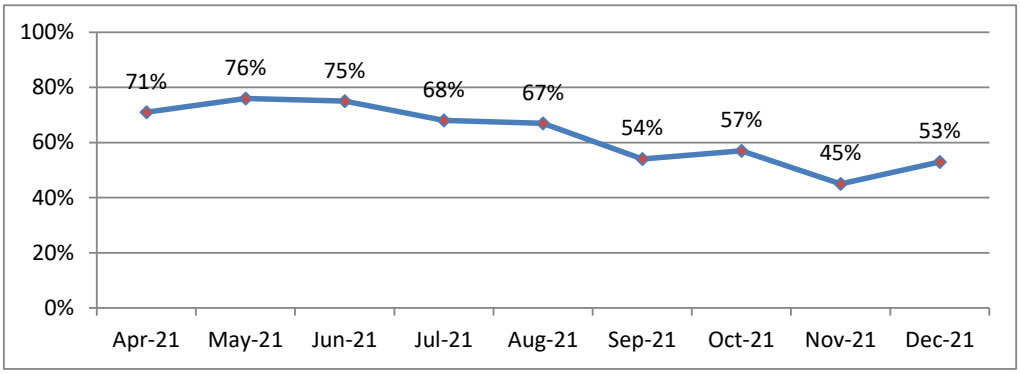
3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5-day response

The PALS and Complaints teams endeavour to respond to concerns within the 5-day timeframe in order to try and obtain quicker resolution for children and young people. For Q3, the KPI of 100% of concerns responded to within 5 days was not met, with 51% of PALS reported to be concluded within this time period as recorded within the Ulysses system and shown in Table 5 below. Figure 20 shows that the improvement in compliance which significantly improved in Q1 has not been sustained in Q2 and Q3. The Chief Nurse has met with the senior leadership team to drive improvement and it is expected that a significant improvement in performance will be evident and sustained going forward.

Table 5: Compliance within 5-day response to PALS concerns

PALS	Received Q3	Q3 5-day response	Q3 Overdue
Surgery	106	40 (37%)	67 (63%)
Medicine	145	78 (52%)	72 (48%)
Community	126	81 (65%)	44 (35%)
Corporate	18	5 (33%)	10 (67%)
Total	**395**	**204 (51%)**	**193 (49%)**

Figure 20: Percentage compliance with the 5-day response to informal concerns 2021/2022



4. Compliments in Q3

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback and demonstrating that a family feels compelled to share this with us by taking precious time to share what has been good about their experience. This feedback also provides important balance with concerns raised. Appendix I provides a sample of compliments received.

Table 6: Compliments recorded on Ulysses	
Division	**No. of compliments**
Community	48
Medicine	11
Surgery	6
Corporate	2

Conclusion

Action is required to improve compliance and ensure families receive a timely response to their concern. An action plan has been devised to address the recommendations made by MIAA following a review in Q3 (Appendix II). The Chief Nurse is working with the Divisions and Corporate services to ensure improvement is made and sustained.

Appendix I: Examples of compliments

Surgery Division

Dental & Oral Max Facial Medics: *"I wanted to say a BIG thank you to your dental team for taking great care of my daughter during her procedure last week."*

4A: *"we have experienced nothing but absolute genuine care & compassion with some wonderful people making a very difficult situation so much better. I am now in training to run a 10K to raise some funds for this amazing hospital & it's fabulous staff, it will always hold a special place in our hearts."*

Ophthalmology: *"I just wanted to say how fantastic the doctor was with (Childs name), very patient and just had a lovely way with him. He came out smiling saying I hope we see him again it was fun! and actually the male receptionist (not sure on name) was also very helpful!"*

Community Division

Sefton: *Patient noted that he would like to say thank-you for everything, and it has been nice to know that someone has been there for him*

DJU: *A thank you card from parents to the whole team at DJU. The parents also sent individual cards to several the staff team to individually thank them.*

Card reads: "To each one of you... Thank you for being so caring, kind and patient with our rainbow (child name). We were so very lucky to have you as our safe-haven and tremendously grateful that we have sunshine back in (child name)'s life. We have had some very tough days, but you held our hand throughout them all. Remember you are so valuable to each of these children but also their families. Thankyou...thankyou....thankyou.... for being such a huge part of our journey. The Dewi will always be remembered as a special place. All our love (family names) xxx"

ASD/ADHD: *After calling mum, she wanted to pass her thanks on to the whole service, said we are 'unbelievable' and 'amazing' and she has been overwhelmed by how much support she's had for (Child's name) since being on our pathway (she mentioned previous not so great experiences elsewhere)*

Medicine Division

Radiology: "*I took my 1-year old son for an x-ray on Friday afternoon and was very impressed with the service we received. He was referred by his GP and we were given an appointment on the same day that we called to book. The car park being attached to the main site is brilliant, so easy and stress less and the spaces are a good size. The building is welcoming and well signposted. We only waited 5 minutes to be seen and the 2 gentlemen (radiologists) were excellent with (Childs name), given that he is a lockdown baby and is struggling to adapt to strangers still. Most adults (parents) were wearing a mask, which was comforting. Thanks so much".*

3B: *"Everyone on 3B, where do we begin? We want you to know that our son's journey to recovery would have been incomplete without seeing your smiles. It would have been impossible to remain positive had you not given us hope through these tough times. You sat and listened, been a friend, been agony aunts, you are not just nurses but angels in disguise. Not a moment goes by when we don't have an overwhelming sense of gratitude for you all for going above and beyond your call of duty and look after us like a family. We feel thank you isn't enough. You all should be so proud of yourselves."*

Emergency Department: *"Mother called to pass compliment on to A&E staff Doctors / Nurses Play Specialist etc and with special mention to the play specialist. Encouraging (Childs name) to have inhaler and providing toys to make whole experience positive & easier. Also, in general care and compassion overall during visit to A&E on".*

Corporate Division

Covid swabbing: *This patient has additional needs and Mum attended the Covid swabbing garage this morning for the pre-op Covid swab. Both parent and patient had a very positive experience today. Mum stated that the staff member (Mum did not get a name but said he was male) was 'brilliant' when both communicating with the patient and obtaining his swab. Mum said that the staff member was using sign language to the patient as he was non-verbal and made them both feel very much at ease. Mum was 'very impressed'*

Covid vaccine centre: *"My son received his Covid vaccine today. The staff were amazing and professional, and my son was not frightened by the experience at all. Thank you."*

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	**Proposal regarding Alder Hey becoming the Legal Entity for the Paediatric Sexual Assault Referral Centre (SARC).**
Report of:	**Lisa Cooper, Director Community & Mental Health Services**
Paper Prepared by:	**Dr Linda Teebay, Consultant Forensic & Legal Medicine, Safeguarding Paediatrician and Forensic Lead Paediatric SARC**

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	Costs (estimates): £15k for initial assessment / accreditation, ongoing costs of £5k/year to retain accreditation. Invoices to the Legal Entity will be reimbursed by Merseyside Police
Links to risk register	

1. Introduction

The purpose of this paper is to present to Trust Board a proposal regarding Alder Hey becoming the Legal Entity for the Paediatric Sexual Assault Referral Centre (SARC).

2. Background

Alder Hey currently provides the Rainbow Centre which includes the paediatric SARC for Merseyside. This service provides a holistic assessment for children and young people who are suspected or known to have been sexually abused. The assessment is completed by the safeguarding paediatricians supported by specialist nurses, psychologists and forensic physicians (also known as FME's) who provide the forensic aspect of the assessment.

The Rainbow SARC has a formal contractual arrangement in place with St Mary's SARC (Central Manchester University Hospitals NHS Foundation Trust) to provide the forensic physicians and are also responsible for assuring that the forensic physicians meet all personnel and competence requirements.

3. Accreditation and Legal Entity

From October 2023 it is a legal requirement that all SARCs achieve accreditation via the UK Accreditation Service (UKAS). UKAS is independent and the single accreditation body for the UK. Accreditation demonstrates adherence to quality standards including technical and clinical competence.

A key requirement for accreditation is the identification of the 'Legal Entity'. The Legal Entity is the organisation which is awarded the UKAS accreditation.

3.1 Assessment for Accreditation

Accreditation will be assessed against the international standard: ISO 15189:2012 "Medical laboratories — Requirements for quality and competence" and supported by the Forensic Science Regulator (FSR) FSR-S-116 standard for medical examination of adult / child sexual assault and the associated guidance FRS-G-212 **(Appendices)**.

Key areas covered by the ISO:

- Governance: personnel, training/competencies, SOPs, documentation etc
- Accommodation and environmental conditions
- DNA control and contamination risks
- QMS including assurance and sustainability

3.2 Issue of Legal Entity

The accredited Legal Entity will be legally responsible (and therefore liable) for all the work being delivered under its accreditation, irrespective of who is delivering it. They will therefore need to demonstrate through documented evidence (for example

policies, procedures, agreements, contracts and records) that it has control over all aspects of the delivery of forensic medical examination services.
A consideration when deciding which organisation should host the Legal Entity is "*who provides / manages the majority of the aspects of the SARC work and is able to demonstrate competency to the ISO standard?*". A registered organisation is defined in the ISO and has legal responsibility for

- Liability
- Direction and control
- Information and data
- Management system
- Financing the activities performed under the accreditation.

The identification of the Legal Entity for the Rainbow SARC has currently not been resolved. NHS England & Improvement as the current commissioners of the SARC have advised that the issue relates to the forensic aspects of a SARC medical assessment and that they will not accept responsibility to provide Legal Entities. They have advised that local NHS Trusts may be the most appropriate organisation for the role of Legal Entity.

Rainbow SARC currently fulfil several of the requirements needed to acquire the UKAS accreditation. In addition, the Quality Standards department of Merseyside Police are supporting the service with the additional changes required to meet the relevant ISO standard.

It should be noted that the Trust's pathology laboratory gained UKAS accreditation (ISO 15189 for medical laboratories), with the Trust being the Legal Entity for this accreditation.

4. Proposal

It is proposed that Alder Hey accepts the role of Legal Entity and therefore retains overall control of the Rainbow SARC. The service will continue to work collaboratively with Merseyside Police to achieve and retain UKAS accreditation. Merseyside Police will finance costs incurred by the Trust acquiring and retaining UKAS accreditation.

The oversight and management of achievement of UKAS accreditation will be monitored via the Community and Mental Health Divisional Governance arrangements.

5. Next Steps

The Trust Board is asked to note the contents of this report and approve the Trust to accept the role of Legal Entity in relation to the Rainbow SARC.

Appendices


ISO 15189 2012.pdf


FCN-QP-SAR-GUI-00 03 Guidance for Forer_Sexual_Assault_Exam


32068-212_Guidance ments_Sexual_Assault


32068-116_Require

Forensic Capability Network

Guidance for Forensic Medical Examination Services, ISO 15189 and Legal Entity

Table of Contents

1 Overview

1.1 Background

The Forensic Science Regulator (FSR) has identified a requirement for the accreditation of forensic medical examination services to the international standard ISO 15189 by 1st October 2023. This requirement applies to all facilities carrying out evidence recovery from complainants of alleged or suspected sexual assault, including Sexual Assault Referral Centres (SARCs), facilities within police premises, such as patient examination suites or sympathy suites, and those within National Health Service (NHS) premises. Further, this requirement applies to the personnel involved in performing, supporting and managing the delivery of forensic medical examination services at these facilities, regardless of whether that service is provided by different or multiple providers (charity, NHS England and Improvement, private) and regardless of the commissioning arrangements or funding structure in place.

A key requirement for accreditation is the identification of the 'Legal Entity'. This is the organisation which is awarded the accreditation, is responsible for ensuring that accreditation requirements are met and is financially and legally responsible for the activities performed under the accreditation. It should be noted that where the term 'legal entity' is used in this document, it is with this definition in mind. The array and complexity of operating models and funding structures for the delivery of forensic medical examination services is such that identification and establishment of the 'legal entity' for the accreditation of these services is proving difficult in many cases.

1.2 Purpose

This document provides guidance on the governance requirements of a legal entity in relation to accreditation and aims to assist with determining and establishing an appropriate legal entity for the accreditation of forensic medical examination services by:

- identifying the responsibilities of a legal entity as required by ISO 15189 such that these responsibilities and requirements may be mapped against the operating model of a given service, and
- providing guidance for the formulation of policies, procedures and agreements to assist with the recognition of the legal entity.

Appendix 1 describes the current SARC operating model landscape and uses examples from that landscape to demonstrate how the requirements of ISO 15189 can be demonstrated by a nominated legal entity in a given model.

2 Governance Requirements

To meet the requirements of ISO 15189 the designated legal entity will need to demonstrate through documented evidence (for example policies, procedures, agreements, contracts and records) that it has control over all aspects of the delivery of forensic medical examination services. Where multi-site accreditation is required then this control must be demonstrated across all sites. A number of specific areas requiring consideration for accreditation are discussed below.

2.1 Legal Responsibility (ISO 15189:2012 section 4.1.1.2)

The accredited entity is legally responsible (and therefore liable) for all the work being delivered under its accreditation irrespective of who is delivering it. Further, where an entity

or accreditation is dissolved or terminated, the original entity remains responsible for all previously accredited work, unless that liability is transferred to, or taken on by, another party.

2.2 Legal Entity (ISO 15189:2012 section 4.1)

The provider of the forensic medical examination services can be the same legal entity (organisation) as its customer (e.g. Police providers) but it can also be another legal entity. Accreditation is held by the legal entity which takes responsibility for the delivery of the forensic medical examination services and for ensuring conformity to ISO 15189. If services are delivered using personnel employed by another organisation then there should be clear contractual arrangements for the use of these personnel and the competence requirements. This can be considered as 'contracting in' the appropriate resources. This needs to be managed in accordance with the requirements of ISO 15189 to ensure it is clearly evident that the service is delivered under the control and responsibility of the accredited legal entity.

2.3 Management System (ISO 15189:2012 section 4.2)

The QMS directs and controls the quality of services delivered by the forensic medical examination facility and personnel. The legal entity has overall responsibility and accountability for this QMS. It must be clear that the management system including supporting policies and procedures are owned and controlled by the legal entity and that all personnel undertaking the accredited activities work to the content of that management system. For example, all personnel will work to the required policies/procedures covering confidentiality, impartiality, competence, professional development, complaints, examination procedures, labelling of items, retention etc. Where services are delivered using personnel employed by other organisation(s) then it must be demonstrably clear that these personnel are working under the control of, and to the requirements of, the accredited legal entity/QMS rather than following the policies or procedures of their 'home' organisation.

2.4 Direction and Control (ISO 15189:2012 sections 4.1.1.3, 4.1.1.4, 4.1.2, 4.2, 4.4.1, 4.6, 4.15, 5.1, 5.2, 5.10.2)

It must be clear that the accredited entity has direction and control over resources to deliver the accredited work (e.g. staff, equipment, facilities) including ensuring appropriate staffing levels. An organisational chart that identifies the lines of responsibility, clinical governance structures and legal responsibilities that cover all aspects of the service must be documented.

A senior manager (for example Clinical Director/Service Director or however named) appointed by the legal entity will have responsibility for the services provided. This includes providing leadership of service provision and having authority and responsibility for the management and implementation of policy.

Where services are delivered using personnel employed by other organisation(s) there must be demonstrable formal agreement between the parties on the specific details of direction and control for those personnel. Approval to work at the facility will be evidenced and documented by the accredited entity and will include records to evidence competency and authorisation.

The legal entity must also be able to demonstrate assurance on compliance with accreditation requirements for other supporting services such as IT, procurement, facility management and exhibit storage. Where services are provided externally, evaluation and approval of them as a supplier must be maintained.

2.5 Information and Data (ISO 15189:2012 section 5.10)

The legal entity has responsibility for all reports/outputs of the accredited activities. It must be clear that the accredited entity owns and has access and control over the records,

information and data generated from the accredited activities. It is particularly important that measures are in place to facilitate access to that information in the event the legal entity ceases to exist (see also FSR CoP 7.1.2).

2.6 Multi-site accreditation (UKAS GEN 1)

Multi-site accreditation may be requested where forensic medical examination services are delivered at more than one site (location) by the same legal entity and under the same management system. Key considerations for multi-site accreditation include:

- management: Service Director (or however named) suitably involved with management at all sites; management at all sites demonstrably part of and interacting with QMS
- personnel: common competence criteria, centralised management of resources and competence; centralised training and education
- management system: common management system implemented at all locations; common policies, procedures and documentation; centralised quality assurance and implementation of any corrective action across all sites (as relevant)
- monitoring of the effectiveness of the management system: centralised planning for monitoring the effectiveness of the management system; audit program covering all locations, comprehensive analysis of audit outcomes; centralised following of customer feedback, complaints and non-conformities across all sites
- records available at head office

Footnote

The above is not an exhaustive list but highlights some key areas for consideration when determining and establishing the legal entity for the accreditation of the delivery of forensic medical examination services.

3 References

Document name	Responsible Organisation
BS EN ISO 15189:2012 Medical laboratories – Requirements for quality and competence	British Standards Institution
ILAC G19:08/2014 Modules in Forensic Science Process	International Laboratory Accreditation Cooperation
FSR-C-100 Codes of Practice and Conduct for Forensic Science Providers and Practitioners in the Criminal Justice System	Forensic Science Regulator
FSR-C-116 Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence Issue 1	Forensic Science Regulator
FSR-G-212 Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations Issue 1	Forensic Science Regulator
The Role of the Clinical Director in the Sexual Assault Referral Centre (SARC) October 2020	Faculty of Forensic and Legal Medicine (FFLM)
GEN 1 – General Principles for the Assessment of Conformity Assessment Bodies by UKAS Edition 2, July 2020	UKAS
Technical Bulletin – Accreditation requirements for Police Force Collaborations February 2020	UKAS

Appendix 1

This appendix aims to identify how the legal entity requirements of ISO 15189 may be met by the nominated legal entity of a given operating model. The three examples given are taken from the current SARC landscape.

Current SARC Landscape

Model	Premises	Provider / SARC Manager	Forensic Clinician
1	**NHS**	**NHS**	**FSP**
2	**NHS**	**FSP**	**FSP**
3	Council	NHS	NHS
4	Police	Charity	FSP
5	Police	FSP	FSP
6	**Police**	**Police/Charity**	**NHS**
7	Police	Police/Charity	FSP

The legal entity must take responsibility for and be able to demonstrate control over all aspects of the delivery of the forensic medical examination service.

This includes

- Competency for personnel working within the service delivery
- QMS and procedural documents and policies
- Compliance with accreditation for supporting services, i.e. IT, exhibit storage, procurement, facility management.
- Ownership and control of records including reports and outputs.

Provided the above points (and those detailed in the main body of this document) are achieved by the identified legal entity, then any combination of organisation should be possible.

Model 1:

Premises	Provider / SARC Manager	Forensic Clinician
NHS	**NHS**	**FSP**

- **FSP identified as the legal entity for accreditation**

The FSP will be legally responsible for the work being delivered. The FSP must demonstrate control over all aspects of service delivery including the NHS premises and NHS personnel involved in operating the service. Any NHS personnel involved in the delivery of the service must be 'contracted-in' to the FSP for their given role and responsibilities in the service. Contract(s) must be a formal agreement between the FSP and the NHS and must include details on specific direction and control of those personnel. Contract(s) should be available to UKAS for assessment purposes.

The QMS, including all policies and procedures, is owned and controlled by the FSP and there must be evidence to demonstrate that all personnel involved in service delivery (irrespective of their employer) are conforming to the FSP QMS documents whilst delivering that service (and not to the policies and procedures of their employer / NHS). The FSP QMS

must also define the training and competency requirements for all personnel and the FSP must be able to demonstrate that these requirements are met by all personnel, including any contracted-in.

The FSP must have an organisational chart to clearly demonstrate the lines of responsibility, clinical governance structures and the legal responsibilities to cover all aspects of the service. This should also identify the senior manager of the SARC who has overall responsibility for the service delivery, leadership and management and implementation of policies. If this person is from the NHS, then they must be 'contracted-in'.

Details of the arrangement for the FSP to use NHS premises must be formally agreed and documented. There may be several options here including, the NHS (premises owner) providing facilities that meet the defined requirements/specification of the FSP (legal entity) or the FSP having authority to develop the facilities themselves. Regardless of who owns the premises, the FSP must demonstrate control over the accommodation/examination room(s) and equipment used to deliver the service including any exhibit storage facilities. The FSP has responsibility for the suitability of the accommodation and equipment used including security and access. The full requirements are given in ISO 15189 and FSR-C-116.

The FSP must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by the NHS or by another external party, then the FSP should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the FSP and reports are issued by, and under the authority of, the FSP.

- **NHS identified as the legal entity for accreditation**

The NHS will be legally responsible for the work being delivered. The NHS must demonstrate control over all aspects of service delivery including the FSP Forensic Clinician(s) involved in operating the service. Any FSP Forensic Clinicians involved in the delivery of the service must be 'contracted-in' to the NHS for their given role and responsibilities in the service. Contract(s) must be a formal agreement between the NHS and the FSP and must include details on specific direction and control of the Forensic Clinicians. Contract(s) should be available to UKAS for assessment purposes.

The QMS, including all policies and procedures, is owned and controlled by the NHS and there must be evidence to demonstrate that all personnel involved in service delivery, including the FSP Forensic Clinicians are conforming to the NHS QMS documents whilst delivering that service (and not to the policies and procedures of their employer / FSP). The NHS QMS must also define the training and competency requirements for Forensic Clinicians and the NHS must be able to demonstrate that these requirements are met by contracted-in FSP personnel.

The NHS must have an organisational chart to clearly demonstrate the lines of responsibility, clinical governance structures and the legal responsibilities to cover all aspects of the service.

The NHS has responsibility for the accommodation/examination room(s) and equipment used to deliver the service including security, access and correct handling. Policies and procedures must give consideration to the use of contracted-in FSP Forensic Clinicians.

The NHS must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by an external party, then the NHS should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the NHS and reports are issued by, and under the authority of, the NHS.

Model 2:

Premises	Provider / SARC Manager	Forensic Clinician
NHS	**FSP**	**FSP**

- **FSP identified as the legal entity for accreditation**

The FSP is legally responsible for the work being delivered. The FSP must demonstrate control over all aspects of service delivery including the NHS premises used in operating the service.

The QMS, including all policies and procedures, is owned and controlled by the FSP. Details of the arrangement for the FSP to use NHS premises must be formally agreed and documented. There may be several options here including, the NHS (premises owner) providing facilities that meet the defined requirements/specification of the FSP (legal entity) or the FSP having authority to develop the facilities themselves. Regardless of who owns the premises, the FSP must demonstrate control over the accommodation/examination room(s) and equipment used to deliver the service including any exhibit storage facilities. The FSP has responsibility for the suitability of the accommodation and equipment used including security and access. The full requirements are given in ISO 15189 and FSR-C-116.

The FSP must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by the NHS or by another external party, then the FSP should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the FSP and reports are issued by, and under the authority of, the FSP.

- **NHS identified as the legal entity for accreditation**

The NHS is legally responsible for the work being delivered. The NHS must demonstrate control over all aspects of service delivery including the FSP personnel involved in operating the service. Any FSP personnel involved in the delivery of the service must be 'contracted-in' to the NHS for their given role and responsibilities in the service. Contract(s) must be a formal agreement between the NHS and the FSP and must include details on specific direction and control of those personnel. Contract(s) should be available to UKAS for assessment purposes.

The QMS, including all policies and procedures, is owned and controlled by the NHS and there must be evidence to demonstrate that all personnel involved in service delivery, including the FSP personnel are conforming to the NHS QMS documents whilst delivering that service (and not to the policies and procedures of their employer / FSP). The NHS QMS must also define the training and competency requirements for FSP personnel and the NHS must be able to demonstrate that these requirements are met by contracted-in FSP personnel.

The NHS must have an organisational chart to clearly demonstrate the lines of responsibility, clinical governance structures and the legal responsibilities to cover all aspects of the service. This should also identify the senior manager of the SARC who has overall

responsibility for the service delivery, leadership and management and implementation of policies. If this person is from the FSP, then they must be 'contracted-in'.

The NHS has responsibility for the accommodation/examination room(s) and equipment used to deliver the service including security, access and correct handling. Policies and procedures must give consideration to the use of contracted-in FSP personnel.

The NHS must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by an external party, then the NHS should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the NHS and reports are issued by, and under the authority of, the NHS.

Model 6:

Premises	Provider / SARC Manager	Forensic Clinician
Police	**Police/Charity**	**NHS**

- **Police identified as the legal entity for accreditation**

The Police will be legally responsible for the work being delivered. The Police must demonstrate control over all aspects of service delivery including the charity personnel and NHS Forensic Clinician(s) involved in operating the service. Any charity personnel and NHS Forensic Clinicians involved in the delivery of the service must be 'contracted-in' to the Police for their given role and responsibilities in the service. Contract(s) must be a formal agreement between the Police and the charity / NHS and must include details on specific direction and control of the respective personnel. Contract(s) should be available to UKAS for assessment purposes.

The QMS, including all policies and procedures, is owned and controlled by the Police and there must be evidence to demonstrate that all personnel involved in service delivery, are conforming to the Police QMS documents whilst delivering that service (and not to the policies and procedures of their 'home' organisation – charity or NHS). The Police QMS must also define the training and competency requirements for the roles undertaken by charity personnel and Forensic Clinicians and the Police must be able to demonstrate that these requirements are met by the contracted-in charity and NHS personnel.

The Police must have an organisational chart to clearly demonstrate the lines of responsibility, clinical governance structures and the legal responsibilities to cover all aspects of the service. This should also identify the senior manager of the SARC who has overall responsibility for the service delivery, leadership and management and implementation of policies. If this person is from the charity, then they must be 'contracted-in'.

The Police has responsibility for the accommodation/examination room(s) and equipment used to deliver the service including security, access and correct handling. Policies and procedures must give consideration to the use of contracted-in charity personnel and NHS Forensic Clinicians.

The Police must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by an external party, then the Police should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the Police and reports are issued by, and under the authority of, the Police.

- **NHS identified as the legal entity for accreditation**

The NHS will be legally responsible for the work being delivered. The NHS must demonstrate control over all aspects of service delivery including the charity or police premises and the charity and police personnel involved in operating the service. Any charity or police personnel involved in the delivery of the service must be 'contracted-in' to the NHS for their given role and responsibilities in the service. Contract(s) must be a formal agreement between the police and/or charity and the NHS and must include details on specific direction and control of those personnel. Contract(s) should be available to UKAS for assessment purposes.

The QMS, including all policies and procedures, is owned and controlled by the NHS and there must be evidence to demonstrate that all personnel involved in service delivery (irrespective of their employer) are conforming to the NHS QMS documents whilst delivering that service (and not to the policies and procedures of their home organisation of the police or charity). The NHS QMS must also define the training and competency requirements for all personnel and the NHS must be able to demonstrate that these requirements are met by all personnel, including any contracted-in.

The NHS must have an organisational chart to clearly demonstrate the lines of responsibility, clinical governance structures and the legal responsibilities to cover all aspects of the service. This should also identify the senior manager of the SARC who has overall responsibility for the service delivery, leadership and management and implementation of policies. If this person is from the charity or police, then they must be 'contracted-in'.

Details of the arrangement for the NHS to use the police premises must be formally agreed and documented. There may be several options here including, the police (premises owner) providing facilities that meet the defined requirements/specification of the NHS (legal entity) or the NHS having authority to develop the facilities themselves. Regardless of who owns the premises, the NHS must demonstrate control over the accommodation/examination room(s) and equipment used to deliver the service including any exhibit storage facilities. The NHS has responsibility for the suitability of the accommodation and equipment used including security and access. The full requirements are given in ISO 15189 and FSR-C-116.

The NHS must be able to demonstrate assurance on the compliance for accreditation requirements with all of the supporting services such as IT, procurement and facility management. If these services are provided by an external party, then the NHS should treat them as a 'supplier' and complete supplier evaluation and approval accordingly.

All records and notes are owned by the NHS and reports are issued by, and under the authority of, the NHS.

Footnote

It is recommended that where an operating model includes multiple organisations that legal input is sought to ensure the clauses of any contract between parties meet the aforementioned expectations.

UKAS will assess the appropriateness and effectiveness of any given arrangements.

Document Control

Document status	DRAFT
Author	Sonia Marshall – Lead Scientist (FCN)
Approved By	Guylaine Hanford – Quality Officer (FCN)

Update History

Version	Issue date	Reason for issue	Updated by
1.0	29/09/2021	Due to the complex landscape of SARC, there has been a delay in deciding who would be the legal entity for responsibility for accreditation to ISO 15189. This has been identified as a risk to achieving accreditation targets set by the FSR by both the APCC SARC task and finish group and the FCN SARC Network group	Sonia Marshall – Lead Scientist (FCN)

Grey shaded sections will denote changes from previous version

Forensic Science Regulator
Overseeing Quality

Forensic Science Regulator Guidance

Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations

FSR-G-212

Issue 1

CONTENTS

1. Introduction

1.1.1 This guidance should be used alongside Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, which sets out the requirement for accreditation to the international standard ISO 15189 Medical laboratories – Requirements for quality and competence for the forensic medical examination[1] services relating to alleged sexual assault.

1.1.2 The remit of the Forensic Science Regulator covers obtaining samples for scientific analysis in criminal investigations and does not cover medical practices; any reference to medical practice is included for context, as forensic sampling and the medical care of patients[2] overlap.

1.1.3 Throughout this guidance, reference is made to sexual offences and sexual assaults rather than alleged offences and alleged assaults. This is because some patients have not themselves made allegations.

2. Background

2.1.1 Sexual offences are devastating crimes; the impact of sexual violence is now well evidenced and can include significant consequences to the long-term health and well-being of patients. In the aftermath of an assault all patients, regardless of age or gender, should have access to a timely, high-quality forensic medical examination:

a. to address their concerns;
b. minimise trauma; and
c. aid and support their recovery.

2.1.2 At the same time the collection of evidence can provide patients with the option to assist in any criminal investigation. The evidence collected in the form of information and items may aid a criminal prosecution, prevent further sexual violence or assist with the exoneration of the innocent.

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[1] Activity includes recording, collecting samples for scientific analysis and documenting injuries.

[2] In the context of this document, a patient is an individual subjected to or suspected of being subjected to sexual assault.

2.1.3 The provision of dedicated services for the health and well-being of patients and delivery of justice has considerable benefits. Such services provide patients with the opportunity for high-quality care alongside forensic medical examination[3] and the possible collection of samples/evidence. This provides both the police and the patient with the best possible opportunity to recover evidence for use within an investigation, if the patient so chooses, and minimises the risk of a miscarriage of justice:

a. the risk of wrongful conviction(s);
b. wrongful acquittal(s); or
c. obstructing or delaying investigation(s).

2.1.4 Whilst the need to provide high-quality medical care is of primary importance, it is essential that due consideration is given to the demands of the forensic context to achieve high-quality samples for scientific analysis. Defined standards are necessary for all stages of the patient's 'journey' immediately before and during the forensic medical examination. These ensure that there is confidence in the relevance of any medical findings documented during the examination, and in any subsequent scientific results from the samples taken during the examination. The patient's care pathway varies, based on the individual case and local variation of service delivery. However, this should not detract from achieving the best health and justice outcomes for the patient.

2.1.5 The implementation of standards and guidance as part of an process is assessed by a third party, the United Kingdom Accreditation Service (UKAS). UKAS is the national accreditation body that provides external scrutiny and assurance that the appropriate standard is being met in the UK.

2.1.6 Safeguarding issues, safety plans specifically relating to children, and social issues are very important, and reference is made to the medical and therapeutic needs of the individual. However, these fall outside the Forensic Science Regulator's remit and are therefore not part of this guidance; this guidance covers the following areas related to forensic science practice:

[3] The medical and therapeutic needs may override the requirement to collect forensic science related evidence.

a. training and ongoing competence of personnel;
b. accommodation and environmental conditions;
c. equipment used for the examination;
d. examination process and methods;
e. handling, storage and transport of forensic samples;
f. the notes, reports and statements generated;
g. quality management; and
h. continuous improvement, review and audit.

2.1.7 This document provides good practice for the forensic medical examination of patients who may have been subjected to sexual assault. These encompass:

a. the gathering of information;
b. retrieval of personal samples and other trace evidence from an individual for forensic purposes;
c. the collection of clothing from the individual; and
d. recording the presence or absence of injuries.

3. Scope

3.1.1 This guidance applies to cases submitted to criminal courts in England and Wales. Scotland and Northern Ireland may also institute parallel arrangements for their jurisdictions.

3.1.2 The purpose of this guidance is to support meeting the standard ISO 15189:2012 Medical laboratories – Requirements for quality and competence and the requirements set out by the Forensic Science Regulator in the Codes[4] and in Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116[5].

3.1.3 This guidance covers the facility where a forensic medical examination and the collection of evidence from a patient takes place. The most frequently used type of facilities in England and Wales are known as sexual assault referral centres (SARCs). Other facilities also exist within police premises, such as patient

[4] Forensic Science Regulator, Codes of Practice and Conduct for Forensic Science Providers and Practitioners in the Criminal Justice System.

[5] Forensic Science Regulator, Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116.

examination suites or sympathy suites, and within National Health Service premises. For the purpose of the Forensic Science Regulator's Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 and this guidance, these facilities wherever they are located are referred to collectively as a 'medical examination and sample collection facility' (the facility) and are recognised as a forensic unit for the purposes of relevant forensic science standards and guidance.

3.1.4 This guidance encompasses parts of the pathway from the first disclosure or first suspicion, to the completion of the forensic medical examination and directly related activities within the facility. Other services provided to the patient, such as counselling, practical and emotional support, are outside the scope of this guidance. The use of early evidence kits (EEKs) is included, as these may be used at the facility, if not prior to the patient's arrival at the facility.

3.1.5 Figure 1 (for adults) and Figure 2 (for children), set out in the Forensic Science Regulator's Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, outline where the facility's practices and procedures occur within the patient's 'journey' from the incident to court.[6] These figures also identify where the various standards and guidance apply.

3.1.6 It is important to note that the facility may require the input of multiple service providers working together to deliver the service for the patient. Due to the historical commissioning and funding arrangements that have evolved in England and Wales, a range of service providers may come together to deliver different elements of the service provision. The forensic medical provider will, in many services, be different to the provider of crisis workers, other professionals and core administrative staff.

3.1.7 This guidance applies to all personnel involved in performing and supporting the medical examination and managing the facility, including services provided by

[6] These diagrams are not care pathways nor are they intended to be used as referral routes.

different or multiple providers regardless of the commissioning arrangements or funding structure.

3.1.8 Areas such as medical evaluation and treatment, suicide risk and mental health assessments, medical case reviews and post-forensic examination treatment/follow-up are outside the scope of this guidance. These come under the responsibility of clinical governance.

3.1.9 For the purposes of this guidance it is assumed that all relevant training, processes and reporting to meet the requisite legal, medical and safeguarding requirements are already in place.

4. Implementation

4.1.1 The requirements set out in this guidance and the Forensic Science Regulator's Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 shall be incorporated into the policies, processes and procedures within the facility.

4.1.2 This document is available for incorporation into an organisation's standard operating procedures and quality management system (QMS) from the date of publication.

5. Modification

5.1.1 This is the first issue of this document.

6. Terms and Definitions

6.1.1 The terms and definitions set out in the Forensic Science Regulator's Codes of Practice and Conduct (the Codes), DNA Anti-Contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities FSR-G-207, Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116 and the glossary section apply to this document. Those in ILAC G19:08/2014[7] apply where there is no corresponding definition set out in the Forensic Science Regulator's guidance and the Codes.

[7] ILAC G19:08/2014 Modules in a Forensic Science Process.

6.1.2 The word 'shall' has been used in this document where there is a corresponding requirement in ISO 15189:2012, the Codes and FSR-C-116; the word 'should'[8] has been used to indicate generally accepted practice where the reason for not complying, or any deviation, shall be recorded. The word 'may' has been used for recommendations. Recommendations have been used to indicate what ideal practice is when it is practicable.

7. Management Requirements

7.1 General (ISO 15189 4.1)

7.1.1 A nominated senior manager from the service provider with responsibility for the facility shall be identified, to support the delivery of good practice and the quality standards stated.

7.1.2 This guidance defines requirements for quality and competence that fall into two main categories:

a. technical requirements, which are covered in section 8 of this document; and
b. management requirements, which are covered in this section.

7.2 Organisation and Management Responsibility (ISO 15189 4.1)

7.2.1 The organisation and management responsibility of the facility shall be defined and documented.

7.2.2 The management responsible for the facility shall produce an organisation chart that makes clear the lines of responsibility, clinical governance structures and legal responsibilities that cover all aspects of the services, including all personnel working therein.

7.2.3 The role and responsibilities for all personnel working within the facility shall be defined and documented to manage resources, training, competency and service provision.

[8] In good medical practice 'should' is used when providing an explanation of how to meet the overriding duty and where the duty or principle will not apply in all situations or circumstances, or where there are factors outside the practitioner's control that affect whether or how guidance can be followed (General Medical Council, 2013).

7.2.4 The facility shall be managed by a person or persons with the competence, authority and responsibility for all aspects of the services provided.

7.3 Quality Management System (ISO 15189 4.2)

7.3.1 A quality management system (QMS) shall be established and maintained that directs and controls the quality of services at the facility by all providers . The legal entity that takes overall responsibility and accountability for quality at the facility shall be defined.

7.3.2 A quality manager shall be appointed to ensure that the QMS functions correctly. The QMS shall include the elements outlined in 7.4 to 7.6 below.

7.4 Quality Manual (ISO 15189 4.2.2.2, 4.1.2.3)

7.4.1 The quality manual shall include the following elements.

a. A quality policy signed by the senior management of the legal entity for the facility. This shall include:

   i. a commitment to good professional practice;
   ii. the provision of quality examination; and
   iii. compliance by all staff with the standards and good practice to which the facility operates.

b. A statement of the facility's service standards and a description of the objectives of the quality system.
c. Quality objectives and plans.
d. A description of the organisation, structure, responsibilities and authorities.
e. A description of the elements of the quality system and any references to documented quality system procedures including:

   i. control of documents;
   ii. control of records; and
   iii. control of collected samples and material.

7.5 Procedures, Instructions and Forms (ISO 15189 4.2, 5.5.3)

7.5.1 The procedures, instructions and relevant forms sit below the quality manual in the hierarchy of required documentation and shall include the following.

a. Policies that document the intentions and direction of the facility, as formally expressed by its senior management.
b. Procedures (often called standard operating procedures or SOPs) that outline the practical way to translate the policies into action.
c. Day-to-day work instructions that are needed in the work area for easy reference, for example, step-by-step guidance on how to use a particular instrument, or decontaminate a work surface.
d. Forms, that is, documents on which records are made that provide evidence that a procedure and/or related instructions have been carried out.

A Document Control System (ISO 15189 4.3)

7.5.2 A document control system may be an electronic or paper-based system and requires that:

a. documents are authorised for adequacy prior to issue;
b. documents are reviewed and updated as required, and re-authorised with the changes highlighted;
c. relevant versions of documents are available at the point of use; and
d. unintended use of obsolete documents is prevented.

Continual Improvement Process (ISO 15189 4.12)

7.5.3 Opportunities to improve the effectiveness of the management of quality in the facility arise in a number of ways. They fall into three major categories of documented procedures that identify the sources for corrective, preventative and improvement actions.

a. These may include evaluation and audits, trials and customer feedback, peer review and checking of outputs, self-assessment and suggestions from staff.
b. Regardless of source, all shall be logged into an improvement, corrective, preventative process for subsequent assessment and action. All actions are classified and prioritised on the basis of a risk assessment.
c. Those taken forward are allocated to an appropriate owner to be resolved by an agreed target date.

d. These are included as part of the management review.

Evaluation And Audits (ISO 15189 4.14)

7.5.4 The facility shall have an ongoing rolling audit programme for the coming year and beyond. This shall include across the audit programme cycle:

a. each area of work;
b. all stages of the examination; and
c. an assessment of staff competency in both practical work and in report writing.

7.5.5 Audits typically fall into two categories: internal (or in-house) and external.

a. Internal audits are carried out by the facility itself, focusing on some aspect of activity, for example, that staff are up to date with their training and competency records.
b. External independent assessment by auditors from other facilities or by the United Kingdom Accreditation Service (UKAS) are carried out if, for example, the facility is seeking accreditation or is accredited to ISO 15189.[9]
c. Audits provide an important mechanism for detecting and investigating quality issues or 'non-conformities' and provide a major input into the management review.

7.6 Management Review (ISO 15189 4.15)

7.6.1 Regular management reviews shall be conducted by the facility management team to ensure that performance of the unit and the procedures followed are, and continue to be, effective from a quality perspective. This should be discussed and highlighted as part of the induction of any new staff members.

7.6.2 As a minimum the management review shall be conducted annually. However, initially these shall be undertaken more frequently as the review process beds in

[9] Current published standard is ISO 15189:2012 Medical laboratories – Requirements for quality and competence.

and the frequency becomes appropriate to the maturity of the quality management system. Inputs to the review shall include the following.

a. Significant changes in organisation and management, staff (including the induction of new staff members) and other resources or processes.
b. Post-implementation review of changes to procedures and practice.
c. Assessments and audits of quality. These may include reports of assessments of outside bodies, internal audits of the quality management system and of the examination procedures.
d. New quality incidents (i.e. occasions where a mistake has occurred, or quality procedures have not been adhered to).
e. A review of the status of preventative, corrective and improvement actions.
f. Patient survey, complaints or feedback.

7.6.3 A report of the management review shall be generated that includes the following.

a. A summary of the successes and failures since the last review.
b. Decisions made and actions taken with regard to:
    i. the needs of users;
    ii. resource management (personnel, accommodation, equipment, consumables);
    iii. quality management, including audits and assessments;
    iv. health and safety;
    v. education and training; and
    vi. financial requirements.
c. Future quality objectives and priorities.

7.6.4 This report should be readily available (in electronic or paper form) and be shared with staff within the facility.

8. Technical Requirements

8.1 Personnel: Training and Competence (ISO 15189 4.4, 5.1; ILAC G19 3.3)

8.1.1 All personnel working within the facility, including any non-facility staff shall have undergone:

a. training and assessment of competency; and

b. ongoing competency in the theoretical and practical aspects of forensic science according to the role(s) within which they are working.

8.1.2 The forensic healthcare practitioner and their organisation shall ensure that the practitioner accesses and undertakes continuing professional development to maintain ongoing competency,[10] and that records are kept to evidence this.

8.1.3 The guidance and requirements refer to all personnel working and/or providing services (ISO 15189 4.4) within the facility. Information and guidance for practitioner-related roles, including others is provided in Annex A of this guidance.

8.2 Accommodation and Environmental Conditions (ISO 15189 5.2; ILAC G19 3.11)

General

8.2.1 Accommodation at the facility shall be age appropriate, accessible to the community it serves and with adequate security for the service users and staff. For example, consideration should be given to the style of decor and availability of toys where the facility is being accessed by child patients.

8.2.2 The Department of Health and Social Care has published Building Notes[11] that provide best practice guidance on the design and planning of new healthcare buildings and on the adaptation or extension of existing facilities, for example:

a. outpatient department;[12]

b. sexual and reproductive health clinics;[13]

c. sanitary bathroom;[14]

[10] Example guidance is provided in Faculty of Forensic and Legal Medicine (2017a).

[11] Department of Health Building Notes (HBN) series.

[12] Department of Health Building Note 12: Designing an out-patients department.

[13] Department of Health Building Note 12-01: Consulting, examination and treatment facilities. Supplement A: Sexual and reproductive health clinics.

[14] Department of Health Building Note 00-02: Designing sanitary spaces like bathrooms.

d. sterile environments;[15] and

e. hospital accommodation for children.[16]

8.2.3 It is expected that generic requirements such as lighting and sound/acoustics are already provided in the relevant Building Notes. The following requirements are specific to those facilities that conduct forensic medical examinations.

Layout

8.2.4 There should be an entrance for access to the facility by the patient and their companions that is separate and not open to public traffic.

8.2.5 The design of the facility shall include measures to prevent cross-transfer and environmental contamination. This is to take account of the increasing sensitivity of methods used within forensic science and the high volume of throughput for such a facility.

8.2.6 The layout of the rooms and corridors should enable the workflow to progress through the sexual assault referral centre (SARC) in one direction, to minimise cross contamination and control designated DNA clean rooms or areas.

8.2.7 The forensic area of the facility shall include the following.

a. A pre-examination waiting room that is a separate waiting area for patients who may undergo a forensic medical examination. This area cannot be classed as DNA clean if it is used by patients and their supporters who may be conversing and interacting whilst not wearing personal protective equipment (PPE). It can be designated as a DNA clean area, if its use is controlled such that those entering (other than the patient) are wearing PPE and actions to mitigate against DNA contamination are undertaken.

b. A dedicated forensic medical examination room that shall be a designated DNA clean area – this is where the forensic medical examination will take place, the patient's clothing shall be removed (if not previously collected) and forensic samples are collected. The room shall have access to the bathroom/toilet facility, if linked to the medical examination room, the

[15] Department of Health Building Note 13: Sterile services department.

[16] Department of Health Building Note 23: Hospital accommodation for children and young people.

bathroom is also considered to be a DNA clean area for cleaning and environmental monitoring (EM) purposes.

c. A dedicated bathroom/toilet facility which shall have access from the medical examination room and corridor, where early evidence collection can be conducted and/or the patient can shower post-examination.

d. A dedicated area for staff and visitors to change into or put on barrier/ personal protective clothing that is away from the DNA clean examination area.

Structure

8.2.8 The forensic medical examination room shall have adequate space to minimise the risk of cross-contamination[17] between the patient's outer clothing and the forensic medical examination area and equipment.

8.2.9 The size of the forensic medical examination room should be adequate to house:

a. the examination couch;
b. storage units;
c. equipment including photographic equipment;
d. the screen/curtain; and
e. the maximum number of individuals who could be in attendance with the patient (crisis worker, paediatrician, forensic medical clinician, interpreter, companion).

8.2.10 The layout of the forensic medical examination room should effectively shield the patient from the non-medical practitioners during the examination and sample recovery stage to avoid cross-contamination from these individuals.

8.2.11 Ceilings should be hard plasterboard or laminated tiles of smooth finish resistant to degradation from frequent cleaning.[18] Fitting should be flush or anti-

[17] Although the focus is DNA contamination other evidence types (such as dried flaking body fluids, hairs, fibres and particulate debris) can also cross-contaminate.

[18] The active agent, corrosive nature and downstream effects from the cleaning materials used need to be understood; surfaces need to be resistant to degradation because of frequent contact with the cleaning reagents.

ligature to allow ease of cleaning. Neither unbagged insulation nor fibrous material should be used above the ceiling.

8.2.12 Walls should be of smooth finish, sealed and resistant to degradation from frequent cleaning.

8.2.13 Floors should be of a readily cleanable durable material, for example, vinyl, and fully sealed.

8.2.14 The edges between the floors, walls and ceilings should utilise coving that provides a smooth curved join rather than a right angle, to facilitate cleaning by avoiding crevices and dust traps.

8.2.15 Window glazing shall be sealed to prevent draughts and ideally the sills slope downwards with an easily cleanable surface. Where blinds are required, ideally these should be on the outside of the window or within a sealed window unit.

Air Quality and Airflow

8.2.16 Airflow within and between designated forensic areas of the facility shall be kept to a level that minimises the risk of trace evidence being transferred from the patient to the environment and from environmental background DNA to the patient. This means that portable fans shall not be used and there shall be no strong air currents notably through vents or windows that may be positioned near the examination couch, sampling and packaging areas.

8.2.17 For the forensic medical examination room, the air in and out should be balanced, if there is a differential in pressure then there should be positive pressure within the examination area, so that air is not sucked in from outside.

8.2.18 The use of any air conditioning/ventilation system shall be designed to minimise the risk of cross contamination using suitable filtration and the control of airflow to minimise draughts. Any air supplied from outside the room shall be filtered to reduce the risk of external contaminants.

8.2.19 A minimum airflow of 20 times whole room replacement per hour should be used. The clean air should enter the room over the examination couch using, for example, a sock diffuser to reduce air wafts with extraction near door/exit.

8.2.20 Where physical building changes or new build has been identified or is necessary then the requirements set out in Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence FSR-C-116, section 7.2.2 applies.

8.3 Forensic Medical Examination Room Furnishings, Equipment, Reagents and Consumables (ISO 15189 5.2, 5.3; ILAC G19 3.12)

8.3.1 The style and finish of fixtures and fittings, such as air-conditioning, ceilings, lighting and working space shall allow for effective repeat cleaning by either being flush or anti-ligature.

8.3.2 The furnishings, equipment, reagents and consumables that are utilised within the facility shall be such that they minimise the risk of DNA contamination. The Faculty of Forensic and Legal Medicine (FFLM) has provided guidance on the equipment for use in forensic medical examination rooms.[19]

Environment, Furnishings and Equipment

8.3.3 The work surfaces and chairs should be of smooth finish, sealed, readily cleanable and resistant to degradation from frequent cleaning.[20] Workstation drawer units should provide sufficient storage capacity to enable work surfaces to be kept clear, other than equipment in daily use.

8.3.4 The following criteria for furnishings and equipment shall apply.

a. Workbench surfaces, storage cupboards, seating and examination couches shall be impervious to water, easy to clean and resistant to disinfectants and cleaning reagents.
b. In areas where a patient undresses and where they are then subsequently forensically examined, floor surfaces shall be impervious and any joins in the floor shall be sealed.
c. Computer keyboards, colposcopes and equipment controls shall be protected by removable flexible covers that can be cleaned or replaced

[19] Faculty of Forensic and Legal Medicine (2016b).

[20] The active agent, corrosive nature and downstream effects from the cleaning materials used need to be understood; surfaces need to be resistant to degradation because of the frequent contact with the cleaning reagents.

(for example, keyboard, colposcope arm and head covers). Equipment with flat surfaces and smooth clean lines is preferable (for example, touch screens).

d. Where a curtain shields the examination couch, the curtain shall be disposable. The frequency of curtain replacement will depend on the number of forensic medical examinations conducted in the room and shall be subject to risk assessment. For example, in a facility where more than 20 patients are forensically examined each month, the curtain should be changed monthly. Where fewer medical examinations are conducted the disposable curtain should be replaced at least every three months. However, if any staining is visible on the curtain or material is thought to have been inadvertently transferred to the curtain, it shall be replaced immediately. A record of the date and reason for changing the curtain shall be kept.

e. There shall be a designated hand-wash basin within the room where the patient is being examined. The taps shall be capable of being operated without being touched by hand.

f. The medical examination couch shall have height and position adjustments to allow for ease of movement. The couch should have disposable covering, which is changed between each examination.

g. Wall clocks, height charts and weighing scales shall have surfaces that can be wiped.

h. There shall be a labelled storage area for keeping consumables used for the forensic medical examination and packaging of samples.

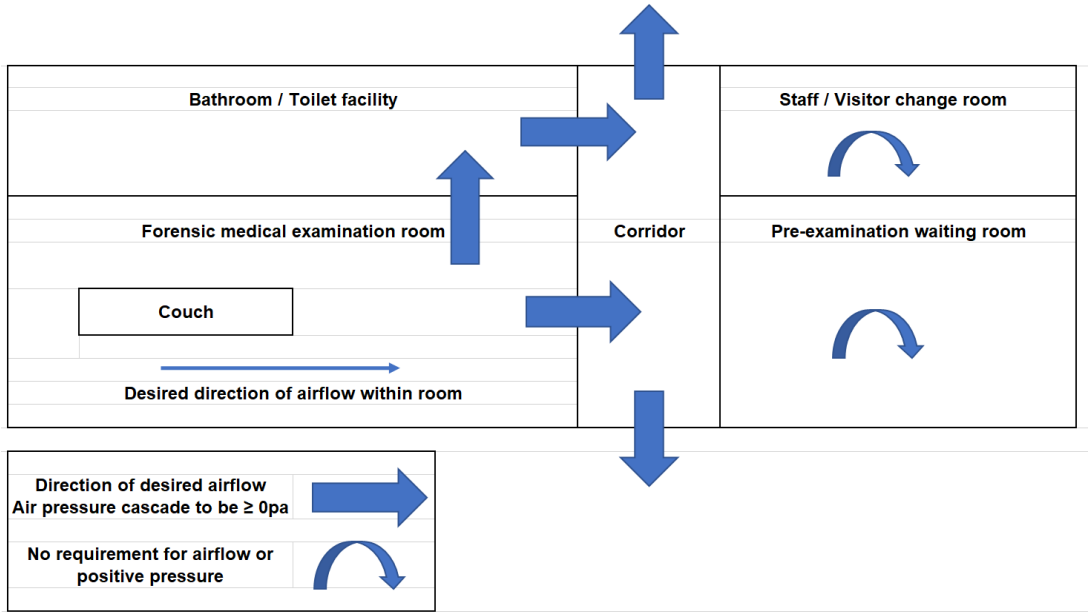
i. A colposcope shall be available for all child examinations and for adults as appropriate to record relevant injuries and findings.

j. There shall be an approved sharps box and clinical and domestic waste receptacles, and appropriate disposal provisions arranged.

k. There shall be equipment to enable photo documentation for general injuries and/or general observations.

8.3.5 The areas of the facility (the pre-examination waiting area, examination area and the dedicated bathroom/toilet facility) shall always be secure; entry into and exit from the forensic medical examination room shall be controlled and all

personnel accessing the room shall be recorded to include date, time and activity/role.



8.3.6

Figure 1: Simple schematic of relative airflow direction and pressure for the forensic medical examination room

DNA Decontamination

8.3.7 Cleanliness of the forensic examination area of the facility is important to maintain the quality of the forensic medical examination and minimise the risk of contamination. Monitoring cleanliness enables corrective actions to be undertaken where contamination is established. It also provides evidence of due diligence and effective cleaning. See sections 9.4, 9.5, 9.6 and 9.7 in this guidance for further details.

8.3.8 Guidance on cleaning processes can be found in The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208, section 8.6.[21] The following practices shall apply to the forensic medical examination room.

a. Cleaning of the designated DNA clean controlled areas shall be undertaken prior to and/or after each examination.

[21] Forensic Science Regulator, The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

b. Deep cleaning should be undertaken at least every month.[22]

c. The room shall be sealed or locked after each clean and the door labelled to identify the status of the room. This does not negate the requirement for monthly deep cleaning if the room is still sealed more than a month from the previous cleaning.

d. The date of cleaning, (time if appropriate) and by whom shall be recorded in the cleaning logs and retained.

Reagents

8.3.9 Cleaning products and spillage kits that have been demonstrated to be effective in removing and denaturing DNA in conjunction with appropriate cleaning procedures shall be used.[23] These chemicals shall always be used in a manner compliant with relevant health and safety requirements.

8.3.10 The facility may take advice from forensic science providers (FSPs) as to which validated cleaning product[24] to use, but shall demonstrate that the cleaning product is effective,[25] in their hands at their facility.

8.3.11 The application of the cleaning product shall be carried out according to the manufacturer's guidelines and in line with standard operating procedures – it is the combination of the cleaning agent and how it is physically used that determines its effectiveness. The effectiveness of the cleaning at removing DNA shall be demonstrated by environmental monitoring (see section 9.7 for more details) undertaken at regular intervals

[22] Environmental monitoring results will be required to demonstrate a trend that there is little to no risk for deep cleaning to be conducted more than one month apart.

[23] Further guidance is available in Forensic Science Regulator, The control and avoidance of contamination in crime scene examination involving DNA evidence recovery FSR-G-206; Forensic Science Regulator, DNA Anti-contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities FSR-G-207; and Forensic Science Regulator, The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

[24] Examples of cleaning agents include 10% sodium hypochlorite (bleach, Presept™) solution, 1% Solution Rely+On™ Virkon®, Microsol (10%) and Distel (1%) (Trigene Advance).

[25] National Institute of Justice Forensic Technology Center of Excellence (2011).

Consumables Including Personal Protective Equipment/Barrier Clothing

8.3.12 Consumables are single-use commodities used in the collection, preservation and processing of material for forensic analysis, and are bought and used up recurrently. These include PPE or barrier clothing, tamper-evident containers, swabs, and packaging that comes into direct contact with the material for forensic analysis. A consumable can also be equipment used in the collection, processing and safe handling of the material, for example, disposable tweezers and scissors.

8.3.13 The use of barrier clothing/PPE is detailed in section 9.2; it is required to minimise contamination and shall be single-use. Barrier clothing/PPE include:

a. disposable outer barrier clothing such as scrubs or an apron with disposable long sleeve covers;
b. non-latex unpowdered gloves in a range of sizes;
c. face mask;
d. mob cap; and
e. shoe covers.

8.3.14 Consumables that are free from detectable DNA[26] or forensic DNA grade[27] shall be used where these exist for sampling. The kit modules shall have a batch/lot and use-by date information recorded on them to ensure shelf life rotation. A record of the batch/lot information and expiry date shall be recorded on the examination records.

8.3.15 Exhibit packaging is required to preserve forensic science related evidence. It is an important principle that the packaging standards used for the collection of evidence are the same for patients who self-refer to the facility and those who are referred to the facility by the police. Such packaging includes:

a. paper exhibit bags of varying sizes;
b. plastic tamper-evident bags of varying sizes;
c. breathable exhibit bags for wet exhibits;

[26] 'Detectable' means by the most sensitive DNA method(s) used in forensic analysis. This information may be available through the Association of Forensic Science Providers (AFSP) body fluid forum (BFF).

[27] Produced in compliance with ISO 18385:2016 Minimizing the risk of human DNA contamination in products used to collect, store and analyse biological material for forensic purposes.

d. white securitainers of varying sizes;
e. labels;
f. sealing tape;
g. vomit collection vessels;
h. white disposable paper towel rolls; and
i. dedicated forensic kit modules to ensure comprehensive forensic sample collection.[28]

8.3.16 The consumables (including barrier clothing) and reagents used shall not be past their expiry date, be stored and handled appropriately to minimise contamination of them prior to and during use.

8.4 Examination Methods and Procedures (ISO 15189 4.4, 5.4.2, 5.5)

General Principles

8.4.1 All professionals working at the facility who come into contact with patients shall have the relevant skills, knowledge and competency to work with patients in the aftermath of a sexual assault.

8.4.2 Facility staff shall have a clear understanding of the different ways that patients who have been subjected to sexual assault may behave following an assault. A non-judgemental approach shall be adopted in every case.

8.4.3 It is well known that some patients will be unable to make an immediate decision about whether they wish to report the assault to the police or be involved in the criminal justice process. It is widely accepted that pressure to report may discourage the future involvement of the patients in any subsequent court proceedings. However, the patient shall be informed that a forensic medical examination could assist them to make the decision to report at a later date and offered the option of the self-referral route.

8.4.4 It is an important principle that acute medical needs take precedence over evidential needs. Therefore, the initial response to acute injury, the need for

[28] Faculty of Forensic and Legal Medicine (2018a).

trauma care, and the safety needs of the patient will take priority over the collection of forensic science related evidence.

8.4.5 While the time spans of the assault will be an important factor in determining whether a forensic medical examination should take place, each case shall be properly considered, with the needs of the patient being the paramount consideration.

8.4.6 It is common for patients who have been subjected to sexual assault to have showered, eaten or taken other self-protective actions that may have destroyed evidence prior to engaging with the facility. Staff shall react in an understanding and non-judgemental manner if this has happened. Staff shall record the actions that have been taken by the patient on the forensic examination paperwork (see section 10.1 in this guidance for more details).

8.4.7 Gathering information about the assault can be a difficult process for patients who have been subjected to sexual violence. Not only can discussing the assault cause them to feel re-violated, but also their emotional and physical condition may make communication difficult. They may also be uncomfortable discussing personal matters with involved professionals. Those seeking information about the assault shall seek to create an information-gathering process that is as respectful to the patients as possible and minimises repetition of questions relating to the assault.

8.4.8 It is important to note that the forensic medical examination should be a thorough process that can take a considerable length of time to conduct. An open mind shall be kept as to all forensic opportunities, rather than a focus solely on DNA. The speed of the examination process shall always be dictated by the needs of the patient.

Prior to the Patient's Arrival at the Facility – Initial Contact

8.4.9 It is important that staff at the facility ensure that patients are always given the correct information and advice regarding a forensic medical examination and the options available to them. Where possible the facility shall seek to work in partnership with other relevant services (such as the police, social workers,

health professionals and other support organisations). The facility shall ensure that such partners have been made aware of:

a. the services that can be provided at the facility; and
b. the importance of the recovery of forensic science related evidence if they provide the initial contact/first response to the patients.

8.4.10 Staff at the facility shall be able to provide basic information to the patient about:

a. options to attend the facility and the opportunity to undertake a forensic medical examination, treatment and advice;
b. options to report the sexual offence to the police if they so choose;
c. potential medical concerns of the patient that relate to the sexual assault; and
d. the importance of body fluids and the recovery of such forensic science related evidence.

8.4.11 In relation to the collection of forensic samples, the facility staff providing the initial contact/first response to the patient shall be able to explain the impact that the following might have on the collection of that evidence:

a. washing and method undertaken, for example, showering or bathing;
b. urinating;
c. defecating;
d. smoking;
e. drinking;
f. eating;
g. brushing hair or teeth;
h. vomiting;
i. rinsing mouth; and
j. sexual activity.

8.4.12 In particular where the patient reports vaginal or anal assault, samples shall be taken in accordance with current Faculty of Forensic and Legal Medicine (FFLM) guidance.[29] Where the assault is suspected of being drug/alcohol

[29] Faculty of Forensic and Legal Medicine (2018a).

facilitated, then an appropriate urine or hair sample from the patient should be taken. Ideally, the urine sample should be collected using an early evidence kit (EEK). However, if the patient is unable to wait to urinate until an EEK is available, the professional providing the initial contact/first response shall explain to the patient how they could collect a sample of their urine in a clean receptacle that can be handed to the police or staff at the facility later. At the earliest opportunity, this sample shall be transferred to the EEK collection vessel and the original receptacle shall be retained.

8.4.13 The staff at the facility providing the initial contact to the patient will need to explain that the clothing worn at the time of the assault and any current underwear (if the clothing has been changed) may be taken as evidence; the patient should retain the clothing and not wash any of it. This also applies to sanitary products or underwear liners being worn or discarded, but available for evidence collection.

Decision to Undertake an Examination

8.4.14 Forensic samples are only one consideration in deciding upon the merits of undertaking a forensic medical examination. Opportunities to recover other forensic science related evidence, such as the presence of injuries and their sequelae,[30] as well as an evaluation of therapeutic issues for the patient shall be considered. The time spans for conducting a forensic examination will vary on a case-by-case basis.

8.4.15 Where there is any question about whether a forensic medical examination is required immediately, or indeed at all, the forensic healthcare practitioner shall be consulted as soon as possible. The decision about whether and when to carry out the examination should be made in accordance with the flowcharts for pre-pubertal and post-pubertal complainants provided by the FFLM in the Guide to Establishing Urgency of Sexual Offence Examination,[31] the Recommendations for the Collection of Specimens from Complainants and

[30] Preceding injury in the same individual.

[31] Faculty of Forensic and Legal Medicine (2016c).

Suspects[32] and the medical needs of the patient (for example, HIV post-exposure prophylaxis, emergency contraception).

8.4.16 Where children disclose sexual offences the need for, and timing of, a forensic medical examination could be particularly pertinent. It shall not be for the police officers/investigators and/or social workers to make decisions about whether children disclosing sexual abuse shall be examined or at what time. In these circumstances the forensic healthcare practitioner and/or paediatrician shall be consulted for advice on the recovery of potential forensic science related evidence.

8.4.17 Where it is necessary for the patient to be taken to an emergency department from the facility (where the patient appears to have serious injuries or an altered level of consciousness) the forensic healthcare practitioner shall attend at the hospital. It is generally accepted that in these circumstances forensic integrity may be compromised. However, the needs of the patient shall come before the gathering of forensic science related evidence. In these cases forensic healthcare practitioners shall work alongside other healthcare providers or provide advice to those who are treating the patient. Any forensic samples shall be collected using recognised forensic sample kit modules (please see section 8.3.14 above). Hospital swabs are not fit for forensic purposes and shall not be utilised. Blood and urine samples taken at hospitals, although not necessarily containing appropriate preservative, may still provide useful evidence and in the absence of any more suitable specimens shall be considered for forensic analysis.

Attendance of the Forensic Healthcare Practitioner

8.4.18 Local policy will dictate who has the responsibility for requesting the attendance of the forensic healthcare practitioner and the expected time frames for attendance at the facility.

[32] Faculty of Forensic and Legal Medicine (2018a).

8.4.19 The provider of the forensic medical workforce should ensure that they are able to "provide a timely response (within 2 hours, or as agreed for a particular case) to reflect the clinical and forensic needs of patients".[33]

8.4.20 To prevent cross-contamination, the forensic healthcare practitioner attending the forensic medical examination of the patient of a sexual offence shall not provide any medical examination or any other service to the suspect in that case, for example, where the suspect(s) is in custody. Where the provider of the forensic healthcare practitioner for the facility is also the provider of the forensic healthcare practitioners in the custody setting, there shall be two separate rotas in operation. These shall ensure that the forensic healthcare practitioner available for sexual offence forensic medical examinations is not also used for custody medicine at that time. Where more than one patient is referred who may be involved within the same incident, or different patients are thought to be part of a linked series of cases, they should be examined in separate suites and by different forensic healthcare practitioners.

8.4.21 In exceptional circumstances (for example, very remote locations) it may become necessary to use the same forensic healthcare practitioner. In this case, the reason and rationale behind the decision should be documented, together with the steps that have been undertaken to reduce the risk of contamination. For example, cleaning of mobile equipment, showering, change of clothes shall be recorded, documented and disclosed to the forensic unit processing the samples and in any subsequent report or statement provided for the criminal justice system.

Arrival of the Patient

8.4.22 On the patient's arrival at the facility, a crisis worker (CW) or equivalent shall meet the patient (and their supporters). The CW shall accompany the patient to the pre-examination waiting area of the facility to provide privacy for the patient and support their sense of safety and security.

8.4.23 The CW shall provide immediate support to the patient by explaining to them:

[33] Faculty of Forensic and Legal Medicine (2016a).

a. their role in supporting and advocating for the patient throughout their time at the facility;
b. the options available to the patient, including the opportunity to have a forensic medical examination (8.4.10) and how the CW will be supporting them throughout the forensic medical examination;
c. the purpose of the forensic medical examination and its potential value, both in terms of the medical examination and the collection of forensic samples; and
d. how the medical examination will be conducted.

8.4.24 Although the CW may be repeating what has already been relayed to the patient by the professional providing the initial contact/first response, it is important that the patient understands why they are at the facility and the options available to them at that time.

8.4.25 Where a urine sample has not already been collected, the CW shall ensure that a urine sample is collected where appropriate, using the EEK[34] (if the patient is able to pass urine at that time). Where there is any suggestion that penis–mouth penetration (fellatio) may have taken place, or the nature of the sexual assault is unknown, the CW shall obtain oral samples using the EEK.[35] The CW can also collect non-intimate skin swabs, for example, hand swabs where appropriate.

8.5 Medical Examination and Evidence Collection (ISO 15189 5.4.3, 5.4.4, 5.5; ILAC G19 4.3.3)

Preliminary Matters

8.5.1 When the CW is satisfied that the patient is ready for the forensic medical examination to take place, the forensic healthcare practitioner shall introduce themselves to the patient (and their family if the patient is a child) and explain what is going to happen during the medical examination.

[34] Faculty of Forensic and Legal Medicine (2018a).
[35] *Ibid.*

8.5.2 Where specialised equipment, such as a colposcope,[36,37] is to be used during the examination, the forensic healthcare practitioner shall explain the purpose and function and how it will be used during the examination.

8.5.3 The forensic healthcare practitioner shall explain to the patient that they can:

a. ask questions at any time during the examination;
b. have a break at any time during the examination;
c. decline any part of the examination or evidence collection; and
d. stop the examination at any time.

Obtaining Consent

8.5.4 The forensic healthcare practitioner shall obtain informed consent[38] from the patient for:

a. a full medical history;
b. a forensic medical examination;
c. the collection of forensic and/or medical specimens;
d. taking of notes, body diagrams, photographs/videos/digital images for recording information to be used for evidential purposes, second opinions from medical experts, peer review and audit;
e. completion of a report or statement for the police (if the police have already been involved and if a report or statement is requested);
f. agreement, where applicable, to the use of their anonymised photographs/videos/digital images/medical notes for teaching or research purposes;
g. (for self-referrals) offer retaining and storing their samples[39] for a defined period of time if the patient is unsure whether or not to send samples for anonymous testing or to proceed with a police complaint before destruction;

[36] Faculty of Forensic and Legal Medicine (Reviewed, 2017b).
[37] Faculty of Forensic and Legal Medicine (2017c).
[38] See Supreme Court judgment UKSC11 2015 *Montgomery* v. *Lanarkshire Health Board*.
[39] Faculty of Forensic and Legal Medicine (2016d).

h. (for self-referrals who do not want to progress to a police complaint) obtain permission to process samples anonymously (if available) before destruction.

8.5.5 The forensic healthcare practitioner shall ensure that valid consent is given in accordance with guidelines from the FFLM,[40] the General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) in accordance with the Mental Health Capacity Act 2005. In situations where there is no capacity to consent, the detail of the decision making shall be documented such that the basis of the decision can be reviewed by another competent forensic healthcare practitioner.

8.5.6 The forensic healthcare practitioner shall ensure that the patient understands the purpose of the examination and that consent is freely given.

8.5.7 The forensic healthcare practitioner shall ensure that the patient is aware that there is no obligation to give consent and that it can be withdrawn at any time during the examination. If consent to any part of the examination is declined at any stage, that refusal and any reason should it be offered, shall be recorded.

8.5.8 Where the patient is a child, reference shall be made to the GMC[41], the Royal College of Paediatrics and Child Health (RCPCH)[42] and the FFLM[43] guidances for obtaining valid consent. Consent for a forensic medical examination shall be obtained from one of the following:

a. parents/carers with parental responsibility;
b. a child of sufficient age and understanding (as assessed by the forensic healthcare practitioner with advice from professionals);
c. children's services, where the child is the subject of a Care Order, or an interim Care Order;
d. a Family Proceedings Court as part of a direction attached to an interim Care Order, an Emergency Protections Order or a Child Assessment Order.

[40] Faculty of Forensic and Legal Medicine (2011).
[41] General Medical Council (2012).
[42] Royal College of Paediatrics and Child Health Child Protection Companion.
[43] Royal College of Paediatrics and Child Health and Faculty of Forensic and Legal Medicine (2015).

First Account

8.5.9 Where an adult patient has already reported the assault to the police, the forensic healthcare practitioner shall take an initial account of the assault from the professional attending with the patient, usually a police investigator. For adult patients who self-refer the healthcare practitioner will need to take the initial account.

8.5.10 If the patient is a child the initial account may be provided by a social worker or a police investigator, though the recommendation is for a police investigator to be present.

8.5.11 It shall be noted that police representatives will want to collect information from the patient to help in the apprehension of suspects and the investigation. However, an achieving best evidence (ABE) interview shall not take precedence where a timely forensic medical examination is required.

8.5.12 The forensic healthcare practitioner may confirm and record the first account with the patient and seek any clarification about the account where necessary, minimising re-traumatisation. This is unlikely to be appropriate with a young child or vulnerable adult.

8.5.13 If the patient has not reported the assault to the police and has self-referred to the facility, the forensic healthcare practitioner (where appropriate) will take the account directly from the patient after consent has been given.

Medical/Social History

8.5.14 The forensic healthcare practitioner (where appropriate) shall take a medical/social history from the patient in sufficient detail to enable them to undertake a holistic assessment of the therapeutic needs of the patient and any issues which may impact on interpretation of scientific or medial evidence. Where the patient is a child, a full paediatric history will be taken. This may be from a parent, care-giver or from the child themself – depending on the age and capacity of the child. In line with current practice, the child shall be given the opportunity to talk to the practitioner independently of carers. Care shall be taken to ensure that questions are pertinent to the purpose of the medical examination and any subsequent findings. The FFLM has produced sample

forms that can be utilised to ensure that important information is routinely asked by forensic healthcare practitioners[44] and paediatricians[45].

8.5.15 The forensic healthcare practitioner shall use the medical history, together with the first account, to guide the examination, evidence collection and support any subsequent forensic laboratory examination and findings.

Safeguarding

8.5.16 Safeguarding is an important aspect of the holistic assessment of the patient. Consideration of safeguarding issues needs to be addressed in all cases particularly if the patient:

a. is a child;
b. is a carer for children; or
c. is a carer for an adult at risk.

Addressing Practical and Emotional Needs

8.5.17 Forensic healthcare practitioners should ensure that the therapeutic, practical and emotional needs of the patient, both prior to and during the examination, are met wherever possible. Pressing issues (for example, for the treatment of serious injuries, crisis intervention and support, translation and interpretation) shall be addressed before commencing with the examination.

8.5.18 The facility shall have procedures in place and forensic healthcare practitioners shall be trained to accommodate the patient's communication skill level and preferred mode of communicating. This is particularly important for patients with communication-related disabilities and/or where English is not their first language.

8.5.19 Where interpreters are necessary, family members shall not be used and the gender preference of the patient shall be taken into account. Where interpreters are in attendance as opposed to online resources, they shall be present prior to

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44 Faculty of Forensic and Legal Medicine (2010, Revised 2014).

45 Faculty of Forensic and Legal Medicine (2012).

questioning and there should be space for them in the examination room to interpret for the patient.

Record of Attendees

8.5.20 A record of all persons in attendance at any time during the forensic medical examination shall be made. The name and contact details for each visitor, including non-facility professionals in attendance, which areas they accessed and whether they wore full or partial PPE/barrier clothing in the DNA clean controlled areas shall be recorded. This is in case a DNA sample is required from them at a later date for contamination elimination purposes. (Please refer to section 9.3 in this guidance for more details.)

Roles and Responsibilities of those conducting the examination

8.5.21 Where more than one person is conducting the examination, for example, in the case of a child where a paediatrician and another forensic healthcare practitioner might be present, all practitioners shall agree and document their respective roles and responsibilities within the examination before it commences.

Removal of Clothing

8.5.22 Clothing worn at the time of the incident, or afterwards, may contain important evidence in sexual assault cases as it provides a surface upon which traces of foreign materials, such as semen, saliva, blood, hairs, fibres, and debris from the crime scene, may be found.

8.5.23 Where damage to clothing is detected, the forensic healthcare practitioner shall ask the patient whether the damage relates to the assault. Damaged or torn clothing may be significant as it may be evidence of force. It is good practice for the forensic healthcare practitioner to see the patient in the damaged clothes before they are removed and take photographic evidence of the observations where appropriate – this may indicate or correlate with the presence of physical injuries. Any existing holes, rips or stains on clothing shall not be cut through on removal of the clothing. This is particularly important if the patient is receiving

emergency medical treatment by other medical staff such as in an emergency department.

8.5.24 The patient shall be permitted to remove their clothing in the forensic medical room where they can be afforded some privacy by being able to stand behind a curtain or screen.

8.5.25 Consideration shall be given to the use of a disposable floor standing sheet to collect foreign material dislodged from clothing during undressing. It shall be placed onto the floor to act as a barrier. Care shall be taken to avoid any evidence transfer. The patient shall be asked to remove footwear first and these shall be individually packaged if they are likely to yield relevant evidence, for example, debris from an outdoor scene location.

8.5.26 The patient shall be asked to disrobe, one item at a time, trying to maintain the orientation that the garment is worn during removal. Damage may be noted or highlighted during undressing and it may be appropriate to photograph this before the item is removed (for example, damaged tights).

8.5.27 The professional/practitioner collecting and subsequently packaging the clothing shall wear two pairs of gloves (doubled gloved) and hold an exhibit bag open for the patient to place the item inside. The outer gloves worn by the professionals do not require changing unless the professional handles individual items of clothing. Where the patient is a self-referral or a non-police-referral, the professional collecting the clothing will be a CW. Where the patient is a police-referral, the professional collecting the clothing could be a police investigator, specialist trained officer (STO) or a CW.

8.5.28 No more than one item shall be placed in each exhibit bag; for example, each sock or shoe shall be packaged individually.

8.5.29 Any staining/soiling or detectable odours on the clothing shall be noted on the exhibit label and on the forensic medical examination exhibit collection documentation. If the facility utilises exhibit bags with windows, the soiled areas, where possible, should be visible through the window. Heavily soiled or notably wet items shall either be double bagged for transporting to a drying facility or placed in a breathable bag if available. Wet items can also be packaged in a plastic tamper-evident bag and frozen with clear information about the condition

of the item (for example, wet/damp/heavily soiled) being recorded on the exhibit label. Double bagging involves the item being placed in an open plastic exhibit bag, which is then inserted inside a sealed paper evidence bag.

8.5.30 All exhibit bags shall be sealed at the open end using adhesive tape, even where self-seal bags are utilised, before they are transported for storage either within the facility or at an agreed alternative storage facility. Additional sealing/labelling of the exhibits shall be the responsibility and ownership of the professional/practitioner collecting the items from the patient. This should be done as soon as practically possible before items are stored.

8.6 The Examination Process (ISO 15189 5.5; ILAC G19 4.7)

8.6.1 The forensic healthcare practitioner shall consider the medical, psychological and safeguarding needs of the patient, alongside the collection of information that could potentially be used to support an investigation or subsequent court case relating to the assault. It is important that the forensic medical examination shall be carried out methodically to ensure that all relevant information relating to the assault is sought.

8.6.2 With regard to the collection of forensic samples, forensic healthcare practitioners, as part of the forensic medical examination, shall routinely collect the following information from the patient or if not appropriate (for example, the patient is a young child), then from alternative sources:

a. time and date of the sexual assault(s);
b. nature and description of sexual assault(s);
c. recent consensual sexual activity;
d. post-assault activities, for example, washing;
e. assault-related medical information (including physical injuries);
f. details of known medication(s) and alcohol consumption and/or other drug use by the patient;
g. description of assailant (if known) – to assist in risk assessment for HIV, etc.

8.6.3 There is a FFLM pro forma designed to assist forensic healthcare practitioners in the assessment of adult male and female patients.[46] Organisations can use their own pro forma provided that it meets the FFLM content as the minimum requirement. The FFLM has also designed a similar form for children.[47]

8.6.4 Where the patient is a child or young person the paediatric forensic medical examination[48] shall include a comprehensive assessment. This shall consider the physical development and emotional well-being of the child or young person against the background of any relevant medical, family or social history that is known. The forensic medical assessment provides an opportune health screen for previously unknown medical conditions and learning/social communication difficulties. Children may be particularly vulnerable and subject to other forms of abuse such as neglect. This enables a full evaluation of the degree of significant harm suffered, or likely to be suffered, by the child as described in the Children Act 1989 and 2004. This assessment shall also lead the planning of any ongoing investigation or treatment required by the child, and appropriate reassurance for the child and family. Use should be made of the FFLM pro forma designed to assist the forensic healthcare practitioner in the assessment of a child or young person who may have been sexually abused.[49] Organisations can use their own pro forma, provided that it meets the FFLM content as the minimum requirement.

8.6.5 Forensic healthcare practitioners shall seek to collect as much evidence (samples, injuries, trace evidence) from the patient as possible, guided by the scope of the informed consent.

8.6.6 The forensic healthcare practitioners shall thoroughly examine the patient from top to toe and check for any injuries, areas of pain or soreness. It is important that the forensic healthcare practitioner notes any medical signs that may impact on a differential diagnosis, either positive or negative. The forensic healthcare practitioner shall check with the patient how any findings may have

[46] Faculty of Forensic and Legal Medicine (2010, Revised 2014).
[47] Faculty of Forensic and Legal Medicine (2012).
[48] Faculty of Forensic and Legal Medicine and Royal College of Paediatrics and Child Health (2012).
[49] Faculty of Forensic and Legal Medicine (2012).

occurred and this shall be documented. All injuries shall be photographed[50] and if appropriate noted on a body diagram to demonstrate the relationship between multiple injuries.

8.7 Sample Collection and Handling (ISO 15189 5.2.5, 5.4.3, 5.4.4.3, 5.4.5, 5.4.6, 5.4.7; ILAC G19 4.3.3)

8.7.1 Having regard to the medical history and the first account of the assault, appropriate forensic samples shall be taken by the forensic healthcare practitioner. The FFLM has produced recommendations for the collection of samples.[51] While the FFLM recommendations refer to specific time spans, it is important to note that these will vary on a case-by-case basis.

8.7.2 Where recommendations provide the order of sampling for a particular site, for example, the vagina, this should be followed. If for any reason it is not, then this shall be recorded:

a. in the documented notes with the reasons why; and
b. on the associated documentation, for example, on the exhibit list and/or forensic medical examination paperwork.

8.7.3 During the collection of the samples, the forensic healthcare practitioner shall take steps to minimise contamination (see also sections 8.3.12 and 9.2 in this guidance).

8.7.4 The facility shall have clear policies for packaging, labelling and sealing samples since this is critical for their admissibility during criminal proceedings.

8.7.5 It shall be the responsibility of the person who obtains the sample to ensure that each sample is appropriately labelled as detailed in the FFLM guidelines on the labelling of samples.[52] In the event that a CW, STO, police investigator or scenes of crime officer (SOCO), also known as crime scene investigator (CSI), is requested to assist with the labelling process, the responsibility to ensure that

[50] Faculty of Forensic and Legal Medicine (2017c).
[51] Faculty of Forensic and Legal Medicine (2010, Revised 2014).
[52] Faculty of Forensic and Legal Medicine (2016e).

the samples are correctly labelled remains with the forensic healthcare practitioner.

8.7.6 Handling of the forensic samples shall be restricted to those persons necessary, who are involved and recorded in the chain of custody.

8.7.7 The identification/exhibit number and/or timings shall reflect the order of sampling. Where two swabs have been taken from the same site there shall be a clear indication on the swab label regarding the order in which the swabs were obtained. These are normally indicated by 'wet' and 'dry' and utilising the letters 'A' (for the first sample) and 'B' (for the second sample). Where the order of sampling is reflected on the swab label (for example, A and B), the timings can then be recorded as the same.

8.7.8 A chain of custody is required for all forensic samples and for sexually transmitted infection (STI) samples where they may be relevant to the forensic case.

Transfer of Samples

8.7.9 Where the patient has reported the assault to the police, it shall be the responsibility of a police investigator to transfer evidence from the facility to the designated storage site used by the police, or directly to the forensic science provider's laboratory. This shall be documented appropriately to demonstrate the chain of custody.

8.7.10 Where the patient has not reported the assault to the police, it shall be the responsibility of the forensic healthcare practitioner or CW to transfer evidence from the examination room to the storage room(s) within the facility. This shall be documented appropriately to demonstrate the chain of custody.

8.7.11 It is important that the transit time between collection and storage of samples shall be minimised wherever possible. Samples shall be packaged to avoid potential degradation. For example, all samples collected during the forensic medical examination shall be transported in a timely fashion in suitable insulated carrying containers to keep the samples cold during transportation.

Storage of Samples

8.7.12 Samples collected before or during the forensic medical examinations shall be stored in secure locations at the facility with access restricted to authorised nominated personnel (for both police and non-police (self) referrals).

8.7.13 All forensic medical samples shall be properly stored until required for forensic examination in the laboratory. Detailed information on the required storage conditions is given in the FFLM recommendations.[53]

8.7.14 The facility shall follow sample storage policies agreed with the police and the forensic science provider to ensure that:

a. optimal storage conditions are adopted for all samples collected as part of the forensic medical examination; and
b. the hazards for handling and storing evidence such as blood and urine are understood.

8.7.15 Where samples are held in cold storage at the facility, a system shall be in place to ensure that samples are kept at a specified temperature at all times. This system shall include maintaining temperature monitoring logs and the ability to identify failure of the equipment in a timely manner.

8.7.16 The facility shall ensure that policies are in place to address evidence storage in cases where the patient is undecided about reporting to the police. It is important that there is adequate space and provision at the facility to store samples taken from patients who self-refer.

8.7.17 Where a limited-time policy for storage of samples is implemented at the facility, i.e. agreement to store a self-referral patient's samples for a limited time only, it is important that the patient is informed at the time of the forensic medical examination regarding the length of time that their samples will be stored. This is critical as it will be the period of time within which the patient has to decide whether to report the assault to the police.

8.7.18 In the event that the patient does not pursue a police complaint within the agreed time limit, then if they choose to provide consent to analyse the samples

[53] Faculty of Forensic and Legal Medicine (2018a).

anonymously, then where this service is offered these should be provided to the police to process anonymously (real name withheld and name not on the exhibit labels). Otherwise the samples shall be destroyed in a safe and timely manner. The patient shall be furnished with suitable information regarding this retention and destruction policy.

Sample Management

8.7.19 The sample management processes for documentation, labelling, handling, transfer and storage of samples and evidence collected as part of the forensic medical examination shall be documented. The processes should ensure that there is no loss, contamination or alteration of evidence, for example, the use of barriers on surfaces and the wiping of exhibit bag exteriors as appropriate to minimise the transference of DNA.

8.7.20 The forensic healthcare practitioner shall have the responsibility for maintaining control of the collection, labelling and sealing of samples obtained as part of the forensic medical examination until the samples are handed over. Where the referral is a police-referral the samples shall be handed:

a. to authorised police personnel for transport to a designated storage site used by the police; or
b. directly to the forensic science provider's laboratory for police-referrals.

This handover shall be documented and a record retained. The documentation shall continue with each transfer of the evidence.

8.7.21 Where the referral is a self- or non-police-referral, the samples shall be placed in storage at the facility by the forensic healthcare practitioner or handed to a CW. This handover shall be documented. The responsibility for maintaining the integrity of the samples thereafter shall sit with the facility's management team. Any subsequent movement or transfer of the samples shall be documented and a record retained.

Images

8.7.22 The facility shall determine the conditions (including specialist lighting) required for obtaining the resolution and image quality to:

a. allow for re-sizing downstream processing to achieve life size images; and
b. demonstrate the features of interest clearly.

8.7.23 The method(s) used for the electronic capture, storage and transfer of images shall maintain the security and integrity of the data.

8.7.24 It is the responsibility of the facility to ensure that any images taken by medical personnel at the facility adhere to the following process.

a. The images are taken by personnel who:

i. understand the concept of image quality and resolution;
ii. understand the effect and degradation of resolution by the capture and processing of images being used; and
iii. are appropriately trained and competent to carry out the role – this may vary depending on whether the image is intimate or non-intimate.

b. The images are retained and stored securely.
c. Their existence and location is recorded by the facility and acknowledged in the patient's medical records.

8.7.25 Due to the highly personal nature of the photography (including still photographs, video, CD or DVD) involved in sexual assault cases and due to the likelihood that this photo documentation will be used for second opinions and/or peer review, it shall be the responsibility of the forensic healthcare practitioner to obtain the forensic images of intimate areas during the forensic medical examination. Where the patient is a child and a permanent record is not obtained, the forensic healthcare practitioner shall record the reason for this in the documentation. The FFLM has published guidelines on photography.[54]

8.7.26 The forensic healthcare practitioner (where appropriate) shall be appropriately trained and familiar with how to operate the equipment required to capture the permanent record.

[54] Faculty of Forensic and Legal Medicine (2017c).

8.7.27 Imaging records taken by forensic healthcare practitioners shall be stored securely by the facility. Each facility shall have a defined system for the secure storage of records, which protects the anonymity of the patient.

8.7.28 Procedures shall be in place to enable the disclosure of images where a request is made in court proceedings. The FFLM has produced detailed guidance on the handling and disclosure of intimate images.[55]

9. Ensuring The Quality Of Examination Procedures (ISO 15189 5.6; the Codes)

9.1.1 To ensure optimum levels of cleanliness, evidence of the following shall be routinely sought at regular intervals. The interval will vary depending on how often forensic medical examinations are conducted and any level of risk identified during audits of the facility.

a. Adherence to procedures that minimise the possibility of contamination from the moment a patient arrives at the facility to undertake a forensic medical examination until completion of that examination.
b. Record keeping for the use of locks/security seals to rooms in the forensic area of the facility i.e. the pre-examination waiting room, medical examination room and bathroom.
c. Steps that have been taken to identify contamination (or the possibility of contamination occurring). Environmental monitoring (EM) sampling is considered as good practice and shall be undertaken, see 9.7 in this guidance.
d. Staff engaged at the facility understand the scientific basis for both preventative and decontamination procedures and are competent in conducting practical cleaning regimes and associated record keeping.
e. Staff engaged at the facility understand the difference between a deep clean, cleaning requirements for DNA clean controlled areas and a

[55] Faculty of Forensic and Legal Medicine (2017b).

general clean.[56] Staff undertaking the role of cleaning shall be trained in these procedures and shall be monitored annually to ensure compliance.

9.2 Use of Personal Protective Equipment/Barrier Clothing (ISO 15189 5.2.5)

9.2.1 To undertake a medical examination, the forensic healthcare practitioner shall wear personal protective equipment (PPE)/barrier clothing as defined in 8.3.13 and below.

a. Disposable single-use barrier clothing such as scrubs or aprons and disposable sleeve covers. As a minimum, the arms shall be covered.
b. Non-latex powdered gloves in a range of sizes.
c. Face mask.
d. In addition it is preferable to wear the following:
    i. mob cap; and
    ii. overshoes.

9.2.2 The purpose of wearing a face mask to reduce the risk of contamination shall be explained to the patient. If the patient objects or where the forensic healthcare practitioner considers the use of a face mask to be upsetting and the face mask is subsequently not worn, then this shall be recorded in the examination case notes with the reasons. However, the forensic healthcare practitioner's DNA profile shall be available for contamination elimination purposes (please refer to section 9.3 below for more details)

9.2.3 The order for putting on PPE/barrier clothing shall be undertaken in an appropriate sequence. The following order is an example:

a. face mask;
b. overshoes;
c. mob cap;
d. inner base gloves;
e. scrubs or apron and sleeve covers; and
f. outer gloves.

[56] Forensic Science Regulator The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208.

9.2.4 PPE/barrier clothing shall be changed after every forensic medical examination, cleaning or maintenance task. The PPE/barrier clothing shall be appropriately disposed of after use.

9.2.5 Hand hygiene is a key part of the examination procedure. Hands shall be decontaminated by washing[57] before donning gloves and following their removal. Non-sterile gloves may be used where it is possible to undertake evidence collection without touching any key parts of the patient, for example, by utilising aseptic non-touch techniques and venepuncture where blood for toxicology is collected. Where swabs are used the sampler shall hold them at the base, away from the sampling end.

9.2.6 Double gloving should be employed with the top gloves being changed for different sample sites or after touching surfaces such as taps or door handles in the forensic examination room. Top gloves shall also be changed after manoeuvring the curtain around the couch regardless of whether it is a disposable variety or other type.

9.2.7 Gloves shall not be washed and alcohol gel shall not be applied as this may compromise the integrity of the gloves.[58]

9.2.8 Any other person entering the forensic areas of the facility (including family member, friend or supporter) shall be made aware of the potential contamination risks. The forensic healthcare practitioner and other professionals in attendance shall wear PPE/barrier clothing to mitigate against extraneous DNA being deposited in the facility's DNA clean examination room. A family member, friend or supporter in attendance should also wear PPE/barrier clothing if entering the medical examination room. If the individual objects consideration should be given to excluding that individual from the medical examination room. If the forensic healthcare practitioner considers it to be too upsetting for the supporter to wear full PPE/barrier clothing for the examination, this shall be recorded in the case notes and increases the requirement for effective cleaning and the requirement for a DNA elimination

[57] Liquid soap with good hand washing technique should be adequate, if further guidance is required then the DNA forensic science providers may be able to advise on current best products.

[58] Chalmers and Straub (2016).

sample (see 9.3 below). All attendees shall be recorded (see 8.5.20 in this guidance).

9.3 DNA Elimination Samples (ISO 15189 5.2.6; FSR-P-302)

9.3.1 Any individual entering a facility may inadvertently introduce their DNA into the environment. This may subsequently contaminate an exhibit or sample during or after its recovery, which may mislead[59] an investigation, waste resources and cause unnecessary delay. The provision of an elimination sample, and for the DNA profile derived to be included on a searchable elimination database as appropriate, assists in detecting contamination and ensuring the relevance of detected DNA profiles.

9.3.2 The facility shall ensure that a policy is in place to address the following:

a. agreement/consents for sample donation and the use of profile information;
b. security and access of information at a local/national level;
c. secure storage and retention of samples;
d. secure and recorded transfer of samples in accordance to guidance provided by the forensic science provider[60] that will undertake the DNA profiling for elimination purposes; and
e. sharing of profile information (between staff member, facility management, forensic medical provider, police investigator and elimination database provider).

9.3.3 All staff working within the facility shall provide a DNA elimination sample prior to entering any part of the forensic area of the facility. This shall include (but is not limited to) the forensic healthcare practitioner, paediatricians, crisis workers (CWs), cleaning staff and contractors. All other attendees entering the facility, (including the patient, whether police-referral or self-referral cases, interpreters, friends and family) should provide a DNA elimination sample prior to entry otherwise they shall have their details and contact information recorded in case there is a need to request a sample at a later date for contamination elimination

[59] Gill (2014).
[60] This could be the police force if the force acts as an intermediary.

purposes. Consideration should be given to excluding from the medical examination room any individual(s) who are not willing to provide their details.

9.3.4 A record shall be kept of:

a. which room is used for each examination;
b. the date and times of the examination: and
c. the names of all persons who enter the examination room during the examination, including interpreters and any person who supports the patient (please see section 8.5.20 in this guidance for more details).

9.3.5 The policy and procedures for taking and managing DNA elimination samples and the investigation of any identified contamination should be in accordance with the Forensic Science Regulator protocol FSR-P-302.[61]

9.4 Decontamination Measures (ISO 15189 5.2.6; FSR-G-208)

9.4.1 In the event that multiple patients from the same incident attend the facility at the same time, staff shall ensure that they do not have contact with more than one patient to prevent cross-contamination. If this is absolutely unavoidable, steps shall be taken to ensure that appropriate precautions are taken to minimise cross-contamination. This shall include staff showering, including washing their hair, and changing their own clothes between each patient. As a minimum, all PPE/barrier clothing shall be changed between contacts. The forensic medical examination room, including equipment, shall be cleaned between each examination.

9.5 Cleaning (ISO 15189 5.2.6; FSR-G-208)

9.5.1 Each area shall have a cleaning schedule, with the frequency of cleaning dependent on the extent of use of the area and the equipment within it. Cleaning shall be carried out and recorded on a cleaning log to show all activities undertaken as per the schedule.

[61] Forensic Science Regulator DNA contamination detection – the management and use of staff elimination databases FSR-P-302.

9.5.2 As a minimum cleaning shall be undertaken using cleaning equipment dedicated solely for use in each area and using a cleaning regime validated or verified to provide effective[62] DNA decontamination.

9.5.3 Verification of the efficacy of the cleaning materials, processes and staff using the standard operating procedures (SOPs) shall include sampling areas immediately after cleaning by an individual not involved with cleaning, and processing of the samples as for environmental samples. Any profiles obtained shall only be checked against the facility staff, including those conducting the cleaning, to facilitate assessing whether the cleaning is effective and whether the cleaning staff are inadvertently transferring their DNA. It might be necessary for a check against consumable manufacturing elimination databases to exclude consumables as the source for unknown profiles.

9.5.4 Cleaning shall be conducted by appropriately trained staff every time the pre-assessment (waiting) room, medical examination room and bathroom areas of the facility have been used.

9.5.5 Cleaning shall be undertaken using cleaning equipment dedicated solely for use in each DNA clean area and using a cleaning regime validated or verified to provide effective DNA decontamination.

9.5.6 In the DNA clean controlled examination areas, between the examination of patients, as a minimum the following should be cleaned.

a. Work surfaces – identify and decontaminate all surfaces that may either directly or indirectly come into contact with the patient during sample recovery activities, consumables or exhibits. These surfaces should also be cleaned before use, particularly if there is a period of non-use that could allow dust[63] to settle on surfaces.
b. Individual pieces of equipment including:
    i. pens;
    ii. examination couch;
    iii. mobile examination light with magnifying lens; and

[62] Ballantyne *et al.,* 2015.
[63] Farash *et al.,* 2014.

iv. colposcope with attachments for photo-documentation.

c. IT equipment (graphic pads and pens, and keyboards).

9.5.7 On a weekly basis (assuming there has been no gross contamination with body fluid material, for example, blood) the following shall be decontaminated:

a. floors;
b. equipment such as sphygmomanometers, computers, keyboards and all exposed cables; and
c. all contact surfaces such as cupboards, door handles and fridges.

9.5.8 Deep cleaning shall be regularly scheduled and should be conducted at least every month regardless of the number of patients who have undergone a forensic medical examination at the facility. This ensures that build-up of dust deposits from ventilation/heating systems are kept to a minimum.

9.5.9 The whole area deep clean shall include areas not already covered by the other cleaning:

a. lights and vents;
b. walls and ceiling;
c. windows and blinds; and
d. the insides of cupboards and drawers.

9.5.10 Cleaning or replacement of air filters should be undertaken at a frequency recommended by the manufacturers.

9.5.11 For rooms that are used on an infrequent basis, i.e. less than once a week, whether new or being recommissioned after a contamination event, cleaning as detailed in sections 9.5.6 to 9.5.9 shall be undertaken prior to commencing use.

9.5.12 Where a spill or leak of biological material occurs, it should be removed using a cleaning regime validated to provide effective DNA decontamination. Depending on the circumstances and extent of the spillage it may be appropriate to undertake environmental monitoring of the affected area to provide assurance that all contamination has been removed.

9.5.13 Cleaning processes adopted shall be documented and their effectiveness verified in the hands of the end-user. It is also essential to ensure that consideration is given to the health and safety implications of using these

cleaning regimes, which shall be risk assessed and safe systems of work established prior to use.

9.5.14 An example of cleaning surfaces is as follows:

a. spray the entire surface with a chemical that destroys DNA (for example, 1% solution of sodium hypochlorite);
b. leave for five minutes;
c. wipe the entire surface thoroughly (warp/weft motion) using disposable cleaning roll (or similar); and
d. finally clean with distilled water[64] to remove cleaning agent residue.

9.6 Decontamination of Re-usable Equipment (ISO 15189 5.3.1.3; FSR-G-208)

9.6.1 Items that are not suitable for immersion in fluid without damaging them should be thoroughly cleaned using disposable cleaning roll or wipes liberally wetted with a chemical that destroys DNA, followed by cleaning with distilled water. Where equipment or items are susceptible to corrosion, then an appropriate cleaning agent that does not corrode[65] shall be used.

9.6.2 Small items thought to be contaminated that are suitable for immersion in fluid without damaging them should be submerged in a cleaning agent, scrubbed/wiped down to remove material and then rinsed in sterile distilled water.

9.7 Environmental Monitoring and Gross Contamination (ISO 15189 5.2.6; FSR-G-208; FSR-G-212)

9.7.1 The principle of EM is to undertake a programme of testing on a periodic basis:

a. to check that particular rooms or areas are DNA clean; and
b. to assess whether the decontamination policy for the area in question is effective and has been carried out properly.

[64] Safety testing has revealed that cleaning with hypochlorite and ethanol can produce levels of gaseous chlorine at or above the recommended exposure limits (Ballantyne *et al*., 2015).

[65] Activ8™ contains no oxidising or corrosive ingredients and can therefore be used with confidence on all surfaces, including fabrics and carpets.

9.7.2 The EM sampling regime shall be proportionate to the risk; for example, equipment or areas where large amounts of biological material are inevitably present should be sampled more frequently. Components typically sampled vary according to the function of the area.

9.7.3 The person collecting the EM samples (for example, swabs) shall be different to the person who undertakes the cleaning. The forensic science provider undertaking the EM sample testing should be able to advise on the level of gross contamination from the results obtained. The service level/turnaround times specified in contracts with the DNA EM sample testing provider(s) should be short. This allows for any contamination issues to be identified as early as possible, so that the facility can take immediate action. It also minimises the number of cases that will require a review because they were processed through the affected area or involved the use of affected equipment.

9.7.4 EM samples shall take the form of a dip sample exercise and be conducted midway between each deep clean; this may be done by using monitoring forms with pre-printed sample collection sites. Initially the monitoring should be carried out monthly to build a picture of the background level of DNA across the operational work areas and a steady state of acceptable levels is maintained. Based on the results returned, the frequency of the sampling can be adjusted, and areas targeted based on risk and previous results.[66]

9.7.5 Samples should be taken by swabbing selected areas and equipment that are in contact with operators, patients and/or the items themselves at all stages in the supply chain. The development of a training manual explaining the EM dip-sampling procedure, which includes photographs of the sites to be swabbed, is good practice. Table 1 sets the risk considerations, the frequency of monitoring and follow-up actions for unacceptable levels of DNA for various examples of equipment and areas within the facility.

[66] Forensic Science Regulator The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis FSR-G-208, section 8.7.

Table 1. Example of Environment Monitoring – Risk Level, Mitigation and Actions

Item	Considerations	Contamination Risk	Action for Fail (L1[1] or L2[2])	Monitoring[3]	Frequency
Client bed (couch)	Clean disposable cover used for every examination	Low	Re-clean	Cleaning efficiency. Monitor level for any significant increase	Quarterly
Medical trolley	No clean disposable sheet used on trolley	High	Embargo[4]	Thorough decontamination – re-sample and test[5]	Frequent. Sample prior to use for examinations and randomly select for testing
	Clean disposable sheet used on trolley	Medium/Low	Re-clean	Re-sample and test if L2[2]	Routine. Sample prior to use for examinations and randomly select for testing
Colposcope	Equipment that is close to and handled during examination of patient. Change outer gloves every time handled	High	Re-clean. Re-sample and test if L2[2]	Embargo[4] Thorough decontamination – re-sample and test[5]	Frequent. Sample prior to use for examinations and randomly select for testing
Initial room chair	Patient wearing outer clothing and is not examined in that area	Low	Re-clean	Cleaning efficiency. Monitor level for any significant increase	Quarterly
Initial room internal door handle	Inadvertent transfer by patient. Staff hand washing and double gloving in examination room prior to examination	Medium/Low	Re-clean. Re-sample and test if L2[2]	Cleaning efficiency. Monitor level for any significant increase	Monthly to quarterly intervals as appropriate, based on previous result

Notes:
1. Forensic science provider (FSP) profile result classified as fail: re-clean and re-sample.
2. FSP profile result classified as fail: close laboratory/isolate equipment/re-clean all areas and re-sample.
3. Monitor level for any significant increase in non-staff profile elements through staff elimination database checks.
4. Immediate isolation, decontamination and sample at every use until acceptable result returned.
5. Include water swab sample control that acts as a routine water swab consumable handling check, and record result in monitoring records.

9.7.6 Where gross DNA contamination is identified through EM the room or equipment in which it has been identified shall be quarantined immediately and deep cleaned. Following the deep clean, EM samples shall be taken again and re-tested until the facility has reached the documented 'pass' level, and the room or equipment can be reinstated for use. This may mean closing the entire facility if gross contamination has been identified in more than one room.

9.7.7 Profiles obtained should only be checked against the facility staff, including those conducting the cleaning, to facilitate assessing whether:

a. the cleaning staff are inadvertently transferring their DNA; or

b. the cleaning is ineffective by the level of unknown DNA sources detected.

It might be necessary for a check against consumable manufacturing elimination databases as part of any root cause analysis.

9.7.8 If the repeated EM results still show an unacceptable level or gross contamination, the facility management shall either:

a. investigate to identify the root cause and implement corrective procedures; or

b. utilise an external reviewer to look at the results, policies and processes.[67]

10. Documentation – Recording Of Notes And Statements

10.1 Note Taking and Record Keeping (ISO 15189 4.13; ILAC G19 3.5)

10.1.1 Each contact with the patient by any professional shall be recorded in the set of case notes pertaining to that patient. All notes shall be clear, accurate and legible and include details of all activity that has taken place that is directly relevant to contact with the patient at the facility.

10.1.2 Notes should be recorded contemporaneously but where this is not possible, notes shall be made as soon as possible after the activity has taken place.

[67] In February 2014 an independent review was commissioned by Hampshire Police to assess apparent DNA contamination present in EM results of the sexual assault referral centre. This independent review resulted in the development of policies and procedures to respond to contamination levels.

10.1.3 All manual notes shall be made in permanent ink, signed and dated, including time if appropriate by the professional recording the notes. The name, role and professional registration/identification number of the professional shall be included and legible. If the recorder is not the practitioner undertaking the tasks then the practitioner's details are recorded and the practitioner reviews, signs and dates the notes as a true and accurate record.

10.1.4 For electronic notes, the name, role and professional registration/identification number and date, including time if appropriate, of the professional undertaking the tasks is recorded. These details are reviewed by the practitioner for accuracy.

10.1.5 Where any additions or amendments are made to the notes by any person, the amendment shall be clear, and signed and dated. If the amendment is made by someone other than original professional, the name, role and professional registration/identification number of that individual shall be recorded in the notes.

10.1.6 Where a correction to the notes is required, a single line shall be run through the correction so that the original note can still be read.

10.1.7 Where abbreviations are included in notes they shall be unambiguous and easily understood, for example, LVS for low vaginal swab.

10.1.8 It is important that any decision made by the professional is recorded along with the reason for making the decision. Where there is an expected course of action that is not followed, the reason for making the decision not to follow the expected course shall be detailed in the record.

10.1.9 Case notes shall contain sufficient details to enable a practitioner to generate a statement, if required, at a later date.

10.1.10 There is a range of specimen pro formas published by the Faculty of Forensic and Legal Medicine (FFLM) to assist forensic healthcare practitioners with the process of note taking and sample information.[68,69,70] However, it is important

[68] Faculty of Forensic and Legal Medicine (2016f).
[69] Faculty of Forensic and Legal Medicine (2012).
[70] Faculty of Forensic and Legal Medicine (2010, Revised 2014).

for forensic healthcare practitioners to recognise that further information or activity may need to be recorded in the notes that is not prompted by the pro formas, for example, the batch number of consumable items such as swabs used, and barrier clothing/personal protective equipment (PPE) worn during the examination. The pro formas should be seen as a guide only and not a definitive list of information for inclusion in the patient's notes.

10.1.11 All notes (including permanent records such as colposcope images)[71] shall be retained by the facility in a secure location that complies with data protection requirements. The notes shall be available and accessible when they are required for the purpose of second opinion, peer review, the investigation and/or any criminal justice proceedings.

10.1.12 Where notes are required to be removed from the facility, the reason for removal shall be documented and a record kept by the facility of the professional removing and returning the notes. It is preferable for copies, or secure electronic access (with audit tracking) to records to be used so that the potential to lose records is eliminated.

10.2 Preliminary Findings (ISO 15189 5.7.1, 5.8.1; the Codes)

10.2.1 Where the police request a written account of the findings immediately following the forensic medical examination, the forensic healthcare practitioner shall clearly state in writing that the written account contains preliminary findings only and that these findings shall be confirmed at a later date. The preliminary findings report shall be subject to an accuracy check and a critical conclusion(s) check by another competent person prior to release to the police. The police shall be made aware that they should exercise care in making decisions based on the content of the preliminary findings rather than on a full statement or report, as the preliminary findings will not include full details of the forensic medical examination. If the preliminary findings have not undergone a critical conclusion check before release this shall be stated with the preliminary findings.

[71] Faculty of Forensic and Legal Medicine (2017b).

10.3 Statements and Reports (ISO 15189 5.7.1, 5.8.1; the Codes; FSR-G-200; FSR-G-225)

10.3.1 The facility shall define a process for the production of statements and reports in an agreed format and to an agreed standard. Due regard shall be taken to the disclosure obligations and the requirements set out in the Criminal Procedure Rules and Criminal Practice Directions[72] for experts. Though duties to the court of professional witnesses and experts are similar, it shall be borne in mind that the court can deem an individual 'an expert' to give an opinion based on their experience and knowledge. In addition, opinion evidence may rely on the statements provided by other practitioners to base opinions upon. Legal obligations are set out FSR-I-400[73] and disclosure requirements in the CPS Guidance for Experts on Disclosure, Unused Material and Case Management.[74]

10.3.2 All cases shall be subject to an independent peer review of all critical conclusions by a second competent individual, in a timeframe that minimises potential harm. Depending on the case, this can be:

a. either completed in stages (please see section 10.3.4 below for more details) as the case progresses; or
b. for the whole case as part of the peer review of the contents of the statement or report against the findings recorded and agreed.

10.3.3 The facility shall define:

a. a process to include the timings and stages of the peer review of the case by a second competent individual; and
b. who has a suitable level of experience and authority to perform such reviews (see 8.1).

10.3.4 Review areas shall as a minimum include:

a. medical care, including risk assessment and subsequent management;

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[72] Available at: www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015.

[73] Forensic Science Regulator Legal Obligations for Witnesses Providing Expert Evidence FSR-I-400.

[74] Available at: www.cps.gov.uk/legal-guidance/cps-guidance-experts-disclosure-unused-material-and-case-management.

b. forensic sampling and documentation;

c. follow-up decisions and management, including safeguarding; and

d. peer review of the content and accuracy of the report or statement and whether it is fully supported by the documented case notes.[75]

10.3.5 Forensic healthcare practitioners shall be appropriately trained to produce a statement that is acceptable for use within in the criminal justice process. All forensic healthcare practitioners shall be provided with ongoing support from a competent individual to assist them with statement writing.[76]

11. Acknowledgements

11.1.1 This guidance has been developed and produced in consultation with representatives from the Faculty of Forensic and Legal Medicine (FFLM) of the Royal College of Physicians, the Royal College of Paediatrics and Child Health (RCPCH), the United Kingdom Association of Forensic Nurses and Paramedics (UKAFN), the College of Policing, Hampshire Constabulary, Cellmark Forensic Services, United Kingdom Accreditation Service (UKAS) and members of the Forensic Science Regulator's medical forensics specialist group following the award to Principal Forensic Services and Lime Culture Community Interest Company to prepare the initial text.

12. Review

12.1.1 This document is subject to review at regular intervals.

12.1.2 If you have any comments please send them to the address as set out at: www.gov.uk/government/organisations/forensic-science-regulator or email: FSREnquiries@homeoffice.gov.uk.

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[75] The format for expert and non-expert technical reports is set out in Forensic Science Regulator Expert Report Guidance FSR-G-200 and Forensic Science Regulator Non-expert Technical Statement Guidance FSR-G-225 respectively.

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15. Abbreviations

Abbreviation	Meaning
ABE	Achieving best evidence
ASET (UKAFN)	Advanced standards in education and training
CJS	Criminal justice system
COP	College of Policing
CPS	Crown Prosecution Service
CW	Crisis worker
DNA	Deoxyribonucleic acid

Abbreviation	Meaning
ED	Emergency department
EEK	Early evidence kit
EM	Environmental monitoring
FFLM	Faculty of Forensic and Legal Medicine
FSR	Forensic Science Regulator
GMC	General Medical Council
HCPC	Health and Care Professions Council
ICIDP	Initial Crime Investigators Development Programme
ISO	International Organization for Standardization
ISVA	Independent sexual violence adviser
MedExD	Medical Examiners Elimination Database
NMC	Nursing and Midwifery Council
PAS	Publicly available specification
PPE	Personal protective equipment
QMS	Quality management system
RCPCH	Royal College of Paediatrics and Child Health
SARC	Sexual assault referral centre
SOP	Standard operating procedure
STI	Sexually transmitted infection
STO	Specialist trained officer
STODP	Specialist Trained Officer Development Programme
UKAFN	United Kingdom Association of Forensic Nurses and Paramedics
UKAS	United Kingdom Accreditation Service

Abbreviation	Meaning
UKSC	United Kingdom Supreme Court

16. Glossary

Accredit(ation): Procedure by which an authoritative body gives formal recognition that a body or person is competent to carry out specific tasks. [Back]

Chain of custody: Chronological documentation of the movement and location of items, from seizure until presented to court. [Back]

Child(ren): A child is anyone who has not yet reached their 18th birthday. [Back]

Competency: The ability of an individual to do a job properly. [Back]

Complainant: A person who makes a complaint or allegation of having been the victim of a criminal offence. See Patient. [Back]

Consumables: Single-use commodities used in the collection, preservation and processing of material for forensic analysis. [Back]

Crisis Worker: A dedicated support worker whose role is to provide immediate information, advice and advocacy to a patient of sexual violence prior to and throughout a forensic medical examination. [Back]

Critical Conclusions Check: another suitably qualified and competent healthcare practitioner scrutinises the report to ensure that (i) the report is internally consistent, (ii) the conclusions drawn are justifiable from the information set out in the report and (iii) the report is capable of being understood without reference to other material. See Peer Review. [Back]

DNA Clean Area: Area in which appropriate DNA contamination prevention measures shall be maintained at all times. [Back]

DNA Contamination: The introduction of DNA, or biological material containing DNA, to an exhibit, or subsample derived from an exhibit during or after its

recovery from the scene of crime or a person. In the context of the facility this could occur for any or al of the following reasons (not an exhaustive list).

a. Poor practice[77] employed by staff using fixtures and fittings and/or collecting forensic samples.
b. DNA contamination from anybody who has had access to the forensic waiting room and/or the medical examination room. Here key risk groups are people from whom elimination DNA profiles have not been taken and included in an elimination database, and therefore may be inadvertently associated with a crime rather than being identified as contamination. These may include visitors, contractors and people accompanying a patient into the forensic waiting room and/or the medical examination room.
c. Insufficient use of cleaning regimes, or ineffective cleaning reagents used, as part of either cleaning DNA clean controlled areas or a subsequent deep clean.
d. Residual DNA from the manufacture/maintenance of fixtures and fittings that have not been deep cleaned. [Back]

Early Evidence Kit (EEK): A dedicated kit used to collect forensic samples that are affected by both time and activities undertaken by a patient post-assault. [Back]

Elimination Database: Collection of DNA profiles held in a searchable format from staff whose access/role/activities are deemed to be a potential DNA contamination risk. This may include not just the staff working within a specific facility, but also profiles from visitors to the facility, staff of manufacturers supplying consumables for DNA processing, and unsourced contamination profiles. The profiles are used to identify instances of inadvertent contamination. [Back]

[77] It should be noted that even good practice does not eliminate the risk of contamination, it only helps to minimise it.

Environmental Monitoring (EM): A sampling and analytical (DNA) process for equipment, furniture and work areas that both monitors and audits the cleaning procedures and decontamination methods applied within the facility. [Back]

Evidence: Facts, information and samples taken to support or contradict an assertion. It also includes the absence or presence of injuries (fresh and healing), scars, and elements of the history pertaining to and provided by the patient. [Back]

Examination: Activity or process of observing, searching, detecting, recording, prioritising, collecting, analysing, measuring, comparing and/or interpreting. [Back]

Facility: The physical environment used for any medical examination and sample collection, which in part is a forensic unit. [Back]

Finding: Information obtained from an investigation or examination. [Back]

Forensic: Scientific methods, techniques and processes used to aid an investigation into a crime. [Back]

Forensic DNA Grade: Consumables that are compliant with the requirements set out in ISO 18385:2016 Minimizing the risk of human DNA contamination in products used to collect, store and analyse biological material for forensic purposes. [Back]

Forensic Healthcare Practitioner: The term is used to describe forensic physicians (both doctors and paediatricians), forensic nurses, forensic midwives and paramedics. [Back]

Forensic Medical Examination: Activity or process of observing, assessing, prioritising, recording, collecting samples for scientific analysis, documenting injuries and interpreting with reference to sexual assault offences. [Back]

Forensic Process: The joining up and interaction of various forensic plans or activities.

Forensic Science Provider: An organisation that undertakes any part of the evidence recovery, analytical process and interpretation on behalf of the police

or other criminal justice system customers. Police evidence recovery laboratories are also included. [Back]

Forensic Unit: A forensic unit is a legal entity or a defined part of a legal entity that performs any part of the forensic science process. [SOURCE: ILAC-G19:08/2014 Modules in a Forensic Science Process] [Back]

Gross Contamination: Is the transfer of DNA from a single person where a partial or complete DNA profile (these alleles are 'dependent') is obtained as a result of a single contamination event and the donor could be identified.

The term is also used in environmental monitoring (EM) sampling where a profile from multiple persons from an unidentified number of events is obtained and the donors cannot be identified. [Back]

Item: Object, substance or material that is collected or sampled as part of the forensic process. [Back]

Non-Police-Referral: The term used to describe a patient who has not reported a sexual offence to the police and is referred to support services, including a forensic medical examination, by professionals, for example, doctors, counsellors, independent sexual violence advisers (ISVAs). [Back]

Patient: In the context of this document, a patient is an individual subjected to or suspected of being subjected to sexual assault. [Back]

Peer Review: Evaluation of the work of other competent practitioners in the same field to assess that there is sufficient basis for the conclusions and/or opinions, and the implications for the disclosure of unused material in criminal investigations. See Critical Conclusions Check. [Back]

Personal Protective Equipment (PPE): Items, for example, clothing and gloves, which are used to prevent skin and mucous membrane exposure when in contact with blood and body fluid on or from any patient. PPE is also worn to protect the practitioner from contact with harmful chemicals, for example, during decontamination and to minimise the chance that the wearer causes inadvertent DNA contamination. [Back]

Police-Referral: The term frequently used to describe a patient who has reported a sexual offence to the police and is seeking/offered additional support services including a forensic medical examination. [Back]

Quality Management System (QMS): A management system to direct and control an organisation with regard to quality. [Back]

Report: Communication method of the forensic findings. These include but are not limited to:

a. streamlined forensic reports (SFRs);
b. section 9 statements (Criminal Justice Act 1967);
c. interim reports. [Back]

Self-Referral: The term frequently used to describe a patient who has not reported a sexual offence to the police or other professional and is seeking/accessing support services including forensic medical examination. [Back]

Standard: A standard is an agreed way of doing something that is to a level of quality or attainment. [Back]

Statement: A statement is one form of a report. It is formatted to comply with the provisions of s9 Criminal Justice Act 1967. [Back]

17. Annex A: Guidance On The Professional Roles Associated With The Facility

17.1 Professional Providing Service Within the Facility

Crisis worker (however named)

17.1.1 The primary role of the crisis worker (CW) (or professional fulfilling the role, such as a paediatric nurse) is to provide immediate support to the patient and significant others where relevant (for example, family members where the patient is a child) prior to and throughout the examination process.

17.1.2 The CW acts as an advocate for the patient, providing information to the patient to enable them to make informed choices about what will happen to them at the facility.

17.1.3 The CW may be required to assist in the recovery of forensic science related evidence by:

a. advising and providing the early evidence kit (EEK) where appropriate;
b. recovering clothing from patients; and
c. assisting with the packaging and labelling of forensic samples collected.

17.1.4 The CW may be involved in the cleaning of those areas of the facility where the collection of forensic samples is undertaken.

17.1.5 The CW shall be competent to:

a. provide information and initial crisis support to the patient (and/or their significant others);
b. communicate and engage with the patient (and/or their significant others);
c. advocate on behalf of the patient (and/or their significant others);
d. carry out an initial assessment to identify the needs of and risks to the patient of sexual violence;
e. provide and give guidance on the use of the EEK;
f. assist in the collection and labelling of forensic samples (if appropriate); and
g. clean the medical examination and DNA clean areas of the facility to the accepted standard (if appropriate).

17.1.6 Organisations employing CWs shall ensure that the CW is trained to an appropriate standard that is maintained in order to meet the competencies to undertake the role. Such training shall include the following role and responsibilities (to include boundaries and safe practice):

a. communicating and working effectively with the patient and third parties;
b. assessing need, risk and safety;
c. providing advocacy on behalf of the patient;
d. having a general forensic awareness, including an overview of the forensic medical examination;
e. giving guidance on how to use the EEK;
f. assisting with the collection, packaging and storage of forensic samples;
g. cleaning the forensic areas of the facility.

17.1.7 Competency assessment shall take place after training, followed by ongoing assessment through regular clinical and management supervision. The organisation shall ensure that the CW accesses and undertakes continuous professional development.

Forensic Nurses, Midwives and Paramedics

17.1.8 The Nursing and Midwifery Council (NMC) sets the general professional standards for nurses working in the UK. The Health and Care Professions Council (HCPC) sets out the general standards for paramedics working in the UK. For the individual nurse providing care, the NMC is clear that the nurse shall recognise and work within their competence.[78] The HCPC also includes that healthcare professionals should recognise and work within their competence.[79]

17.1.9 Healthcare professionals who work in a forensic setting undertake various roles, therefore competencies will vary depending on the role undertaken. For example, some nurses will be purely supportive, others will be performing forensic examinations independently, thereby working at an advanced level as

[78] Nursing and Midwifery Council (2015).
[79] Health and Care Professions Council (2016).

defined by the Department of Health,[80] NMC[81] and the Royal College of Nursing[82].

17.1.10 Nurses (including midwives) and/or paramedics who undertake forensic medical examinations independently shall hold relevant qualifications and competence to meet the requisite standard of practice. This includes the expectations of what the forensic nurses/midwives/paramedics should achieve in relation to training, mentoring and supervision, and accesses and undertakes continuous professional development.

17.1.11 The Faculty of Forensic and Legal Medicine (FFLM) provides advice for obtaining qualifications in clinical forensic medicine,[83] and quality standards for nurses of patients who have been subjected to sexual offences.[84] The United Kingdom Association of Forensic Nurses (UKAFN)85 has developed advanced standards in education and training for nurses in the sexual assault setting.

Forensic physician

17.1.12 The General Medical Council (GMC) sets the competencies for doctors working in the UK. For the individual doctor providing care, the GMC is clear that the doctor shall recognise and work within the limits of their competence.[86]

17.1.13 The forensic physician provides the medical and forensic examination for the patient. The FFLM has provided advice on qualifications[87] and the forensic physician shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role to conduct a medical and forensic examination. Forensic physicians should meet the quality standards in forensic medicine[88] set out by the FFLM in relation to training, mentoring and

[80] Department of Health (2010).
[81] Nursing and Midwifery Council (2005).
[82] Royal College of Nursing (2018) Standards for Advanced Level Nursing Practice.
[83] Faculty of Forensic and Legal Medicine (2018c).
[84] Faculty of Forensic and Legal Medicine (2019).
[85] UK Association of Forensic Nurses (2018). Course details are available at: http://ukafn.org/aset/
[86] General Medical Council (2013).
[87] Faculty of Forensic and Legal Medicine (2018c).
[88] Faculty of Forensic and Legal Medicine (2016a).

supervision, and accesses and undertakes continuous professional development.

Paediatrician

17.1.14 The role of the paediatrician is to provide for a child patient either:

a. the medical element of a forensic medical examination, which will include a comprehensive assessment of the physical and emotional development of the child or young person; or

b. both the medical and forensic elements of the forensic medical examination, which will also include a comprehensive assessment of the physical and emotional development of the child or young person.

17.1.15 The role of the paediatrician in the forensic examination of a child patient will depend upon the competency of the paediatrician. The FFLM and the Royal College of Paediatrics and Child Health (RCPCH) Guidelines on Paediatric Forensic Examination in Relation to Possible Child Sexual Abuse[89] states:

"A single doctor examination may take place provided the doctor concerned has the necessary knowledge, skills and experience for the particular case. When a single doctor does not have all the necessary knowledge, skills and experience for a particular paediatric forensic examination two doctors with complementary skills should conduct a joint examination. Usually such examinations involve a paediatrician and a forensic medical practitioner. However, it may be necessary to involve another medical professional such as a genito-urinary physician or family planning doctor, if the case demands it."

17.1.16 Paediatricians should meet the quality standards in forensic medicine[90] set out by the FFLM in relation to training, mentoring and supervision, and have access to and undertakes continuous professional development. The RCPCH has guidance regarding numbers of examinations and maintenance of competence.[91] The RCPCH and the FFLM have produced a service

[89] Faculty of Forensic and Legal Medicine and Royal College of Paediatrics and Child Health (2012).

[90] Faculty of Forensic and Legal Medicine (2016a).

[91] Royal College of Paediatrics and Child Health (2017).

specification for the clinical evaluation of children and young people who may have been sexually abused.[92]

Cleaner Specialising in DNA Decontamination

17.1.17 A person with responsibility for the decontamination cleaning of the forensic areas of the facility. The cleaner shall be deemed competent to:

a. conduct the DNA decontamination cleaning to the required standard as defined in section 9.5 of this guidance; and
b. utilise the cleaning agents in a manner compliant with relevant health and safety requirements.

17.1.18 The decontamination cleaner shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to cleaning:

a. instruction and practical demonstration in the effective use of cleaning reagents, cleaning equipment and personal protective equipment (PPE) (barrier clothing);
b. instruction and practical demonstration in effective cleaning techniques to remove any potential contamination within the facility;
c. a basic understanding of the scientific principles for DNA decontamination procedures;
d. maintenance and accurate recording of the cleaning logs; and
e. environmental sampling if appropriate.

Person with Responsibility for Quality Management (ISO 15189 4.1.2.7)

17.1.19 The named person with overall responsibility for ensuring the facility's compliance shall establish, implement and maintain an appropriate quality management system, in conformity with ISO 15189:2012.

17.1.20 The named person and those who undertake these tasks shall be competent in:

a. implementing and maintaining a quality management system;

[92] RCPCH and FFLM (2015).

b. reporting on the functioning and effectiveness of the quality management system; and
c. co-ordinating awareness of the needs and requirements of users.

17.1.21 These personnel shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following:

a. a comprehensive understanding of the essential elements and functionality of a quality management system;
b. how to implement a quality management system and ensure that it is properly maintained;
c. an understanding of the staff roles and responsibilities required for the effective operation of the quality management system; and
d. auditing the quality management system.

17.2 Professional Providing Initial Contact/First Response Internal and External

17.2.1 The first professional responding to a phone call or personal contact from the patient, for example:

a. staff at the facility;
b. the police;
c. a social worker, if the patient is a child or young person;
d. health professionals (such as GPs, emergency department [ED] staff, sexual health staff); and
e. staff at another agency, such as rape support services.

17.2.2 The first professional at the facility shall be competent to:

a. provide relevant information and immediate support to the patient (and/or their significant others);
b. communicate and engage with the patient (and/or their significant others);
c. carry out an initial assessment to identify the immediate needs of and risks to the patient; and

d. provide information regarding the preservation and prevention of loss of forensic science related evidence until the patient receives appropriate practical support.

17.2.3 The professional providing initial contact/first response shall be trained to an appropriate standard to ensure that they are able to meet the competencies to provide initial response to patients. Such training shall include the following:

a. communicating and working effectively with the patient and third parties, including assessing age, disability, language;
b. assessing the patient's immediate needs, risk and safety, including emergency medical provision;
c. having a general forensic awareness, including forensic science related evidence preservation, for example, not laundering clothes, urine samples if an early evidence kit (EEK) is not immediately available; and
d. being aware of the options available to patients for forensic medical examination, including timescales and police/self-referrals.

17.3 Police Personnel

First Response Police Officer

17.3.1 The first response police officer is the professional who responds to the patient following the response from the call handler/initial contact person. The first response police officer shall be competent to:

a. provide information and support to the patient (and/or their significant others);
b. communicate and engage with the patient (and/or their significant others);
c. carry out an initial assessment to identify the immediate needs of and risks to the patient;
d. provide information regarding the preservation and prevention of loss of forensic science related evidence;
e. provide an overview of the forensic medical examination; and
f. gather initial forensic science related evidence, including the EEK and clothing.

17.3.2 The first response police officer shall be trained to an appropriate standard to ensure that they are able to meet the competencies to provide an appropriate initial response to patients. Such training shall include the following:

a. developing communication skills to work effectively with the patient and third parties, including assessing age, disability, language;
b. how to assess the patient's immediate needs, risk and safety, including emergency medical provision;
c. how to use the EEK;
d. how to preserve, package and label forensic samples;
e. being aware of the options available to patients for forensic medical examination, including timescales; and
f. having an overview of the forensic medical examination.

Specialist Trained Officer

17.3.3 The specialist trained officer (STO) is the police officer who takes responsibility for the patient following the first response police officer or call handler/initial contact response, in the event that a first response police officer has not been dispatched. The STO shall be competent to:

a. provide information and initial crisis support to the patient (and/or their significant others);
b. communicate and engage with the patient (and/or their significant others);
c. carry out an initial assessment to identify the needs of and risks to the patient;
d. assist in the collection and labelling of forensic samples;
e. provide information regarding the preservation and prevention of loss of forensic science related evidence;
f. provide an overview of the forensic medical examination; and
g. gather initial forensic science related evidence, including from the EEK, and clothing.

17.3.4 The STO shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to the forensic medical examination:

a. the STO's role and responsibilities;
b. communication and working effectively with the patient and third parties;
c. assessment of need, risk and safety;
d. general forensic awareness including an overview of the forensic medical examination;
e. use of the EEK;
f. assisting with the collection, packaging and storage of forensic samples;
g. preserving, packaging and labelling forensic samples; and
h. the options available to patients for forensic medical examination, including timescales.

17.3.5 The STO Development Programme (STODP) developed by the College of Policing (COP) is an example of good practice in relation to training STOs.

Investigation Officer

17.3.6 The investigation officer is a detective at detective constable (DC) or detective sergeant (DS) level who has competencies in:

a. forensic knowledge;
b. strategy setting in relation to sexual offences; and
c. management and practical knowledge of the forensic science related evidence collection at a scene and subsequent forensic medical examination.

17.3.7 The investigation officer may be part of a joint investigation team or a member of a dedicated team dealing with adult sexual offences and or child protection cases. In terms of training the investigation officer, the Initial Crime Investigators Development Programme (ICIDP) as defined by the COP is recommended as good practice. The investigation officer shall be competent to:

a. conduct an evaluation of the material gathered during the initial response to develop an investigation strategy;
b. ensure that the material is retained and recorded in line with current legislation and policy;

c. develop and maintain investigative strategies, identifying and prioritising lines of enquiry to maximise the gathering of forensic information that could assist with the forensic medical examination;
d. deal with patients who have been subjected to sexual assault in an ethical and effective manner, recognising their needs with respect to race, diversity and human rights; and
e. be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role.

17.3.8 Such training shall include the following in relation to the forensic medical examination:

a. ensuring the source and provenance of different types of potential forensic material recovered during the forensic medical examination and/or following the use of an EEK;
b. ensuring the forensic medical examination is incorporated within any wider forensic strategy that is developed as part of the investigation;
c. understanding the role and responsibilities of the STO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and local forensic science provider;
d. planning and communication with the appropriate staff at the sexual assault referral centre (SARC) regarding when and how possible forensic science related evidence may be retrieved from the patient, including contingencies where the care of the patient may affect forensic science related evidence recovery; and
e. collating information about the forensic medical examination and retrieval of forensic science related evidence, including the security of forensic samples and any subsequent access to the samples.

Authority for Forensic Science Submission

17.3.9 This is a person with a crime scene, forensic science or investigative police background who has up-to-date knowledge in relation to forensic science, and associated evidence-based sampling time frames. This person shall understand forensic strategy setting and have knowledge of contractual forensic

arrangements with the forensic science provider(s). In respect of the forensic medical examination, this person shall be competent to:

a. explore and identify all potential forensic opportunities from the evidence collected at the forensic medical examination and any samples obtained from the use of an EEK;
b. formulate a forensic strategy in all sexual offence cases in order for the relevant samples to be collected at the forensic medical examination; and
c. establish the facts from the witness accounts and consider the best items for forensic submission in consultation with the investigating officer and the forensic science provider.

17.3.10 The forensic submissions authoriser shall be trained to an appropriate standard to ensure that they are able to meet the competencies to undertake the role. Such training shall include the following in relation to the forensic medical examination:

a. ensuring the source and provenance of different types of potential forensic material recovered during the forensic medical examination and/or following the use of an EEK;
b. ensuring the forensic medical examination is incorporated within any wider forensic strategy that is developed as part of the investigation;
c. understanding the role and responsibilities of the STO, crisis worker, forensic healthcare practitioner, paediatrician, forensic authoriser and local forensic science provider;
d. planning and communicating the forensic strategy requirements from the point of first submission to any subsequent phased submissions with the local forensic science provider; and
e. having an understanding of the forensic science results in relation to sexual offences and the ability to challenge results where appropriate with the forensic science provider.

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Forensic Science Regulator
Overseeing Quality

Codes of Practice and Conduct

Sexual Assault Examination: Requirements for the Assessment, Collection and Recording of Forensic Science Related Evidence

FSR-C-116

Issue 1

CONTENTS

1. Introduction

1.1.1 Sexual offences are devastating crimes and the impact of sexual violence can include significant consequences to the long-term health and well-being of complainants. The timely collection of evidence can provide complainants with the option to assist in any criminal investigation. This can increase the likelihood that the best evidence can be obtained to investigate and aid a criminal prosecution, so that if a criminal offence has occurred, the perpetrator can be caught and prevented from continuing to commit further sexual offences. Scientific evidence can also assist with exoneration of the innocent.

1.1.2 The provision of dedicated high quality healthcare alongside forensic and medical examination [1] for the collection of evidence has considerable benefits for both the health and well-being of complainants and the delivery of justice. Such services provide both the police and the complainant with the best possible opportunity to recover evidence for use within an investigation, and minimise the risk of a miscarriage of justice. This includes the risk of wrongful conviction(s), wrongful acquittal(s) and delaying investigation(s).

1.1.3 For the purpose of this document, the term 'patient' is used to refer to victims and complainants of sexual assault, both those alleging and those suspected to have been subjected to sexual assault.

1.1.4 In order to achieve high quality and consistent forensic science related evidence provision, defined standards are necessary for all stages of the complainant's 'journey' immediately before and during the forensic medical examination [2]. These standards should not intrude on the healthcare of the patient, but provide confidence in the relevance of any findings documented during the examination, and any subsequent scientific results from the samples taken during the examination. The care pathway for the patient varies based on the individual case and the local variation of service delivery.

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1 The medical and therapeutic needs may override the requirement to collect forensic science related evidence.

2 Activity includes recording, collecting samples for scientific analysis and documenting injuries.

However, this should not detract from achieving the best health and justice outcomes for the patient.

1.1.5 Forensic healthcare practitioners include doctors, paediatricians and other healthcare professionals (including nurses and midwifes) (7.1) who provide medical and related care to individuals alleging that they were subjected to sexual offences and to persons detained on suspicion of committing these crimes.

2. Scope

2.1.1 This standard applies to cases for which submission to criminal courts in England and Wales applies. Scotland and Northern Ireland may also institute parallel arrangements for their jurisdictions.

2.1.2 The remit of the Forensic Science Regulator covers the forensic sampling for criminal investigations and not medical practices; any reference to medical practice is included for context as forensic sampling and the medical care of patients overlap. The General Medical Council (GMC), the Nursing and Midwifery Council (NMC) and the Health and Care Professions Council (HCPC) regulate doctors, nurses and paramedics respectively.

2.1.3 The Forensic Science Regulator has determined that ISO 15189 Medical laboratories – Requirements for quality and competence is the appropriate international standard for the forensic medical examination services to be accredited to.

2.1.4 The purpose of this appendix to the Forensic Science Regulator's Codes of Practice and Conduct [3] (the Codes) is to set the requirements for the forensic medical examination of patients relating to alleged sexual assault. This covers where the medical examination and collection of evidence [4] from a patient [5] routinely [6] takes place. The names, locations and settings where

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3 Forensic Science Regulator's Codes of Practice and Conduct for Forensic Science Providers and Practitioners in the Criminal Justice System.

4 This applies to acute and historic cases where, for example, sexually transmitted infection samples are required for evidential purposes.

5 These requirements apply to both self-referrals and patients referred by the police.

6 The use of ad hoc locations such as emergency departments and care homes are not included; however, anti-contamination good practice for the examination and recovery is expected.

these examinations take place are varied. For the purpose of this standard they will collectively be known as the 'medical examination and sample collection facility' (the facility) and will be recognised in part as a forensic unit for the purposes of relevant forensic science standards and guidance.

2.1.5 Figure 1 (for adults, see page 7) and Figure 2 (for children, see page 8) outline where the facility, procedures and practices occur within the patient's 'journey' from allegation to court. [7] The figures identify the stages where the standards and guidance apply within and outside the control of the facility. The facility shall identify those stages in their local care pathway which are within their control and therefore within the scope of accreditation they require.

2.1.6 The requirement applies to personnel involved in performing and supporting the delivery of the forensic medical examination service at the facility. This includes:

a. the provision of services provided by different or multiple providers regardless of the commissioning arrangements or funding structure; and

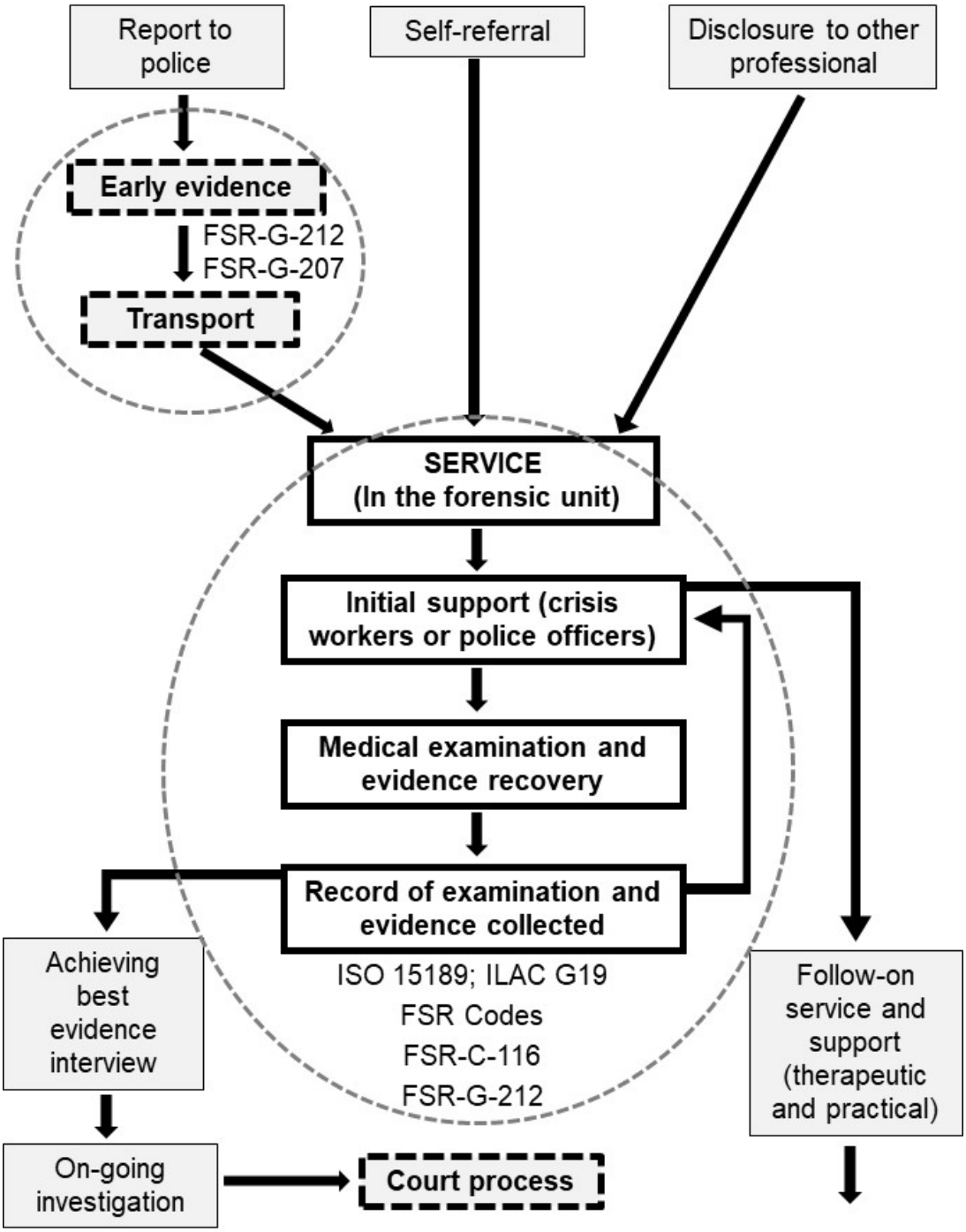
b. those with responsibility for managing the processes, personnel and the facility.

2.1.7 The Forensic Science Regulator's Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations, FSR-G-212, provides guidance on the forensic science aspects of this standard.

2.1.8 Areas such as medical evaluation and treatment, suicide risk and mental health assessments, case reviews and post-forensic examination treatment/follow-up are outside the scope of this standard.

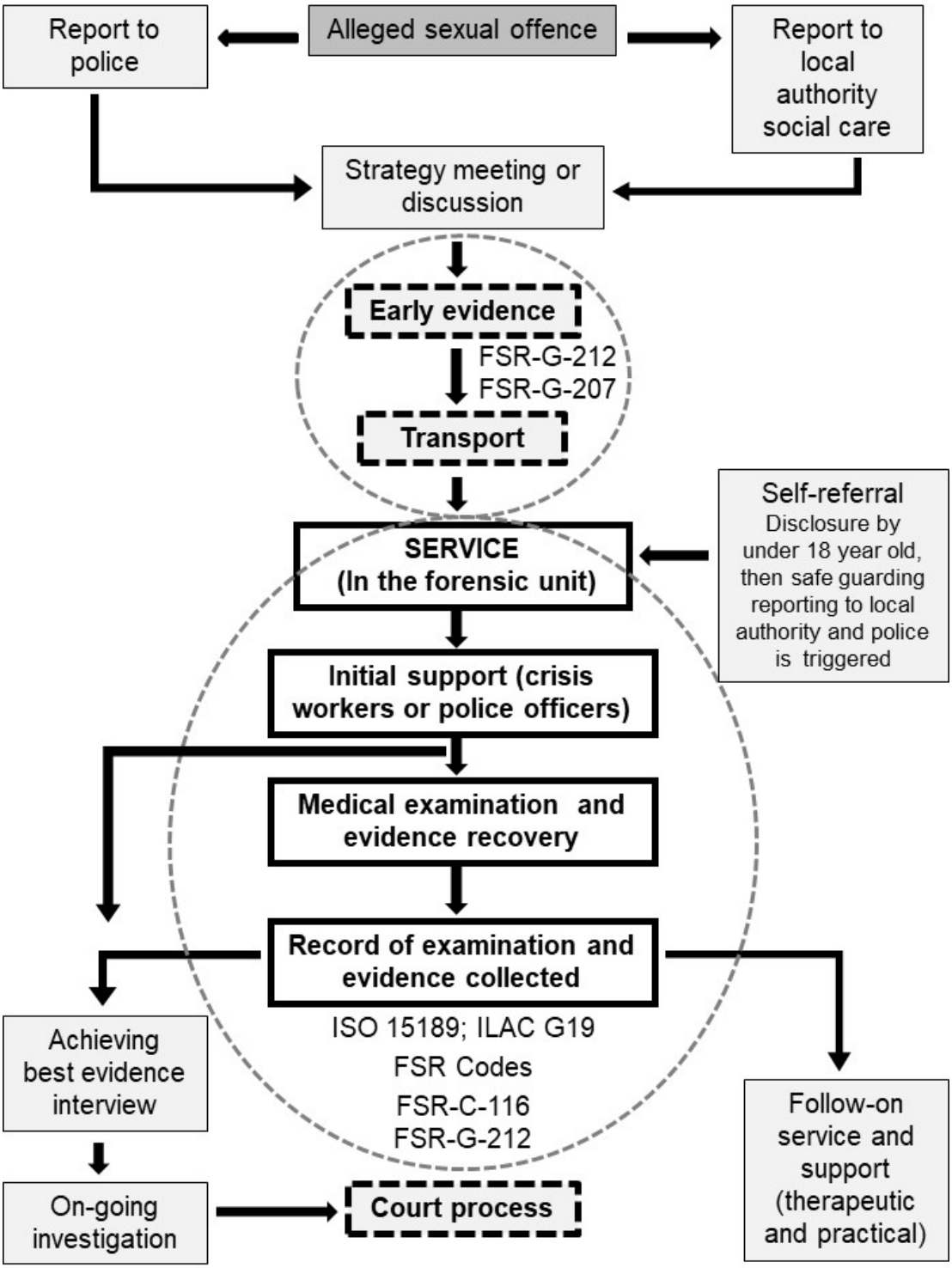
[7] These diagrams are not care pathways nor are they intended to be used as referral routes.

Figure 1. Adult Patient's Journey from Allegation to Court via the (Medical Examination and Sample Collection) Facility.



The standards and guidances apply at the stages in bold text within the facility (solid lines) and outside the control of the facility (dashed lines).

Figure 2. Child Patient's Journey from Allegation / Disclosure / Professional Concern of Abuse to Court via the (Medical Examination and Sample Collection) Facility.



The standards and guidances apply at the stages in bold text within the facility (solid lines) and outside the control of the facility (dashed lines).

3. Implementation

3.1.1 Within the remit of clinical governance the service provider with responsibility for the facility shall ensure that there is a named person with responsibility for ensuring the facility's compliance with this standard. [8]

3.1.2 To meet this standard the requirements set out in the following shall be incorporated into the policies, processes and procedures within the facility:

a. ISO 15189 Medical laboratories – Requirements for quality and competence;
b. ILAC G19:08/2014 Modules in a Forensic Science Process;
c. Forensic Science Regulator, Codes of Practice and Conduct for Forensic Science Providers and Practitioners in the Criminal Justice System (the Codes);
d. Forensic Science Regulator, DNA Anti-Contamination – Forensic Medical Examination in Sexual Assault Referral Centres and Custodial Facilities FSR-G-207; and
e. Forensic Science Regulator, Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations FSR-G-212.

3.1.3 This document is available for incorporation into an organisation's standard operating procedures and quality management system from the date of publication.

3.1.4 The following stages with implementation dates apply.

Stage	Implementation Date
Quality management system, quality manual drafted, and quality personnel appointed.	October 2020
Job roles, skills, training and competency requirements framework and standard operating procedures (SOPs) developed.	April 2021

[8] This role may be included as part of the role of 'laboratory director' as given in ISO 15189 (4.1.1.4) and would be in addition to their clinical governance role.

Stage	Implementation Date
Validation/verification of methods and processes and staff competency evidenced against final SOPs.	October 2021
Internal audits, improvement implementation, management review in place. Initial assessment visit scheduled.	April 2022
Accreditation to ISO 15189 Medical laboratories – Requirements for quality and competence with compliance to the Codes.	1 October 2023

3.1.5 A self-assessment readiness checklist is provided in Annex A of this document.

4. Modification

4.1.1 This is issue 1 of this document.

5. Terms and Definitions

5.1.1 The terms and definitions set out in the glossary section apply specifically to this document.

5.1.2 The word ‘shall’ has been used in this document where there is a corresponding requirement in ISO 15189 or the Forensic Science Regulator’s Codes of Practice and Conduct and guidance; the word ‘should’ [9] has been used to indicate generally accepted practice where the reason for not complying or any deviation shall be recorded.

6. Management Requirements

6.1 General

6.1.1 The management requirements set out in ISO 15189 Medical laboratories – Requirements for quality and competence shall be met to achieve

[9] General Medical Council Good Medical Practice. In this guide ‘should’ is used when providing an explanation of how to meet the overriding duty, where the duty or principle will not apply in all situations or circumstances, or where there are factors outside the practitioner’s control that affect whether or how the guidance can be followed.

accreditation through assessment by the accreditation body. In the UK, assessment against international accreditation standards is undertaken by the United Kingdom Accreditation Service (UKAS).

6.2 Organisation and Management Responsibility (ISO 15189 4.1)

6.2.1 A senior manager from the service provider with responsibility for the facility shall be identified, to support the quality standards.

6.2.2 Management within the facility shall conform to the requirements of the international quality standard ISO 15189 Medical laboratories –Requirements for quality and competence, substituting 'facility' where the standard states 'laboratory'. The management requirements shall include:

a. the organisation and management responsibility of the facility shall be defined and documented;
b. legal entity shall be determined so that it is clear which organisation can be held legally responsible for the facility's activities (ISO 15189 4.1.1.2).

6.3 Quality Management System (ISO 15189 4.2)

6.3.1 A quality management system (QMS) (however called) shall be established and maintained by a quality manager. The QMS shall comply with section 4 of ISO 15189 including, but not limited to, the following:

a. a quality manual (ISO 15189 4.2.2.2 and 4.1.2.3);
b. procedures, instructions and forms (ISO 15189 4.2; 5.5.3);
c. a document control system (ISO 15189 4.3);
d. service agreements (ISO 15189 4.4) that set out the deliverables to the 'customers' – these may be police forces or health trusts – and other bodies as relevant shall be documented;
e. the assessment of external services and critical supplies, for example, provision of critical consumables and external cleaning services with maintenance of the list of authorised suppliers (ISO 15189 4.6);
f. a documented complaints/customer feedback and resolution process (ISO 15189 4.8);

g. a documented process for identifying and controlling non-conformances (ISO 15189 4.9), such as errors, inadequate cleaning service and contaminated consumables;
h. events of non-conforming work that could potentially cause a miscarriage of justice being referred to the Forensic Science Regulator (ISO 15189 4.9);
i. a documented corrective and preventative action processes (ISO 15189 4.10; 4.11);
j. a continual improvement process (ISO 15189 4.12);
k. evaluation and audits scheduled and completed (ISO 15189 4.14); and
l. a management review (ISO 15189 4.15).

7. Technical Requirements

7.1 Personnel: Training and Competence (ISO 15189 4.4, 5.1; ILAC G19 3.3; FSR-G-212)

7.1.1 The employing body, whether responsible for the facility directly or as a service provider commissioned to work at that facility, shall for the staff in their employ have a documented policy defining the knowledge, skills, experience and competency, and a procedure for the training, competency and ongoing competency for each role within the facility. This shall include:

a. all professionals and personnel working or delivering a service within the facility;
b. training and competency requirements including retraining for any lapse of competence for each role profile;
c. where relevant, expert witness and criminal justice system (CJS) [10,11] related training including written evidence, court skills and avoiding cognitive bias; [12]
d. assessment of training and competency;

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10 CPS Guidance for Experts on Disclosure, Unused Material and Case Management.

11 Criminal Procedure Rules and Criminal Practice Directions.

12 Forensic Science Regulator, Cognitive bias effects relevant to forensic science examinations, FSR-G-217.

e. authorisation and commencement for the activities that their staff undertake;
f. continuing professional development to maintain ongoing competency;
g. regular review and appraisal regarding each individual's performance; and
h. records to evidence competency and authorisation.

7.1.2 If not employed by the legal entity or the facility but providing a service (ISO 15189 4.4, 4.6, 5.1 and ILAC G19 4.1.3), then assessment and approval to work at the facility shall be evidenced and documented by the facility, prior to the start of any contract.

7.1.3 Guidance on roles within the facility and other related roles is provided in Guidance for the Assessment, Collection and Recording of Forensic Science Related Evidence in Sexual Assault Examinations, FSR-G-212.

7.2 Accommodation and Environmental Conditions (ISO 15189 5.2; ILAC G19 3.11; FSR-G-207; FSR-G-208)

General

7.2.1 Accommodation at the facility shall be fit to meet the well-being, medical and forensic examination needs of all its end users in a secure environment for both users and staff.

7.2.2 In order to meet the accommodation and environmental requirements if physical building changes or new build have been identified or are necessary, and where the timescale for these are beyond the implementation date for accreditation, the facility shall undertake the following.

a. Complete a full risk assessment and identify areas for strict ongoing monitoring (8.4, 8.5 and 8.6 below).
b. Implement the risk mitigation and record quality failures (6.3.1j above).
c. Have a documented plan for improvements with timescales that are regularly reviewed.
d. As a minimum disclose in all reports to CJS end users that the facility does not meet the requirements in this standard and detail what mitigation is in place (9.2 below).

7.2.3 The facility shall have in place policies and procedures for the authorised access to the building, rooms, areas, equipment and consumables. These shall include controlled areas and rooms that require access to be recorded (7.2.5 and 7.5.9 below).

Layout of the accommodation

7.2.4 Consideration shall be given to the design and layout of the facility. This shall include measures to prevent cross-transfer and environmental contamination.

7.2.5 There shall be designated patient bathroom and medical examination areas cleaned to DNA standards as set out in FSR-G-212. These shall be secure at all times and entry and exit shall be controlled.

Air quality and air flow

7.2.6 Air movement within and between rooms shall be managed with measures taken to minimise the risk of contamination from environmental background DNA.

7.3 Forensic Medical Examination Room Furnishings, Equipment, Reagents and Consumables (ISO 15189 5.2, 5.3; ILAC G19 3.12; FSR-G-207; FSR-G-208)

7.3.1 The furnishings, equipment, reagents and consumables that are utilised within the facility shall be such that they minimise the risk of DNA contamination.

Environment, furnishings and equipment

7.3.2 The walls, floors, work surfaces, chairs should be of smooth finish, sealed, readily cleanable and resistant to degradation from frequent cleaning. [13] Workstation/work surfaces shall be kept clear, other than for equipment in daily use.

[13] The active agent, corrosive nature and downstream effects from the cleaning materials used need to be understood; surfaces need to be resistant to degradation as a result of frequent contact with the cleaning reagents.

DNA decontamination

7.3.3 The facility shall have a policy in place that sets out DNA anti-contamination good practice (8.4–8.6 below). This shall include:

a. the routine cleaning regimes for rooms, areas, equipment [14] and consumables (8.4 and 8.5 below);
b. the frequency of deep cleaning for the forensic medical examination room;
c. the access control to the DNA clean areas (7.2.5 above and 7.5.9 below);
d. records of the name of the cleaner, and where and when cleaning was carried out;
e. monitoring the effectiveness of the cleaning through environmental monitoring (EM) (8.5 and 8.6 below).

Cleaning reagents

7.3.4 The facility shall use cleaning products and spillage kits that have been demonstrated to be effective in removing and denaturing DNA in conjunction with appropriate cleaning procedures. These chemicals shall always be used in a manner compliant with relevant health and safety requirements.

7.3.5 The facility shall demonstrate that the cleaning product continues to be effective at removing and denaturing DNA through environmental monitoring (8.6 below).

Consumables including personal protective equipment/barrier clothing

7.3.6 The facility shall have a policy and procedures for the procurement, receipt and storage of reagents and consumables (including barrier clothing) that are fit for the purpose of their intended use. [15,16] These shall also include use, handling instructions and disposal.

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14 This includes mobile equipment and consumables carried by medical practitioners on call.
15 ISO 18385:2016.
16 British Standard BS PAS 377.

7.4 Examination Methods and Procedures (ISO 15189 4.4, 5.4.2, 5.5)

7.4.1 The service provider shall have documented procedures for the examination processes undertaken by the personnel at the facility. These shall include:

a. the relevant skills, knowledge and competency requirements (7.1 above) to work with patients;
b. documenting and recording relevant information pertaining to the patient throughout the process (9.1 of this report); and
c. prior to patient's arrival at the facility – initial contact.

7.4.2 The facility shall provide accessible correct information and advice about the facility to other relevant on-site service providers and the services that are provided to potential end users (general).

7.4.3 Staff at the facility shall be able to provide basic information to patients about the:

a. options available to them for examination, treatment and advice;
b. documentation of the presence or absence of injuries;
c. importance of body fluids and the recovery of forensic science related evidence;
d. impact that actions following the incident might have on the collection of evidence;
e. requirement for an early evidence kit (EEK) sample, as appropriate;
f. retention of relevant clothing worn at the time and subsequent to the incident.

Decision to undertake an examination

7.4.4 The decision to undertake a forensic medical examination shall be made by a competent forensic healthcare practitioner (7.1 above).

7.4.5 The forensic healthcare practitioner shall provide advice on the recovery of potential forensic science related evidence.

a. Where there is concern about child sexual abuse a paediatrician should be consulted, as part of the strategy discussion, in order to determine whether the child should be examined and if so, at what time and by which practitioner(s).

b. Where it is necessary for the patient to be taken to an emergency department (or undergo an examination in other premises, for example, residential property) the forensic healthcare practitioner shall either attend and/or instruct other healthcare providers.

7.4.6 Samples shall be collected using recognised forensic sample kit modules (7.3.1 above). Consideration of the usefulness of blood and urine samples taken at hospitals for forensic analysis shall be based on the individual case circumstances.

Attendance of the forensic healthcare practitioner

7.4.7 Local policy shall dictate who has the responsibility for requesting the attendance of the forensic healthcare practitioner and the expected time frames for attendance at the facility.

7.4.8 The facility or provider of the forensic medical workforce shall ensure that a timely response can be provided to reflect the needs of the patient.

7.4.9 The forensic healthcare practitioner attending the forensic medical examination should not provide any service to custodial facilities, for example, police stations and detention centres during that shift. [17] Where more than one patient is referred who may be involved in the same incident, or different patients are thought to be part of a linked series of cases, they should be examined in separate suites and by different healthcare practitioners. Where this is not possible, this should be documented, and an explanation provided; measures taken to minimise the potential for cross-contamination shall be documented.

Arrival of the patient

7.4.10 The process for the end-to-end journey through the facility for a patient (and their supporters) shall be defined. This shall include:

a. who shall meet, accompany and support the patient;

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17 Only in exceptional circumstances (for example, in very remote locations) it could become necessary to use the same forensic practitioner. In these circumstances the reason and rationale behind the decision and the steps that have been undertaken to reduce the risk of contamination shall be recorded, documented and disclosed in any subsequent report or statement provided for the CJS.

b. their role in supporting and advocating for the patient throughout their time at the facility;
c. information on the options available, the purpose of the forensic medical examination to the patient, and how they will be supported throughout;
d. pre-examination activities to be undertaken, and by whom;
e. how the examination will be conducted; and
f. follow-up and referrals post-examination.

7.5 Examination and Evidence Collection (ISO 15189 5.4.4, 5.4.3, 5.5; ILAC G19 4.3.3)

Preliminary matters

7.5.1 The forensic healthcare practitioner shall introduce themselves to the patient (and their supporter[s]). For younger children or those who are not Gillick competent, [18] the supporter(s) should be a parent or someone with parental responsibility; an older competent child may wish to have a responsible or trusted adult with them. The practitioner shall explain what is going to happen during the medical examination; this shall include:

a. explaining the consent requirements (7.5.2 below);
b. if specialised equipment, such as a colposcope is to be used, explaining its purpose, function and how it will be used;
c. explaining that the patient can stop the examination at any time for any reason or indeed no reason, since consent is freely given and withdrawn, but the potential implications of stopping the examination should also be explained; and
d. explaining about early evidence samples if these have previously been taken by police or other personnel.

18 A Gillick competent child (under 16 years of age) is able to consent for their own medical treatment, without the requirement for parental permission or knowledge.

Obtaining consent

The forensic healthcare practitioner shall obtain informed consent [19] from the patient. Ordinarily written consent is required, but where the patient cannot read or write, then verbal consent (ideally witnessed) would be sufficient. The procedure for obtaining consent shall include the following.

e. That it is given in accordance with current guidelines from the Faculty of Forensic and Legal Medicine (FFLM) [20], the General Medical Council (GMC) and the Nursing and Midwifery Council in accordance with the Mental Capacity Act 2005.

f. It should confirm the patient (or representative/person with parental responsibility if the child or young person is not Gillick competent, see section 7.5.4 below) understands:

   i. the purpose of the examination;
   ii. that the consent is freely given;
   iii. that there is no obligation to give consent; and
   iv. that consent can be withdrawn at any time during the examination.

g. It should advise that if consent to any part of the examination is declined at any stage, that refusal and any reason, should it be offered, shall be recorded.

h. It should also advise that the notes, images recorded and any reasons for refusal shall be documented and may subsequently be used for evidential purposes, second opinions from medical experts, peer review and audit.

i. It should provide details of with whom information will be shared or to whom it will be disclosed, for example, for the purposes of the investigation/criminal justice, safeguarding, follow-up/ongoing care.

7.5.2 In situations where there is no capacity to consent, the detail and basis of the decision made in the patient's best interests shall be documented such that

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19 UK Supreme Court (2015) *Montgomery* v. *Lanarkshire Health Board* UKSC11 2015.

20 FFLM (2011).

the basis for the decision can be reviewed by another competent healthcare practitioner.

7.5.3 Where the patient is a child, reference shall be made to the GMC [21], the Royal College of Paediatrics and Child Health (RCPCH) [22] and FFLM [23] guidance's for obtaining valid consent.

7.5.4 Where the patient does not want to proceed with a police complaint, having taken due regard of the provisions in the Human Tissue Act 2004 [24,25], if available the retention for anonymous analysis of samples could be offered.

First account

7.5.5 Where the patient has already reported the assault to the police or another, an initial account of the incident shall be obtained from the appropriate source(s).This account shall be:

a. confirmed by the professional who has undertaken the first account;
b. confirmed or further clarification obtained where appropriate, minimising traumatisation;
c. if not confirmed, the reason shall be clearly documented in the notes;
d. recorded in the case notes (9.1 below);
e. used to determine the forensic medical examination strategy; and
f. added to medical/social history

7.5.6 The forensic healthcare practitioner shall obtain and record the medical/social history in sufficient detail to enable them to undertake a holistic assessment of the needs of the patient. This information shall:

a. be confirmed or further clarification obtained where appropriate;
b. be recorded in the case notes (9.1 below);
c. be used in conjunction with the first account information to determine the forensic medical examination strategy;

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21 General Medical Council (2012).
22 RCPCH Child Protection Companion.
23 RCPCH and FFLM (2015).
24 Available at: www.legislation.gov.uk/ukpga/2004/30/contents
25 FFLM (2016).

d. support any subsequent forensic laboratory examination and findings; and

e. address practical and emotional needs.

7.5.7 Prior to commencing and during an examination, the forensic healthcare practitioners should ensure that the therapeutic, practical and emotional needs of the patient are considered. This shall include immediate:

a. treatment of serious injuries;
b. addressing of any time-dependent medical needs or interventions;
c. crisis intervention and support; and
d. translation and interpretation, if required. [26]

Record of attendees

7.5.8 A record of all persons in attendance at any time during the forensic medical examination shall be made. In addition to retaining this record on the patient's case notes, it shall be retained in the facility and readily accessible for contamination investigations.

Roles and responsibilities of those conducting the examination

7.5.9 Where more than one practitioner is conducting the examination, their respective roles and responsibilities shall be agreed in advance of the examination and these should be documented.

Removal of clothing

7.5.10 The facility shall have a documented procedure for the removal, packaging and labelling of clothing to minimise contamination and the loss of evidence. The integrity of the items once packaged shall be maintained, prior to handing over to the police.

7.6 The Examination Process (ISO 15189 5.5; ILAC G19 4.7)

7.6.1 The examination process shall be defined and documented. The process shall include:

[26] Where interpreters are necessary, family members shall not be used and the gender preference of the patient shall be taken into account.

a. the collection and documentation of relevant information;
b. the examination strategy;
c. the order of the examination activities;
d. photography; and
e. documentation and recording.

7.7 Sample Collection and Handling (ISO 15189 5.2.5, 5.4.3, 5.4.4.3, 5.4.5, 5.4.6, 5.4.7; ILAC G19 4.3.3; FSR-G-207 and the Codes)

7.7.1 The facility shall have a documented procedure for taking appropriate forensic samples on a case-by-case basis. These shall include:

a. DNA anti-contamination good practices;
b. sample recovery good practice;
c. recording, labelling and packaging of samples; and
d. chain of evidence and sample transfer.

Storage of samples

7.7.2 The facility shall have a policy and procedures in place for the taking, storage, retention and destruction of samples. These shall include due consideration of the Human Tissue Act 2004.

Sample documentation

7.7.3 The facility shall have a procedure in place for the documentation and recording of sample collection, labelling, and the transfer and storage of samples and evidence collected (section 9 below).

Images

7.7.4 The facility or service provider shall have a policy and procedures in place for the electronic capture, storage and transfer of images. These shall include:

a. personnel authorised to take images;
b. the conditions required for obtaining the resolution and image quality to demonstrate the features of interest clearly;
c. recording on case notes;
d. the security and integrity of the data;
e. access to images for peer review/second opinions; and

f. disclosure of images for CJS proceedings and dealing with the information security implications.

8. Ensuring the Quality of Examination Procedures (ISO 15189 5.6; the Codes)

8.1 Contamination Minimisation

8.1.1 The facility shall have a policy and procedures in place that minimise the possibility of contamination from the moment a patient arrives at the facility to undertake a forensic medical examination until the completion of that examination. The requirement to minimise contamination shall be balanced against the needs of the patient at every stage.

8.1.2 Although the main focus is to minimise DNA contamination, other forensic science related evidence types such as dried flaking body fluids, hairs, fibres, and particulate debris that can cross-contaminate are just as important and shall be considered within the examination and recovery procedures.

8.2 Use of Personal Protective Equipment/Barrier Clothing (ISO 15189 5.2.5; FSR-G-207; FSR-G-212)

8.2.1 Personal protective equipment (PPE)/barrier clothing shall be worn and changed between each patient to minimise contamination. Further guidance is provided in FSR-G-212.

8.2.2 The policy and procedures for the use of PPE/barrier clothing shall as a minimum include:

a. the PPE/barrier clothing that the forensic healthcare practitioner and attendees at the medical examination shall wear;
b. the order in which to put on PPE/barrier clothing;
c. the frequency of changing PPE/barrier clothing; and
d. the disposal of PPE/barrier clothing.

8.3 DNA Elimination Samples (ISO 15189 5.2.6; FSR-P-302)

8.3.1 A policy and procedures shall be in place to obtain a DNA elimination sample for its inclusion on a searchable elimination database from all staff who work

at the facility prior to entering any part of the forensic area of the facility. These will include (but is not limited to) forensic healthcare practitioners, paediatricians, crisis workers (CWs), cleaning staff and contractors.

8.3.2 All other attendees entering the facility, (including the patient, whether police-referral or self-referral cases, interpreters, friends and family) are not required to give a DNA elimination sample prior to entry but shall have their details recorded in case there is a need to request a sample at a later date for contamination elimination purposes.

8.3.3 Consideration should be given to excluding from the medical examination room any individuals who are not willing to provide their details. These policy and procedures shall take into account the requirements and guidance set out in the Forensic Science Regulator's Protocol FSR-P-302 [27] and shall include the following.

a. The taking of the DNA elimination samples.
b. Agreement/consent for sample donation from:
    i. practitioners and support staff, for example, CWs; and
    ii. visitors (for example, interpreters, relatives, service engineers).
c. Security and access of information at a local/national level.
d. Secure storage and recorded transfer of samples.
e. The investigation of an identified contamination event.
f. Details of those with whom the profile will be shared.

8.4 Decontamination Measures (ISO 15189 5.2.6; FSR-G-208)

8.4.1 A policy and procedures shall be in place for dealing with the event that multiple patients from the same incident attend the facility at the same time.

8.5 Cleaning (ISO 15189 5.2.6; FSR-G-208)

8.5.1 A policy and procedures shall be in place for cleaning rooms, areas and equipment (7.3.3 above). These shall include:

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[27] Forensic Science Regulator, DNA contamination detection – the management and use of staff elimination databases, FSR-P-302.

a. training and authorisation of staff (7.1 above);
b. good practice cleaning methods equivalent to those used in forensic DNA laboratories; [28]
c. frequency of good practice cleaning and deep cleaning;
d. decontamination of re-usable equipment (ISO 15189 5.3.1.3); and
e. records of cleaning including the name of the cleaner and when.

8.6 Environmental Monitoring and Gross Contamination (ISO 15189 5.2.6; FSR-G-208; FSR-G-212)

8.6.1 A policy and procedures shall be in place for monitoring of the level of background DNA and the effectiveness of the cleaning regimes in place (7.3.3 above). These shall include:

a. an environmental monitoring sampling (EMS) programme that reflects the operational risk profile and is proportionate to the risk;
b. the frequency of EMS;
c. training of personnel (7.1 above);
d. personnel and methodology used for collecting the EM samples;
e. the areas and equipment to be sampled for each monitoring event;
f. DNA analysis of the EM samples by a forensic science provider which is accredited to ISO 17025 and required to provide timely processing and reporting of results;
g. advice and feedback from the forensic science provider undertaking the EMS;
h. defined follow-up processes to investigate gross contamination and address unacceptable levels of DNA contamination.

[28] Forensic Science Regulator, The control and avoidance of contamination in laboratory activities involving DNA evidence recovery and analysis, FSR-G-208.

9. Documentation – Recording of Notes and Reports

9.1 Note Taking and Record Keeping (ISO 15189 4.13; ILAC G19 3.5; the Codes)

9.1.1 A policy and procedures shall be in place for documenting, recording and storing information pertaining to each patient. These shall include:

a. the clarity, accuracy, legibility and permanency of notes and records;
b. detailing all activity and decisions that are directly relevant to the patient;
c. recording the notes contemporaneously;
d. recording barrier clothing/personal protective equipment (PPE) worn by the forensic healthcare practitioner(s) and attendees during the medical examination;
e. identification of the forensic healthcare practitioner, and the date and time (if appropriate) of the activity;
f. amendments made to the record(s);
g. the generation of preliminary findings or final reports; [29,30]
h. the secure retention of notes, including permanent records such as colposcope images, [31] complying with data protection requirements; and
i. access to notes and images for second opinion, peer review, investigation and criminal justice proceedings.

9.2 Reports (ISO 15189 5.7.1, 5.8.1; the Codes; FSR-G-200; and FSR-G-225)

9.2.1 The service provider shall have a process for the production of statements and reports in a format that takes due regard to the disclosure obligations, the requirements set out in the Criminal Procedure Rules and Criminal Practice Directions[32] for experts. Legal obligations are set out in FSR-I-400

29 Forensic Science Regulator, Expert Report Guidance, FSR-G-200.
30 Forensic Science Regulator, Non-Expert Technical Statement Guidance, FSR-G-225.
31 FFLM (2017).
32 Available at: www.justice.gov.uk/courts/procedure-rules/criminal/rulesmenu-2015.

[33] and disclosure requirements in the Guidance for Experts on Disclosure, Unused Material and Case Management [34].

9.2.2 Forensic healthcare practitioners shall be appropriately trained (7.1 above) and supported to produce a report that is acceptable for use within in the criminal justice system. The format for expert and non-expert technical reports set out in FSR-G-200 and FSR-G-225 should be adopted.

9.2.3 The facility shall define a process that can be evidenced for the end-to-end peer review stages of the case as it progresses. There should be a critical conclusions check of the report/statement by a second competent individual with a suitable level of knowledge, experience and authority to perform such a review.

10. Review

10.1.1 This published document will form part of the review cycle as determined by the Forensic Science Regulator.

10.1.2 The Forensic Science Regulator welcomes comments. Please send them to the address as set out at: www.gov.uk/government/organisations/forensic-science-regulator, or email: FSREnquiries@homeoffice.gov.uk

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12. Abbreviations

Abbreviation	Meaning
BS EN	British Standard European Norm
CJS	Criminal justice system
CPS	Crown Prosecution Service
CW	Crisis worker
DNA	Deoxyribonucleic acid
EEK	Early evidence kit
EM	Environmental monitoring
EMS	Environmental monitoring sampling
FFLM	Faculty of Forensic and Legal Medicine
FSR	Forensic Science Regulator
GMC	General Medical Council
ILAC	International Laboratory Accreditation Cooperation
ISO	International Organization for Standardization
PAS	Publicly available specification
PPE	Personal protective equipment
QMS	Quality management system

RCPCH	Royal College of Paediatrics and Child Health
SOP	Standard operating procedure
UKSC	United Kingdom Supreme Court

13. Glossary

CHILD(REN): A child is anyone who has not yet reached their 18th birthday. [Back]

COMPETENCY: The ability of an individual to do a job properly. [Back]

COMPLAINANT: A person who makes a complaint or allegation of having been the victim of a criminal offence. See Patient. [Back]

CONSUMABLES: Single-use commodities used in the collection, preservation and processing of material for forensic analysis. [Back]

CRITICAL CONCLUSIONS CHECK: another suitably qualified and competent healthcare practitioner scrutinises the report to ensure that (i) the report is internally consistent, (ii) the conclusions drawn are justifiable from the information set out in the report and (iii) the report is capable of being understood without reference to other material. See Peer Review. [Back]

DNA CLEAN AREA: Area in which appropriate DNA contamination prevention measures shall be maintained at all times. [Back]

DNA CONTAMINATION: The introduction of DNA, or biological material containing DNA, to an exhibit, or subsample derived from an exhibit during or after its recovery from the scene of crime or a person. In the context of the facility this could occur for any or all of the following reasons (not an exhaustive list).

a. Poor practice [35] employed by staff using fixtures and fittings and/or collecting forensic samples.

[35] It should be noted that even good practice does not eliminate the risk of contamination, it only helps to minimise it.

b. DNA contamination from anybody who has had access to the forensic waiting room and/or the medical examination room. Here 'key risk groups' are people from whom elimination DNA profiles have not been taken and included in an elimination database – they therefore may be inadvertently associated with a crime rather than being identified as contamination. These may include visitors, contractors and people accompanying a patient into the forensic waiting room and/or the medical examination room.

c. Insufficient use of cleaning regimes, or ineffective cleaning reagents used, as part of a general forensic clean or a subsequent deep clean.

d. Residual DNA from the manufacture/maintenance of fixtures and fittings that have not been deep cleaned. [Back]

EARLY EVIDENCE KIT (EEK): A dedicated kit used to collect forensic samples that are affected by both time and the activities undertaken by a patient post-assault. [Back]

ELIMINATION DATABASE: Collection of DNA profiles held in a searchable format from staff whose access/role/activities are deemed to be a potential DNA contamination risk. This may include not just the staff working within a specific facility, but also profiles from visitors to the facility, staff of manufacturers supplying consumables for DNA processing, and unsourced contamination profiles. The profiles are used to identify instances of inadvertent contamination. [Back]

ENVIRONMENTAL MONITORING (EM): A sampling and analytical (DNA) process for equipment, furniture and work areas that both monitors and audits the cleaning procedures and decontamination methods applied within the facility. [Back]

EVIDENCE: Facts, information and samples taken to support or contradict an assertion. It also includes the absence or presence of injuries (fresh and healing), scars, and elements of the history pertaining to and provided by the patient. [Back]

EXAMINATION: Activity or process of observing, searching, detecting, recording, prioritising, collecting, analysing, measuring, comparing and/or interpreting. [Back]

EXAMINATION STRATEGY: Plan outlining the roles, task and requirements for the examination phase of a forensic process. [Back]

FACILITY: The physical environment used for any medical examination and sample collection, which in part is a forensic unit. [Back]

FINDING: Information obtained from an investigation or examination. [Back]

FORENSIC: Scientific methods, techniques and processes used to aid an investigation into a crime. [Back]

FORENSIC HEALTHCARE PRACTITIONER: The term is used to describe forensic physicians (both doctors and paediatricians), forensic nurses, forensic midwives and paramedics. [Back]

FORENSIC MEDICAL EXAMINATION: Activity or process of observing, assessing, prioritising, recording, collecting samples for scientific analysis, documenting injuries and interpreting with reference to sexual assault offences. [Back]

FORENSIC PROCESS: The joining up and interaction of various forensic plans or activities.

FORENSIC SCIENCE PROVIDER: An organisation that undertakes any part of the evidence recovery, analytical process and interpretation on behalf of the police or other criminal justice system customers. Police evidence recovery laboratories are also included. [Back]

FORENSIC UNIT: A forensic unit is a legal entity or a defined part of a legal entity that performs any part of the forensic science process. [SOURCE: ILAC-G19:08/2014 Modules in a Forensic Science Process.] [Back]

GROSS CONTAMINATION: Is the transfer of DNA from a single person where a partial or complete DNA profile (these alleles are ‘dependent’) is obtained as a result of a single contamination event and the donor could be identified.

The term is also used in environmental monitoring sampling (EMS) where a profile from multiple persons from an unidentified number of events is obtained and the donors cannot be identified. [Back]

ITEM: Object, substance or material that is collected or sampled as part of the forensic process. [Back]

PATIENT: In the context of this document, a patient is an individual subjected to or suspected of being subjected to sexual assault. [Back]

PEER REVIEW: Evaluation of the work of other competent practitioners in the same field to assess that there is sufficient basis for the conclusions and/or opinions, and the implications for the disclosure of unused material in criminal investigations. See Critical Conclusions Check. [Back]

PERSONAL PROTECTIVE EQUIPMENT (PPE): Items, for example, clothing and gloves that are used to prevent skin and mucous membrane exposure when in contact with blood and body fluid on or from any patient. PPE is also worn to protect the practitioner from contact with harmful chemicals, for example, during decontamination and to minimise the chance that the wearer causes inadvertent DNA contamination. [Back]

QUALITY MANAGEMENT SYSTEM (QMS): A management system to direct and control an organisation with regard to quality. [Back]

REPORT: Communication method of the forensic findings. These include but are not limited to:

a. streamlined forensic reports (SFRs);
b. section 9 statements (Criminal Justice Act 1967);
c. interim reports. [Back]

STANDARD: A standard is an agreed way of doing something that is a level of quality or attainment. [Back]

STATEMENT: A statement is one form of a report. It is formatted to comply with the provisions of s9 Criminal Justice Act 1967. [Back]

14. Annex A: Self-Assessment Readiness Guide

14.1 About this Self-Assessment

14.1.1 This self-assessment contains an overview of the standards that a facility shall achieve in order to meet the Forensic Science Regulator's (FSR's) Codes of Practice and Conduct (the Codes) relating to the forensic medical examination of sexual assault patients.

14.1.2 The purpose of the self-assessment is to provide a guide that can give an indication of the areas where a facility may need to improve, or where it is doing well. It is important to note that this self-assessment template does not provide information about 'how' to demonstrate compliance with the standard, as some of this level of information is contained within the guidance FSR-G-212.

14.1.3 This self-assessment is divided into two categories: Management Requirements and Technical Requirements. The requirements contained in each of these two categories are there to provide a general overview as to how your facility is performing in each area.

14.2 Self–Assessment Completion

14.2.1 Against each requirement there are four possible assessment options. These indicate where a facility currently stands on any particular requirement.

a. Fully Met – Every aspect of the standard has been met or exceeded. A facility can evidence this by both documented and practical examples where applicable.
b. Partially Met – Some or most of the standard has been met and can be evidenced. This option should be selected if a facility undertakes activities to meet the standard but cannot evidence it, or has not effectively communicated with employees about it.
c. Not Met **–** None or very little of the standard has been met. This option should be selected if activities, procedures or systems are still under development or have not been implemented.

d. Not Applicable – The standard covers an area that does not relate to a facility due to the nature of its activities, location or other practical reason.

14.2.2 Against each requirement evidence to support the assessment score is recorded, these could include standard operating procedures (SOPs), completed forms, logs, audit, activity witnessing and demonstrations.

Part A. Management Requirements

1	**Organisation and Management Responsibility**	**Assessment**	**Evidence**
1.1	The organisation and management responsibility of the facility is defined and documented.		
1.2	The facility has an organogram/organisation chart or similar that clearly shows the lines of management/reporting (e.g. responsibility, clinical governance structures and legal responsibilities) that cover all aspects of the facility, including the personnel working therein.		
1.3	The facility is managed by a person or persons with the competence and delegated responsibility for all aspects of the services provided.		
1.4	Policies on business continuity, independence, impartiality, integrity and confidentiality are in place at the facility.		
2	**Quality Management System**	**Assessment**	**Evidence**
2.1	A quality management system (QMS) is in place that directs and controls the activities for all providers of services at the facility with regard to quality.		
2.2	The QMS for the facility includes all of the elements listed below: • quality manual; • procedures, instruction and forms; • document control system; • non-conformance process; • continual improvement process; • risk evaluation and audit; • management review; • customer feedback and complaints process; • provision of goods and services (contracts and service-level agreements [SLAs]).		

2	Quality Management System	Assessment	Evidence
2.3	A quality manager (however named) has been appointed to ensure that the QMS functions correctly.		

Part B. Technical Requirements

3	Training and Ongoing Competence of Personnel	Assessment	Evidence
3.1	All professionals working within the facility have undergone training in both theoretical and practical aspects of forensic science according to the roles within which they are working. These would include sampling, packaging and anti-contamination procedures.		
3.2	All professionals working within the facility have been assessed for competency in the theoretical and practical aspects of forensic science according to their roles. Records are kept showing how competency was achieved and is maintained.		
3.3	Each individual has access to continuing professional development to maintain ongoing competency.		
3.4	Records of individuals' continuing professional development are maintained and retained.		
3.5	All professionals working within the facility have the required background checks/clearances.		
4	**Accommodation and Environmental Conditions**	**Assessment**	**Evidence**
4.1	Accommodation at the facility is age-appropriate and accessible to the communities it serves, including service deliverers.		
4.2	Accommodation at the facility has adequate security for the service, users and staff (e.g. security camera at facility entrance/alarm system linked to local police response). There is an entrance for use by the patient and their companions that is separate and not open to the public.		

4	Accommodation and Environmental Conditions	Assessment	Evidence
4.3	The forensic areas of the facility include a pre-examination waiting room (a separate waiting area for patients who may undergo a forensic medical examination), which is cleaned to DNA standards. There is a policy regarding its use and whether it can be designated and maintained as a DNA clean area.		
4.4	The forensic area of the facility includes a dedicated forensic medical examination room, of sufficient size and appropriate layout, which is the designated DNA clean area.		
4.5	The forensic area of the facility includes a dedicated bathroom/toilet facility, cleaned to DNA standards, accessed from the medical examination room and corridor, where early evidence collection can be conducted and where the patient can shower post-examination.		
4.6	There is a dedicated area for staff and visitors to change into or put on barrier/personal protective clothing that is away from the DNA clean examination areas.		
4.7	The forensic area of the facility is secure at all times with controlled entry into and exit from the designated forensic medical examination room. Records of all personnel (date, time and activity/role) entering the room are maintained.		
4.8	Air movement within and between rooms is managed with measures taken to minimise the risk of contamination from environmental background DNA.		
4.9	Air flow within and between designated forensic areas of the facility is kept to a level that minimises the risk of trace evidence being transferred from the patient to the room environment and vice versa.		
4.10	The layout of the rooms and corridors enables the patient and workflow to progress through the facility in one direction preventing the patient from revisiting any designated DNA clean rooms or areas.		
4.11	The style and finish of fixtures and fittings, such as air-conditioning, ceilings, lighting and working space allow for effective repeat cleaning.		

5	Furnishings and Equipment used for the Examination	Assessment	Evidence
5.1	Workbench surfaces, storage cupboards, seating and examination couches are impervious to water, easy to clean and resistant to disinfectants and cleaning reagents.		
5.2	Batch numbers, expiry dates and the maker of the reagent are displayed on the packaging of reagents/consumables. Batch/lot information is recorded in the case records.		
5.3	Consumables are stored in a secure main store cupboard or room and transferred in small numbers into the medical examination room storage area. Those used for sampling are free from detectable levels of human DNA or forensic DNA grade.		
5.4	In areas where a patient undresses and where they are subsequently forensically examined, floor surfaces are impervious and any joins in the floor are sealed.		
5.5	Computer keyboards, colposcopes and equipment controls are protected by removable flexible covers that can be cleaned or replaced (e.g. colposcope arm and head covers).		
5.6	Where a curtain shields the examination couch, the curtain is disposable.		
5.7	Guidance is provided on the frequency of curtain replacement and a record is kept of the date and reason for changing the curtain.		
5.8	There is a designated hand-wash basin in the forensic examination room. The taps are capable of being operated without being touched by hand.		
5.9	The medical examination couch has height and position adjustments to allow for ease of movement. Disposable covering is changed between each examination.		
5.10	There is a labelled storage area for keeping consumables used for the forensic medical examination and packaging of samples, which is kept suitably clean and protected from contamination.		
5.11	Equipment records and unique identifiers per key item are used. For example, which colposcope was used is noted.		

5	Furnishings and Equipment used for the Examination	Assessment	Evidence
5.12	There is an approved sharps box and clinical and domestic waste receptacles; appropriate disposal provisions are in place.		
5.13	A general forensic clean of the waiting room, forensic medical examination room and bathroom is undertaken prior to and/or after each examination. Additionally, an up-to-date cleaning protocol is held with a cleaning log, recording the cleaner, date, time and areas cleaned.		
5.14	Deep cleaning of the forensic medical examination room is undertaken in accordance with the cleaning procedure and takes place at least every month.		
5.15	The forensic medical examination room is sealed after each clean and the door labelled.		
5.16	The cleaning products and spillage kits used, and the manner of application, have been demonstrated to be effective in removing detectable levels of DNA.		
5.17	The application of the cleaning product is carried out according to the manufacturer's guidelines and in a manner compliant with health and safety requirements.		
5.18	Standards used for the collection of evidence are the same for both patients who self-refer to the facility and those who are referred to the facility by the police.		
5.19	Where appropriate (e.g. colposcope) records are kept of equipment calibrations, cleaning, maintenance and/or service records.		
6	**Examination Methods and Procedures**	**Assessment**	**Evidence**
6.1	All healthcare professionals working at the facility who come into contact with patients of sexual violence have the relevant skills, knowledge and competency to work with patients in the immediate aftermath of an alleged sexual assault.		
6.2	Facility staff have a clear understanding of the different ways that patients of sexual assault may behave following an assault. A non-judgemental approach is adopted in every case.		

6	Examination Methods and Procedures	Assessment	Evidence
6.3	Staff at the facility ensure that patients (and their accompanying person) are always given the correct information and advice regarding a forensic medical examination and the options available to them.		
6.4	Staff at the facility are able to provide basic information to patients and their accompanying person about: • options to attend the facility and the opportunity to undertake a forensic medical examination; • options to report the sexual offence to the police if they so choose; • potential medical concerns of the patient that relate to the alleged sexual assault; • the importance of body fluids and the recovery of such forensic evidence; • the provision of early evidence samples; • the impact different actions may have on the collection of evidence; and • the value of clothing in providing evidence.		
6.5	Staff at the facility are aware that the time spans for conducting a forensic examination will vary on a case-by-case basis. The decision whether or when to carry out a forensic medical examination is made in consultation with a forensic healthcare practitioner. The collection of forensic samples is only one aspect and consideration is always given to other forensic evidence, such as interpretation of injuries and the therapeutic needs of the patient.		
6.6	The facility has a policy in place that identifies who has the responsibility for requesting the attendance of the forensic healthcare practitioner and/or paediatrician, and the expected time frames for attendance at the facility.		
6.7	The provider of the forensic medical workforce ensures that they are able to 'provide a timely response' (within two hours, or as agreed for a particular case, specifically if a child is involved) to reflect the clinical and forensic needs of the patient.		
6.8	Separate rotas are in place to ensure that the forensic healthcare practitioner available for sexual offence forensic medical examinations is not also used for custody medicine during the same time period.		

6	Examination Methods and Procedures	Assessment	Evidence
6.9	Where more than one patient is referred who may be involved within the same incident, or different patients are thought to be part of a linked series of cases, they are examined in separate suites and by different forensic healthcare practitioners.		
6.10	Where it exceptionally becomes necessary to use the same forensic healthcare practitioner for both forensic medical examinations of a patient and custody medicine examination, the reasons are recorded together with the steps undertaken to reduce the risk of contamination.		
6.11	A crisis worker (or equivalent) is available to meet the patient (and their accompanying person), accompany them to the pre-examination waiting area of the facility and provide immediate support.		
6.12	The crisis worker is able to ensure that a urine sample or oral sample is taken using the early evidence kit and that non-intimate skin swabs are taken where appropriate		
6.13	The forensic healthcare practitioner or paediatrician (where appropriate) uses the medical history, together with the first account, to guide the examination, evidence collection and support any subsequent forensic laboratory examination and findings.		
6.14	Where more than one person conducts the examination, all forensic healthcare practitioners agree their roles and responsibilities before the examination commences and document this.		
6.15	A record of all persons in attendance at any time during the forensic medical examination is made. The name and contact details for each visitor, including non-facility professionals in attendance, are recorded, including details of the areas they accessed, together with information about which PPE if any was worn in DNA controlled areas.		

7	Collection, Storage and Transport of Forensic Samples	Assessment	Evidence
7.1	The facility has clear policies for uniquely labelling, sealing and storage of samples to provide a clear documented chain of continuity for all forensic samples and for sexually transmitted infection (STI) samples where they may be relevant to the forensic case.		
7.2	Where the patient has reported the alleged assault to the police, it is the responsibility of a police officer to transfer evidence from the facility to the appropriate laboratory or other designated storage site used by the police. This is recorded appropriately to demonstrate the chain of custody.		
7.3	Where the patient has not reported the alleged assault to the police, it shall be the responsibility of the forensic healthcare practitioner or crisis worker to transfer evidence from the examination room to the storage room(s) within the facility. This is recorded appropriately to demonstrate the chain of custody.		
7.4	Samples collected before or during the forensic medical examinations are stored in secure locations at the facility with access restricted to authorised nominated personnel (for self- and non-police referrals).		
7.5	The facility follows sample storage policies agreed with the police and the forensic science provider to ensure that optimal storage conditions for all samples collected as part of the forensic medical examination are maintained. A policy on storage timescale requirements and a destruction timeline is also in place and agreed.		
7.6	Where samples are held in cold storage at the facility, a system is in place to ensure that samples are kept at a specified temperature at all times, which includes maintaining temperature monitoring logs and use of alarms to notify failure of the equipment.		
7.7	The facility has ensured that policies are in place to address evidence storage in cases where the patient is undecided about reporting to the police.		
7.8	There is adequate space and provision at the facility to store samples taken from patients who self-refer.		

7	Collection, Storage and Transport of Forensic Samples	Assessment	Evidence
7.9	The sample collection, labelling, transfer and storage of evidence collected as part of the forensic medical examination is documented to ensure that there has been no loss or alteration of evidence prior to criminal proceedings.		
7.10	Forensic healthcare practitioners or paediatricians (where appropriate) are appropriately trained and familiar with how to operate the equipment required to capture a permanent record/image.		
7.11	Imaging records taken by forensic healthcare practitioners or paediatricians (where appropriate) are stored securely by the facility.		
7.12	The facility has a defined system for the secure storage of records, which protects the anonymity of the patient.		
7.13	Procedures are in place to enable the disclosure of notes and images where a request is made in court proceedings.		
8	**Ensuring the Quality of the Examination Procedure**	**Assessment**	**Evidence**
8.1	System wide auditing the quality of forensic medical examination procedures to include the following: • adherence to procedures that minimise the possibility of contamination; • record keeping for the use of locks/security seals for rooms in the forensic area; • steps that have been taken to identify contamination; • that staff understand the scientific basis for preventative and decontamination procedures; • that staff are competent in conducting cleaning and the associated record keeping; and • that an audit plan is in place.		

8	Ensuring the Quality of the Examination Procedure	Assessment	Evidence
8.2	To undertake a medical examination, the forensic healthcare practitioners wear barrier clothing/personnel protective equipment (PPE) as defined below: • disposable barrier clothing such as scrubs or aprons and disposable sleeve covers; • face mask; and • non-latex powder-free gloves (available in a range of sizes). In addition, it is preferable to wear the following: • mob caps; • shoe covers. Where it is considered inappropriate to wear a face mask (or other PPE item), this is recorded with the reasons.		
8.3	Forensic healthcare practitioners know the correct order in which to put on barrier clothing/PPE and change it after every forensic examination, cleaning or maintenance task.		
8.4	The facility has processes in place to address: • agreement/consents for DNA elimination sample donation and use of profile information; • security and access of information at a local/national level; • secure and recorded transfer of samples in accordance with guidance provided by the forensic science provider that will undertake the DNA profiling for elimination purposes; and • sharing agreement of DNA profile information (between staff member, facility management, forensic medical provider, police investigator).		
8.5	All staff working within the facility have provided a DNA elimination sample prior to entering any part of the forensic area of the facility.		
8.6	DNA elimination samples are taken taking account of the requirements and guidance in the Forensic Science Regulator's Protocol FSR-P-302.		
8.7	A record is kept of: • which room is used for each examination; • the date and times of the examination; and • the names of all persons who enter the examination room during the examination, including interpreters and any person who supports the patient.		

8	Ensuring the Quality of the Examination Procedure	Assessment	Evidence
8.8	Cleaning of the facility is carried out and recorded on a cleaning log for audit purposes.		
8.9	Cleaning is conducted by appropriately trained staff every time the forensic waiting, examination and bathroom areas of the facility have been used.		
8.10	Cleaning is undertaken using cleaning equipment dedicated solely for use in each DNA clean area and using a cleaning regime validated or verified to provide effective DNA decontamination.		
8.11	Deep cleaning is regularly scheduled and conducted at least every month.		
8.12	The environmental monitoring sampling (EMS) scheduling plan is in place (appropriate frequency established through trend analysis) and sampling is conducted midway between each deep clean.		
8.13	When contamination is identified, the room or equipment is immediately deep cleaned and EMS swabs are taken. The quarantine or use of the room or equipment is determined by risk, and the criteria to be reinstated are clearly defined.		
9	**Records, Notes and Statements**	**Assessment**	**Evidence**
9.1	Each contact with the patient by any professional is clearly, accurately and legibly recorded in the set of case notes pertaining to that patient.		
9.2	Notes are recorded contemporaneously or, where this is not possible, notes are made as soon as possible after the activity has taken place. Batch numbers of consumables/reagents/equipment/barrier clothing/PPE, and who used/wore them, are recorded in the case notes.		
9.3	All notes (including permanent records such as colposcope images) are retained by the facility in a secure location that complies with data protection requirements.		
9.4	The notes are available and accessible if they are required for the purpose of the investigation, peer review, second opinion and any court proceedings.		

9	Records, Notes and Statements	Assessment	Evidence
9.5	Where notes are required to be removed from the facility, the reason for removal is documented. A record is kept by the facility of the professional removing and returning the notes within an agreed timescale.		
9.6	The facility has defined a process for the production of statements and reports in an agreed format and to an agreed standard. There is a policy regarding quality assurance of statements/reports.		
9.7	Where preliminary findings are provided, these are recorded in writing with appropriate caveats.		
9.8	The facility has defined a process for a critical conclusion check of the report/statement by a second competent individual.		
9.9	Forensic healthcare practitioners are appropriately trained to produce a statement that is acceptable for use within in the criminal justice process.		
9.10	All forensic healthcare practitioners are provided with ongoing support from an appropriately experienced forensic physician to assist them with statement writing.		

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Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

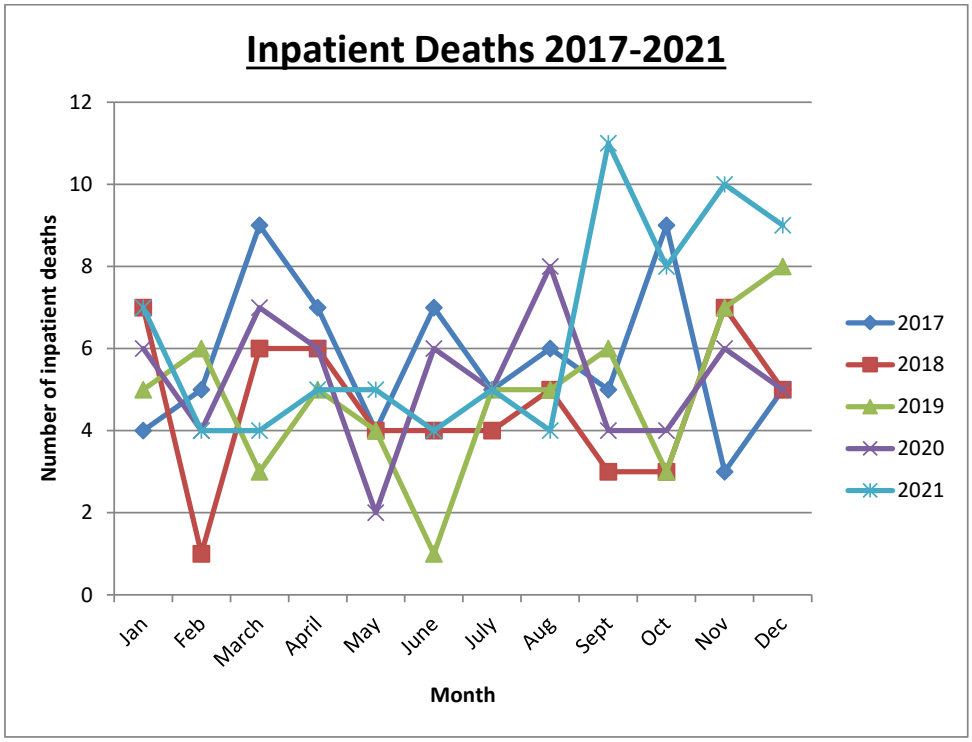
Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

The percentage of cases being reviewed within the 4-month target has stayed consistent since the last report. This shows how hard the group has been working as the number of cases has increased as is shown by the graph below. The number of deaths in September, October and November has remained unusually high. Therefore, a preliminary review has been taken to check that are no worrying issues that need to be addressed urgently.
There are unusually high numbers of out of hospital cardiac arrests (OOH's) where the prognosis is extremely poor and such cases are usually very uncommon. In September, there were three OOH's, 2 fireplace related deaths and 3 COVID deaths with associated co morbidities and prematurity.
During October, there were 4 SUDI's (Sudden unexpected death of an infant) and the outcomes were inevitable before admission to AHCH and 4 in-patient deaths which were made up of 3 complex cardiac cases and 1 very premature baby.
The November deaths consisted of 8 in-patient deaths all with underlying medical conditions and 2 ED cases of whom one was a trauma and another SUDI.

	2017	2018	2019	2020	2021
Jan	4	7	5	6	7
Feb	5	1	6	4	4
March	9	6	3	7	4
April	7	6	5	6	5
May	4	4	4	2	5

June	7	4	1	6	4
July	5	4	5	5	5
Aug	6	5	5	8	4
Sept	5	3	6	4	11
Oct	9	3	3	4	8
Nov	3	7	7	6	10
Dec	5	5	8	5	9
	69	55	58	63	76



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

1) One of the most significant changes will be the introduction of the Medical Examiner (ME) process. This will be a legal requirement by April 2022 providing scrutiny for all deaths. There are several reasons for the ME legislation – 'enabling families to have a voice', improving accuracy of death certificates and ensuring every death is reviewed. Since we are a Paediatric Trust and, our mortality numbers are significantly less than our adult peers we are already able to scrutinize all deaths. The death certificates are completed by senior clinicians and in a very timely manner. In addition, if there are any concerns regarding a child death,

the case follows the coronial process. Lastly, we are very fortunate in having the bereavement team who support and engage with families, so we have contact and are currently working on formalizing the feedback we receive. The main challenge for AHCH introducing the ME process is ensuring that it doesn't slow down the current process and impact negatively on the families. Currently, options are being considered as to how to achieve this.

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

3) The feedback tool for families has been created so formalising the feedback that is obtained for the review process. This form is going through the final stages of approval with it being reviewed by the bereaved families group. It is vital that this is done as correctly as possible so avoiding the possibility of causing any distress at an unbelievably difficult time for the families

4) Concerns have been raised about alerts on the Meditech such as difficult airway which has proven to be very difficult to achieve on the current system. Several teams across the Trust have highlighted this as an issue and it has been raised to the highest level for resolution of the problem.

5) Another recurrent issue is the escalation of unwell cardiac patients as their deterioration is not as easy to assess using the PEWS tool and potentially a very unstable group. It is therefore vital that any change is identified earlier and there is work being undertaken re escalation especially out of hours so that a senior with the required cardiac expertise is contacted immediately .

Current Performance of HMRG

Number of deaths (Jan. 2021 – Dec. 2021)	76
Number of deaths reviewed	44
Departmental/Service Group mortality reviews within 2 months (standard)	62/67 (93%)
HMRG Primary Reviews within 4 months (standard)	27/38 (71%)
HMRG Primary Reviews within 6 months	26/29 (90%)

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

The meetings have been extended to try and catch up the backlog and we have started to hold extra meeting to resolve the situation. The HMRG members have been very supportive and committed during some very long meetings covering some very difficult and emotive cases.

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
							Internal	External		
Jan	7	6	6	5	5	1			1	1
Feb	4	4	4	2	3	2		2		3
March	4	4	3	2	4	1			1	
April	5	5	4	4	5	2			1	2
May	5	5	5	5	5	1			2	
June	4	4	4	1	4	3			1	1
July	5	5	4	5		2				3
August	4	3	4	3		1				2

Sept	11	9	11			2			1	1
Oct	8		8						1	
Nov	10		9							
Dec	9									

Potentially Avoidable Deaths

There have been no avoidable deaths in this reporting period but there are several cases which have not been completed because further information is required before reaching a decision on the management and care provided. There have been three traumatic deaths and a two of these have been STEIS reported. The RCA's are being held over the next few weeks and then the cases will be discussed again at HMRG.

Learning disabilities

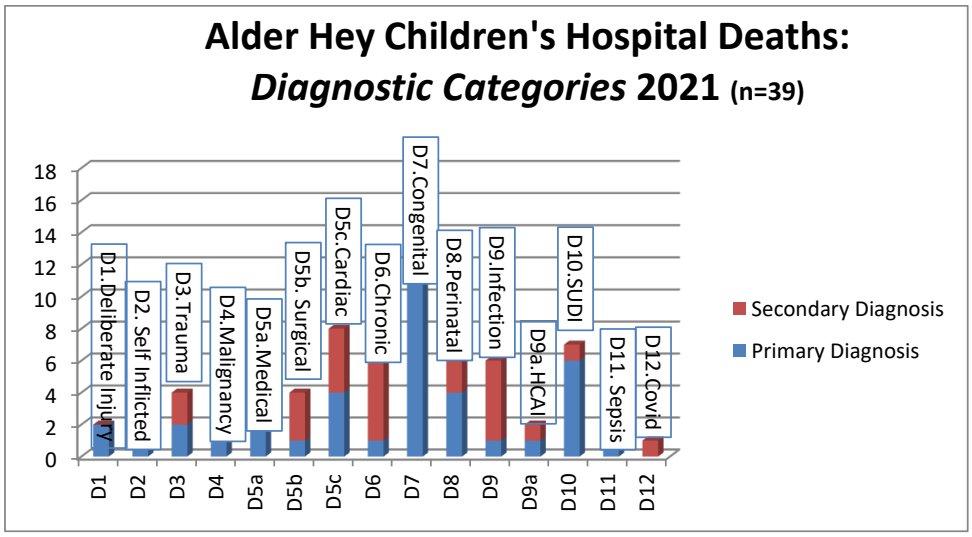
The output table of the mortality process above records any children/YP that were identified as having learning disabilities. Out of the 44 cases reviewed, 13 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.
In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend /issues in patients with learning disabilities which can occur at any age not just over 4.

Family

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

The Snowdrop team have highlighted the issues relating to inconsistencies of a PM being undertaken depending on area. Changes in whether a PM or not is being completed has caused a great deal of distress for the families that have been caught up in it and this is something that will be fed back.

Primary Diagnostic Categories



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

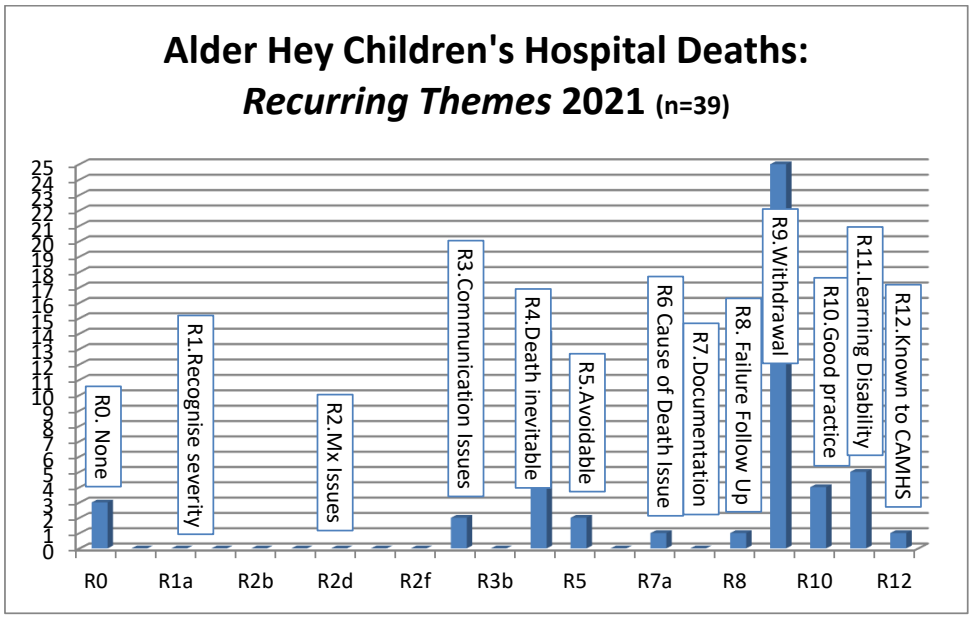
D1	Deliberately inflicted injury, abuse or neglect
D2	Suicide or deliberately self-inflicted harm
D3	Trauma & other external factors (excludes deliberate self-harm (D2)
D4	Malignancy
D5	Acute Medical or Surgical condition subcategory D5a. Medical D5b. Surgical D5c. Cardiac
D6	Chronic Medical Condition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

The number of cases reviewed so far in 2021 show that the highest diagnostic code is children with underlying congenital conditions (28%). These are often the most complex cases with several issues that need to be identified, monitored and treated. These would include the congenital cardiac cases which can be incredibly challenging and involve high risk procedures due to the nature of the underlying anatomy.

The next most common category (15%) is the sudden expected deaths of infants /children (SUDI's /SUDIC's), most of these cases have not been closed yet as they have delayed whilst waiting for the inquests to be held. They will then be re discussed and the coding confirmed.

There is one sepsis and one hospital acquired infection (HAI) over this period clearly these needed close review. The hospital acquired infection was a very unwell patient on ECMO and every possible preventative measure was taken. There was a detailed review and there were no avoidable factors identified just several high-risk factors which predisposed to infection. The sepsis was a case when there were no concerns re care but a very unwell baby that unfortunately despite everything possible being done died. It is vital that HAI's and sepsis continue to be closely monitored to check that no concerning trends develop but there is currently no cause for concern.

Recurrent Themes



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

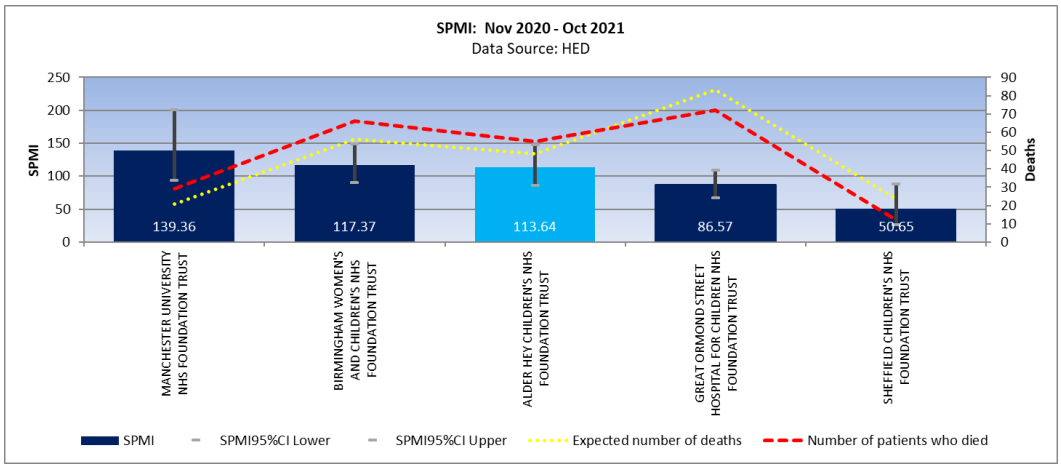
The recurrent codes that are the commonest are withdrawal of care (64 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child /young person suffers unnecessarily when all treatment options are explored but are not suitable. Death was concluded to be inevitable in 36%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

Section 2: Quarter 3 Mortality Report: October 2021 – December 2021

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

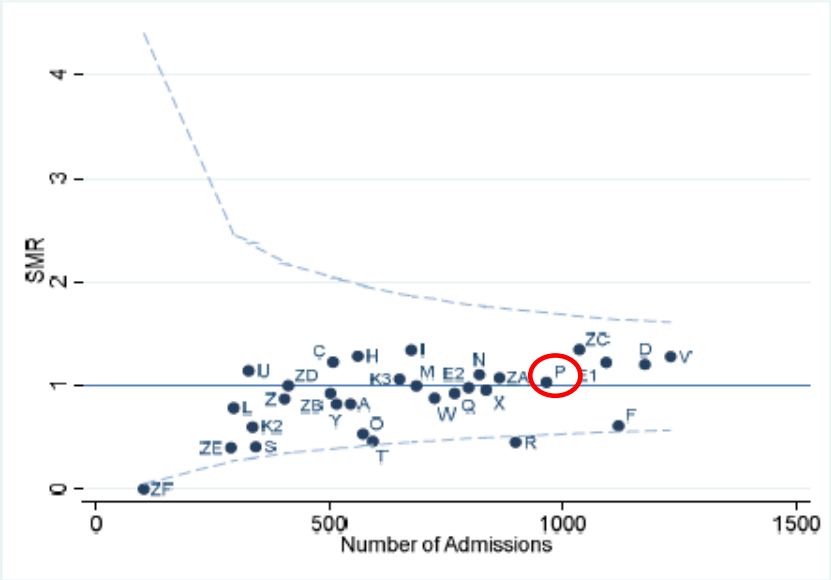
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates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



The chart shows that Alder Hey has performance of 55 deaths against 48.4 expected deaths. Although this shows a figure that is slightly higher this is probably as a result of COVID, when the workload that AHCH undertook had to be prioritised. This resulted in the higher risk, more urgent admissions and less of the 'cold case /lower risk workload'. This would impact on some of the figures but in recent months there have been higher figures than the 'norm' These have explained as number of cases where death was inevitable and some extremely complex cardiac cases where the operations were very high risk but the outcome was not clear till much later. The trauma deaths were very unusual have 3 in such a short time period and that is why concerns re fireplace fixing were highlighted as there were also a number of other children injured so the problem needed to be addressed to prevent any others and it was. Birmingham is the best Trust to compare AHCH with similar caseload and demographics.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2019 Annual Report of the Paediatric Intensive Care Audit Network January 2016-December 2018), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
The chart below is taken from PICANet's most recent report and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.



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

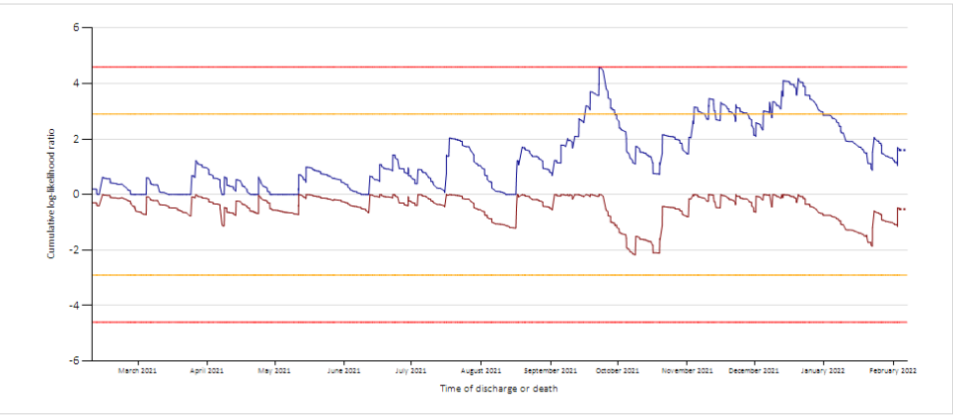
Statistical analysis of mortality:

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

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

The following chart shows 12 months data from March 2021 to February 2022.

RSPRT Control Chart- Liverpool Alder Hey



The RSPRT (Risk-adjusted resetting probability ratio test) plot presents the mortality of your unit cumulatively, accounting for what is expected based on PIM3 scores. All discharges and deaths within the date period specified by the user will be included in the above plot.
The top half of the graph (blue line) tracks whether mortality is higher than expected and the bottom half of the graph (brown line) looks at whether mortality is lower than expected.
Two sets of control limits are shown on the graph as orange and red lines. In between the orange lines is the 'safe zone' representing the variability that you might normally expect. The area between the upper orange and upper red lines is defined as a 'warning zone' indicating that mortality is currently higher than might be expected based on risk and natural variation.
Until there is a death the blue plotted line in the top half of the graph remains flat and the brown plotted line gradually drops in the bottom half. When a death occurs the blue line moves up and the brown line moves closer to zero. The blue line resets to zero if the upper red line is crossed, this indicates a potential cause for concern.
A series that turns into a dashed line indicates that there are no other discharges within the selected period to plot on the chart.
For a more technical explanation please see https://www.picanet.org.uk/wp-content/uploads/sites/25/2018/06/RSPRT_explanation.pdf

Monday, February 07, 2022 7:41 AM

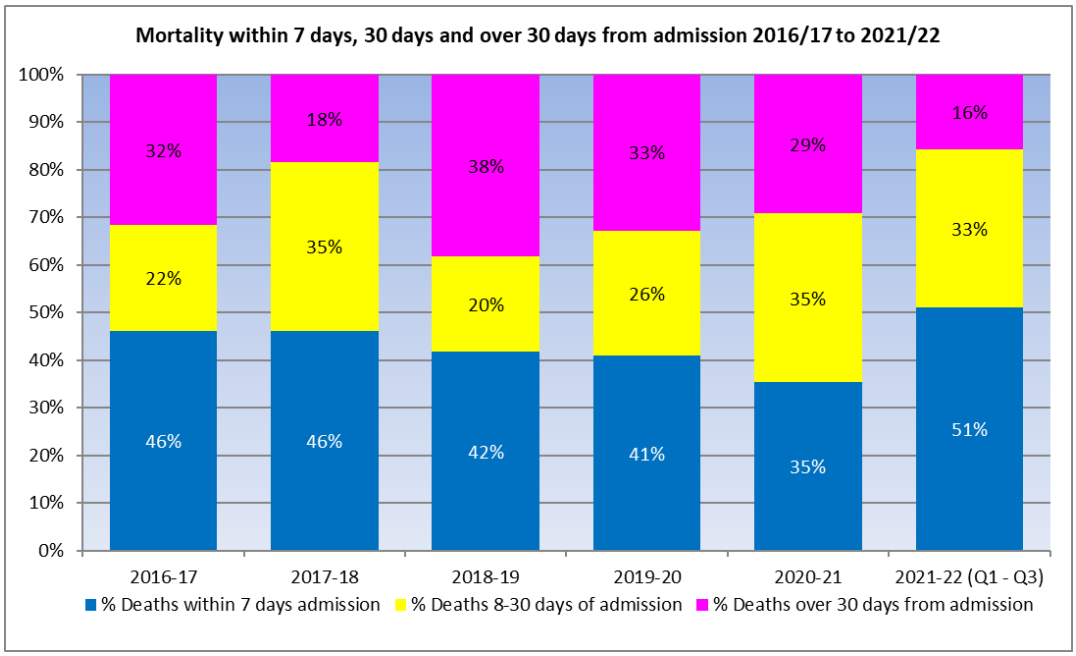
In September 2021 we had a run of 11 deaths in PICU that contributed to a spike on the RSPRT. Due to the rapid review of deaths in our mortality meeting this was quickly identified. An earlier RSPRT graph had shown a reset at this point, but following further calibration with subsequent patient outcomes, this did not occur and instead showed steady decrease in October. We acknowledged that September had been a particularly difficult month with several deaths that were, in retrospect, inevitable from admission including three out of hospital cardiac arrests, severe end stage chronic lung disease and respiratory failure with an underlying mitochondrial disorder. Chronic, critically unwell cases often score low on PIM3 at admission, but the outcome remains guarded, as was the case for at least two of these patients. All cases had been

reviewed in a timely manner in our mortality meetings and in each case, we recorded an outcome in section D of "adequate or above standard of care provided" and section E "adequate / standard practice". There were no identified themes or concerns. A further increase in December / January crossing into the warning zone will be discussed in February, following conclusion of our service group reviews. The RSPRT has subsequently returned to the 'safe zone' without reset.

Real time monitoring of mortality

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. However, in the current financial year (April 2021 – December 2021) 51% occurred within 7 days of admission, 33% occurred within 8-30 days from admission, and 16% deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, although the 4-month target has fallen for the reasons stated above. There are extra meetings being held to prevent the figure falling further especially as several cases will need further and comprehensive discussion as they are difficult cases. It is imperative that they receive the time they require to ensure that all possible learning is obtained to ensure that the care we provide is the best possible.

There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them. Some of the issues are difficult to address but the organisation is working on solutions.

One of the biggest challenges that the mortality review process is facing is the integration of the ME process without impacting on the bereaved families or causing issues for the clinical and bereavement workers involved

References

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

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

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

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are

displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

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

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

Alder Hey Digital and Information Technology Update

1. Introduction

The purpose of this report is to provide the Board of Directors with an update on national digital developments, Alder Hey Digital and Information Technology progress and key areas of digital transformation.

2. Executive Summary

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

- Engagement with regards to the refresh of the Digital Strategy including input from the Forum, Medical Board and Divisional leadership teams
- HIMSS Level 7 accreditation in November 2021
- Successful implementation of an Electronic Anaesthetic Record in the Division of Surgery
- Successful implementation of an Electronic Opthalmology Record
- Go live of digital symptom tracker with the Emergency Department
- Award of national investments to support a range of digital initiatives within community, across the hospital setting and for virtual ward/remote monitoring
- Engagement with national teams on new national digital structures
- Development of a draft refreshed service model for the iDigital service

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

3. National Digital Changes

Nationally, there have been some significant developments with structures and ways of working. This includes the retirement 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’.

Key priorities for the new ‘transformation unit’ include:

- Expanding the functions and uptake of the NHS App;
- Increase diagnostics capacity
- Data architecture and infrastructure for population health, planning and research
- Population health and personalised prevention
- Exploiting the NHS’s purchasing power
- NHS as a platform for rapid cycle research and innovation
- Redesign pathways using digital tools

Nationally a weekly CIO touchbase is in place which includes updates and input to emerging national changes.

Regionally, work is underway to refresh the regional digital strategy and associated programmes of work.

4. Digital Futures

Internally, progress with Digital Futures implementation remains good with work progressing at pace.

Key delivery programmes continue to progress and benefits realised and tracked. The Digital Oversight Collaborative has good oversight of progress with a wide range of services and clinical representation in place.

In terms of current progress to date, other headlines include:

- In November, the Trust was successfully accredited as a Stage 7 EMRAM Trust. The assessment took place over two days, with colleagues from several different areas involved in demonstrating the digital capabilities of the hospital
- Support the Trust maintaining the national KPI for the % of outpatient's appointments delivered digitally
- Finalisation of a business case to develop a new website and staff intranet that will support the foundation for access to new digital solutions for patients and families
- Successful pilot of Islacare
- Ophthalmology electronic record implementation
- Go-live of a new Bedside Verification Power BI Dashboard to support front line teams

Looking forward, engagement for the refreshed digital strategy is in train with input from a wide range of stakeholders across the Trust and regionally. This refresh will drive a set of a transformation programmes from April 2022 onwards.

5. AlderC@re

One of the key priority programmes for 2022 is the Alderc@re programme. Alderc@re is the programme which will see a major upgrade to the Trust's core electronic patient record system – Meditech. This upgrade will impact all staff who utilise Meditech and is a major change programme for Alder Hey.

The programme will see the deployment of Meditech's newest product, Meditech Expanse. The Alder Hey deployment is a first of type deployment in the UK. Other Trusts locally and nationally are planning to go live with Expanse over the next few years.

Internally, significant developments have taken place over the past 6-12 months with regards to the AlderC@re programme. The programme has been delayed for a period of time due to a number of factors. Following extensive work on the challenging areas, a decision has been taken recently by the Trust Executive to agree a go live date during September/October 2022.

The governance and leadership of the programme has recently been reviewed and refreshed. The programme go live is subject to resolution of a number of key risks, primarily in relation to electronic prescribing, resolution of agreed go live 'red line' criteria and clinical / operational sign off.

Alder Hey's plans to date have been predicated on a go live with the version of Meditech Expanse v2.1. An opportunity was presented to Alder Hey to proceed with a go live of Expanse v2.2 which would bring additional functionality. Consideration was given to this

opportunity, however the AlderC@re Programme Board recommendation was to proceed with v2.1. This recommendation was based on a deployment confidence level that adding additional, untried, functionality at this stage would add risk to the deployment in 2022. Consideration will be given to deploying v2.2 in 2023.

A gateway process has been developed to support the Trust and Divisional sign off of AlderC@re which will support additional resources from Divisions to ensure the system meets the needs of the users. This has been signed off at Alderc@re and Improvement Board. An operational governance framework has been developed and signed off.

In terms of leadership, a Programme Director has been recruited, the programme management and project management support has been refreshed, and there is a major focus on the clinical safety sign off processes. Clinical safety is a key item for the AlderC@re Board linking to the wider Trust clinical safety processes, this includes a series of critical criteria that require assurance before going live. The Programme Director will oversee the management of Meditech as a supplier and will engage more widely with other NHS Meditech customers to share knowledge as they embark on parallel journeys to deploy Expanse.

With regards to the Electronic Prescribing and Medicines Administration (EPMA) issues, there are a suite of issues with development timescales for delivery this year. These issues are classed as ‘show stoppers’ and Alder Hey would not proceed with a recommendation to go live at the ‘Go / No Go’ project milestone if these issues are not resolved or fit for purpose. These issues are monitored fortnightly at the programme board.

A review of functionality and options for supporting theatres processes is also underway that will run in parallel to the AlderC@re Programme with co-dependencies between the two programmes of work.

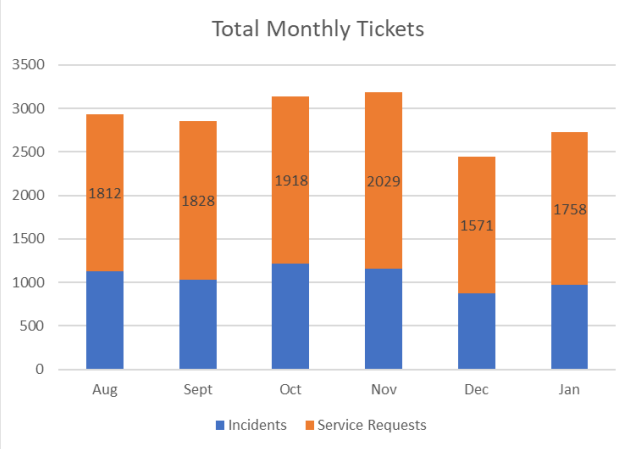
For non-EPMA build issues that are critical for Go Live, Meditech has delivered several solutions which are being tested by Alder Hey to confirm that they can deliver the requirements for the organisation. These items form part of the critical path of the programme and are regularly reviewed as a priority.

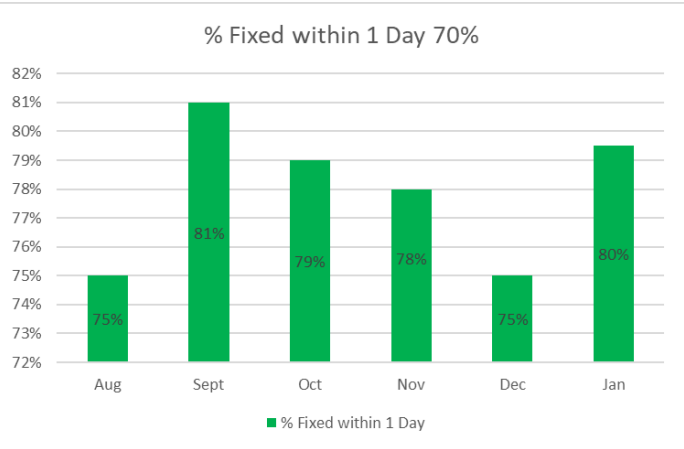
6. Operational IT Performance

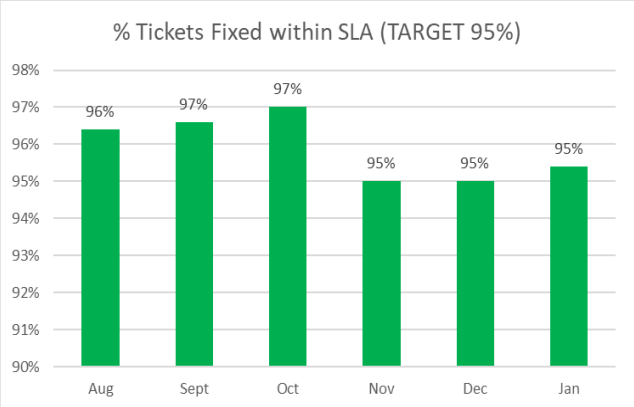
Key operational targets continue to be delivered or improved upon. 95% of incidents or requests are resolved within target, reducing average response and fix times and improving customer satisfaction. This is achieved despite a backdrop of supporting 50% more devices and a similar increase in activity compared to the same time last year.

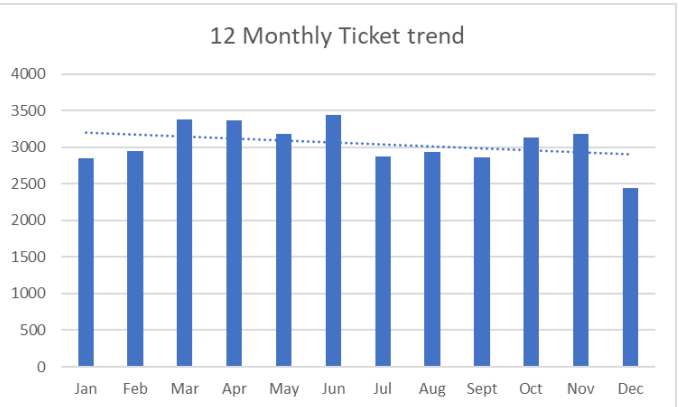
This report provides performance to the end of January 2022. Key highlights include:

- Continue with a downward trend for overall Ticket resolutions per month.
- Tickets resolved remain above 95% SLA Targets
- Resolutions within 1 Day remain high and above SLA
- 70% of Service Desk contacts were via Live Chat or the Self Service Portal
- 12 Month ticket trend shows a steady decline in overall numbers









7. Digital Partnership

Progress to date with iDigital as a new integrated service has been excellent in a very short space of time. Some leadership changes have afforded the opportunity to review the effectiveness of the current service model and whether it is fit for the future priorities of both Alder Hey and Liverpool Heart and Chest.

An outline for a refreshed model for iDigital has been co-designed with colleagues including input from digital, clinical, divisional and operational stakeholders across both Trusts. The model has also been peer-reviewed by a range of digital professionals regionally and nationally for feedback.

It is proposed that the new model be based on a more streamlined professional digital portfolio model underpinned by a single operating model. The portfolio model responds to the current priorities of both Trusts and would be the next stage of the evolution of iDigital.

The digital agenda ahead over the next 12 months is huge and it is important that as a service, iDigital remains on the front foot of developments with an ability to work at pace. It is also paramount that iDigital can continue to attract a high calibre of professionals to provide exceptional services to AH and LHCH.

8. Summary and Recommendations

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

2022 is a year with a range of significant developments for Alder Hey, notably with the upgrade of Meditech planned for September/October subject to sign off of key risks, operational and clinical readiness etc.

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

The Board of Directors is asked to note operational updates and progress with technology and digital maturity programmes including revised go live dates for the Alderc@re programme.

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report January 2022

How Did We Do?

Executive Summary **Month: January** **Year: 2022**

Alder Hey Children's NHS NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Performance in meeting the sepsis target in ED and the wider Trust continues to be less than the 90% target, reflecting continued activity pressures.
- 1 clinical incident resulting in permanent harm relating to the grade 4 pressure ulcer.

Highlight

- 0 hospital acquired infections in month
- 0 never events

Challenges

- 1 grade 4 pressure ulcer reported in month. StEIS reported with 72- hour review completed to include lessons learned. Duty of candour applied in line with regulation 20. Level 2 RCA commenced
- 3 medication errors resulting in harm. A patient was prescribed Gentamicin every 24 hours instead of every 36 hours requiring blood and audiology testing. A patient on Methylphenidate developed high blood pressure but there was a delay in diagnosing and treatment. A patient received a second dose of Ondansetron due to poor handover and had an ECG performed to ensure no impact. All incidents were fully investigated, with no lasting harm. All lessons learned will be shared across the Divisions.

The Best People Doing their Best Work

Caring

- Overall Family and Friends score for service users recommending the Trust is above 90% despite the activity pressures.
- Complaints and PALS are at a seasonal average.

Highlight

- Improved Family and Friends score in AED in January, up to 74% which is the highest score since August
- Continued excellent Family and Friends scores across in-patients, out- patients, Community, and mental health.

Challenges

- Continued high activity levels and pandemic impact, reflect the AED Family and Friends score recommending the Trust.

Delivery of Outstanding Care

Effective

Access to Urgent Care for CYP improved in January 2022, likely linked to an overall reduction in attendances as the public responded to the Omicron risk. 28-day breaches reduced following increased scrutiny by the Operational teams, however work required still in this area.
There was deterioration in the WNB rate however again this may relate to public response to the risks associated with Omicron.

Highlight

- Improvement in month against the 4-hour ED standard

Challenges

- Theatre utilisation – review underway across Surgery and Medicine to understand the drivers for performance and enact improvement plans.

Delivery of Outstanding Care

Responsive

Challenges remain in relation to the recovery of RTT performance and the reduction of 52 week waits; staff availability and a planned reduction of theatre capacity in January in response to the predicted impact of Omicron hindered progress in month, plans have ramped up from February.
The number of Super Stranded (+21 days) increased in month; clinical teams continue to manage the complex discharge planning which is associated with the majority of these patients.

Highlight

- Achieved 100% against the Cancer Faster Diagnosis standard in month.

Challenges

- 52-week breaches
- RTT recovery
- Super -stranded inpatients (21 days> LOS)

The Best People Doing their Best Work

Well Led

Finance
The month 10 year to date position is showing a surplus of £1.7m. This is a large improvement against month 9 due to additional income (£1.3m) for ERF following a successful challenge to reinstate 19/20 activity baselines. Divisional positions also improved in month when compared to previous trajectories largely through non recurrent funding received and lower than trend spend in theatres and critical care.

Cash in the bank at the end of January was £87.8m.
The overall capital expenditure year to date to January was £18.4m.

Mandatory Training
As of the 31st of January, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance. Our three key areas of concern remain Resuscitation Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen

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.

significant compliance drops due largely to the impact of COVID on face to face training restrictions. **PDR** As of the 31st of January 2022, our Trust appraisal rate was 72.47%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation. **Sickness** Attendance management is a fundamental aspect of staff availability and as highlighted in previous reports, therefore remains under close scrutiny by the HR BP team. As part of this the following is undertaken: • Trust sickness level updates (headcount and WTE) provided to Daily Operational / Tactical Command meetings. • Weekly monitoring of overall absence sickness absence, drilling down into short and long term absence and return to work activity across all divisions. Regular 1:1's with line managers to discuss workforce issues, including the design individual plans with the aim of supporting people whilst off ill and to facilitate a return to work, if possible. • Escalation of areas of concern / emerging themes to key divisional meetings, as applicable. • Blended learning is currently in development and will launch shortly. **Turnover** A deep dive exercise as been undertaken to further understand the increase in turnover levels across the Trust and an action plan may be needed at a divisional and Trust wide level as an outcome. This information will inform future workforce and succession planning, linked to recruitment strategy.	

Game Changing Research and Innovation

Research and Development

Month 10 Research Activity:

- 194 research studies currently open
- 1,009 patients recruited to research studies (10,974 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 – 99%

Highlight

Asthma treatment research underway
The NIHR funded ASYMPTOMATIC study is focussed on learning how best to treat children with asthma and involves working with approximately 250 GP practices.

Partnership established to improve medicines
UK-based pharmaceutical company Proveca Ltd are collaborating with Alder Hey to identify key gaps in medicine provision and develop new products for children and young people.

Challenges

National delay in feedback on NIHR Clinical Research Facility grant applications

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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	3	0	
Jan 2022	Jan 2022	Jan 2022	Jan 2022	Jan 2022	Jan 2022

Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
78 %
Jan 2022

CARING

Friends & Family: Overall Percentage Recommended Trust
90.46 %
Jan 2022

EFFECTIVE

ED: 95% Treated within 4 Hours
80.19 %
Jan 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 %	87.9 %
Jan 2022	Jan 2022	Jan 2022	Jan 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 %	62.01 %	237	19098
Jan 2022	Jan 2022	Jan 2022	Jan 2022

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
87781	2122.25	85.75 %	81.28 %	8.11 %
Jan 2022	Jan 2022	Jan 2022	Jan 2022	Jan 2022

Delivery of Outstanding Care

SAFE

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		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	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.8%	99.8%	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	53	63	98	79	81	89	74	63	91	89	66	78	73		No Threshold	
Clinical Incidents resulting in No Harm	D	284	333	401	395	363	322	330	297	313	276	272	250	232		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	D	81	76	95	91	80	72	95	88	74	86	135	75	104		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	D	1	1	1	1	4	1	1	1	0	1	1	0	1		No Threshold	
Clinical Incidents resulting in severe, permanent harm	D	1	0	0	0	1	0	0	0	0	1	1	0	1		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	6	3	4	4	2	2	2	6	4	2	4	5	3		<=4 N/A >4	✔
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	1		0 N/A >0	✔
Never Events	W	0	0	1	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	89.5%	80.6%	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	87.5%	84.0%	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%	75.9%			>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	1	0	0	0	1	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	3	1	0	0	1	0	2	0	0	1	3	1	0		No Threshold	

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		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	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	95.3%	94.9%	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	93.2%	93.1%	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	92.7%	96.7%	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	94.2%	90.4%	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	96.3%	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 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	96.1%	96.0%	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%		>=95 % >=90 % <90 %	✔
Complaints	W	15	11	23	5	9	15	10	12	13	13	14	9	16		No Threshold	
PALS	W	67	88	110	101	119	150	122	88	148	136	141	106	100		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		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	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%		No Threshold	
ED: 95% Treated within 4 Hours	D	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%		>=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	5	7	12	13	7	13	13	12	32	23	56	23	22		<=20 N/A >20	✔
28 Day Breaches	W	3	1	2	4	3	0	3	8	5	11	12	25	7		0 N/A >0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		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	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	99.3%	93.6%	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	100.0%	98.1%	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	98.5%	98.1%	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	100.0%	94.9%	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	80.3%	85.9%	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	94.9%	92.9%	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	61.1%	63.2%	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	10,648	11,453	11,892	11,110	11,564	11,414	12,096	13,286	13,092	18,495	18,976	19,127	19,098		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	W	222	307	361	283	235	204	187	195	263	318	250	218	237		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	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%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	93.7%	95.8%	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%		>=99 % N/A <99 %	✔
PFI: PPM%		99.0%	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

		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	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	W	243	591	3,825	-954	593	392	-588	-50	836	-853	382	166	2,122		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-1,979	-3,207	-5,794	-910	974	13	162	234	-339	-221	-159	406	964		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	110,776	110,871	92,708	92,708	88,440	82,001	82,006	82,121	88,514	94,111	91,971	90,450	87,781		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	228	2,310	18,172	-494	716	1,598	2,981	-1,713	2,767	-2,609	149	1,475	1,048		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-373	-387	-13,171	-308	-370	-545	553	71	-2,466	2,477	676	-16	6		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	387	-1,333	-1,176	-153	247	-661	-4,122	1,591	534	-720	-443	-1,293	1,068		>=-5% >=-20% <-20%	✔
AvP: IP - Non-Elective	W	747	731	1,066	-97	-100	1,292	-184	-141	-66	1,374	1,365	1,259	1,272		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W	340	358	455	-88	-61	453	-20	-113	-79	402	387	324	321		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W	1,517	1,614	2,098	208	31	2,152	316	-85	231	1,984	2,184	1,847	1,845		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W	23,384	23,051	27,533	2,372	5,026	28,154	6,154	1,851	6,683	25,908	29,419	23,511	24,375		>=0 N/A <0	✔
PDR	W	74.4%	74.4%	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%		No Threshold	✔
Medical Appraisal	W	95.9%	95.9%	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%		No Threshold	✔
Mandatory Training	W	86.0%	85.8%	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%		>=90 % >=80 % <80 %	✔
Sickness	D	7.2%	5.7%	4.7%	4.6%	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.3%	7.4%	8.1%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	2.3%	1.2%	1.2%	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.7%	3.6%		<=1 % N/A >1 %	✔
Long Term Sickness	D	4.9%	4.5%	3.6%	3.5%	3.9%	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.7%	4.5%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	1,373	1,279	2,272	1,071	1,040	960	1,130	1,096	1,368	1,137	1,590	1,521	1,385		No Threshold	✔
Staff Turnover	D	8.9%	8.8%	8.8%	9.4%	9.7%	9.3%	9.6%	9.7%	10.2%	10.7%	11.2%	10.9%	11.4%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	90.5%	94.5%	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	94.4%	97.7%	97.7%	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%		>=85 % N/A <85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

		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	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	80	80	90	100	103	108	117	125	132	139	142	145	148		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	36	36	36	34	36	38	37	38	40	43	44	42	43		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	1	0	6	7	2	3	7	3	7	7	4	1	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	0	2	0	3	1	1	0	2	3	3	0	3		>=1	N/A	<1	✔
Number of patients recruited	W	504	403	105	1,055	1,039	896	439	1,060	983	931	1,038	816	978		>=100	>=86	<86	✔

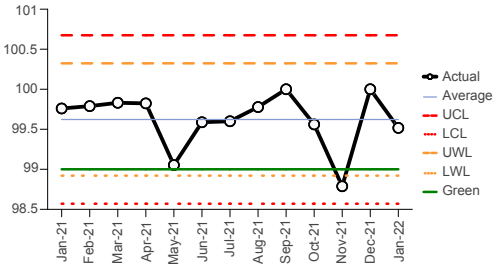
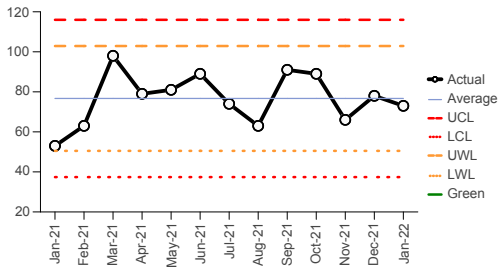
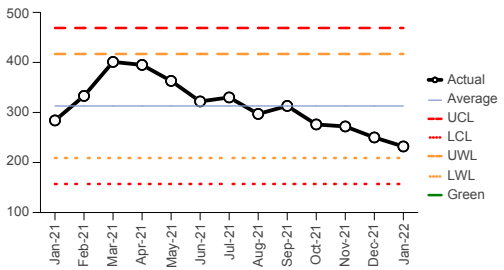
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nathan Askew **Committee:** SQAC	99.52 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nathan Askew **Committee:** SQAC	73	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nathan Askew **Committee:** SQAC	232	No Threshold		

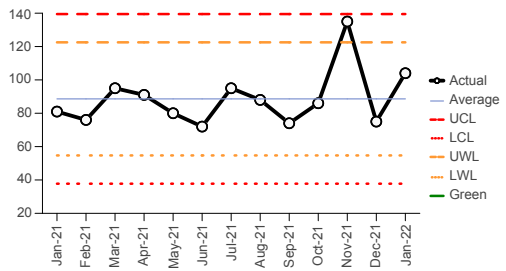
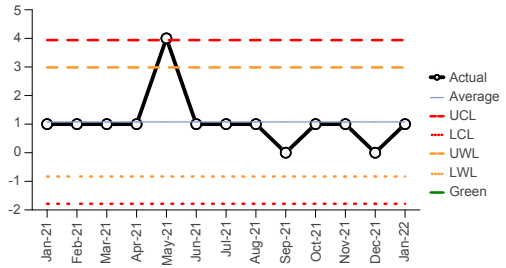
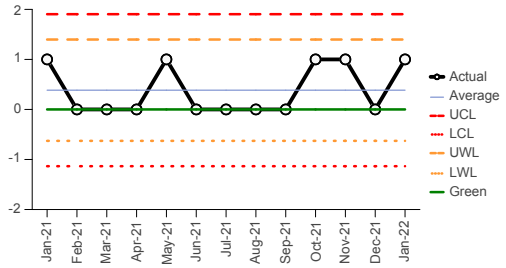
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

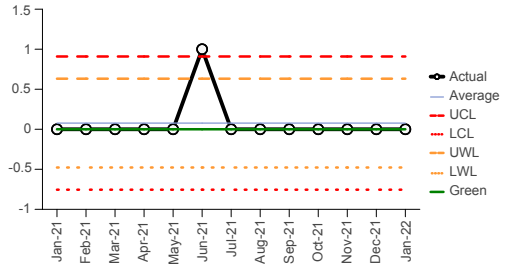
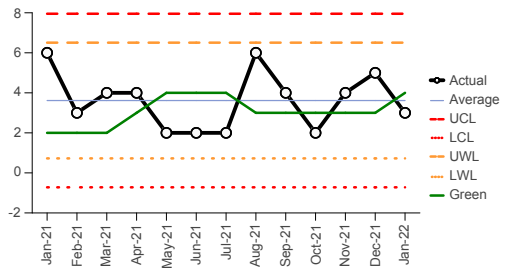
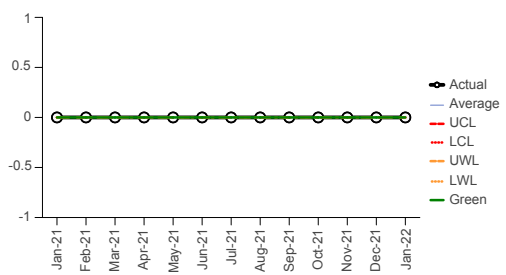
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nathan Askew **Committee:** SQAC	104	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nathan Askew **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	1	R >0 A N/A G 0		Grade 4 pressure Ulcer, StEIS reported, 72 hour review including lessons learned completed, duty of candour applied in line with regulation 20, comprehensive level 2 investigation commenced.

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

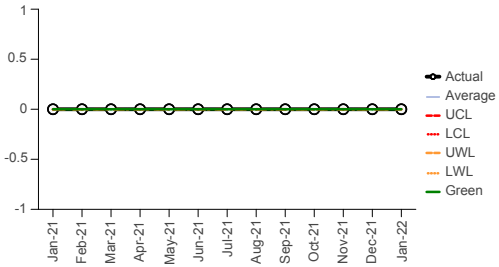
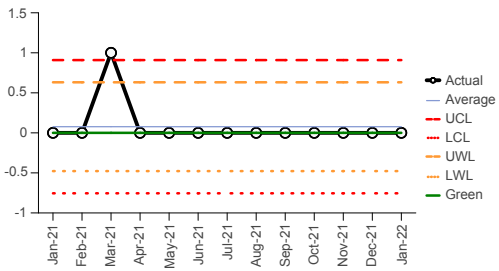
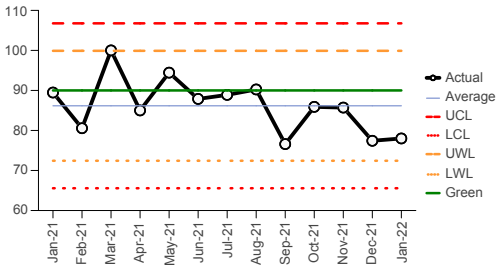
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 20 - Mar 21. 21/22 aim is less than 52 annually for the trust. **Exec Lead:** Nathan Askew **Committee:** SQAC	3	R >4 A N/A G <=4		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	1	R >0 A N/A G 0		Grade 4 pressure Ulcer, StEIS reported, 72 hour review including lessons learned completed, duty of candour applied in line with regulation 20, comprehensive level 2 investigation commenced.
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%. **Exec Lead:** Nathan Askew **Committee:** SQAC	78 %	R <90 % A N/A G >=90 %		Eleven patients did not receive antibiotics within 60 minutes and 3 within 90 minutes; in the main this was due to difficulties gaining intravenous access or difficulty carrying out lumbar puncture. 1 patient required stabilisation first and 1 complex patient required consultation with Leeds. 3 patients delays were incidented for further investigation'

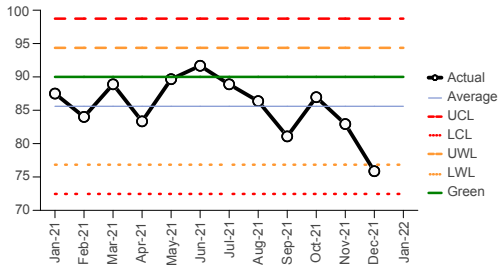
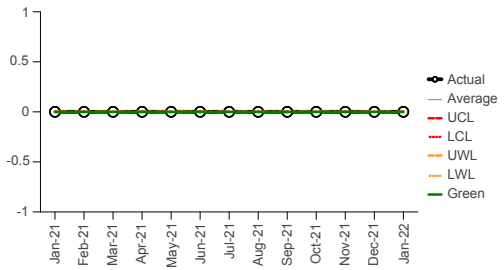
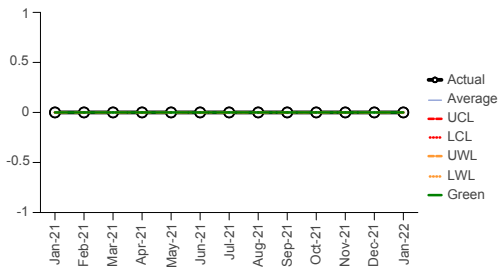
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

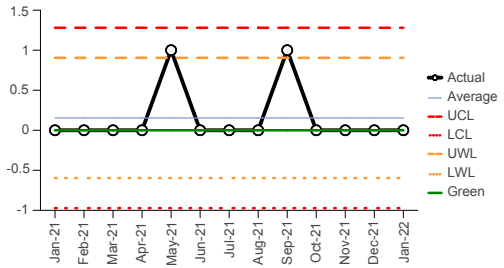
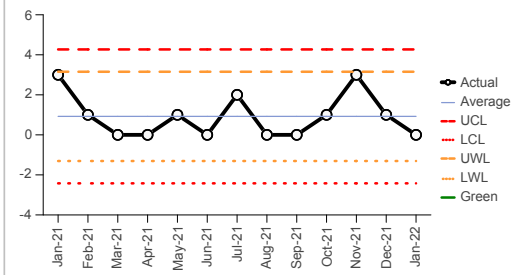
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

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

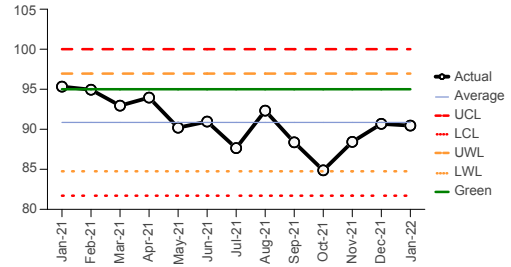
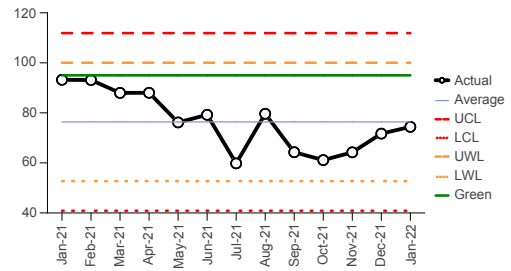
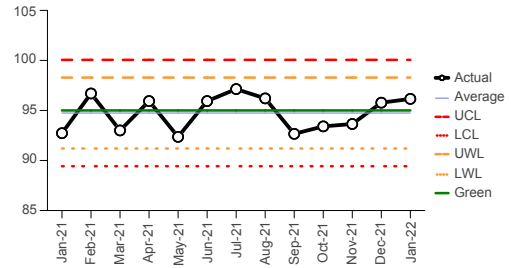
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	90.46 %	R <90 % A >=90 % G >=95 %		January has 1,268 responses from a possible 28,345 (Dec 2021) which gave an overall Trust FFT percentage of 90.46% who found their experiences to be either good or very good This is a 0.22% decrease compared to December. By division - Medicine reports a 0.3% increase, surgery 0.4% decrease and community 1.7% decrease. 81.5% of responses came via SMS message. Collection of face to face collection has been resumed within inpatient wards before discharge.
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	74.40 %	R <90 % A >=90 % G >=95 %		A&E % response good/very good has increased by 2.7% from the previous month. Response rates are low at 4.89% = based on 250 responses from a possible 5103 (Dec 21 attendance data) When asked how we could improve 50% of comments related to waiting times and 30% staff attitude. Other common theme was the 1 parent restrictions in place.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	96.15 %	R <90 % A >=90 % G >=95 %		No Action Required

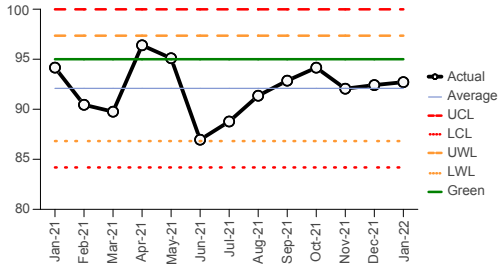
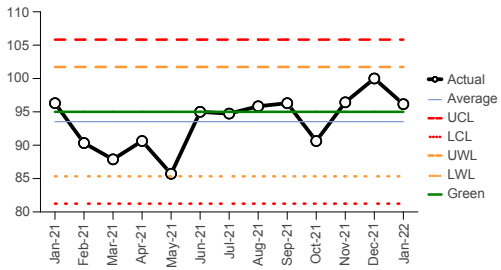
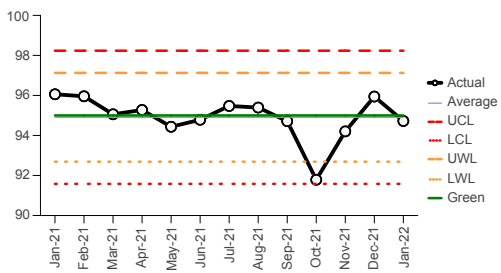
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	92.71 %	R <90 % A >=90 % G >=95 %		During January there has been 0.3% increase for good/very good response and a decrease of 2.75% in poor/very poor. Response rates have increased to 192 – the highest monthly figure since July 2021. 95% of these responses came via SMS.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	96.15 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	94.72 %	R <90 % A >=90 % G >=95 %		The percentage has decreased by 1.24% since Dec 2021 to 94.72%. There were 701 completed surveys, with 26 poor/very poor responses in this area. These poor /very poor responses account for 3.71% of overall percentage. Within poor/very poor comment analysis raised communication issues, staff attitude and issues with video consultations

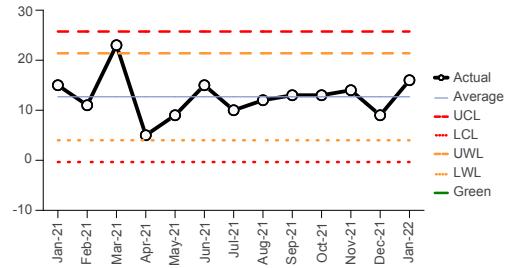
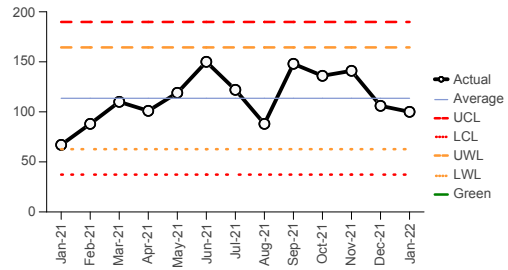
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nathan Askew **Committee:** SQAC	16	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nathan Askew **Committee:** SQAC	100	No Threshold		

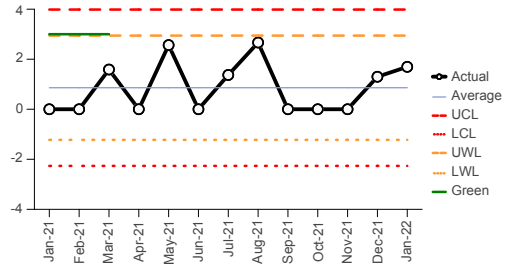
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

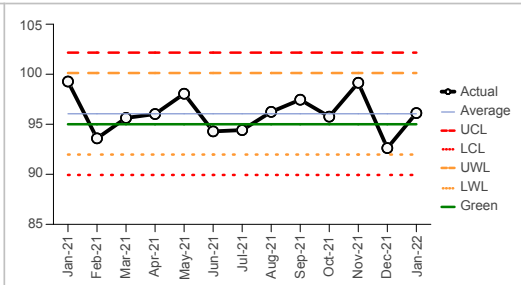
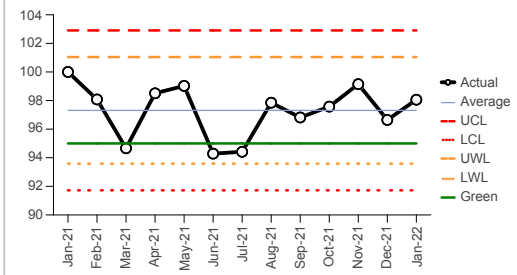
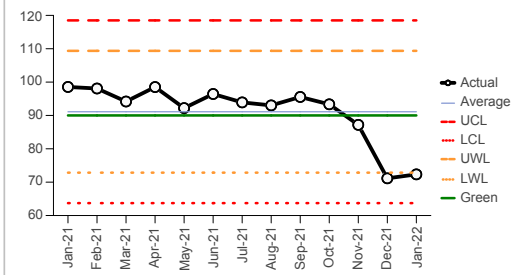
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Nathan Askew **Committee:** SQAC	1.69 %	No Threshold		

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

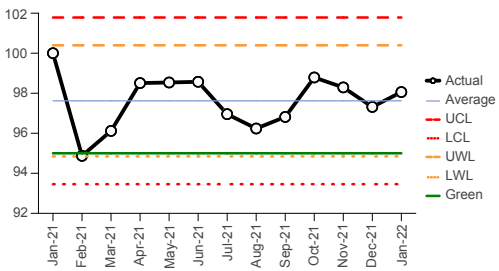
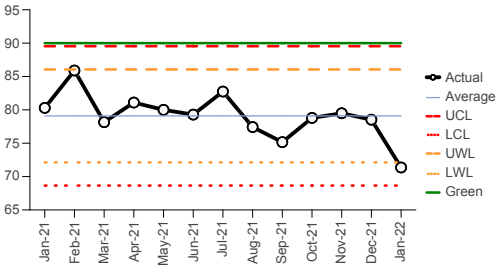
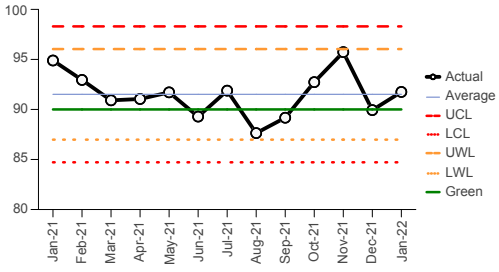
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	96.12 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nathan Askew **Committee:** SQAC	98.06 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	72.33 %	R <85 % A >=85 % G >=90 %		There has been a 1.19% increase of knowing the planned date of discharge. Further work is being carried out (Emergency Care and collaborative programme) to improve timely discharges and information. Benchmark has not been achieved for 3 consecutive months. Across divisions there is a notable difference when parents and carers where asked if discharge had been discussed – Surgery 73.86% said yes whilst 48.21% in Medicine, this continued when asking YP aged 11-16 years Surgery 100% said yes whilst 66% in Medicine.

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	98.06 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	71.36 %	R <85 % A >=85 % G >=90 %		The percentage of patients that reported engagement with play this month was 71.36%, a decrease of 7.16% from December 2021. There were 206 responses during Jan 2022. 49 of those responses said that they did not have access to play/activities. Of the 49 responses, 20.4% (10) came via 4C, 20.4% (10) came via Ward 3A . Surgical Day care has improved by 30% since November and by 14% since December. Play services were affected this month due to staff absence. Recruitment of new play therapists and play service manager has taken place this month.
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	91.75 %	R <85 % A >=85 % G >=90 %		No Action Required

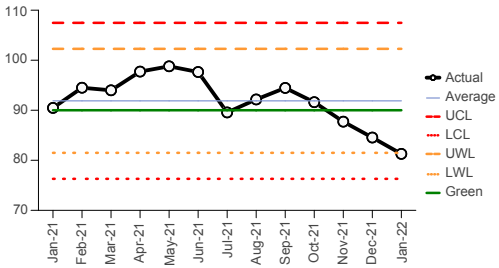
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	81.28 %	R <90 % A N/A G >=90 %		The Safer Staffing meeting is Chaired by an Associate Chief Nurse in hours or Patient Flow at weekends; designated senior nursing staff are allocated to review staffing for their Division and make plans to maintain safe staffing levels. Due to sickness, staff availability has been reduced. All staffing has been maintained with the Green, Amber, Red model devised and agreed to manage staffing at times of winter pressure or surge. In response to the NHSE/I paper published in November 2021: Winter 2021 preparedness: Nursing and midwifery safer staffing, report has been provided to Trust Board with assurance that plans are in place to ensure safe nurse staffing over the winter period and that plans are connected to the wider system staffing planning, resourcing and mutual aid.

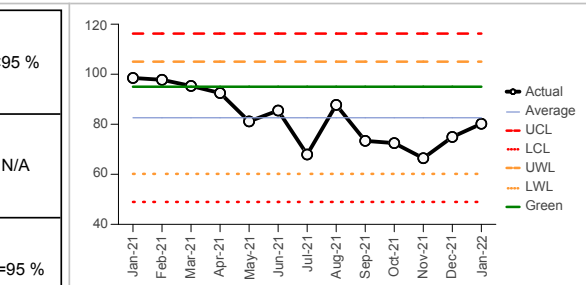
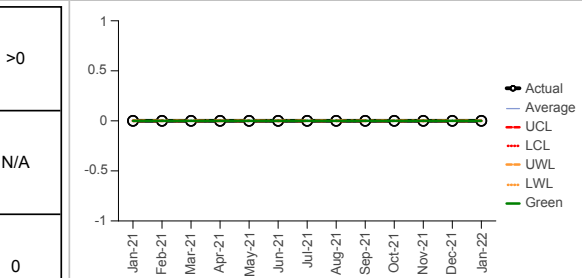
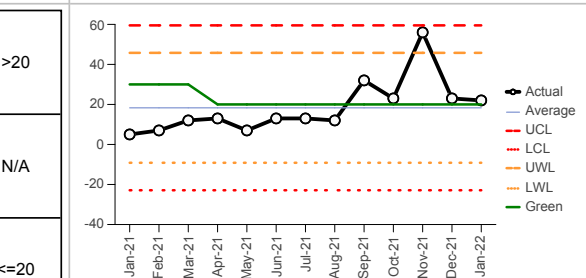
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	80.19 %	R <95 % A N/A G >=95 %		The attendances in January dropped, however still an increase in ED attends compared to 2019 (plus 250). Acuity was still high and workforce remains a challenge. Median Time to triage improved significantly to 10mins, compared to a standard of 15. Median time to clinician wait was 83 minutes compared to a standard of 60. Attendance rates and acuity levels remain high and a challenge in January. Despite this the left before seen rate significantly improved to 4% (5% target).
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	22	R >20 A N/A G <=20		Continued reduction of on the same cancelled operations due to tighter prospective management of TCIs

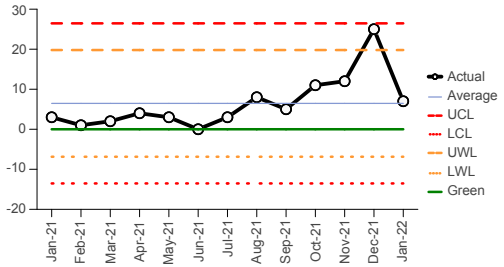
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	7	R >0 A N/A G 0		Significant improvement on 28 day breaches. Following a high number of same day cancellations in November, the Division capped the number of TCIs through December which has had a positive impact on same day cancellations and in turn 28 day breaches.

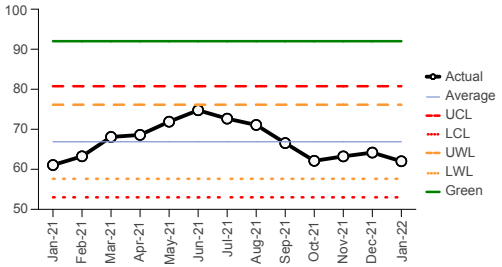
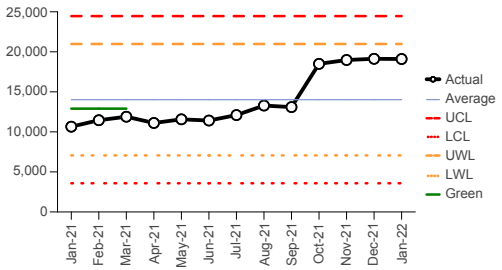
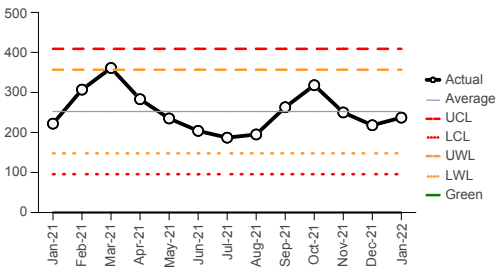
Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

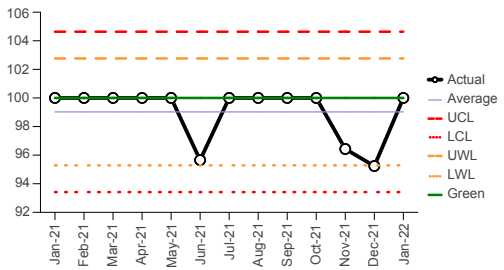
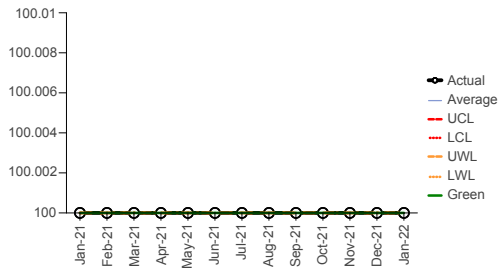
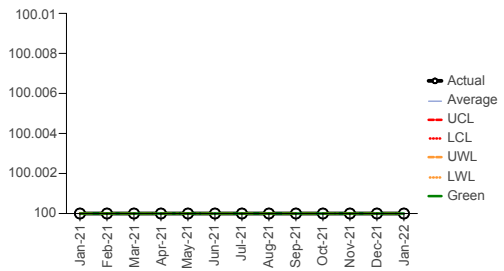
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	62.01 %	R <90 % A >=90 % G >=92 %		The RTT position is slowly improving but has been impacted by a reduced theatre schedule through January to address staff sickness as a result of the Omicron surge. The Division continues to work towards its elective plan.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	19098	No Threshold		
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	237	R >0 A N/A G 0		Increase in 52 week waiters, again challenged by the reduced theatre schedule. The Division's focus is the reduce 52 week wait patients by the end of the next financial year and are working on a trajectory to achieve this.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

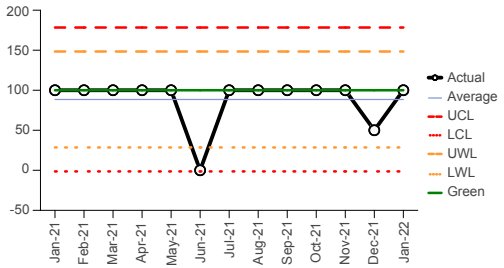
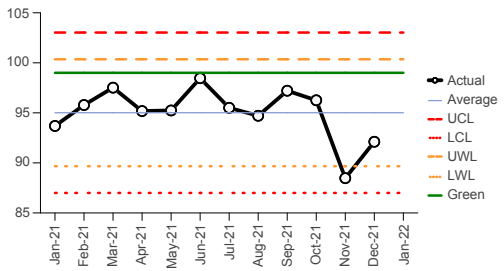
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	87.9 %	R <99 % A N/A G >=99 %		Due to loss in MRI capacity in December with technical issues patients cancelled and rebooked into January which has impacted on performance in month. Position likely to deteriorate in February overall due to inclusion of previously unreported studies but will continue to monitor performance in MRI and gastro to ensure improvements are made.

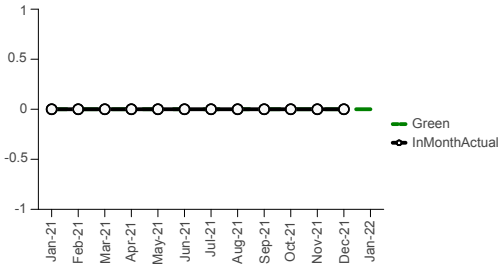
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** SQAC	0	R >1 A <=1 G 0		No Action Required

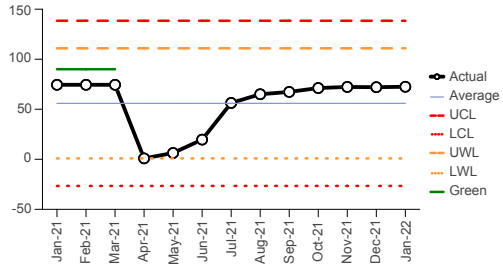
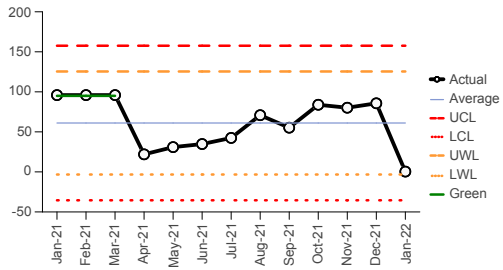
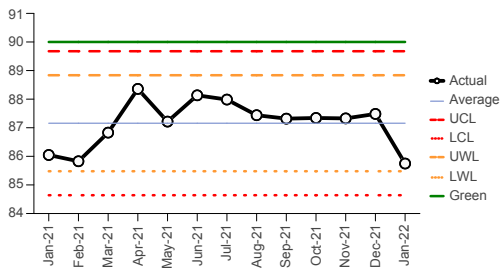
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** PAWC	72.47 %	No Threshold		As of the 31st of January 2022, our Trust appraisal rate was 72.47%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	0.38 %	No Threshold		The Appraisal window for Medics has been reset.
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	85.75 %	R <80 % A >=80 % G >=90 %		As of the 31st of January, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff, managers and SMEs to encourage improvements in compliance. Our three key areas of concern remain 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.

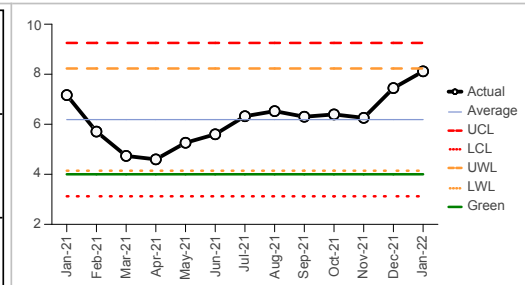
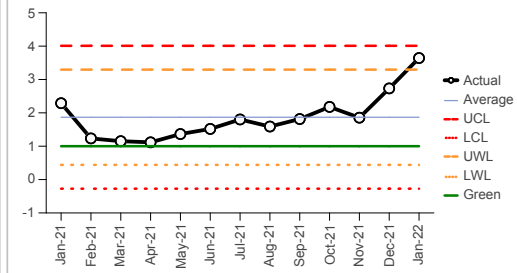
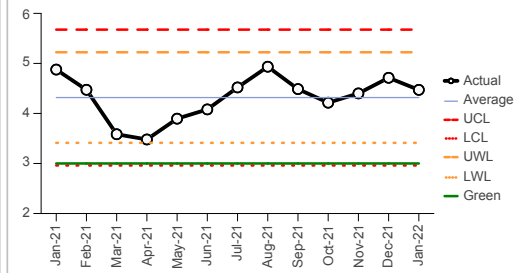
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** PAWC	8.11 %	R >4.5 % A <=4.5 % G <=4 %		Attendance management is a fundamental aspect of staff availability and as highlighted in previous reports, therefore remains under close scrutiny by the HR BP team. As part of this the following is undertaken: • Trust sickness level updates (headcount and WTE) provided to Daily Operational / Tactical Command meetings. • Weekly monitoring of overall absence sickness absence, drilling down into short and long term absence and return to work activity across all divisions. CONTINUED BELOW
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** PAWC	3.64 %	R >1 % A N/A G <=1 %		• Regular 1:1's with line managers to discuss workforce issues, including the design individual plans with the aim of supporting people whilst off ill and to facilitate a return to work, if possible. • Escalation of areas of concern / emerging themes to key divisional meetings, as applicable. • Blended learning is currently in development and will launch shortly.
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	4.47 %	R >3 % A N/A G <=3 %		See Above

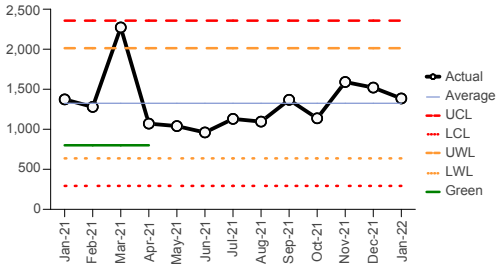
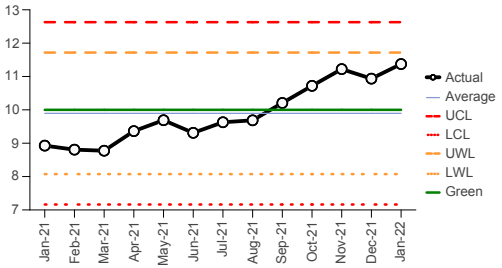
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	1384.62	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	11.37 %	R >11 % A <=11 % G <=10 %		A deep dive exercise as been undertaken to further understand the increase in turnover levels across the Trust and an action plan may be needed at a divisional and Trust wide level as an outcome. This information will inform future workforce and succession planning, linked to recruitment strategy.

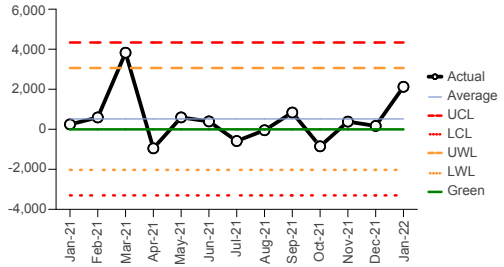
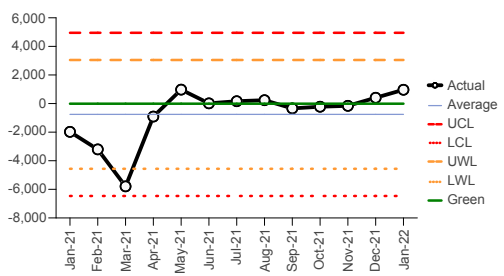
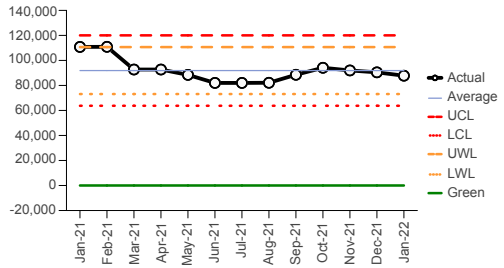
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	2,122	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	964	R <-10% A >=-10% G >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	87,781	R <-20% A >=-20% G >=-5%		No Action Required

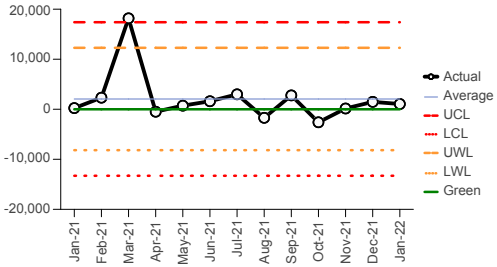
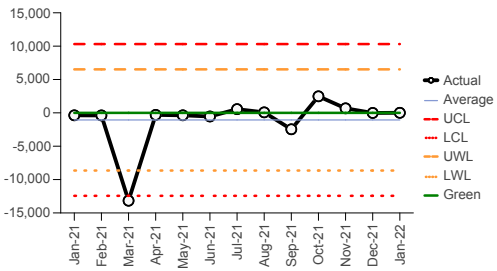
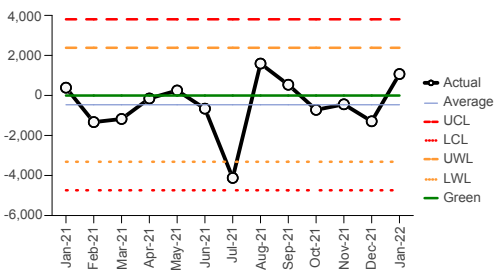
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,048	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	6	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,068	R <-20% A >=-20% G >=-5%		No Action Required

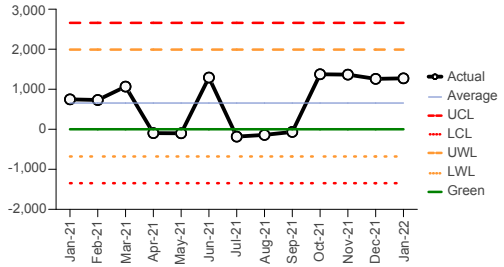
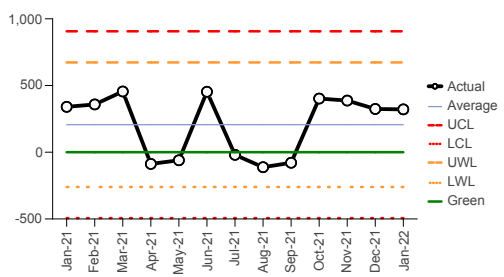
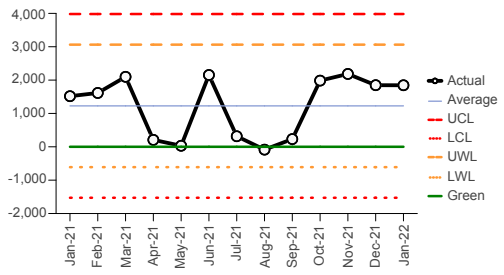
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1272	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	321	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1845	R <0 A N/A G >=0		No Action Required

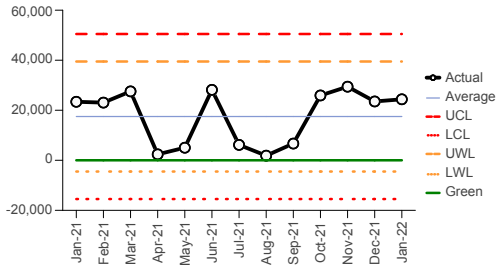
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	24375	R <0 A N/A G >=0		No Action Required

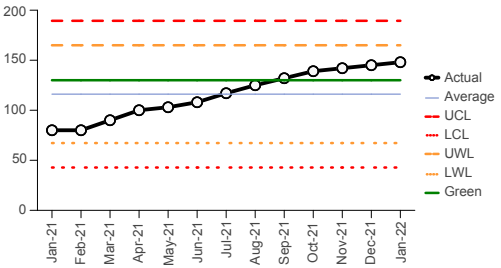
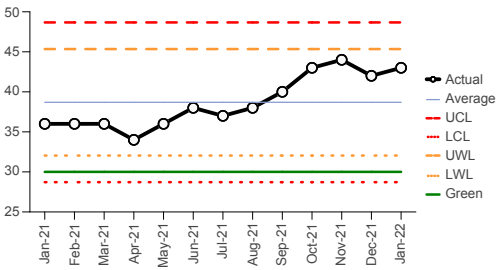
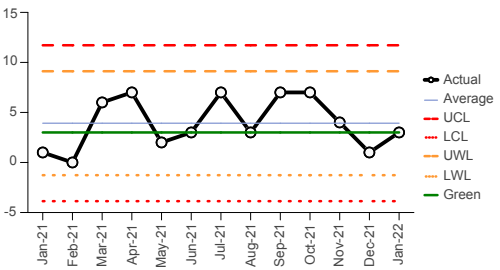
Game Changing Research & Innovation

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 Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	148	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	43	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R <2 A >=2 G >=3		No Action Required

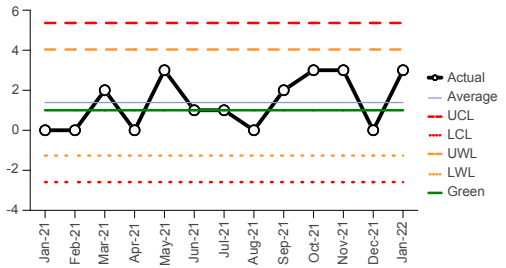
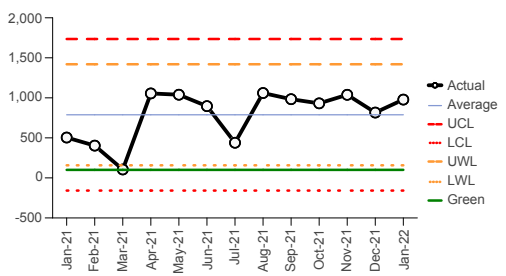
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	978	R <86 A >=86 G >=100		No Action Required

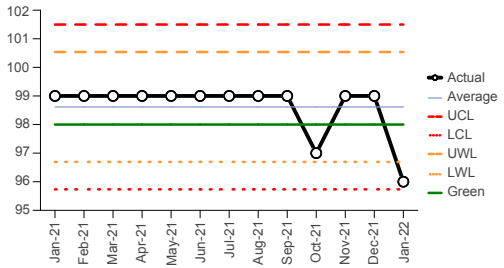
Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	96 %	R <98 % A N/A G >=98 %		

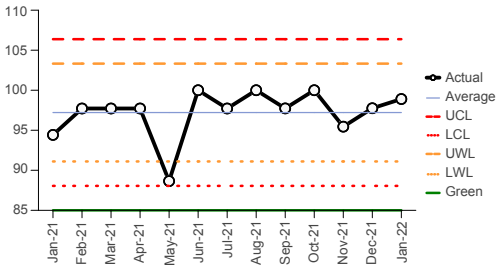
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nathan Askew **Committee:** SQAC	98.90 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	13	30	27	No Threshold
Clinical Incidents resulting in No Harm	D	38	104	75	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	8	23	41	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	1	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	1	0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 N/A >0
Medication errors resulting in harm	D	1	1	1	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	1	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	7	5	4	No Threshold
PALS	W	32	34	28	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			1.7%	No Threshold
ED: 95% Treated within 4 Hours	D		80.2%		>=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	4	18	No Threshold		
28 Day Breaches	W	0	0	7	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		93.3%	97.7%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		98.7%	97.7%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		57.3%	80.9%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		97.3%	98.5%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		58.7%	78.6%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		92.0%	91.6%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	55.0%	64.1%	61.9%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,576	5,955	11,567	No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	5	231	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		92.3%	83.3%	>=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	346	144	-131	No Threshold
Income In Month Variance (£'000s)	W	-112	-308	-17	No Threshold
Pay In Month Variance (£'000s)	W	248	-96	-85	No Threshold
Non Pay In Month Variance (£'000s)	W	210	548	-29	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W	0	887	385	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	116	205	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		1,171	671	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	4,123	8,209	10,094	>=0	N/A	<0
PDR	W	83.0%	74.5%	61.4%	No Threshold		
Medical Appraisal	W	0.0%	0.0%	0.8%	No Threshold		
Mandatory Training	W	91.5%	85.9%	87.0%	>=90 %	>=80 %	<80 %
Sickness	D	6.3%	9.8%	8.4%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	2.5%	4.3%	4.5%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.7%	5.6%	3.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	168	452	474	No Threshold		
Staff Turnover	D	10.5%	11.2%	11.7%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	99.1%	75.2%	83.4%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Weekly meetings take place to review all incidents reported within the Medicine Division with senior management. The division continues to work with the staff to ensure the incidents are closed in a timely manner. Closure process should include quality assurance review of the cause group and type of incident therefore ensuring reporting of trends and themes is accurate. Trajectory to close historic incidents by 4th March. Communicate with the division, as per policy, that incidents should be closed within 30 days. Themes: •Medication incidents: Medicines Safety Officer attends weekly incident review meeting to advise on any actions required following an incident reported. Good engagement and rapid actions taken for concerning incidents. Top cause group – omitted dose/medicine. •Access incidents: Highest area of reporting AED. Top cause group – unexpected arrival of patient: review indicates some relating to poor communication from other trusts transferring to AHCH, other communication from specialities/incorrect use of AED. Matron is working with Patient Flow to address. **Sepsis:** Q3 = 86% for 60minute target Q3 = 94% for 90minute target. AED: Jan 22- 78%. Reviews indicated delays with difficult access and complex patients. 2 incidents reported for further review. Sepsis Lead Nurse for the trust is vacant at the moment. Data not available in Q4 but division is monitoring incidents and acting on concerns.	**Highlight** • Good levels of incident reporting have been maintained. • Good engagement with managers to improve processes and achieve governance targets. **Challenges** • Incidents remain open on Ulysses for extended periods. Work ongoing with managers and teams to close. • Attendance of senior staff to weekly incident review to allow good discussions and dissemination of information.
CARING	**Complaints:** 13 complaints closed in December and January. On track to achieve target of response within 25 working days for complaints received in January 2022. Close daily monitoring continuing to support the new process. Associate Chief Nurse and Governance Team have established new ways of working to achieve compliance. **FFT**: AED provided with themes of poor experiences reported in January 2022 to devise actions for improvement. Themes of positive experiences to be shared with staff too.	**Highlight** • Historic complaints within the division have been reduced with only 1 outstanding but progress being made to close asap. • PALS: Focus on PALS to respond within 5 working days with close monitoring. **Challenges** • Some complex PALS so challenge is sometimes to respond effectively within the timeframes. However, this is a daily focus to support the process.

EFFECTIVE	The Divisions performance against a range of indicators remains challenging; ED Performance witnessed a second month of improvement against November 2021 at 80.2% of C&YP seen within 4 hours; the left before seen percentage reduced to April 2021 levels at 4% in January 2022.	**Highlight** • Improved LBS performance against an improving ED 4-hour performance **Challenges** • ED performance against the 4 Hour Quality standard remains challenged, with some improvement in the last 2 months. • A joint review of theatre utilisation for Gastroenterology with Surgery colleagues is underway due to worsening performance.
RESPONSIVE	Recovery of 52-week RTT breaches continues with challenges remaining in the Sleep service; a refresh of Cancer performance reporting is underway by the Divisional General Manager. Cleansing of the OP and IP new PTL's is identifying and rectifying data quality issues.	**Highlight** ▪ Continue to maintain the Cancer FDS performance **Challenges** ▪ Diagnostics challenges remain; the Division has commissioned a review of the Diagnostics PTL management.
WELL LED	Sickness absence rates remain a significant cause for concern, impacted further by COVID absences through January.	**Highlight** • Renewed focus on RTW; improvement in compliance demonstrated **Challenges** • STS and LTS in Key areas – ED and Ward 4B • RTW within 48 hours remains a challenge • PDR compliance below target but showing some improvement

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	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	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	18	23	33	42	32	35	30	29	33	39	25	49	30		No Threshold
Clinical Incidents resulting in No Harm D	89	97	125	123	125	91	100	98	133	93	87	99	104		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	21	17	19	23	24	17	18	17	14	28	24	18	23		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	0	1	1	0	2	1	1	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm D	1	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm D	4	1	2	0	0	1	0	2	3	1	0	1	1		No Threshold
Medication Errors (Incidents)	34	28	39	29	42	26	14	20	35	24	20	30	28		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	2	4	1	3	2	0	2	1	6	7	4	1		No Threshold
Never Events W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	83.3%	84.6%	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%	83.3%			>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile D	0	0	0	0	1	0	0	0	1	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	2	2	1	5	0	0	2	3	3	4	2	1	0		No Threshold
Hospital Acquired Organisms - MSSA D	1	1	0	0	0	0	0	0	0	1	1	0	0		No Threshold
Cleanliness Scores	98.4%	97.2%	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%		No Threshold
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.	53.9%	68.2%													>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	85.0%	84.0%													>=90 % N/A <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	100.0%	100.0%													>=90 % N/A <90 %

CARING

	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	Last 12 Months	RAG
Complaints W	8	3	12	4	5	2	4	4	3	5	7	2	5		No Threshold
PALS W	25	19	37	24	23	40	41	25	48	50	46	42	34		No Threshold

EFFECTIVE

	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	Last 12 Months	RAG
Referrals Received (Total)	2,093	1,699	2,238	2,144	2,246	2,416	2,259	1,922	2,468	2,610	2,678	3,033	2,824		No Threshold
ED: 95% Treated within 4 Hours D	98.5%	97.8%	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%		>=95 % N/A <95 %
ED: Percentage Left without being seen W	0.5%	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 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes W	0	0	0	0	0	0	0	0	1	0	1	4			0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes W	0	0	0	0	0	0	0	0	1	0	0	3			0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) W	9.0%	7.9%	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%	9.1%	9.6%	9.9%	9.1%		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

		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	Last 12 Months	RAG
Theatre Utilisation - % of Session Utilised	W	83.7%	87.8%	86.3%	86.6%	81.9%	80.1%	82.4%	80.2%	82.7%	81.4%	80.7%	72.7%	79.1%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	0	1	2	0	1	0	3	2	3	5	0	4		No Threshold
28 Day Breaches	W	1	0	0	0	0	0	0	0	1	1	2	2	0		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice		16	14	18	21	19	21	37	42	30	43	45	40	33		No Threshold
OP Appointments Cancelled by Hospital %		12.3%	12.4%	11.6%	10.0%	10.7%	11.6%	14.9%	14.6%	13.7%	15.3%	12.2%	12.0%	12.3%		<=5 % N/A >10 %
Was Not Brought Rate	W P	9.8%	9.3%	8.7%	9.1%	8.8%	9.6%	10.5%	11.1%	9.8%	9.5%	9.3%	9.4%	9.5%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	W	11.7%	10.9%	9.3%	12.3%	10.1%	11.1%	10.6%	11.3%	9.2%	9.5%	8.6%	9.0%	11.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	9.4%	9.0%	8.6%	8.5%	8.5%	9.3%	10.5%	11.2%	10.0%	9.5%	9.5%	9.4%	9.2%		<=14 % <=16 % >16 %
Coding average comorbidities		5.45	5.54	5.41	5.14	5.17	5.58	5.47	5.58	5.50	5.68	5.57	5.49	5.49		No Threshold

RESPONSIVE

		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	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	W	100.0%	96.4%	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	100.0%	100.0%	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	96.9%	98.2%	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	100.0%	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 % >=90 % <90 %
IP Survey: % Patients involved in Play	D	75.0%	89.3%	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D	93.8%	94.6%	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	89.5%	90.8%	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%		>=92 % >=90 % <90 %
Waiting List Size	W	1,731	2,110	2,280	2,509	2,819	3,122	3,338	3,507	3,565	5,605	5,842	5,943	5,955		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	16	4	4	3	6	11	7	13	23	10	15	5		0 N/A >0
Waiting Times - 40 weeks and above		9	37	10	24	12	15									No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	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	94.6%	96.0%	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%			>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr		90.4%	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 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		99.9%	100.0%	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	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%	99.0%	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients		99.0%	98.0%	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients		75.0%	77.0%	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks		100.0%	95.0%	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks		100.0%	100.0%	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%		>=99 % N/A <99 %

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

WELL LED

		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	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	189	160	-586	263	200	-1,036	-347	-58	253	-127	-199	87	144				
Income In Month Variance (£'000s)	W	10	36	170	37	-26	-1	209	-490	201	-184	1,138	829	-308				
Pay In Month Variance (£'000s)	W	-61	-52	-148	-64	60	-150	48	47	121	-35	15	70	-96				
AvP: IP - Non-Elective	W	405	416	676	-153	-78	807	-82	-19	-42	1,003	954	857	887		>=0	N/A	<0
AvP: IP Elective vs Plan	W	123	139	154	-16	-10	161	-25	-58	-25	119	122	91	116		>=0	N/A	<0
AvP: OP New		1,180.00	1,087.00	1,229.00	-383.97	-406.28	1,296.00	-508.93	-568.20	-323.45	1,324.00	1,379.00	1,028.00	1,083.00		>=0	N/A	<0
AvP: OP FollowUp		5,933.00	5,223.00	6,166.00	1,667.17	1,398.80	6,489.00	1,249.46	1,195.03	1,724.47	5,676.00	6,350.00	5,693.00	6,258.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	1,011	1,044	1,283	265	222	1,356	268	117	422	1,251	1,347	1,150	1,171		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	7,955	7,410	8,553	838	699	8,792	334	364	1,193	7,981	8,821	7,705	8,209		>=0	N/A	<0
PDR	W	74.2%	74.2%	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%				
Medical Appraisal	W	94.1%	94.1%	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%				
Mandatory Training	W	88.1%	87.1%	88.5%	89.1%	87.6%	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%	86.7%	85.9%		>=90 %	>=80 %	<80 %
Sickness	D	6.4%	5.2%	4.2%	4.5%	5.4%	5.3%	6.4%	7.1%	6.3%	6.5%	7.4%	9.3%	9.8%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	2.0%	1.4%	1.1%	1.2%	1.5%	1.5%	2.0%	1.9%	1.8%	2.3%	2.2%	3.5%	4.3%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.3%	3.8%	3.1%	3.4%	4.0%	3.7%	4.4%	5.2%	4.5%	4.3%	5.2%	5.8%	5.6%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	247	267	261	210	262	230	265	263	292	311	373	370	452				
Staff Turnover	D	6.6%	6.5%	6.0%	6.5%	6.8%	7.3%	7.5%	8.3%	9.4%	9.6%	10.0%	10.1%	11.2%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	91.2%	97.8%	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%		>=90 %	>=80 %	<90 %

Surgery Division

SAFE	No hospital acquired infections and positive reduction in incidents resulting in no harm. One severe permanent harm undergoing governance process.	**Highlight** • Positive reduction in incidents resulting in no harm. • Reduction in medication errors. • No hospital acquired infections. **Challenges** • Slight increase in incidents resulting in near miss. • One severe permanent harm
CARING	• Reducing PALs complaints and consistently low formal complaints.	**Highlight** • Reduced PALs complaints **Challenges** •
EFFECTIVE	Positive progress on same day theatre cancellations and 28 day breaches as part of Divisional plan. No change in theatre utilisation compared to December. Reduced theatre scheduled through January to address staff sickness from Omicron surge.	**Highlight** • Reduced same day theatre cancellations • Significant reduction in 28 day breaches • Reduced hospital initiated clinical cancellations<6 weeks notice **Challenges** • Increase in referrals received • Reduced theatre utilisation – planned to address Omicron surge. • Increase in appointments cancelled by the hospital to address Omicron surge. • Increased WNB rate
RESPONSIVE	• Deteriorating position for RTT, 52 weeks and waiting list as a result of planned reduction of theatre schedule through January. Full theatre schedule to be phased back in through February.	**Highlight** • Increase in patients feeling enabled with choice about care. • Increase in patients feeling like they have been treated with respect. • Increase in patients knowing date of discharge. **Challenges** • Reduction in patients involved in play. • Deteriorating RTT position • Increased waiting list size • Increased 52 week waiters as a result of reduced theatre schedule through January.
WELL LED	• Better financial position with strong increase. • Focus on mandatory training and appraisals required. • Sickness rate in line with expected Omicron surge.	**Highlight** • Better total control spend • Increased income position • Slight increase on PDRs **Challenges** • High sickness rate

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Surgery

D Drive W Watch P Programme

SAFE

	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	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	24	25	46	23	32	43	27	25	42	33	33	23	27		No Threshold
Clinical Incidents resulting in No Harm D	107	140	174	166	165	163	119	114	107	102	116	117	75		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	38	27	33	35	28	38	32	49	39	43	82	39	41		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	1	0	0	1	2	0	0	1	0	1	1	0	1		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	0	0	0	0	0	0	0	1	1	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	2	4	2	1	2	3	1	1	3	4	1		No Threshold
Medication Errors (Incidents)	23	40	45	43	36	29	24	27	26	20	28	29	20		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Never Events W	0	0	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	91.7%	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	2	0	0	0	1	0	2	0	0	0	2	1	0		No Threshold
Cleanliness Scores	98.9%	97.0%	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%		No Threshold

CARING

	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	Last 12 Months	RAG
Complaints W	2	3	7	0	4	5	3	4	6	4	5	4	4		No Threshold
PALS W	16	23	27	34	42	43	33	25	30	29	41	33	28		No Threshold

EFFECTIVE

	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	Last 12 Months	RAG
Readmissions to PICU within 48 hrs D	0	0	1	0	2	0	1	2	0	0	0	1	1		No Threshold
% Readmissions to PICU within 48 hrs W	0.0%	0.0%	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%		No Threshold
Referrals Received (Total)	2,699	2,904	4,047	3,964	4,119	4,375	3,762	3,236	3,906	3,547	3,912	3,102	3,229		No Threshold
Theatre Utilisation - % of Session Utilised W	87.6%	90.3%	89.5%	84.0%	88.8%	85.2%	85.1%	86.8%	85.3%	87.8%	85.5%	83.9%	83.6%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	5	7	11	11	7	12	13	9	30	20	51	23	18		No Threshold
28 Day Breaches W	2	1	2	4	3	0	3	8	4	10	10	23	7		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	38	50	37	47	46	59	63	74	54	78	43	51	48		No Threshold
OP Appointments Cancelled by Hospital %	10.6%	10.9%	11.8%	10.1%	10.2%	11.3%	9.7%	11.5%	11.5%	10.8%	9.0%	10.5%	12.3%		<=5 % <=10 % >10 %
Was Not Brought Rate W P	10.4%	7.8%	7.1%	6.1%	6.9%	7.1%	8.7%	9.7%	8.6%	8.8%	9.1%	9.2%	9.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	11.5%	10.3%	8.3%	6.9%	8.9%	8.3%	11.1%	11.6%	9.7%	9.5%	10.1%	10.8%	11.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	9.9%	6.9%	6.7%	5.7%	6.0%	6.5%	7.7%	9.0%	8.1%	8.5%	8.8%	8.7%	9.0%		<=14 % <=16 % >16 %
Coding average comorbidities	4.40	4.43	4.54	4.63	4.40	4.49	4.62	4.57	4.51	4.50	4.28	4.51	4.48		No Threshold
CCAD Cases	25	29	34	34	31	39	28	19	23	29	24	33	20		No Threshold

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RESPONSIVE

		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	Last 12 Months	RAG		
IP Survey: % Received information enabling choices about their care	W	99.0%	92.0%	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	100.0%	97.0%	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P	99.0%	98.0%	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	100.0%	96.0%	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D	81.9%	84.0%	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D	95.2%	92.0%	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%	88.5%	91.6%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	54.5%	56.2%	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,132	8,432	8,701	7,773	7,980	7,484	7,787	8,632	8,319	11,360	11,505	11,621	11,567		No Threshold		
Waiting Greater than 52 weeks - Incomplete Pathways	W	221	291	357	276	232	197	174	186	249	294	239	202	231		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	50.0%	90.0%	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%			>=99 %	N/A	<99 %

WELL LED

		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	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-241	57	-708	-716	217	108	583	-5	-137	-349	-598	-657	-131				
Income In Month Variance (£'000s)	W	0	83	152	47	49	209	223	28	-144	-43	68	59	-17				
Pay In Month Variance (£'000s)	W	-360	-157	-526	-599	28	-116	541	-64	-158	-82	-452	-331	-85				
AvP: IP - Non-Elective	W	341	308	390	57	-20	485	-101	-121	-23	371	411	402	385		>=0	N/A	<0
AvP: IP Elective vs Plan	W	217	219	300	-73	-50	291	4	-55	-55	281	265	233	205		>=0	N/A	<0
AvP: OP New		1,955.00	2,065.00	2,601.00	369.54	-64.15	2,827.00	711.90	-106.72	404.80	2,777.00	2,887.00	2,159.00	2,278.00		>=0	N/A	<0
AvP: OP FollowUp		6,182.00	6,422.00	7,888.00	-2,408.10	594.79	8,052.00	1,773.00	-1,023.90	1,266.00	7,591.00	8,868.00	6,462.00	6,724.00		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W	503	570	811	-59	-190	795	46	-203	-192	731	836	696	671		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	9,332	9,756	12,063	-1,991	553	12,421	2,874	-1,132	2,156	11,853	13,505	9,915	10,094		>=0	N/A	<0
PDR	W	66.1%	66.1%	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%				
Medical Appraisal	W	96.8%	96.8%	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%				
Mandatory Training	W	86.7%	86.9%	87.8%	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%		>=90 %	>=80 %	<80 %
Sickness	D	8.3%	6.5%	5.4%	5.2%	5.7%	5.8%	6.7%	6.2%	6.3%	6.0%	5.6%	7.3%	8.4%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	3.1%	1.6%	1.5%	1.5%	1.6%	1.6%	2.2%	1.6%	2.3%	2.5%	1.8%	3.2%	4.5%		<=1 %	N/A	>1 %
Long Term Sickness	D	5.1%	5.0%	3.9%	3.7%	4.1%	4.2%	4.5%	4.5%	4.1%	3.5%	3.8%	4.1%	3.9%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	434	382	542	515	457	332	445	469	532	363	631	535	474				
Staff Turnover	D	7.9%	7.9%	7.5%	7.9%	9.0%	9.0%	9.7%	10.3%	10.5%	11.1%	11.3%	11.2%	11.7%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	89.6%	92.7%	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%		>=90 %	>=80 %	<90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 55009 (Speech and Language Therapy) –** Child arrived at clinic on the wrong day as the appointment had been booked and letter sent with the wrong date. **Improvement –** Staff reminded about the use of duplicate diaries as this can increase the risk of errors in appointments. **Incident 54971 (Tier 4 Inpatient Unit) –** Sample received in lab unlabelled therefore sample was rejected. **Improvement** - Staff reminded about the important of label printing and ensuring this is printed off in advance. **Incident 54893 (Tier 4 Inpatient Unit)** - Child due multivitamin tablet and it was recognised that medication should have been stored in the fridge therefore this was not given. **Improvement -** Importance of checking storage instructions of all medications shared with staff.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 100 incidents reported in January (59 clinical, 41 non-clinical) **Challenges** • Two young people currently on acute inpatient wards awaiting a Tier 4 mental health bed (1 detained under Section 3 Mental Health Act). • Theme highlighted in January through divisional governance structure in relation to missing sample orders on Meditech and errors with sample labelling.
CARING	Improvement changes from complaints: **SO19394 (ASD/ADHD) –** Delay in ASD assessment and delay in receiving appointment with a paediatrician. **Improvement** – administrative team to log all patient related calls on the patient record and ensure calls are returned in a timely manner. **SO19393 (Crisis Care Service) –** Conflicting information provided to family following a visit to the Emergency Department. **Improvement –** Staff to ensure that information provided to young people and their families is thorough and understood before the young person leaves hospital to prevent causing further distress. **SO19356 (Speech and Language Therapy)** – Communication, frequency of appointments and cancelled appointments **Improvement** – Communication to families where appointments have been cancelled due to absence are to be made as soon as possible, and details of potential delays for the next available appointment to also be shared.	**Highlight** • 16 Excellent Reports submitted in January • 16 Compliments submitted in January • 95% FFT scores for OPD • 96% FFT scores for Community & Mental Health Services **Challenges** • 34 PALS received in January. Main themes relate to waiting times for appointment. • 7 formal complaints received in January. Complaints included appointment delays in ASD, SALT and CAMHS and communication issues in CAMHS, Crisis Care and Rainbow.
EFFECTIVE	Public health funding bid submitted for ARFID intervention, including psychoeducation groups for children, families and carers.	**Highlight** • Reduction in hospital initiated clinical cancellations < 6 weeks' notice (12 in January from 17 in December). Communication provided to services to ensure short notice clinic cancellations are avoided as much as possible.

	Public health funding bid submitted to improve effective signposting for families, ensuring professionals and communities and utilising available universal services.	**Challenges** • Continued increase in referrals to Community & Mental Health Services, including a 98% increase in referrals to Mental Health Services January 2022 compared to 2021. • 687 calls received to the Crisis Care Service in January 2022, 4.5% higher than January 2021
RESPONSIVE	New investment agreed with commissioners for the ASD and ADHD diagnostic pathways which will provide additional capacity to reduce waiting times for assessment by November 2022 to agreed local standard of 30 weeks.	**Highlight** • 100% compliance with the EDYS urgent waiting time standard in January. **Challenges** • Access times remain challenging in the division, including waiting times for Mental Health Services, SALT, ASD assessment and Community Paediatrics. Improvement plans are in place for all services and actions to be summarised in divisional access A3 template.
WELL LED	The Community & Mental Health Division was featured in Grand Round twice in January 2022: Parity of Esteem "The rubber duck mystery" - Jacqui Pointon Alder Hey Youth Forum – Lisa Cooper/Alex Jones	**Highlight** • Mandatory training remains above Trust target at 91.5% • Staff turnover reduced to 10.6% in January (11.1% in December 2021) **Challenges** • The division continues to be challenged with sickness absence higher than the Trust target (6.3% in January). Weekly drop-in sessions with HR are held with managers and resource to support timely updates to ESR is in place. • Services including Home Care and Crisis Care Service were adversely affected by the Omicron variant in January. Absence levels due to COVID have since reduced.

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Community

D Drive W Watch P Programme

SAFE

		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	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	5	5	9	7	12	7	11	4	8	4	2	4	13		No Threshold
Clinical Incidents resulting in No Harm	D	61	75	84	74	54	51	92	65	50	64	56	29	38		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	11	21	35	28	19	11	20	10	14	8	9	4	8		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)		18	17	23	17	9	9	10	8	12	18	13	5	6		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%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		0														No Threshold
CCNS: Prescriptions		0														No Threshold

CARING

		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	Last 12 Months	RAG
Complaints	W	5	4	3	1	0	8	0	3	4	2	2	3	7		No Threshold
PALS	W	14	39	41	40	50	55	39	34	62	51	48	25	32		No Threshold

EFFECTIVE

		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	Last 12 Months	RAG
Referrals Received (Total)		776	884	1,107	911	1,318	1,324	1,061	728	1,021	1,116	1,226	1,041	1,081		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice		7	10	7	11	5	9	21	22	17	25	41	17	12		No Threshold
OP Appointments Cancelled by Hospital %		12.7%	9.9%	12.4%	11.7%	9.0%	10.4%	12.0%	13.7%	10.8%	15.0%	8.8%	12.1%	11.9%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	8.9%	10.2%	13.5%	12.7%	14.0%	10.3%	15.5%	10.2%	13.9%	15.8%	15.1%	13.1%	19.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	12.2%	10.8%	12.8%	13.6%	13.0%	12.1%	15.2%	15.4%	13.0%	12.5%	13.9%	13.0%	15.7%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		10.5%	15.2%	17.5%	16.7%	17.7%	13.3%	18.4%	14.7%	16.8%	14.6%	15.9%	16.2%	20.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		17.6%	14.4%	17.6%	17.3%	16.9%	18.5%	21.9%	24.3%	24.0%	20.2%	20.2%	17.8%	27.7%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS		20.3%	11.5%	15.1%	6.9%	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%	18.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS		11.9%	10.8%	12.7%	14.0%	13.3%	12.0%	15.8%	15.3%	10.9%	12.1%	13.9%	14.0%	13.3%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		110.1%	106.6%	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%		No Threshold
CAMHS: Tier 4 DJU Bed Days		238	210	248	239	248	237	217	216	214	267	217	198	219		No Threshold
Coding average comorbidities		3.00		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

		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	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU			1		1					1	1	1		4		No Threshold
CAMHS: Referrals Received		268	351	469	396	536	638	374	297	475	526	567	433	532		No Threshold
CAMHS: Referrals Accepted By The Service		158	182	251	196	254	316	173	141	233	302	308	219	272		No Threshold

Community

D Drive W Watch P Programme

		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	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service		59.0%	51.9%	53.5%	49.5%	47.4%	49.5%	46.3%	47.5%	49.1%	57.4%	54.3%	50.6%	51.1%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	W	66.2%	64.5%	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%		>=92 % >=90 % <90 %
Waiting List Size	W	785	911	911	828	765	808	971	1,147	1,208	1,530	1,629	1,563	1,576		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	0	0	0	3	0	1	2	2	1	1	1	1	1		0 N/A >0
CAMHS: Crisis / Duty Call Activity		657	805	807	744	757	717	573	367	674	563	766	629	687		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	W	65.9%	67.9%	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%		>=92 % >=90 % <88 %
ASD: Completed Pathways		101	98	110	106	143	129	85	223	39	58	68	52	71		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		68.3%	76.5%	67.3%	24.5%	23.8%	15.5%	8.2%	4.5%	12.8%	6.9%	4.4%	9.6%	8.5%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)	P			46.2%	16.7%	23.5%	28.6%	6.7%	21.4%	10.5%	23.8%	21.7%	25.0%	16.7%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)	P			100.0%	100.0%	25.0%	100.0%	50.0%	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	W	119	139	169	120	135	150	582	144	143	165	168	177	150		No Threshold
CCNS: Number of Contacts	D	783	826	896	791	821	835	959	809	736	931	959	951	740		No Threshold

WELL LED

		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	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	321	221	-41	14	212	-11	287	250	540	16	60	185	346		
Income In Month Variance (£'000s)	W	148	996	150	94	88	50	154	75	118	-78	59	118	-112		
Pay In Month Variance (£'000s)	W	65	-81	137	5	-49	-87	260	167	15	142	319	-9	248		
AvP: OP New		643.00	521.00	614.00	113.50	350.95	652.00	-103.00	-2.30	-114.00	593.00	662.00	535.00	522.00		>=0 N/A <0
AvP: OP FollowUp		3,815.00	3,795.00	4,123.00	1,446.90	1,416.84	4,230.00	1,014.00	688.30	1,238.00	3,426.00	4,154.00	3,401.00	3,588.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W	4,460	4,316	4,737	1,561	1,768	4,882	911	686	1,125	4,019	4,822	3,950	4,123		>=0 N/A <0
PDR	W	83.1%	83.1%	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%		
Medical Appraisal	W	100.0%	100.0%	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%		
Mandatory Training	W	89.2%	88.6%	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%		>=90 % >=80 % <80 %
Sickness	D	5.7%	4.7%	3.9%	3.1%	3.9%	4.9%	5.6%	6.4%	5.8%	5.9%	5.5%	5.8%	6.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.9%	1.0%	1.0%	0.9%	1.2%	1.5%	1.4%	1.5%	1.5%	2.1%	1.7%	1.8%	2.5%		<=1 % N/A >1 %
Long Term Sickness	D	3.8%	3.7%	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%	4.3%	3.8%	3.7%	4.1%	3.7%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	226	169	141	183	192	229	171	127	168	192	166	273	168		
Staff Turnover	D	9.3%	9.5%	9.8%	10.7%	9.6%	9.8%	9.8%	9.9%	10.1%	10.9%	12.1%	11.1%	10.5%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.9%	99.4%	100.2%	97.2%	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • All current risks compliant with review dates • CRF working at Gold accreditation on the perfect ward inspection, action plan being reviewed. • CRD division working to Trust covid 19 guidance and has reverted back to safety measures with reduced footfall. • All Incidents reported onto Ulysses system and thematic reviews conducted periodically. • Trust metrics discussed at monthly 121's with staff to encourage compliance. • PDR metric will improve within next PDR window • Incidents increased due to positive Covid Cases.	**Highlight** • Mandatory Training > 90% • GCP training 97% • SOP compliance 99% • ANTT compliance 100% • CRD ICP compliant • CRD presented at performance meetings **Challenges** • PDR Target of has reduced to under TT due to an increase in leavers • Out of hours research blood samples for oncology trials • 9 incidents reported in month (8 Covid related)
CARING	• 0 complaints received • Patient centred follow up care for patients on clinical trials • Patient feedback used to improve quality of patient care and experience • Plans underway to capture patient experience data • Patient compliments received for CRF • Work is underway to retrieve R&D metrics for PALS and complaints separately from corporate data.	**Highlight** • X 0 Complaints or PALS concerns • Collaborative working with local services and teams are being established • Research participating in Trust PEG. • Research attended CYP forum (regular invite established) • Research Patient stories included on agenda **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system. • Compliments to be added to Ulysses as standard practice.
EFFECTIVE	• Studies stratified and selected based on best possible outcomes for children and young people. • Current portfolio planned for detailed review re study performance to utilise capacity and resource more effectively. • Clinicians encourage children and young people to make informed decisions about participating in studies. • Essential skills training commenced in month with excellent feedback from staff	**Highlight** • Important Covid 19 studies remain open within Trust AH one of chosen sites nationally to continue with UPH studies (Recovery) • Trust participating in extension COV09 vaccine study with LSTM. • AH sponsoring flagship Asymptomatic Study • Stop RSV trial. (one of two national sites) now actively recruiting. • Portfolio growth in line with plan. **Challenges** • CRD working with local system partners to improve research participation. • Significant issues with recruitment process has delayed backfilling a number of vacancies affecting timely opening of new studies • RSV recruitment has been affected through HR recruitment challenges.

RESPONSIVE	• All Staff Risk Assessments completed as required • New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • Coordinated and partnership working with local providers to offer joint training programmes. • Targeted training TBA for new managers in the department for risk reporting.	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners continues • TNA requests for CPD training approved for all applicants • Engagement with staff in utilising team fund. Staff requests have been mobilised. **Challenges** • Storage for site files and equipment is insufficient for research department • Research team supporting Trust seasonal vaccine programme
WELL LED	• Staff are supported through line managers and staff support. • Thematic review has been completed for reasons of sickness (non-work related) • LTS numbers rose above Trust Target in month but are now reducing • Engagement with partners in relation to upcoming starting well initiatives. • Service Re-organisation undergoing data collection for audit and review • A new bid submitted to NWC CRN to establish a community outreach team within the division • Internal staff survey completed in January. Results will be discussed at March team brief	**Highlight** • Division supporting staff with Flexible working (hybrid model) • CRD engaging staff with SALS • Commercial Funding envelope being reviewed • CRN 21/22 forecast stable in Q3 • Funding secured for support services totalling £60k • Core business hours established through recent service re-org (audit ongoing) **Challenges** • Correct model for the future working to be established • Some staff will experience changes to working patterns period of adjustment needed • Recruitment and retention being monitored carefully due to increase in leavers • F2F exit interviews established with leavers with key questions focussed on retention • Some staff who have recently returned to work are completing phased return which reduces capacity • Increase in SSS and SI in January due to covid 19 cases in line with Trust data.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

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

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

1. Purpose

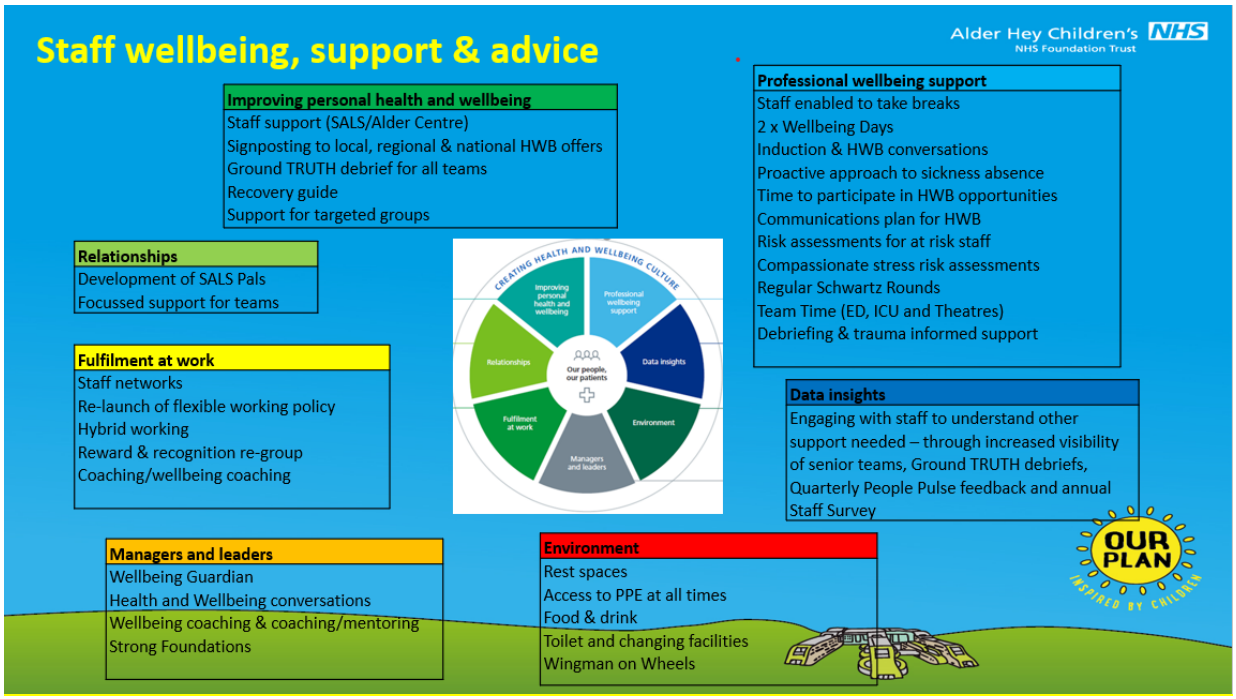
The purpose of this paper is to provide the Board with a strategic update on the Alder Hey People Plan and our response to the requirements of the national NHS People Promise.

2 Wellbeing

2.1 Winter Wellbeing Plan

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:



Since the last report, progress continues in the development of the SALS Pals project with a funding bid approved from NHSE/I to implement and evaluate a year-long pilot embedding SALS Pals in Theatres, Wards, a Community service and continuing to embed the role in ED. We have submitted a further bid to NHSE/I to develop a digital version of the Ground TRUTH tool and are awaiting feedback. In the meantime, interviews are being held this week for an Assistant Psychologist who can support the implementation of the tool in high pressure areas as part of the Winter Wellbeing plan.

The Ground TRUTH continues to be used across the Trust and main themes are fed back to the Executive team monthly via a dedicated Ground TRUTH slot. The tool is also being offered to the Executive team to enable them to build and monitor their own adaptive resilience at this challenging time. We are in the process of developing a communications plan for Ground TRUTH so that themes can be fed back to the organisation via a monthly Ground TRUTH Bulletin and slot on the briefings.

In terms of organisational support, there has been a significant rise in demand through SALS and OD for support for teams as per the last report, but also an increased demand for facilitated conversations where there has been conflict or breakdown in working relationships. We are understanding this rise

Our support for leaders and leadership development continues through the Strong Foundations leadership programme, and our internal coaching and mentoring framework. Strong Foundations is currently running cohorts 15 to 20 and is fully booked until May this year. Feedback about the programme continues to be exceptionally positive and attendance has been over 90% in every group despite the pressures and challenges over this winter period. Below is a brief snapshot of leadership activity over 2021:

Leadership development activity Jan – Dec 2021

Programmes	Numbers completed	Notes
Strong Foundations	184 leaders/managers	From January – December 2021. 11 cohorts have completed and 2 had commenced during Dec 2021 due to finish in Feb 2022.
Coaching/Mentoring	32 members of staff have accessed 162 hours of coaching	We now have 22 trained coaches at Alder Hey offering wellbeing coaching, performance/general coaching, mentoring, Snr manager/exec coaching.
Leadership & Management Apprenticeships	13 completed and 15 on-going	The management and leadership apprenticeships range from Team Leader L2 to Senior Leader Master's Degree L7,
Mary Seacole (Local In-house)	23 starts 4 completed	The Mary Seacole Programme was placed on hold during 2020-2021 due to covid resulting in most of the candidates not feeling able to complete
NW Leadership academy Short Courses	41 candidates	The numbers refer to staff accessing short courses (1-3) days across a variety of Leadership subjects
National Leadership academy programmes	11	Latest updated information from the Academy was Sept 2021, the only programmes accessed during 2021 were Edward Jenner 1 & 2. From March 17th 2020 National Programmes stopped except for Seacole Local. Applications for Rosalind Franklin have recently reopened

2.2 Staff Support

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 not 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. SALS has been working with the Alder Centre over the past month to contact all staff on the waiting list for counselling to offer an additional triage with SALS and faster access to psychological intervention where indicated. There has been a communication to the organisation regarding this change with FAQs and clear guidance on how staff can access support from 1st February with the rationale for the change.

SALS remains very busy. In January, the service received 250 contacts (compared to 199 in December). Of those contacts, 200 were unplanned, that is staff presenting with urgent issues, high levels of distress or crisis. Of all contacts, 57 were from Nursing staff, 44 of those contacts from Admin & Clerical, 14 were from Medics, and 18 contacts were from Additional Health Services. Medicine had the highest number of contacts (65), followed by Community (40), then Surgery (39), and then Corporate (11). All new contacts were responded to within 24 hours.

The main presenting issues were as follows:

Stress, Anxiety (both work and home)
Vaccinations
Relationships/Teams, workplace stress
Physical illness – Long covid/Cancers
Trauma
Domestic Abuse
Requests for Counselling (in line with new process)

Feedback data from 96 staff members indicates that the service is well received and having a positive impact, as illustrated in the data below:

11. Did we resolve your query, or signpost you to the right place?

More Details Insights

Yes	90
No	2
Not sure	4

13. How do you feel now?

More Details Insights

I feel good	24
I feel better than I did before I...	70
I feel just the same	2
I feel no better	0

15. Would you recommend us to your colleagues or friends in Alder Hey?

More Details Insights

Yes	96
No	0

2.3 Health Wellbeing Steering Group

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

- 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

There are a number of separate task and finish groups currently reporting into the HWB Steering group including: a group looking at financial support for staff (particularly in light of the imminent cost of living rises); an Induction group; and a group progressing the Stress Risk Assessor project being funded by NHSE/I.

3 Staff Engagement

3.1 Staff Survey 2021 & Quarterly People Pulse

The annual Staff Survey closed on the 26th November 2021. The final response rate for Alder Hey was 52% which is a significant achievement in the current circumstances and places us above average in our sector (Acute and Acute & Community) for total response rates. The average national response rate was 45%.

The official publication date for the national 2021 NHS Staff Survey results has not yet been confirmed in part due to the significant changes to last year's survey detailed in the last report. However, we have now received our Summary and Full reports from our Survey provider and we expect to receive our local benchmark report and optional directorate report under embargo by no later than **6pm on Thursday 24th February**. Please see the separate Staff Survey update paper for more details and a summary of the Trust levels results.

As regards the Quarterly People Pulse, we have now completed Q4 of our data collection (the Pulse was open for the month of January) and expect the results to be available in mid-February.

4 Equality, Diversity & Inclusion

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

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

5 Staff Availability

Table 5.1- Sickness position as of 7th January 2022

	Trust		Community		Corporate		Medicine		Research		Surgery	
Reason	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff	%	No of Staff
Non Covid Related Sickness	5.55%	227	5.85%	44	6.75%	51	5.02%	61	10.29%	7	4.92%	64
Covid Related Sickness	1.37%	56	0.40%	3	0.66%	5	2.14%	26	0.00%	0	1.69%	22
Absence Related to Covid - not inc sickness	0.51%	21	0.53%	4	0.26%	2	0.25%	3	0.00%	0	0.92%	12
Absence Related to Covid Inc Sickness	1.88%	77	0.93%	7	0.93%	7	2.39%	29	0.00%	0	2.61%	34
All Absence (total of above)	7.43%	304	6.78%	51	7.67%	58	7.41%	90	10.29%	7	7.53%	98

Sickness absence as of 7th January (7.43%), has seen a steady reduction since the last reporting period. Sickness absence was reported at 9.34 % in the last reporting period and was 12.5% beginning of Jan 2022. The number of staff with covid related sickness absence has almost halved, with 56 staff currently absent with covid related symptoms, compared to the previous reporting period, with 100 staff absent with covid related symptoms. The general sickness absence position is also on a downward trajectory, with the current position at 5.55% compared to 5.62% last month.

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 to the Trust operational/tactical command and twice weekly to Trust Gold command.

6. Vaccination as a condition of Deployment

The Government passed legislation requiring vaccination as a condition of deployment which was due to come in from 1 April 2022. However, on 31st January 2022 the Secretary of State announced that this is being reconsidered. The Government's decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation, it is however expected that the decision will be reversed.

As a result of this announcement HSE/I has written to NHS employers requesting that Trusts do not serve notice of termination to employees affected by the VCOD regulations. Alder Hey had not issued letters of notice at this point and all activity related to VCOD has been placed on hold, with the expectation that the Government consultation announced, will confirm the expectation and news reports that the VCOD decision will be reversed.

7. 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 7.11- Employee Relations Activity and Stage 3 Sickness Management Per Division as of the 8th February 2022

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery H/C 1326	1	4	1	0	1	1	5	**13**
Medicine H/C 1223	1	2	0	0	0	0	3	**6**
Community H/C 687	0	0	1	0	0	1	3	**5**
Corporate & Research H/C 695/65	0	2	1	0	0	0	2	**5**
Grand Total	**2**	**8**	**3**	**0**	**1**	**2**	**13**	**29**

8. Training

As of the 7th of February 2022, 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 concern remain 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 stayed 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, the Health & Safety team were without a designated trainer for Moving & Handling level 2 for a large portion of the year, they have now appointed someone to this role and we have arranged 6 days of workshops for staff to attend with 116 staff currently booked on.

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

Table 8.1- Mandatory Training compliance – 7th February 2022

Trust	Overall Mandatory Training	Change (Since Last Report)
Trust	87.89%	+0.47%
Division	**Overall Mandatory Training**	**Change (Since Last Report)**
411 Alder Hey in the Park	84.38%	-3.06%
411 Capital	63.64%	+0.00%
411 Community	91.74%	+0.26%
411 Corporate Other Department	81.46%	-1.00%
411 Executive	92.69%	-5.11%
411 Facilities	76.40%	+2.35%
411 Finance	86.64%	-2.37%
411 Human Resources	92.42%	-0.58%
411 IM&T	86.37%	+2.05%
411 Innovation	84.43%	+9.77%
411 Medicine	86.73%	+0.34%
411 Nursing & Quality	88.55%	-1.23%
411 Research & Development	91.87%	-0.78%
411 Surgery	88.27%	+0.64%

Table 8.2 – PDR Compliance as of 31st January 2022

As of the 31st of January 2022, our Trust appraisal rate was 72.47%, 18% lower than our target of 90%. The 2021 PDR window has now closed but we will continue to provide an update throughout the year. The figures below will continue to flux as staff move around the organisation.

Org L2	Reviews Completed %
411 Alder Hey in the Park L2	60.00
411 Capital L2	100.00
411 Community L2	82.96
411 Corporate Other Department L2	64.00
411 Executive L2	42.86
411 Facilities L2	71.28
411 Finance L2	92.00
411 Human Resources L2	78.43
411 IM&T L2	82.86
411 Innovation L2	80.00
411 Medicine L2	74.48
411 Nursing & Quality L2	86.96
411 Research & Development L2	80.65
411 Surgical Care L2	61.40
Grand Total	72.47

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	**Leader Standard Work - Supporting Performance and Improvement**
Report of:	Director of Corporate Affairs
Paper Prepared by:	Associate Chief Operating Officer – Improvement and Planning

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

NHS
Alder Hey Children's
NHS Foundation Trust

BRILLIANT BASICS

Standard Work -

Supporting Performance and Improvement

Contents

Listen Focus Be informed Empower Challenge Data driven Adapt Vision

1.0 Background

In the context of the drive during the last two years towards "reducing the burden of reporting" it has been identified by Executives and senior leaders that a lot of their effort is focussed on firefighting and there is not enough time to focus on the strategic, long term outlook of the organisation. The pandemic has also significantly affected the way in which meetings are now managed and diarised, with use of MS Teams.

Given the ambition contained within the Trust's strategy and "2030 Vision", it is imperative that we utilise the Brilliant Basics approach to review and change how we work in order to support prioritisation of workload and ultimately free up time of senior leaders, to "focus on what matters" most at Alder Hey.

"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. It is important that the Non-Executive Directors are briefed about the proposals and have an opportunity to comment as part of a whole Board discussion before moving to the implementation phase.

This paper provides a summary of the full document which was presented to the Executive team on 3rd February 2022.

2.0 Scope

Leadership Behaviours and Standard Work is a broad area, but the following points should be noted:

- The phrase "focus on what matters" inherently includes regulatory obligations, risk profile/appetite and the Trust's strategic objectives. Further detail and definition may warrant Board discussion to ensure clarity and agreement.
- This paper works in collaboration with the Trust's "governance lite" agenda.

3.0 Reason for Action

An "A3 thinking" model has been used (see Appendix A) to understand the current problems and issues, using data (eg from diary exercise) and feedback from Executives and senior managers. The following "reasons for action" were identified as part of "understanding the current situation" within box 2 of the A3 thinking process:

- Insufficient time for priorities:
  - Too many meetings; too long (often >2 hours) with loss of productivity; often with "overloaded" attendance.
  - Back-to-back meetings throughout whole day(s) do not give opportunity to take breaks during the day and insufficient time for planning or reflection.
- Imbalance in frequency of meetings:
  - Too many weekly meetings which is unsustainable, does not differentiate priorities.
  - No daily routines for Executives to monitor day to day performance and safety issues.
- Performance Review Meetings (PRM):
  - Bi-monthly PRM for Divisions is extremely broad and can lack focus on key priorities.
  - In contrast, corporate functions do not have a Performance Review so key metrics under "Well Led" (eg mandatory training, absence rates) are not reported to Executive team in the same way as Divisional KPI's.
- An unsustainable number of priorities and projects requiring Executive oversight.
- Unbalanced time and attention given to each Strategic Objective.

- Inconsistent approaches and lack of standardised practice, including gaps in regular monitoring of agreed driver metrics for each strategic objective.
- Inconsistent approach to reporting, with multiple formats
- Too much reactive firefighting, including multiple requests for "deep dives" which do not always align to previous agreements of priorities or strategic objectives.

4.0 Recommendations for New Routines

The following recommendations are the solutions that were co-designed to address the root cause of the "reasons for action" and enable the team to reach the goals as set out in box 3. A total of 20 recommendations were identified (see Appendix B).

These will also enable the organisation as a whole to focus its energy on projects that matter and shift from traditional oversight of 'mile wide inch deep' to new approach of 'inch wide mile deep'.

The recommendations can be summarised into the following themes:

- Create space in diaries with protected break times and allocated time for establishing leadership behaviours such as planning and reflection.
- Change length and frequency of meetings, with addition of daily touch points and reducing weekly-to-monthly and monthly-to-quarterly as appropriate.
- Review required attendance, rationalise, "buddy", or delegate attendance as appropriate.
- Reduce the breadth and scope of projects under executive oversight and being reported to strategic executive meetings.
- Introduce rotational agendas, ensuring equal coverage of all strategic objectives, with consistent approach to using high level metrics to show improvement over time.
- Implementation of Business Rules for meetings and routines for a standard approach which will improve efficiency. This includes using the principle of Drive and Watch metrics to support pro-active performance management and reduce firefighting

5.0 Benefits of New Routines

By implementing these recommendations, the Executive team will:

- Create more time in their diaries by overall reduction in meetings.
- Ensure greater focus on what matters, with equal time allocated to all strategic objectives.
- Introduce daily rhythm with executive touchpoint on safety and operational issues.
- Implement a more effective approach to Performance Review Meeting, with greater focus in Divisional PRMs and introducing oversight of key "Well Led" metrics in corporate functions.
- Enable a targeted communication strategy as fewer areas of focus, less priorities but all are delivering the strategic objectives directly.
- Introduce more consistent performance monitoring using metrics / evidence to demonstrate improvement over time.
- Bring in a standardised reporting format to eliminate unnecessary/ non-value-added information and reduce wasted time adjusted to each project lead's personal style. Enables Executives to know exactly what is required from them in terms of decisions / assurance / discussion and feedback.
- Use A3 Summary Progress Reports to shows actual progress and key issues / risks, with clearly articulated actions and facilitate efficient discussions through focused data and succinct information that will add value to the Executives and project leads.
- Reinforce clear timeframes for papers to be circulated and read in advance which releases more time in meetings for discussion of key points, moving away from reliance on slide decks. This is a more efficient use of time, produces greater productivity with focus on the key points in each report.

- Use Driver and Watch metrics to enables greater breadth of performance oversight and assurance. This supports prioritisation, with greater focus on what matters through agreed priorities and focus on Driver metrics.
- Place greater emphasis on trajectory over time (pro-active management), rather than focus on most recent reporting period which when seen in isolation can potentially mislead the view of actual performance (leading to reactive response).

6.0 Our Commitments and Aims

A full paper on standard work was discussed by the Executive team on 3rd February 2022. Consideration was given to all 20 recommendations and there was broad acceptance that these new routines would help to create time and space to focus on Strategic Objectives.

There were some minor amendments put forward and discussion about phased implementation to ensure that the changes are effective. It was also agreed that some recommendations should be "commitments" with strict implementation, and other recommendations should be "aims" as agreed in principle but recognise some local and individual flexibility.

6.1 Commitments – to be applied to the whole Trust

- No "corporate" / management meetings between 12.30-13.30 every day.
- No corporate meetings to start before 8am or finish after 5pm. (This reflects the established "out of hours" time associated with management on-call rotas, but it is noted that individual flexible working arrangements may vary, for example starting at 9am or finishing by 4pm).
- Pro-actively focus on fewer, clearly agreed priorities.
  - Use drive and watch metrics to differentiate between priorities and support pro-active performance routines.
  - Implement business rules to support this focus and restrict reactive requests.
- Improved "meeting hygiene": including papers circulated in advance, allowing meeting time to be used for discussion of key points (rather than presentation/explanation of papers) and adherence to start and finish times.
- Standard formats for reporting, depending on purpose of the report:
  - For decision / investment: Full written paper
  - For assurance / performance monitoring: A3 Summary Progress Report
  - For discussion / information: Written paper or presentation (slides).
  - For Improvement Projects: Use A3 Improvement Plan template

6.2 Commitments – for Executive team and senior leaders

- Convert Daily Operational Update into an Executive-led Daily Safety Briefing.
- Refresh Performance Reviews – quarterly (not bi-monthly) and add corporate teams.
- Standard rotational agenda for Strategic Execs, with equal coverage to all strategic. objectives, and use of scorecard to ensure metrics reviewed once per month for each strategic priority.
- Find time for ½ hour reflection each week:
  - What have I learned from children and young people this week?
  - What have I learned from colleagues and staff this week?
  - What could I do differently to be even more effective?
  - What have I/we achieved this week, and how can we celebrate these successes?

6.3 Our aims (agreed principles, but recognise local and individual flexibility)

- Reduce length and frequency of meetings:
  - Aim for duration to last no more than 2 hours
  - Consider reducing frequency of recurrent meetings (eg could weekly meetings become bi-weekly or monthly)

- Review attendance at meetings – giving consideration to essential attendance, "buddy arrangements", and/or delegate attendance.
- Each Executive director to clear their diaries for ½ day each week

7.0 Conclusion

A summary of the benefits to adopting the recommendations throughout this document and shown in box 5 of the A3 thinking document, and include:

- Finding time to focus on what matters
- Prioritising projects for executive input and oversight
- Extending the assurance and reviewing capability of the Executives
- Enabling the Executives some team time to plan and reflect
- Enabling a focussed, consistent approach and structure to all Executive meetings
- Facilitating equal focus across all the Strategic objectives
- Enabling project leads to have a consistent approach to reporting progress, celebrating success and asking for help.

8.0 Next Steps and Actions

A full action plan, relating to each of the 20 recommendations, has been produced and a Gantt chart included in box 6 of the A3 thinking document. A summary of the immediate next steps includes:

- Initial actions to be implemented with effect from 1st April 2022, utilising March as a transitional month to communicate and explain changes to routines.
- Working group session with Executive Assistants to empower this key group of staff to implement changes in diary management and meeting hygiene (eg set schedules for papers to be circulated in advance).
- Work with Communications teams to cascade the commitments for the whole Trust, with message to recognise how busy everyone is and taking actions to "make more time".
- Establish rotational agenda for weekly Executive meetings (with CEO EA).
- Confirm arrangements for executive coaching sessions and diarise weekly reflection time.
- Develop clear plan for converting current Daily Operational Update into an exec-led Daily Safety Briefing.

NHS Alder Hey Children's NHS Foundation Trust

APPENDIX A – A3 Thinking (in progress) for Standard Work to Support Exec Routines

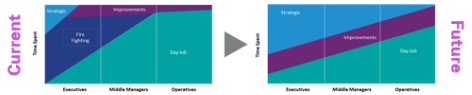
BRILLIANT BASICS

Title: Leader Standard Work to Support Exec Routines
Exec lead: Erica Saunders
Operational lead: Andy McColl and Chloe Ashford-Smith

NHS Alder Hey Children's NHS Foundation Trust

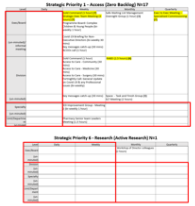
1. Problem Statement

There is inconsistent and insufficient time to 'focus on what matters'
Brilliant basics is a strategic initiative to enable the execs to focus on what matters, reduce Trust dependency on their 'firefighting' skills and supports development of a continuous improvement, problem solving culture driven by a set of strategic objectives that are cascaded through the Trust. There is no standard practice for the execs to support their new approach to an OMS

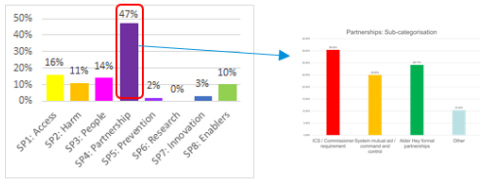


2. Current Situation

Method:
Mapped 6 Exec diaries over 6 weeks by looking at all meetings associated with the Strategic Priorities - purpose of meetings, frequency and level of staff involvement.
The analysis revealed the following findings:



Findings:
- **3** hours for strategic execs each week –all
- **7** execs attend SQAC; Audit and risk committee
- **0** daily meetings which take place to support to Strategic Priorities
- Few meetings with frontline and specialties across the Strategic Priorities
- Limited coverage on Research, Innovation and Prevention
- Nearly **50%** of all meetings fall under Partnerships



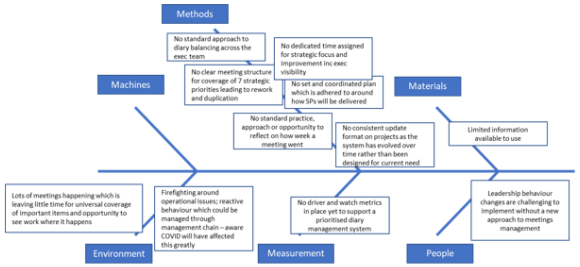
- Inconsistent approach to exec receiving project updates - not always clear what this ask is and therefore challenging to coach the presenters
- Min **43** projects with exec oversight over the 2 month period
- No clearly defined link between projects and strategic priorities
- Deep dives are regular part of the agenda – the new OMS would remove the need for these on a routine basis

3. Vision/Goals

Opportunity/ vision – To have balanced diary commitments in order to support strategic performance and improvement objectives of the Trust
- To shift from reactive to proactive response to problems
- To develop our staff to solve their own issues and not come to us every time, investing time in the leaders of the future
- To incorporate reflection time and daily safety huddles within the Exec standard work
- Find more time for exec visibility

4. Analysis (Issues and Root Cause) Key root cause themes:

1. Methods: Lack of standard methods for diary alignment, project updates and balance across the 7 strategic priorities because the current position has evolved over time rather than been designed for todays requirements - Gap
2. Environment: Firefighting and operational pressure – COVID and Winter - Challenges
3. People: Everything appears to be priority which increases the reliance on execs firefighting skills and draws them away for the scorecard system (driver and watch), limited opportunity to utilise new leadership behaviours within the current non standard structure - Behaviours



Note: There is need for wide scale project assurance as no other system in place to enable this or escalation – *the new OMS will enable this using the strategic planning framework and filter – ongoing with Dani therefore our of scope here*

5. Opportunities, Change ideas and associated metrics

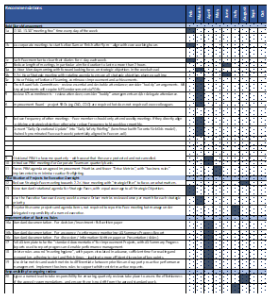
- Finding time to focus on what matters
- Prioritising projects for exec input and oversight
- Extending the assurance and reviewing capability of the execs
- Enabling the Execs some team time to plan and reflect
- Enabling a focussed, consistent approach and structure to all exec meetings
- Facilitating equal focus across all the Strategic objectives
- Enabling project leads to have a consistent approach to reporting progress, celebrating success and asking for help

6. High Level implementation plan

20 recommendations across 3 categories agreed to be implemented by the Executive team Jan 2022
1. Bold diary management
2. Prioritisation of projects for executive oversight
3. Implementation of business rules

Implementation team:
- **Exec Lead**: Erica Saunders
- **Operational lead**: Andy McColl
- **Implementation start date**: March 2022
- **End of 1st phase & review of performance**: June 2022

Programme plan in place in the form of an action based gantt chart to show progress against plan



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7. Performance tracking

Programme plan in place in the form of an action based gantt chart to show progress against plan

8. Learning and what next

- *Reflection and learning is important*
- *If successful/unsuccessful – what more can be done?*
- *What did we learn?*
- *What next?*

APPENDIX B – Consolidated Table of full recommendations inclusive of the logic and link to Brilliant Basics principles

Reason for Action	Recommendation	Brilliant Basics Principle
Bold Diary Management		
Insufficient time for priorities, and too many meetings.	1. Implement time with no "Corporate" Meetings: a. 12.30-13.30 "meeting-free" time every day of the week b. No corporate meetings to start before 8am or finish after 5pm – agree and align with core working hours c. Each Exec member to clear their diaries for ½ day each week. 2. Reduce length of meetings, in particular aim for duration to last no more than 2 hours. This is consistent with "Governance Lite" model and will maintain productivity over a shorter time. 3. Reduce time allocated for Exec meetings from 4½ hours down towards 3 hours per week: a. ½ Hour Monday morning with forward looking focus on strategic objectives in the week ahead b. 2-2½ Hour Strategic meeting with rotating agenda to ensure all strategic objectives given equal time c. ½ Hour Friday morning reflection of learning, continuous improvement and achievements. Include weekly feedback from CYP/Families and from frontline staff. Once a month this time can be used for team coaching sessions. 4. Trust Board Sub-Committees – review essential and desirable attendance; consider "buddy" arrangements (eg 1 of Medical Director or Chief Nurse). NB Any adjustments will require NED endorsement via TORs. 5. Review ICS commitments – review attendees and either "buddy" with exec colleagues and/or delegate attendance. 6. Improvement Board – project SROs (eg CNO, COO) are required but does not require all exec colleagues to be present.	Leadership Behaviours Wellbeing / Protected Breaks Leadership Behaviours Strategy into Action Focus on what matters Leadership Behaviours CYP Voice / Frontline staff Leadership Behaviours Focus on what matters
Imbalance in frequency of meetings: - Too many weekly meetings. - No daily routines for Execs to monitor day to day performance and safety issues.	7. Reduce frequency of other meetings – Exec members should only attend weekly meetings if they directly align to driving a strategic objective; otherwise reduce frequency to bi-weekly or monthly. 8. Convert "Daily Operational Update" into "Daily Safety Briefing" (benchmark with Toronto Sick Kids model): • Chaired by nominated Exec each week (potentially aligned to Exec on-call) • Amend agenda for greater focus on Safety • 1 Page briefing completed each day and circulate to Exec team, or potentially to wider audience across Trust (completed by PA of Exec oncall). • Time allocated at weekly exec meeting to update on key operational and safety issues from these daily calls.	Focus on what matters Data Driven

Frequency of Performance Review Meetings: – Divisional PRM often cancelled or postponed	9. Divisional PRM to become quarterly – reducing frequency from 6 to 4 per year, but with caveat that these are protected and not cancelled. This will give appropriate timeframe to see performance trends. 10. Introduce PRM meetings for Corporate Teams on quarterly basis (with time created for these by reducing frequency of Divisional PRMs). 11. Focus PRM agenda on agreed Improvement Priorities (reported using A3 Summary Progress Report template) and fewer "Drive Metrics". Implement "business rules" with regard to watch and drive metrics (ref recommendation 19) to minimise reactive firefighting.	Strategy into Action Strategy into Action Focus on what matters Data Driven
Prioritisation of Projects for Executive Oversight		
An unsustainable number of priorities and projects with Executive oversight. Unbalanced time and attention given to each Strategic Objective	12. Reduce Strategic Exec meeting towards 2-2½ Hour meeting with "strategic filter" to focus on what matters. 13. New standard rotational agenda for Strategic Execs a. Week 1: Outstanding Care (Safety; Access) b. Week 2: Outstanding People; Collaboration (Inequalities; Prevention; Partnership) c. Week 3: Pioneering (REI; Digital); Sustainability (Finance; Green) d. Week 4: Trust Board. 14. Use the Executive Scorecard every week (for themes on agenda) to ensure Driver metrics reviewed once per month for each strategic priority. 15. Deprioritise some projects and agenda items, not required to report to Exec meeting but manage under delegated responsibility of a named executive.	Leadership Behaviours Strategy into Action Focus on what matters Data Driven Focus on what matters
Implementation of "Business Rules"		
Inconsistent approach to Reporting	16. Introduce standard formats, depending on the purpose of the report a. For decision / investment: Full written paper b. For assurance / performance monitoring: A3 Summary Progress Report c. For discussion / information: Written paper or Presentation (slides). 17. Full A3 template to be the "standard documentation" for Improvement Projects, with A3 Summary Progress Reports used to report progress and enable performance management. 18. Stricter rules around "meeting hygiene", with papers circulated in advance, sufficient time for reading and preparation, adhering to start and finish times – leading to more efficient discussion of key points.	Leadership Behaviours Challenge Assumptions Focus on what matters Leadership Behaviours
Too much reactive firefighting	19. Use drive metrics and watch metrics to differentiate between priorities and support pro-active performance management. Implement business rules which restrict re-active requests and "deep dives" for watch metrics, with process for formal escalation to "Drive" which includes development of A3 Improvement Plan.	Focus on what matters Data Driven
Responsibility for ongoing review		
Exec Ownership	20. Agree a named lead to take responsibility for ensuring quarterly reviews take place to assess the effectiveness of the agreed recommendations, and ensure there is no drift from the agreed standard work.	Leadership Behaviours

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 24th February 2022

Paper Title:	**2022 Review of Risk Appetite Statement and Proposed Risk Tolerances**
Report of:	Director of Corporate Affairs
Paper Prepared by:	Governance Manager Director of Corporate Affairs Associate Director of Nursing and Governance

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

1. Purpose and Context

The Good Governance Institute's (GGI) guidance for boards states that 'Risk appetite, defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take' in pursuit of its strategic objectives, is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change inevitably brings, and therefore should be at the heart of an organisation's risk management strategy – and indeed its overarching strategy.'

Risk tolerance is different to risk appetite in that it reflects the boundaries within which the board is willing to allow the true day-to-day risk profile of the organisation to fluctuate while the senior team are executing strategic objectives in accordance with the board's strategy and risk appetite. Risk tolerance is assessed using the Trust's risk grading scores of impact x likelihood.

The purpose of a Risk Appetite Statement is to articulate what risks the Board is willing or unwilling to take to achieve the Trust's Strategic Objectives. Risk appetite is a matter of judgment based on each organisation's specific circumstances and objectives. There is no on-size-fits-all solution. As a healthcare provider several factors will influence the Trust's level of risk appetite and will include consideration of all major areas of the Trust's work: compliance and regulation, finances and reputation, quality and innovation, wellbeing of staff and the safety and care of patients, plus increasingly the external environment including strategic partnerships.

The Board recognises that it is neither possible nor desirable to eliminate all the risks which are inherent in the delivery of healthcare and is willing to accept a certain degree of risk where it is considered to be in the best interest of patients and to achieve its strategic objectives.

2. Rationale for a Risk Appetite approach

It is good practice to review the Risk Appetite Statement on an annual basis and/or following any significant changes or events.

Alder Hey's draft risk appetite statement was presented to the Board in March 2021 setting out the proposed risk appetite for the Trust. The review for 2022 serves both to aid an assessment as to whether any changes to appetite levels are required to support decision making, particularly in the context of the Covid-19 pandemic; and to overlay the suggested risk appetite with associated risk tolerance thresholds.

3. Background and best practice

The UK Corporate Governance Code states that '**the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'**. This means that at least once a year, the Board should consider the types of risk they may wish to exploit and/or can tolerate in the pursuit of objectives. This helps demonstrate to our regulators, services users, and other stakeholders that there are clear and effective processes for managing risks, issues, and performance across the Trust.

Alder Hey expresses its risk appetite using statements against eleven key risk categories:

1. Compliance and Regulatory
2. Financial
3. Commercial
4. Quality – Safety
5. Quality – Effectiveness
6. Workforce

7. Reputation
8. Systems and Partnerships
9. Clinical Innovation
10. Environment
11. Technology

In drafting the Trust's risk appetite across these eleven domains, reference has been made to the Good Governance Institute's Risk Appetite for NHS Organisations Matrix (Appendix 1).

The Trust operates within a healthcare system where there are quality, service and financial challenges that have to be overcome as part of system development; never more so than in the last two years. The Trust recognises the importance of working alongside other providers in the system and their potential impact on the organisation. Stakeholders extend also to children, young people and families, suppliers of services to the Trust, the public, the government, and government bodies including regulators.

All processes, procedures and activities undertaken by the Trust carry with them a degree of risk. It is necessary for the Board to agree the level of risk that it is willing to accept, based on what it considers to be justifiable and proportionate to the impact on patients, carers, the public, members of staff and the wider organisation.

4. Relationship to the Board Assurance Framework and Risk Management Strategy

A good board assurance framework (BAF) is a live tool that helps boards to focus on the risks that may compromise the achievement of the organisation's strategic objectives and be confident that the systems of internal control are robust. It is the key document that should be driving the board and committee agendas, providing a structure that enables the board to focus on the significant risks, highlights any key controls - management actions to avoid or mitigate risks - that have been put in place to manage the risk, any areas requiring further action, sources of evidence or assurance and any gaps in assurance. The BAF should help boards streamline assurance, locate where and how assurance is tested and develop proportionality in reporting. The Board can strengthen its existing approach by explicitly identifying its risk appetite and risk tolerance for each risk type and agreeing what is sufficient in terms of controls and the assurances that the controls are operating effectively.

Moreover, risk appetite is not just relevant to the BAF, it will be used for all Trust risks which are managed at all levels throughout the Trust i.e., within services and Divisions, overseen at Integrated Governance Committees, the Risk Management Forum and ARC (i.e. including the Corporate Risk Register)

4.1 Current BAF Strategic Risk Profile (by risk type)

BAF Risk	Risk type	Risk rating (IxL)	
		Current	Target
Financial Environment	Financial	**4x4**	4x3
Workforce Sustainability and Development	Workforce	4x4	3x2
Employee Wellbeing		3x3	3x2
Workforce Equality, Diversity & Inclusion		4x3	3x2
Inability to deliver safe and high-quality services	Quality - Safety	3x3	2x2
CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID.	Quality - Effectiveness	**4x5**	3x4
Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	Systems and Partnerships / Commercial	4x3	4x2
Risk of partnership failures due to robustness of partnership governance.		3x3	3x2
Digital Strategic Development and Operational Delivery	Technology	4x1	4x1
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	Clinical Innovation	3x3	3x2
Failure to fully realise the Trust's Vision for the Park	Environment	3x3	3x2
Children and Young People waiting beyond the national standard to access planned care and urgent care	Regulatory / Compliance	**3x5**	3x3
ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.		**4x4**	3x3

5. Proposed risk appetite and thresholds

Definitions of risk appetite are set out in the table below. These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix.

Summary
Alder Hey recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff the public and strategic partners. As such the Trust will not accept risks that provide a negative impact on patient safety.

However, Alder Hey has a greater appetite to take considered risks in terms of their impact on organisational issues. The Trust has greatest appetite to pursue investment opportunities that will accrue long term benefits in terms of sustainability and growth.

Further detail on the statement is provided below.

The *risk appetite* is shown in **BOLD** text and the proposed risk thresholds are also shown with a comparison to the current BAF score (where available) for relevant risks.

Category	Proposed Risk appetite statement	Risk appetite level	Risk score threshold	Current BAF score
Compliance and Regulatory	• Alder Hey has is a **MINIMAL** risk appetite for risk which may compromise the Trust's compliance with its statutory duties and regulatory requirements.	LOW	4-6	**3x5** **4x4**
Financial	• Alder Hey has a **MINIMAL** risk appetite to financial risk in respect of meeting its statutory duties. • Alder Hey has an **OPEN** appetite for risk to support investments for return and minimise the possibility of financial loss by managing associated risks to a tolerable level.	LOW	4-6	**4x4**
		MEDIUM	10-12	No return-on-investment BAF Risk
Commercial	• Alder Hey has an **OPEN** appetite for investments which may grow the size of the organisation	MEDIUM	10-12	4x3
Quality – Safety	• Alder Hey has **NO** appetite for risk that compromises patient safety	NONE	1-3	3x3
Quality – Effectiveness	• Alder Hey has a **MINIMAL** risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	4-6	**4x5**
Workforce	• Alder Hey has a **CAUTIOUS** risk appetite for risk that may threaten the sustainability of its workforce, in terms of numbers, skill, health and wellbeing	MEDIUM	10-12	**4x4** 3x3
	• Alder Hey has a **CAUTIOUS** risk appetite for risk which may compromise its plans to develop a more diverse and inclusive workforce	MEDIUM	10-12	4x3

Reputation	• Alder Hey has a **CAUTIOUS** risk appetite for actions and decisions that whilst taken in the interest of ensuring quality and sustainability of the patient in our care, may affect the reputation of the organisation	MEDIUM	10-12	No associated BAF Risk
Systems and Partnerships	• Alder Hey has a **SEEK** risk appetite for system working and partnerships which will benefit our local population	HIGH	**15-25**	4x3 3x3
Clinical Innovation	• Alder Hey has a **SEEK** risk appetite for clinical innovation that does not compromise quality of care	HIGH	**15-25**	3x3
Environment	• Alder Hey is committed to providing patient care in a safe environment and has an **OPEN** risk appetite for risks related to the Trust's estate and infrastructure except where they adversely impact on patient safety and regulatory compliance	MEDIUM	10-12	3x3
Technology	• Alder Hey has an **OPEN** risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users.	MEDIUM	10-12	4x1

Risk rating matrix used for Trust risks

Initial Risk Rating					
Severity	*Likelihood* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
5 Catastropic	Score:5	Score:10	Score:15	Score:20	Score:25
4 Major	Score:4	Score:8	Score:12	Score:16	Score:20
3 Moderate	Score:3	Score:6	Score:9	Score:12	Score:15
2 Minor	Score:2	Score:4	Score:6	Score:8	Score:10
1 Negligible	Score:1	Score:2	Score:3	Score:4	Score:5

6. Recommendations

The Board is asked to:

- review and discuss the annual review of the Trust's Risk Appetite Statement and proposed thresholds.
- Once agreed, approve the statements for 2022/23 and keep under review via the BAF and Audit and Risk Committee oversight.

Erica Saunders

February 2022

Appendix 1 – Risk Appetite Matrix

RISK APPETITE LEVEL ▶ / RISK TYPES ▼	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2 CAUTIOUS Preference for very safe delivery options that have a low degree of residual risk and only a limited reward potential.	3 OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4 SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risks)	5 SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward scanning and responsive systems are robust.
FINANCIAL How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overarching factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with the statutory, regulatory of policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any action.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo on order to improve outcomes for stakeholders.
QUALITY How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of short-term impact on quality outcomes with potential for longer term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is a commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	We are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive change.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

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

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

Board Assurance Framework 2020/21

1. Purpose

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

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The 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
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 9th February 2022

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

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

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

4. Summary of BAF - at the 9th February 2022

The diagram below shows that all risks remained static in-month except for risk 1.2 which has improved, and risk 1.6 which AB is proposing to close BAF and manage residual risk through other existing BAF risks.

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	STATIC	IMPROVED
1.6 AB	**CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID.**	SQAC	**4x5**	3x4	STATIC	**CLOSED**
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development.**	PAWC	**4x4**	3x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing.**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion.**	PAWC	4x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park.**	RABD	3x3	3x2	STATIC	STATIC
3.2 DJ	**Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.**	RABD	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment.**	RABD	**4x4**	4x3	STATIC	STATIC
3.5 DJ	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.**	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 January'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.

- ***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 ICB transition by 3mths, along with Omicron variant wave has focused system efforts on mutual aid for Dec/Jan.

- ***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 2022.

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

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  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.

- ***CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (AB).***
  The peak of Omicron has passed and the adverse effect on staff availability is easing, with absence rates falling from a high of 11% in December to 8% at the end of January. Throughout this period we have maintained full access to urgent and emergency services and sustained a high level of access to elective services.

  With the improvement in staff absence figures, the low number of admissions for RSV and the high levels of elective recovery we are proposing to close BAF risk 1.6 and manage residual risk through other existing BAF risks. This is consistent with our decision to cease Gold Command arrangements on the 8 February. The long-term effects of Covid-19 on mental health services, access to planned care, urgent care demand and staff wellbeing will be managed under other BAF risks as follows: the residual risk relating to workforce will be managed under BAF 2.2, and the residual risk relating to waiting list backlogs and access to planned care, urgent and mental health care will be managed under BAF 1.2.

- ***Inability to deliver safe and high-quality services (NA).***
  The risk has been reviewed. Additional actions relating to gaps in assurance have been included, monitoring reports for these actions are presented monthly to SQAC. The current rating remains.

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

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

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed. New digital strategy in development with feedback from stakeholders underway. Executive decision with regards to revised dates for Aldercare programme.

- ***Workforce Sustainability and Development (MS).***
  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.

- ***Employee Wellbeing (MS).***
  Risk review and all controls and actions reviewed and updated. No change to risk rating

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

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

BAF Risk	Strategic Aim	Related Corporate Risk(s)
1.1 Inability to deliver safe and high-quality services (3x3=9)	Delivery of **outstanding care**	(2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity. * (linked to 2.1) (2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors (2233) Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies (2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list, caused by un-validated follow up waiting list and training issues leading to patients not being booked appropriately for follow up appointments (2312) Patients not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial caused by lack of medical cover for Neurosurgical and Craniofacial patients. *(Linked to 2.1) (2326) Delayed diagnosis and treatment for children and young people caused by lack of paediatric phlebotomy provision in the local area for children and young people requiring blood tests requested from primary care providers. * (2436) Significant reduction in the service provision. No 3D photography service, limited on-call service, limited appointments available Monday to Friday, caused by significant staffing gaps due to sickness. * (2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval caused by UNHM and Alder Hey are served by two different transport services (KIDS & NWTS) meaning neither will transport non-time critical patients between trusts. Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours. (2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs * (Linked to 1.2 &1.6) (2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. *(Linked to 2.1) (2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.* (Linked to 2.1) (2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.6 &2.1.) (2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.* (linked to 1.2 & 2.1) (2501). Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic *(linked to 1.2. & 2.1) (2327) Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence

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 (4x5=20)	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) (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) (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) (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) (2501) Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic (Linked to 1.1 & 2.1)
1.6 CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID (4x5=20)	Delivery of **outstanding care**	(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) (2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service has increased. (linked to 1.1) (2517) Risk of Children & 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) (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)

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) (2100) Risk of inability to provide safe staffing levels.(Linked to 1.1) (2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients(Linked to 1.1) (2340) Risk in the amount of training delivered will suffer due to the inability of resuscitation staff providing it, equally with holding the cardia arrest bleep, caused by insufficient staff in resuscitation team. (linked to 1.1) (2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. (linked to 1.1) (2517) "Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS. (linked to 1.1) (2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately. (linked to 1.1) (2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 1.1 & 1.6)
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 (4x4=16)		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**	(2427) Reduced financial performances
4.2 Digital Strategic Development and Delivery (4x1=4)		(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list (2265) Children and Young People on the waiting list experience an avoidable delay to care

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

October 2021 - Nathan Askew This risk has been reviewed, controls for haps in assurance continue. There has been progress with all 3 safety priority workstreams with clear plans in place across medication safety, deterioration and parity of esteem.
September 2021 - Nathan Askew the risk as been reviewed and updates undertaken of some control actions. Work continues in relation to gaps in assurance relating to medication safety. Other controls remain in place
August 2021 - Nathan Askew This risk as been reviewed and completed actions updated. The remaining gaps in assurance and control continue.

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		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x3	Trend: IMPROVED

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

Gaps in Controls / Assurance

1. 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. 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. Provision of additional capacity - including Accelerator Bid. Chronological booking. Theatre transformation to focus on Day Case and start times with expectation to increase number of patients per list.
see attachment for 'standard workstream update'. Actions include: 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 Symptom checker has gone live
Increase eating disorder service capacity 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.

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.

January 2022 - Adam Bateman
We have improved access for patients with a long waiting time for treatment: the number of children and young people waiting over 52 weeks for care has reduced from 267 patients on the 8 December 2021 to 234 on the 5 January 2022. Omicron is the biggest threat to access to services presently as it has caused an increase in staff absence which is leading to a reduction in capacity. Absence has increased from 6.3% in November to 12% in early January 2022. We are mitigating this through track and trace and team resilience measures. Presently the theatre schedule is holding up well against strong headwinds with 126-129 of 139 theatre sessions scheduled on average per week.

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2100, 2340, 1910, 2312, 2501, 2517, 2516, 2497		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	28/02/2022	Overall Mandatory Training still at 88% as of 31/12/2021. Key hot spots in Resus and Estates staff have been improving - Resus is now at 81% overall and Estates staff at 75%. Plan to roll out 8 day's of intense training for practical moving and handling level 2 to improve compliance in this area in early February.

3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	28/02/2022	Delayed as a result of needing to respond to covid. workforce planning happening in response to backlog and nre pressures (accelerator and RSV)
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	28/02/2022	Discussions have taken place in January in respect of the relaunch of this group, Feb will see the relaunch of the recruitment strategy group supported by the brilliant basics team.

Executive Leads Assessment
February 2022 - Sharon Owen 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 This risk is monitored through the gold command structure. Daily reports and key actions are in place in respect of staff availability. Staff availability will be further impacted as a result of the legislative changes in respect of the Covid19 vaccine as a condition of employment. Working group identifying those in scope.
December 2021 - Sharon Owen This risk remains high on the register. Staff availability monitored at gold command as part of winter plan with specific support plans in place.

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)	2020 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
Time to Change implementation	Time to Change implementation
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	
Trust Wellbeing Team	Wellbeing Action Plan
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	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.	18/02/2022	Learning Review underway. Expected completion date by mid February
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	31/03/2022	Funding for SALS/Pals being offered by NHSE/I to pilot scheme at Alder Hey. Proposal being agreed with a view to a pilot until end March 2023. In interim period, Assistant Psychologist in recruitment to provide support to wards and Theatres as per Winter Wellbeing plan.
Action plan developed with ED including SALS drop ins in ED, weekly support sessions for senior leadership team, SALS support for wellbeing lead in ED and wellbeing champions, support for Wellbeing week in ED w/c 8th Nov, Wingman on Wheels, Massage van.	01/03/2022	
Business case to be written and taken to IRG to secure funding for proposed staff support model combining SALS and Staff counselling. 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
January 2022 - Jo Potier Risk review and all controls and actions reviewed and updated. No change to risk rating
December 2021 - Jo Potier Risk reviewed and actions updated to reflect progress. No change to risk rating.
November 2021 - Jo Potier Risk reviewed and controls and actions reviewed. Action added regarding additional support for ED through the winter period and other actions updated. No change to overall risk rating.

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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.

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Appoint PM and legal team to review NE plot and produce Business Cases/Board papers	28/02/2022	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	

Executive Leads Assessment

February 2022 - David Powell
Review prior to February Board

January 2022 - David Powell
Review prior to January Board

December 2021 - David Powell
End of year review

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) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed. 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 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - 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

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

December 2021 - Dani Jones
Risk reviewed; no change in score. Controls evidenced and actions updated.

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 - Full electronic access to budgets & specialty performance results - Finance reports shared with each division/department monthly - Financial in-month and forecast position reported through SDG, Exec Team, RABD, and Trust Board - Financial recovery plans reported through SDG and RABD - Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend 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. First draft to be presented alongside plans to RABD and Trust Board
2. Five Year capital plan	31/03/2022	Refreshed 5 year capital plan approved by RABD to be presented to Trust Board in February with reduced overall capital funding requirement. Significant risk remains regarding the CDEL allowance for C&M in 22.23 and beyond and currently no approved plan for 22/23 with significant gap on likely allowance and requirement. Further work ongoing with C&M ICS
1. Uncertainty of income for 22/23 and beyond	31/03/2022	Internal business planning and budget setting underway with draft plans complete end of February to assess affordability. . Income allocations yet to be confirmed through commissioner/ICS. Uncertainty remains with regards to expected efficiency factor for C&M organisations and level of affordability for new investments to deliver the operational plans.

Executive Leads Assessment

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

January 2022 - Rachel Lea
Risk reviewed and actions updated.

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

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

Existing Control Measures	Assurance Evidence (attach on system)
Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda	Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) 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 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

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

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

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

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.

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

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	
6. Discovery and business case under way to create case for change to build with a partner a science/innovation / technology expansion space on Alder Hey Health campus	28/02/2022	

Executive Leads Assessment

February 2022 - Claire Liddy
February review - no change

January 2022 - Claire Liddy

Board Assurance Framework 2021-22

Jan review - - no change
November 2021 - Claire Liddy NOV review - risk static
October 2021 - Claire Liddy OCT review - no change
September 2021 - Claire Liddy risk review SEPT. no change

Board Assurance Framework 2021-22

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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.

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	16th February 2022 – Summary 19th January 2022 – Approved Minutes
Report of:	Kerry Byrne, Non Executive Director, (Chaired Safety Quality Assurance Committee on 16th February 2022)
Paper Prepared by:	Kerry Byrne, Non Executive Director

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 24th November 2021, along with the approved minutes from the 20th October 2021 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

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

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

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

- Verbal update on the RCPCH invited review
- Quality Priorities – update on the Medication Errors and Deteriorating Patients projects
- CQC Action Plan (for the three remaining actions overseen by SQAC)
- Q3 DIPC Report
- Monthly ED Activity Update
- Q3 ED Mental Health Attendance Report
- Clinical Quality Steering Group verbal update
- NICE Guidance Compliance Update
- Q3 Complaints & PALs
- Q3 Patient and Family Feedback
- Transition Update
- Complex Children & Young People with Complex Behaviour Closure Report (relating to Section 31 Notice)
- Board Assurance Framework
- SQAC Metrics and Divisional Reports
- SQAC Terms of Reference
- Ratification of the following policies:
  - Hospital Visiting Policy
  - Zero Tolerance of Racist, Homophobic, Prejudiced, or Discriminatory Behaviour Policy (new policy)

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

None

4. Positive highlights of note

The Committee was pleased to receive the closure report in respect of the Children & Young People with Complex Behaviour Programme which was put in place following receipt of the Section 31 Notice. The Committee recognised the significant amount of work that took place to both enable the Notice to be removed quickly following the development of a comprehensive action plan, and the delivery of the actions in the plan.

The Committee was also pleased to receive an update from the Divisions showing a significant reduction in the number of complex young people on the Transition Exception Register from (52 to 12) following significant work in this

area. For future reports the Committee agreed to receive information on transition volumes for all patients, not just those classed as complex.

An update was provided for each of the Divisions and Services on their position against relevant NICE Guidelines. Whilst there remains significant work to undertake (there are 60 "open" Guidelines currently), this month's report showed improved progress in undertaking self-assessments against the Guidelines, developing and delivering actions to achieve compliance.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on
Wednesday 19th January 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director (Chair of SQAC)	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Robin Clout	Interim Deputy CIO	(RC)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Urmi Das	Director – Medicine Division	(UD)
	John Grinnell	Acting Chief Executive	(JG)
	Adrian Hughes	Deputy Medical Director	(AH)
	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)
	Natalie Palin	Associate Director of Transformation	(NP)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)
21/22/172	Jennie Williams	Head of Quality Hub	(JW)
	Kath Stott (observing)	Senior Audit Manager, MIAA	(KS)

21/21/168 Apologies:

Dani Jones	Director of Strategy & Partnerships	(DJ)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC). FB introduced and welcomed Kath Stott, Senior Audit Manager, MIAA who was observing SQAC meeting as part of the Committee Effectiveness Review.

21/22/169 Declarations of Interest
SQAC noted that there were no items to declare.

21/21/170 Minutes of the previous meeting held on 15th December 2021 –
Resolved: Committee members were content to **APPROVE** the minutes of the meeting held on 15th December 2021.

21/21/171 Matters Arising and Action Log
Action Log
The action log was updated accordingly.
FB reminded committee members that the Committee are still operating under the governance light approach, and as such those starred items would be taken as read, with any questions addressed as required.

Matters Arising

Quality Improvement Progress Reports

21/22/172 Quality Priorities Monthly update

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

- Medication Errors – SQAC **NOTED** that the Business Case had been written and is progressing through the divisional process and is being led by Pharmacy. This is due to be presented to Investment Review Group, in the January 2022 meeting.
- Parity of Esteem – JW advised that given ongoing pressures across the organisation, a decision was reached to postpone the Programme Board meeting, with no significant progress update to report to SQAC.
- Deteriorating Patients – work is ongoing on Ward 4C to refine the processes in the pathway, and to reduce the current levels of administration needed.
- Concern had been expressed from the Steering Group members, regarding the review of ACT, and their role in the deteriorating patient's pathway.
- JW advised that the DETECT Study is closing in August 2022, with the aim of a thorough end to end proposal required, to embed within the ACT team.

NA expressed his thanks to staff on Ward 4C, and to James Ashton for the ongoing focus, and for staff embracing the quality initiative and methodology.

NA acknowledged the concerns raised with regards to the ACT review time frames. NA provided reassurance that this would be mitigated as much as possible, planning for the required changes was underway.

NA acknowledged the continued good work, over a sustained busy, and challenging period, and advised that he anticipated continued progress going forward.

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

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

FB expressed thanks to JW & Quality Improvement team.

21/22/173 CQC Action Plan

SQAC received and **NOTED** the CQC Action plan. SQAC **NOTED** that ongoing work is progressing, in order to pursue those final actions, in order to ensure completion.

21/22/174 DIPC Exception Report

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

21/22/175 Assurance ED Activity Monthly Update

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

21/22/176 ED MH Audit Information

SQAC received and **NOTED** the MH Audit information and welcomed the agreed actions.

21/22/177 Aggregated Analysis report including incidents, complaints, PALS, Claims and Inquests

CU presented the Aggregated Analysis report, Complaints, PALS, Claims and Inquest Report -1st April 2021 – 30th September 2021, key issues as follows:-

A summary of the themes from the report was provided.

- The majority of incidents reported continue to be no harm, near miss or low harm incidents. From 1st October 2021, (previous reporting period), the divisions had received monthly trend data of the top ten themes, with divisional feedback included within the report, which displayed some evidence of lessons learnt.

  A Bass questioned whether future reports could clearly identify and articulate issues of concern for each of the Divisions, which would be more meaningful to Divisions, rather than detailing numerous figures within the report.

  CU referred to the divisional trend data that is shared with each of the Divisions. FB advised that it is important for SQAC to receive updates from Divisions on lessons learnt, and highlighted the importance for each of the divisions reviewing the trend data, to ensure that any appropriate action required is taken.

Resolved: Offline discussion to be held with A Bass and Division of Surgery colleagues

KB advised that SQAC do not review the trend analysis data, and that this is useful data for SQAC, KB alluded to the last four pages of the Aggregated Analysis report which KB found the most informative.

KB advised that it would be helpful for future reports to identify trends, themes, and to highlight any systemic, or trust wide issues, requiring a strategic response, rather than an individual tactical response. KB also requested whether the report could be streamlined into appropriate stats, and trends, with the report focussing on strategic responses that are required.

FB thanked KB for comments, and advised that the report is work in progress, and that CU had noted comments as appropriate, in order to incorporate feedback, for inclusion within future reports.

JG advised that it would be helpful to include a succinct detailed front cover summary, highlighting any pertinent issues requiring SQAC focus. CU noted comments.

NA agreed with comments raised, and advised that the Divisions are certainly sighted on divisional trends, and reiterated that this is very much a work in progress. NA advised that N Palin had offered to work with individuals, in order to undertake a review of data, and to review how data is presented within reports to Committees. NA suggested that this report be the first report to be addressed through that review process. NA advised that it would be beneficial to look towards other Trusts, in terms of identifying good practice and adopting any good practice at Alder Hey.

SQAC **NOTED** that NP would review the Aggregated Analysis Report, to ensure

that meaningful information is included in future reports, and together with CU, both would identify good practice from other Trusts, with the aim to adopt good practice at Alder Hey.

LC suggested that a reporting template for the divisions and corporate services would be helpful to set expectations and standardise the reporting into SQAC. FB welcomed this approach.

A Bass stated that any future report should ensure that the statistics contained within the reports are converted into meaningful information, such as lessons learnt. A Bass stated that it is essential for this report to be completed in a robust method, to ensure that the information received to SQAC can be efficient and meaningful for all.

UD welcomed the use of a divisional template, and suggested that the divisions be involved in devising such a template.

NA welcomed the helpful discussion. He advised that there is opportunity to work at pace, and suggested that a reiteration of an enhanced, and more meaningful report could be presented at the April 2022 meeting. NA advised on the importance of the need to be really clear regarding information requirements.

Resolved: SQAC received and **NOTED** the Aggregated Analysis, and acknowledged that the next Quarterly report, which is due to be presented in April 2022, would be presented in a different format. SQAC also acknowledged that the Aggregated Analysis report continued to be work in progress, with the requirement for SQAC to review, and provide any comments and feedback, following SQAC review of the next reiteration of the report in April 2022.

FB thanked CU for the Aggregated Analysis report including incidents, complaints, PALS, Claims and Inquests

Clinical Governance Effectiveness

22/22/178 CQSG Key issues update

NA advised that the Clinical Quality Steering Group had met on 11th January 2022, the meeting had focussed on key issues as follows:-

NA referred to good progress made in terms of Transition meeting, which focussed on future roles and responsibilities in relation to transition, it is envisaged that good progress would be made in the next update.

Detailed discussion took place on a range of quality governance metrics, that are declining rapidly. NA advised that this prompted a meeting of the Senior Nursing Leadership and Governance Team, which was held on 13th January 2022. A range of issues were identified, in terms of ensuring clarity on required expectations, clarity of roles and responsibilities, reporting requirements, structure of reporting, and issues regarding processes. Additional resources had been secured to review process, identifying waste, and removing any unnecessary, or non added value steps within process, and to use the resource to implement required change for each of the strands. NA advised that following discussion it was evident that the term devolved

governance is thought to be very open to interpretation. NA & ES are working constructively on defining the governance model within the organisation.

NA advised that five 'quick win' areas had been identified, all of which are planned to be addressed by 17th February 2022, which are being monitored through the Senior Nursing Leadership Team meeting, scheduled to take place within 4-6 weeks' time.

SQAC welcomed an update on developments at February 2022 meeting, NA advised that an update could be given, however, the full improvement plan will be developed once the additional resource is in place.

FB thanked NA for CQSG key issues update, and welcomed an update on progress at the February SQAC meeting.

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

21/22/179 NICE Compliance Monthly Update

CU presented the NICE Compliance Monthly update; reporting period up to end of December 2021, key issues as follows:-

- There is evidence of some progress made since the last reporting period, however there is further work to do for the Trust to be in a positive assurance position.
- In terms of progress made since October 2021, - 3 had been completed and closed, 13 had made substantial progress, 27 had made minimal progress, and 13 had made no progress since November 2021.
- CU reflected on the report and advised that it would be clearer to split those guidelines that are at assessment stage, and those that are at recommendation stage, with expected completion dates included for all. SQAC **NOTED** that future reports would be presented in that format.

FB reminded all that this is a new way of reporting and referred to the need for assurance that the NICE guidelines are implemented, and that the Trust can demonstrate compliance. FB advised that it would be useful to receive comments on the RAG ratings, and to receive further clarity regarding the details of agreed, and non agreed recommendations within future reports.

FB questioned whether SQAC are able to assist or provide any further support in order to accelerate progress.

KB welcomed the separation of the assessment and recommendations. KB questioned whether colleagues are being realistic when creating actions plans. KB advised that on review of the report, it appeared that there are underlying issues within the Division of Medicine and questioned whether there is a requirement to make a fundamental change. UD advised that a Medical Lead for Governance had been appointed, and is due to commence in post in February 2022, with a review of NICE Guidelines being a key priority once in post.

SQAC agreed that Executive Colleagues would consider feedback raised offline, in order to agree ownership, and to enable SQAC to demonstrate how the Trust comply with NICE guidelines, with the expectation of SQAC receiving details regarding the planned approach at February 2022 meeting, with the updated NICE report to be presented to March 2022 meeting.

In advance of the February 2022 SQAC meeting, FB would meet with NA to receive an update on the proposed plan.

Resolved SQAC received and **NOTED** the National Institute for Health & Care Excellence Report. SQAC **NOTED** that Executive Team colleagues would consider feedback raised, in order to agree ownership, and enable SQAC to demonstrate how the Trust would comply with NICE guidelines. SQAC **NOTED** that good practice at other organisations would be reviewed. SQAC to receive an update on the plan at February 2022, NICE refreshed report to be presented at March 2022, with the expectation that this would demonstrate an improved position.
Meeting to take place with FB & NA, in advance of February 2022 meeting.

FB thanked CU for NICE Compliance update.

21/22/180 Corporate Risk Register Update

CU presented the Corporate Risk Register Update, which provided a summary of the current Corporate Risk Register (CRR) pertaining to the remit of SQAC.
There are currently five themes identified on the Corporate Risk Register, including access to services (9 risks), people (1 risk), major trauma (2 risks), medicine management (1 risk) and IM&T (1 risk). Most of the risks had been subject to 'deep dives' with oversight through the Risk Management Forum.

FB queried whether any colleagues wanted to share any update, or whether they requested any further information. KB referred to Risk 2497, regarding the 'delayed diagnosis and treatment for children and young people', in terms of the risk associated with the Eating Disorder Service. KB questioned the statement that there would be an increased wait for urgent assessment, and questioned whether SQAC are content with this. LC advised that this risk is detailed on the Risk Register, and related to the 100% increase in referrals. LC stated that 2 young people had breached the 7 day urgent standards, with no further breaches to date.

Discussion took place regarding risk 2312 - 'Risk of Patients not being 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. FB referred to the Business Case being approved relating to 2 WTE General Paediatricians, with the medical Division recruiting to the two vacant posts, however the capacity had been diverted to support patients in HDU. A Bateman advised that he is happy to offer support to the Medicine Division to review this risk offline, AB advised that the team job plans required review, in order to determine how this risk is addressed.

Resolved: SQAC received and NOTED the Corporate Risk Register Update and NOTED AB offer of support to review risk 2312 with Medicine Divisional Leads.
FB thanked CU for Corporate Risk Register Update.

21/22/181 Board Assurance Framework

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

21/22/182 Divisional Reports by exception/Quality Metrics

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

- LC advised that sickness absence levels across the Division, particularly during December 2021 and January 2022, which related to the new Covid Omicron strain, and the subsequent impact on waiting times for services, together with the increased number of referrals for ASD/ADHD, eating disorder services and Mental health services remain a challenge for the Division. LC advised that as a result the Division are now seeing complaints from parents and families regarding waiting times.

- LC advised that there had been some limited success with discussions with CCG, which had resulted in short term investment regarding ASD & ADHD, with ongoing discussions taking place with CCG.

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

- Division continue to focus on workforce challenges, with particular focus on ED workforce, in order to ensure alignment to pressures, with daily huddles which take place.
- Sickness/absence is a significant concern, within the division, with regards to non Covid absence, and long term sickness absence. Managers are referring staff to occupational health for guidance on how to support employees to remain in work, with a planned training session scheduled for training leads within the division, which is facilitated by the HR Business Partner, to share the appropriate process on facilitating staff return to work.

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

- A Bass advised that the Division of Surgery had pre prepared for the loss of staff due to sickness by reducing theatre capacity subtly, from 139 sessions, plus emergency provision, to 129 sessions, plus emergency provision, the Division had successfully managed this, through the hard work of clinical staff, and from service managers, and as a result the Division have not had to cancel any additional sessions.
- The Division had seen the highest number of patients who had tested positive for COVID which had impacted on the Division.
- A Bass reported that Richard Craig would be providing support to A Bass, in providing leadership to the Division of Surgery, during the interim period, whilst A Bass is Acting Chief Medical Officer, until a permanent Chief Medical Officer commences in post.

FB referred to the decline in compliance on sepsis bundle compliance and advised that SQAC would retain focus on Sepsis over the coming months. FB had highlighted this previously to Dame JW, ahead of Trust Board, and Dame JW is fully aware that this is being reviewed. NA advised that he envisaged improvement over the coming months.

FB thanked the Divisional Leads for the Divisional Updates. FB acknowledged the period of extreme extraordinary pressure for all of the Divisions, which they are currently working under, together with the impact regarding the high level of COVID for staff and patients, with the hope that the organisation will start to see improvements following the Omicron Covid Wave.

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

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

JG advised that there had been challenging reports detailed within the SQAC meeting pack, and that colleagues needed to reflect on this, JG highlighted the importance of continued commitment from all.

JG welcomed the safety metrics, which are on trajectory, given the challenges faced over the previous months, and the importance of focussing on areas of concern which are working well.

FB advised that it is important to highlight this, and important to note that there are areas that had been identified for improvement, in terms of the way in which colleagues are

reporting, in order to improve oversight, and to improve alignment. FB stated that it is unrealistic to expect to initially get these reports correct.

FB alluded to the good discussion held regarding how other organisations achieve best practice, and the broader lessons learnt, on how to incorporate change for reporting in the future.

FB advised that it is important to take some time on establishing what good practice looks like for the organisation, and how this fits well into Trust structures.

21/22/183 Any other business

None.

21/22/184 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Quality Priorities update received, with sustained progress made in month for Medication errors, Deteriorating Patients and Parity of Esteem, with good level of assurance provided.
- 2 major reports were received – Aggregated Analysis Report including incidents, complaints, PALS, Claims and Inquests, and the NICE Compliance Report, both reports are 'work in progress'. SQAC identified a number of ways in which to improve report content, and agreed to take discussions offline, in order to establish a different format and presentation of both reports.
- SQAC **NOTED** that CQSG continue to meet on a monthly basis, with key issues identified and followed up as appropriate.
- SQAC received divisional updates, and recognised pressures which all of the Divisions are under, with good progress being made.
- Essential Safety metrics are holding up well, with significant work ongoing, to gain assurance, and report to SQAC on those elements.

21/22/185 Date and Time of Next meeting

16th February 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th February 2022

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	15th February 2022 – Summary 18th January 2022 - Approved Minutes
Report of:	Fiona Marston, Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

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

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

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

2. **Agenda items received, discussed / approved at the meeting)**
   - People Plan
   - Staff Turnover
   - Staff Survey 2021
   - Vaccine as a Condition of Deployment
   - Communications Update
   - Corporate Report Metrics/Workforce KPIs for December 2021
   - Board Assurance Framework/Key Workforce Risks – December 2021
   - Policies Ratified:
     - Smoke Free Policy
     - Zero Tolerance of Racist, Homophobic Prejudiced or Discriminatory Behaviour Policy
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – (highlights prior to approval) 08.12.21
     - Health & Safety Committee – 13.12.21
     - JCNC – 26.11.2021
     - Education Governance – 09.12.21
     - BAME Task Force Action Log – 8.02.22

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

- The 2021 staff survey identifies a number of potential risks; an increase in staff working more unpaid hours, increased levels of staff reporting they have experienced disability discrimination, and a reduction in people saying their appraisal was good quality. A Trust wide action plan will be produced with relevant actions in response to the areas we need to focus on, which will include responses to divisional results, once received.
- SALS are experiencing increased requests to support work-based relationship conflict, the reasons for which are multi-factorial. SALS have a range of support available to teams and individuals to help manage this.
- Staff Turnover – a comprehensive report was received on the review undertaken by Katie Jones, HR Manager, to understand the rise in turnover in recent months. Actions agreed included:
  - Reviewing the process for recording, monitoring and reporting of turnover, with regular detailed reports to be submitted to PAWC.
  - Agreed to include divisional EDI metrics in future reports
  - A particular challenges raised was how do we find out early when staff are thinking of leaving, and how do we support them to stay, if appropriate?

4. **Positive highlights of note**
   - Sickness is starting to see a downward trend (stress/anxiety/depression).
   - Staff Survey: a high level Trust wide action plan is to be developed with a view to building the divisional data into it. There is much to celebrate but Alder Hey must address aspects that achieved low scores. There is an action for the over-arching plan (response to the staff survey) to come back to PAWC in March/April, with a specific action relating to disability.
   - Vaccination as a condition of deployment – the process was paused two weeks ago pending the outcome of public consultation.
   - Communications: a 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.

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

6. **Recommendations**

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

Alder Hey Children's NHS Foundation Trust

Confirmed People and Wellbeing Committee
Minutes of the last meeting held on 18th January 2022
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Fiona Beveridge	Non-Executive Director (Deputy Chair)
	Melissa Swindell	Chief People Officer
	Mark Flannagan	Director of Communications & Marketing
	Erica Saunders	Director of Corporate Affairs
	Adam Bateman	Chief Operating Officer (Part attendance)
	Nathan Askew	Chief Nurse
	Ian Quinlan	Non-Executive Director
	Racheal Greer	ACOO – Community & Mental Health
	Jason Taylor	Acting Associate COO – Research
	Rachel Hanger	Associate Chief Nurse – Surgery
	Cath Wardell	Associate Chief Nurse – Medicine
	Mark Carmichael	Associate Chief COO - Medicine
In attendance:	Sharon Owen	Deputy Chief People Officer
	Jo Potier	Associate Director of Organisational Development
	Ayo Barley	Head of Equality, Diversity & Inclusion
	Kathryn Allsopp	Head of Operational HR
	Katherine Birch	Director – Alder Hey Academy
	Pauline Brown	Director of Nursing
	Alfie Bass	Deputy Medical Director
	Amanda Kinsella	Head of Health & Safety
	Adrian Hughes	Deputy Medical Director
	Jackie Friday	Executive Assistant (Minutes)
Apologies:	Dot Brannigan	Governor
	Clare Shelley	Associate Director of Operational Finance
	John Chester	Director of Research & Innovation
	Gill Foden	HRBP – Medicine
	Jacqui Pointon	Associate Chief Nurse
	Phil Oconnor	Deputy Director of Nursing

21/22/74 **Declarations of Interest**
Fiona Marston – Liverpool School of Tropical Medicine

Introductions
Received for Ayo Barley – Head of Equality, Diversity & Inclusion.

21/22/75 **Minutes of the previous meeting held on 23rd November 2021**
Resolved : The minutes of the last meeting were approved as an accurate record.

21/22/76 Matters Arising and Action Log

No matters Arising. The action log was updated accordingly.

Trust People Plan 2019-2024

21/22/77 People Plan

The Committee received the People Plan Update Report, this report is a regular report presented to Trust Board and is noted as read. MKS brought particular attention to:

Sickness absence, of which a divisional update will be shared under item no. 21/22/80. Across January so far the Trust has reached a peak of up to 12.5% (increase in both Covid and non Covid absence). This increase is also reflected across the country. The data in the pack is the position at 11th January – 9.5% and is seeing a downward trend – today overall sickness is at 8.24%. The decrease has been aided by the support given to staff with Covid absence including of a Smart Release process. Sickness absence remains the biggest area of focus of HR with continued support of people's wellbeing at work and with the help from IPC team in supporting staff with Covid and getting them back to work.

Employee Relations activity – the detail on page 26 of the pack was highlighted. 12 people are being managed through that final stage process of long-term sickness, with only 4 disciplinary cases and 3 MHPS. A quarterly update is shared with the Board and remains an area of focus.

Mandatory Training Compliance – just below 90%. The Learning & Development Manager and the Alder Hey Academy Director are focussed on the topics which require face to face support (Resuscitation & Manual Handling). KB confirmed significant progress has been made in terms of Resuscitation, with courses moving online and trainers now in place to support Manual Handling. KB is confident we will see improved progress in the coming months and this will be monitored closely. With reference to particular staff groups – Facilities have moved from a position of 58% in October 2021 to 74% as at date of reporting. A lot of work is taking place across the board to see improvements both in terms of topic and staff group.

AK referred to manual handling compliance figures - Health & Safety performed a deep dive into staff that had been identified as requiring training. The outcome showed that Managers do not appear to be updating ESR when people do not require to be trained (i.e. when staff are on long term sick, maternity leave). Conversations have taken place recently with L&D/managers to resolve this and this should impact on increased compliance rates going forward.

FM – thanked KB in terms of the tremendous improvement made in Facilities mandatory training, noted as an outlier for a period of time.

FM referred to SALS and the large numbers of contacts made to the service identified in the report and recognised this may reflect where we are at the moment in terms of the environment we work in.

AH referred to sickness levels coming down and was mindful about next steps. AH shared the discussions that had taken place at the North West Critical Care call that morning. Generally everything is looking better across the region. The central message is about restoration and recovery, the concern is about resilience of staff and the expectation of making demands of staff to crack on.

MKS acknowledged the pertinent points raised and advised that although it is good that sickness is decreasing again, before the spike sickness was higher that target at 5.5%-6%. MKS recognised that Covid absence is reducing although other elements of sickness have not seen a reduction and suspects some of this is being seen through SALS (burnout and resilience theme). JP confirmed evidence is coming through specifically related to that via the Staff Survey. MKS confirmed sickness will continue to remain an area of focus going forward.

Resolved: PAWC received and noted the update of the People Plan

21/22/78 Staff Survey 2021

JP shared an overview on the report - The final response rate for Alder Hey was 52% and places the Trust above average in sector (Acute and Acute & Community) for total response rates (national average was 45%). The report includes the initial results (questions level data) of the of the Staff Survey, this shows comparisons to last year and to the Trust's compactor group.

JP highlighted that key changes have taken place with the report (change in metrics), which in turn makes it difficult to look at long term trends. Although JP acknowledged the questions were more coherent and is aligned to the NHS People Promise (reported back through the 7 people promise elements). JP advised within that there are new sections, with a lot more added to the health & wellbeing section, inclusive of team functioning, compassionate culture and inclusion. JP outlined some of the general trends of which a small decline has been identified in comparison to the previous year. Although it was recognised that this was to be expected as when the last staff survey took place at the height of the pandemic there was a lot of adrenaline, positive feelings with people pulling together, whilst now on reflexion people are feeling more exhausted which is normal under the circumstances.

This data reflects back to AH's comments of how staff may be feeling, despite the support being offered by SALS etc. - 31% the feeling of burnout, 29% feeling exhausted at the thought of another day or shift, 43% feeling worn-out at the end of the day, 35% finding work emotionally exhausting and 45% reporting work related stress.

Other headlines – some positive changes are – the increase in confidence from last year in raising concerns about unsafe clinical practice and confidence that the organisation will address concerns. 72% of people rating Alder Hey as a good place to work sees a decline from last year, but high given the morale decline. 90% recommending Alder Hey as place for family and friends receiving care.

The Committee noted that the initial results can be shared internally only until the final results are published centrally (mid-March). Raw data and a management report is expected by the end of January, once received the Staff Survey Group will meet to plan the internal feedback programmed which will include sharing Divisional and team level results in readiness to use through Big Conversations format and supporting teams to plan and deliver these conversations.

ES referred to the 63% of staff reporting working more unpaid hours – with remote working and accessibility to emails phone etc – ES queried if there is anything that we could be doing to promote and encourage people to achieve the right balance.

MKS reflected on earlier processes and areas of focus following the feedback of Staff Survey responses in previous years and noted wellbeing will be a big part of the response to this year. A Trust wide plan will be pulled together to outline what needs

to be addressed and changed as a result of feedback received. Evidence has shown that by looking at local data, - engaging Divisions and departments to make local decisions, has greater impact, as it is finding that balance within individual teams once data has been reviewed.

The Committee noted that FB shared on the chat - in relation to the Staff Survey - the requirement to understand the demographics to and the EDI issues.

FM congratulated JP and the Team in terms of percentage response received under the current circumstances.

Resolved: PAWC received and noted the update on Staff Survey.

21/22/79 Recruitment Recovery Plan

SO provided an update on the progress made against the recovery plan. The recovery plan was put in place following the significant increase of recruitment activity at the Trust, coupled with a static staffing establishment, reduced resource in the Team and outdated processes. This has resulted in delays in time to hire and on occasion poor candidate experience with a detrimental impact on clinical services.

SO shared the top-level position of the recovery plan. SO was happy to report that it now takes 35 days to hire, compared to 77 days at its peak in November. Some ongoing issues still to be addressed, this is a longer-term improvement journey for recruitment and the recruitment team and the provision they provide. A recruitment management tool – Trac System – has been introduced (rolled out in November). This automated process has helped to manage the levels of activity and has been well received across the organisation. The Team are continuing to provide some training across the organisation.

SO highlighted the requirement to implement as many automated systems as possible as there is still a lot of time consuming manual processes in place. I.e. The Recruitment Team also run Employment Services function in terms of pay changes every month (on average between 200-250 pay changes per month). The Team are continuing to work with the Brilliant Basics programme to support them on their improvement journey and data quality over the coming months.

MKS added her thanks to SO and the Team for their efforts. MKS acknowledged there are some specific issues that are being dealt within the Surgical Division, there is still a lot of work to do and it remains on the risk register. Additional resource will need to be looked at over the longer term as activity has more than doubled over the last 12 to 18 months. MKS advised that at the beginning of December 2021 the Team was joined by a new Operational Head of HR. Kathryn Allsopp has been appointed and will be instrumental in ensuring HR has the required systems and processes in place.

ABass thanked SO for all the hard work that had gone into these processes. ABass shared some feedback from the Medical Board that he attended the previous week in relation to issues with Recruitment/Employment Services processes and the negative impact on staff morale (i.e. changes in peoples pay impacts on pensions). ABass recognised these are fundamentally basic functions of the Trust, so they have to work and would support the expansion of this Team to a number that will provide a really good service to the staff that work at Alder Hey.

SO welcomed ABass's support and agreed with the points raised and advised that what has now been put in place will remedy some of that. SO advised that she is picking up the specific issues raised by Surgery in terms of delays in recruitment and

acknowledged that some of this sits outside of the realms of Recruitment Department (i.e. The Home Office) and escalation points are in place.

FM thanked ABass and recognised that it is really important for us to have open dialogue as we are all trying to move along the same trajectory.

Resolved: PAWC received and noted the Recruitment Recover Plan

Governance

21/22/80 **Corporate Report Metrics – November 2021**

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

Trust Metrics

Community & Mental Health – RG shared a summary – some improvement in PDR rates - remain above 90% in Mandatory Training, this has been a real focus for the Division. Sickness similar to update provided earlier – hit a high during early January at 8%, this has actually come down this week at 6%, so followed the same pattern as across the rest of the organisation. Residual level sickness still requires a bit of work. RG echoed the comments made around recruitment. Seen some significant improvements across the division, the introduction of Recruitment drop in sessions has been really helpful for managers in terms of being able to escalate quickly.

Medicine Division – MC shared a summary – as of yesterday sickness was as 10.7% and it has remained high, similar to other Divisions throughout late December early January. 4.6% relates to Covid – with a significant Non Covid absence issue. Undertaken a high-level deep dive with our HR Business Partner. Seeing regular reports in terms of long-term sickness with a number of staff with more than 180 days absence on the long-term list. Also receiving regular reports on return to work on compliance/noncompliance and we are encouraging Service Managers to update and ensure they are completed in a timely manner. A number of hotspots i.e. ED and JP and the SALS team are supporting with long term absence, this impacts on services. PDR & Mandatory Training compliance work continues to support this.

CW referred to return to work completion and advised from speaking to staff the general theme coming back is they are being completed but not being input on to the system – some of this is due to staff availability. Work is progressing with HR on this issue with the option of returns to work taking place over the phone for the Divisions in some instances. This Division will be focussing on this issue as it has dropped significantly.

FM referred to staff turnover (10.3%) – and queried if this was the standard fluctuation that you might expect to see?

CW confirmed that discussions to take place with the HRBP – the plan is to look at the breakdown of different staff groups and exit interviews and review all of that data together. Feedback will be shared once complete.

Action 21/22/80/1 – Medicine Division – increased staff turnover – feedback following review of data - CW

Surgery Division – RH referred similar sickness increases as the other Divisions. Completion rates of return to work for short term sickness has significantly increased over December/January period. Band 7's tends to manage the whole team in relation to return to works. Looking at accountabilities with the possibility of Band 6's stepping up to share this task and spread the load to support completion in a timely way. PDR summer window – no change across the year until we reach the next summer months when it will run again. Mandatory Training position – currently meeting with nurse staffing on a monthly basis to see improved compliance processes/methodical approach – a divisional wide approach will then be rolled out.

FM – referred to staff turnover increases in month (October 10.70%, November 11%, December 12.40%) headcount 1288. FM asked how the Division is going to assess what the underlying issues are in relation to increasing turnover.

RH – referred to receiving the singular metric as quite a challenge, as it is hard to get to that further detail of any underlying issues. Seeing further detail on a regular basis will enable Divisions to work out the impacts on specific areas. This is something that will be worked on.

SO – highlighted that she has requested that the HR Team pick up a specific piece of work around turnover for the organisation. This is currently being pulled together and nearly finalised. It is hoped to present at the next Committee. FM thanked SO for highlighting as very helpful. CW commented in the chat that this would be beneficial to the Divisions.

Action 21/22/80/2 – Staff Turnover – report on findings – SO

JP added - in support of RH's point about more detail being made available – The Staff Survey has quite detailed information as to why people are intending to leave and where people intend to go.

FM referred to the Divisional SALS statistics and asked JP would that show the numbers in each Division coming to SALS, as this would also correlate in support of the data available. JP confirmed that data is available.

Research & Development Division – JT shared a summary – As mentioned at the last Committee – the ambition was to incorporate Innovation information into these metrics. Some further work is required on this by the ESR Team & BI to make that available. PDR's as with previous update 90% was achieved during the window and anticipate getting back to that position. Mandatory Training remains above trust target again, no complacency – as making sure this remains this way. Sickness has seen a reduction, currently have no staff off due to Covid. Sickness long term should be showing as green as below the 3% target at 2.55%. Return to works, supporting managers to get the right position. Staff Turnover – it is always something we need to look into, but not something that the Division is facing or is concerned about as temperature check ok.

Corporate Services – The report for Corporate was showing a lot of red, return to works – a lot of work to do. Staff Turnover - it would be interesting to see the completed piece of work on this. MKS highlighted that we don't particularly have a place at the moment were Corporate Services come together to discuss this data and suggested that the heads of Corporate should pick up outside of this meeting to talk about how we move collectively towards making sure that people metrics are improving.

ES confirmed that the purpose of past meetings with heads of departments – this was in relation to the move to the new hospital. ES acknowledged lots of value came out of heads of departments coming together. ES referred to conversations with the COO about performance reviews and how we ensure that we have equity in line of sight and accountability across all areas. One to take away for discussion with Execs in terms of best approach.

AB was happy to the lead on the commitment to agree the right performance framework for Corporate Services and report back to this Committee.

Action 21/22/80-3 Discuss and agree the right performance framework for Corporate Services and report back to the Committee – AB

Action 21/22/80-4 – Look at producing 1/4ly report with year-on-year comparisons in the metrics in relation to turnover – SO/MKS

FM – confirmed it is important that we pick up on these things in the narrative so we can absorb that information.

FB – referred to staff turnover and emphasised the importance of this focussed piece of work. FB highlighted we can see the increase but don't know much of what that entails – (described in the previous minutes as 'good turnover versus bad turnover'). FB referred to earlier agenda item relating to unprecedented recruitment levels. This could also be captured in the staff turnover figures i.e. people who've moved from one job in the organisation to another job as part of that process. A deep dive is the only way to really get at what is happening in the different staff groups. It may or may not be a problem at all, but currently you can't tell from the headline figures.

NA agreed with FB the importance of data for 'different staff groups'. NA shared that 15% turnover is the national average for nursing and midwifery. Previously when reviewed, the Trust was sitting at 8-9% for nurses and support staff, below the national average. NA suggested we might need to look at the workforce data and think about what the story is we are trying to tell, or what is it we are trying to understand and perhaps look at it in a slightly different way. NA advised that Alder Hey has had a stable workforce for a long time and some turnover in many areas could be seen as beneficial thing for our workforce. NA referred to the deep dive that took place last year for nursing leavers. It found that most people were leaving the organisation for promotion or moving within the organisation for change. NA thought some of that level of data would be useful to look at within each of the divisions too.

FM thanked NA and acknowledged it would be useful to know how we sit in the context of the national picture.

In the Committee chat A Barley offered to provide support to SO.

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

20/22/81 Board Assurance Framework – November 2021 & HR & Workforce Risk Presentation

The Committee received a full BAF report for November, noted as read. ES advised of the 3 risks 2.1 Sustainability & Development Risk is the one that needs most focus just now. ES referred to vaccine issue/staff turnover and the requirement to include these in the report. ES and MKS to have a conversation outside of this Committee to

agree how they will be featured (either as a separate strategic risk or at Corporate risk level). ES asked if the gap in control for DBS's has now been resolved. SO confirmed it had. ES referred to the EDI risk and advised she would welcome a conversation with ABarley and MKS about how it will be framed as a strategic risk – once ABarley gets to know the organisation a bit more.

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

21/22/82 CQC Action Plan – November 2021

The Committee received a report outlining CQC regulatory requirements, monitored at PAWC. ES advised the action plan is complete and suggested removing this item going forward. The action from CQC's perspective was in relation to Mandatory Training and this is monitored elsewhere through the Division of Medicine. ES recommended that this is closed down in relation to where this Committee is concerned.

FM thanked ES for the recommendation and asked the Committee to raise any concerns or objections to this recommendation – none were raised.

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

21/22/83 Wellbeing Guardian Update

JP shared a summary outlining the progress against the implementation of the 9 core Health & Wellbeing Guardian principles. JP advised that the Chair - FM was appointed to the new role of Wellbeing Guardian in February 2021 (nationally this is a new role too). Work has begun to bring the organisation through all the phases of implementation of this role. JP confirmed we are currently at phase 2 of the process where principles are being embedded. JP acknowledged there is work still to do around assurance for certain areas. Activity is being tracked via monthly meetings with FM and the SALS Team, with crossover meetings with OD and HR via a focussed action group. The document shares a flavour of the work already underway in relation to those principles and also outlines what is still to do.

FM thanked JP for a good overview and highlighted that EDI featured as one of the areas to be progressed and looked forward ABarley's support. FM advised there is a Network in the Northwest of Wellbeing Guardians, giving us the opportunity to share best practices with other Trusts and also learn from them.

Resolved : PAWC received and noted the contents of the Wellbeing Guardian Update

21/22/84 Non-Clinical Claims Report

The Committee received a report prepared by the Head of Health & Safety. AK shared some background information relating to live claims.

The current scheme for the NHS is the Risk Pooling Schemes for Trusts (RPST) this is the collective name for two separate schemes covering non-clinical risks, the Liabilities to Third Parties Scheme (LTPS) and the Property Expenses Scheme (PES). AK advised that the current Claims are subject to excesses - Employer Liability £10k, Public Liability £3k, and PES £20k.

The Trust is part of a PFI scheme and under the PFI scheme the Trust is responsible for all of their own employer liability claims irrespective of where negligence sits with the Trust and is responsible for damages/costs. The Trust has 30 days to investigate and determine liability for Employer Liability claims. Public Liability is 40 days. Failure to comply to timeframes incurs further costs. If liabilities are agreed then fixed costs will be maintained and the claim will continue under the protocol, if liability is disputed the claim will have three months to allow the Trust to further investigate.

As outlined in the document - AK shared the status as of January 2022 for claims

AK shared the breakdown for divisions and benchmark stats with Trusts in the local area, the latter of which shows encouraging statistics in comparison in recent years. This has been supported by better resource/embedded structure within the Health & Safety Team to facilitate processes (supported by an increase in health & Safety Training and the correct Risk Assessments taking place and automated processes).

AK outlined other support that has helped to reduce claims i.e. Sharps Safety Group to look at sharps incidents and claims; the introduction by Health & Safety Team of Facilities Health & Safety Group, this format will also be rolled out across the Divisions and will afford a better insight to deep dive into claims; attendance by a Health & Safety Advisors at the Divisional Integrated Governance Groups – all this gives the Health & Safety Team a much stronger foundation than previously afforded to facilitate change and improvement.

The main aim is to continue to support reduced accidents and strengthen processes going forward via health & safety training of managers to arm them with the skills and knowledge to embed more of a safety culture within Divisions/Departments. AK advised that currently the majority of the Health & Safety Team are on fixed term contracts and it is hoped this resource continues as there has been significant improvement in claims and processes (i.e. correct Risk Assessments in place).

FM thanked AK for a very comprehensive and noted the comments raised.

IQ queried if we ever used any other firm other than Clyde & Co. as better deals are had with utilising more than one firm? Also is there any flexibility to settle at an early stage as costs may exceed the settlement?

In response AK advised that a panel of solicitors is used. Clyde's were the newly appointed panel solicitors (Chosen by NHSR and the preferred choice). Previously we have engaged Hill Dickinson's and are starting to engage them more. In relation to saving on costs AK advised the quicker we can investigate a claim the better. As soon as an incident comes through to the Health & Safety Dept an investigation process commences (prior to the incident landing in the portal process). This enables any 'admit of liabilities' to be handled as quick as possible and keep within the cost structure and limit costs.

RH valued the overview within the Divisions and would welcome an oversight of the monthly breakdown of claims that are coming through and the areas they are in. RH thought it would be beneficial to take accountability at future Divisional Health & Safety meetings as well as through Divisional Governance meetings directly with clinical teams caring for patients.

AK confirmed this could be facilitated and advised these are non-clinical claims that are being addressed today not CNST claims. Work will continue to put in place separate meetings within the Divisions to discuss non clinical claims and to ensure

work can progress collectively to learn any lessons and to stronger embed any training or assessment required.

MKS thanked AK and the team for the focus and effort that has gone into reducing non clinical claims, particularly in areas where there have been repeated claims. MKS advised the systems and processes put in place, while they make a difference, focus is still required on needle stick. MKS advised that we engage Weightmans to manage non clinical claims (on a retained basis). This is more cost effective than it would be to employ a member of staff and works well for the Trust to keep on top of claims. This in turn frees up AK and the team to concentrate on better processes to reduce claims. The last 2 Health & Safety reports received at PAWC provide good assurance to the Board in this particular area.

FM echoed MKS comments – its seems there is a good balance in reducing the number of claims, whilst making this a fair process.

Resolved : PAWC received and noted the contents of the Non-Clinical Claims Update

21/22/85 Vaccination as a Condition of Deployment

MKS advised that the legislation passed in December 2021 is Vaccine as a Condition of Deployment - if you are required to undertake CQC related activity or you are deployed to support CQC regulated activity, then it will be a condition of your ongoing employment that you are fully vaccinated. Initial guidance has been received this month, phase 2 of the guidance was published on Friday 14th January 2022. MKS noted the implementation date for this legislation has been confirmed as 1st April 2022 and invited KA who is leading on this project to supply an update on plans so far.

KA presented on Vaccine as a Condition of Deployment – KA advised initial focus (via 1:1's with managers) has been on identifying the vaccination status of staff who the Trust did not have on record as having had the vaccination. The scope of staff impacted has been progressed and discussed at the Vaccination Working Group and at Execs.

KA shared a summary Project Plan Overview in terms of next steps. Moving this week to formal process (following the phase 2 guidance received on Friday) in relation to re deployment and how we engage with Union colleagues. Meetings will commence this week with Unions, to agree formal process for those that remain unvaccinated/unknown status. AK noted the Vaccination Group next week will be discussing some of the risks relating to this (updating of the risk register). AK outlined financial plans to support people in lieu of notice and reconfiguration of roles where practical along with the opportunity to apply for any internal in scope jobs/redeployment and noted local policy on redeployment does not apply – but acknowledged redeployment is a slim option.

Further key next steps to be focussed on this week are: sharing information about new starters who haven't updated on their vaccination status, (it is hoped to have an clearer view on status by end of this week); informing those on maternity leave or long term sick of the legislation whilst being mindful and sensitive to individual

circumstance as they are currently out of the workforce and it impacts them in a different way; update recruitment paperwork; agree a process to support the volunteers/contractors; 'System C onboarding' - ESR currently has to be updated manually, the national team have purchased a license that will bring two processes together - and is expected to be in place at the Trust by 31st January and will help the Trust going forward with recording processes.

MKS acknowledged the challenges faced and advised that questions have been raised on the national calls relating to the request for more clarity on scope. MKS acknowledged the support of the Unions (they attend the working group). A cohort of experts have been identified at the Trust to have one to one conversations with staff should they wish to. Doing as much as possible to give staff an informed choice. MKS advised she feels comfortable that there is a good action plan and great support with Staffside working in partnership. This item is on the agendas of weekly Execs and an update will be presented to Board the following week (inclusive of stats).

KB provided assurance to the Committee in respect of students who are on clinical placements with us and post graduate trainees at Deanery level. The same approach that is being taken with volunteers apply to clinical students. This information has been shared with KA.

FB commented about students at University of Liverpool (replicated across other providers) whereby a number of students are declining the opportunity to be vaccinated. Looking to the future some concerns have been raised about the impacts across every student group (trainee doctors, dentists, allied health professionals, nursing group etc), so there will be a decline in the pool by a small percentage, which is something to bear in mind for the future.

NA added he is supportive of the approach the Trust has taken. HR have worked hard to get us to where we are particularly with the delay of guidance. NA emphasised that it incredibly clear the people who make a personal choice not to be vaccinated will follow a very clear process which ultimately will lead to them not being able to practice registered activity in the private sector anywhere in England. Getting that message across is key. NA referred to other vaccinations that registered practitioners have to undertake and thought the same perspective should be applied with Covid. We can be supportive but it is individual's choice.

FM thanked NA, & FB for their comments and was really impressed with all that had been heard from MKS and acknowledged the huge amount of work performed by KB, KA and the HR Team.

Resolved : PAWC received and noted the contents of the Vaccination as a Condition of Deployment Update

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21/22/86 **Policies**

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

Retirement & Return Policy & Mandatory Training Policy

SO advised both policies have been discussed/consulted on/agreed with Staff Side colleagues at the Policy Review Group. SO highlighted the key change in the Retirement Policy, which is there is a reduced break in service (was 4 weeks now 24hours, aligned with pension requirements). More clarity has been added in relation to process.

SO highlighted to the Committee that due to current commitment in terms of vaccination of deployment, PRG has been put in abeyance for the next couple of months. Agreement has been reached with Staff Side colleagues to extend a number of policies that will expire in that time frame.

Mandatory Training Policy

KB advised that some minimal updates made in relation to clarification for NHSP – expectations and responsibilities have been added.

FM reflected on the good summary at the beginning and paid thanks. It was hoped this would become common practice for all polies brought to this Committee. FM advised that it helps in terms of focussing the mind and doesn't detract people being able to read the entire document should they wish to.

Resolved: PAWC received and ratified the above policies

21/22/87 **Board of Directors Summary**

- Staff Survey follow-up
- Recruitment Recovery Plan
- Staff Turnover – deep dive
- Vaccination as a condition of deployment

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

21/22/88 The Committee received the minutes for the following for information, noted as read.

- Local Negotiating Committee – 06.10.21
- Health & Safety Committee – 21.10.21
- Joint Consultation & Negotiation Committee – 20.10.21
- Education Governance – 14.10.21
- BAME Task Force Action Plan – 9.12.21

Resolved: PAWC noted the content of the minutes.

21/22/89 **Any other business**

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

21/22/90 **Review of Meeting**

FM reviewed the meeting; really great dialogue. FM's second meeting as Chair. FM advised any feedback would be welcome and if there is anything in particular in relation to improving the way the Committee is managed, please don't hesitate to share this. FM advised that some really difficult topics were discuss today, particularly about vaccination, where there are no alternative solutions, we all understand the balance between what we are asked to do and implementation of the law. FM thanked everybody. The Committee will be run monthly for the near future at the request of the Board.

21/22/91 **Date and Time of Next meeting**

15th February 2022, 10am.

Minute Reference	Action	Who	When	Status
Trust People Plan 2019-24				
21/22/60-1 **21/22/60-2**	Non Agenda for Change (AFC) Pay Update • Deferred increase to on-call payments to be included in overall review of on-call arrangements • Pay Review – small anomalies across the Trust – to also include review of approach for Non-AFC practices	NA/AB MKS/SO	March 2022 Spring 2022	Noted on 18.01.2021 – the review has commenced.
Governance				
21/22/80-1	Trust Metrics - Medicine Division Increased staff turnover – feedback following review of data.	CW	February 2022	
21/22/80-2	Trust Metrics - Staff Turnover Report on findings	SO	February 2022	
21/22/80-3	Trust Metrics – Corporate Services Discuss and agree the right performance framework for Corporate Services	AB	TBC	
21/22/80-4	Trust Metrics Look at producing a 1/4ly report with year-on-year comparisons in the metrics in relation to turnover	SO/MKS	February 2022	
21/22/64	Divisional Metrics • Include the number of staff in each Divisional metric report	MKS/HRBP's/ Divisions	Immediate	Noted on 18.01.2021 – inclusion complete – Closed.
21/22/66	Health & Safety • To produce a current status dashboard for Health & Safety to inform the Board	MKS/AK	March 2022	Noted on 18.01.2021 – an update will be brought back to March committee
21/22/67	Policies • Policies – key points of change summary to be added – to inform the Committee of changes made	MKS/SO		Noted on 18.01.2021 – to be included in future policies – Closed.
Equality, Diversity & Inclusion				
21/22/58	• Monitor 3 action Plans WRES/WDES/BAME		Ongoing	
Policies				

21/22/49	• Convene a meeting with JP/KB/MF to review Inductions at the Trust (outcomes will inform an updated Induction Policy to adapt/reflect the current climate)	MKS	TBC	Noted on 23.11.2021 – MKS confirmed an initial meeting took place with DS/JP Noted on 18.01.2021 a working group has been setup to review – an update will be brought to a future Committee – Closed.
AOB				
21/22/53	• Present about the Wellbeing Guardian role and the progress against the 9 principles that the Trust is being monitored against.	FM	January 2022	Noted on 18.01.2021 as received.

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 11th October 2021**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. R. Lea	Acting Director of Finance	(RL)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
In Attendance:	Mr. J. Chester	Director of Research	(JC)
	Mr. R. Clout	Deputy Chief Digital Information Officer	(RC)
	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
Item 21/22/34	Ms. M. Walsh	Strat House	(MW)
Item 21/22/37	Mr. K. Bell	AI HQ Team	(KB)
Item 21/22/39	Ms. E. Kirkpatrick	Finance Manager	(EK)
Item 21/22/40	Mr. S. Hosny	Innovation Consultant	(SH)
Item 21/22/41	Mr. S. Hosny	Innovation Consultant	(SH)
Apologies:	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. N. Murdock	Medical Director	(NM)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. K. Warriner	Chief Information Officer	(KW)

21/22/30 Introductions and Apologies

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

21/22/31 Declarations of Interest

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

21/22/32 Minutes from the Meeting held on the 14th June 2021

Resolved:

The minutes from the meeting that took place on the 14th of June were agreed as an accurate record of the meeting.

21/22/33 Matters Arising and Action Log

Action 20/21/62.1: *Innovation Strategy Discussion Update (submit the final version of the Innovation Strategy to the Committee during April's meeting)* – It was confirmed that the strategy will be completed in preparation for December's meeting, pending approval of the Brand Strategy on the 11.10.21. **ACTION TO REMAIN OPEN**

Action 21/22/23.1: *Health Tech Seed Fund Proposal (submit a report on a pre-seed fund approach and product pipeline during August's meeting)* – A further meeting has been scheduled to take place w/c 11.10.21 with Marc d'Abaddie and his colleagues to review the opportunities and prepare a best case to submit to the Innovation Committee. **ACTION TO REMAIN OPEN**

21/22/34 Innovation Final Brand Strategy and Assets – Strat House

The Innovation Committee was provided with an update on the new Brand Strategy for the Innovation Centre. It was reported that an external agency, Strat House, was appointed in January 2021 to provide expert support to the Trust in creating a new Brand Strategy for innovation to help the Innovation Centre become a globally renowned brand. An overview of the background, rationale and scope of the exercise was provided to the Committee and a presentation on the new brand deliverables was shared by Melanie Welsh from Strat House.

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Ian Quinlan queried as to whether the trademark will be branded or protected. It was confirmed that it will.

A question was raised about the critical factors in terms of judging the brand as a success. It was reported that Strat House will conduct 'Brand Tracking' on an annual basis to measure the improvement in awareness of key messages. In terms of measuring success, the next step is to agree KPIs/metrics/questions to be asked and look at cost effective ways of putting that tracking in place.

Fiona Marston did not feel that the branding drew attention to the Innovation Centre's unique selling position (USP) in terms of what it does and how it achieves this. It was pointed out that the USP of an organisation tends to be a summary of the entire brand key but for the Innovation Centre the USP is the product of two combined areas; product truth and the ground purpose.

Members of the Committee felt that the A brand is really strong and encompasses all of the colours/brands that can be seen across the Trust. It was pointed out that there isn't an A like it, the branding has a more corporate feel and it was felt that it is an excellent piece of work.

Strat House left the meeting whilst a discussion took place on the approval of the brand. The Committee agreed to approve the use of the brand as the Innovation Centre moves towards finalising its strategy and use some of the material provided by Strat House in order to define the work of the Innovation Centre.

Resolved:
The Innovation Committee approved the new branding created by Strat House.

21/22/35 Q2 Performance Report

The Committee was provided with an update on performance for the period from the 1.4.21 to the 30.9.21. The following points were highlighted:

- During Q1 and Q2 there have been 44 new innovations that are new into pipeline with 20 piloted or deployed during this period.
- *Impact to Care: Was Not Brought (WNB) Artificial Intelligence (AI)* – It was reported that the WNB algorithm was built in the Trust's AI Headquarters to address a high WNB rate of 11.9% in 2019/20. This was piloted at Alder Hey and was selected as an Accelerator Programme Innovation project to be rolled out to ten paediatric trusts. Work is taking place with the teams across the trusts to predict WNB patients and look at interventions in order to reduce WNB rates. It was confirmed that Alder Hey's WNB algorithm has the most efficacy and success rate to date therefore the Trust is looking to roll this project out on a broader scale.
- *Brand and Reputation* – The Committee received an overview of the highlights and successes of Q1 and Q2. It was reported that Social Media Impressions have increased by 15%, from 112k to 130k. PR and social media exposure will come in line with the new brand going forward and work will take place on a PR programme.
- *Delivery Highlights*
  - **As One (CYPMH) Mental Health Platform**: This platform has received a lot of interest from other trusts therefore work is taking place to see if it can be rolled out in association with Alder Hey's technical partner; Mind Wave.
  - **Little Hearts at Home Pilot:** This pilot is a combination of an app, platform and dashboard for the remote monitoring of cardiac patients. It was reported that Cardiac Consultants are working with a pilot site in Blackpool in order to progress this project.
- *Commercial* – The Committee received an update on inward investment discussions, and attention was drawn to the status/next steps of prospective partners.

The Chair raised a question about how the Trust can increase the visibility of the Innovation Centre at Central Government level and asked members if they could offer any advice. A number of suggestions were made; 1. Employ an organisation who would lobby on behalf of the Trust. It was pointed out that this option would be expensive and require a lot of strategic thinking. 2. Compile a stakeholder map to look at a number of streams in terms of influence, with the Trust's R&I agenda at the heart of it. 3. Link in with the opportunities that will arise as a result of the launch of a new review by Innovate UK and the Government's Levelling Up agenda

The Chair pointed out that there are consultants that the Trust could potentially employ to help the organisation with this area of work and queried as to whether this is a route that the Innovation Centre would wish to take. Claire Liddy felt that having external professional support would be beneficial in terms of navigating/guiding the Trust to take advantage of the imminent windows of opportunities, especially as the Innovation Centre now has a new brand and strategy. Fiona Marston felt that before the Trust invests money into an external company/consultant it is necessary for Alder Hey to have a clear and concise pitch that identifies its USP and highlights its achievements, of which some are

award winning, so that it can position itself and build upon this. Attention was also drawn to the importance of having a sharp message when pitching for funding.

John Grinnell advised that in the event the Trust does employ external expertise it will be necessary to narrow the Trust's approach in terms of identifying the clients that it wishes to influence, prior to the engagement of an outside source. Ian Quinlan drew attention to the importance of distilling the strategy into the elevator pitch and keeping it short, succinct and to the point.

Jon Corner pointed out that there is funding available that focusses on distributed wellbeing and felt that the Innovation Centre should start to look at how it takes the unique offer of Alderhey@anywhere and align it to other funding sources and build partnerships. Fiona Marston advised of her support for Alderhey@nywhere but felt that further work is required to address the gaps.

Following discussion, it was agreed to circulate the Trust's elevator pitch that is in draft form with the view to receiving constructive feedback from Committee members.

21/22/35.1 **Action: CL**

The Chair referred to the KPIs in the report and drew attention to the lack of a KPI for impact following the deployment of projects. It was felt that this information would be beneficial for investors in terms of an elevator pitch. It was reported that this information is being shown via individual case studies at the present time, but it was agreed that this should be reviewed following the deployment of each project.

21/22/36 **Research and Innovation Vision**

The Committee was provided with a number of slides that provided information on Alder Hey's R&I vison.

The Chair queried as to how the governance for the R&I strategy will fit. It was reported that a structure is required that represents the joining up of research and innovation, but these decisions will need to be made at organisational level. The Committee was advised that this matter has been raised. Erica Saunders drew attention to the previous Committee structure for research, education and innovation that was stood down some time ago and pointed out that since then ongoing dialogue has taken place with Dame Jo Williams and Louise Shepherd about the point at which the organisation commences to amalgamate these areas of work again. Following discussion, it was agreed that a further conversation will take place to discuss governance and concur as to which Assurance Committee the R&I Strategy will sit under.

21/22/36.1 **Action: JC/ES**

21/22/37 **Alderhey@nywhere Vison and Roadmap**

The Committee was provided with an overview of the Alderhey@nywhere platform programme that aims to deliver a Minimum Viable Product in Q4 2021/22. A detailed market comparison has shown that no existing digital platform provides all required features or data collation for AI capability.

It was reported that the platform will allow Alder Hey to establish an agnostic approach to offering digital services to patients and onboarding remote monitoring products to support

the exponential growth in the industry and onward application into healthcare, maximising opportunity. The existing work on the CYP As One Mental Health platform and AlderPlay combined with other partner technology and the Trusts digital and data infrastructure can potentially not only meet those needs but create a unique platform and blueprint for healthcare delivery of the future.

Information was provided on the key workstreams included in the Alderhey@nywhere platform, the key benefits and the next steps. The Committee was advised that the project governance, structures and timetable will be activated in October and together with Digital will be submitted to the Digital Oversight Committee. A number of slides were shared to inform the Committee of the Trust's vision for the Alderhey@nywhere platform along with the scope and proof of concept for Phase 1 of the project.

John Grinnell drew attention to the importance of focussing on outpatients from a front door perspective as part of Phase 1 as it is felt that the impact would be significant in terms of patients being able to update their appointments on line. It was reported that the Innovation Centre is working with the Digital team/Outpatient team to look at the roadmap as there may be some short term solutions that can be deployed imminently, as well as longer-term solutions in due course.

Fiona Marston queried as to how the Trust will build something into the programme to address the fact that some families don't have access to the internet or devices. It was reported that the Trust is working with schools, GPs, various organisations, Inequality teams and Public Health teams around ensuring equitable access to care.

Jon Corner advised of the potential for Alderhey@nywhere to align with agendas in terms of distributed health and drew attention to the funding opportunities that are available to support this area of work.

It was suggested that an evaluation of the As One (CYPMH) platform will help towards informing the strategy in terms of commercialisation/roll out and assist with lessons learnt. The Committee was advised that a research project is due to take place in association with the University of Liverpool to review the As One (CYPMH) programme in order to provide an evaluation. In addition to this the Trust has applied for further funding to conduct a larger research study. From a headline perspective, it was reported that the Trust has received just under 2000 referrals via the platform since May 2021 and a 4 Star rating from patients/parents, along with qualitive feedback that was really positive.

The Committee was advised that it is too early to measure the impact of the As One (CYPMH) platform as the pilot only went live in August 2021 but it was felt that it would be beneficial to submit the acquired data in terms of the KPIs of the pilot.

21/22/37.1 **Action: EH**

A discussion took place about the various devices that will plug into the Alderhey@nywhere platform and how they will be deployed in a potentially different way to address a collective solution rather than an individual one. It was reported that the next step is to develop a road map with the Digital team to look at short-term solutions versus long-term solutions that will plug into the platform.

Resolved:
The Committee noted the update provided on the vision and roadmap for Alderhey@nywhere

21/22/38 Commercial Software Engineering Project

The Committee was provided with an overview of a Commercial Software Engineering (CSE) project and related agreement with a large technology partner. The due diligence document was also submitted to provide an overview of the negotiations and terms of the agreement.

It was reported that the Innovation Strategy sets out how the Trust's Innovation Centre will work strategically via agreements with technology giants/large corporates. As a result of this the Centre has spent the last twelve months testing and analysing the technologies of a number of large corporate organisations to see if they fit with the strategy and whether the respective organisation/s are able to match in terms of value/cash in kind contributions.

A major programme for Alder Hey Innovation Centre is the development of the digital platform Alderhey@nywhere enabling the remote monitoring of acute and chronic conditions, patient self-management and longer term AI augmented decision making for preventative interventions. It was reported that the Alderhey@nywhere platform vision has been selected as a CSE project.

Discussions were held on management and ownership of data with the tech partner, potential commercial models in terms of royalties on data usage and ownership of any IP generated as a result of the partnership. The Committee requested a financial model on the costs of the partnership over the term of the agreement and ongoing potential financial flows if the partnership is successful.

Resolved:
The Committee approved the recommendation to progress with the programme which is estimated to commence on the 8th of November 2021. It was also agreed to map out a commercial pathway to provide clarity on what it looks like.

21/22/38.1 Action: EH

21/22/39 Charity Request and Grants Update

The Committee was provided with an update on the recent request to Alder Hey Children's Charity for funding of £200k for three years to provide stability for the Innovation Centre whilst it builds its portfolio of innovations until it has a sustainable external funding stream.

It was reported that the initial request was not approved by the Charity as they wished to seek further assurance in terms of 1. The link between the funding requested and the outcomes/impacts. 2. The income figures forecast and the trajectory for innovation moving to a sustainable funding position. It was reported that the Trust has commenced to compile a 5-year financial forecast for innovation which will address the additional streams of assurance requested by the Charity. It was agreed to share the high level forecast with the Committee during the next meeting.

21/22/39.1 Action: EK

The Trust has agreed with the Charity that the financial forecast can be approved outside of the Charity's Board with an update submitted in due course.

The Committee was updated on the grants that the Innovation Centre has applied for and those currently in the pipeline. Following discussion, Fiona Marston offered her assistance in the event the Innovation Centre decides to apply for biomedical catalyst grants.

Resolved:
The Committee noted:

- The update of the bid for pump prime funding to Alder Hey Children's Charity.
- The grant/funding bids recently submitted along with those in the pipeline for review.
- A review of funding opportunities submitted and in pipeline will become a standing item on the agenda for the committee.

21/22/40 **Commercial Partnership Agreement Schedule**
Resolved:
The Innovation Committee received and noted the quarterly update and contents of the Commercial Partnership Agreement schedule.

21/22/41 **Draft Intellectual Property Policy (IP)**

The Committee received the draft Intellectual Property Policy and was provided with an overview of its contents. A review has taken place of other trusts' IP policies alongside the IP policies of IP commercialisation companies. With the support of a legal IP lawyer a draft policy applicable to Alder Hey has been prepared.

The Committee discussed the contents of the draft IP Policy and felt that in order for it to be understood, it needs to be simplified and more succinct. As a result of the discussion a number of suggestions were made to help provide greater clarity for the reader of the document

The Chair queried as to whether the Trust could acquire some examples of IP policies from industry or various Science Parks. Fiona Marston advised that all of the major universities have IP policies, and offered to obtain a copy of an IP policy from the various institutions.

Following discussion, it was agreed to refine the draft IP Policy based on the comments made during the meeting and submit a further version on the 7.2.22. It was suggested contacting Elvina White to request a copy of the Trust's template for policies.

21/22/41.1 **Action: SH**

21/22/42 **Board Assurance Framework Update**
Resolved:
The Committee received and noted the Board Assurance Framework report.

Alder Hey Children's NHS Foundation Trust

21/22/43 Any Other Business

The Chair advised that Jonathan Hague is stepping down as a member of the Innovation Committee from the 11.10.21. The Chair offered her thanks to Jonathan for his contribution to the Committee.

21/22/44 Review of Meeting

The Chair felt that the Committee had a really good discussion around strategy and the implications for some of the Trust's commercial arrangements. The Chair thanked Shereef Hosny for the work that has been conducted on the draft IP Policy.

Date and Time of the Next Meeting: Monday 13th December, 1:00pm-4:00pm, via Teams

Alder Hey Children's NHS Foundation Trust

Innovation Committee
(Innovation Strategy Session)

Confirmed Minutes of the meeting held on **Monday 24th January 2022**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. J. Grinnell	Acting CEO	(JG)
	Mr. R. Guerrero	Clinical Director of Innovation &Consultant Congenital Cardiac Surgeon	(RG)
	Mrs. R. Lea	Acting Director of Finance	(RL)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
In Attendance:	Mr. J. Chester	Director of Research and Innovation	(JC)
	Mr. R. Clout	Deputy Chief Digital Information Officer	(RC)
	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
Observing	Ms F. Ashcroft	Chief Executive, Alder Hey Charity	(FA)
Apologies	Mr. A. Bass	Acting CMO	(AB)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Mr. D. Powell	Development Director	(DP)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Mrs. L. Shepherd	CEO	(LS)
	Mrs. K. Warriner	Chief Information Officer	(KW)

21/22/45 Apologies

The Chair noted the apologies that were received.

21/22/46 Declarations of Interest

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

21/22/47 Innovation Strategy and Delivery Plan

The Committee received a presentation on the Trust's Innovation Strategy 'Today's Child, Tomorrow's Healthier Adult'. A number of slides were shared that provided information on the;

- Overall vision of the strategy.
- Content and landscape.

- Strategic objectives.
- The Dual approach.
- Technology areas
- Financials and KPIs.
- Approval and next steps

Committee members provided feedback in a structured way on the various elements of the strategy. The Committee agreed the two strategic objectives that were put forward; develop solutions to tackle healthcare inequalities and solutions to optimise healthcare 2:1 return on investment.

Attention was drawn to the importance of the strategy reflecting Alder Hey's track record in terms of what it has done and what has already been achieved. It was felt that this will set the basis for what the Trust is planning to do and why it is able to deliver the five technology areas. It was agreed to have a discussion on this matter outside of the meeting.

21/22/47.1 **Action: FM/CL/EH**

A discussion took place around USP and finding a way to emphasise Alder Hey's USP. It was agreed to review the narrative in the strategy relating to culture.

21/22/47.2 **Action: CL**

The Chair requested that a piece of work take place to capture the policies in scope with the strategy, for example, patient data/AI/partnership agreements/ethical AI, etc. and agree as to which Assurance Committee they should feed into.

21/22/47.3 **Action: CL**

Attention was drawn to the importance of having a small number of KPIs to measure performance against the objectives expressed in the strategy to measure impact. It was also suggested that the two KPIs in the strategy should become high level strategic targets with a comment included to highlight that an operational plan will be delivered in keeping with the strategy, with key KPIs based on impact, patient outcomes and aligned investments.

Following discussion, it was agreed to meet as a smaller group to explore this further.

21/22/47.4 **Action: FM/CL/EH**

Approval
The Committee was asked to:

- Approve the high level principles of the strategy.
- Note that there are some outstanding actions that need addressing, and an amended document will be received by the Committee on 7.2.22 for approval
- It was reported that the final publishable version of the strategy will be submitted to the Trust Board in February/March 2022.

For noting
The Committee approved the high level principles of the strategy and agreed to receive the amended document on the 7.2.22 for approval.

21/22/47.5 **Action: CL**

It was agreed that the next steps will be to develop the operational plan to deliver the Strategy, and methods to measure performance against delivery of the strategy.

21/22/47.6 **Action: SA/CL**

21/22/48 **Any Other Business**

There was none to discuss.

Date and Time of the Next Meeting: Monday 7th February 2022, 1:00pm-4:00pm, via Teams.