Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 26th May, commencing at 12:35pm

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (9:00am-9:15am)							
1.	**22/23/32**	**12:35 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/33**	**12:36 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/34**	**12:37 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 28th April 2022.**	**D**	Read enclosure
4.	**22/23/35**	**12:40 (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.	**22/23/36**	**12:45 (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
Strategic Update							
6.	**22/23/37**	**12:55 (5 mins)**	**Liverpool Clinical Review - Terms of Reference.**	L. Shepherd/ D. Jones	To formally receive the Terms of Reference for the Liverpool Clinical Review.	**N**	Verbal/ Read enclosure
7.	**22/23/38**	**13:00 (5 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
Operational Issues							
8.	**22/23/39**	**13:05 (20 mins)**	**Operational Update; including:** • **Financial Update for Month 1, 2022/23.**	A Bateman R. Lea	To receive an update on Operational performance. To provide an update on the position for Month 1 – 2022/23.	**A** **A**	Read report Presentation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**22/23/40**	**13:25 (10 mins)**	**Digital Strategy 2022/23.**	K. Warriner	To receive and approve the 2022/23 Digital Strategy.	**D**	Read report
10.	**22/23/41**	**13:35 (15 mins)**	**Quality Strategy 2022/23; including:** • **Patient Safety Strategy Update.**	N. Askew/ A. Bass	To receive and approve the 2022/23 Quality Strategy. To receive an update on the Trust's Patient Safety Strategy and to approve the formation of the Patient Safety Board.	**D** **N/D**	Read report Read report
11.	**22/23/42**	**13:50 (10 mins)**	**Brilliant Basics; including:** • **Action Plan for 2022/23.**	N. Askew	To receive an update on the Brilliant Basics Programme and the plan for 2022/23.	**N**	Read report
12.	**22/23/43**	**14:00 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
13.	**22/23/44**	**14:05 (10 mins)**	**IPC Update.**	B. Larru	To receive an update from the DIPC.	**A**	Presentation
14.	**22/23/45**	**14:15 (15 mins)**	**Corporate Report; including Divisional updates:** • **Medicine.** • **Community & Mental Health.** • **Surgery.**	A. Bateman M. Carmichael L. Cooper B. Pettorini	To receive a report on the Trust's performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
The Best People Doing Their Best Work							
15.	**22/23/46**	**14:30 (20 mins)**	**People Strategy Objectives – 2022/23; including:** • **EDI Steering Group Terms of Reference.** • **Freedom to Speak Up.** • **FTSU Review Tool for Boards.**	M. Swindell G. Dallas/ M. Swindell K. Turner E. Saunders	To receive the People Strategy objectives for 2022/23. To receive the ToR for the EDI Steering Group. To receive an update on the current position. For information purposes.	**N** **N** **A** **I**	Presentation Read report Read report Read report
Strong Foundations (Board Assurance)							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
16.	**22/23/47**	**14:50 (5 mins)**	**Board Assurance Framework Report Year-end Report 2021/22.**	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
17.	**22/23/48**	**14:55 (5 mins)**	**Proposal for the Appointment of a Senior Independent Director.**	Chair	To receive a proposal for the appointment of a Senior Independent Director.	**D**	Read report
18.	**22/23/49**	**15:00 (15 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.5.22.** - **Approved minutes from the meeting held on the 25.4.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 18.5.22.** - **Approved minutes from the meeting held on the 27.4.22.** • **People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 23.5.22** - **Approved minutes from the meeting held on the 25.4.22.**	I Quinlan F. Beveridge F. Marston	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Items for information							
19.	**22/23/50**	**15:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
20.	**22/23/51**	**15:19 (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: Monday 20th June 2022, 9:30am-11:30am, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in April 2022
387: Deed of Easement relating to the access road to Ronald McDonald House on the site of Alder Hey – Bevan Britton

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M1, 2022/23	R. Lea
IPC Report	B. Larru

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 28th April 2022 at 9:00am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Acting Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Deputy Chief Executive/CFO	(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. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing	Prof. J. Jankowski	Member of the public.	(JJ)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
Patient Story	Dr. L. Willets	Clinical Psychologist	(LW)
Item 22/23/11	Mr. A. Pitman	Green Project Director	(AP)
Item 22/23/15	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 22/23/16	Ms. C. Lee	Associate COO for Surgery	(CL)

Patient Story

The Chair welcomed Clinical Psychologist, Laura Willets, who had been invited to April's Board to share a story on behalf of a patient who accessed psychological support through the Paediatric SARC Psychology service. Laura provided some background information on the SARC and advised of the support that children receive when they come to the service because of suspected sexual abuse.

The patient story is about Joe, a 14-year-old boy, who attended the SARC after reporting sexual abuse that had been going on for a number of years. When he came to the Centre he was in a lot of emotional pain, he was very quiet, his mood was low, and he was very anxious.

A psychological assessment was conducted via SARC, and it was agreed that combined therapy would help Joe with his goals. Joe engaged in 26 sessions and started to feel much

better, he began to open up to his mum and people at school but there were still some tensions at home due to the impending trial of his abuser, which impacted on the whole family. A while after discharge, Joe's mum made contact with the service to say that Joe was struggling due to receiving a date for the trial, he also had the pressure of exams at school and felt that he needed someone to talk to. Laura advised that further ongoing support was offered to help Joe express and process his emotions and provide him with some coping mechanisms.

Laura informed the Board that a big part of her role was to contain Joe's distress as he had disconnected from all those around him and didn't have a sense of a future. Laura referred the family to various services as they were struggling to cope with the situation too. Links were also made with the Crisis Care team so that Joe could contact them if he needed to during the trial.

After the trial took place Joe realised that the trauma hadn't disappeared and chose to participate in EMDR trauma therapy which really helped him. Joe is now back at school full time and is engaging in positive activities. He has recognised that there will be times when life will be stressful but is able to draw on the coping mechanisms that he has learnt. Joe does have occasional reminders of the abuse, but he has said that he feels like the child that he used to be and is much happier. Laura shared feedback from Joe and his mum with the Board. Joe said "It's been amazing that I've had this support. I don't know where I'd be without it. It has been really good. I feel so cared for with this therapy and everything that you do for me and mum".

Louise Shepherd referred to some of the restrictions that are in place in terms of the therapy that can be offered to CYP when going through a legal process, which can affect their health and wellbeing. A question was raised about the consideration that the Board needs to give to this issue. Laura reported that the SARC at Alder Hey is the only service that offers the support that Joe received but this is not being replicated across the country. It was suggested that consideration be given to the submission of further bids for the support that is required. The Chair felt that it would be beneficial to evaluate the service and feed the outcome into the System. Lisa Cooper advised that the SARC sits within the Community Division and discussions are taking place around the promotion and the development of the service as there a large number of CYP who don't come to Alder Hey for forensic examination and therefore don't receive the benefits of the Psychology service.

The Chair asked that thanks be relayed to Joe for allowing his story to be shared with the Board. The Chair also thanked Laura for supporting Joe on a very difficult journey.

22/23/01 Welcome and Apologies

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

22/23/02 Declarations of Interest

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

22/23/03 Minutes of the previous meetings held on Thursday 31st March 2022
Resolved:
The minutes from the meeting held on the 31st of March 2022 were agreed as an accurate record of the meeting.

22/23/04 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 21/22/276.2: *NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review' - Discuss the possibility of Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and child health across the BAME communities* – It was reported that tackling health and inequalities/data that the Trust generates is being addressed via the Accelerator Programme. The Innovation Committee received a presentation on the Lab to Life Child Health Data Centre which is focussing on a different area of work therefore it was suggested that a conversation take place with Claire Dove to provide an update and discuss the possibility of further funding to support the Accelerator Programme in respect to health inequalities. **ACTION TO REMAIN OPEN**

22/23/05 Chair's and CEO's Update

The Chair advised the Board that the ICS is continuing to develop and influence what is happening on the financial front regionally. The Trust is also continuing to work with partners and is taking a leadership role to address the recovery of services for children and young people (CYP).

It was reported that a decision has been made by the Northwest region to task the ICS with undertaking a review of acute services in Liverpool. The draft Terms of Reference (ToR) were issued on the 27.4.22 and will be discussed on the 29.4.22 during a meeting with Liverpool City Council and all of the trusts involved. The Board was advised that the ToR are fairly generic and will be formally acknowledged at the next System Oversight Board of the ICS.

Louise Shepherd informed the Board that the Ronald McDonald UK Foundation Charity formally merged with the McDonald House Charity on the 27.4.22 and will take responsibility for running McDonald House which is based on the site of Alder Hey. A meeting has taken place between Alder Hey and the Trustees of the Charity who have experience of running family houses around the country. The Charity have a number of really good ideas in terms of moving forward with McDonald House and it is felt that this is an opportunity for the Trust to think creatively about what a new family offer could mean for Alder Hey.

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

22/23/06 Operational Plan for 2022/23

The Board received the Operational Plan for 2022/23 which sets out Alder Hey's priorities for the year. The Trust is focused on improving the health of children and young people through outstanding care that is safe and accessible; being a great place to work and supporting the workforce; and achieving financial sustainability. The plan integrates and interconnects the organisation's plans for activity, quality, workforce, finance, and risk.

Attention was drawn to the Trust's key achievements in 2021/22 as detailed in the report.

The Board was advised that Alder Hey played a leading role in co-ordinating acute paediatric services in C&M. A Paediatric Gold Command arrangement was established to manage acute paediatric services during Respiratory Syncytial Virus (RSV), Covid-19 and winter pressures. It was reported that paediatric providers in the region have worked effectively to deliver a C&M paediatric escalation

framework, support recovery and provide mutual aid, staff a Paediatric Clinical Assessment Service (NHS 111), support CYP with complex behaviours and provided a dedicated vehicle to establish a service over the winter to support patient transfers and mutual aid.

From a national perspective, Alder Hey is one of the ten paediatric trusts that forms the Children's Hospital Alliance. In 2021/22 the Alliance collectively secured £20m in national investment to fund a paediatric accelerator programme. Over the last twelve months the programme has invested £1m in an innovation programme, delivered more elective activity than pre-Covid, developed an intervention programme to address inequalities, and data and benchmarking. Within this programme, Alder Hey's Innovation Centre has developed an Artificial Intelligence 'Was Not Brought' Predictor which identifies families at risk of not attending appointments. It was confirmed that this technology has been rolled out to all trusts in the Alliance.

Louise Shepherd advised the Board that a further bid has been submitted to sustain the accelerator programme particularly around the work that the Innovation Centre has been leading on, with the Virtual Ward being one of those innovations.

The Chair felt that this is a remarkable list of achievements that instils a great sense of pride and highlighted the importance of recognising the contributions of the Executive Team, the Trust's workforce, and partners in terms of what was achieved in 2021/22 regardless of the challenges that Covid brought.

Attention was drawn to the five operational priorities that have been set for delivery in 2022/23; 1. Recover access to services. 2. Outstanding for safe care. 3. A great place to work. 4. Deliver financial sustainability. 5. Safely digital systems.

John Grinnell pointed out that the plan will require a much more rapid implementation of transformation to achieve the productivity/access targets that are described in the plan. This is at a time when the workforce has hardly recovered from the challenges of the last two years. It was confirmed that the Assurance Committees will be monitoring progress against the targets and the transformation that will be taking place.

On behalf of the Board the Chair thanked all those involved in compiling the Operational Plan and acknowledged the challenges and risks. It was pointed out that this is a huge step up for Alder Hey, but it was felt that the Trust should take this opportunity to make that step and deliver the results of what is a very impressive plan.

Resolved:
The Board received and approved the Operational Plan for 2022/23 and noted the National Paediatric Accelerator evaluation.

22/23/07 ICS Development Update

A number of slides were submitted to the Board to provide an update on the development of ICS's. The following information was shared:

- The Board was refreshed on the various geographies that the Trust is working across: Place, ICS, Regional, National, and International.
- *Place – What's new?*
  - Nine Place Directors have been appointed.
  - Acute collaborative discussions are ongoing in Liverpool.
  - The One Liverpool Plan has been reinstated.

- There is a new plan for prosperity that focuses on the Liverpool City Region being a place of innovation and targets fairness for all and health equity.

- *ICS - What's new*?
  - Integrated Care Board appointments have been made.
  - C&M are forming.
  - Local decisions - Need to demonstrate system benefit and best use of resources.
  - Alder Hey's role in C&M;
    - Mandate from CMAST re CYP recovery.
    - ICS supported a two-year bid for CYP transformation.
- *C&M Provider Collaboratives;*
  - Mental Health, LD, and Community trusts collaborative: It was reported that there has been a move towards a proposed Lead Provider model with a case being put forward in collaboration. Discussions are very adult sector orientated, but the Trust is driving forward its comments and thoughts on the CYP role and the connection between that and the CYP Transformation Programme.
- *ICS: Prevention pledge, Marmot and Health inequalities;*
  - Alder Hey's prevention pledge is becoming established with the Health Inequalities and Prevention Steering Group who are overseeing the pledge.
  - There has been a successful bid for a Health Education England Population Health Fellow.
  - The Trust is developing its role as an Anchor Institution.
  - Relationships are being built with the Marmot team.
  - Alder Hey is connected with the national Core 20+5 CYP Health Inequalities model that is to be published imminently.
- *NW Region - What's new?*
  - SpecCom is progressing a case for change for 3 system reviews.
  - New NHS NW Paediatric Recovery Group.
  - Continued partnership with Royal Manchester Children's (RMCH) for specialised CYP services at Northwest level.
  - Mutual aid from Alder Hey for RMCH long wait patients (Gastro and Plastics).
  - There is uncertainty for Specialist Commissioning in the new architecture.
- *National - What's new?*
  - Children's Hospital Alliance: Phase 2 Accelerator pitch for £30m has been submitted to the Centre.
  - The Welsh Commissioners have opened a case for change to repatriate some paediatric specialisms. Early discussions are taking place regarding this.
- *International - What's new?*
  - Developing opportunities.
  - Strategic ambition needs reframing by the Trust as part of its 2030 vision and Strasys analysis.
- What does this mean for Alder Hey?
  - Alder Hey will continue to advocate and lead for CYP across every pitch and continue to shape the Trust's offer.
  - The Trust has a unique opportunity to be truly led by CYP.
  - The organisation's 2030 vision must align with the needs of C&M and Place(s).
  - The Trust is committed to collaborators and partners in all relevant system groups, at every level.
  - Alder Hey's success is heavily impacted by C&M.

- Alder Hey must continue to collaborate on every pitch and consider its readiness for specialist service delegation/lead provider.

Anita Marsland highlighted the importance of engaging with the new Place Leads in order to promote Alder Hey. It was reported that the Trust is going to make contact with all nine of the Place Leads from a transformation perspective.

The Chair felt that it is imperative that the Board is updated on ICS developments on a regular basis.

Resolved:
The Board noted the ICS development update.

22/23/08 Next Steps in Developing the Trust Strategy

John Grinnell opened the agenda item by providing an overview of the thinking that has taken place which has resulted in a refresh of the Trust's 2030 vision. It was pointed out that the organisation needs to reconstruct its vision via the lens of its populations in a much rigorous and evidence-based way. It was reported that Alder Hey has been working with a company called Strasys who have helped other trusts develop their vision into a more data driven, population health piece that drives strategies.

Why now? - Dani Jones reported that Alder Hey's 2022/23 Operational Plan is set in context of C&M ICS's expectations and the Trust's existing 2019-2023 "Our Plan" Strategy, which was developed in 2019 in line with the NHS Long Term Plan. It is recognised that the impact of Covid-19 has driven radical shifts in healthcare as well as a massive architectural shift in NHS and Social Care. In light of these major context changes the Board has recognised the need to expedite the organisation's strategy refresh for 2030, undertaking this in 2022.

Attention was drawn to the strategy session that took place in January 2022 which highlighted the need for the Trust to focus more on; CYP being at the heart of all that the organisation does, developing strategic intelligence/empirical evidence for decision making and shaping the vision to meet the needs of its populations.

What are we doing and why? - The aim is to have the greatest impact on CYP's lives: to be smart about the things the Trust choses to do between now and 2030 by creating a deep understanding of CYP and families' health and wellbeing needs, by September 2022.

The purpose is to provide outstanding care that is sustainable and continues to meet the changing needs of CYP. The Trust will need to think differently about how it does this given the changing environment

It was reported that the Trust will do this by working with Strasys, who are experts in analytical insight healthcare analysis and have a successful track record of looking at population segments in different ways. This analysis will support the Trust's clinical strategy and initiatives by providing analysis and evidence to support the organisation's thinking. The development phase has commenced, and the aim is to publish the 2030 vision in Autumn 2022, following crucial engagement with clinical and corporate colleagues, CYP, families, Trust Governors, and system partners.

It was pointed out that the Trust is in a strategy transition year, therefore pragmatism is required to support sub-strategies in development, for example, Quality and Safety, Research, Education and Innovation Framework, Innovation and Digital. It

was confirmed that the Board will consider these together in May 22. Further detail will also be provided during May's Trust Board in terms of the Trust's 2022/23 offer into the wider system as part of the Operational Plan.

Fiona Beveridge expressed her interest in meeting with the leads of Strasys and suggested a group session if other NEDs were interested. The Chair asked that NED colleagues advise as to whether they are agreeable to meet with the Strasys Project Leads.

The Chair thanked Dani Jones for the presentation and felt that the Board had received an outline of expectations in terms of what needs to be addressed over the summer months.

22/23/09 Digital and Information Technology Year-End Update.

The Board received a year-end update on the progress against the Digital Futures Strategy, the overall service, key areas of transformation and operational performance. The following points were highlighted:

- It was reported that one of the Trust's key achievements in 2021/22 was receiving international HIMSS Level 7 accreditation.
- MIAA has conducted audit reviews on IT Service Continuity and Resilience, and Data Quality of which both received substantial assurance opinions.
- The refresh of the Digital Strategy for C&M is underway with a strategy session taking place in May to look at the finer details. The Board was advised that the Trust is actively engaging with regional teams and will ensure its contributions are captured and portrayed in the refreshed strategy.
- The Trust is continuing to head towards a go live date of September/October for the Alder Care Programme. It was reported that the programme is progressing against plan, but it was pointed out that there have been a number of challenges due to it being such a significant change programme.
- Work on the Trust's website is progressing and elements of it will be included in the safe systems work referred to in the 2022/23 Operational Plan.
- It was reported that the score relating to BAF risk 4.2 *(Digital Strategic Development and Delivery)* has increased due to some of the challenges that the Trust has in terms of gaps in the Digital workforce. It was confirmed that a number of mitigations have been implemented to address the challenges.
- Attention was drawn to the appointment of the new Chief Clinical Information Officer, Dr Chris Grime, following a recent recruitment process. It was pointed out that this appointment will help drive Alder Hey's Digital Strategy forward with the voice of clinicians at the heart of the Trust's digital work.

Shalni Arora queried as to whether the gaps in the digital workforce will have an impact on other risks in the BAF from a transformational, safety, quality, and recovery perspective. It was reported that this may have an impact elsewhere, but the Trust is confident that the mitigations that have been put in place via the Skills Development Network and the recruitment drive will address the challenges.

Resolved:
The Board received and noted the Digital and Information Technology year-end update.

22/23/10 Alder Hey in the Park Campus Development Update

The Board received an update on the progress, risks, and actions on key capital

projects. The following points were highlighted:

- *Catkin Building and Sunflower House Construction* – It was confirmed that both schemes will be completed by the 15.5.22.
- *Neonatal and Urgent Care Development* – Phase 1 of the enabling work to create a temporary car park for the Emergency Department has been completed and is awaiting handover. It was reported that construction of the development will commence June once the commercial aspect of details have been addressed.
- *Park Reinstatement* – The Board was advised that there is a plan in place for vacating the old Catkin building based on temporary cabin accommodation for staff. There is also a suite of schemes that are being established to enable staff to be rehoused in alternative accommodation. Once staff have been fully briefed on plans for their respective move work will take place on an internal piece of comms to broadcast in detail the forthcoming moves.
- *North East Plot Development* – Negotiations are ongoing with Step Places about the buyback land option.
- *Police Station* – The Trust is close to completing the legal agreements for the Police Station which will provide some long-term expansion potential. The Trust is also looking at neighbouring sites.

Resolved
The Board received and noted the Campus Development update provided as at the 28th of April 2022.

22/23/11 Alder Hey's Green Plan Progress Report

The Chair welcomed the new Green Plan Project Director, Alex Pitman, who advised of the importance of operationalising the plan in order to show progress. It was pointed out that work has been taking place to look at the pragmatic things that can be done quickly and discussions are being held with staff members who are providing lots of ideas on this subject.

The Board received a report that sets out the next phases of Alder Hey's Green Plan and the proposed actions that will move the Trust forward to Net Zero. The following points were highlighted:

- A governance structure has been developed and a monthly Programme Board established, which will be chaired by Garth Dallas, to take forward the process of delivering the Net Zero Plan. The workstreams will need to be very operationally focussed and a risk profile is to be developed that will cover both high level and operational risks.
- Three initial phases have been identified in the Green Plan, of which, Phase 1 has commenced in terms of beginning to deliver with the immediate goals of energy, waste, and travel. The Trust aims to embed Phase 1 within the next four to six months and start wider engagement and communication across Alder Hey in May/June.
- It was reported that the first phase of work is targeted to save £1m in energy costs and reduce energy related carbon emissions by 10%, and £30k in waste costs. There is a caveat in respect to energy savings that requires a lot of negotiation with the SPV and Executive oversight.
- The Board was advised that one of the key areas that will need to be addressed by the Programme Board is the measuring of progress against clear objectives. It was confirmed that this information will be included in the next update report.

- From a partnership perspective, Alex Pitman is scheduled to meet with the newly appointed Green Travel Co-ordinator at LUFT. It was also pointed out that one of the major strategic shifts is to arrange for the NHS/ICSs as a whole to work in partnership with regions and Local Authorities on the Green Travel Plan agenda.

Garth Dallas reported that the Green Plan aims to focus on practical results and portray the Trust as a measure of good practice around sustainability within every aspect of the work it conducts. There are phases of work that it was felt will encourage staff to take on board the overall culture of 'simple things that can make a change'.

Resolved:
The Board received and noted the update on the Trust's Green Plan.

22/23/12 Serious Incident Report

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.3.22 to the 30.3.22. The following key points were highlighted:

- It was reported that there were no new Serious Incidents declared or Level 2 RCAs commissioned in March.
- *StEIS Reference Number 2021/20934 (Delay in treatment)* - It was confirmed that this Serious Incident was fully investigated and closed in March 2022. The investigation of this incident was based on an aggregate review of three incidents relating to the Urology Outpatients Department. The three incidents relate to the booking and scheduling process for appointments and follow ups. It was reported that the learning from this incident is about taking time to consider the impact when making changes, particularly at pace, to systems and processes and consider how the Trust minimises the risk in the system.
- *Progress position of action plans* – It was reported that work is still ongoing to address the open action plans that are past their expected date of completion. It was confirmed that this work will be completed by the end of April.

.

Resolved:
The Board received and noted the contents of the Serious Incident report for period from the 1.3.22 to the 30.3.22.

22/23/13 Ockenden Review Update 2022

The Board was advised that the Ockenden report is the outcome of an independent review of the maternity services provided by the Royal Shrewsbury and Telford (RST) NHS Trust. Whilst the report focuses on the maternity care of women at the RST Trust the report also covers neonatal care and highlights some wider learning points for organisations. The Trust reviewed the overall report as some of the themes and learning required consideration by Alder Hey.

Following the review, the Trust agreed six categories that are directly applicable to Alder Hey, in order to provide assurance that the organisation has robust procedures in place to address the recommendations in the report. A Trust wide action plan will be developed which will be monitored via the Safety and Quality Assurance Committee and presented to the Trust board for information and approval in June.

22/23/13.1 Action: NA

Louise Shepherd queried as to whether the recommendation that refers to Neonatal Partnerships has been addressed in collaboration with the Liverpool Neonatal Partnership team (LNP). It was confirmed that a discussion has taken place with the LNP team, and it has been agreed to conduct a joint review and submit an independent report in due course. Following discussion, it was agreed to share Alder Hey's action assessment plan with the Board at Liverpool Women's Hospital (LWH) to ensure that both organisations are sighted on any potential problems and arrange a meeting with LWH's leadership team to enable a joint statement to be issued so that clarity is provided in terms of the joint approach to this matter.

22/23/13.2 Action: NA

Resolved:
The Board received and noted the 2022 Ockenden review update.

22/23/14 Mental Health Units Use of Force Act (2018)

The Board was updated on the changes made to the Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England, which came into effect on the 31st of March 2022. The following points were highlighted:

- The Use of Force Act (2018) applies to all patients in mental health units.
- Alder Hey has taken a number of actions to ensure compliance with the Act;
  - *Appoint a Responsible Person* – The Trust has appointed the Chief Nursing Officer as the "responsible person" who will be supported in this function by the Director of Community and Mental Health Services.
  - *Review relevant policies and procedures to ensure they meet new requirements* – The current Trust policy has been updated to include the relevant components of the Act and is in draft format awaiting approval. The section on training requires some further minor clarification in relation to what should be provided, when and how often, but it was confirmed that standards are met in relation to current provision within the Trust's Tier 4 Children's Inpatient Unit.
  - *Provide information to patients about use of force* - An appropriate leaflet for CYP is currently being developed with an Independent Advocate and relevant Children's Forums. This will be available in May 2022.
  - *Staff training on use of force* - It was reported that all clinical staff and Tier 4 Children's Inpatient Unit clinical staff have completed the physical intervention training and will receive annual refresher training to enable safe and proactive physical restrictive interventions where risk requires this. New staff are being put through the Train the Trainer in CALMS Physical intervention approaches
- Improvements regarding the reporting of restrictive physical interventions were made in 2021 to the Trust's incident reporting system but additional work is now required to update this. This will be completed by June 2022.

Resolved:
The Board noted the contents the Mental Health Units Use of Force Act (2018) report.

22/23/15 IPC Update

The Board received a presentation on the roadmap for Alder Hey in terms of getting to and sustaining the new normal for living with Covid. A number of slides were shared which provided information on the following areas:

- It was reported that during March there has been an increase of positive testing among staff and patients, on a par with figures in December 2021.
- The number of BA.2 cases have decreased in Liverpool as at the 5.4.22 but attention was drawn to the enormous amount of cuts that have been made to the testing programme. It was pointed out that without data from testing it will be harder for the Trust to prepare for the next surge.
- It was reported that there has been an increase in Flu and RSV in children during the last two weeks and Public Health England have advised of an increase in scarlet fever, chicken pox and severe acute hepatitis. The Board was also advised of the reduction in children having routine vaccinations.
- The Board was advised of the importance of building on what has been learnt from the pandemic and what has been proven to be effective to reduce the transmission of Covid; vaccination, the wearing of masks, physical distance especially when unmasked, training staff on the use of PPE.
- *Future IPC guidelines for the Trust* - Universal mask usage to become the norm during respiratory and viral season, continue with Covid-19 testing in order to control transmission, have a data driven approach to lift restrictions. It was also pointed out that the track and trace of exposed staff and rapid access to Covid-19 testing should continue.
- It was confirmed that the roadmap for the living with Covid-19 response has been deferred by a week but is still in place.

It was questioned as to why patients from outer reaches of the region are having to travel to Alder Hey's testing station for a PCR test ahead of planned surgery. It was reported that the Neurosurgery Department was able to arrange local testing for patients but other surgical departments in the Division struggled to do this due to lack of support therefore Track and Trace offered an on-site service for patients. The Board was advised that the Trust is in the process of looking at an alternative approach for families. Following discussion, it was agreed that the Trust should look towards progressing a model, if possible, based on local testing for patients and share this information via the network.

22/23/15.1 Action: BL

Resolved:
The Board noted the IPC update.

22/23/16 Corporate Report

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

Medicine

Sepsis (safe domain) – It was reported that a Lead Nurse for Sepsis has been appointed and will commence in post on the 11.5.22. In the absence of the Sepsis Nurse in ED, the Matron and Governance Lead are reviewing Sepsis data from BI on a daily basis which has confirmed that to date that the Trust is compliant with the identified one-hour target. This area of work has been included on the risk register until the Lead Nurse for Sepsis is in post on a full-time basis.

ED Performance (effective domain) – The Board was advised that the four-hour access target for March was recorded at 64.9%, with 10% of patients leaving prior to being seen. There has also been a rise in PALS/complaints. The Board was advised that work is taking place to mitigate this issue via discussions with the ED team and the use of the 'Go to Doc' facility which is supported by GPs seven days a week and

is situated in the Outpatient Department. The Trust has also recruited four new ED consultants.

Surgery

Hospital acquired infections (safe domain) – The Division of Surgery (DoS) has implemented a new process within the Division whereby all hospital acquired infections are reviewed at the new Divisional IPC meeting.

Complaints (caring domain) – It was reported that there has been a theme with regard to complaints around patients with long term care needs therefore the DoS has implemented a buddy system for families to enable issues to be raised with a matron/senior nurse so that they can be addressed in the early stages.

Paediatric Dentistry (responsive domain) – The Board was advised of the specific challenge around compliance from an inpatient/outpatient perspective for dentistry. There is an action plan in place that is addressed on a weekly basis to improve this area of work, but it was pointed out that paediatric dentistry is a national problem, and the Trust is struggling to find the appropriate workforce to support additional capacity. Alder Hey is also seeing an impact around other service closure in C&M, most recently in Southport.

The Chair queried as to whether the System is sighted on the problems being experienced relating to paediatric dentistry. The Board was provided with an overview of the issues being experienced following the resignation of an Orthodontist in Southport with a patient cohort of 800. It was confirmed that the Trust is in negotiations with the CCG to see how this matter can be addressed as Alder Hey doesn't have capacity to treat this cohort of patients. Louise Shepherd drew attention to the importance of the Trust having oversight of paediatric services and working in collaboration with the ICS and commissioners to address this predicament.

Mandatory training position (well led domain) - There has been a focus on mandatory training with the nursing teams which including a weekly challenge board to improve compliance. It was confirmed that this has had an impact therefore the DoS is looking to replicate this process across other staff groups in the Division.

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

22/23/17 People and Wellbeing Update
Resolved:
The Board received and noted the contents of the People and Wellbeing report.

EDI Steering Group Update

It was reported that a meeting took place between Garth Dallas and Melissa Swindell to discuss the progression of the EDI Steering Group. It was confirmed that the group will focus on a very inclusive agenda which will cover race, disability, LGBT, gender, leadership, recruitment, and other areas. One of the next steps is to draft the ToR ahead of the inaugural meeting in May.

Resolved:
The Board noted the EDI Steering Group update.

22/23/18 Recognition of the Trust as a Going Concern

Resolved:

The Board agreed that 2021/22 annual accounts and associated financial statements should be prepared on a Going Concern basis following the agreement by the Audit and Risk Committee on the 21.4.22 to support this recommendation.

22/23/19 Board Assurance Framework

The Board was provided with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives. The Following points were highlighted:

- It was reported that the financial environment and new ICS NHS legislation/system architecture present the biggest risks to the Trust heading into the new financial year.
- The Board was advised that Alder Hey received a very strong opinion from MIAA on the organisation's assurance framework which enabled the Trust to issue a strong Annual Governance Statement.
- The risk rating for BAF risk 4.2 (*Digital Strategic Development and Delivery*) has increased due to gaps in the Digital workforce.

Resolved:

The Board received and noted the contents of the Board Assurance Framework report as at the end of March 2022.

22/23/20 Financial Update for Month 12 – 2021/22

The Trust achieved an in-month trading deficit of £935k in March with the draft year end position for 2021/22 a £137k surplus against the breakeven plan. It was felt that this is a positive achievement given the risks that were inherent within the plan at the start of H2.

Attention was drawn to a number of key areas included in the year end-position;

- Income £26.9m favourable variance to plan.
- Non-Pay £28.1m adverse variance to plan.
- Capital spend of £30.1m.
- CIP achievement in year of £6m against the £7m target, recurrent gap of £2.8m.
- Cash at the year-end was £91.5m.

Rachel Lea offered thanks to all those involved in helping the Trust achieve a successful year-end position. The Chair reiterated Rachel's thanks.

Resolved:

The Board received and noted the financial update for M12, 2021/22.

22/23/21 Board Assurance Committees

Audit and Risk Committee - The approved minutes from the meeting held on the 20.1.22 were submitted to the Board for information and assurance purposes. An overview was provided of the agenda items that were discussed during the meeting

that took place on the 21.4.22, and attention was drawn to the substantial assurance 'Head of Audit Opinion' which was provided by MIAA for 2021/22.

RABD – The approved minutes from the meeting held on the 28.3.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 25.4.22 there was a focus on the Campus including the contractual/PFI issues, and the six areas of focus that the Committee are going to track and monitor in 2022/23.

SQAC – The approved minutes from the meeting held on the 23.3.22 were submitted to the Board for information and assurance purposes. An overview was provided of the agenda items that were discussed during the meeting that took place on the 27.4.22, and attention was drawn to the 20% reduction in medication errors that was reported to the Committee.

PAWC – The approved minutes from the meeting held on the 22.3.22 were submitted to the Board for information and assurance purposes. An overview was provided of the agenda items that were discussed during the meeting that took place on the 25.4.22, with specific attention being drawn to the increase in sickness absence rates (7.8%) which are impacting the Trust.

Innovation Committee – The approved minutes from the meeting held on the 7.2.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 19.4.22 it was reported that the Committee received a presentation on the Lab to Life Child Health Data Centre, an update on the Alder Hey Any Where Platform and discussed the Operational Plan that will support the delivery of the Innovation Strategy.

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

22/23/22 Any Other Business

There was none to discuss.

22/23/23 Review of the Meeting

The Chair felt that the Trust had ended the financial year in a good position and drew attention to Alder Hey's major successes, as highlighted in the Operational Plan. The Chair pointed out that over the next few months it will be necessary as a Board to work together to look at how things can be done differently to further transform what the Trust is delivering to CYP.

Date and Time of Next Meeting: Thursday the 26th of May 2022 at 9:00am via Teams.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2022- March 2023)

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2022							
24.2.22	21/22/276.2	BAME Inclusion Taskforce Update	*NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.* - Discuss the possibility of Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and child health across the BAME communities.	S. Arora/ C. Dove	28.4.22	May-22	**22.4.22** - An update will be provide on the 28.4.22. **28.4.22** - It was reported that tackling health and inequalities/data that the Trust generates is being addressed via the Accelerator Programme. The Innovation Committee received a presentation on the Lab to Life Child Health Data Centre which is focussing on a different area of work therefore it was suggested that a conversation take place with Claire Dove to provide an update and discuss the possibility of further funding to support the Accelerator Programme in respect to health inequalities. **ACTION TO REMAIN OPEN**
24.2.22	21/22/272.1	Q3 Mortality Report	*New Medical Examiner Process* - Liaise with the Children's Alliance to see if they can offer any support on the new ME process.	A. Bass	26.5.22	May-22	**31.3.22** - A meeting has been scheduled for the 28.4.22 between the Trust, Manchester Children's Hospital and the regional ME to discuss a way forward in terms of providing a service for a relatively small number of children. It was agreed to provide an update on the outcome of the meeting during May's Board meeting. **ACTION TO REMAIN OPEN**
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.	Adrian Hughes	30.6.22	On track Jun-22	
16.12.21	21/22/214.1	Chair's/CEO's Update	Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.	K. McKeown	28.4.22	Jun-22	
28.4.22	22/23/13.1	Ockenden Review Update 2022	Submit the Trust wide action plan that has been compiled following the 2022 Ockenden Review, to the Board on the 30.6.22.	N.Askew	30.6.22	On track Jun-22	
28.4.22	22/23/15.1	IPC Update	*PCR Testing for Patients Ahead of Surgery* - Look towards progressing a model, if possible, based on local testing for patients and share this information via the network.	B. Larru	30.6.22	On track Jun-22	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
24.2.22	21/22/271.1	SARC Accreditation	Align the accreditation process with the changes that the Trust wants to make to the SARC service and provide an update on the outcome in terms of what the whole process will entail.	L. Cooper	26.5.22	Closed	22.4.22 - This action has been deferred to May 2022. **28.4.22** - This process has commenced and updates will be fed into SQAC when appropriate. **ACTION CLOSED**
28.4.22	22/23/13.2	Ockenden Review Update 2022	Share Alder Hey's action assessment plan that has been compiled following the Ockenden review, with the Board at Liverpool Women's Hospital (LWH) to ensure that both organisations are sighted on any potential problems and arrange a meeting with LWH's leadership team to enable a joint statement to be issued so that clarity is provided in terms of the joint approach to this matter.	N. Askew	26.5.22	Closed	**25.5.22** - The Trust has shared its action assessment plan with LWH and a joint statement is in the process of being compiled. **ACTION CLOSED**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	Liverpool Independent Clinical Review – Terms of Reference
Report of:	Louise Shepherd, CEO
Paper Prepared by:	Dani Jones, Director of Strategy Erica Saunders, Director of Corporate Affairs

Purpose of Paper:	Decision Assurance **Information** **X** Regulation
Background Papers and/or supporting information:	Liverpool Independent Clinical Review
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** **X** Game-changing **research and innovation** **Strong Foundations**
Resource Impact:	N/A

Independent Clinical Review
TERMS OF REFERENCE

1 Introduction

To ensure acute hospital services in Liverpool are fit for purpose for the future to improve outcomes and patient experience, improve equity, reduce variation, improve productivity, efficiency and effectiveness making best use of the systems assets.

Cheshire and Merseyside Integrated Care System (C&M ICS) have been asked by NHSE/I to commissioning an independent review of the acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The review needs to address the longstanding issue and position of Liverpool Women's Hospital NHS Trust, which has been subject to clinical review, however a solution is yet to be agreed. There are areas of outstanding practice and service which should be identified and build upon.

However, no service exists in isolation, the review must consider the opportunities to delivery care closer to home and principles as set out in the "One Liverpool" strategy, and the interdependencies with and obligations to the Cheshire and Merseyside system as a whole and beyond.

Our objectives are to:

1. Identify the optimum acute care model for Liverpool, and make recommendations about the priority of the service changes that need to be made (considering any consequences on out of hospital care including Mental Health)
2. Identify the risks and governance implications for any proposed model on the wider role played by all the Liverpool trusts in relation to services provided to populations outside of the city boundary, ensuring that the needs of these populations are appropriately met, and that due consultation is given to reducing existing inequalities of access.
3. Identify opportunities to move care closer to home/digitise the service model and consequences on Community and primary care (physical and mental health services, all age), and consideration of the consequences for social care.
4. Improve equity and integration in terms of access and outcome (clinical and patient experience) in line with the aims and objectives of the ICS and One Liverpool Strategy.
5. Describe the outcomes and solution that will be achieve financial and operational sustainable from a revenue and capital perspective giving recommendations on value for money.

2 Scale and scope of the review

The independent review will

- Develop an acute care model for secondary and tertiary services across Liverpool and corresponding out of hospital model for primary and community services that must deliver
    - Best clinical/evidence-based practice and be patient focused
    - Reduce clinical risk
    - Improve equity and quality (clinical, patient experience and outcome)
    - Efficient and effective (value for money)
    - Safe and sustainable (workforce and financial)

- Ensure that the proposed model incorporates the opportunities to maximise education, research, and innovation opportunities, that enhances the reputation of the Liverpool system both nationally and internationally and improves workforce supply and retention
- Identifies opportunities to modernise service models, through better use of technology and telehealth and delivered as close to home as possible and delivers sustainable services out of hospital supported by a single longitudinal care record.
- Identify areas of good practice that could be rolled out/shared.
- Identify the estate and infrastructure (including Digital) requirements of any proposals and associated workforce, capital/revenue consequences
- Identify the risks to delivery and governing implications of any proposed models
- Consider the patient and public engagement and consultation requirements in any solution/options

This review should be conducted in full recognition of the NHS Long Term Plan and One Liverpool Strategy. The One Liverpool Strategy commits to being all age, physical and mental health, empowering residents, improve equity and outcome focused.

3 Population included

It must be recognised that Liverpool Hospitals and community providers offer services to a large population from across Merseyside, particularly across Liverpool, Sefton, and Knowsley. Tertiary providers also offer services to patients from Cheshire, Merseyside, Isle of Man, North Wales and nationally. Also supporting service provision at neighbouring DGHs, and train future staff for a significantly wider footprint.

The Cheshire & Merseyside Acute & Specialist Trusts provider collaborative (CMAST) will be included in the process as a major stakeholder.

4 Organisations to be included

1) To be included in the review, key organisations are as follows:

    a. NHS Trusts

        a. Alder Hey Children's NHS FT
        b. Clatterbridge Cancer Centre NHS FT

c. Liverpool Women's NHS FT
d. Liverpool Heart and Chest NHS FT
e. Liverpool University Hospitals FT
f. Mersey Care NHS FT
g. The Walton Centre NHS FT

b. General Practice – 1 Local Medical Committee (LMC) 10 Primary Care Networks (PCNs)
c. Liverpool City Council
d. Cheshire & Merseyside Acute & Specialist Trusts provider collaborative and Cheshire and Merseyside out of hospital collaborative

5 Accountability for the review

The Review will be commissioned by Liverpool CGG on behalf of the ICS (until the Integrated Care Board is established) with day-to-day oversight through the One Liverpool Partnership Board. Regular updates and reports will be provided to the C&M ICB. Engagement with other partners will be built into the communication plan.

6 Conflicts of Interest

The Review will be independent however arrangements to manage conflicts and potential conflicts of interest to ensure that recommendations made will be taken and seen to be taken, without any possibility of the influence of external or private interest.

7 Working Groups

To assist the review team, deliver on its role and responsibility, the One Liverpool Partnership Board will provide guidance and support to the review process and support the establishment of working groups and agree the membership, role, and remit for each working group.

8 Monitoring Effectiveness

The One Liverpool Partnership Board will ensure delivery of the agreed work plan and deliverables in line with timescales. It will keep and provide regular updates on progress, issues, and risks to the C&M ICB.

9 Outcome and Timescales

Stage 1

Produce a detailed acute model of care considering the requirements above that describes any opportunity for wider reform and or consequences for other services across the system.

Our outcomes objectives for this review are:

- improved outcomes and equity for the population
- patient/user/citizen centred services
- improved quality, safety, and patient experience
- improved efficiency and effectiveness
- increased ability to recruit and retain staff

The report will set out clear recommendations and decisions required, together with any identified risks, governance implications, workforce risks/opportunities, sustainable capital and revenue requirements/consequences, prioritised based on clinical risk and patient outcome/benefit.

Stage 2
Produce a detailed implementation plan that sets out the priorities for delivering the new model of care. Considering the need for fulfilling statutory responsibilities to engage and consult. Sets out the clinical and workforce leadership requirements to deliver plans and consider the appropriate governance arrangement to support timely decision making and value for money.

The proposed methodology, time scale and clinical leadership of this review needs to be set out in any proposal as part of the procurement process and be in place for the commencement of the contract noting the staged approach set out above.

Agreed by: **Date:**	**System Oversight Board** **27 April 2022**

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Campus Development Monthly Update**
Report of:	**Development Director**
Paper Prepared by:	Associate Development Director (Acting) Jim O'Brien

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

Campus Development report on the Programme for Delivery

May 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 5 in Quarter 2 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Salient Points

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Programme and Cost Pressure	Working closely with contractor to finalise and agree in preparation for presentation to Board
Sunflower House / Catkin	Programme delay; HO 1st July 2022	Weekly route to HO meetings held, internal contingency on programme held.
Temporary Modular Office	Planning approval	Working with LCC liaison and LPA to agree route.
Main Park Reinstatement	Vacation of Catkin, linked to Sunflower House / Catkin and modulars projects and their programmes.	PM brought in to over see the management of these works to coordinate and tie together.
Innovation Park 2	Programme delay; HO 22nd July 2022	Project meetings being held to mitigate works and fast track elements.

3. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2021-2023 (financial years).

Table 1.	21/22				22/23			
Scheme	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Neonatal and Urgent Care Development Contractor Selection								
Neonatal and Urgent Care Enabling – Car Park								
Neonatal and Urgent Care Enabling – Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (March 2024)								
Sunflower House / Catkin Construction								
Sunflower House / Catkin Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Alder Centre)								
Police Station Design								
Police Station Construction								
Relocations								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 2-100%) **COMPLETE**								
Main Park Reinstatement (Phase 3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Medical Photography / Orthotics								
Innovation Park 2								

4. Project updates

Neonatal and Urgent Care Development

Current status	Risks/issues	Actions
Phase 1 of the enabling works to create a temporary ED car park have completed. Infrastructure enabling and realignment of the Blue Light road paused to re-assess. Finalising contractor selection and contract award. Developing costs and programme.	Project delays in contractor selection and appointment. Programme delay due to contractor selection and pause of enabling works. Project Co engagement extending the programme and increasing costs. NHSEI delay start by Trust requiring a separate approval for the PFI variation.	Fast tracking cost and programme elements. Establishing early works and enabling schemes to maintain momentum. LOI being agreed. Continue working with Project Co to mitigate impact. Liaising with NHSE/I and PFU to avoid delays

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Completion date delayed until 1st July 2022. 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.	Further programme delays. Budget for furniture is inadequate.	HO date advised by contractor is 17th June 2022, Trust have extended this internally to 1st July 2022 to mitigate any further construction delays. Costed schedules to be produced to ensure affordability and then order furniture.

Modular Office Buildings

Current status	Risks/issues	Actions
LOR and Portakabin engaged to provide both modular solutions. Larger unit by Alder Centre being provided by LOR; layouts agreed and signed off and programme agreed. Smaller unit in Police Station car park being provided by Portakabin; design agreed awaiting layouts to approve. Planning being submitted 22/04/22 for both modules.	Planning consent.	Liaising with dedicated LCC liaison officer to ensure approval in line with LCC time scales.

Police Station

Current status	Risks/issues	Actions/next steps
Documents with lawyers for checking. Signature expected in April 2022 Agreement made to renovate whole building. Asbestos survey complete and design commenced. Layouts agreed with Stakeholders and progressing to tender / direct award.	Police do not release the space while decisions are made in regard to additional police funding and its use. (Risk 2088, risk rating 12) Asbestos works more extensive than anticipated. Cost increase due to additional asbestos and condition works.	Complete legal agreements. Reviewing asbestos report (obtained 21/04/22) Reviewing works and costings.

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Phase 1 of the park is now operational. Grassed area being re-seeded and drainage installed to ensure longevity. A planning application for the Multi-Use Games Area (MUGA) has now been submitted. The application is set to be determined by delegated powers by 22nd April 22. Decision pushed back by LCC, who have asked for an acoustic survey to be provided.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9)	Performing acoustic survey and liaising with LCC liaison officer to ensure progress is maintained

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Landscaping completed for Phase 2 with number of paths started. Phase 3A is planned to start in May within existing Springfield park. Aiming to complete and seed the majority of this Phase in October 22, with a planned early hand back in Summer 2023. LCC engaged and supporting AH in these works.	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.

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.

Medical Photography / Orthotics

Current status	Risks/Issues	Actions/next steps
Project on site and due to complete in June 2022. Commissioning workshop started and occupation being planned. Early occupation by Orthotics complete; only storage from Histo to be moved on completion of main works.	Project Co and sub-contractors do not manage the works efficiently.	Regular site meetings to monitor progress.

Innovation Park 2

Current status	Risks/Issues	Actions/next steps
Works commenced on site. Project delayed due to additional fire stopping within existing building. HO date of 22nd July 2022	Delays to works delays the move from Catkin.	Regular site meetings to monitor progress.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
Land value presented to Trust. Trust considering options.	Value of option not viable to Trust.	Challenge value through independent, jointly appointed valuer.

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.

5. Trust Board of Directors

The Board of Directors is requested to receive and acknowledge the update provided as of 26th May 2022.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th May 2022

Paper Title:	**Operational Update: recovery of services for children & young people**
Report of:	**Adam Bateman, Chief Operating Officer**
Paper Prepared by:	Adam Bateman, Chief Operating Officer Karl Edwardson, Head of Information Rachel Greer, Associate Chief Operating Officer Chloe Lee, Associate Chief Operating Officer Mark Carmichael, Associate Chief Operating Officer

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

1. Introduction

In April the Trust has made good progress in the recovery of elective services, as evidenced by our achievement of the national 104% recovery standard.

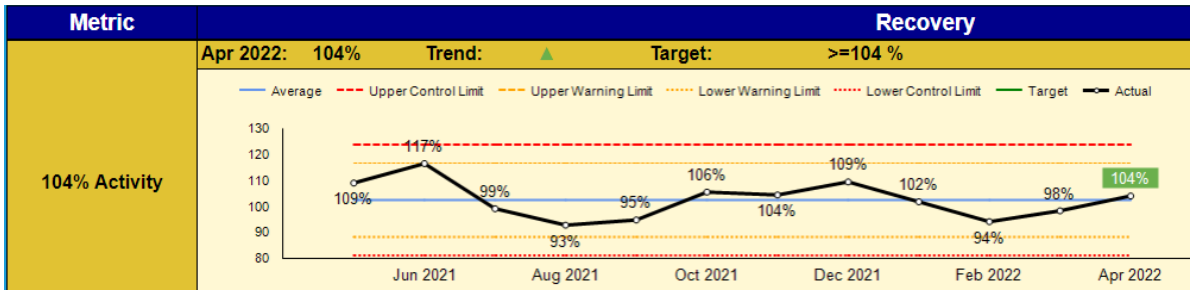
In outpatient care our recovery of services for patients requiring a new outpatient appointment is more challenged – with performance at 91% of pre-Covid levels. Conversely, follow-up care numbers are high (110%). This analysis reinforces the need to precipitate the development of our approach to follow-up care, and, with the capacity released, increase the number of patients able to access a new outpatient consultation.

In mental health and neuro-developmental pathways we have seen significant rises in referrals for the service and a plateau in waiting times to access services. We are not achieving the stretching internal waiting time standards we have set for these services. In each service, however, new investment and workforce expansion is being delivered and advanced.

In urgent and emergency care demand remains high – attendances were up 9.8% on 2019 levels. Performance relating to the number of patients seen within 4 hours has improved on the previous month to 72.4%. Nonetheless, we are clear that this remains one of our top operational priorities as it is below the standard we want to achieve; we need to make a radical shift in our approach to urgent care this year, and in doing so achieve a better patient experience and shorter wait for care.

2. Recovery of elective & outpatient services

2.1 Elective recovery



The Trust achieved 104% elective activity volume in April. Medicine elective recovery is high at 108.9%. Surgical recovery remains a challenge at 91.4%. The actions being progressed through the 'Productive Theatres' transformation group is as follows:

i. Focus on increasing day case productivity with clear goals set for cases and recovery levels by specialty

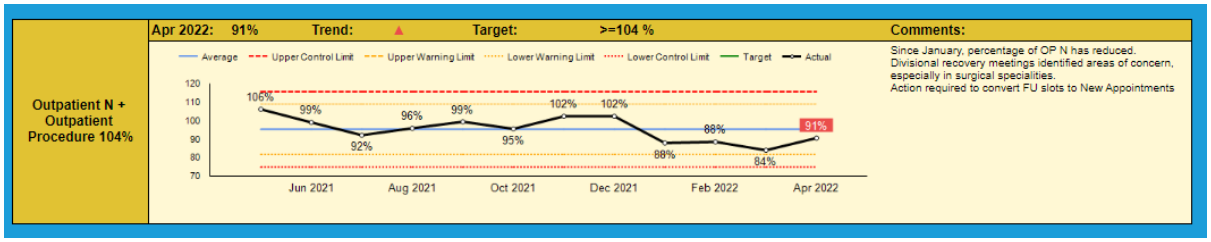
ii. Innovating to expanded list of day case procedures, sedation lists and rapid recovery

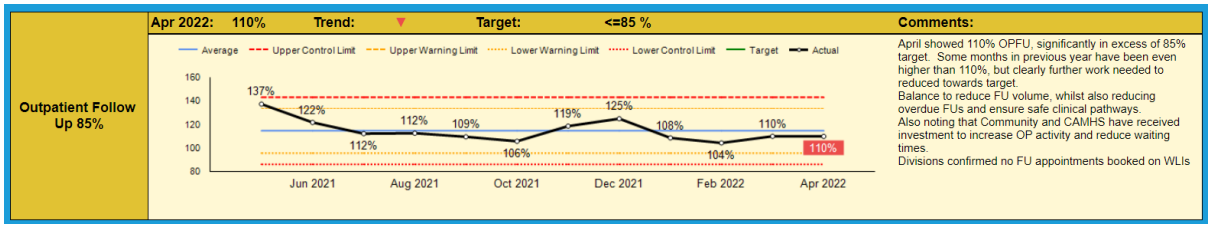
iii. Shift to pre-list planning to bring equipment, consent and list order arrangements to be concluded prior to the day of surgery. Thus, improving efficiencies to increase the number of cases per session.

iv. Increase in weekly number of theatre sessions in the schedule following anaesthetic recruitment

v. High intensity and 'Super Saturday' operating lists

2.2 Outpatient recovery

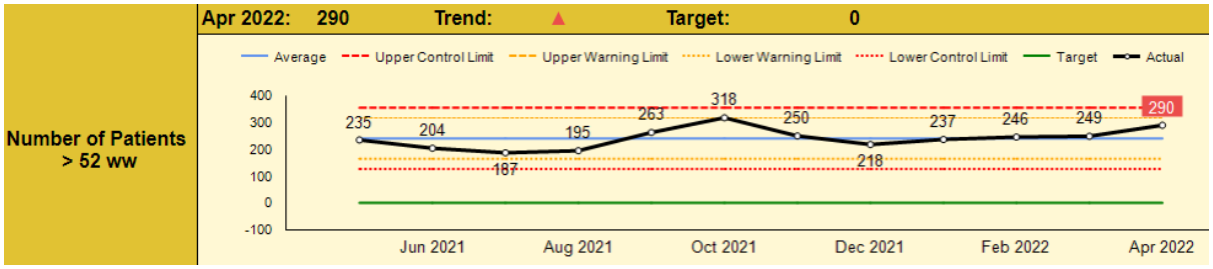




The 'Advancing Outpatient Care' programme has the following project plan that is being implemented:

Workstream	Remit	End	Update
1. Advancing care models	9 specialties to go-live on PIFU	July 22	Live in 3 specialities, 6 other specialities lined up to go live
	48 Speciality 'Developing Follow Up Care Plans' to be submitted. For local departmental action.	End of May 22	11 submissions received to date, deadline for all is end of May.
2. Booking & scheduling	New outpatient scheduling system	August 22 (TBC)	Choose a booking system – exploring systems now. Query Bookwise.
	Better processes and performance management to deliver high clinic utilisation	August 22	Explore digital solutions to backfill slots – explore potential within AlderCare platform?
3. Digital and Innovation	Increase use of virtual consultations in specialties with less than 25% usage	March 23	Data analysis of virtual consultations by speciality. High adoption in Community
	Roll out of WNB AI predictor to 6 specialties.	End of July	AI predictor live in Gen Paeds Next 6 specialties – rapid deployment in specialties with highest WNB volume
	Patient portal available, making patient letters available to patients digitally	Oct 22	Development and build of patient portal

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

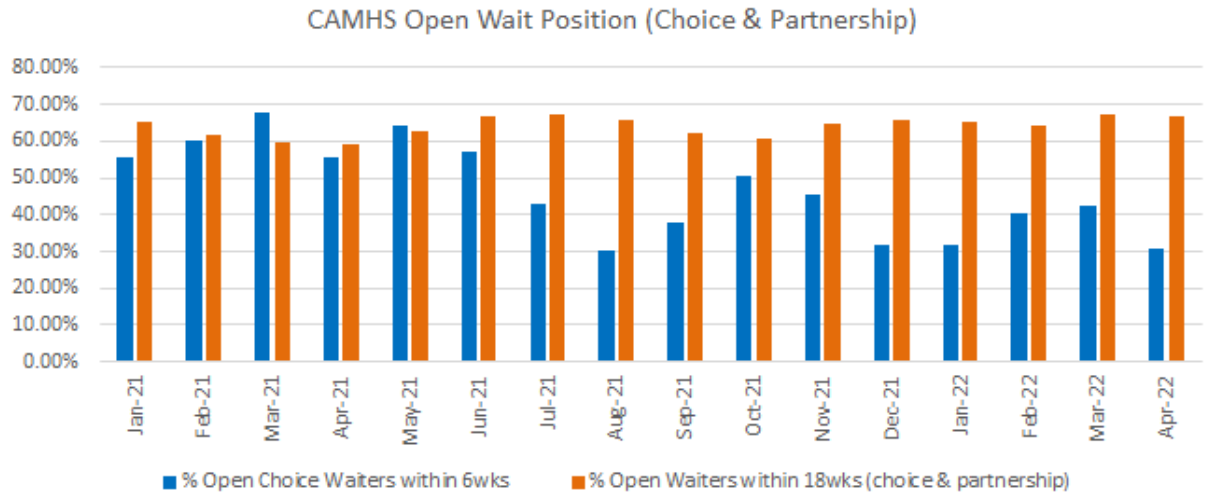


The number of C&YP waiting over 52 weeks has increased in April. The increase is driven by higher demand than available capacity in Paediatric Dentistry. This specialty represents 67% of the total long wait waiting list. A Paediatric Dentistry support plan is in place to allocate more theatre and clinical sessions to the team, expand learning disability oeprative capacity and increase the workforce.

Alder Hey has no patients waiting over 104 weeks for treatment as of the 20 Mary 2022. We are providing aid to support Royal Manchester Children's Hospital clear a waiting list backlog in gastroenterology and plastics.

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

Specialist CAMHS



Access to locality based mental health services (Liverpool and Sefton) remain challenged due to a continued increase in referrals and increase in complexity of presentation. There continues to be a high number of children and young people requiring urgent assessment and treatment has lengthened the routine appointment time.

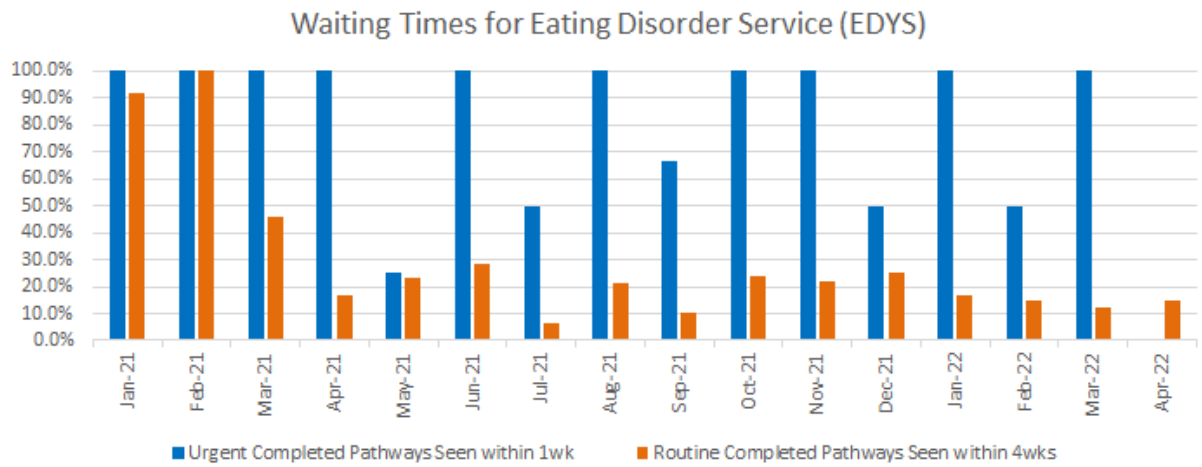
Actions

i. Required growth in capacity has been identified and a business case has been developed and shared with commissioners, with an aim to secure investment for 22/23

ii. Workforce plan developed using Brilliant Basics methodology to improve workforce availability rate and increase headcount

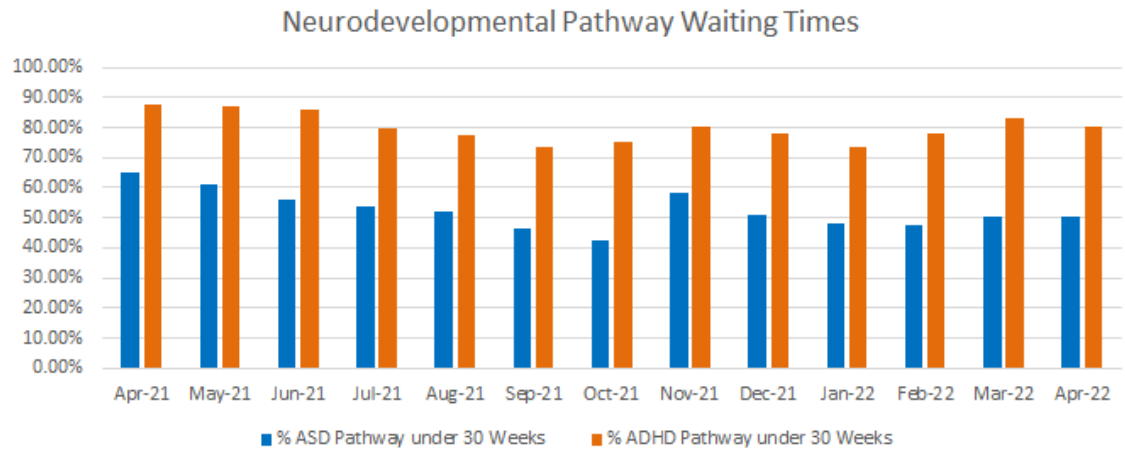
iii. Utilisation of short-term resource including overtime and agency staff to provide appointments for the longest waiting children.

Eating Disorder Service



Access times for Eating Disorder Services has been challenged for the past 12 months. However, we are projecting delivery of the routine 4 week waiting time standard from May 2022 following successful recruitment and a new assessment model for the service

4.4 Waiting times for Neurodevelopmental Pathways



Waiting times for the ASD and ADHD diagnostic pathways has remained static in April and referrals continue to be significantly above the predicted levels for 2022.

Actions

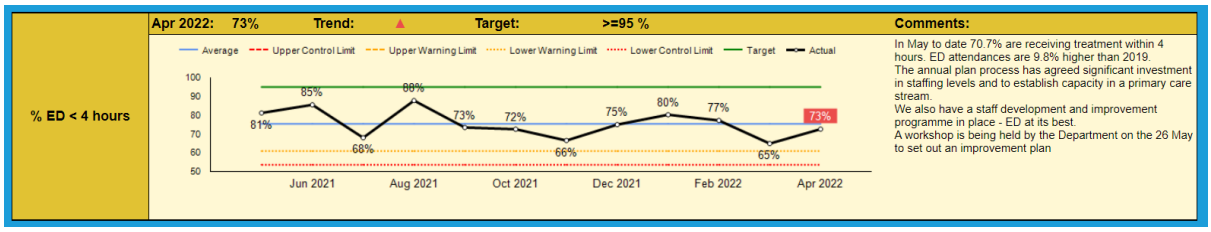
i. Investment agreed by commissioners is being utilised and recruitment to clinical posts is underway

ii. Assessment capacity continues to be provided by independent sector provider

iii. A pathway improvements is being tested to reduce waiting times between assessments.

3. Emergency and urgent care admissions and attendances

3.1 Emergency Department attendances to hospital & 4 hour standard



A programme of work is underway to support staff wellbeing and improve the children and young people's experience of our urgent and emergency care service: 'ED at its best' is the team working together to achieve this.

In May the following tests of change are scheduled to start:

Action	Impact	Start date
Increase in GP cover to 1 GP per day, and 2 GPs per day on 3 out of 7 days	Shorter time to clinical assessment	Complete
Dedicated doctor on Yellow stream	Ensure wait to be seen in maintain when acuity in department increases.	16/5/22
Book low acuity patients attending overnight into GP appointments the following morning	Reduce pressure out of hours on staff and improve patient experience for lower acuity patients	23/5/22
Refresh of roles and responsibilities for shift leadership	Ensure consistency of key roles in managing ED department flow and escalation.	23/5/22

We are working to a more radical set of changes planned for Quarter 2. The Department and members of the Executive Team are working together on these proposals. An update on the agreed changes will be shared at the June meeting of the Trust Board.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	Digital and Data Strategy
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 and Data Futures Strategy
Action/Decision Required:	To note To approve **X**
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 Data Strategy

1. Introduction

The purpose of this report is to provide the Board of Directors with the direction for the refreshed Digital and Data Strategy – Digital and Data Futures.

2. Digital and Data Futures

Digital and Data Futures is the successor to 'Digital Futures' which was a three year strategy launched in 2019. Delivery of Digital Futures has been incredibly successful for Alder Hey and has seen some major achievements and benefits. This includes external awards, accreditations and recognition.

Digital and Data Futures has been developed over the past 3 – 6 months with a range of stakeholders internally and externally. It has had significant clinical input, divisional input and portrays the priorities of our children, young people and their families.

This strategy sets out the direction for the next phase of a long standing and successful digital journey for Alder Hey. It is part of a suite of components in delivering our vision to create a 'Healthier Future for Children and Young People'.

At the heart of this vision are a set of joined up facets including providing outstanding care, creating a great place to work, working in partnership and pioneering new innovations, research and education opportunities. All of these are underpinned by Digital and Data Futures.

Digital and Data Futures sets out a step change in our approach to digital and importantly incorporates our ambitions and approach in relation to data.

Our ambition through the strategy is to deliver 'Outstanding Digital and Data Excellence'.

At the heart of this is our 'north star' vision and focus on creating the best experience and outcomes, truly empowering Children, Young People and Families, and Staff.

Through this we will strive to:

- Provide the best possible digital technology services and systems to support, enable and drive outstanding safe care
- Deliver Information Technology basics well, within an operational excellence framework that enables Alder Hey colleagues to do their very best work
- Embed digital developments and innovations at scale within divisions and clinical teams to maximise the opportunity of new models of care
- Ensure analytics and data are at the heart of operational and clinical services and at the forefront of service developments
- Champion the digital profession and collaborative working through the support and development of a talented digital workforce
- Play a critical role in advocating for children and young people digital and data priorities locally in Place, regionally and nationally

3. Outcomes and Benefits

Through Digital and Data Futures, we believe that we will make an impact across a range of outcomes and deliver significant benefits. These are grouped into four key areas as highlighted below.

Safety and Clinical Outcomes

- Improve Patient Safety
- Enhance Clinical Outcomes
- Support elective and covid recovery

Experience and Empowerment

- Continually improve staff and patient experience
- Empower children, young people and families to achieve their goals
- Empower staff to innovate and deliver new models of care

Population Health

- Improve the population health of children and young people
- Reduce Digital Exclusion
- Support the reduction in Health Inequalities

Efficiency

- Release more time for direct patient care
- Release cost improvement efficiencies
- Net zero contribution

4. Delivery

We will focus on four key delivery themes:

1. Digital Children, Young People & Families – New Models of Care
2. Outstanding records and safe systems
3. Healthier Populations through Data and Analytics
4. Digital Service Excellence

The themes have a range of delivery programmes. These include Trust wide and divisional priority programmes of work.

There are a range of priorities for 22/23 as reflected in the Trust's operational plan. Key programmes include:

Theme	Programme	Deliverables
Digital Children, Young People & Families – New Models of Care	Virtual Services	Expansion of Online Symptom Checker (Y1) New Intranet and Website Advice & Guidance Consolidation (Y1) Patient Portal/ Alderhey@nywhere (Y1) Virtual Wards/Clinics (Y1) Digital Community and Mental Health (Y1)
	Outpatient Transformation	Optimising Virtual Consultations (Y1) Patient Initiated Follow Ups (Y1)
Outstanding records and safe systems	Aldercare	Aldercare Go Live (Y1) EPR Optimisation (Y1)
	Surgery Digital Programme	Digital Theatre Management Solution (Y1)

		Digital Outpatient Room Booking and Utilisation (Y1) Bed Management and Patient Flow (Y1)
	Medicine Digital Programme	Integration of Telederm with GP practices (Y1) Expansion of symptom checker (Y1)
	Community and Mental Health Digital Programme	Sunflower House (Y1) Tier 4 In Patient Unit Digitisation (Y1)
Healthier Populations through Data and Analytics	Clinical Outcomes	Analyse our data and work with clinicians to improve outcomes (Y1) Establish a patient reported outcomes measures service (Y1)
	Population Health	Analysing data to identify and reduce health inequalities (Y1) Work with partners to embed a population health approach for childrens transformation (Y1) Develop a strategic intelligence function (Y1)
	Making Data Count	Redeveloping all corporate reporting (Y1) Corporate and Divisional Dashboards (Y1)
	Access to Data	Implement a new Analytics Portal (Y1) Widen the Analytics community within the organisation (Y1)
Digital Service Excellence	Service Improvement	Device strategy and refresh
	Service Excellence	Informatics Skills and Development Network Level 3 iDigtal staff forum developments
	Security and Resilience	Cyber Essentials + Data Security and Protection Toolkit

A clear governance structure will continue to support the delivery of the strategy ensuring it continually meets the needs of the organisation and Children, Young People and Families. The Digital Oversight Collaborative will remain the core function and will report into to the Board of Directors via the Resource and Business Development Committee.

5. Summary

The opportunity of digital and data is immense for health and care services. It has developed exponentially over the past three years and is at the core of operational delivery, safety and innovation. The covid 19 pandemic has been a digital transformation catalyst for many businesses and heath services across the globe. This will grow and grow as we continue to innovate and deliver health and care services for the future.

It is an exciting time for Alder Hey as we make a further step change aligned to our organisational ambitions.

The Board of Directors is asked to endorse the direction of travel for the Digital and Data Futures strategy and approve the priorities programmes for 22/23.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Quality Strategy 2022-23**
Report of:	**Nathan Askew, Chief Nursing Officer & Alf Bass, Chief Medical Officer**
Paper Prepared by:	Nathan Askew and Alf Bass

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	The 2022-23 quality strategy builds on work previously undertaken to drive improvement across patient safety, patient experience and clinical effectiveness. The strategy will be delivered through the Brilliant Basics approach, an overview of which is given in the paper whilst noting a more detailed paper on the agenda provides further detail on the years objectives for embedding Brilliant Basics throughout the organisation. **Patient Safety** A patient safety board will be developed which will instigate and oversee the 18 workstreams that will deliver the patient safety strategy. Reporting directly to SQAC the board will bring together the work already undertaken and prioritise the other aspects of the strategy. **Patient experience** In addition to the bast work undertaken across the organisation relating to patient experience the focus this year will be developing our approach to engaging with children, young people and their families, whilst demonstrating how we uphold the rights of the child. This will ensure we have the correct systems and processes that enable us to ensure the voice of children and young people are truly at the heart of everything we do. **Clinical Effectiveness**

	The focus this year will be on the procurement and implementation of a new digital management system which will improve our reporting across a range of areas and improve how the trust is able to triangulate the information. This will ensure that we develop improved learning from incidents, complaints and claims. Initial briefs are included in the appendices of the report and will be further developed. The board are asked to note the content and approach for this year and approve the quality strategy for 2022-23.
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:	There is a financial requirement to support the expansion of the quality hub to support the engagement of 2 young people apprentices and a band 6 to develop the engagement part of this strategy. This resource has been allocated to the programme.

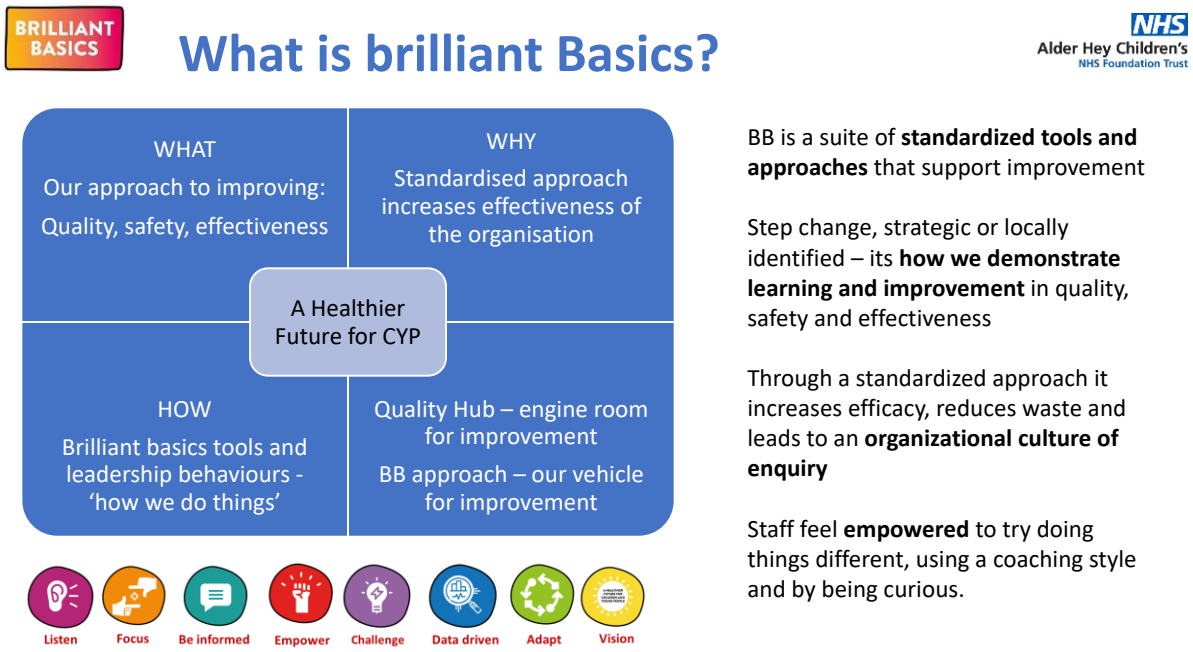
Quality Strategy 2022–23

Introduction

Alder Hey has a strong focus on delivering high standards of quality care delivered through patient safety, patient experience and clinical effectiveness. This year sees continued developments in all three areas as we deliver against our quality strategy and importantly embark on a journey to outstanding as an organisation.

Brilliant basics

This year we will continue to embed our approach to quality improvement throughout the organisation through our program of Brilliant Basics. Brilliant Basics empowers all staff to make small changes that lead to big improvements and ultimately healthy futures for the children, young people and their families. Brilliant basics is the way that we 'do' improvement at Alder Hey.



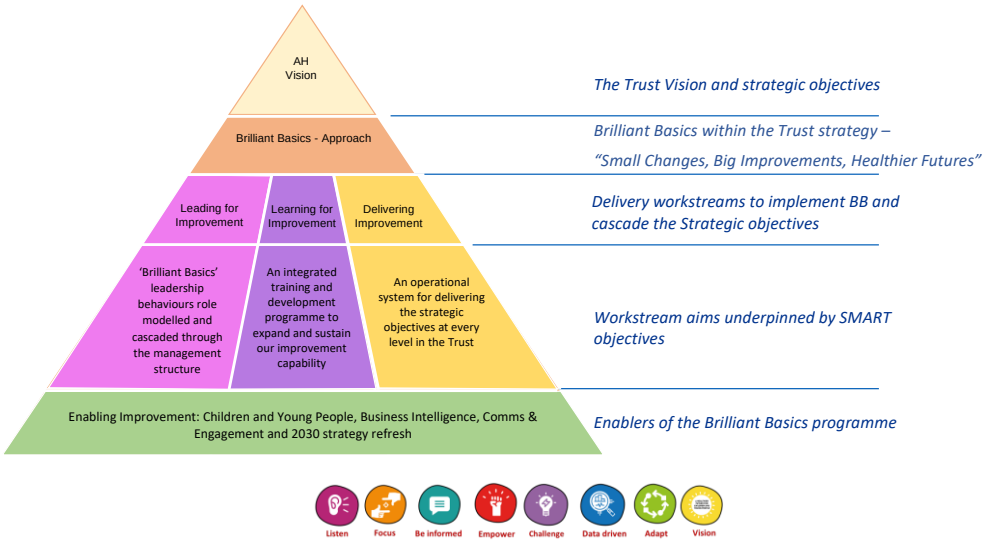
Over the last year we've developed our program for quality improvement which has led to some amazing achievements throughout the organisation. This year we plan to further develop and embed this through three main work streams:

- Leading for improvement
- Learning for improvement
- Delivering improvement

This approach will ensure that our staff are skilled in leading teams focused on improving the quality of care that we provide. Our leaders will role model coaching behaviours that empower our teams to make improvements locally to the care that they deliver. We will develop an agile educational suite that will enable our workforce to tailor their learning needs about quality improvement.

Through the knowledge and skills alongside our leadership behaviours we will deliver improvement both locally within teams and strategically at trust level which will clearly demonstrate the improvement journey and the impact that this has achieved.

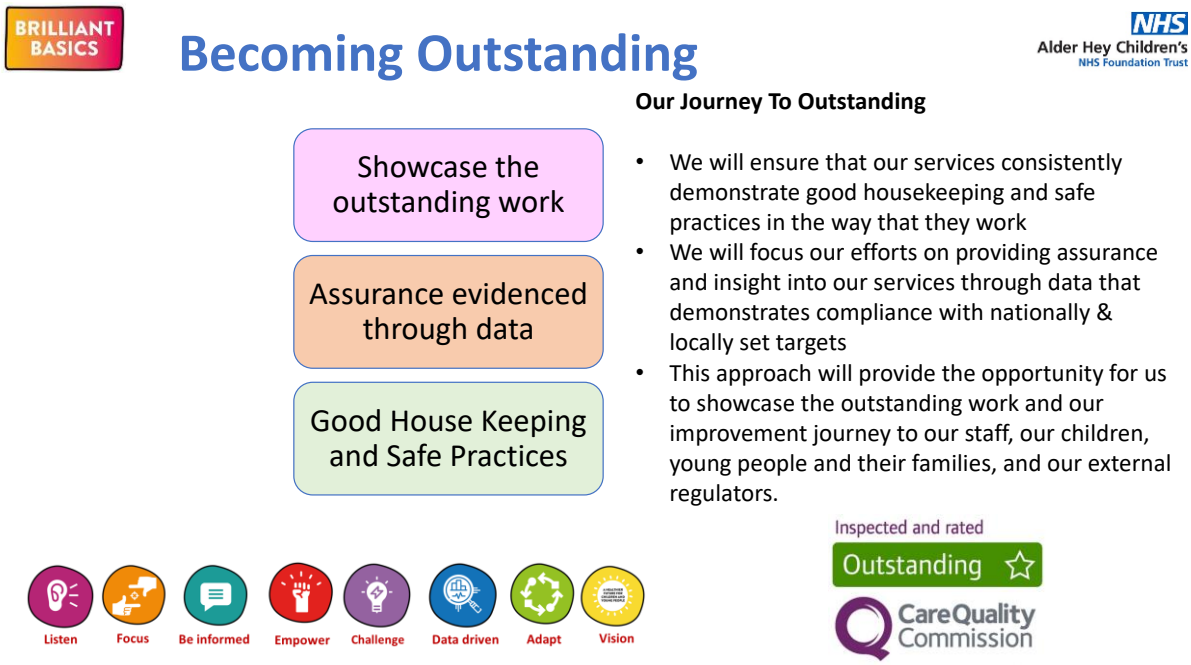
How do we use Brilliant Basics?



As an organisation we have a long history of continuous improvement. However, the new approach will focus on embedding the knowledge, skills and leadership capabilities throughout the organisation. This builds on the work that has previously been undertaken to lay the foundations and build capability which now ensures continuous improvement becomes part of the culture of how the organisation thinks, learns and delivers.

Becoming outstanding

The brilliant basics approach will enable us to ensure there is less variability in the way that we safely deliver care to children, young people and their families. It will allow individual services to make improvements in areas that really matter to them and contribute to our strategic aims as an organisation. We will additionally focus on providing assurance to the Trust Board and to our external regulators through the data that we collect and compliance with nationally and locally agreed quality indicators. This will provide the opportunity for our services to demonstrate their improvement journey and showcase the outstanding work that is achieved at Alder Hey.

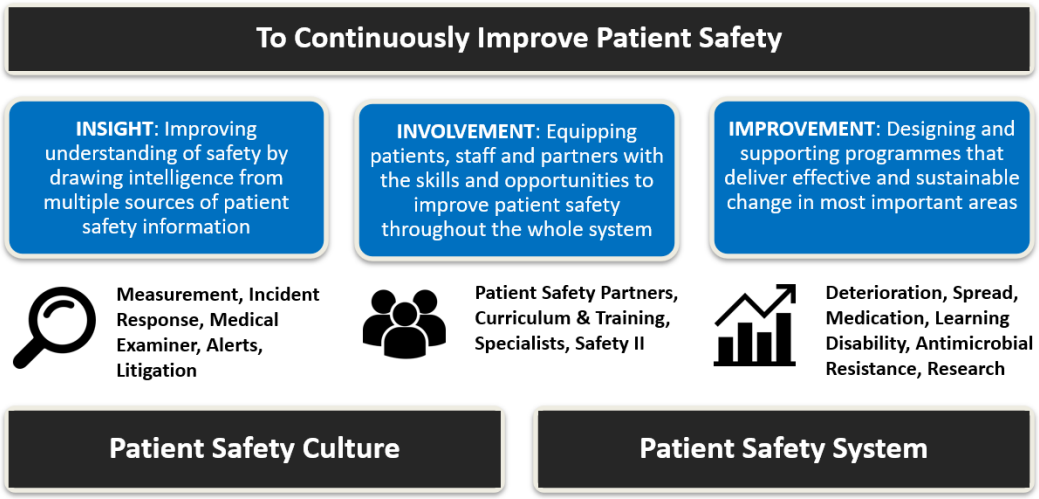


Supporting brilliant basics

In addition to the brilliant basics program there will be further developments in all three areas of patient safety, patient experience and clinical effectiveness.

<u>Patient safety</u>

This year will see the next stage and implementation of a Patient Safety Strategy which was approved by the Trust Board in August 2021. The patient safety board will be formed reporting directly to safety and quality assurance committee which will be chaired jointly by the CMO & CNO. The patient safety board will ensure that all work programs from the patient safety strategy have clear implementation plans and demonstrate improvement in those areas. Appendix 1 contains more details about the work of the Patient Safety Board.



Patient experience

This year we will embark on a program of work that increases the voice of children and young people throughout our organisation and develop a system of work that demonstrates the role that Alder Hey plays in upholding the UN Convention on the rights of the child. This work will be led by young people and will develop a suite of metrics relating to the rights of the child that will enable us to demonstrate clear improvement in how we uphold these both in the services that we provide and the impact that we have within the wider community. Appendix 2 presents a summary of the work that will be undertaken in relation to engagement and CYP rights.

Clinical effectiveness

This year we will undertake a systematic review of systems, processes and application on a range of areas related to clinical effectiveness. This review will ensure that we are able to demonstrate compliance with national and local targets and will facilitate a robust and safe management system within the organisation leading to clear demonstration of learning from when things go wrong and embracing good practice when things go well. Building on becoming a learning organisation will take time and will link across all aspects of safety, effectiveness and experience. Appendix 3 gives an overview of the remit of our improvement work on clinical effectiveness this year.

Summary

The approach to patient safety, patient experience and clinical effectiveness will underpin the work that has been undertaken across the organisation through the brilliant basics program to embed a culture of quality improvement. Clear leadership and role modelling of a coaching style will empower our staff to make small changes that lead to big improvements and a healthier future for children, young people and their families.

Alder Hey Children's NHS Foundation Trust

Briefing Paper: Patient Safety Strategy Update to Trust Board

Mr Alfie Bass, Chief Medical Officer & Nathan Askew, Chief Nursing Officer
Will Weston, Medical Services Director, 06/04/2022

1. Introduction

This paper provides an overview of progress with the implementation of the Patient Safety Strategy at Alder Hey Children's NHS Foundation Trust. The current status is described, as well as indicating the next steps as we move into the 2022-23 financial year.

2. Background

In 2019, NHS England launched the National Patient Safety Strategy and required each NHS Trust in England to adopt it as a framework for developing their local patient safety strategy. This strategy brought together a range of best practice principles to fundamentally change the NHS approach to patient safety.

Shifting the focus towards continuous improvement across a range of measures, creating a fair and just culture where staff are supported when things go wrong, and learning form what works well, not just what goes wrong, are all fundamental shifts in approach.

The new approach seeks to develop a positive patient safety culture through the development of an effective patient safety system. To do this, a range of activities are grouped into:

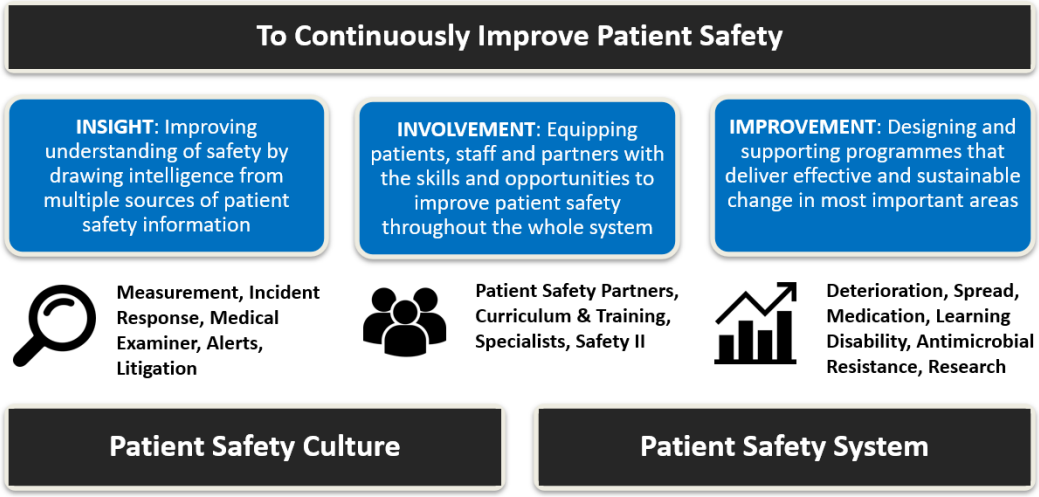
- **Insight** – gathering data to understand areas for improvement, focussing resources on learning from across a smaller number of themes, and demonstrating meaningful change.

- **Involvement** – ensuring that patients, their families and staff are treated as partners in patient safety. For them to actively be part of reviews, safety work and to contribute to improvements in the organisation. Providing high quality education and training on patient safety to all who work in the NHS at a level suitable to their role.

- **Improvement** – develop systems and processes that constantly seek to improve and make meaningful change that positively impacts the safety of the patients that we care for.

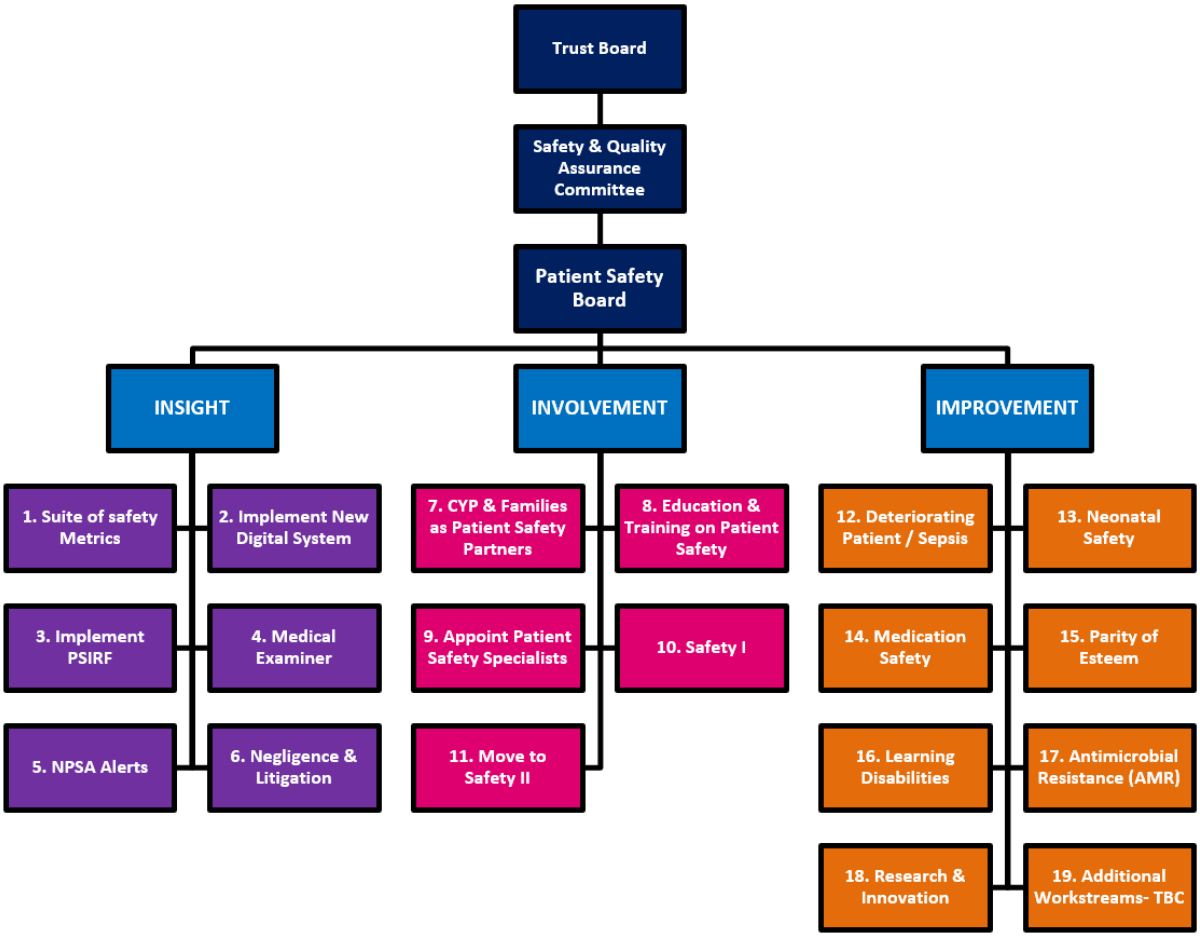
At Alder Hey, these principles were guided through the development of our Patient Safety Strategy which was presented to and approved by the Board in September 2021. Unfortunately, due to a range of factors including the continued impact of COVID-19, the implementation of the strategy has been delayed.

However, under the leadership of the Chief Medical Officer and Chief Nursing Officer, the implementation and delivery plan are now in place following a readiness assessment. The future delivery and monitoring of our patient safety journey is presented as the update to the Board.



3. Patient Safety Board

It is agreed that to effectively monitor the implementation of the Patient Safety Strategy, the Trust will form the Patient Safety Board. Reporting directly to Safety and Quality Assurance Committee (SQAC), the Patient Safety Board will bring together all the major workstreams of the strategy. The Patient Safety Board will agree and approve each associated improvement work plan and monitor the impact of those plans through monthly updates.



It is acknowledged that this will alter the monitoring of some areas from current committees such as Clinical Quality Steering Group (CQSG), however, this will provide additional time and focus within CQSG for other areas related to patient safety.

4. Workstream prioritisation

It should be noted that many aspects of the Patient Safety Strategy are areas of focus that the Trust has previously identified and has existing programmes of work in place. To this end, not all the workstreams will have the same level of maturity, and therefore a gap analysis of the desired outcomes in the strategy and their current status was undertaken.

In addition and since the strategy covers 5 years, it is not practical to give the same level of priority to all areas. Some areas are dependent on other workstreams delivering aspects of the strategy first, whilst others are pending national guidance, systems or direction.

To reflect this, each workstream has been prioritised – with '1' being the most urgent to demonstrate progress against. The readiness and prioritisation assessment are shown in the Appendices. The areas of most pressing need are:

- Review of safety metrics
- NPSA alerting processes
- Education and Training
- Appointment of patient safety specialists
- Deteriorating patient and sepsis

These projects will need to rapidly form working groups with senior leadership that will enable the development of improvement plans. These 5 areas will form the focus of the Patient Safety Board for the first 6 months, along with update reporting from the other areas currently underway.

5. Next Steps

- A video explaining the Patient Safety Strategy and the role of all our staff in its delivery is in development
- The Patient Safety Board will be formulated
- Senior leads for each workstream will be appointed

6. Conclusion

The Patient Safety Board brings together a range of workstreams that will have a direct improvement to the safety of our children, young people, their families, and our staff. The Patient Safety Board will report into SQAC on a bimonthly basis. The Patient Safety Board will update the Trust Board bi-annually. The improvement work will utilise the Brilliant Basics approach.

7. Appendix 1: Readiness and Prioritisation Assessment

BRAG (Blue, Red, Amber & Green) Status Definitions	
B	Action Complete
R	Action Not on Track
A	Action Mainly on Track
G	Action on Track

#	Deliverable	BRAG	Priority	Outcome
1	Suite of safety Metrics	A	1	Review existing metrics and dashboard so can ID, measure and improve.
2	Implement New Digital System	R	3	Adopt and impliment new national reporting system - Paused pending national guidance
3	Implement PSIRF	R	2	Redesign governcne processes in line with PSIRF -Paused pending national guidance
4	Medical Examiner	A	1	Implement the medical examiner role - Paused pending national guidance
5	NPSA Alerts	A	1	Review current processes to ensure going to correct departmental channels & acurate recording
6	Negligence and Litigation	A	3	Develop a system to ensure insight and learning embedded to prevent harm based on litigation activity
7	CYP & Families as Patient Safety Partners	R	3	Fornmal implementaiton of children, young people and their families as safety partners
8	Education & Training on Patient Safety	R	1	Adopt the national safety framework and embed throughout organisation
9	Appoint Patient Safety Specialists	R	1	Appoint patient safety specialists
10	Safety I	A	2	Enhance learning from events when things go wrong - demonstrate a true learning organisaiton
11	Move to Safety II	R	3	Develop systems and processes that demonstrate leanring and sharing of good practice
12	Deteriorating Patient / Sepsis	G	2	Establish current status
13	Neonatal Safety	R	2	Establish current status
14	Medication Safety	A	2	Establish current status
15	Parity of Esteem	G	2	Establish current status
16	Learning Disabilities	A	2	Establish current status
17	Antimicrobial Resistance (AMR)	A	2	Establish current status
18	Research & Innovation	R	3	Establish current status
19	Additional Workstreams- TBC	R	1	Establish current status

*Action 7 is dependent on CYP engagement work laying foundations for CYP & families undertaking the formal role of safety partners

Appendix 2 – CYP rights and engagement summary

Children's and Young Peoples @ the heart of all we do

Rights and involvement (2022/24)

SRO: Nathan Askew, Chief Nurse **Clinical Lead:** Lisa Cooper **Operational/ Project lead**: Marianne Hamer

1. Purpose

The purpose of this paper is to outline the ambitions for Alder Hey to realise the visions of 'Healthier Happier Lives', through embedding children's rights and involvement into how we work: -

- **Children's Right** – Recognising the trust's requirements to uphold the UN Convention on Rights of the Child at an individual, statutory and system level.
- **Involvement** – to enhance Alder Hey's approach to engagement with children and young people and their families, to ensure that we have innovative approaches to capturing the voice of children and young people from the diverse communities that we serve.

2. Background

Since 2021, Alder Hey has worked with the Point of Care Foundation (POC), to ensure that Brilliant Basics way of working is focused on the voice of children and young people. POC have supported with: -

- Developing the Brilliant Basics training materials with KPMG
- Developing an approach to children and young people's involvement in improvement, which is now part of the quality hub's toolkit, and is included on the sharepoint site.
- Participation in step change projects as required (including the work on ward 4C relating to children and young people with complex emotional needs/challenging behaviour).
- Initiating a programme of work with the Executive Team to establish a work programme to make real the aspiration of "children and young people at the heart of all we do".

The United Nations Convention on the Rights of the Child contains 52 standards that set out the Rights of a Child (Appendix 1). Most countries including the United Kingdom have signed up to the convention. Many countries use the standards wholly or in part to promote children and young people's involvement. There are four central principles that underpin the implementation: -

- **Non-discrimination:** the rights of all children should be ensured without discrimination of any kind.

- **The best interest of the child:** whenever decisions or actions are taken that affect children, the bests interest of the child must be the primary consideration.

- **Right to life and development** of the child: all children should be enabled to develop in an optimal way; physically, mentally, spiritually, morally, and socially.

- **Right to be heard:** children should be able to express their views freely in all matters affecting them to participate in all decision-making processes related to their lives, and to exert influence over such decisions in accordance with their age and maturity.

3. Current state

The work with POC has supported a consideration around the trust's ambitions for 'Right's and Engagement'. The current resources, capacity and capabilities have been reviewed to understand barriers to the achievement of the trusts vision. It should be noted that whilst patient experience covers a range of functions that relate to engagement with children, young people and their family's engagement is much broader than experience.

Patient Experience Team: The primary focus of this team is to drive patient experience, including the core functions of collecting and analysing feedback thought the Friends and Family Test (nationally mandated). The patient experience team also support the trust volunteers, who contribute to patient satisfaction and reduce anxiety faced by families.

It's recognised that the Friends and Family Test has some significant limitations, into truly providing a picture of experience. It also doesn't allow an understanding of the experiences at different stages of children and young people's care pathway.

Patient Shadowing

There are opportunities for staff including our students to shadow children and young people in a structured way, providing real insight to how children, young people and their families experience our services, including the impact their health condition has on them external to the health service.

Alder Hey Youth Forum

Alder Hey has a strong voice through our youth forum. The forum have been involved in a range of activities but there is recognition that the forum could play a more active role in how we engage with our young people moving forward.

4. Key deliverables

Vision	**Children and Young people at the heart of all we do**
Objective 1.	To embed the Rights of the Child into governance process and day to day working (2)
Objective 2.	**Right to Express:** To maximise and empower children's and young peoples' involvement in strategic and day to day decisions that affect their lives. (12 + 13)
Objective 3	To maximise the involvement of children and young people from seldom heard communities. (23)
Objective 4	**Right to best possible health:** To ensure that Alder Hey builds its service that maximises the potential of every young person (24)

(Referenced rights) – Appendix 2

Objective	Deliverables
1. To embed the Rights of the Child into governance process and day to day working (2)	**To ensure that the trusts policies and procedures support children's rights and engagement*** • Amend HR policies to ensure children and young people consistently part of recruitment • Establish remuneration and reward policies for involved children and young people • Expand range of posts to which HR policy applies and audit implementation • Implement new policy and recruit children and young people as volunteers • Implement remuneration and reward policies for the involvement of children and young people in the Trust's work **To embed Children's and young people's voice into leadership behaviours** • Coaching for the Executive team to embed children and young people's voice* • Embed informal contact with Children and Young People into executive standard work *(BB: Leading for Improvement)* • Leadership meetings to begin with "what I have learned this week from children and young people" *(BB: Leading for Improvement)* • Managers' children and young people shadowing programme implemented • Cascade senior sponsorship throughout all divisions
2. **Rights to express**: To maximise and empower children's and young peoples' involvement in strategic and day to day decisions that affect their lives. (12)	**Enhance the methods and opportunities for children's and young people's involvement** • To expand the current mechanisms for capturing children, young people and families voice and provide really time measurements to support daily improvement. • Review sources of systematic feedback from children and young people– how they are used for improvement and consider whether alternative provision is needed • Develop the engagement and involvement tools and methods into an "Alder Hey way" toolkit* would be a longer term, objective. • To ensure that children and young people are engaged in the development of Alder Hey, futures and strategy development. (12) • Support children and young people to raise concerns (13)
3. To maximise the involvement of children and young people from seldom heard communities. (23)	• Expansion of Alder Hey's Youth Forum, to wider participation particularly from seldom heard youth groups.* • Involve children and young people with a disability in their care, embed 'what matters' to me conversations around care. (23) • To proactively reach out to community provides, and local services to capture the voice from children and young people who are often missed.
4. **Right to best possible health:** To ensure that	**Rights of the Child** • Rights to express: Every child or young person to have a daily goal (12)

Alder Hey builds its service that maximises the potential of every young person (24)	• To develop career opportunities for children and young people with a disability, through development of inter opportunities within Alder Hey. (23) • Rights to Best health: ensure that every child and young person have a holistic health plan (24)
Enabling actions	**To enhance communication** • Establishment of children and young people communications group and establish workplan • Launch celebration and showcasing events highlighting good work in involvement • To utilise social media as a method to capture, engagement and co-produce

In considering the delivery mechanism the current resources and capabilities have been considered. The areas that have been * are considered areas, were specialist expert support would be required.

5. Workstream measures

Enabling area	Year 1: Measures	Data Source
Rights	**Driver – outcome** To achieve accredited Rights organisational status	Accreditation
Involvement	**Watch** To increase the numbers of children and young people (including those seldom heard), who are activity involved in decision making. *(Establish baseline, based on current data sources)*	Captured through Youth Forum and children and young people engagement sources
Involvement	**Watch** Range of engagement mechanisms increased	
Children's Rights	**Watch** Number of policies that have been revised to embed the rights of children and young people **Watch** Pilot small number of rights and demonstrating through data our commitment to upholding those right	Captured through deliver plan Requires development

6. Delivery options

The achievement of the Trust's ambitions has been considered in the context of the current resources and capabilities. Recognising that the assignment of an Executive Lead, without resources to execute the key deliverables within this paper, will mean that the scale of ambition will need to be reduced.

- Point of Care, contract management will be through the SRO; with reporting into the BB Friday Forum
- Engagement and staff team – will be managed through the Quality Hub, but with direct connections into the Patient Experience Team. This linkage with Quality Improvement, will ensure that the children's and young people's voice, can directly inform the improvements made through everyday and larger scale improvements.

7. Funding

	Detail	Cost
Specialist contract	**Point of Care – 24 Days** • Develop the engagement and involvement tools and methods into an "Alder Hey way" toolkit • Expansion of Alder Hey's Youth Forum, to wider participation particularly from seldom heard patient groups. • Coaching for the Executive team to embed children and young people's voice	£22,000
Youth Worker	1 Band 6 Youth worker	£44k
Youth Engagement Apprentice	2 x Band 3	£50k
Resources and materials	IT equipment and expenses	£9k
Total		**£125k**

Appendix 3 – Governance project summary

1. Risk and Governance Project Brief **Aim:** Optimising the effectiveness of the Quality, Clinical Governance and Risks function		
SRO: Nathan Askew	**SMEs:** David Pilsbury	**Project Manager:** Natalie Deakin
Reason for action	• The optimisation of risk management and clinical governance, has a critical role in reducing clinical harm. The effectiveness of the systems and process is essential in support of a patient safety culture and increases an organisational learning culture. • The trust is committed to ensuring that the systems of control, are intuitive, meet best practice standards and add value for clinical teams. • The Trust should be able to clearly demonstrate learning from incidents and other routes of feedback	
Background	Feedback from key organisational stakeholders has identified that the current systems and processes, are not optimised and there is variation in approach across the organisation. • **Staff:** lack of clarity on roles and responsibilities, causing duplication and confusion. • **Efficiency:** Inefficiencies identified in current systems and processes. • **Learning:** The current reporting presentation provides limited insight for learning.	
Key Outputs of Project	• Independent commissioned review • Able to demonstrate good levels of responsiveness when things go wrong and ensure that there is evidence of learning form individual incidents and complaints as well as building organisational learning in this area. • Optimising the effectiveness of Quality, Clinical Governance and Risks processes and functions by implementing the outcomes of the independent review. • Implementation of a new risk management system (to replace Ulysses)	
Exclusions	None identified	
Proposed Workstreams / Change Ideas	New digital management system Reduction of duplication	
Expected Benefits	1. Reduce harm 2. Improve organisational learning 3. Improve quality, risk and clinical governance systems and processes 4. Reduce duplication	
Reporting Arrangements	The Risk and Governance Project will report into Strategic Execs under the Outstanding Safety programme on the second Thursday of each calendar month	
Risks to delivery		
Links to System Working		
Is full PID available? (Y/N)	In development	
Signed by Exec Sponsor		

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Patient Safety Strategy Update**
Report of:	**Nathan Askew, Chief Nursing Officer & Alf Bass, Chief Medical Officer**
Paper Prepared by:	Will Weston, Medical Services Director

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Background Papers and/or supporting information:	This paper provides an overview of progress with the implementation of the Trust Patient Safety Strategy. The paper informs the board of the formation of a patient safety board to oversee the various workstreams that are required to deliver the strategy. Each work stream has had a readiness assessment completed and been prioritised to for the work plan of the board. The Patient Safety Board will report to SQAC, a copy of the terms of reference are included in the pack. Many aspects of the strategy already have working groups in place, and this is an opportunity to review the role and remit of the workstreams, utilising the Brilliant Basics approach. Trust Board are asked to note the contents of the report and to approve the formation of the patient safety board.
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:	A business case to support the introduction of nationally manded roles is under development.

Briefing Paper: Patient Safety Strategy Update to Trust Board

Mr Alfie Bass, Chief Medical Officer & Nathan Askew, Chief Nursing Officer
Will Weston, Medical Services Director, 06/04/2022

1. Introduction

This paper provides an overview of progress with the implementation of the Patient Safety Strategy at Alder Hey Children's NHS Foundation Trust. The current status is described, as well as indicating the next steps as we move into the 2022-23 financial year.

2. Background

In 2019, NHS England launched the National Patient Safety Strategy and required each NHS Trust in England to adopt it as a framework for developing their local patient safety strategy. This strategy brought together a range of best practice principles to fundamentally change the NHS approach to patient safety.

Shifting the focus towards continuous improvement across a range of measures, creating a fair and just culture where staff are supported when things go wrong, and learning form what works well, not just what goes wrong, are all fundamental shifts in approach.

The new approach seeks to develop a positive patient safety culture through the development of an effective patient safety system. To do this, a range of activities are grouped into:

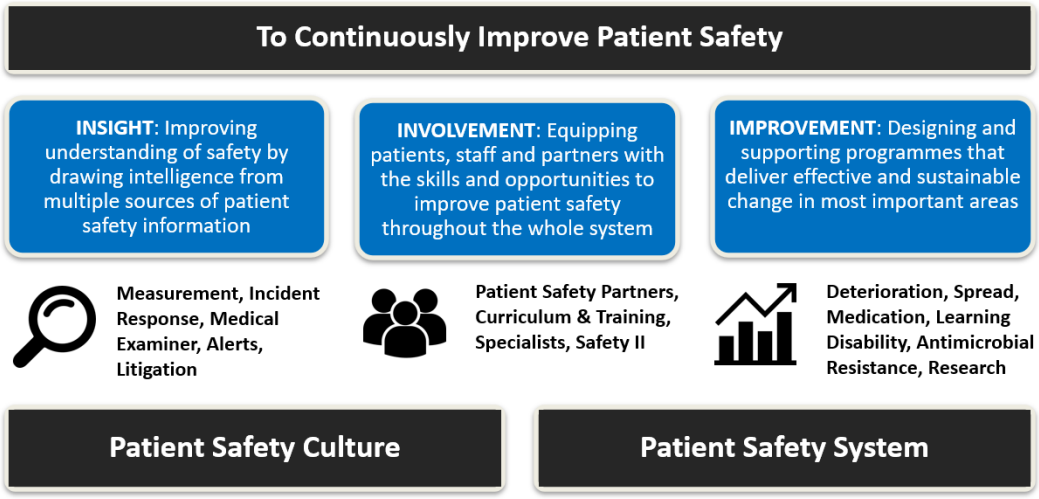
- **Insight** – gathering data to understand areas for improvement, focussing resources on learning from across a smaller number of themes, and demonstrating meaningful change.

- **Involvement** – ensuring that patients, their families and staff are treated as partners in patient safety. For them to actively be part of reviews, safety work and to contribute to improvements in the organisation. Providing high quality education and training on patient safety to all who work in the NHS at a level suitable to their role.

- **Improvement** – develop systems and processes that constantly seek to improve and make meaningful change that positively impacts the safety of the patients that we care for.

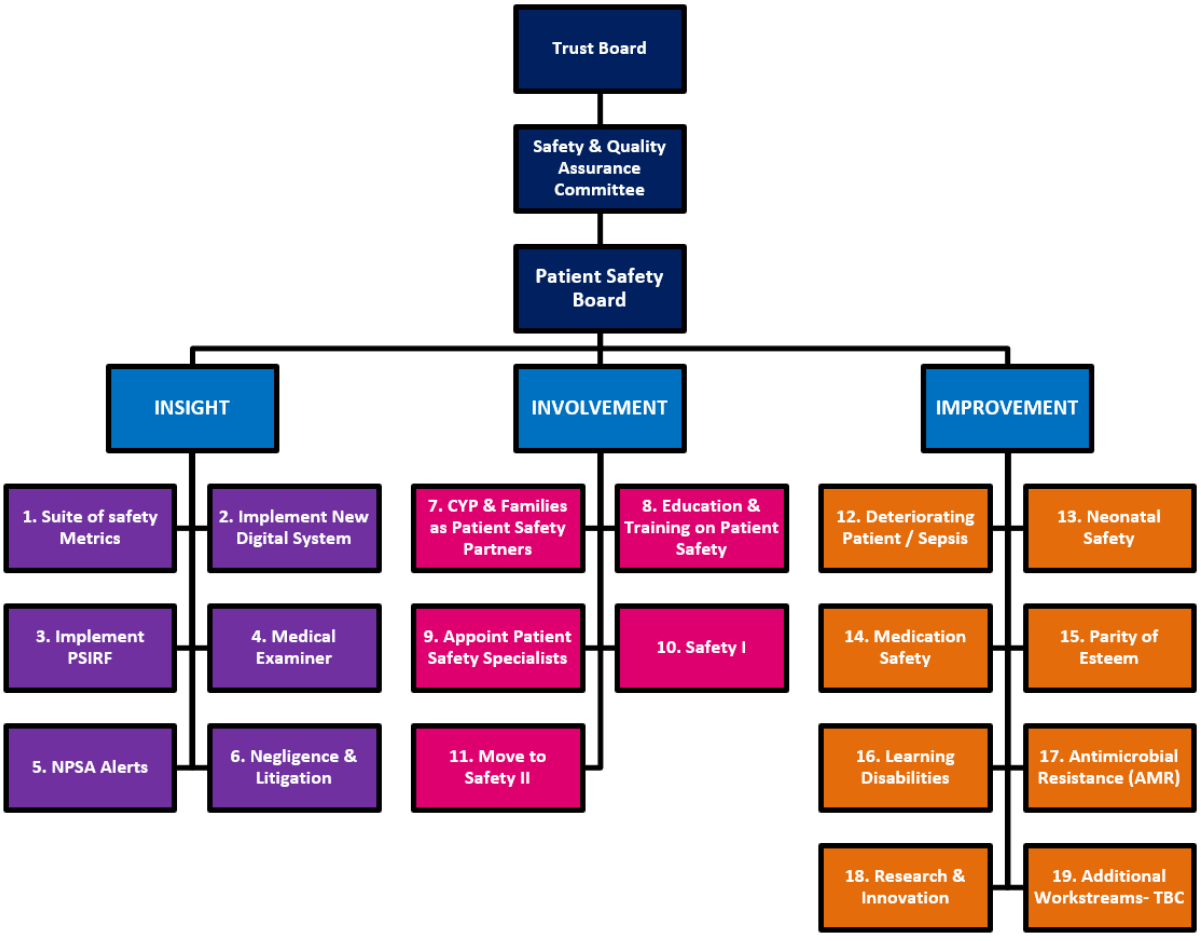
At Alder Hey, these principles were guided through the development of our Patient Safety Strategy which was presented to and approved by the Board in September 2021. Unfortunately, due to a range of factors including the continued impact of COVID-19, the implementation of the strategy has been delayed.

However, under the leadership of the Chief Medical Officer and Chief Nursing Officer, the implementation and delivery plan are now in place following a readiness assessment. The future delivery and monitoring of our patient safety journey is presented as the update to the Board.



3. Patient Safety Board

It is agreed that to effectively monitor the implementation of the Patient Safety Strategy, the Trust will form the Patient Safety Board. Reporting directly to Safety and Quality Assurance Committee (SQAC), the Patient Safety Board will bring together all the major workstreams of the strategy. The Patient Safety Board will agree and approve each associated improvement work plan and monitor the impact of those plans through monthly updates.



It is acknowledged that this will alter the monitoring of some areas from current committees such as Clinical Quality Steering Group (CQSG), however, this will provide additional time and focus within CQSG for other areas related to patient safety.

The Patient Safety Board structure is described below, and the Terms of Reference are included in the Appendices.

4. Workstream prioritisation

It should be noted that many aspects of the Patient Safety Strategy are areas of focus that the Trust has previously identified and has existing programmes of work in place. To this end, not all the workstreams will have the same level of maturity, and therefore a gap analysis of the desired outcomes in the strategy and their current status was undertaken.

In addition and since the strategy covers 5 years, it is not practical to give the same level of priority to all areas. Some areas are dependent on other workstreams delivering aspects of the strategy first, whilst others are pending national guidance, systems or direction.

To reflect this, each workstream has been prioritised – with '1' being the most urgent to demonstrate progress against. The readiness and prioritisation assessment are shown in the Appendices.

The areas of most pressing need are:

- Review of safety metrics
- NPSA alerting processes
- Education and Training
- Appointment of patient safety specialists
- Deteriorating patient and sepsis

These projects will need to rapidly form working groups with senior leadership that will enable the development of improvement plans. These 5 areas will form the focus of the Patient Safety Board for the first 6 months, along with update reporting from the other areas currently underway.

5. Next Steps

- A video explaining the Patient Safety Strategy and the role of all our staff in its delivery is in development
- The Patient Safety Board will be formulated
- Senior leads for each workstream will be appointed

6. Conclusion

The Patient Safety Board brings together a range of workstreams that will have a direct improvement to the safety of our children, young people, their families, and our staff. The Patient Safety Board will report into SQAC on a bimonthly basis. The Patient Safety Board will update the Trust Board bi-annually. The improvement work will utilise the Brilliant Basics approach.

7. Appendix 1: Readiness and Prioritisation Assessment

BRAG (Blue, Red, Amber & Green) Status Definitions	
B	Action Complete
R	Action Not on Track
A	Action Mainly on Track
G	Action on Track

#	Deliverable	BRAG	Priority	Outcome
1	Suite of safety Metrics	A	1	Review existing metrics and dashboard so can ID, measure and improve.
2	Implement New Digital System	R	3	Adopt and impliment new national reporting system - Paused pending national guidance
3	Implement PSIRF	R	2	Redesign governcne processes in line with PSIRF -Paused pending national guidance
4	Medical Examiner	A	1	Implement the medical examiner role - Paused pending national guidance
5	NPSA Alerts	A	1	Review current processes to ensure going to correct departmental channels & acurate recording
6	Negligence and Litigation	A	3	Develop a system to ensure insight and learning embedded to prevent harm based on litigation activity
7	CYP & Families as Patient Safety Partners	R	3	Fornmal implementaiton of children, young people and their families as safety partners
8	Education & Training on Patient Safety	R	1	Adopt the national safety framework and embed throughout organisation
9	Appoint Patient Safety Specialists	R	1	Appoint patient safety specialists
10	Safety I	A	2	Enhance learning from events when things go wrong - demonstrate a true learning organisaiton
11	Move to Safety II	R	3	Develop systems and processes that demonstrate leanring and sharing of good practice
12	Deteriorating Patient / Sepsis	G	2	Establish current status
13	Neonatal Safety	R	2	Establish current status
14	Medication Safety	A	2	Establish current status
15	Parity of Esteem	G	2	Establish current status
16	Learning Disabilities	A	2	Establish current status
17	Antimicrobial Resistance (AMR)	A	2	Establish current status
18	Research & Innovation	R	3	Establish current status
19	Additional Workstreams- TBC	R	1	Establish current status

8. Appendix 2: Terms of Reference- PATIENT SAFETY BOARD

8.1. Purpose and Duties

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

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

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

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

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

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

The two foundations of culture and systems will be supported by:

- improving understanding of safety by drawing intelligence from multiple sources of patient safety information (Insight)
- equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (Involvement)
- designing and supporting programmes that deliver effective and sustainable change in the most important areas (Improvement).

The purpose of this programme is to:

- **Develop a Patient Safety Implementation Plan which is aligned with the National and Trust Patient Safety Strategies.**
- **Monitor the delivery of the Patient Safety Implementation Plan.**
- **Progress monitoring and intervention, where necessary, to help deliver constructive and timely outcomes in accordance with the Patient Safety Implementation Plan, avoiding unnecessary delays and deviations from the plan.**

The meeting will be constructive and the discussions within it will identify key actions which may require resolution at a specialty, divisional or Trust level.

The meeting will also require data updates, and assurance regarding the training of staff, to ensure that there are sufficient well-practised individuals to execute and sustain the Trust Patient Safety Strategy in a robust and timely fashion.

8.2. Membership & Quoracy

It is acknowledged that names may change over time. With regard to the divisional triumvirate, at least one member of the triumvirate will be required at each meeting.

Chief Medical Ofc (Acting) [CO-CHAIR]	Alfie.Bass@alderhey.nhs.uk
Chief Nurse [CO-CHAIR]	Nathan.Askew@alderhey.nhs.uk
Associate Chief Nurse, Community & Mental Health	Jacqui.Pointon@alderhey.nhs.uk
Associate Chief Nurse, Liverpool Neonatal Partnership	Jennifer.Deeney@alderhey.nhs.uk
Associate Chief Nurse, Medicine	Catherine.Wardell@alderhey.nhs.uk
Associate Chief Nurse, Surgery	Rachael.Hanger@alderhey.nhs.uk
Associate Chief Operating Ofc, Community & Mental Health	Rachel.Greer@alderhey.nhs.uk
Associate Chief Operating Ofc, Medicine	Mark.Carmichael@alderhey.nhs.uk
Associate Chief Operating Ofc, Surgery	Asia.Bibi@alderhey.nhs.uk
Associate Director of Nursing & Governance	Cathy.Umbers@alderhey.nhs.uk
Associate Director of Transformation	Natalie.Palin@alderhey.nhs.uk
Chief Pharmacist	Mo.Azar@alderhey.nhs.uk
Divisional Director, Community & Mental Health	Lisa.Cooper@alderhey.nhs.uk
Divisional Director, Medicine	Urmi.Das@alderhey.nhs.uk
Divisional Director, Surgery (Acting)	Richard.Craig@alderhey.nhs.uk
Governance Medical Lead, Medicine	Atrayee.Ghatak@alderhey.nhs.uk
Governance Medical Lead, Surgery	Christopher.Talbot@alderhey.nhs.uk
Head of Nursing	Pauline.Brown@alderhey.nhs.uk
Medical Services Director	Will.Weston@alderhey.nhs.uk
Nurse Consultant, Learning Disabilities	Joann.Kienan@alderhey.nhs.uk
Risk & Governance Lead, Community & Mental Health	Sarah.Stephenson@alderhey.nhs.uk
Risk & Governance Lead, Medicine	Sarah.Balogh@alderhey.nhs.uk
Risk & Governance Lead, Surgery	Camille.Cortez-James@alderhey.nhs.uk
TBC	

Other colleagues may be invited to attend meetings. The meeting will be deemed quorate if there is attendance from:

- Chief Medical Officer / Chief Nurse,
- at least one member of each divisional triumvirate,
- and at least two other members of the group

8.3. Meetings

8.3.1. *Frequency and Locations*

Meetings will be held monthly via MS Teams, although members must ensure they are in a setting where confidentiality can be maintained.

8.3.2. *Chair*

The meetings will be chaired by the Chief Medical Officer or the Chief Nurse.

8.3.3. *Administration*

Unless otherwise agreed, notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed and supporting papers, shall be forwarded to each member of the group and any other person required to attend no later than 10 working days before the date of the meeting. Members are to send agenda items and data to the Chair at least 7 working days prior to the meeting. An attachment with the finalised agenda will be sent at least five working days prior to the meeting. Minutes will be taken, and a hyperlink will be circulated within 5 working days of the meeting.

8.3.4. *Governance Arrangements*

The Patient Safety Board will report into the Safety and Quality Assurance Committee (SQAC).

9. Appendix 3: Glossary

LFPSE	Learn From Patient Safety Events
LRMS	Local Risk Management System
NRLS	National Reporting and Learning System
NRLS	National Reporting and Learning System
PSI	Patient Safety Investigation
PSII	Patient safety incident investigation
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
SIF	Serious Incident Framework
StEIS	Strategic Executive Information System

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	Brilliant Basics - Delivery Plan 2022-2025
Report of:	Nathan Askew, Chief Nursing Officer and AHP/HCP Lead
Paper Prepared by:	Natalie Palin, Associate Director of Transformation, Andy McColl, Associate Chief Operating Officer

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	• Brilliant Basics Programme Update – (30th Sept 2021) • Leader Standard Work - Supporting Performance and Improvement (24TH Feb 2022)
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:	N/A resource requirements for 2022/23 are within the existing budget provision.

1. Introduction

The purpose of this paper is to outline the intended delivery approach and priorities for 2022-25 for the delivery of Brilliant Basics, our vehicle for improvement. The delivery plan details the systems of control and monitoring arrangements, which will support the programme achievements.

2. Background

Brilliant Basics is our vehicle for improvement and support our journey towards **'outstanding'**. Building on the long history in Alder Hey to continuously improve and enhance outcomes for children and young people. Over the last 12 months we have worked with KMPG and Point of Care (POC) to create a model, that reflects best practice and embeds children and young people's involvement.

The Brilliant Basics delivery plan, has been informed through stakeholder engagement, testing and learning. This had led to the three-overarching delivery workstreams 'Leading Improvement, Learning for Improvement and Delivery Improvement.'

3. Conclusion

The delivery plan details the approach for 2022-25 and the monitoring and assurance approach, to ensure that delivery is within the expected range. The learning from the previous year and stakeholder engagement have informed the plan, and the Executive team remain committed to embed BB as 'how we work in Alder Hey'. In accordance with working in a continuous improvement manner, we will continue to incorporate learning into the programme.

4. Recommendations

- To report on a quarterly basis into Board, around the progress and impact of Brilliant Basics across the organisation.

NHS
Alder Hey Children's
NHS Foundation Trust

BRILLIANT BASICS

Brilliant Basics - Delivery Plan

2022-2025

'Small Changes, Big improvements, Healthier futures.'

Contents

Appendices

A) Delivery Plan for each workstream
B) Children Young People – Involvement and Rights brief
C) Communications Plan for Brilliant Basics

Strategic Driver Metric	**Outstanding Safety**: 25% reduction in harms **Best place to work**: Increase staff empowerment score *(staff survey)*
Watch measures	• 100 service managers and matrons trained in BB • % of staff able to describe BB approach to improvement • % of staff able to make improvements • 12 teams received BB training and coaching
Executive Sponsor (SRO):	Nathan Askew
Operational Lead	Andy McColl
Quality Improvement Lead	Natalie Palin
Clinical Lead:	Clinical Lead (vacant)
Workstream sponsors:	John Grinnell (*Leading Improvement),* Melissa Swindell (*Learning for Improvement*), Adam Bateman (*Delivering Improvement*)

1. Introduction

1.1 Purpose of Brilliant Basics

The purpose of this paper is to outline the delivery approach and priorities for Brilliant Basics (BB) in 2023/25; and to provide assurance to the board around the systems of control that support the achievement of the BB vision: 'Small Changes, Big improvements, Healthier futures.'

- **What**: BB our approach to improving quality, safety, and effectiveness
- **Why**: BB a standard approach to increase the effectiveness of the organisation
- **How:** Brilliant Basics tools and behaviours for 'how we do things'

Brilliant Basics is not an initiative, it is our vehicle for improvement, it's a way of working '*how we do things at Alder Hey'*. The whole Executive is committed to BB being the '*the only show in town'*, and has adopted new ways of standard working approaches, to create the time and focus to work in a BB way (*this includes revised Exec meeting framework and Exec visibility programme).*

1.2 Background and Progress (Table 1, details key areas of success 2021/22)

Alder Hey has a long history of improving and has built on the experiences and learning of these previous approaches to develop Brilliant Basics as our vehicle to support our journey towards outstanding.

Diagram 1: Our Journey to outstanding

Subject Expert support: Alder Hey has been working in partnership with KPMG and Point of Care since 2021, with the aim of embedding an operational improvement system 'Brilliant Basic'. Despite the contracts coinciding with the pandemic the trust continued with its ambition and has demonstrated a tenacity and agility to make it work. We have benefited from the relationship with these two specialist providers, regarding quality management, improvement tools and involvement. The formal contract with KPMG and POC came to an end in March 2022.

Children, young people involvement: In developing Brilliant Basics a deliberate focus on children and young people's involvement has been incorporated into all programme aspects. Through standard work '*what have we learnt from children and young people'* as part of the new Exec routines, understanding what matters to CYP as part of the BB approach, responding to feedback through improvement huddles and staff training / development.

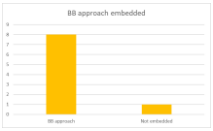
Quality Hub: In January 2021 the Trust Quality Hub was established as the engine room for improvement; the team comprised of an improvement practitioner; programme lead a Clinical Lead. The team have benefited from learning development from KPMG and POC, which has further enhanced the team's knowledge around QI, leadership for improvements and engagement. The team was fully established from January 2022, which has improved team capacity to achieve the intended benefits.

Communications: A key success in the programme was the design principles of '*show don't tell'*. What this has meant is that the communication drive began in earnest once demonstratable benefits and real-life staff stories could be utilised. This approach has fundamentally shaped the understanding of BB into something tangible based on actions and approaches. The development of the BB principles (Diagram 2) has also provided a simple transferable understanding of what it means be *'doing things in a BB way'*.

Diagram 2: Brilliant Basics Improvement Principles

Table 1: Brilliant Basics 2021/22 successes (To be updated)

Workstream	Measures	Successes to date
Quality Hub	**Team capacity** and capability to provide dedicated support 	✓ **Additional capacity within the team** (2 Band 6s) – recruitment of Band 4 ✓ Newsletter highlighting case studies of improvement across the trust ✓ Improvement board developed ✓ Improved data presentation to allow committee to focus on improvement and reduce meeting documentation ✓ Launched Quali-tea drop in session (Appendix c, photos and case studies link)

Workstream	Measures	Successes to date
Children and Young people	**Listen to children and young people**	✓ **Co-design embedded into POE** ✓ Co-design of BB ✓ Toolkit for involvement
Strategy into action	**Individual / Team Coached** 	✓ **Manager Training (40 senior managers)** ✓ Introduction session for Operational management team (52 managers) ✓ Commenced changes to Divisional PRM, with focus on fewer priorities (iterative process and ongoing) ✓ Inclusion of corporate teams, to ensure Trust-wide Embedding A3 approach as standard ✓ Standard work approach approved and communicated
Brilliant Basics Learning and coaching	**Team**: Satisfaction scores: Wave 1 – Average 4.3/5 	✓ Wave 1 – 3 teams (Nov21) ✓ Wave 2 – 4 teams (March 22) ✓ Wave 3 – 6 teams (started April 22) ✓ All waves a combination of clinical and corporate teams ✓ Monthly A3 lunch and learn sessions available for staff to drop in ✓ Speciality improvement Session Pilot ✓ Resources available on SharePoint site
Step change	**Standardised approach** 	✓ **Upskilling of DMO Team to include QI tools and techniques** ✓ The start of collaborative working with Quality Hub Team (buddies) ✓ Embedded the **BB approach** in 8 out of the 9 transformational change projects (89%) ✓ Adopting A3 problem solving into the way we work
Communication	**Recognisable look and feel for BB** 	✓ Developed a **core set of principles** and (largely) kept to them – specifically, 'show don't tell' ✓ Created a **recognisable look and feel** for Brilliant Basics, embedded in Our Plan ✓ Developed the **Brilliant Basics Approach** ✓ Co-created a **narrative 'descriptor'** that we are consistent in delivering; ✓ Taking BB beyond the programme ✓ **Delivering a set of agreed standard work** items that are not overt and don't feel 'forced'

2. Proposed Structure

2.1 Evolution

In accordance with continuous improvement, we have developed the 2022/25 priorities and approach, to consider learning and stakeholder feedback. The stakeholder engagement highlighted a requirement to streamline approach and simplify language. The refinement of language and workstreams has been of critical importance, recognising the proliferation of business terminology in Lean improvement approach. The evolution of the approach has not impacted on the content, but provided enhanced clarity on structure, and delivery of clear tangible work stream objectives.

Table 2: Brilliant Basics current workstreams and proposed

Current Workstreams	Proposed Workstreams	
Leadership Behaviours	Leading for Improvement	
Children & Young People		
Communications		
Managers Training	Learning for Improvement	
Frontline Training		
Quality Hub		
Strategy into Action	Delivering Improvement	
Step Changes		
	Enabling activities: Children and Young people's involvement, measurement, communication, and Healthier Futures	

2.2 Workstream development for 22/25

Table 3 details the areas of enhancement and focus for 22/25 based on learning and recognition that this is a multi-year programme; and BB is a cultural change programme which requires a combination of coaching, behaviours, and process changes to sustain. The enabling actions have also been clearly detailed, which will continue to ensure that BB eventually becomes '*how we work*', rather than a specific programme. In doing so the relevance to staff across the organisation in both clinical and non-clinical roles will increase.

The ambition to integrate BB across the organisation, has also provided an opportunity to enhance the linkages with the academy and organisational development. This integration recognises the conditions for improvement and learning being '*psychological safety',* this has resulted into testing a joint working model for 'stronger together' integration of OD/BB as illustrated in adjacent diagram.

2.3 Children's and Young people's involvement

Children and Young people's involvement is a key priority for the programme, building on our successes to date. Appendix 1 details the ambitions and aims around Involvement and Children's Rights. Enhancing consistency by which involvement drives, improvements will support the development of outcomes defined by CYP and sustained change based on 'what matters.' Our intent over 22/23 is to continue to enhance capacity and capability, create a community of practice and CYP outcome measures. The development of these areas, of work will be informed through on-going engagement and involvement of CYP, including the Youth Forum.

Table 3: Brilliant Basics enhancements 22/25

Proposed Workstreams	Key deliverables
1. Leading for Improvement	Standard work and daily safety meetings
	Go look and learn
	High performing teams (Stronger Together)
2. Learning for Improvement	Digital learning platform
	12 front line teams coached
	100 managers trained
3. Delivering Improvement	Strategic Exec score card
	A3 Thinking for strategic and divisional priorities
	Step change: project benefit realisation
Enabling improvement	Children and Young people Involvement and Rights approach
	Communication plan
	BI support and systems
	Stronger Foundations

2.4 Routines for each Workstream

Proposed standard routines, for reporting to ensure effective programme management and governance is proposed through the listed below mechanisms. The SRO is accountable for assuring the adherence to the standards below: -

Propose standard work for each workstream:

- Frequent (e.g., twice weekly) huddles led by workstream leads.
- Monthly briefing to Exec Lead
- Fortnightly (moving to monthly updates), after 3 months at "Friday Forum" BB
- Quarterly reporting progress into Board

The proposal is that the BB Friday Forum is attended by all Exec leads, workstream leads, SMEs, with rotational agenda so each workstream provides update once per month.

Summary of this to go to Execs/Board for information, so whole Exec Team / Board is kept up to date.

4. Plan on a Page for 2022-25: Brilliant Basics

Workstream	Leading for Improvement (John Grinnell)	Learning for Improvement (Melissa Swindell)	Delivering improvement (Adam Bateman)
Workstream aim	**'BB' leadership behaviours role modelled and cascaded through the management structure**	**An integrated training and development programme to expand and sustain our improvement capability**	**Deliver the strategic objectives at every level in the trust the BB way**
Metrics	Objectives for achieving key deliverables are on target and completed on time		
Key workstream deliverables	1. Executive standard work implemented	1. Design, develop and manage use of online Training approach including a self-directed Brilliant Basics handbook	1. Integrated OD approach into Brilliant Basics improvement approach, to support cultural changes to be sustained
	2. Executive coaching – 1:1 for personal development and Exec BB coaching (leadership behaviours)	2. Provisions of frontline ongoing coaching and training programme to support the roll out of huddles to all front line and connect with OMS	2. Categorisation, alignment, and Prioritisation of all projects (including safety priorities) using the strategic alignment framework – reported via the Execs and Healthier Futures Board
	3. NED development programme delivered	3. Provision of ongoing managers coaching and training programme (note proposed model for community and MH)	3. Visual management of performance improvement and project progress – including review of corporate report, scorecards, driver and watch metrics
	4. Development and ongoing governance, oversight and assurance of Brilliant Basics programme – OMS	4. Brilliant Basics Improvement Huddles to all coached teams	4. Cascade priorities through the operational management system of BB (PRMs, negotiating priorities, scorecards – annual refresh) and using standard work
	5. "Go, Look, listen" / Exec Link role implemented 6. Daily Safety Briefings (Executive led) implemented	5. Cascading and sharing and showcasing improvements – inc celebration events	5. Implementation of new routines and standard work throughout the organisation to deliver the strategic objectives
	7. Cascade of leadership behaviours and standard work from Execs to other senior leaders	6.Deliver and sustain the integrated improvement model where Stronger foundations and BB align	6. Operational transformation programme (Step change/time limited projects) benefits delivered
	8. Develop an integrated improvement model to incorporate 'high performing teams' (management accreditation and standards) and stronger foundations with Brilliant Basics/Organisation Development		7. Tested the Specialty quality improvement workshop and evaluated its effectiveness
Enabling improvement: Comms & Engagement, BI, Children and Young People and 2030 strategy refresh			

5. High Level milestones

4.1. Milestones

Outline high level timeframes for the milestone objectives over next 3 years for each workstream are details in appendix 1. The high-level programme milestones are detailed in the table below, progress delivery milestones, will be monitored through the routines for each workstream (detailed in section 2.3).

Workstream	Milestone	By when
Leading Improvement	Implement Executive standard work, including daily safety briefing	July 2022
	Integrated improvement model developed	Sept 2022
Learning for improvement	Digital learning platform implemented	Dec 2022
	12 front-line teams will have received training and supportive coaching	Sept 2022 (6) March 2023 (12)
Delivering improvement	A3 developed for each of the strategic objectives	Nov 2022
	Operational transformational programme – benefits delivered	March 2023
Children's Rights and Involvement	Recruitment and Training of Involvement and Rights Team	Sept 2022

4. Resources

4.1 Resources

Resources for the core team is already in place and the current investment supports the Quality Hub team. In reviewing the ambitions for 2022-25, a recognition that for 2021/22 we have benefited through the additional expertise from POC and KPMG. Additional investment for 2022/23 is part of the transition plan and is in place. A risk /opportunity and prioritisation approach has been applied to ensure resources are targeted appropriately. No additional resources requested are being made in this document (instead the table below, details the areas of priority for 22/23).

Priority areas (2022/23)	Details
1. Improvement Coaching	• **Output:** Delivering improvement coaching and OD interventions. Addressing resource gap in OD interventions alongside improvement. Additional coaching, Organisational Development to embed habits and leadership behaviours (Learning and Delivering Improvement)
2. Children and young people involvement and rights	• **Output:** Enhance the current trust position regarding the UN Rights of the Child and enhance involvement practice. • **Impact:** Increased involvement of Children and young people in improvements, through creation of an Involvement and Rights Team
3. Point of Care (Specialist support)	• **Impact:** To enhance the approach to children and young peoples' involvement, supporting embedding the Right and Involvement team.
4. Digital online material	• **Output**: Creation of online learning materials. • **Impact**: Blended learning offer for self-directed personal development
5. Comms and materials	• **Output**: Investment in communication materials to showcase and share learning. • **Impact**: To share and showcase the trust improvement work

(Details of the approve proposals are detailed within the appendix)

6. Conclusion

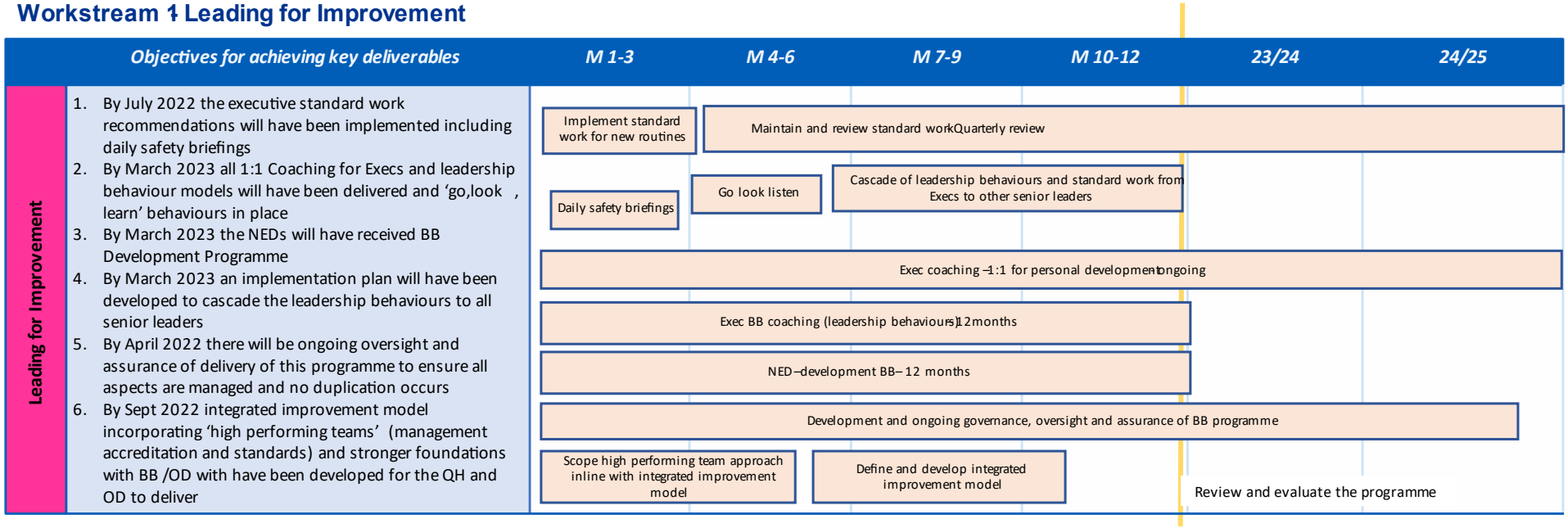
5.1 Conclusion

In conclusion the delivery plan, details the approach for 2022-25 and the monitoring and assurance approach, to ensure that delivery is within the expected range. The learning from the previous year and stakeholder engagement have informed the plan, and the Executive team remain committed to embed BB as 'how we work in Alder Hey'. In accordance with working in a continuous improvement manner, we will continue to incorporate learning into the programme.

Appendices (A): Delivery Plan for each workstream

BrilliantBasics Objectives for 22/23 (ambition)

Workstream 1 Leading for Improvement



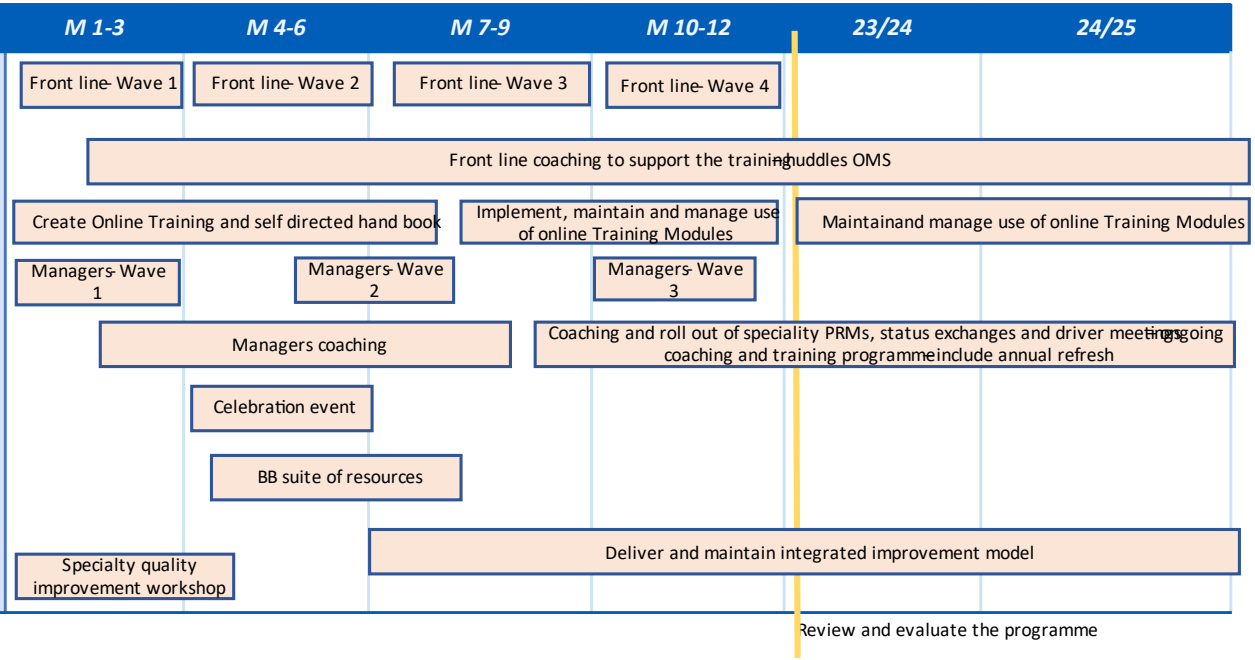
Brilliant Basics Objectives for 22/23 (ambition)

Workstream 2- Learning for Improvement

Learning for Improvement

Objectives for achieving key deliverables

1. By Dec 2022 there will be a high quality easily accessible digital learning platform available for all staff to access and all staff will have an understanding of what BB is
2. By march 2023, 100 (3 waves) service managers and matrons will have received managers training and will be able to demonstrate improvement to their divisional colleagues
3. By March 2023 an Integrated improvement model will have been designed and implemented across 2 specialities and will have delivered the target metrics
4. By March 2023, 12 front line teams (4 waves) will have received training with supportive coaching, implemented improvement huddles
5. By June 2022 deliver a second celebration event to showcase improvements
6. By Oct the QH and OD will have been given the scope form the 'Leading for Improvement' lead to develop and deliver the integrated improvement model
7. By June 2022 the Specialty quality improvement workshop would have been tested, its effectiveness evaluated and recommendations made on the next stage



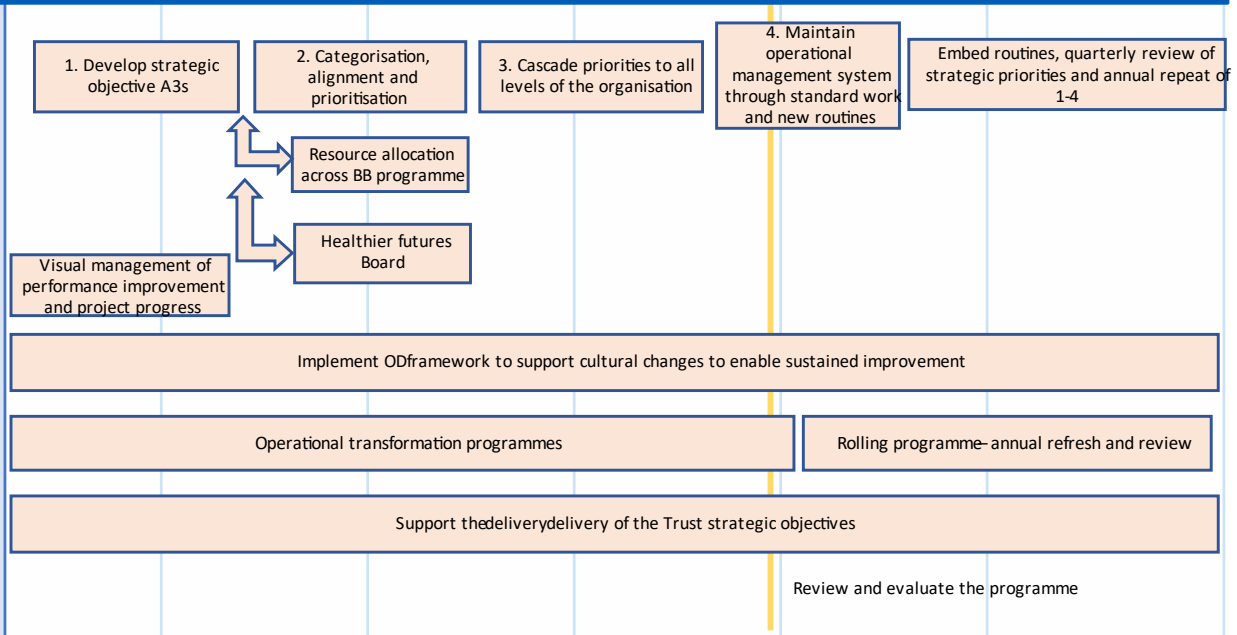
Brilliant Basics Objectives for 22/23 (ambition)

Workstream 3- Delivering Improvement

Delivering Improvement

Objectives for achieving key deliverables

1. By May 2022 there will be a visual management system in place to enable senior leaders to see performance data quickly and clearly
2. By Nov 2022 there will be A3s developed for each strategic objective, all improvement projects will have been categorised and prioritised using the strategic filter (including safety priorities), resources required to deliver the ongoing programme will have been defined and agreed and all divisions will have negotiated their priorities and set the scorecard objectives. There will be in place the system for delivering the strategic objectives at every level in the Trust.
3. By March 2023 an OD framework will have been designed and implemented to support the changes required to enable a culture of continuous improvement within a team through OD team analysis and OD/ leadership coaching
4. By Sept 2022 all prioritised improvement projects will be reported to the Healthier futures Board
5. By March 2023 the Operational transformation programme (Step change/time limited projects) benefits will have been delivered
6. By March 2023 the QH and DMO will have supported the delivery of the Trust strategic objectives through Improvement coaching, Improvement facilitation and project management of the defined priority projects



Brilliant Basics Objectives for 22/23 (ambition)

BB programme enablers– for teams that are independent of BB programme yet will enable the spread and pace

	Supporting objectives for achieving key deliverables	*M 1-3*	*M 4-6*	*M 7-9*	*M 10-12*	*23/24*	*24/25*
Enabling improvement	1. By March 2023 all improvements will evidence involvement of CYP which will be championed by execs and senior leaders through the CYP shadowing programme this will enable leading, learning and delivering improvement 2. By July 2022 the Trust 2030 strategy will have been refreshed and A3s written for each of the strategic objective to enable the delivery of improvement 3. By June 2022 SharePoint site will have been implemented and an ongoing maintenance programme established with the QH to enable Learning for improvement 4. By April 2022 there will be an ongoing comms programme in place to enable all staff access to relevant BB information 5. By June 2022 the BI requirement to support BB will have been scoped and a recommendation developed – understand what data is already in place	CYP - programme					
			Trust 2030 vision refresh				
		Implement Sharepoint and populate with improvement resources		Ongoing BB aligned Comms programme and maintenance of Sharepoint			
		22/23 Comms plan		Delivery of comms plan			
			Scope BI support			Review and evaluate the programme	

Appendices B: Children's Rights and Involvement – Brief

Children's and Young Peoples @ the heart of all we do

Rights and involvement (2022/24)

SOR: Nathan Askew, Chief Nurse **Clinical Lead:** Lisa Cooper **Operational/ Project lead**: Marianne Hamer

1. Purpose

The purpose of this paper is to outline the ambitions for Alder Hey to realise the visions of 'Healthier Happier Lives', through embedding children's rights and involvement into how we work: -

- **Children's Right** – Recognising the trust's requirements to uphold the UN Convention on Rights of the Child at an individual, statutory and system level.
- **Involvement** – to enhance Alder Hey's approach to engagement with children and young people and their families, to ensure that we have innovative approaches to capturing the voice of children and young people from the diverse communities that we serve.

2. Background

Since 2021, Alder Hey has worked with the Point of Care Foundation (POC), to ensure that Brilliant Basics way of working is focused on the voice of children and young people. POC have supported with: -

- Developing the Brilliant Basics training materials with KPMG
- Developing an approach to children and young people's involvement in improvement, which is now part of the quality hub's toolkit, and is included on the sharepoint site.
- Participation in step change projects as required (including the work on ward 4C relating to children and young people with complex emotional needs/challenging behaviour).
- Initiating a programme of work with the Executive Team to establish a work programme to make real the aspiration of "children and young people at the heart of all we do".

The United Nations Convention on the Rights of the Child contains 52 standards that set out the Rights of a Child (Appendix 1). Most countries including the United Kingdom have signed up to the convention. Many countries use the standards wholly or in part to promote children and young people's involvement. There are four central principles that underpin the implementation: -

- **Non-discrimination:** the rights of all children should be ensured without discrimination of any kind.

- **The best interest of the child:** whenever decisions or actions are taken that affect children, the bests interest of the child must be the primary consideration.

- **Right to life and development** of the child: all children should be enabled to develop in an optimal way; physically, mentally, spiritually, morally, and socially.

- **Right to be heard:** children should be able to express their views freely in all matters affecting them to participate in all decision-making processes related to their lives, and to exert influence over such decisions in accordance with their age and maturity.

3. Current state

The work with POC has supported a consideration around the trust's ambitions for 'Right's and Engagement'. The current resources, capacity and capabilities have been reviewed to understand barriers to the achievement of the trusts vision. It should be noted that whilst patient experience covers a range of functions that relate to engagement with children, young people and their family's engagement is much broader than experience.

Patient Experience Team: The primary focus of this team is to drive patient experience, including the core functions of collecting and analysing feedback thought the Friends and Family Test (nationally mandated). The patient experience team also support the trust volunteers, who contribute to patient satisfaction and reduce anxiety faced by families.

It's recognised that the Friends and Family Test has some significant limitations, into truly providing a picture of experience. It also doesn't allow an understanding of the experiences at different stages of children and young people's care pathway.

Patient

There are opportunities for staff including our students to shadow children and young people in a structured way, providing real insight to how children, young people and their families experience our services, including the impact their health condition has on them external to the health service.

Alder Hey Youth Forum

Alder Hey has a strong voice through our youth forum. The forum have been involved in a range of activities but there is recognition that the forum could play a more active role in how we engage with our young people moving forward.

4. Key deliverables

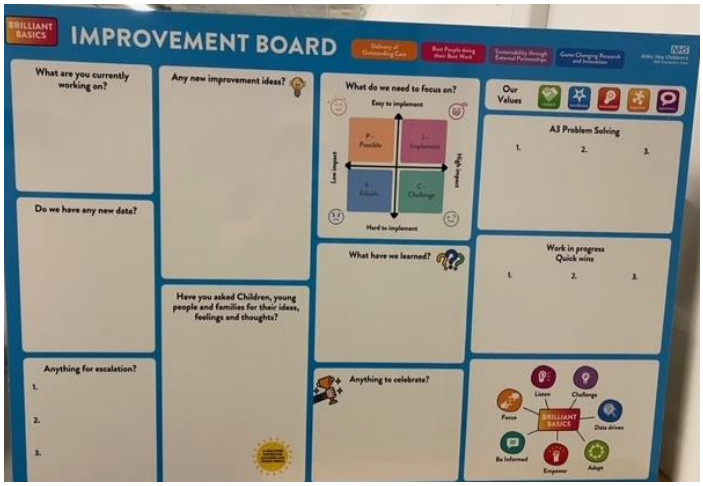
Vision	**Children and Young people at the heart of all we do**
Objective 1.	To embed the Rights of the Child into governance process and day to day working (2)
Objective 2.	**Right to Express:** To maximise and empower children's and young peoples' involvement in strategic and day to day decisions that affect their lives. (12 + 13)
Objective 3	To maximise the involvement of children and young people from seldom heard communities. (23)
Objective 4	**Right to best possible health:** To ensure that Alder Hey builds its service that maximises the potential of every young person (24)

(Referenced rights)

Appendices C: Plan for Brilliant Basics

BB%20Comms%20Pack.pptx

[Alder Hey Quality Improvement Space - Stories (sharepoint.com)]



Picture 1: Improvement Board

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st April 2022 – 30th April 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	

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 (CQSG), Quality and Safety Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

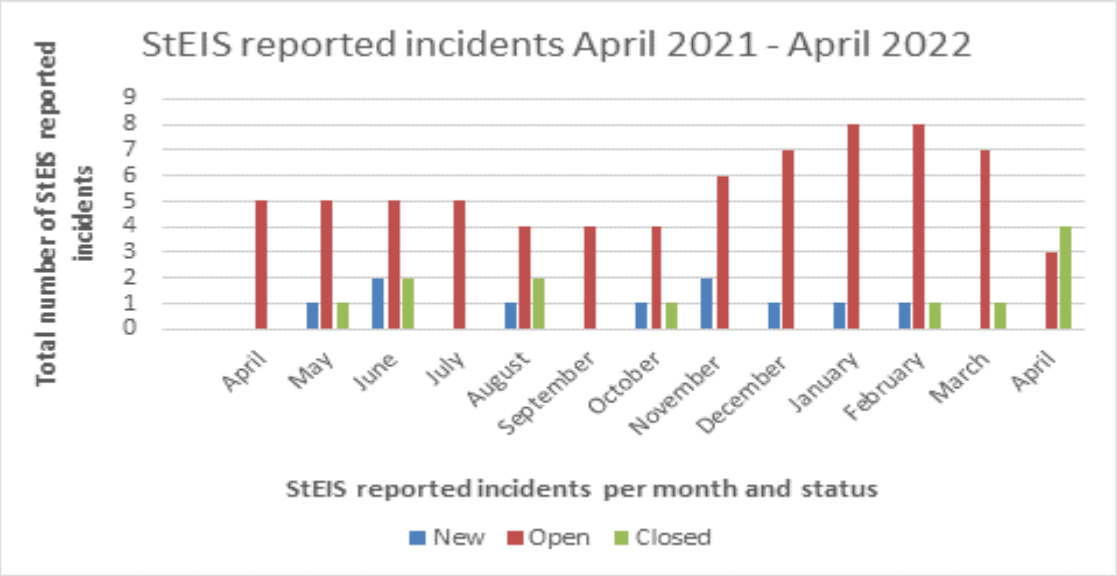
Serious incidents that do not meet the StEIS criteria are discussed at the weekly patient safety meeting and where appropriate an RCA level 2 is instigated.

2. Serious Incidents activity April 1st 2021 – 30th April 2022

During 1st April 2021 – 30th April 2022, the Trust reported as follows

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

Note: Seven StEIS reportable incident investigations and one internal level 2 incident investigation were carried forward to 2022/23 from the previous financial year.



Graph 1 – StEIS reported incident status by month

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

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

Table 1: StEIS reported serious incident 2022

4. **Never Events**

Zero 'never events' were declared in April 2022.

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

Five serious incidents' investigations were closed in March 2022, including four StEIS reported investigations and one internal level 2 investigation

StEIS reference	Date reported	Incident	Summary
2022/1581	24/01/2022	Category 4 Pressure Ulcer.	
2021/25961	15/12/2021	Patient receiving active treatment for leukaemia relapsed.	

2021/17974	16/07/2021	Severe Haemophilia A: Treatment outside usual clinical pathway.	Refer to appendix 1
2021/12203	27/06/2021	Delay in treatment. Delay in transfer to HDU. Suboptimal care of deteriorating patient?	

Table 2: StEIS *SI investigations report completed April 2022*

Ulysses reference	Date reported	Incident	Summary
52535	17/09/2021	Investigation into Care pathway concerns	Refer to appendix 1

Table 3 Internal level 2 investigation

6. Learning from serious incidents

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

6.1. Serious Incident action plans

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

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

Table 3 below provides an overview of progress position for open action plans, past expected date of completion. The Division of Surgery, Corporate Services and Community & Mental Health currently have no action plans past expected date of completion. The Division of Medicine has two action plans past expected date of completion, including reference: 39858,which has one outstanding action relating to sharing lessons learned and recommendations for improvement. The report has been shared with two trusts and establishing correct contact at Betsi Cadwalader Trust for report to be sent securely. Low risk as actions for AHCH are implemented and sharing is underway. Also reference 46716, has four outstanding actions. Meeting held with lead and agreed outstanding actions to be completed by end of May 2022. Low risk due mitigations in place.

Division	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	April	Total
Surgery	11	4	4	5	5	5	3	6	6	0	3	3	0	55
Medicine	3	1	3	1	1	1	3	4	4	6	2	2	2	33

CMH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Corporate	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	14	5	7	6	6	6	6	10	10	6	5	5	3	91

Table 3: *SI action plans past expected date of completion April 2021- April 2022*

6.2 Measuring the effectiveness of serious incident actions

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

All action plans are expected to be specific, measurable, achievable, realistic, timebound (SMART) in their design.

Although the Trust monitors the effectiveness of actions, in many cases via audit, in addition the actions plans are monitored for potential risk, particularly where actions have gone past expected date of completion, to ensure mitigations are in place to minimise risk.

There is evidence of positive changes in practice that will lead to improvements which in turn will minimise risk of same or similar 'harm' incidents recurring, for example:

- Prevention and management of pressure ulcer policy amended, to reflect the requirement for daily tissue viability specialists to review high risk patients. The tissue viability specialists now review all patients at high risk of developing pressure ulcers daily and advise staff accordingly.
- Ulysses now includes drop down criteria to enable staff complete incident forms accurately where document management plans are not followed. This is being closes monitored by the tissue viability team to ensure risk to patient safety is minimised.
- Concerns escalated by the tissue viability specialist now documented on the PICU team leader daily checklist and discussed with staff on duty.

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 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 for the four StEIS reported incidents and the one internal level 2 RCA investigation completed in April 2022.

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

Since the 1st of April 202, there were five investigation reports completed and submitted to commissioners. key themes contributing to the serious incidents included:

- Communication issues (staff to staff) (5/5)
- Guidelines, Policies, Procedures not adhered to/not followed/lack clarity (5/5)
- Documentation not completed (5/5)
- Escalation processes not followed (4/5)
- Leadership issues (4/5)
- Equipment issues (3/5)
- Staff training and development (3/5)
- Communication issues (staff to patients and families) (2/5)
- Consent issues (2/5)
- Staffing resource (2/5)
- Deviation from national guidance (2/5)

Root cause themes

The primary themes noted in root causes was communication issues, documentation (written and verbal) issues, guidelines, policies pathways issues and escalation issues.

Themes 2021/22

The eight investigations cited in previous reports for 2021/22 showed some similar themes as the investigation themes cited above, including, communication issues, Guidelines, Policies, procedures not adhered to/not followed/lack clarity, documentation not clearly visible/not completed, escalation processes not followed, and leadership issues.

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

1. **Precise for completed StEIS (ref: 2022/1581)investigation report. (Ulysses reference: 54938)**

Background

The patient was being nursed on Extracorporeal Membrane Oxygenation (ECMO) when the pressure ulcer to her left ear was identified. The tissue Viability Nurse (TVN) reviewed, and the incident was classified as a category 4 pressure ulcer.

Root Cause's

The following were identified as the root causes for the incident:

- Category 4 pressure ulcer to left ear caused by the lack of mobility and oscillation friction from the HFOV (High Flow Oscillatory Ventilation) and the required ECMO (Extracorporeal membrane oxygenation) treatment for her critically ill clinical condition.
- The presence of the ECMO cannulas in the right side of the neck meant that the patients head position head position was tilted to left side, causing more pressure on her left ear which is a prominent area and does not have much tissue.

Lessons learned

1. Ensure that referrals made by the clinical teams are followed up and actioned.
2. Ensure that management plans made by tissue viability and clinical teams should be followed through.
3. Ensure that identified clinical concerns are escalated to the senior clinical team, for oversight and action.
4. Consider frequency of reviews of high-risk patients as part of the Tissue Viability management plan.
5. The process for identifying and booking children into appointments needs to include rules not only on tolerances, but with reference to risk of missed/ delayed follow up.

Recommendations

1. Management plans prescribed by the specialist team should be followed through, to minimise the risk of deterioration in the patients' conditions. The management plan by Tissue Viability team was to keep the left ear covered. There was one occasion when the dressing to the patient's left ear was not in place as advised by the Tissue Viability team.
2. Referral made to the Medical Photography team by the clinical team should be followed through, to ensure that these photographs are saved on the PACS system, to enable availability to all healthcare professionals involved in the patient's care.
3. Consider changing the referral process from the Tissue Viability Team to the Plastic Surgery team for ease of access and joint working when second opinions are required. The Tissue Viability is a senior specialist team that work closely with the Plastic Surgery clinicians and the ability to make direct referral will reflect the joint working currently in place.
4. Ensure that the Tissue Viability team have full access to the Badger system, for complete clinical oversight of the patient they are reviewing.
5. PICU Ward Manager to ensure that PICU staff have updated training on Braden Q assessment scoring.
6. There should be clear lines of communication and escalation from Tissue Viability Team to senior ward staff when the tissue viability management plan is not followed.
7. An alert to suggest when dressings require changing will be helpful to staff when there are different staff handing over and taking care of the patient.
8. The Tissue Viability team should consider increased frequency of assessment and review of high-risk patients on PICU and include scheduling meeting with parents if they were not present at the time of TVN assessment.

Comprehensive action plan based on recommendations in place, to ensure actions for improvement are implemented.

2. **Precise for completed StEIS (ref: 2021/12203)investigation report. (Ulysses reference: 50084)**

Background

The patient was admitted through the Emergency Department. It was documented the patient was unstable, but there was no evidence of appropriate escalation to senior medical staff, although the patient was reviewed on numerous occasions,

Root Cause's

The following were identified as the root causes for the incident:

- Delay in appropriate escalation for the management of sepsis.
- This was an atypical presentation of enterocolitis – with no bowel distention or explosive bowel pattern.
- The panel members agreed that at the time of presentation to the Emergency Department, there were no indicators of an acute surgical problem, and it was clinically appropriate to manage the patient through the Trust's Sepsis Policy. However, the panel members found that there was a missed opportunity to transfer the patient to HDU earlier for monitoring and management of sepsis. In part, this was due to a delay in the escalation for timely medical review. The

gaps in the frequency and accuracy of the patient's vital sign monitoring and PEWS calculation contributed to this incident. The panel members agreed that the patient probably had enterocolitis on admission, but this was an atypical presentation.

Lessons learned

1. The ward may not have been allocated appropriately at the first admission.
2. PEWS scores were not completed to include the parental and nursing concerns and the increase in frequency of observations does not appear to have been carried out.
3. There was a lack of appropriate escalation to, and oversight from the on-call Consultant on 27th May 2021.
4. It is important that all documentation is completed including fluid balance in acute admissions.
5. There was no referral to the surgical team on admission, despite known surgical history as well as a recent critical care admission due to enterocolitis. Patients with a diagnosis of Hirschsprung's disease are at risk of enterocolitis and this should be considered in all acute admissions of this group of patients
6. There was a delay the patient being transferred from the ward to HDU due to the Porter's service.

Recommendations

1. Patients with underlying complex medical background presenting with infection or sepsis should be admitted to an acute medical or surgical ward (3A, 3C or 4C). This needs to be communicated to the Patient Flow Team and Clinical teams to ensure this is in place when reasonably practicable.
2. Communication to trainees/ACT/nurses regarding appropriate escalation of clinical concerns to consultant to empower staff to communicate and escalate if in any doubt
3. Communication to staff regarding ensuring vital signs are recorded entirely and at the correct frequency for the patient's condition
4. Ensure clinical staff have completed their mandatory training in the sepsis pathway.
5. Staff to document any overnight discussion with consultants.
6. Surgical team to be notified if Hirschsprung's disease patients are admitted acutely.
7. Review of communication with Porters team across trust to ensure full understanding of urgency of transfer is achieved. Patients who need to be moved from the ward to critical care should be prioritised.
8. Ensure communication between medical and nursing staff following a review in an unwell patient is both verbal and documented.

Comprehensive action plan based on recommendations in place, to ensure actions for improvement are implemented.

3. **Precise for completed StEIS (ref: 2021/17974) investigation report. (Ulysses reference: 51129)**

Background
The patient was administered new (novel) treatment that may have caused harm.

Root Cause's

- The following were identified as the root causes for the incident:
- The risk/benefits of the novel immunomodulatory treatment were not properly considered once treatment was commenced.
- Commencement of the novel immunomodulatory treatment was appropriate, but that ongoing treatment should have taken into consideration the continued adverse effects THE patient suffered. These adverse effects should have been balanced against the benefits of treatment on an ongoing basis.
- The ongoing risk/benefit of treatment should have been clearly documented, and actively managed throughout the patient's treatment.

Lessons learned

1. The CDEG individual patient request form template did not provide a specific section for clinicians to present discussions with other teams (internally or externally) who have been involved in the development of the proposal, limiting the information available to the CDEG Committee and/or the 'Three Chairs' when considering approval of a new drug/treatment.

2. Consent forms relating to treatment for children and young people should allow clinicians to accurately document all aspects of the agreed treatment.

3. The families concern around the patient's treatment should have been acknowledged, documented, and acted upon.

4. Wherever appropriate and feasible clinical teams should be encouraged to discuss new treatments formally or informally with their peers.

5. Ongoing risk/benefit of ongoing treatment by the haematology team should have been considered, and clearly documented supported by clarity from the CDEG submission when treatment will start/stop/continue.

Recommendations

1. To investigate whether it is possible to determine if the patients long term health issues are related to the novel immunotherapy treatment.

2. To review the haematology/oncology consent forms to ensure that all aspects of a proposed treatment are documented clearly. This will ensure that families or carers for children and young people are able to give informed consent for the agreed treatment.
3. The CDEG submission form and the CDEG individual patient request form must be reviewed and updated.
4. To review oncology treatment pathways/regimes that are used to treat haematology patients
5. To review the process for carrying RCA Level 2 investigations to reduce the time from the date an incident is reported to the time the RCA report is completed

Comprehensive action plan based on recommendations in place, to ensure actions for improvement are implemented.

4. **Precise for completed StEIS (ref: 2021/25961) investigation report. (Ulysses reference: 54286)**

Background

The patient relapsed while on active treatment.

Root Cause's

The following were identified as the root cause for the incident:

The correct treatment regimen was not allocated due to confusion over the interpretation of the Minimum Residual Disease (MRD) result and subsequent action required. It was discovered at the time of replace that there had been a deviation in the treatment recommendations from national guidelines.

Lessons learned

- The CDEG individual patient request form template did not provide a specific section for clinicians to present discussions with other teams (internally or externally) who have been involved in the development of the proposal, limiting the information available to the CDEG Committee and/or the 'Three Chairs' when considering approval of a new drug/treatment.
- Consent forms relating to treatment for children and young people should allow clinicians to accurately document all aspects of the agreed treatment.
- The families concern around the patient's treatment should have been acknowledged, documented, and acted upon.
- Wherever appropriate and wherever feasible clinical teams should be encouraged to discuss new treatments formally or informally with their peers.
- Ongoing risk/benefit of ongoing treatment by the haematology team should have been considered, and clearly documented supported by clarity from the CDEG submission when treatment will start/stop/continue.

Recommendations

1. Alder Hey Haematology Consultants should attend CLCN meetings regularly.
2. The Leukaemia MDT meetings should be reviewed, and specific Terms of Reference developed.
3. A second check of MRD results should be introduced into the Leukaemia MDT meetings
4. The template for the Leukaemia MDT meeting notes should be reviewed. The purpose of these notes should also be clarified - are they the primary reference source for treatment decisions? This information be transferred into the individual patient's medical notes.
5. A process for Day 35 summaries to be shared with POSCUs and GPs and should be developed for all new patients. This will provide an opportunity to review the treatment pathway for a second time.
6. Difficulties with Haematology staffing should be recorded on the Trust risk register.
7. The Glasgow MRD lab should be contacted to ensure they are now reporting MRD results as percentages in line with the recommendations made in 2019.
8. The Haematology team need to ensure that potential pitfalls in interpretation of MRD results are considered and risks mitigated as part of the implementation plan of the new ALL protocol due to be introduced in 2022

Comprehensive action plan based on recommendations in place, to ensure actions for improvement are implemented.

5. **Precise for completed internal level 2 investigation report. (Ulysses reference: 52535)**

Background

accident at home resulted in catastrophic injury,

Root Cause

The following were identified as the root cause for the incident:

The investigation panel reviewed all aspects of the case and concluded that it was not possible to determine absolute and definitive contributory factors and a root cause of death until the post-mortem results are available. However, the investigation panel concluded that due to the initial blunt trauma endured, the outcome for the patient would not have been different through any changes in the pathway of care provided.

Lessons learned themes

1. Care delivery
2. Availability of Equipment
3. Communications
4. Infection Control
5. Policy/Guidelines
6. Training/Experience

7. Resource
8. Documentation

Recommendations for action themes

1. Care delivery
2. Availability of Equipment
3. Communications
4. Infection Control
5. Policy/Guidelines
6. Training/Experience
7. Resource
8. Documentation

Comprehensive action plan based on recommendations in place, to ensure actions for improvement are implemented.

END

Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report April 2022

Alder Hey Children's NHS
NHS Foundation Trust

Contents

Delivery of Outstanding Care

Safe

- Continued evidence of good reporting culture with increased number of incident reported being near miss or no harm.
- Medication errors are average for the month and whilst an increase in pressure ulcers these have all been grade 2 with no grade 3 or 4 reported.
- There are continued challenges with ED sepsis compliance and an absence of in patient data which is being addressed by the medicine division.
- There has been a reduction in cardiac arrests and unplanned admission to critical care which will be monitored through the deteriorating patient group
- A high number of children and young people were stepped down outside of working hours from critical care and more work is needed to understand the drivers for this and to move more patients to step down within hours
- More work is needed to embed the e-consent process and increase compliance towards the target of 75% of children and young people having consent taken before the day of surgery.

Highlight

- High levels of reporting continue
- No grade 3 or 4 pressure ulcers reported
- Reduction in cardiac arrest calls and unplanned admissions to critical care.

Challenges

- Sepsis performance across the Trust
- Need to increase levels of children and young people consented before the day of surgery as e-consent embeds.
- Their will eb s focus on ensuring that critical care step downs occur more in hours

The Best People Doing their Best Work

Caring

- There has been increased FFT scores for all areas with the exception of ED, which is negatively affecting the overall trust score for patient satisfaction.
- Despite an in month reduction in the number of formal complaints and informal concerns there has been deterioration with meeting the trust time frames for responsiveness.
- Challenges continue with provision of play within wards and departments which will be a key focus of the new play manager starting I the trust on 23rd May.
- There has been a decline in families awareness of their expected date of discharge which will be a key focus for all divisions to drive improvement in this area.

Highlight

- Improved FFT scores across most areas

Challenges

- Reduction in families aware of their discharge date
- Continued need to increase responsiveness for PALS and complaints.

Delivery of Outstanding Care

Effective

In April, the Emergency department waiting times remains the most significant performance challenge, with only 73% of patients receiving treatment within 4 hours. The volume of patients is a key element of this challenge, with ED attendances 9.8% higher than 2019. The median time to triage in April was 12 minutes (within the target of 15minutes) however median time to clinician assessment was 106minutes against national target of 60minutes. With regard to patients in department for >12 hours, we continue to be well within the national target of <2% but still working towards aspiration that no child will be in ED >12 hours.

The annual plan process has agreed significant investment in staffing levels and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place – "ED at its best". A workshop is being held by the Department on the 26 May to set out an improvement plan

Highlight

- Median time to triage in April was 12 minutes (within the target of 15 minutes).

Challenges

- Waiting times in Emergency Department, compliance with 4 hour target and some patients total time in department >12 hours

Delivery of Outstanding Care

Responsive

The number of patients waiting >52weeks for planned care rose slightly to 290 patients at end of April. Significant focus has been given to those patients waiting the longest time with the last patient >104 weeks seen at discharged on 17 May. There are only 2 other patients >90 weeks, both with appointment dates. Paediatric Dentistry now comprises 67% of the total 52week waits.

Diagnostic waits remain off track, with specific focus and action plans on MRI, Urodynamics and Sleep Studies, expected to demonstrate improvement in coming months.

Highlight

- Access to Cancer Care
- Total volume of Elective (IP & DC) patients seen in April achieved target of 104% recovery.

Challenges

- Elective waiting times, particularly in Paediatric Dentistry.
- Diagnostic Waiting Times.

The Best People Doing their Best Work

Well Led

Finance
For the month of April (Month 1), the Trust is reporting a deficit of £0.8m which is £0.5m away from plan.
This deficit is largely driven by costs associated with clinical supplies, backdated pay costs and the non-delivery of CIP in month 1 which was £0.4m against a target of £1m.
Cash in the bank at the end of April was £90.1m. The capital expenditure for the first month of the year was £0.4m. The external audit for 2021/22 has now commenced and is progressing well thus far.

Sickness
After a fluid few months with regard to levels of absenteeism linked to sickness, I am pleased to report that the Trust is currently experiencing a downward trajectory of absence linked to sickness absence in general and also COVID absence in particular.

Highlight

Challenges

- Complete Year End Audit
- Significant challenge with regards to the CIP requirement in year which is £14m for 22/23.

However sickness absence remains higher than the trust target of 4% (6.53% as at 6th May 2022), therefore this remains a key priority area and robust monitoring, support, advice and activity remains in place as detailed previously; with escalation through divisional management teams, as well as reporting to JCNC and PAWC on a regular basis **Turnover** The Trust target for staff turnover rate is to achieve less than 10%. The rolling 12 month turnover rate has been on an upward trajectory from December 2021. In order to address increasing turnover rates a number of actions are in place or being developed. For example, the leave reason of Resignation – other/not known has been removed from the leavers form completed by managers. This will provide more detail around the reasons people are leaving the Trust. Also, the exit interview process will shortly be re-launched to obtain more data rich information to support the Trust with retention.	

Game Changing Research and Innovation

Research and Development

Month 1 Research Activity:

- 193 research studies currently open
- 1,008 patients recruited to research studies (1,008 in 22/23)

Divisional Participation:

- Division of Medicine – 154 open studies
- Division of Surgical Care – 33 open studies
- Division of Community & Mental Health – 6 open studies

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 78.4%

Highlight

- Highest recruiter of patients to research studies amongst NHS organisations in the North West in 21/22

Challenges

- Post-pandemic recovery of clinical research capacity

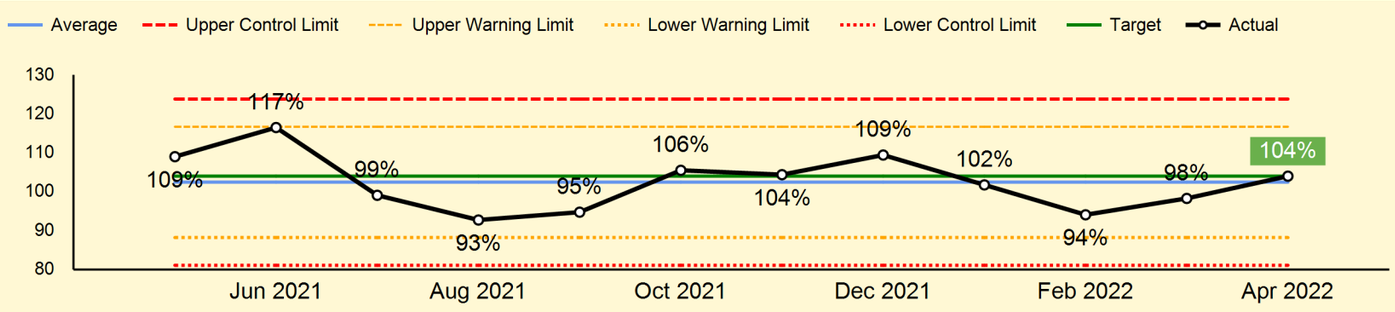
Alder Hey Children's
NHS Foundation Trust

Part 1 - Executive Scorecard

Recovery

104% Activity - Elective and Daycase

Apr 2022: 104% **Trend:** ▲ **Target:** **>=104 %**

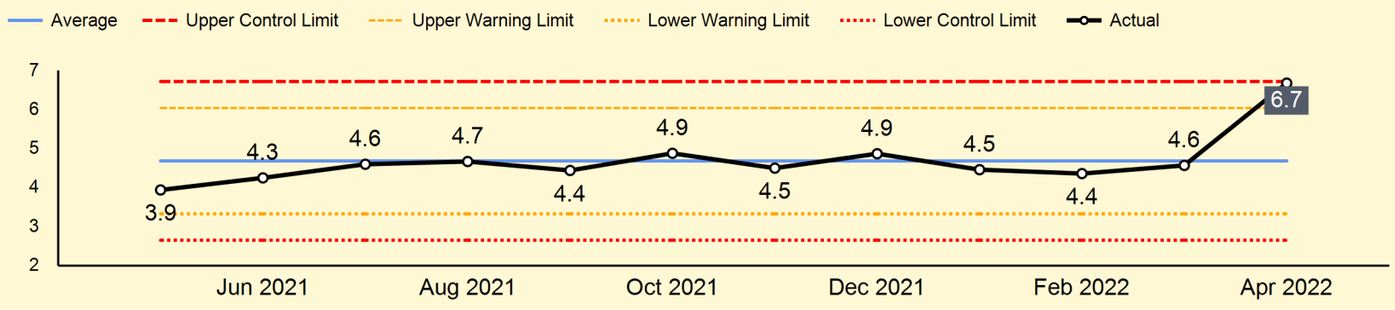


Comments:

Achieved 104% volume in April
Medicine elective recovery is good at 108.9%
Surgery elective recovery is challenged at 91.4% (last 4 weeks)
Previous 12 months shows variable performance but >104% can be achieved.
Improvement actions in place through OP Transformation and Theatres Working Groups required to ensure consistency of achieving >104%

Average patients per Theatre Session (DC)

Apr 2022: 6.7 **Trend:** ▲ **Target not set**

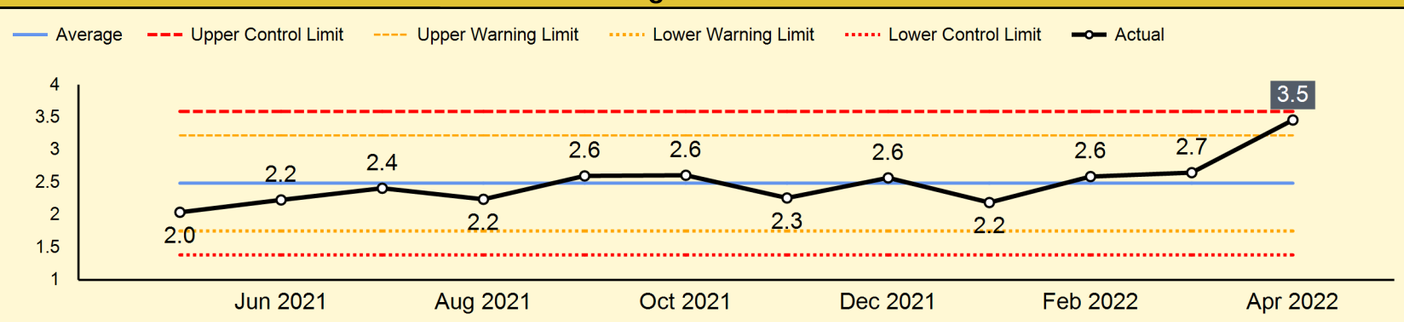


Comments:

Spike in April patients per session is positive but needs to be maintained.
Consistent range over last 12 months has been 4.4-4.9
Target to be agreed with Theatre teams, but will be set above pre-pandemic level

Average patients per Theatre Session (EL)

Apr 2022: 3.5 **Trend:** ▲ **Target not set**

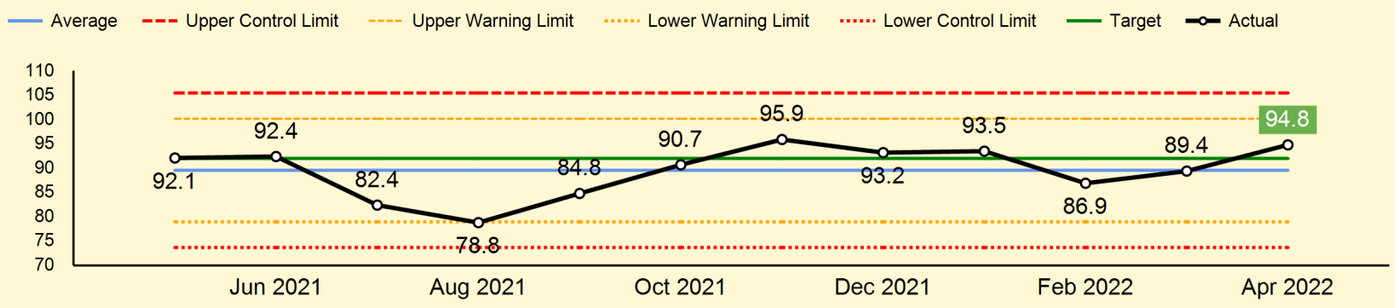


Comments:

Spike in April patients per session is positive but needs to be maintained. This reflects end of elective cap associated with omicron and winter plan
Consistent range over last 12 months has been 2.2-2.6
Target to be agreed with Theatre teams, but will be set above pre-pandemic level

Average Patients per Working Day (DC Spells)

Apr 2022: 94.8 **Trend:** ▲ **Target:** **>=92**

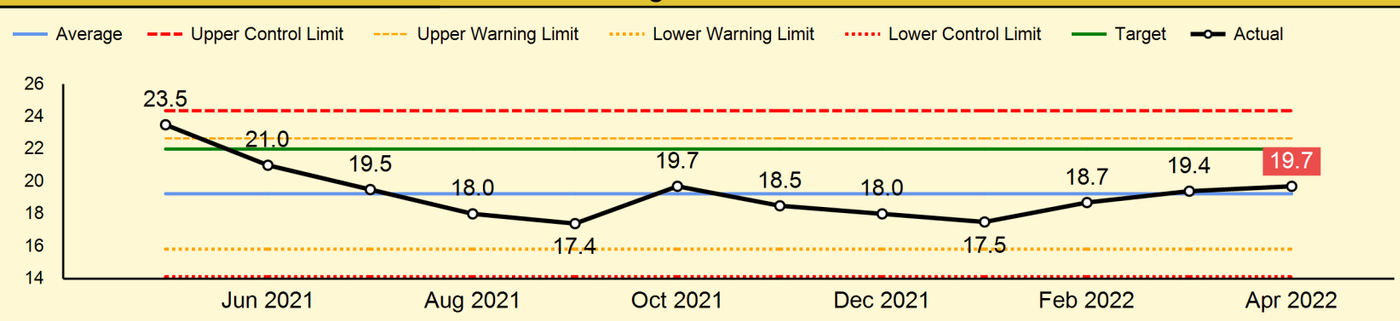


Comments:

April shows highest figure since November which is positive, but further improvements need to be sustained to demonstrate statistical evidence of step change. Increase in patients per day compared to 19/20 due to high volumes in Medical Day Unit. Theatre working group have identified further opportunities in Day Surgery, with actions required to achieve pre-pandemic levels in all specialties

Average patients per working day (Elective Spells)

Apr 2022: 19.7 **Trend:** ▲ **Target:** **>=22**

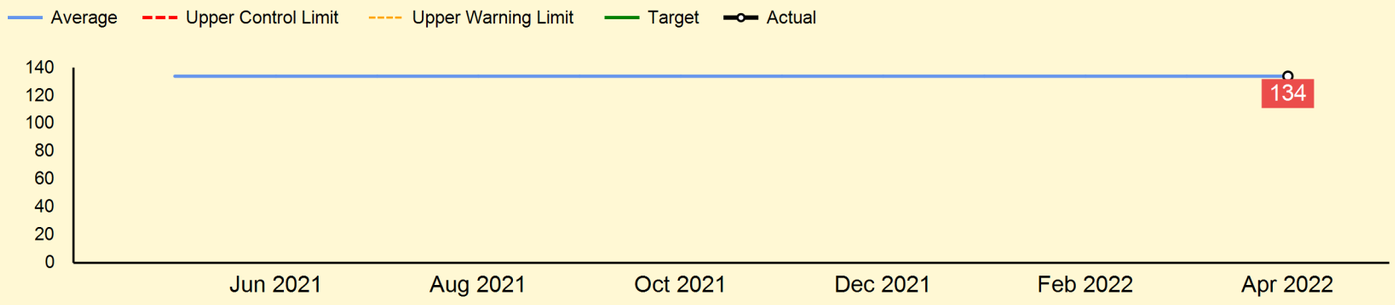


Comments:

Dip in January related to Omicron, with performance otherwise within range of 18.0-19.7. Action to compare current performance with 19/20 baseline at specialty level to identify areas with greatest opportunity for improvement

Theatre Sessions per week

Apr 2022: 134 **Trend:** **Target:** **>=139**

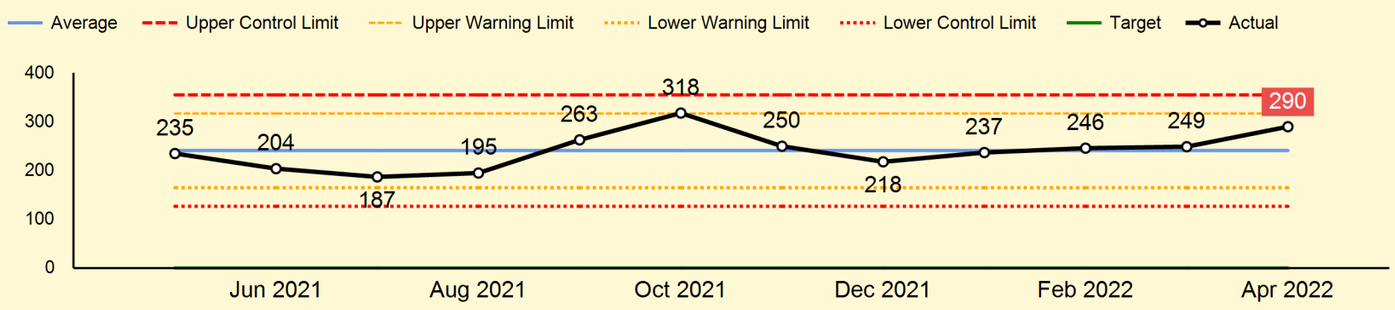


Comments:

Planned to achieve or exceed target of 139 sessions per week in eachof the next 3 weeks (16 May – 3 Jun (pro-rota for BH)

Number of Patients > 52 ww

Apr 2022: 290 **Trend:** ▲ **Target:** **0**



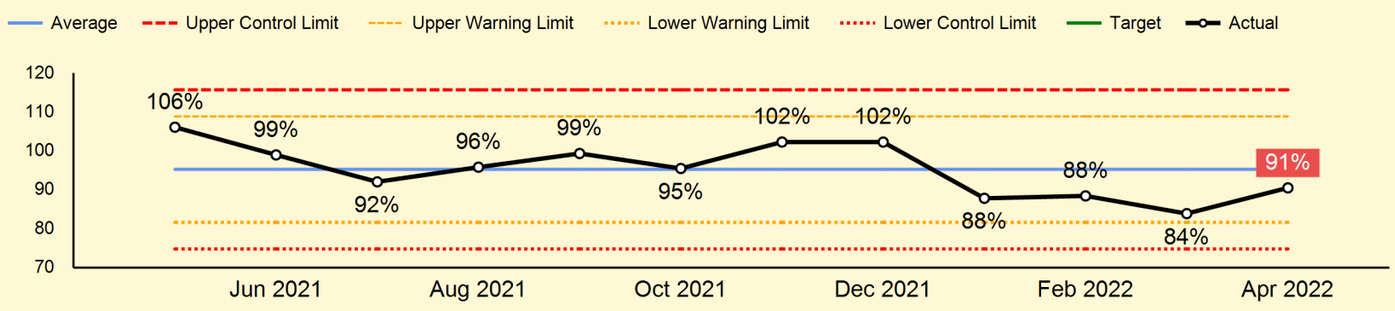
Comments:

2 patients have a wait of > 104 weeks. Both have TCI dates before the end of June.

Paediatric dentistry now comprises 67% of the total 52 ww waits

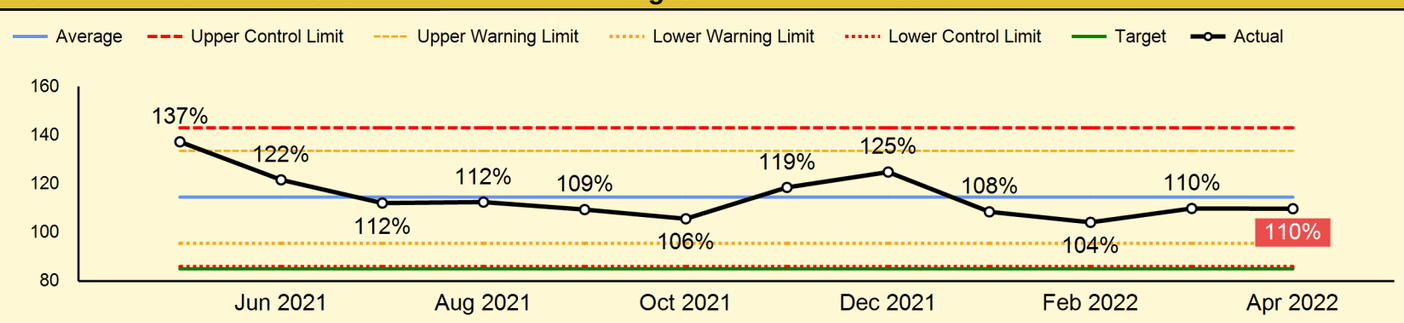
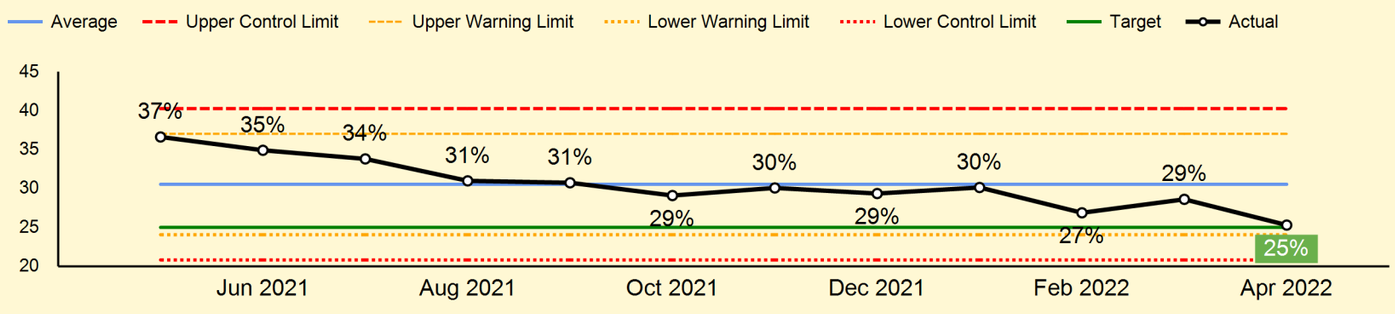
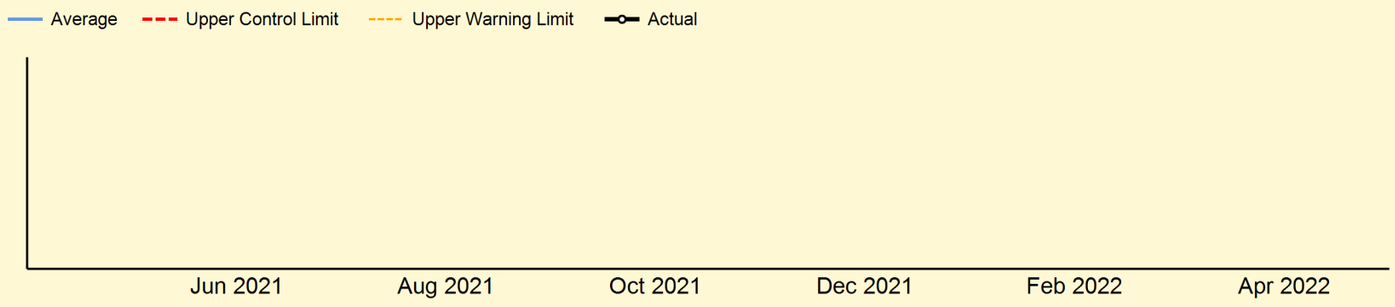
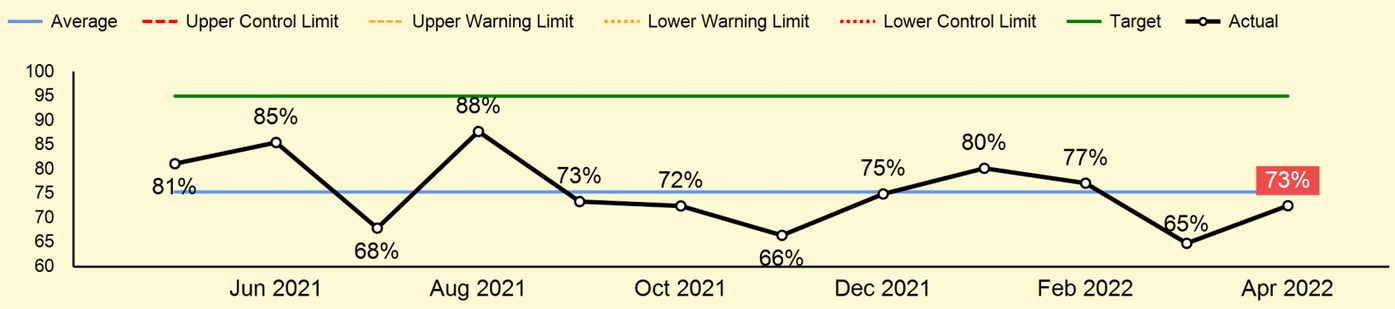
Outpatient New + Outpatient Procedure 104%

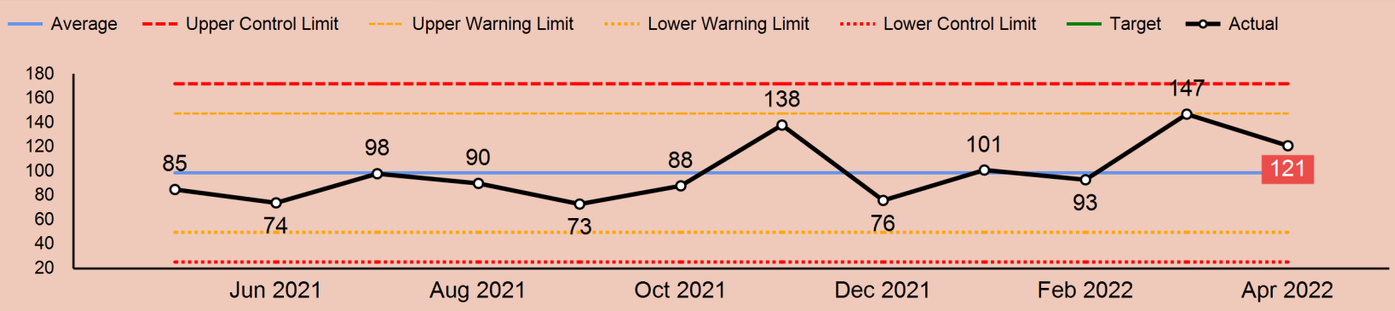
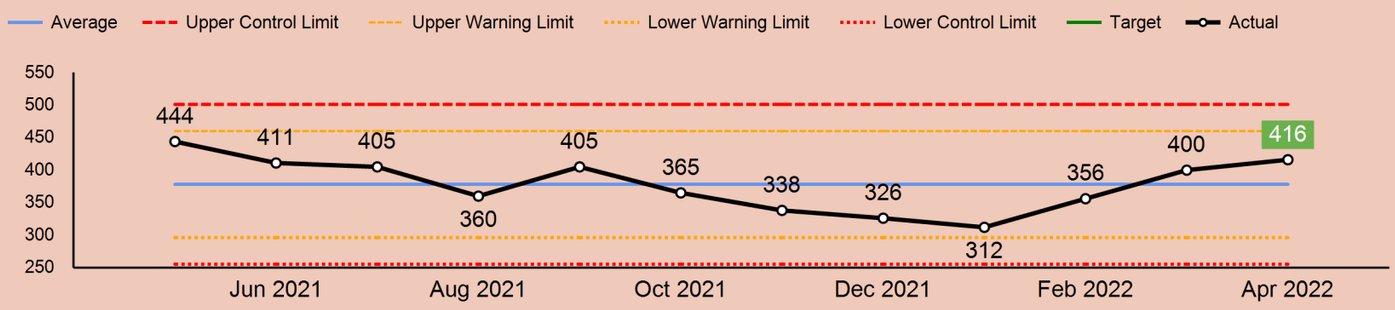
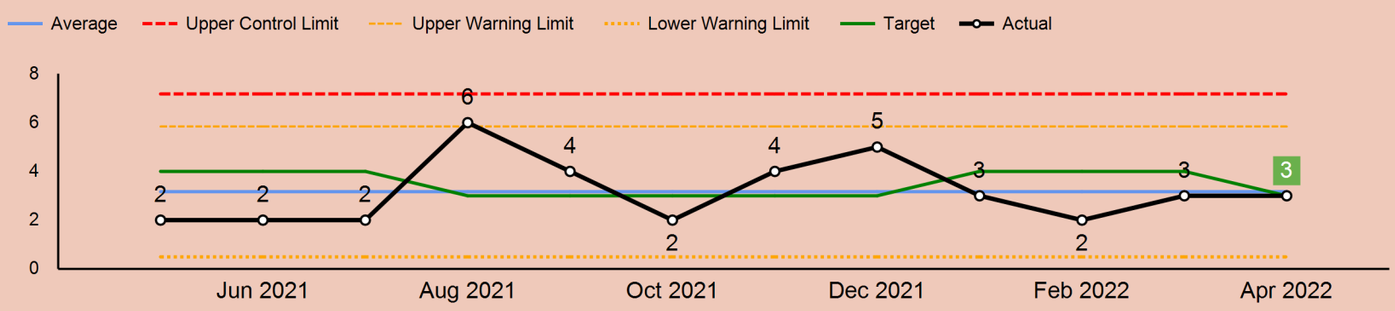
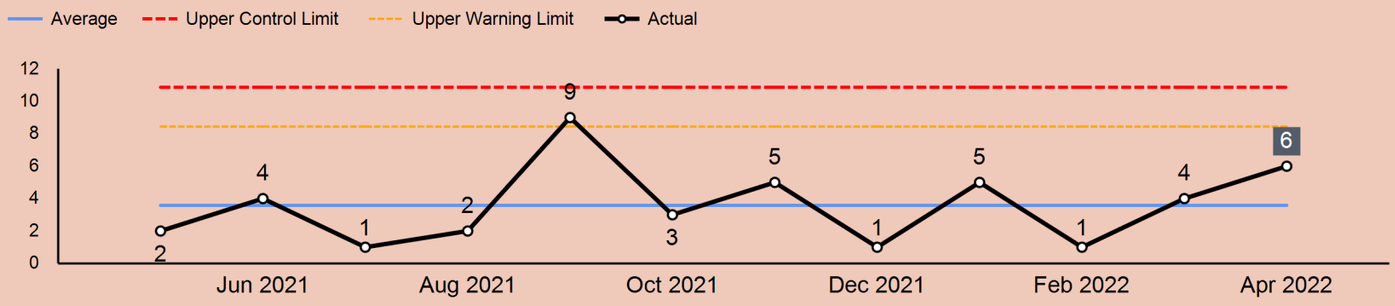
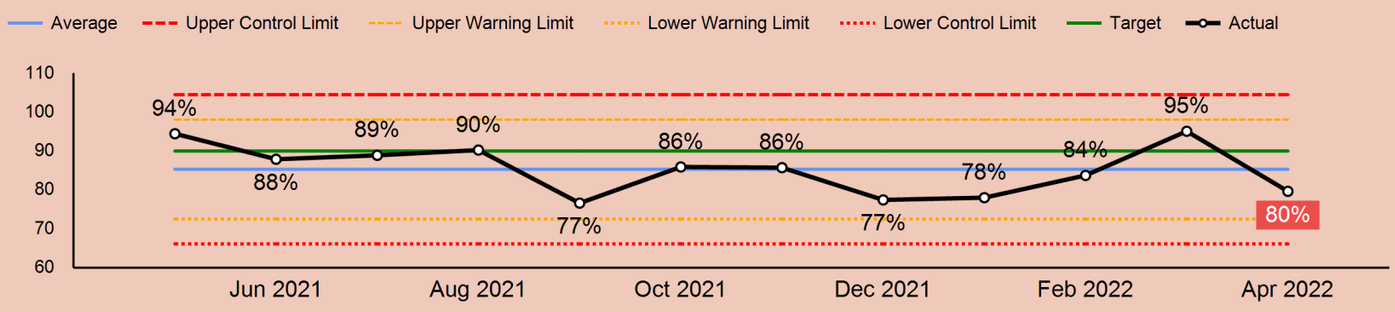
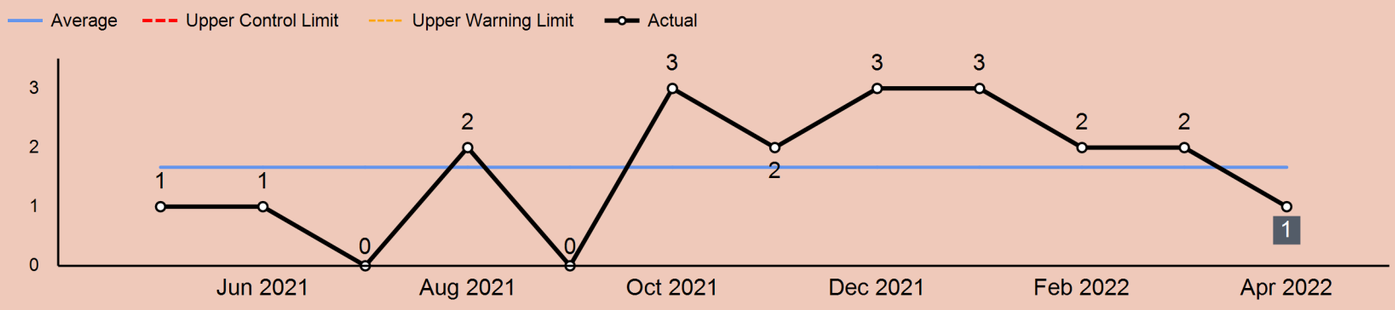
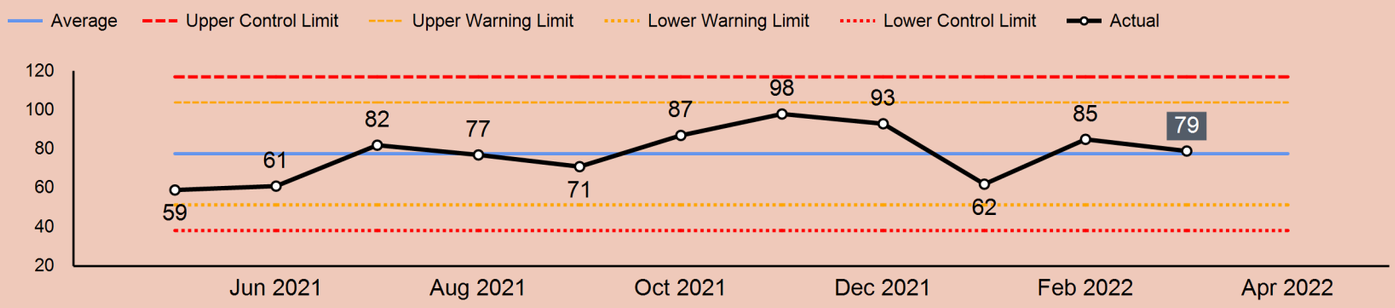
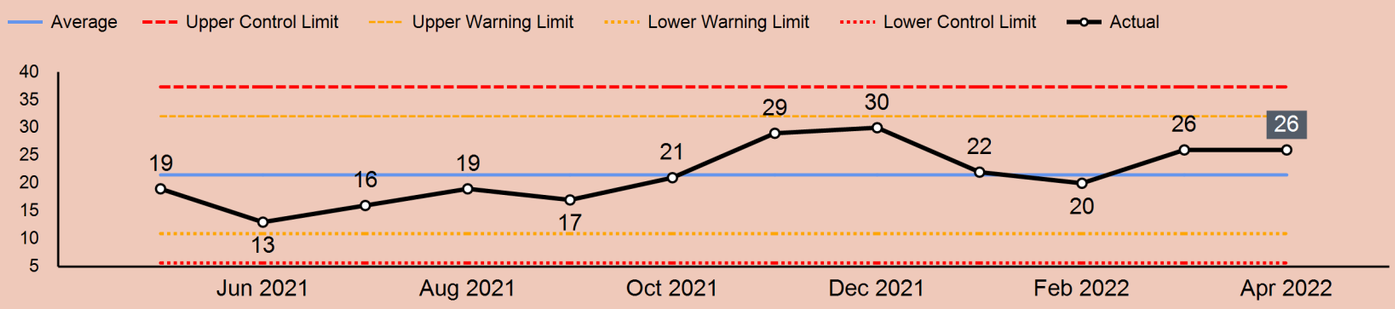
Apr 2022: 91% **Trend:** ▲ **Target:** **>=104 %**



Comments:

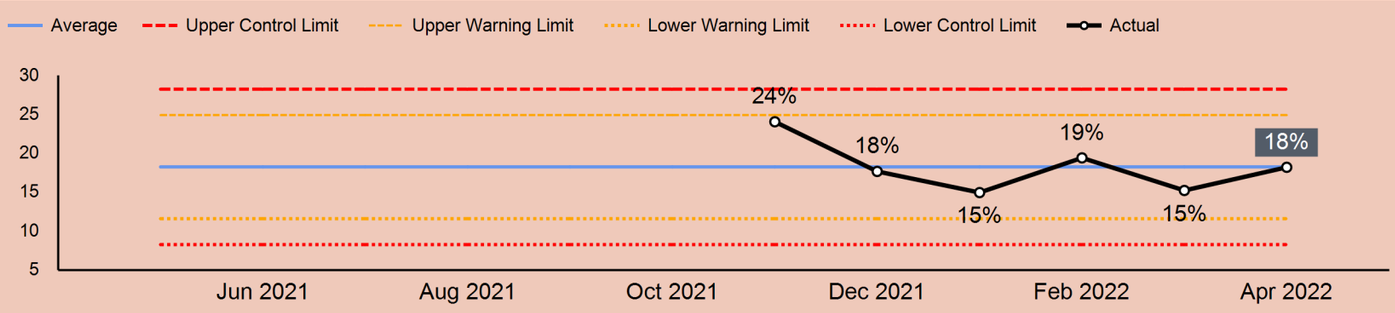
Since January, percentage of OP N has reduced. Divisional recovery meetings identified areas of concern, especially in surgical specialities. Action required to convert FU slots to New Appointments

Outpatient Follow Up 85%	**Apr 2022: 110%** **Trend:** ▼ **Target: <=85 %** 	**Comments:** April showed 110% OPFU, significantly in excess of 85% target. Some months in previous year have been even higher than 110%, but clearly further work needed to reduced towards target. Balance to reduce FU volume, whilst also reducing overdue FUs and ensure safe clinical pathways. Also noting that Community and CAMHS have received investment to increase OP activity and reduce waiting times. Divisions confirmed no FU appointments booked on WLIs
Virtual Outpatient 25%	**Apr 2022: 25%** **Trend:** ▼ **Target: >=25 %** 	**Comments:** Target of 25% Virtual OP appointments achieved in April. However, this is lowest figure in last 12 months, and consistently reducing trajectory. Actions through OP Transformation group to ensure minimum of 25% maintained
No Harm whilst waiting > 52 weeks on waiting list	**Apr 2022:** **Trend:** **Target not set** 	**Comments:** Data collection for this metric is in development.
% ED < 4 hours	**Apr 2022: 73%** **Trend:** ▲ **Target: >=95 %** 	**Comments:** In May to date 70.7% are receiving treatment within 4 hours. ED attendances are 9.8% higher than 2019. The annual plan process has agreed significant investment in staffing levels and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place - ED at its best. A workshop is being held by the Department on the 26 May to set out an improvement plan

Metric	Outstanding Safety		
25% Reduction in Harms	**Apr 2022: 121** **Trend:** ▼ **Target: <=72**		**Comments:** Currently averaging 98 over a 12 month period with a target of 72 per month. This is the first month of the new target and April value, demonstrates natural variation which is in line with previous 12 months performance. Therefore no evidence of reduction in harms towards the target improvement to date.
Incidents rated "No Harm & Near Miss"	**Apr 2022: 416** **Trend:** ▲ **Target: >=383**		**Comments:** This metric should remain at previous year level or increase, to indicate open and transparent reporting culture. April figure of 415 is within the normal range, and 12 month rolling average of 378 is within range of the target of 383, so no special cause variation has been observed in April 2022.
Medications with minor harm or above Incidents	**Apr 2022: 3** **Trend:** ▬ **Target: <=3**		**Comments:** There are small numbers of incidents each month with an average of 3 per month over the past 12 months. April 2022 (3) is consistent with this average - showing neitehr improvement or deterioration in this area.
Pressure Ulcers G2-4	**Apr 2022: 6** **Trend:** ▲ **Target not set**		**Comments:** There are small numbers of pressure Ulcers G2-4 each month with an average of 3.5 per month over the past 12 months. April 2022 (6) is consistent with this average, all of which are Grade 2. There have been no Grade 3-4 in the last 3 months.
Sepsis < 60 mins (ED only)	**Apr 2022: 80%** **Trend:** ▼ **Target: >=90 %**		**Comments:** April 2022 has failed to hit the target this month and demonstrates natural variation in line with the previous 12 months performance. Currently average 85% over the past 12 months which is close to the 90% target. This means that some months will be above target (March 2022) and other months will be below target (April 2022). Improvement work needs to be undertaken to consistently achieve the target of 90%. Please note this data is ED only, and data do not include Inpatient Sepsis targets as this data is not available due to a Sepsis Nursing vacancy.
Cardiac Arrests	**Apr 2022: 1** **Trend:** ▼ **Target not set**		**Comments:** This is a brand new metric presented in the Executive Scorecard. There is no target associated with these data and the numbers are very low month on month.
Unplanned Admission to HDU/PICU	**Mar 2022: 79** **Trend:** ▼ **Target not set**		**Comments:** This is a brand new metric presented in the Executive Scorecard. Performance in April is within the normal range, and work with the clinical team is required to set target for reduction aligned to actions focused on Deteriorating Patients.
Step Downs out of CC out of hours (7pm-7am)	**Apr 2022: 26** **Trend:** ▬ **Target not set**		**Comments:** This is a brand new metric presented in the Executive scorecard. The data is from Meditech where a patient has been discharged from Critical Care to another ward or home. There is no target set for these step downs currently. The current average is 21 step downs over the past 12 months and April demonstrates natural variation in line with this average. Work is required with the clinical teams to use this data to develop better understanding of timeliness of step downs, and associated safety risks.

% Consent before day of surgery

Apr 2022: 18% **Trend:** ▲ **Target not set**

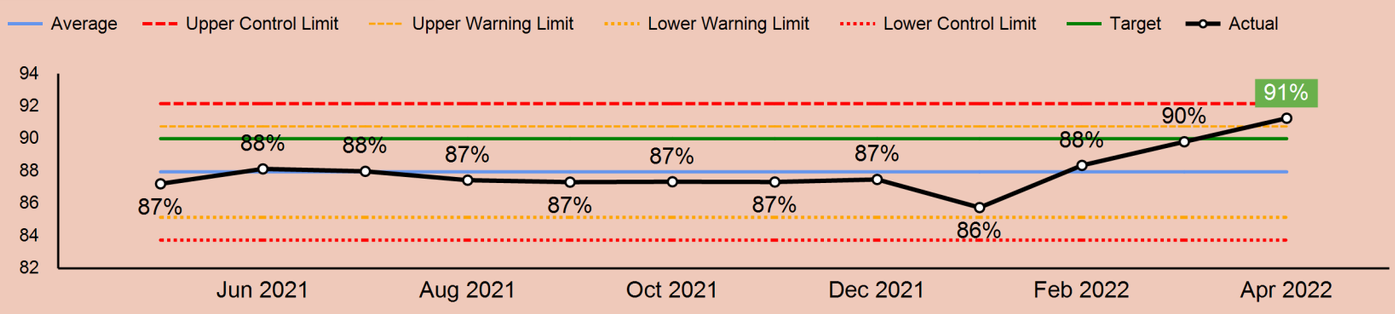


Comments:

This is a new metric that is now readily available following implementation of E-Consent. External benchmarks indicate best practice is 75% patients consent before the day of surgery. Improvement work is required to work towards this target, with emphasis on importance that consent is informed.

% Mandatory Training Compliance

Apr 2022: 91% **Trend:** ▲ **Target:** **>=90 %**

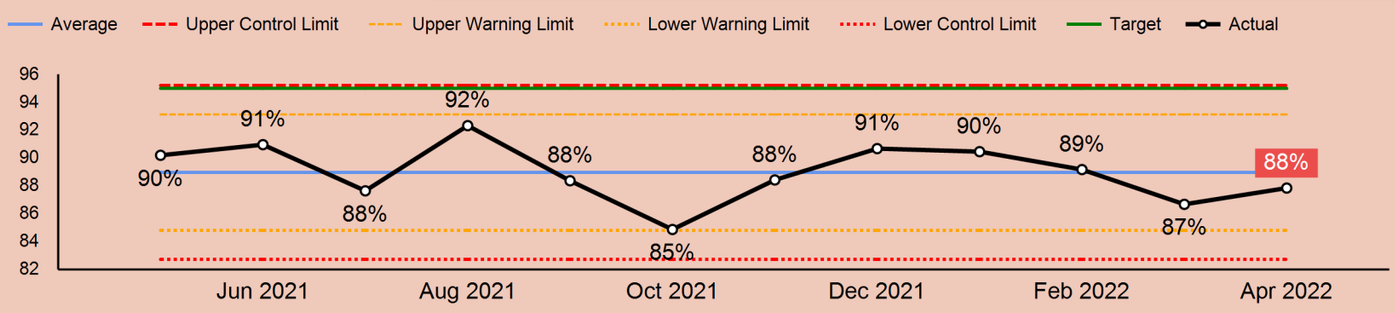


Comments:

Current average is 88% over the past 12 months. Although March 2022 (90%)and April 2022 (91%) have hit the target for the first time in the past 12 months this still demonstrates natural variation in line with the 88% average and it is too early to tell whether this is sustained improvement which would be identified by special cause variation and demosntrate sufficient improvemetn to consistently meet this target. Drill down on the data will give insight regarding individual topic areas and professional groups which are reducing the overall average.

FFT % Recommend Trust

Apr 2022: 88% **Trend:** ▲ **Target:** **>=95 %**

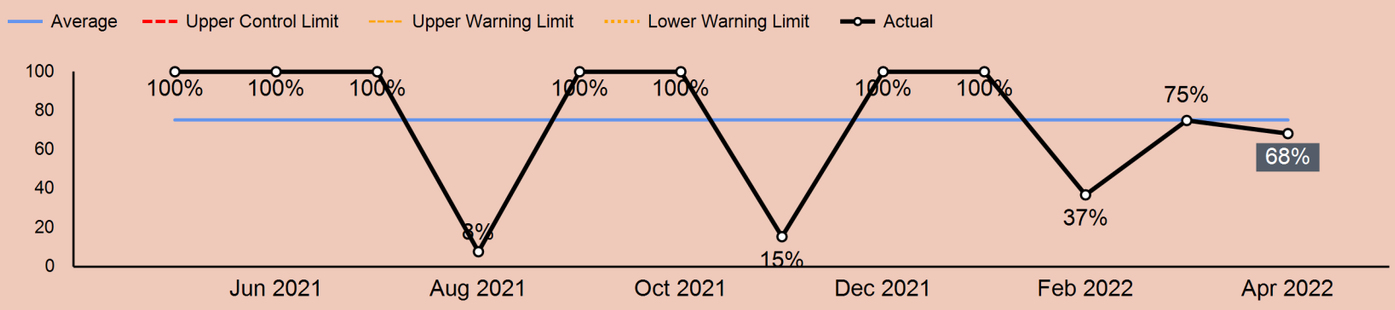


Comments:

Current average is 89% which is below the target of 95%. April 2022 (88%) demonstrates natural variation in line with the current average. The Target is in line with the current Upper Control limit which means significant improvement needs to be undertaken to consistently pass this target. Previous investigation has indicated that this metric has been affected by the current challenges seen in ED.

% Compliants response within 25 working days

Apr 2022: 68% **Trend:** ▼ **Target not set**



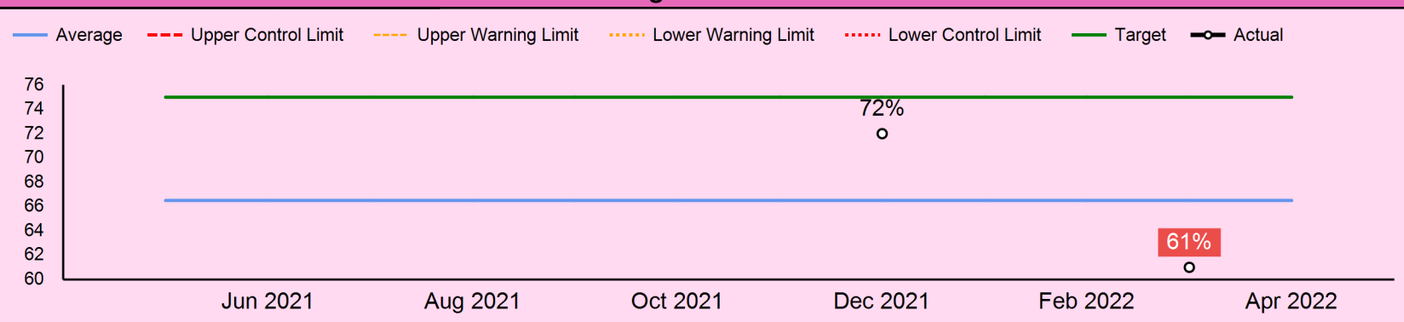
Comments:

The current average is 75% with wide upper and lower control limits which highlight the significant variation observed month on month. Due to low volumes this metric is statistically sensitive (ie 1 breach represents a high percentage) - but improvement work is still required to achieve more consistent performance

Great Place to Work

Metric: > 75% of staff recommend as a place to work

Mar 2022: 61% **Trend:** ▼ **Target:** >=75 %

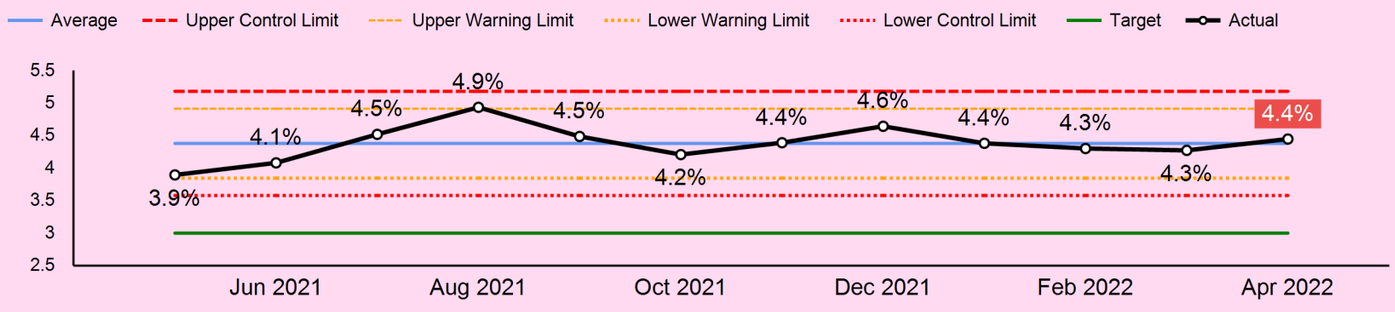


Comments:

Only 2 data points, so difficult to analyse data given the frequency of the survey (quarterly). The underlying position will become clearer after subsequent pulse checks are completed. However, the latest data point of 61% is below the target of >75%.

Long Term Sickness

Apr 2022: 4.4% **Trend:** ▲ **Target:** <=3 %

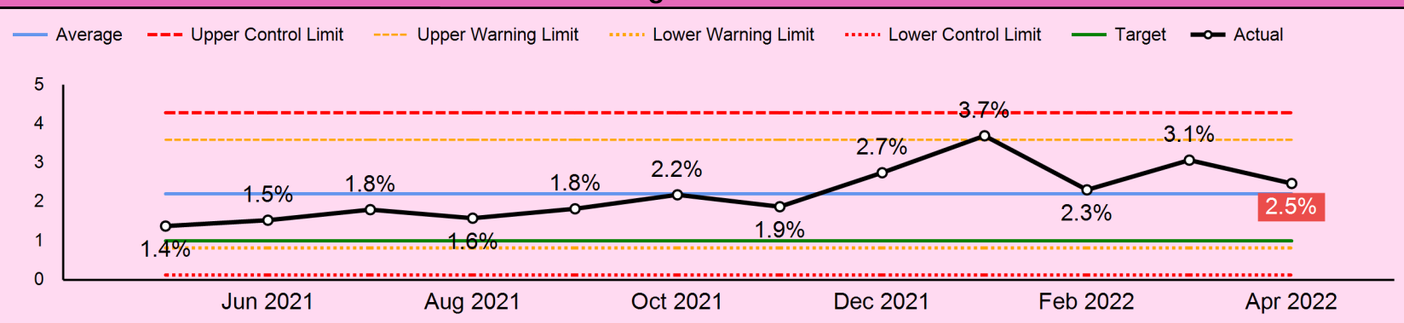


Comments:

Current 12 month average is 4.4%. April 2022 (4.5%) demonstrates natural variation in relation to the 12 month average. The target figure of 3% is well below the lower control limit over the past 12 months so this will not be achieved in any individual month without significant improvement work and actions implemented to reduce LTS towards the target.

Short Term Sickness

Apr 2022: 2.5% **Trend:** ▼ **Target:** <=1 %

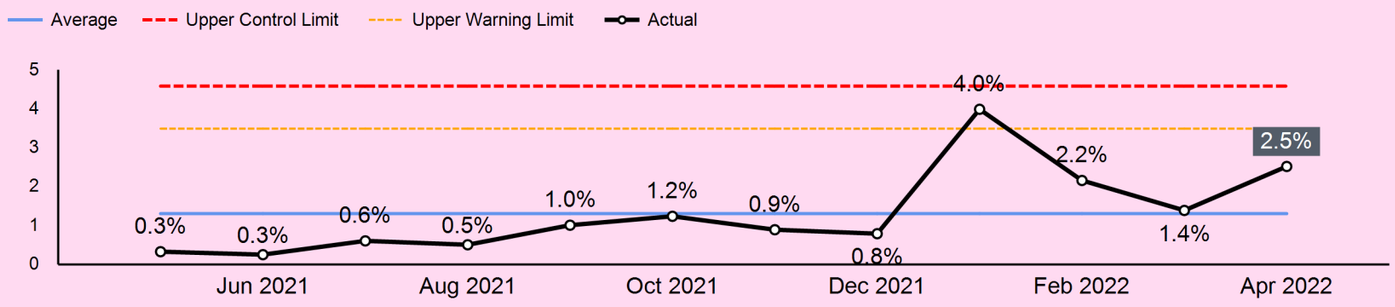


Comments:

Current 12 month average is 2.2%. April 2022 (2.5%) demonstrates natural variation in relation to the 12 month average. The target figure of 1% is at the lower control limit over the past 12 months so significant improvement work would need to be done to achieve this target in any individual month.

Absence COVID Related

Apr 2022: 2.5% **Trend:** ▲ **Target not set**

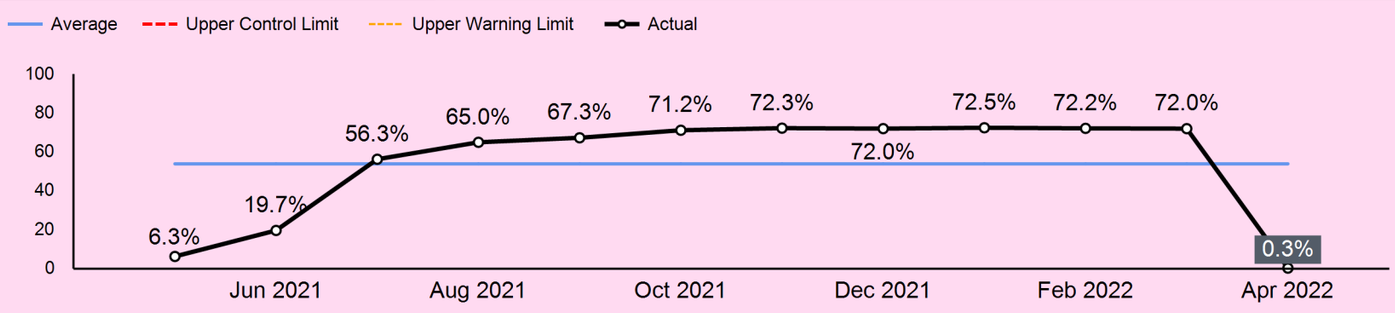


Comments:

Peak in January was above Upper Warning Limit, reflecting the Omicron surge. Figures in 2022 have not yet returned to the 2021 average.

% PDR Compliance YTD

Apr 2022: 0.3% **Trend:** ▼ **Target not set**

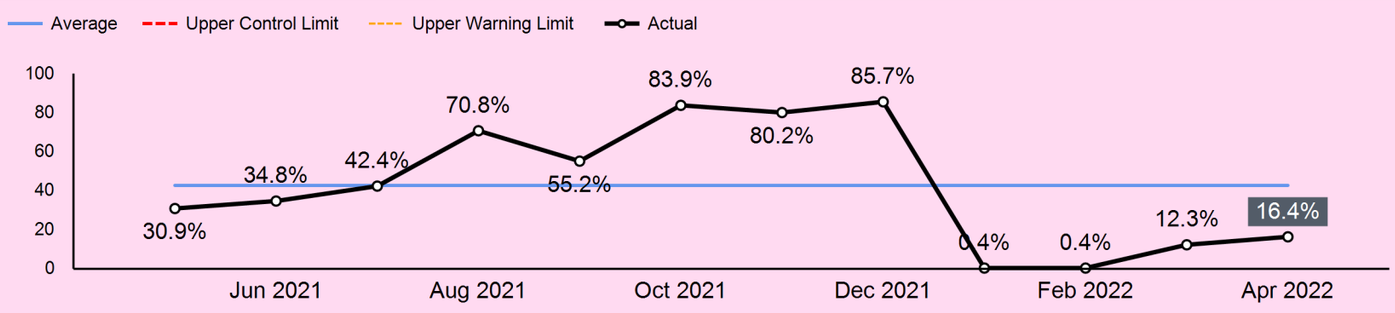


Comments:

PDR compliance in 2021/22 did not achieve the 90% target. In April, PDR Compliance has reset down to 0.3% due to the opening of the PDR window. We would expect to see increase over the coming months, with target for all senior posts to have PDR completed by end of July 2022.

% Medical Appraisals YTD

Apr 2022: 16.4% **Trend:** ▲ **Target not set**

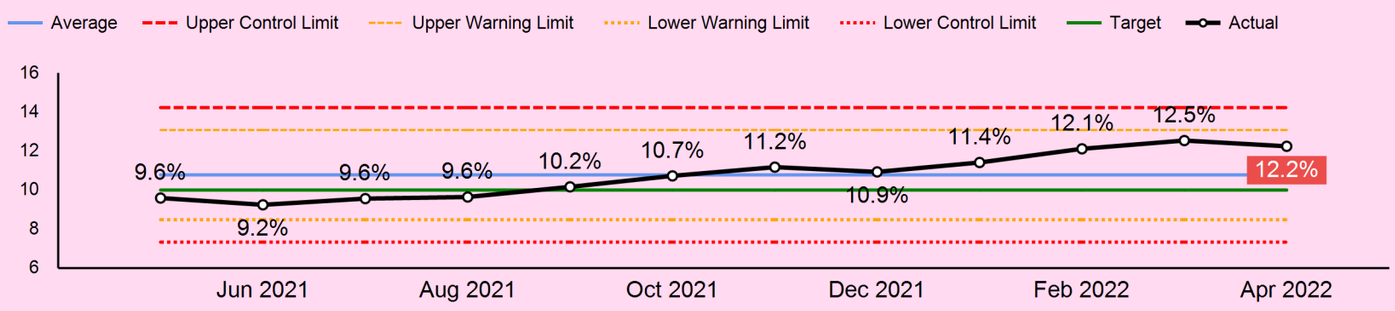


Comments:

Window for Medical appraisals opened in January, and current performance shows steady rise. The new process is for each Consultant to get an appraisal in there birth month so the data will need to be adjusted to reflect this.

% Staff Turnover

Apr 2022: 12.2% **Trend:** ▼ **Target:** <=10 %



Comments:

Not only is the average above the 10% target but the past 7 months show values consistently over the average - therefore special cause variation has been observed. This indicates statistically over a sustained period of time that there is an increase in Staff leaving the organisation. This should be investigated to understand root causes and identify appropriate actions.

My Alder Hey
Executive Scorecard

Dashboard refreshed 19 May 2022 16:29 (although individual metrics may be older)

BRILLIANT BASICS

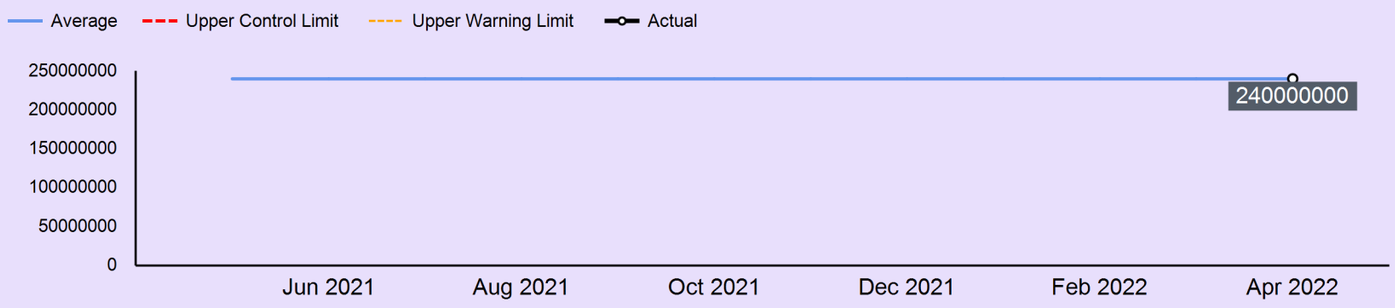
NHS Alder Hey Children's NHS Foundation Trust

Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

Metric	Financial Sustainability		
I&E Breakeven	Apr 2022: £2.4m	Trend:	Target not set

Comments:
At this early stage in the financial year (month 1), the Trust are forecasting to meet the submitted plan of a £2.4m surplus.

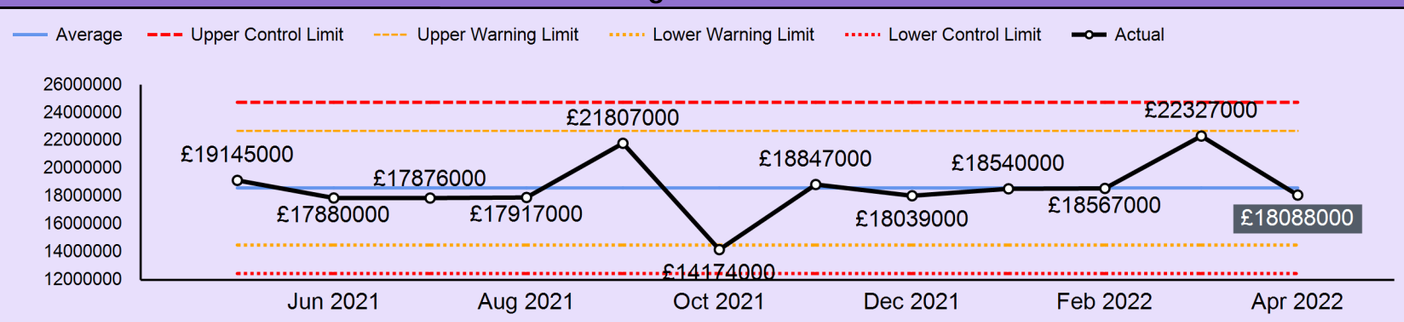


I&E vs Plan (YTD)	Apr 2022: -157	Trend:	Target:

Comments:
Visual is under development.
For the month of April (Month 1), the Trust is reporting a deficit of £0.8m which is £0.5m away from plan. This deficit is largely driven by costs associated with non-pay including clinical supplies, the non-delivery of CIP in month 1 which was £0.4m against a target of £1m.

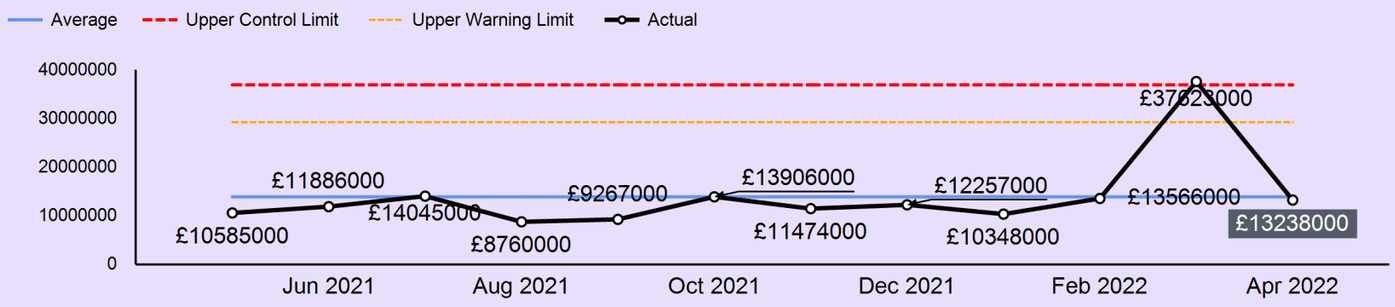
Expenditure Run Rate (Pay)	Apr 2022: £18088000	Trend: ▼	Target not set

Comments:
Pay £0.1m adverse variance to plan -not material.



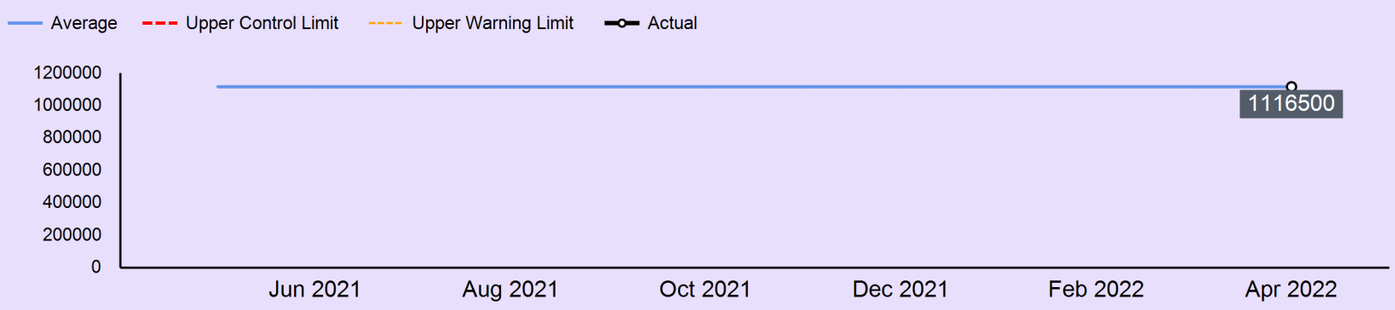
Expenditure Run Rate (Non Pay)	Apr 2022: £13238000	Trend: ▼	Target not set

Comments:
Non-Pay £1.7m adverse variance to plan
£1.4m drug costs largely offset by income
£0.3m including clinical supplies and non-delivery of CIP offset by slippage in other areas.



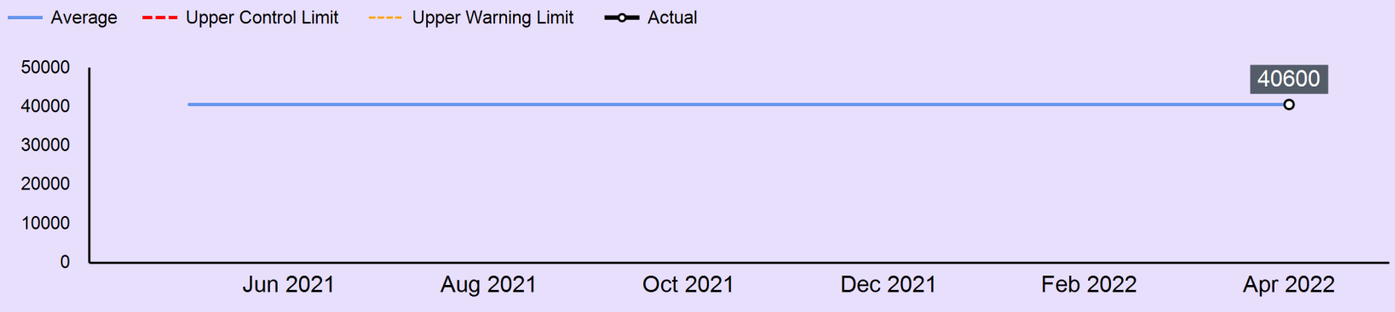
CIP Forecast	Apr 2022: 1116500	Trend:	Target not set

Comments:
The Trust is forecasting to deliver £11.1m of the £17m savings target at this early stage of the year. Further work is ongoing to identify opportunities.



CIP Delivered (YTD)	Apr 2022: 40600	Trend:	Target not set

Comments:

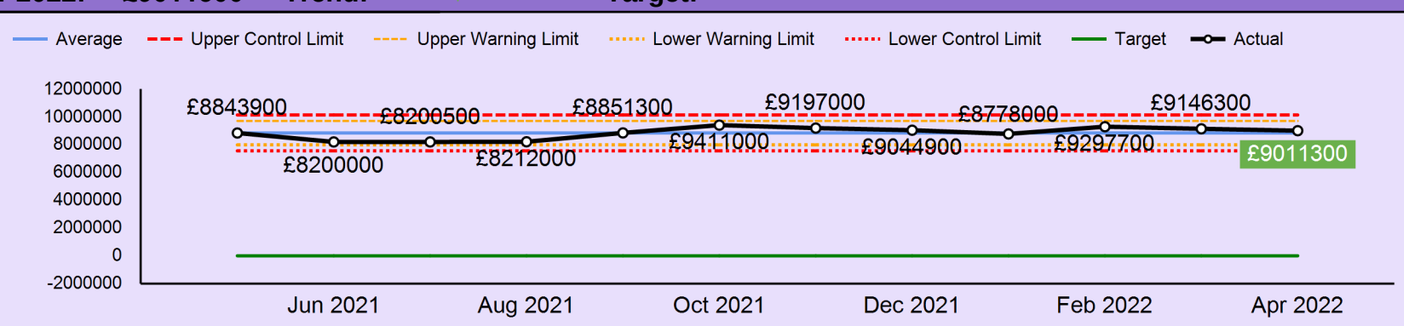


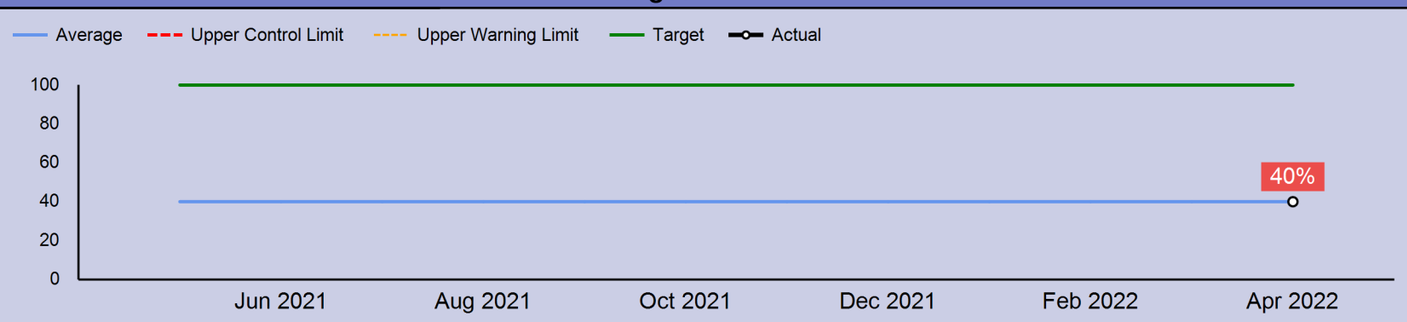
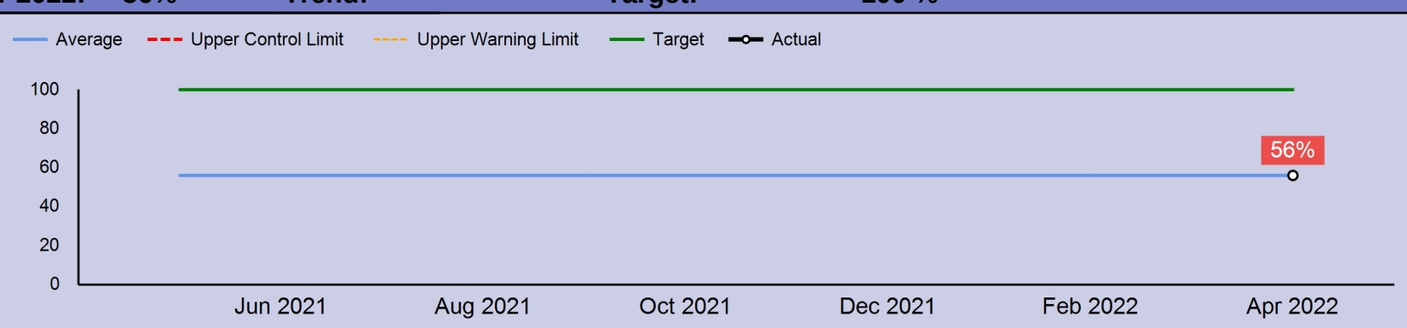
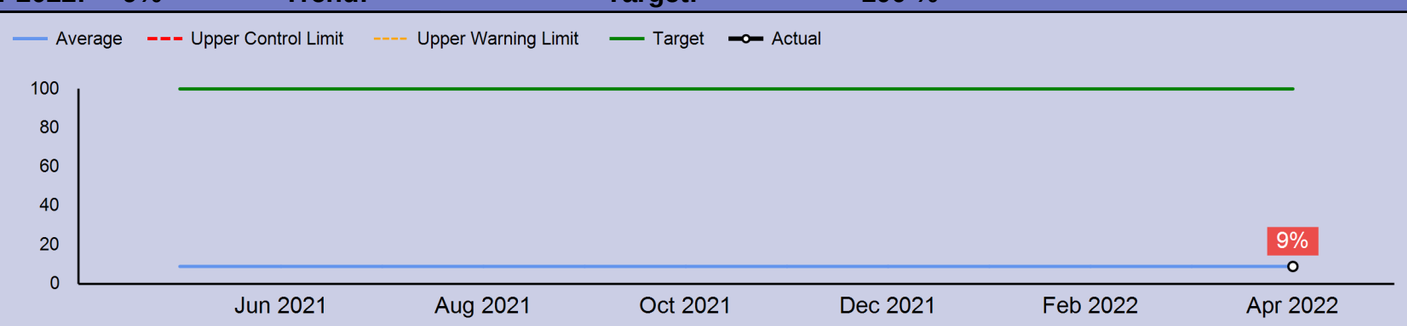
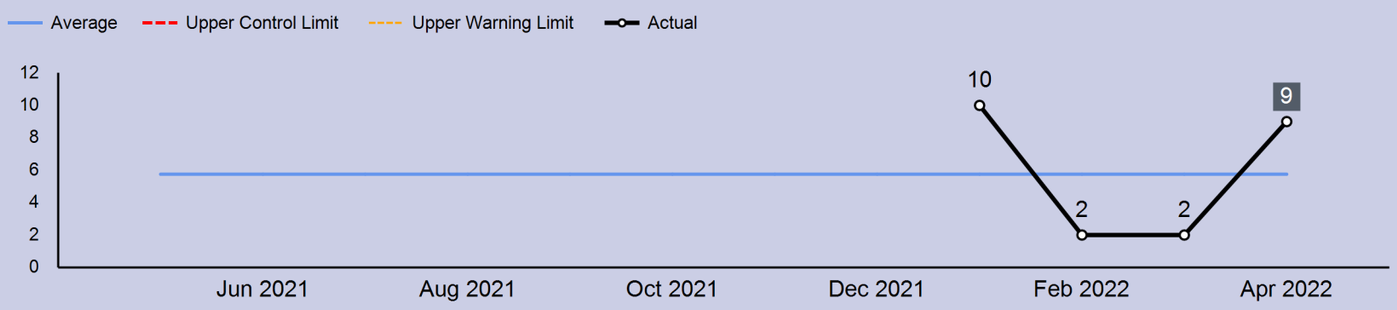
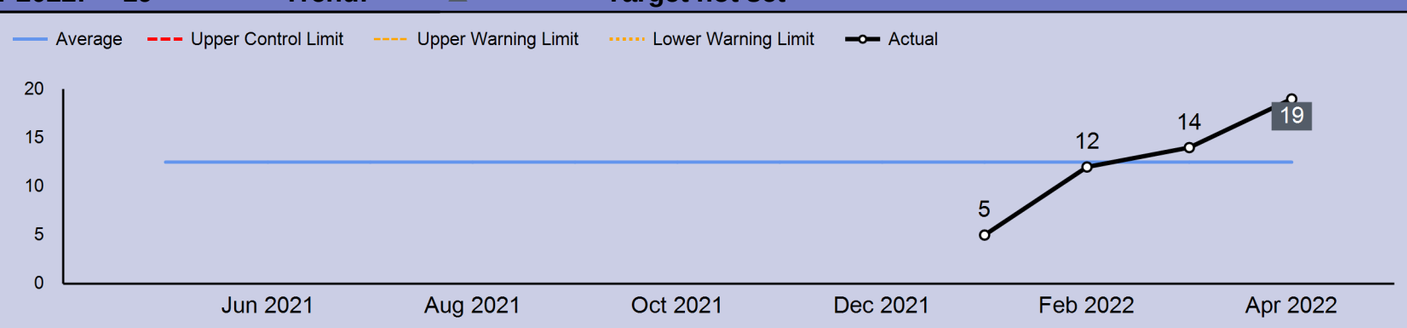
Capital Plan (vs CDEL)	Apr 2022: 44500	Trend:	Target:

Comments:
Visual is under development.
Capital spend to M1 is ahead of plan by £0.4m, including ongoing spend to complete the Catkin / Sunflower building, Development Team costs and IMT capital staffing charges.

Cash	Apr 2022: £9011300	Trend: ▼	Target:

Comments:
No Comment Required



Metric	Safe Systems		
100% safety compliance	**Apr 2022: 40%** **Trend:** **Target: 100 %**		**Comments:** Within the programme, the clinical team have identified a number of key 'patient safety criteria' which must be met prior to go live to achieve a safe and successful implementation. There are currently 40% of the solutions signed off and approved. By End of May we estimate to be at 73%. 1 critical criteria is awaiting a confirmed resolution date with the rest scheduled for completion by 1st August 2022.
% system build completion	**Apr 2022: 56%** **Trend:** **Target: 100 %**		**Comments:** Within the new system the majority of the modules need fully rebuilding and this section will aim to track and monitor build progress by Meditech and the System Development Team. Overall there is 56% of the system now built however, there are some key areas, such as Community Wide Scheduling which still require a huge amount of resource and build time.
% specialty sign off	**Apr 2022: 9%** **Trend:** **Target: 100 %**		**Comments:** As part of the programme, each specialty will need to review and approve any of their bespoke specialty documentation. This is another area which has fell behind and a recovery plan is currently being established, which will include a schedule for engaging with the Divisions and completing the build work. This is currently at 9% and is the only data point available.
Number of staff involved in prototype testing	**Apr 2022: 9** **Trend: ▲** **Target not set**		**Comments:** Its important we engage the users and involve them in the testing of the new system. Users have been invited to test the current prototypes to help get a feel for how the new system will function and ensure it meets their needs. A total of 23 staff have now been involved and despite a dip in March figures are now on the rise in April.
Number of staff trained in Alder Care	**Apr 2022: 19** **Trend: ▲** **Target not set**		**Comments:** Training and educating users on how to get the utilise and get the best out of the system is one of the key priorities in the programme. This will be delivered through multiple different methods to cater for the different needs of staff groups. The training numbers are currently low and will increase significantly in the 6 weeks leading up to go live.

Alder Hey Children's
NHS Foundation Trust

Part 2 - Dashboard of Metrics

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%	99.6%	99.8%	99.6%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	79	81	90	73	62	91	89	65	76	74	78	92	100		No Threshold	
Clinical Incidents resulting in No Harm	393	363	321	332	298	314	276	273	250	238	278	308	316		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	91	80	73	94	88	73	86	136	76	99	90	145	118		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	1	4	1	1	1	0	1	1	0	2	2	1	2		No Threshold	
Clinical Incidents resulting in severe, permanent harm	0	1	0	0	0	0	1	1	0	0	1	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	4	2	2	2	6	4	2	4	5	3	2	3	3		<=3 N/A >3	✔
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0	✔
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%	83.7%	95.1%	79.6%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	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	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	0	1	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	0	1	0	2	0	0	1	3	1	0	0	1	1		No Threshold	

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%	89.2%	86.7%	87.8%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%	69.5%	59.3%	60.3%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%	90.5%	94.4%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%	93.9%	95.7%	96.5%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	90.6%	85.7%	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%	100.0%	96.2%	95.5%	94.1%	96.4%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%	94.1%	93.3%	93.9%		>=95 % >=90 % <90 %	✔
Complaints	5	9	15	10	12	13	13	14	9	16	20	19	15		No Threshold	
PALS	101	119	149	122	88	148	136	141	106	99	133	135	101		No Threshold	

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%				No Threshold	✔
ED: 95% Treated within 4 Hours	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%		>=95 % N/A <95 %	✔
ED: Patients In Department >12 Hours	0	3	2	17	0	14	47	46	26	11	23	70	19		0 N/A >0	✔
ED: Median Time to Triage (Mins)		6	1	8	10	14	17	17	13	10	12	20	12		<=15 N/A >15	✔
ED: Median Time to Clinical Assessment (Mins)		140	117	158	76	100	108	129	87	83	102	125	106		<=60 N/A >60	
ED: Number of patients spending >12 hours from decision to admit to admission	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	13	7	13	13	12	32	23	56	23	22	16	23	22		<=9 N/A >9	✔
28 Day Breaches	4	3	0	3	8	5	11	12	25	7	3	9	10		0 N/A >0	✔
Clinic Letters Completed within 10 Days	14.0%	25.9%	56.1%	60.4%	60.5%	64.7%	60.7%	67.9%	55.1%	70.3%	63.4%	66.4%	58.5%		>=95 % N/A <95 %	✔

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%	93.0%	95.3%	95.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%	96.7%	97.8%	99.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%	67.6%	66.1%	66.4%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%	97.1%	98.7%	97.1%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%	80.9%	87.3%	78.7%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%	91.9%	93.0%	95.3%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%	61.5%	61.3%	60.1%		>=92 % >=90 % <90 %	✔
Waiting List Size	11,110	11,564	11,414	12,096	13,286	13,092	18,495	18,976	19,127	19,098	19,731	20,612	21,894		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	283	235	204	187	195	263	318	250	218	237	246	249	290		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	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	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)	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%	63.3%	56.9%	51.9%		>=99 % N/A <99 %	
PFI: PPM%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	97.0%	99.0%	99.0%	96.0%	92.0%	99.0%			>=98 % N/A <98 %	✔

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	-955	592	391	-589	-51	835	-854	381	165	2,122	-726	-904	-481		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	-910	974	13	162	234	-339	-221	-159	406	964	403	-5,413	-445		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	92,708	88,440	82,001	82,006	82,121	88,514	94,111	91,971	90,450	87,781	92,978	91,464	90,114		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	-494	715	1,597	2,980	-1,713	2,766	-2,610	149	1,474	1,047	273	27,774	1,414		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-308	-370	-545	553	71	-2,466	2,477	676	-16	6	9	-7,579	-172		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	-153	247	-661	-4,122	1,591	534	-720	-443	-1,293	1,068	-1,008	-21,099	-1,722		>=-5% >=-20% <-20%	✔
PDR	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%	72.2%	72.0%	0.3%		No Threshold	
Medical Appraisal	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%	0.4%	12.3%	16.4%		No Threshold	
Mandatory Training	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%	88.4%	89.8%	91.3%		>=90 % >=80 % <80 %	✔
Sickness	4.6%	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.3%	7.4%	8.1%	6.6%	7.3%	6.9%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.7%	3.7%	2.3%	3.1%	2.5%		<=1 % N/A >1 %	✔
Long Term Sickness	3.5%	3.9%	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.6%	4.4%	4.3%	4.3%	4.4%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	1,074	1,048	966	1,138	1,104	1,375	1,142	1,597	1,529	1,401	1,627	2,093	1,583		No Threshold	
Staff Turnover	9.3%	9.6%	9.2%	9.6%	9.6%	10.2%	10.7%	11.2%	10.9%	11.4%	12.1%	12.5%	12.2%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%	84.0%	81.7%	83.7%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%	100.0%	100.0%	97.5%		>=85 % N/A <85 %	✔

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	100	103	108	117	125	132	139	142	145	148	150	153	154		>=130	>=111	<111	✔
Number of Open Studies - Commercial	34	36	38	37	38	40	43	44	42	43	44	38	40		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	7	2	3	7	3	7	7	4	1	3	0	3	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	0	3	1	1	0	2	3	3	0	3	0	0	1		>=1	N/A	<1	✔
Number of patients recruited	1,055	1,039	896	439	1,060	983	931	1,038	816	978	937	1,157	917		>=100	>=86	<86	✔

Alder Hey Children's
NHS Foundation Trust

Part 3 - Divisional Performance

Medicine Division

SAFE		**Highlight** • **Challenges** • Increase in harm incidents. • 7 CLABSI and 1 MRSA in month
CARING	6 new complaints and 33 PALS in month.	**Highlight** • Listening event taking place within ED to increase understanding of workforce issues **Challenges** • PALS have reduced to 33 from 50+ in 2 months prior
EFFECTIVE	ED performance improved compared to March overall but continues to show regular variability. ED improvement meetings continue alongside meetings with the executive team. Respiratory achieved 100% on their theatre utilisation in April but others ran in the 70's. Rheumatology have been asked to reduce their lists overall and in Gastro there is high variability between consultants that will be addressed by the service manager.	**Highlight** • Reduction in patients waiting in ED over 12 hours. **Challenges** • ED performance • Theatre utilisation at 78%
RESPONSIVE	RTT performance has remained at around 60% compliance. Locum consultant has started in Gen Paeds to tackle our wait for new patients. The business case for dermatology is due to be presented at Divisional Board. A business case has been submitted for the purchase of several home PSG kits to improve our waiting times for sleep studies which is one of the main drivers of our diagnostic wait time performance.	**Highlight** ▪ New locum started in Gen Paeds with focus on delivering new patient capacity. **Challenges** ▪ RTT performance ▪ Diagnostic 6 week target
WELL LED	M1 - £343K Deficit The division are showing adverse position to plan due to £250k unachieved CIP in month and clinical supplies pressure of £211k offset by vacancies within pay. There are also pressures emerging with junior doctors in Gen Paeds	**Highlight** • Mandatory training is green 90.68% (first time in 2022) • As at 18/5/22 sickness absence reduced to 6.64%, 81 people. **Challenges** • CIP Target £3.6m • Mandatory training stretch target (95-100%) not yet achieved. Key priority areas identified inc teams and training topics e.g. resus, safeguarding. • Removal of HR Wellbeing Officer post from 30/5/22 risks a negative impact on sickness levels.

Medicine

SAFE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	42	32	36	29	28	33	39	24	49	32	38	38	43		No Threshold
Clinical Incidents resulting in No Harm	123	125	89	101	100	134	93	87	100	104	105	88	107		No Threshold
Clinical Incidents resulting in minor, non permanent harm	23	24	17	18	17	13	28	25	18	19	16	16	19		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	2	1	1	0	0	0	0	0	0	0	0	1		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	1	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	0	0	1	0	2	3	1	0	1	1	0	0	1		No Threshold
Medication Errors (Incidents)	29	42	26	14	20	35	24	20	30	28	18	20	31		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	1	3	2	0	2	1	6	7	4	1	4	2	0		No Threshold
Never Events	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	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)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	1	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	5	0	0	2	3	3	4	2	1	0	1	3	7		No Threshold
Hospital Acquired Organisms - MSSA	0	0	0	0	0	0	1	1	0	0	0	0	1		No Threshold
Cleanliness Scores	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%	98.8%	99.4%	99.7%		No Threshold

CARING

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Complaints	4	5	2	4	4	3	5	7	2	5	5	4	6		No Threshold
PALS	24	23	40	43	26	49	50	45	42	35	50	52	33		No Threshold

EFFECTIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Referrals Received (Total)	2,177	2,272	2,451	2,300	1,952	2,508	2,661	2,725	3,107	2,957	2,560	3,410	2,514		No Threshold
ED: 95% Treated within 4 Hours	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%		>=95 % N/A <95 %
ED: Patients In Department >12 Hours	0	3	2	17	0	14	47	46	26	11	23	70	19		0 N/A >0
ED: Median Time to Triage (Mins)		6	1	8	10	14	17	17	13	10	12	20	12		No Threshold
ED: Median Time to Clinical Assessment (Mins)		140	117	158	76	100	108	129	87	83	102	125	106		No Threshold
ED: Percentage Left without being seen	3.8%	7.4%	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%	6.1%	4.0%	5.9%	10.6%	7.6%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	0	0	0	0	0	1	0	1	4	0	1	1	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	0	0	0	0	0	1	0	0	3	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%	9.2%	9.6%	9.9%	9.1%	8.8%	9.5%	9.4%		No Threshold
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised	73.6%	76.9%	73.9%	74.2%	72.2%	78.5%	76.6%	76.7%	73.7%	70.8%	74.9%	79.3%	78.6%		>=90 % >=80 % <80 %

Medicine

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
On the day Elective Cancelled Operations for Non Clinical Reasons	2	0	1	0	3	2	3	5	0	4	0	5	9		No Threshold
28 Day Breaches	0	0	0	0	0	1	1	2	2	0	0	2	1		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	21	19	21	37	42	30	43	45	40	33	37	26	36		No Threshold
OP Appointments Cancelled by Hospital %	10.1%	11.0%	11.6%	15.0%	14.7%	13.8%	15.2%	12.4%	12.2%	12.5%	13.3%	12.8%	14.9%		<=5 % N/A >10 %
Was Not Brought Rate	8.6%	8.2%	9.3%	9.9%	10.7%	9.2%	9.1%	8.8%	8.9%	8.6%	7.7%	8.0%	8.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	12.0%	9.1%	10.8%	10.3%	10.8%	8.6%	9.3%	8.6%	8.8%	10.4%	7.3%	9.0%	8.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	7.9%	8.0%	9.0%	9.9%	10.7%	9.4%	9.1%	8.9%	8.8%	8.3%	7.8%	7.8%	8.8%		<=14 % <=16 % >16 %
Coding average comorbidities	5.14	5.17	5.58	5.47	5.58	5.50	5.68	5.57	5.49	5.50	5.41	5.54	5.73		No Threshold

RESPONSIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%	92.1%	93.4%	92.2%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%	97.0%	95.9%	98.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%	58.4%	53.7%	51.0%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	94.3%	100.0%	97.8%	93.1%	87.2%	90.2%	100.0%	94.9%	96.2%	97.3%	95.0%	97.5%	95.1%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%	80.2%	89.3%	80.4%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%	92.1%	96.7%	95.1%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%	63.4%	62.8%	61.5%		>=92 % >=90 % <90 %
Waiting List Size	2,509	2,819	3,122	3,338	3,507	3,565	5,605	5,842	5,943	5,955	6,136	6,411	6,922		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	4	3	6	11	7	13	23	10	15	5	2	2	5		0 N/A >0
Waiting Times - 40 weeks and above	24	12	15												No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	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	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	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%	88.5%	66.7%	59.6%	55.2%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	91.1%	92.6%	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%	88.2%	89.8%	90.4%	88.9%	89.9%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%	99.0%	99.0%	97.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%	82.0%	89.0%	83.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%	64.0%	67.0%	61.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%	72.5%	77.1%	73.2%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%	93.5%	91.2%	87.1%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

Medicine

WELL LED

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	263	200	-1,036	-347	-58	253	-127	-199	87	144	-261	-344	-377		No Threshold
Income In Month Variance (£'000s)	37	-26	-1	209	-490	201	-184	1,138	829	-308	135	273	1,294		No Threshold
Pay In Month Variance (£'000s)	-64	60	-150	48	47	121	-35	15	70	-96	-218	-376	-174		No Threshold
AvP: IP - Non-Elective	702	791	807	820	692	826	1,003	954	857	887	911	902	-29		>=0 / N/A / <0
AvP: IP Elective vs Plan	147	167	161	128	129	111	119	122	91	116	132	159	-2		>=0 / N/A / <0
AvP: OP New	1,116.00	1,161.00	1,295.00	1,239.00	1,026.00	1,346.00	1,326.00	1,379.00	1,031.00	1,094.00	1,056.00	1,174.00	-300.34		>=0 / N/A / <0
AvP: OP FollowUp	5,831.00	5,892.00	6,502.00	5,700.00	5,167.00	6,005.00	5,695.00	6,383.00	5,748.00	6,365.00	5,255.00	6,651.00	2,169.87		>=0 / N/A / <0
AvP: Daycase Activity vs Plan	1,237	1,177	1,361	1,228	1,131	1,270	1,264	1,361	1,159	1,196	1,225	1,468	139		>=0 / N/A / <0
AvP: Outpatient Activity vs Plan	7,992	8,035	8,804	7,835	7,126	8,294	8,004	8,854	7,768	8,327	7,210	8,918	1,499		>=0 / N/A / <0
PDR	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%	74.2%	74.0%	0.0%		No Threshold
Medical Appraisal	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%	0.0%	10.2%	13.5%		No Threshold
Mandatory Training	89.1%	87.6%	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%	86.7%	85.9%	87.0%	88.9%	90.2%		>=90 % / >=80 % / <80 %
Sickness	4.5%	5.5%	5.3%	6.4%	7.1%	6.3%	6.5%	7.4%	9.3%	9.8%	8.0%	9.0%	8.5%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness	1.2%	1.5%	1.5%	2.0%	1.9%	1.8%	2.3%	2.2%	3.6%	4.5%	2.9%	4.1%	3.2%		<=1 % / N/A / >1 %
Long Term Sickness	3.4%	4.0%	3.7%	4.4%	5.2%	4.5%	4.3%	5.2%	5.8%	5.3%	5.2%	4.8%	5.3%		<=3 % / N/A / >3 %
Temporary Spend ('000s)	210	262	230	265	263	292	311	373	370	452	495	614	484		No Threshold
Staff Turnover	6.5%	6.8%	7.3%	7.5%	8.3%	9.4%	9.6%	9.8%	9.9%	11.2%	12.2%	12.8%	12.5%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate)	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%	77.0%	81.3%	76.3%		>=90 % / >=80 % / <90 %

Surgery Division

SAFE	Incidents are reviewed daily via rapid review process to allow timely review and response. A new process has been implemented within the division whereby all acquired infections will be reviewed at our new divisional IPC meeting which runs pre the trust IPCC meeting.	**Highlight** • 0 Never events for 12 months consecutively • 0 CLABSI (ICU) since December • 0 Hospital acquired infections • Increase in near miss/no harm reporting **Challenges** • Sepsis inpatient data not available
CARING	We saw a reduction in PALS & formal complaints in month and our response times within the division are improving. We have a clear process to review themes from all monthly PALS/complaints and we have implemented a system to 'buddy up' families with matrons/senior nurse/AHP for complex families with long term care needs.	**Highlight** • Reduction in both PALS and formal complaints in April, considerable decrease of PALS by 10 compared to previous month **Challenges** • PALS response times could still be improved due to current process which is under review
EFFECTIVE	The division is focused on recovery plans and we have maintained a higher compliance with theatre utilisation for the second month. Work continues to push target to 90% target, improving the data quality will support this. Only 3 specialities below 85%. We have seen a huge improvement in on the day cancellations from 18 to 0 in April and a significant improvement in re-booking of 28 day cancelled operations at just 3 for April. Division is reviewing data for specialties with highest WNB rates which remains a challenge, particularly with news and are expediting the rollout of WNB AI tool along with adopting PIFU in further specialties.	**Highlight** • 0 readmissions to PICU within 48 hours second consecutive month • Theatre utilisation slightly decreased but remains much improved at 87.5% • 0 on the day cancellations non-clinical • Significant reduction in 28 day re-booked cancelled operations **Challenges** • WNB rate increased for NEW OPA's • Divisional recovery plans are a challenge and individual actions underway with specialty teams
RESPONSIVE	Our waiting list size continues to grow within the Division (13,085). The division are reviewing the root cause of growth and ensuring we are clear in which areas the demand is growing. Discussions ongoing within speciality teams around the data provided on waitlist additions and actions we can take to control e.g. triage criteria, N:FU ratio work. We are also revitalising discussions around further working with our DGH colleagues, particularly in Ophthalmology & Paediatric Surgery. The > 52 week RTT challenge remains predominantly in Paediatric Dental in terms of both OP & IP. A weekly action plan is in place to improve the position and a trajectory is	**Highlight** • Increase in % patients who felt they received information enabling choices about their care

	to be completed WE 20/05/22 to show when we will reach compliance. We are also seeing an impact on Spinal and Orthopaedic RTT compliance due to Radiology workforce constraints, which is reflected on the risk register.	**Challenges** • Increase in patients waiting > 52 weeks • Diagnostic compliance remains a challenge within Urodynamics along with endoscopy due to decontamination unit closure (now resolved)
WELL LED	Overall Sickness absence rates have improved in month. Our mandatory training position is now compliant with the 90% target. This is a result of focused work particularly within our nursing teams via a weekly challenge boards approach. We are looking to replicate across other staff groups. Temporary spend although reduced in month remains high and this is a key focus for the division for Q1 with a plan to reduce based on key investments and CIP plans.	**Highlight** • Mandatory training is now over target at 91.1% • Sickness absence rates decreased to 6.5% **Challenges** • Temporary spend reduced in month but remains high

Surgery

SAFE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	23	32	43	27	25	42	33	33	21	25	21	34	38		No Threshold
Clinical Incidents resulting in No Harm	164	165	164	120	113	107	103	117	117	78	114	133	108		No Threshold
Clinical Incidents resulting in minor, non permanent harm	35	28	38	31	49	39	43	82	40	40	43	42	46		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	1	2	0	0	1	0	1	1	0	2	1	1	1		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	1	1	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	4	2	1	2	3	1	1	3	4	1	2	2	1		No Threshold
Medication Errors (Incidents)	42	36	29	24	27	26	20	28	29	21	21	26	25		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Never Events	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	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)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	0	1	0	2	0	0	0	2	1	0	0	1	0		No Threshold
Cleanliness Scores	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%	98.7%	99.1%	98.5%		No Threshold

CARING

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Complaints	0	4	5	3	4	6	4	5	4	4	10	10	8		No Threshold
PALS	34	42	43	33	25	29	29	42	33	28	45	43	32		No Threshold

EFFECTIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	0	2	0	1	2	0	0	0	1	1	1	0	0		No Threshold
% Readmissions to PICU within 48 hrs	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%				No Threshold
Referrals Received (Total)	3,964	4,120	4,374	3,767	3,240	3,935	3,587	3,960	3,130	3,294	3,455	4,250	3,359		No Threshold
Theatre Utilisation - % of Session Utilised	77.0%	83.0%	78.4%	79.5%	81.0%	83.8%	86.7%	79.4%	81.5%	77.2%	85.9%	88.7%	87.5%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	11	7	12	13	9	30	20	51	23	18	16	18	13		No Threshold
28 Day Breaches	4	3	0	3	8	4	10	10	23	7	3	7	9		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	47	46	59	63	74	54	78	43	51	48	34	50	39		No Threshold
OP Appointments Cancelled by Hospital %	10.0%	10.0%	11.2%	9.6%	11.3%	11.3%	10.5%	8.8%	10.5%	12.8%	12.4%	13.7%	14.4%		<=5 % <=10 % >10 %
Was Not Brought Rate	6.6%	7.3%	7.9%	9.5%	10.1%	8.6%	7.8%	8.3%	9.1%	9.3%	8.1%	7.8%	9.2%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	7.6%	9.8%	9.3%	12.1%	12.0%	9.9%	9.3%	10.2%	10.5%	11.0%	9.7%	8.6%	11.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	6.2%	6.3%	7.3%	8.5%	9.5%	8.1%	7.3%	7.6%	8.6%	8.6%	7.6%	7.6%	8.4%		<=14 % <=16 % >16 %
Coding average comorbidities	4.63	4.40	4.49	4.62	4.57	4.51	4.50	4.28	4.51	4.57	4.63	4.51	4.41		No Threshold
CCAD Cases	34	31	39	28	19	23	29	24	33	20	22	27	29		No Threshold

Surgery

RESPONSIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%	93.6%	96.4%	97.7%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%	96.5%	99.0%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%	73.1%	73.8%	75.4%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%	98.2%	99.5%	98.3%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%	81.3%	86.2%	77.7%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%	88.5%	91.6%	91.8%	90.8%	95.4%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%	61.5%	61.9%	61.0%		>=92 % >=90 % <90 %
Waiting List Size	7,773	7,980	7,484	7,787	8,632	8,319	11,360	11,505	11,621	11,567	11,949	12,413	13,085		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	276	232	197	174	186	249	294	239	202	231	244	246	282		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%	66.7%	32.5%	35.4%	29.6%		>=99 % N/A <99 %

WELL LED

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-716	217	108	583	-5	-137	-349	-598	-657	-130	-232	-581	-606		No Threshold
Income In Month Variance (£'000s)	47	49	209	223	28	-144	-43	68	59	-16	23	131	10		No Threshold
Pay In Month Variance (£'000s)	-599	28	-116	541	-64	-158	-82	-452	-331	-85	-358	-196	-218		No Threshold
AvP: IP - Non-Elective	497	471	485	406	384	420	371	411	402	385	385	451	-2		>=0 N/A <0
AvP: IP Elective vs Plan	265	269	291	286	238	256	281	264	231	204	225	273	-62		>=0 N/A <0
AvP: OP New	2,529.00	2,554.00	2,824.00	2,709.00	2,332.00	3,115.00	2,778.00	2,887.00	2,166.00	2,282.00	2,131.00	2,637.00	-689.15		>=0 N/A <0
AvP: OP FollowUp	7,455.00	7,747.00	8,038.00	7,672.00	6,369.00	7,402.00	7,685.00	8,990.00	6,462.00	6,791.00	6,929.00	8,442.00	332.02		>=0 N/A <0
AvP: Daycase Activity vs Plan	704	665	795	710	622	710	731	836	696	672	611	718	-112		>=0 N/A <0
AvP: Outpatient Activity vs Plan	11,442	11,680	12,428	12,014	10,090	12,071	11,963	13,653	9,954	10,221	10,333	12,327	-731		>=0 N/A <0
PDR	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%	61.3%	61.1%	0.3%		No Threshold
Medical Appraisal	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%	0.8%	14.4%	19.8%		No Threshold
Mandatory Training	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%	88.5%	89.4%	91.1%		>=90 % >=80 % <80 %
Sickness	5.2%	5.7%	5.8%	6.7%	6.2%	6.4%	6.0%	5.6%	7.2%	8.3%	6.0%	7.0%	6.5%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.5%	1.6%	1.6%	2.2%	1.6%	2.3%	2.5%	1.9%	3.2%	4.4%	2.6%	3.3%	2.6%		<=1 % N/A >1 %
Long Term Sickness	3.7%	4.1%	4.2%	4.5%	4.5%	4.1%	3.5%	3.8%	4.0%	3.9%	3.4%	3.7%	3.9%		<=3 % N/A >3 %
Temporary Spend ('000s)	515	457	332	445	469	532	363	631	535	474	535	824	621		No Threshold
Staff Turnover	7.9%	8.9%	8.9%	9.6%	10.2%	10.4%	11.1%	11.4%	11.3%	11.8%	12.2%	12.4%	12.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%	86.6%	80.5%	86.8%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 56783 (**ASD/ADHD) Clinical report sent to family which included details of another child and incorrect diagnosis information **Improvement** – Future reports to be written and sent using centralised Trust transcription service which will reduce errors and improve turnaround time. **Incident 56629** (Community Physiotherapy) Pressure sore identified by family following use of new splints **Improvement** – physiotherapy service liaising with orthotics service to confirm pressure area leaflets are available upon provision of orthosis.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 171 incidents reported (140 clinical, 31 non-clinical) **Challenges** • Increase in number of self-harm incidents (63 reported in April) relating to a young person in the Tier 4 Inpatient Unit.
CARING	Improvement changes from complaints includes: **SO20255** (Liverpool Mental Health Services) – Complaint related to treatment provided by Liverpool Mental Health Services **Improvement** – Meeting held to resolve the complaint and actions to resolve concerns included provision of Cognitive Behaviour Therapy (CBT) treatment at an alternative community hub and additional input from clinical lead for psychiatry.	**Highlight** • 11 Excellence Reports submitted in April • 21 Compliments submitted in April • 100% FFT Scores for Community • 96% FFT Scores for Mental Health 94% FFT Scores for Outpatients **Challenges** • 31 PALS recorded in April; this is a small decrease compared to March (35 PALs). • 1 formal complaint in April (reduction). This complaint relates to communication concerns regarding a referral and appointment status in Developmental Paediatrics.
EFFECTIVE	Mental Health workforce plan launched with Divisional Board utilising Brilliant Basics methodology at Divisional Development Day. This will be undertaken for all services in the division in 2022/2023.	**Highlight** • Reduction in hospital-initiated clinic cancellations with <6 weeks notice in April (2 cancellations recorded in April, compared to 13 cancellations in March). • Reduction in mental health presentations to ED in April 2022 (61 attendances), highlighting ongoing use of the Crisis Care Service in support children and young people in mental health crisis. **Challenges** • WNB rates for the Community & Mental Health Division are higher than the Trust standard. Further investigation is underway to understand causes and tools including the WNB predictor are being explored.

RESPONSIVE	Access times remain challenging in the division due to a continued increase in demand and workforce pressures. Access is one of the divisional priorities and the brilliant basics methodology utilising an A3 has been completed to support improvement. Monthly senior team reviews commenced regarding A3 priorities as per brilliant basics plan.	**Highlight** • No breaches in the Eating Disorder urgent waiting time standard • Access has improved for young people awaiting a routine Eating Disorder assessment with appointments available within 4 weeks. **Challenges** • Increase in number of children and young people waiting greater than 52 weeks for an appointment in Developmental Paediatrics. This is due to increased referrals and absence in the medical team which has since improved.
WELL LED	Divisional Development Day held (face to face) which focused on priorities for 2022/2023 and included review of staff survey results; workforce planning; clinical plans & strategies. 8 young people from across the Youth Forums completed Level 2 qualification in Youth Work.	**Highlight** • Mandatory training remains above Trust target at 94.4%. Action plan in place to address individual staff with non-compliance. **Challenges** • Sickness absence levels remain above Trust target at 6.0%. This is a decrease from March absence rates at 6.4%. Twice weekly drop-in sessions are provided by HR to support line managers.

Community

SAFE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	7	12	7	11	4	8	4	2	4	13	14	10	13		No Threshold
Clinical Incidents resulting in No Harm	74	54	51	92	65	50	63	56	29	40	51	64	88		No Threshold
Clinical Incidents resulting in minor, non permanent harm	28	19	12	20	10	14	8	9	4	7	17	65	39		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	17	9	9	10	8	12	18	13	5	6	5	15	5		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	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		99.0%	97.5%		86.8%				98.6%	98.5%	98.2%	97.3%	100.0%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Complaints	1	0	8	0	3	4	2	2	3	7	4	4	1		No Threshold
PALS	40	50	55	39	34	63	51	48	25	31	29	35	29		No Threshold

EFFECTIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Referrals Received (Total)	912	1,284	1,326	1,061	729	1,021	1,116	1,233	1,062	1,142	1,147	1,402	875		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	11	5	9	21	22	17	25	41	17	12	8	13	2		No Threshold
OP Appointments Cancelled by Hospital %	12.9%	10.2%	11.9%	13.6%	15.7%	12.2%	17.0%	9.6%	13.9%	13.7%	14.0%	16.8%	13.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	15.6%	17.7%	13.8%	19.0%	13.6%	15.7%	17.2%	16.4%	15.8%	16.2%	12.2%	11.0%	17.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	14.2%	13.6%	12.5%	16.0%	16.1%	13.8%	13.4%	14.0%	13.1%	12.2%	13.2%	11.8%	14.6%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	18.2%	22.5%	17.1%	19.8%	17.1%	19.9%	16.9%	16.7%	18.0%	18.5%	11.1%	12.7%	15.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	17.4%	17.0%	18.5%	21.9%	24.3%	24.0%	20.1%	19.0%	15.8%	15.6%	14.8%	14.4%	17.5%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	6.9%	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%	18.3%	16.2%	13.4%	22.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	14.0%	13.3%	12.0%	15.8%	15.2%	10.9%	12.0%	13.8%	14.0%	12.4%	13.8%	12.3%	14.8%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%	128.6%	128.6%	128.6%		No Threshold
CAMHS: Tier 4 DJU Bed Days	239	248	237	217	216	214	267	217	198	219	252	279	270		No Threshold
Coding average comorbidities	9.00		2.00		8.00			4.50	7.00	3.50			15.00		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU	1					1	1	1		4					No Threshold
CAMHS: Referrals Received	396	536	638	374	297	475	526	567	433	534	483	622	350		No Threshold
CAMHS: Referrals Accepted By The Service	197	254	316	173	141	233	302	307	219	274	232	318	171		No Threshold

Community

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	49.7%	47.4%	49.5%	46.3%	47.5%	49.1%	57.4%	54.1%	50.6%	51.3%	48.0%	51.1%	48.9%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%	54.1%	52.0%	49.7%		>=92 % >=90 % <90 %
Waiting List Size	828	765	808	971	1,147	1,208	1,530	1,629	1,563	1,576	1,646	1,788	1,887		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	3	0	1	2	2	1	1	1	1	1	0	1	3		0 N/A >0
CAMHS: Crisis / Duty Call Activity	746	757	718	573	367	675	563	766	629	687	619	751	652		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%	67.2%	70.6%	69.2%		>=92 % >=90 % <88 %
ASD: Completed Pathways	107	149	136	101	231	53	64	90	67	80	64	43	41		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	24.3%	26.8%	17.6%	10.9%	4.3%	11.3%	7.8%	14.4%	17.9%	11.2%	6.2%	2.3%	9.8%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)			28.6%	6.7%	21.4%	10.5%	23.8%	21.7%	25.0%	16.7%	15.0%	12.0%	15.0%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)			100.0%	50.0%	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%	50.0%	100.0%			>=95 % >=92 % <92 %
CCNS: Number of Referrals	120	135	150	582	144	143	165	168	177	150	140	157	134		No Threshold
CCNS: Number of Contacts	791	821	835	959	809	736	931	959	951	740	823	904	800		No Threshold

WELL LED

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	14	212	-11	287	250	540	16	60	185	346	-77	93	36		No Threshold
Income In Month Variance (£'000s)	94	88	50	154	75	118	-78	59	118	-112	-106	78	53		No Threshold
Pay In Month Variance (£'000s)	5	-49	-87	260	167	15	142	319	-9	248	228	-112	17		No Threshold
AvP: OP New	558.00	688.00	561.00	544.00	478.00	523.00	527.00	629.00	480.00	505.00	569.00	592.00	15.21		>=0 N/A <0
AvP: OP FollowUp	3,936.00	4,075.00	4,230.00	3,734.00	3,072.00	3,804.00	3,424.00	4,160.00	3,411.00	3,756.00	3,597.00	4,070.00	844.79		>=0 N/A <0
AvP: Outpatient Activity vs Plan	4,495	4,763	4,791	4,278	3,550	4,328	3,951	4,795	3,905	4,274	4,178	4,681	868		>=0 N/A <0
PDR	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%	82.5%	82.6%	0.0%		No Threshold
Medical Appraisal	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%	0.0%	8.6%	10.8%		No Threshold
Mandatory Training	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%	92.4%	93.3%	94.4%		>=90 % >=80 % <80 %
Sickness	3.1%	3.9%	4.9%	5.6%	6.4%	5.8%	5.9%	5.5%	5.7%	6.2%	5.6%	6.1%	5.8%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	0.9%	1.2%	1.5%	1.4%	1.5%	1.6%	2.1%	1.7%	1.7%	2.5%	1.5%	2.1%	1.6%		<=1 % N/A >1 %
Long Term Sickness	2.2%	2.7%	3.5%	4.2%	4.9%	4.3%	3.8%	3.7%	3.9%	3.6%	4.1%	4.0%	4.2%		<=3 % N/A >3 %
Temporary Spend ('000s)	183	192	229	171	127	168	192	166	273	168	278	493	202		No Threshold
Staff Turnover	10.7%	9.6%	9.8%	9.8%	9.9%	10.1%	10.9%	12.1%	11.1%	10.4%	11.2%	12.5%	11.8%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	97.2%	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%	99.1%	99.4%	96.9%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • 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 • Incident bulletin now regular shared with CRD team to increase shared learning following incident reviews • Nursing leads now part of Senior Nurse on Site rota supporting safe staffing levels across the trust.	**Highlight** • Mandatory Training > 90% • GCP training 97% • SOP compliance 82.8% (dropped due to SOP review window) • ANTT compliance 100% • CRD ICP compliant • 100% compliance report on recent CD audit **Challenges** • PDR Target of has reduced to under TT due to an increase in leavers and new schedule for PDRs • X4 incidents reported in month (2 covid sickness reporting/2 medication incidents)
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 • R&D metrics for PALS and complaints are recorded separately from corporate data (action completed) • Staff survey completed under people plan • CRD delivery staff survey completed to explore team support and capture ideas on improvement.	**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) • PRES link and paper versions given to all families to capture feedback- awaiting response rate from CRN **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	• Continuation of reset of current portfolio to review study performance and utilise capacity and resource more effectively. • Clinicians encourage children and young people to make informed decisions about participating in studies. • Systems and processes are being reviewed as part of effective and efficient ways of working • Acting matron working with other matrons to explore research awareness across the trust and have survey to explore research awareness in clinical ward nursing teams.	**Highlight** • CCP WHO Public health study initiated in response to hepatitis outbreak in children word wide. • 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 plans • Accepted as site for Harmonie (Little Lungs) RSV vaccine trial. **Challenges** • CRD working with local system partners to improve research participation.

RESPONSIVE	• First improvement project underway following our first CRD improvement survey with informal support from Brilliant Basics team (trial archiving and storage) • Coordinated and partnership working with local providers to offer joint training programmes. • Targeted training planned for new managers in the department for risk reporting. • New desk plan for IITP staff to aid desk access	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners continues • Team fund has been utilised as per staff requests • Plan has been made to have regular archiving events to clear closed studies and send to offsite storage. **Challenges** • Storage for site files and equipment is insufficient for research department • Research team support for Trust vaccine programme ongoing • Desk space for research staff
WELL LED	• Engagement with partners in relation to upcoming starting well initiatives. • Impact of changes to working pattern undergoing data collection for audit and review • Internal staff survey results have been collated and shared • Review of CRF grant for £2m award from NIHR with new plan being confirmed • New education post confirmed and in process of recruiting to post.	**Highlight** • Division supporting staff with Flexible working (hybrid model) • CRD engaging staff with SALS **Challenges** • Correct model for 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 • Partner trusts have higher banding for the non-clinical roles that we have in the division.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	EDI Steering Group Terms of Reference
Report of:	Chair of the EDI Steering Group
Paper Prepared by:	Chief People Officer

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

Equality, Diversity, and Inclusion Steering Group

DRAFT

Terms of Reference

1. Purpose

The purpose of the Equality Diversity and Inclusion Steering Group (EDISG) is to oversee the Trusts strategic ambitions and specific EDI goals, and to ensure that EDI is at the heart of the Trusts policies and practices as an employer, health care provider and procurer or services.

To ensure that the Trust is committed to:

- Meeting the General Equality Duty as outlined in the Equality Act 2010
- Providing EDI leadership, insight and input as it relates to staff, volunteers and patients
- Development of a culture promoting Equality, Diversity and Inclusion to eliminate discrimination
- Ensuring mutual respect and civility exists in the workplace & for patients, families, carers and staff to be inclusive of all
- Implementation of the Equality Delivery System (EDS2/3) and the action plan
- Implementation of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and associated action plans
- Implementation of the Gender Pay Gap and the action plan

In addition, the EDISG will work in cooperation with other Trust steering groups and committees as required to provide critical challenge to the Trust Board in terms of its practice, approach, and development of EDI.

2. Role

To provide support, advice, assurance and governance for the Trust Board via the People and Wellbeing Committee on all equality, diversity and inclusion matters, and as an aid to the delivery of effective healthcare and employee experience.

3. Duties

To create, implement and monitor progress of a strategy to promote equality, diversity and inclusion across the Trust for patients and staff including a focus on:

3.1 Delivery of the Trusts performance

- To review the Trusts performance in EDI using the EDS2/3, GPG, WDES and WRES and any future initiatives.
- Ensuring there are clear reporting and accountability processes in place throughout Trust departments and divisions on EDI matters.
- To assess risks associated with ED&I and advise the Trust Board.

- To report the Trust's progress to the Trust Board via the People and Wellbeing Committee

3.2 Inclusive recruitment and progression practices and increased representation

- Identify and recommend positive action initiatives to address systemic inequality & to promote equality, diversity and inclusion within all policies, to ensure that the Trust is promoting this agenda across all practices.

- The monitoring, on behalf of the Trust Board, of progress against the EDS2/3, WRES, WDES, Gender Pay Gap and general action plan to ensure the Trust progresses towards its aim of inclusivity and equitable opportunities for employment opportunities, and progression in the workplace.

3.4 Leadership & culture of inclusion and belonging

- To support the Trust Board and the Head of Equality, Diversity and Inclusion in articulating what we as a Trust mean by equality, diversity and inclusion and how this approach affects our work.

- To ensure that local and other partners recognise the organisation as a champion for equality, diversity and inclusion in all its activities.

3.4 Addressing differentials in experience

- To be responsible for focusing on matters of Race, LGBTQI+ and Disability and Long-Term Health Conditions, whilst maintaining awareness of the wider EDI agenda, and making sure they are explored by the Trust.

- To ensure all staff actively promote equality, diversity and inclusion in their work and are confident in the ability to challenge discrimination when it is identified.

- To support the development and empowerment of staff networks and to provide opportunities for representatives to share EDI related issues and concerns to support the Trusts action planning.

- To promote equality of opportunity for all staff and patients & to ensure all sections of community have ease of access to the Trust, with care and information that supports their need.

- To promote, recognise and value the diverse nature of communities and staff groups.

4. Membership

4.1 The Equality Diversity and Inclusion Steering Group (EDISG) shall consist of:

Non-Executive Director (Chair)
Chief people Officer (Co-Chair)
Deputy Chief people Officer
Chief Nurse
Associate Director of OD
Director of Marketing and Communications
Deputy Chief Medical Officer
Head of EDI
Staff Network representative (s)
Medical Workforce representative
Staff Side representative
Head of Patient Experience
Youth Forum representative
Divisional Representatives
Equality Champion

Other individuals may attend meetings as required.

4.2 The Equality Diversity and Inclusion Steering Group (EDISG) will be deemed quorate provided 4 members are in attendance to include a minimum of:

- Chief People Officer
  Chief Nurse or Deputy Chief People Officer
- 1 Staff representative
- 1 Divisional representative

5. Conduct

The committee will develop a work plan with specific time-focused objectives.

Members and attendees are selected for their specific role or because they are representative of a professional group/speciality/service line or division. As a result, members are expected to:

- Ensure that they read papers prior to meetings
- Contribute fully to discussion and decision-making
- If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress
- Represent their professional group or their speciality/directorate/division as appropriate in discussions and decision making
- Disseminate and feedback on the content of meetings to colleagues in their speciality/service line/division via governance structures and processes.

Agendas, papers and minutes to be distributed not less than 2 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.

6. Frequency of meetings

6.1. Meetings shall be bi- monthly.

6.2. Additional meetings may be held on an exceptional basis.

7. Minutes and reporting

7.1 The minutes of all meetings of the Equality Diversity and Inclusion Steering Group (EDISG) shall be formally recorded.

7.2 The Chair of the Equality Diversity and Inclusion Steering Group (EDISG) will produce a written report to People and Wellbeing Committee after each meeting.

7.3 The Equality Diversity and Inclusion Steering Group (EDISG) will report progress with the People and Wellbeing Committee at least annually.

8. Review

8.1. The terms of reference of the committee shall be reviewed at least annually or when required due to any changes.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th May 2022

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP QUARTERLY PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team in the period of April 2021 to March 2022 and to outline the actions planned for the coming six to twelve month period. For the first time the report also includes data from the SALS service to provide a line of sight across both mechanisms in terms of themes and hotspots.

2. Recommendation

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

3. Analysis of issues raised

3.1 FTSU issues summary April 2021 to the present

Summary of the issue	Number of times raised	Additional comments and observations	Staff group
Recruitment process	6	Process for recruitment appears to lack robustness, however there have been significant changes and this is now improving	Nurse/HCA AHP
Retirement process	2	Apparent lack of understanding in the application of the policy	HCA
Infrastructure/leadership	1	This group includes, staff not being fully aware of the leadership structure and team structure.	Nurse
Clarity on role/responsibilities	2	Staff unclear of their role has led to challenging situations	Nurse
Behaviour and relationship (Staff Safety)	13 (4 cases include a total of 7 staff)	Poor behaviours and break down of relationships have occurred for a variety of reason, including poor application of policies, poor communication and a lack of ability to challenge, in others,	Manager Nurse AHP Admin/clerical Facilities Medical staff

		behaviour not in line with Trust values	
System/process and infrastructure/leadership – staff safety)	9	A large proportion of the concerns raised under this group are as a result of a lack of communication and an apparent lack of transparency	Nurse Admin/clerical Medical staff
Patient safety	3	There was no harm to patients however staff raising a concern have alleged that there would be a potential for harm should the concern not be managed/resolved	Nurse Medical staff
Health and Safety (Staff Safety)	1 (5 members of staff)	This was in relation to the lack of a robust health and safety risk assessment being carried out	Nurse
Policy	3	The application of the sickness policy is not standardised and this has resulted in staff being treated unfairly	Nurse
Detriment	1	This is a newly opened case, to date there has been no evidence of detriment, however it remains under review	Nurse

3.2 Quarter 4 Data

There were cases 20 submitted to the NGO for Q4 of 2021/22. Of the cases raised in Q4, none were done so anonymously.

During the quarter, six cases related to process/policy, eight to behaviours and relationships, five to staff safety and one relating to detriment. Of the 20 cases, six are closed. Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again and scored the process highly in terms of satisfaction.

3.3 SALS contacts December 21021 – April 2022

Month	**Number of contacts per month (New & Follow up)**	**Some of our themes include:**
December 2021	199	Stress, anxiety, trauma, physical illnesses (long covid), requests for stress risk assessments to be undertaken.

January 2022	247	Anxiety, stress, physical illness, issues within work/teams
February 2022	333	Vaccinations, stress, anxiety, physical Illness, (long covid, cancer) team issues. Requests for counselling in line with new model for all staff support are via SALS staff in crisis.
March 2022	350	Stress, anxiety (home/work), financial worries, salaries, requests for counselling, trauma, car parking, coping with organisational change, general workplace queries/issues.
April 2022	312	Stress, anxiety, relationships, salaries, sexual assault, domestic abuse, financial queries, car parking, coping with organisational change, requests for support around staff whose children need additional help, general workplace queries/issues, staff in crisis.

The highest number of users of the service come from the nursing workforce, followed by admin and clerical staff.

Issues raised through the FTSU route continue to increase, with a sharp incline in Q4. This increase can be attributed to the significant impact of the Covid-19 pandemic on staff, with individuals describing how they are emotionally and physically exhausted, with reduced capacity, coupled with a need to increase workload. This has the potential to increase sickness, adding further pressure to the system. Staff describe how they have less ability to deal with issues than they may have had pre-Covid.

Its to be noted that the number of cases raised associated with behaviours and relationships, and a break down in these, is higher than those reported the under the formal Respect at Work Policy. In the data provided by SALS we also see a high number of staff presenting with work related stress that could have elements of poor behaviours and breakdown in relationships. SALS staff have indicated that there is a common theme of conflict, which is also increasing amongst staff.

Staff survey data 2021, would also indicate that staff who experience harassment, bullying or abuse, are less likely to report it compared to 2020, which may well indicate that the picture we are seeing via the routes mentioned above, could be higher

Q14d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	49.6%	55.3%	48.6%	53.9%

3.4 Triangulation against Staff Survey results

In the staff survey results for 2021, Question 21e has seen a slight decline in staff feeling safe to speak up; work is required to understand why this is and what needs to be done to reverse it. Question 21f, is a new question and whilst we are below the best we are above the national average, investment in understanding where the gap exists in terms of this question could be beneficial in encouraging staff to report and speak up.

Staff survey question	Alderhey 2020	Best 2020	Alderhey 2021	Best 2021
Q21e I feel safe to speak up about anything that concerns me in this organisation	71.3%	77.6%	70.3%	75.3%
Q21f If I spoke up about something that concerned me I am confident my organisation would address my concern			59.0%	67.2% (Average 47.9%)

4. Freedom to Speak Up Champions

There is a planned 'brainstorming' session during May 2022 for the FTSU team to evaluate the current FTSU service, review the role of the FTSU Champions in light of the NGO recommendations and look at the sustainability of the FTSU service. This will ensure we have a consistent, standardised approach with a clear succession plan. Feedback from this session will be provided in the next FTSUG Board paper.

5. Learning and Improvement

Speak Up, Listen Up, Follow Up are the three E-Learning modules now available from the National Guardian5's Office. The final module '*Follow Up'*, is developed for senior leaders throughout healthcare - including executive and non-executive directors, lay members and governors - this module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident that they will be listened to and action taken. It is proposed that all those that fall into those categories should consider undertaking the training module.

The *Speak Up, Follow Up* E-Learning modules are still being accessed by staff, but uptake remains poor. Therefore, Board support is sought to encourage staff to undertake this important training, particularly given the link to the raising concerns theme within the recent Ockenden report.

Kerry Turner
Freedom to Speak Up Guardian
May 2022

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts – half year update**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Director of Corporate Affairs

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	National Guardian's Office Strategic Framework 2021
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	

Freedom to Speak Up review tool for NHS trusts and foundation trusts

September 2021

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**In 6 months** **Partial**	**In 6 months** **Partial/ Ongoing**	1. Appraisals and 360 feedback: Executive PDR documentation has included an assessment against Trust Values for the last five years. The Trust Chair's appraisal is based on an MSF approach. Staff survey includes questions inviting views on senior leaders. 2. Concerns raised: The board receives a thematic report on a quarterly basis from the FTSU Guardian 3. Senior visibility: Senior visibility is a priority across corporate communications. This continued virtually and innovatively throughout COVID, using methods such as Alder Hey all Staff Broadcast. Executive visibility has now been reinstated as part of Brilliant Basics. 4. Corporate Induction: CEO or nominated Executive Director, presents at Corporate Induction, highlighting the importance of the Trust's values, behaviours, and speaking up 5. Values and behaviours:	Triangulation of data with SALS now commenced; considering how IR data should best be used to inform the process and assurance via PAWC. Exec team meeting to be used to capture themes from visibility programme as part of BB/leader standard work.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Executives and Non-Executives support the use of the Behavioural Framework, to underpin the Trust's values and the use of them in staff PDR's. The Trust Chair periodically challenges all Board members to reflect on a particular Value at the end of a board meeting. 6. People Plan: the Trust's People Plan includes an objective that 'We will develop a working environment that encourages all staff to 'speak up' and 'listen up' and continue to support the work of our Freedom to Speak Up Guardian and Champions 7. NHS Staff Survey: The annual NHS Staff Survey results of questions related to FTSU are picked up in the Board report and factored into FTSUG's team plans.	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up	p6 Section 1 Section 2 Section 3	Full	Full	1. Executive and Non-Executive Leads: appointments have been made to both positions. 2. Regular 1:1 meetings: these take place between the Guardian, Executive and Non-Executive Director	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				3. Reports to Board**:** Quarterly reports are required to the Board to ensure clear sighting and accountability is upheld, as well as contributing to the Board's own development. The suite of reports includes monitoring of IR cases, each of which has an Executive lead assigned in accordance with Baroness Harding's guidance. 4.Staff Stories**:** Staff stories have been introduced to Board meetings, inviting a member of staff to share an experience of working for Alder Hey - both positive and negative stories are welcomed. 5. Leadership development**:** Leaders are supported and encouraged to continually develop. The Trust's Strong Foundations programme has evaluated very positively among staff at all levels and is the cornerstone of the Trust's leadership development strategy. **6.**Bullying and Harassment**:** The NHS Staff Survey results are used to monitor and measure progress.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				7. FTSU is widely promoted across the Trust via various methods, with regular sessions on the Trust's Induction programmes. The Trust has an annual Speak Up Safely week each October.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	Partial	Partial	The Trust's People Strategy currently incorporates the speaking up strand. It has previously been agreed that keeping messages simple and minimising the number of overlapping strategies is more accessible for staff.	Board to revisit the need for a separate FTSU strategy.
Support your FTSU Guardian					

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events	p7 Section 1 Section 2 Section 5	Full	Full	1. The Executive team supported the increasing of the FTSU Guardian's dedicated hours. 2. The Guardian attends Regional and National training events and conferences. 3. The Board supported FTSU Leads to receive refresher training, and to train champions, with continuous plans to train more. 4. Regular Coaching and Psychological Support sessions are provided to the Guardian. 5. meetings take place between the Guardian, Exec Director and NED. 6. Open access is provided to relevant Directors when dealing with individual concerns. 7. The Guardian has regular access to Regional and National training events. 8. The Guardian has open access to anonymised patient safety and employee relations data for triangulation purposes.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				9. The Guardian has recently stood down as the Chair of the NW Regional Guardian Network. 10. The Guardian is able to raise issues directly with the relevant HR Business Partner, the Medical Director, Chief Nurse, the HR Director/FTSU Executive Lead and any other relevant Executives.	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	Full	Full	The Trust policy is modelled on the NGO policy and aligned with Alder Hey's Policy review cycle. 2. All policies are reviewed by Staff Side. The FTSUG is also an RCN union rep and therefore attends the Policy Review Group	
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate:	P8 Section 6	Partial	Partial	The NED lead for FTSU commissioned work on triangulation of information, specifically a direct link with the work of the Wellbeing Guardian which has not yet completed. The Trust commissioned	Wellbeing Guardian report to be incorporated into data triangulation process

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inpsection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.				modules in Ulysses to enable staff to input concerns in once place.	
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Full	Full	Comprehensive reports are presented at Board, with attendance from the Guardian on a quarterly basis, which can be evidenced by meeting minutes and papers.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Partial	Partial	Initial appointments predated guidance/JDs from National Guardians Office, however followed the Trust's fair recruitment process. Future appointments will follow the established process using the published FTSU guidance and example job description.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Full	Full	Review of data reports and themes are completed quarterly.	Case Reviews, published by NGO, to be included in 1:1s with Executives and NED. Lead: JC
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	Full	Full	1. Regular reports are submitted to Board, and information shared with CQC and the CCG. 2. Discussions take place with relevant oversight organisation- the National Guardians Office and CQC upon their visits, with attendance at national meetings by Guardian. 3. Discussion within relevant peer networks take place as described above. 4. FTSU content is present within the Trust's annual report. 5. FTSU discussion takes place at the Public Board. 6. the FTSU Guardian is a member of the BAME taskforce which was established by the Board in 2020.	
Individual responsibilities					

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	Partial	Partial	NED lead has a specific objective in relation to FTSU, other roles have this evaluated via Values assessment currently.	Ensure each of the key individuals has a specific focus on speaking up within their PDR.

May 2022

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Board Assurance Framework 2022/23 (April)**
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 2022/23

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

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

2. Review of the BAF

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

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

3. Overview at 10th May 2022

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

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

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

4. Summary of BAF - at 10th May 2022

The diagram below shows that all risks remained static in-month with the exception of risk 3.4 which has shown an improvement based on the latest financial plan for 22/23 and mitigations that have been put in place.

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 / SQAC	**3x5**	3x3	STATIC	STATIC
1.3 DP	**Failure to address building deficits with Project Co.**	RABD	4x3	2x3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development.**	PAWC	3x4	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	IMPROVED
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	4x2	4x1	**INCREASED**	STATIC

5. Summary of April'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. Good progress initiating insight/anaysis work for 2030 Vision (Strasys)

- ***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, updated actions and evidence. System shift ongoing, Alder Hey membership and CYP voice in all key groups confirmed.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. LWH & LNP agreed to schedule Pship Assurance Framework for July LNP Board (previously April)

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

- ***Failure to address building deficits with Project Co. (DP)***
  Risk reviewed and no change to risk score. Progress has been made in the month with a change in leadership in the SPV. Work is progressing on a number of areas and will continue to be monitored with appropriate escalation of risk score if required.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  The current number of C&YP waiting over 52 weeks for treatment is 275. Over the past two months the number has plateaued. Sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry. A specialty recovery plan to address this is being finalised by the 6 May 2022. We also have a Trust wide plan to recover services to 104% this year. Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 72.4% of patients within 4 hours, an improvement relative to March (driven largely by a return from absent of a number of staff). Through the annual plan process we have agreed a significant increase in investment to increase staffing levels, and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place - ED at its best.

- ***Inability to deliver safe and high-quality services (NA).***
  This risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk.

- ***Financial Environment (JG).***
  Risk reviewed and score adjusted to 16 based on the latest financial plan for 22/23 and mitigations that have been put in place however recognising the longer term financial risk and uncertainty that still remains. Actions have been updated to reflect latest progress.

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

- ***Digital Strategic Development and Delivery (KW).***
- This risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk.

- ***Workforce Sustainability and Development (MS).***
  Absence remains higher than expected for this time of year and continues to be monitored closely. Recruitment time to hire significantly reduced and meeting target. Stretch target to be put in place from 1st May 2022.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions updated. One control removed and one new control added. 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).***
  May review – static.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

BAF Risk

1.1

Inability to deliver
safe and high-quality services

(3x3=9)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

(2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity. * (linked to 2.1)
(2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors
(2233) Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies
(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)
(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)
(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)
(2327) Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence
(2332) : Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients (Linked to 1.1)
(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.2 & 2.1)
(2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.2 & 2.1)
(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 2.1)
(2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.2 & 2.1)
(2578) Insufficient funding to provide Porter's service (Linked to 2.1)
(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.2)
(2570) Inadequate provision of inherited cardiac conditions (ICC) service for Children within the North West.
(2589) Inability to safely staff Catkin and Community Clinics (Linked to 2.1)
(2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal
(2410) Risk of long waits in ED department (Linked to 1.2)
(2326) Delayed diagnosis and treatment for children and young people (Linked to 1.2)
(2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced. (Linked to 1.2 & 201)
(2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 2.1)
(2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 2.1)

BAF Risk	Strategic Aim	Related Corporate Risk(s)
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (3x5=15)	Delivery of **outstanding care**	(2233) Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies (linked to 1.1) (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) (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) (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) (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1 and 2.1) (2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.1 and 2.1) (2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 2.1) (2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.1) (2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal. (Linked to 1.1 & 2.1) (2410) Risk of long waits in ED department (Linked to 1.1) (2326) Delayed diagnosis and treatment for children and young people (Linked to 2.1) (2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced. . (Linked to 1.1 & 2.1) (1902) Reduced availability of ED Consultants on shift to oversee the safety of the service, including the department's response to Major Trauma cases . (Linked to 1.1 & 2.1)
1.3 Failure to address ongoing building defects with Project Co. (4x3=12)		(1388) Risk of pipe burst due to corrosion

BAF Risk	Strategic Aim	Related Corporate Risk(s)
2.1 Workforce Sustainability & Capability (4x4=16)	**The best people** doing their best work	(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) (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1) (2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 1.1) (2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 1.2) (2578) Insufficient funding to provide Porter's service (Linked to 1.1) (2589) Inability to safely staff Catkin and Community Clinics (Linked to 1.1) (2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal (Linked to 1.1 & 1.2) (2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced (Linked to 1.1 & 1.2) (1902) Reduced availability of ED Consultants on shift to oversee the safety of the service, including the department's response to Major Trauma cases (Linked to 1.1 & 1.2) (2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 1.2) (2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 1.2) (2624) Reduction in the governance of research studies due to staffing levels within the Research Governance team (Linked to 4.1)

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

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

BAF Risk	Strategic Aim	Related Corporate Risk(s)
4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP (3x3=9)	Game-changing **research and innovation**	(2624) Reduction in the governance of research studies due to staffing levels within the Research Governance team (Linked to 2.1)
4.2 Digital Strategic Development and Delivery (4x1=4)		None

Board Assurance Framework 2022-23

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, 2332, 2441, 2461, 2265, 2427, 2326, 2514, 2384, 2233, 2340, 2516, 2312, 2229, 2332, 2383, 2536, 2570, 2246, 2578, 2497, 2100, 2528, 2501, 2589, 2597, 2326, 2535, 1902, 2415, 2230, 2410, 2020, 2617
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.	01/09/2022	Refer to SQAC reports for most up to date progress
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	01/09/2022	Refer to corporate report to SQAC and associated conversations
2. The Trust will deliver the Parity of esteem work program addressing this issue	01/09/2022	Please note most recent report to SQAC. Due to increased COVID response the working group was paused.

Executive Leads Assessment

April 2022 - Nathan Askew
this risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk

March 2022 - Nathan Askew

this risk has been reviewed and current control remain in place.
January 2022 - Nathan Askew This risk has been reviewed. current controls remain on track
November 2021 - Nathan Askew The risk has been reviewed. Current control in place remain on track with particular improvement in all 3 quality priorities. Quality work across the organisation continues to recover following covid 19 and will provide additional assurance against the gaps detailed
October 2021 - Nathan Askew This risk has been reviewed, controls for haps in assurance continue. There has been progress with all 3 safety priority workstreams with clear plans in place across medication safety, deterioration and parity of esteem.

Board Assurance Framework 2022-23

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, 2383, 2246, 2497, 2578, 2528, 2463, 2501, 2501, 2597, 2326, 2535, 1902, 2517, 2410		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - 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	30/04/2022	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.
Urgent Care Improvement Group overseeing several improvement workstreams: PLACE - GP streaming relocation to OPD - complete FUNDING - business case submitted for approval to increase nursing and decision makers - Complete SUPPORT - external company engaged to support GP stream - complete; funding for 22/23 requested via CCG - pending WORKFORCE - subject to funding workforce required including out of hours - pending CAPACITY & DEMAND - review of demand and capacity by stream - pending EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	30/09/2022	Go 2 Doc now covering 7 days per week but still working toward 2 x GP/ACP cover 9am-9pm. OPD rooms still being utilised Mon-Fri whilst a longer term solution is sought for a location for streaming services. - update required before 30/5/22 Meeting with executive team Thurs 5/5/22 and ED senior team to discuss challenges in urgent care and create action plan for short and long term improvements. To reconvene in 2 weeks to discuss ideas. - deadline 19/5/22 'ED at it's Best' launched as listening event for ED staff supported by project management team. Reporting findings and recommendations to Urgent Care Improvement Board (UCIB) monthly. 4 new ED consultants appointed at interviews in April 2022. Anticipated start dates of September 2022. Nursing posts to be advertised following approval of business case for investment in 2022/23. Updates to be provided monthly to UCIB. Capacity and demand work ongoing alongside review of triage guidance to ensure all patients suitably streamed at point of attendance - target for completion 24/5/22 Task and finish groups to be arranged with support teams and medical/surgical specialties to improve pathways for patients that avoid inappropriate attendance at ED - target date of 20/5/22 for start PAU pilot scoping underway to test pathways ahead of implementation in 2024/25. Proposal to be put forward to PAU Project group and UCIB in June 2022.
	09/05/2022	

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.

May 2022 - Adam Bateman
The current number of C&YP waiting over 52 weeks for treatment is 275. Over the past two months the number has plateaued. Sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry. A specialty recovery plan to address this is being finalised by the 6 May 2022. We also have a Trust wide plan to recover services to 104% this year.

Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 72.4% of patients within 4 hours, an improvement relative to March (driven largely by a return from absent of a number of staff). Through the annual plan process we have agreed a significant increase in investment to increase staffing levels, and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place - ED at its best.

April 2022 - Mark Carmichael
Risk rating maintained due to volatile attendances and high absence rates

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

May 2022 - Rachel Lea
Risk reviewed and no change to risk score. Progress has been made in the month with a change in leadership in the SPV. Work is progressing on a number of areas and will continue to be monitored with appropriate escalation of risk score if required.

April 2022 - Rachel Lea
Risk reviewed and no change to risk score. Detailed report to be shared at Trust Board on the latest actions and status.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2340, 2312, 2516, 2497, 2383, 2536, 2246, 2578, 2497, 2100, 2528, 2501, 2589, 2597, 2535, 1902, 2517, 2624, 2617, 2020		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x4	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
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/05/2022	HRBP's have been working with Divisions to help shape divisional workforce plans. Review of Workforce planning tool developed by KPMG and discussions with Strasys
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	31/05/2022	Currently progressing and discussing both the overall people strategy and the recruitment strategy and plan that sits beneath that

Executive Leads Assessment
May 2022 - Sharon Owen Absence remains higher than expected for this time of year and continues to be monitored closely. Recruitment time to hire significantly reduced and meeting target. Stretch target to be put in place from 1st May 2022.
April 2022 - Sharon Owen Sickness absence has continued has remained relatively static but higher than anticipated with absence rates circa 8%, creating pressures points across the Trust. Therefore this risk is not in a position to be reduced, however significant support and measures are in place to support staff and managers. Approx 2% of this is attributable to covid related absences.
March 2022 - Sharon Owen Whilst staff availability issues have continued coupled with high levels of sickness absence, this has continued to drop in the last two months. This has therefore allowed for a reduction in the risk score from 16 to 12.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2021 Staff Survey Report - main report, divisional reports and team level reports
Reward and Recognition Group relaunched after being on hold during the peak of the pandemic	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Care first - online Employees Assistance programme	
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin	Minutes of exec meetings
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
After Action Review to be coordinated to inform learning from incident. Director of Nursing to ask for member of Governance team to lead the review. Risk management plan in place to ensure member of staff is safe and receiving appropriate interventions.	31/05/2022	Still awaiting outcome of review so that learning can be actioned
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	31/05/2022	Assistant psychologist in post since March 30th and will be focussing on supporting development of this model over the coming months
Business case developed and now awaiting opportunity to present at appropriate forum whilst SALS also seeking external funding sources and opportunities for income generation to assist with current cost pressures.	31/05/2022	
Mental Health training for line managers ("Strengthening Others") being developed by SALS/OD to be rolled out to all leaders and managers as a module of Strong Foundations and as stand-alone training available to all via recorded presentation and monthly drop ins run by SALS	13/06/2022	

Executive Leads Assessment
May 2022 - Jo Potier Risk reviewed and actions updated. One control removed and one new control added. No change to risk rating.
March 2022 - Melissa Swindell risk reviewed, actions on track
February 2022 - Jo Potier Actions reviewed and updated and controls reviewed and updated to include 2021 staff survey results. No change to risk rating

Board Assurance Framework 2022-23

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	01/09/2022	

Executive Leads Assessment

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

May 2022 - Melissa Swindell
risk reviewed, actions updated with revised timescales

April 2022 - Sharon Owen
Risk reviewed and actions updated - all actions taken forward by the Trust Head of EDI

Board Assurance Framework 2022-23

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
Set up a campus review	03/06/2022	Review scheduled 10th May 2022

Executive Leads Assessment

May 2022 - David Powell
Risk reviewed prior to May Board

April 2022 - David Powell
Prior to April Board

March 2022 - David Powell
Prior to March Board

Board Assurance Framework 2022-23

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 strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-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 - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	30/09/2022	Target date updated to Q4 21/22 - International strategic plan to be developed in line with 2030 Vision refresh
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/09/2022	Workforce analysis will be a key part of Strasys analysis in developing 2030 Vision refresh. This will support the HRD and system with evidence base for wider workforce planning.

Executive Leads Assessment

May 2022 - Dani Jones
Risk reviewed; no change to score in month. Good progress initiating insight/anaysis work for 2030 Vision (Strasys)

April 2022 - Dani Jones
Risk reviewed; no change to score in month. Ongoing rapid system change pending H&S Care Bill & ICS development, though AH positioning well & aligning system requirements into 2030 Vision refresh esp. with Strasys Pop Health workstream

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

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	30/09/2022	LTFM work delayed due to ongoing requirements of the 22/23 business planning and system requirements.
2. Five Year capital plan	30/09/2022	22/23 Capital plan approved based on current CDEL allocation. Awaiting confirmation of outcome of bids for any further allocation. Work underway with C&M regarding allocations for 23/24 and 24/25.
22/23 CIP programme requires radical transformation focus	31/03/2023	

Executive Leads Assessment

May 2022 - Rachel Lea
Risk reviewed and score adjusted to 16 based on the latest financial plan for 22/23 and mitigations that have been put in place however recognising the longer term financial risk and uncertainty that still remains.
Actions have been updated to reflect latest progress.

April 2022 - Rachel Lea
Risk reviewed and actions updated accordingly. No change to overall score.

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

Board Assurance Framework 2022-23

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 Confirmation of funding for Y2 of programme received April 22
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 Update to Trust Board April 22
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	15/12/2022	

Executive Leads Assessment

May 2022 - Dani Jones
Risk reviewed; no change to score in month, updated actions and evidence. System shift ongoing, Alder Hey membership and CYP voice in all key groups confirmed.

April 2022 - Dani Jones
Risk reviewed; no change to score in month - system shift ongoing (in large part due to delay in Bill to July 22) but system working becoming established and Alder Hey commitment in system continues.

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

Board Assurance Framework 2022-23

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

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 March - initial plan with LWH for presentation to LNP Board in April - this has been moved to June (recognising current pressures in team). Learning to be shared and co-design to pack to be incorporated	01/07/2022	LNP Board agenda item re: completed partnership assurance framework moved to June 22

Executive Leads Assessment

May 2022 - Dani Jones
Risk reviewed; no change to score in month. LWH & LNP agreed to schedule Pship Assurance Framework for July LNP Board (previously April)

April 2022 - Dani Jones
Risk reviewed; no change to score in month - expected update end April in line with scheduled LNP pilot run of partnership assurance round.

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

Board Assurance Framework 2022-23

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: 2624		
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.	31/05/2022	

Executive Leads Assessment

May 2022 - Claire Liddy
May review - static

April 2022 - Claire Liddy
April review - no change

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

Board Assurance Framework 2022-23

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: 4x3	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
Issues securing experienced resources in some services

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Development of new strategy from 22/23	31/05/2022	Date amended to May 2022 to align with wider Trust strategies
Implementation of Alder Care Programme	03/10/2022	Some issues highlighted with programme, risking dates to delivery. Review underway
Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	01/07/2022	New iDigital model supported through AH and LHCH Executives. Recruitment to senior management team partially complete. Recruitment with analytics and transformation teams in progress.

Executive Leads Assessment

May 2022 - Ian Gilbertson
This risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk.

April 2022 - Kate Warriner
BAF reviewed. Score increased to reflect digital workforce gaps in some areas including analytics and transformation with potential impact on BAU and delivery programmes. New service model in the process of being implemented to manage risk.

Good progress with refreshed digital strategy. Aldercare programme making progress against plans.

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 26th May 2022

Paper Title:	**Proposal for the appointment of a Senior Independent Director**
Report of:	Trust Chair
Paper Prepared by:	Erica Saunders, Director of Corporate Affairs

Purpose of Paper:	Decision Assurance Information Regulation
Background Papers and/or supporting information:	• To seek to appoint one of the Trust's Non-Executive Directors as the Senior Independent Director • NHS Foundation Trust Code of Governance
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:	

BOARD OF DIRECTORS

PROPOSAL FOR APPOINTMENT OF A SENIOR INDEPENDENT DIRECTOR

1. Purpose

The purpose of this paper is to propose the appointment of one of the Non-Executive Directors as the Trust's Senior Independent Director.

The role of Senior Independent Director is currently held by Anita Marsland until the end of her term of office on 30th June 2022.

2. Recommendation

The Board is asked to support and approve the appointment of Kerry Byrne to the additional role as Senior Independent Director of the Trust.

3. Foundation Trust Constitution and Code of Governance

Under the Trust's constitution all Non-Executive Director appointments are within the gift of the Council of Governors, including the Senior Independent Director. Provision is made within the NHS FT Code of Governance for a Senior Independent Director as follows: 'In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to provide a sounding board for the chairperson and to serve as an intermediary for the other directors when necessary. The senior independent director should be available to governors if they have concerns that contact through the normal channels of chairperson, chief executive, finance director or trust secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could be the deputy chairperson.'

The proposal to appoint Kerry Byrne will be submitted to the next formal meeting of the Council of Governors on 7th June 2022 and will be subject to the agreement of the Board.

4. Job Role

The job description for the SID is attached for reference. In addition to the general duties set out for all Non-Executives, the SID is assigned the following:

- To act as the point of contact with the Board of Directors should Governors have concerns which normal channels have been unable to resolve or for which normal channels would be inappropriate.
- To facilitate and oversee the performance evaluation of the Chairman and to report on the outcome of this to the Council of Governors.
- To act as the senior officer for dealing with the formal stage of a whistle blowing allegation under the Trust's Whistleblowing policy; the SID may be approached where a member of staff feels it is inappropriate to raise a matter informally or is dissatisfied with the outcome of the informal process.
- To work alongside Executive Director colleagues to advise upon and support best practice governance arrangements.

Kerry Byrne is a highly experienced Non-Executive Director with the requisite skills to carry out this role on behalf of the Board.

Dame Jo Williams
Chair

Alder Hey Children's NHS
NHS Foundation Trust

JOB DESCRIPTION

POST: Non-Executive Director/Senior Independent Director

REPORTING ARRANGEMENTS: Non-Executive Directors are responsible to the Chair

KEY RELATIONSHIPS: Non-Executive Directors, Executive Directors, Council of Governors

JOB SUMMARY: As a member of a unitary Board, the Non Executive Director will bring external skills and challenge to developing the Trust's strategy, holding the Executive Directors to account for its delivery and ensuring that the Board acts in the best interests of children, young people and their families and the wider community. As Senior Independent Director, the post-holder will act as an additional formal link between the Governors and the Board of Directors and as a point of contact for staff under the Trust's Whistleblowing Policy.

TIME COMMITMENT: A minimum of three days per month

REMUNERATION: £15,000 per annum

LENGTH OF APPOINTMENT: Three years

PRINCIPAL DUTIES AND RESPONSIBILITIES

Senior Independent Director

- To act as the point of contact with the Board of Directors should Governors have concerns which normal channels have been unable to resolve or for which normal channels would be inappropriate.

- To facilitate and oversee the performance evaluation of the Chairman and to report on the outcome of this to the Council of Governors.

- To act as the senior officer for dealing with the formal stage of a whistle blowing allegation under the Trust's Whistleblowing policy; the SID may be approached where a member of staff feels it is inappropriate to raise a matter informally or is dissatisfied with the outcome of the informal process.

- To work alongside Executive Director colleagues to advise upon and support best practice governance arrangements.

Strategy Development

- To provide independent judgement, expertise and challenge in the development of the Trust's strategy, vision and values as a member of a unitary Board, taking into account the views of the Council of Governors. To hold the Executive Directors to account for the delivery of the agreed strategy, including the organisation's performance against both financial and clinical quality metrics.

- To participate with fellow directors in providing entrepreneurial leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed.

- To chair a designated assurance Committee as required and take an active part in other committees established by the Board of Directors to exercise delegated responsibility.

Human Resources

- As a member of the Board's Nominations and Remuneration Committees to appoint, remove, support, encourage and where appropriate 'mentor' Executive Directors.

- To contribute to the determination of appropriate levels of remuneration for Executive Directors.

- To take responsibility, in conjunction with the Board, for his/her own personal development and ensure that this remains a priority.

- To actively support and promote a positive organisational culture and reflects this in her/his own behaviour.

Operations

- To maintain the highest standards of conduct and integrity within the Trust and ensure compliance with best practice and statutory and regulatory requirements in all matters, including financial, governance, legal and clinical quality issues.

- To assist fellow directors in setting the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives, and that performance is effectively monitored and reviewed.

- In accordance with agreed Board procedures, to monitor the performance and conduct of management in meeting agreed goals, objectives and statutory responsibilities, including the preparation of annual reports and annual accounts.

- To obtain assurance that financial information is accurate and that financial controls and risk management systems are robust and defensible.

- To ensure the provision of accurate, timely and clear information to Directors and Governors, so that within the boundaries of probity, good governance and risk, the Trust meets all its statutory objectives and remains compliant with its terms of authorisation.

- To use general management and leadership ability and personal knowledge of the community to guide and advise on the work of the Board of Directors and Governors of the Trust.

- To encourage the best use of resources including the development of effective risk and performance management processes.

- To be aware of and understand relevant regulatory and Central Government policies; and comply at all times with the Trust's published health and safety policies, in particular, by following agreed safe working procedures and reporting incidents, using the Trust's risk reporting systems.

Communication and relationships

- To engage positively and collaboratively in Board discussions.

- To ensure effective and constructive dialogue and productive relationships are promoted with the following bodies as relevant:
    - Board of Directors;
    - Council of Governors;
    - all stakeholders in the Trust's community;
    - national healthcare stakeholders; and
    - regulators such as Monitor and the Care Quality Commission

- To participate fully in the work of the Board of Directors and of Governors and maintain appropriate links with the Chief Executive and individual Executive Directors, as well as with the wider local and national health and social care community.

- To represent the Trust's views with national, regional or local bodies or individuals and ensure that the views of a wide range of stakeholders are considered.

- To uphold the values of the Trust, to be an appropriate role model and to ensure that the Board promotes equality and diversity for all its patients, staff and other stakeholders.

- To be an ambassador for the Trust in engagement with stakeholders including the local community, dealing with the media in accordance with Trust policy.

- To be knowledgeable and aware of local issues.

- To set an example on all policies and procedures designed to ensure equality of employment. Staff, patients and visitors must be treated equally irrespective of gender, ethnic origin, age, disability, sexual orientation, religion, etc.

- To promote public understanding of the Trust's values, objectives, policies and services.

- To adhere to the core standards of conduct expected of all NHS managers in accordance with the *Code of Conduct for NHS Managers*.

This job description is indicative of the range of duties for the postholder. It is not intended to be exhaustive and changes will be discussed with the post holder.

The Chair will agree specific objectives with the post holder on an annual basis.

Trust Policies

It is a requirement for all staff to comply with all infection control policies and procedures as set out in the Trust Infection Control manual.

Working towards equal opportunities

The Trust is no smoking site

All posts are open to job share unless indicated otherwise

The Trust is committed to carefully screening all job applicants to ensure the safeguarding of children

Successful candidates to the Trust will be required to complete a Criminal Records Bureau check

Alder Hey Children's NHS Foundation Trust is committed to supporting all staff to balance work and other life needs. This is the responsibility of all employees and will be achieved by consultation, open communication and involvement of all team members. The Trust operates a Flexible Working Policy that is available to all staff.

Alder Hey Children's NHS Foundation Trust is committed to achieving equal opportunities in employment. All employees are expected to observe this policy in their behaviour to the public and fellow employees.

All individuals will have some risk management responsibilities with which you are required to comply, for details of your responsibilities please refer to the current Risk Management Strategy which is available on the intranet and in the local strategies folder.

It is the responsibility of all staff to recognize their role in maintaining a safe environment for patients, visitors and staff; to minimize the risk of healthcare associated infection. Employees are responsible for ensuring that they are fully aware of the Trust's infection prevention and control policies, the post holder will undertake infection control training as required by the position.

The Trust is committed to developing an environment that embraces diversity and promotes equality of opportunity.

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 25th April 2022 at 13:00, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Claire Liddy	Managing Director of Innovation	(CL)
	Rachel Lea	Acting Director of Finance	(RL)
	Anita Marsland	Non-Executive Director	(AM)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Sue Brown	Associate Development Director (Campus)	(SB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Mark Carmichael	Associate Chief Operating Officer	
	Mark Flannagan	Director of Communications	(MF)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Catherine Kilcoyne	Deputy Director of Business Development	(CK)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 15	Graeme Dixon	Head of Building services	

22/23/01 **Apologies:**
No apologies were received for this meeting.

22/23/02 **Minutes from the meeting held on 28th March 2022**
The minutes were approved as a true and accurate record.

22/23/03 **Matters Arising and Action log**
Reforecast of the Telehealth/Second Opinion Project
RABD noted the revised scope of the pilot within the paper. One of the changes being removal of the second opinion and replace with pier to pier, this would be following other Trust's services. Alfie Bass requested that the first pilot takes place with one speciality.

RABD discussed the breakeven position and whether this was an accurate reflection as admin fees had not been included. Given the revised proposal this will have a negative impact on the financial plan 2022/23.

Resolved:
RABD received the reforecast of the above paper and agreed there was a requirement to continue.

The Chair noted all actions for this month are included as an agenda item.

22/23/04 **Declarations of Interest**
There were no declarations of interest.

22/23/05 **RABD Workplan**
To Agree the five top risks for 2022/23

Following a discussion RABD agreed for 2022/23 there were 6 risk areas to be reported on:
Cash/Capital, Cost Improvement Plan, Benefits Realisation, Campus, Productivity, Alder Care.

Resolved:
RABD agreed 6 risks for 2022/23 as above.

22/23/06 **Finance Report**
Month 12 Financial Position
In-month trading deficit of £935k in March with the year-end position for 21/22 a £137k surplus against the breakeven plan. RABD noted the year end achievements and areas of challenge resulting in the overall position. Capital spend was in line with plan.

An update was provided in relation to going concern and the basis of the annual accounts, RABD noted auditors had been content following the April Audit Committee.

Resolved:
RABD received and noted the M12 Finance report.

22/23/07 **2022-23 Plan**
RL presented slides on the latest position noting the final submission would be made on 28th April 2022. The three main headlines are: Breakeven Plan, CIP Target, ERF Income. Changes since the draft and final plan was shared with RABD.

Resolved:
RABD supported the final submission and plans noting focus and scrutiny that will be required going forward.

22/23/08 **Medicine Division: Mitigation Plan and Benefit Realisation**
MC reported on the 84% delivery of the CIP target for 2021/22, the remaining gap has been included in the 2022/23 CIP.

Resolved:
RABD noted the Medicine Division 2021/22 CIP and future plans.

22/23/09 **Capital Update**
Resolved:
RABD noted the details of the paper with a finalised cash position to be received in April.

22/23/10 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
Resolved:
RABD received the Campus and Park paper.

22/23/11 **Innovation and Commercial Activity**
CL went through the paper highlighting the revenue generation and business development activities in Innovation from 21/22, confirmed revenue generation and opportunities for 22/23. This was broken down into three categories:
Inward Investment – successes
Inward Investment – In kind business development
Inward Investment – Future submissions

Resolved:

RABD noted and received Innovation and Commercial Activity from 2021 onwards.

22/23/12 **Digital Future Strategy**

KW highlighted:
Alder Hey and Meditech continue to work together towards a Go Live date of Sep/Oct 2022.
Response rates to Freedom of Information requests have improved.
Outcome following the Digital Merseyside Internal Audit Agency review was substantial, this is one away from the highest recognition received from MIAA.

Resolved:
RABD received and noted the bi monthly digital report.

22/23/13 **Month 12 Corporate Report (starred item – only questions/answers will be noted)**

Resolved:
RABD received and noted the M12 Corporate report.

22/23/14 **Communications update (starred item – only questions/answers will be noted)**

Resolved:
RABD received and noted the communications paper.

22/23/15 **PFI Report**

GD highlighted:
Energy continues to be higher in relation to the increased requirements need for ventilation.
Pipe work survey is in progress, number of incidents have been reported. An external company are due to commence to improve water quality, a start date is to be agreed.
Access routes continue to be developed in relation to drainage/road issues next to the Helipad, work is due to be completed within 8 weeks.
Project Co discussions are ongoing.
KW noted the mobile signal boost that has been implemented within ED and the positive difference it has made.
KW noted Energy increase and asked for details on plans in place. It was agreed an update would be received at the May RABD both on energy and inflation pressures.
Action: Alex Pitman

Resolved:
RABD received and noted the M12 PFI report as well as the current commercial position.

22/23/16 **2021/22 Committee Annual Report**

Under Principal Review Areas/Achievements in 2021/22, the Chair asked for the two deep divisional dives in Surgery and Medicine to be included.

Resolved:
Subject to the above amendment RABD approved the 20/21 Committee Annual report.

22/23/17 **Board Assurance Framework**

The risks around inflation of costs are to be captured within the BAF.

ES provided positive feedback following MIAA assurance review at the April Audit Committee.

Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/18 **Any Other Business**
No further business was discussed

22/23/19 **Review of Meeting**
The Chair noted challenges moving forward including inflation, 6 risks approved for 2022/23.

Date and Time of Next Meeting: Monday 23rd May 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th May 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	18th May 2022 – Summary 27TH April – Approved Minutes
Report of:	Fiona Beveridge, Chair, Safety Quality Assurance Committee
Paper Prepared by:	Julie Creevy, CQAC Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 18th May 2022, along with the approved minutes from the 27th April 2022 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

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

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

2. Agenda items received, discussed / approved at the meeting at the meeting held on 18th May 2022

- Quality Priorities Monthly update was received, which highlighted good progress made by teams, with strong engagement of teams. Noted that these priorities are in the process of being refreshed for 2022-23
- Assurance ED Activity Monthly Update received
- Level 2 Comprehensive Root Cause Analysis – Investigation into the Major Trauma Care Pathway following a Catastrophic injury involving a fireplace. Good discussion held detailing actions that had been put in place to address any recommended actions/learning, with ongoing work progressing.
- Organ Donation Annual Report was received, SQAC NOTED the new ongoing work planned.
- Transition Update was received, SQAC had a detailed discussion regarding current Transition position. SQAC agreed that NA would work with Associate Chief Nurses to define, design and develop metrics in order to track progress, to be included within future Transition Reports, to present Divisional Led Transition reports to SQAC. SQAC acknowledged the requirement to escalate Transition within the wider system regarding factors preventing transition taking place might be necessary on occasion.
- Aggregated Analysis Report received, SQAC NOTED the ongoing work regarding format of the Aggregated Analysis Report, and the clarity that this provides to SQAC.
- SQAC received and NOTED the Quarter 4 Patient & Family Feedback Quarterly report.
- SQAC received the Clinical Audit Annual Plan, and NOTED the significant progress made throughout the year.
- Quality Account was endorsed and NOTED
- Patient Information Leaflet Policy – M13 was received and RATIFIED
- RM47 – Duty of Candour Policy – was received and RATIFIED
- Divisional updates regarding highlights and challenges were NOTED

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

None

4. Positive highlights of note

SQAC NOTED and commended the much improved response rates with regards to Complaint responses.

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
Minutes of the meeting held on
Wednesday 27th April 2022
Via Microsoft Teams

Present:	Kerry Byrne	Non-Executive Director (Chairing meeting)	(KB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Pauline Brown	Director of Nursing	(PB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	John Grinnell	Deputy Chief Executive	(JG)
	Adam Bateman	Chief Operating Officer	(AB)
	Urmi Das	Director – Medicine Division	(UD)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Christine Hill	Pathology Manager, Safety Lead	(CH)
	Dame Jo Williams	Trust Chair	(DJW)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Alfie Bass	Interim Chief Medical Officer	(ABa)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Christopher Talbot	Safety Lead – Surgery Division	(CT)

In attendance:

	Leila Brown	Digital Programme Manager, Programme & Projects	(LB)
22/23/05	Jennie Williams	Head of Quality Hub	(JW)
22/23/05	Bethany Richards	Quality Improvement Project Manager	(BR)
22/23/05	Andrea Gill	Clinical Pharmacy Services Manager	(AG)
22/23/10	Sarah Balogh	Governance Lead, Medicine	(SB)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
22/23/17	Andy Darbyshire	Nurse Consultant Paediatric Critical Care & Long Term Ventilation, Chair of Clinical Ethics Committee	(AD)
22/23/19	Harriet Corbett	Consultant Paediatric Urologist, Associate Divisional Research Director	(HC)
	Garth Dallas	Non Executive Director	(GD)
	Jill Preece	Governance Manager	(JP)
	Natalie Palin	Associate Director of Transformation	(NP)
	Cathy Umbers	Associate Director of Nursing & Governance	(CU)

22/23/01 Apologies:

Fiona Beveridge	Non Executive Director, SQAC Chair	(FB)
Adrian Hughes	Deputy Chief Medical Officer	(AH)
Dani Jones	Director of Strategy	(DJ)

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

22/23/02 Declarations of Interest

SQAC noted that there were no items to declare.

22/23/03 Minutes of the previous meeting held on 23rd March 2022 –

Resolved: KB

Subject to two minor amendments on page 6 of the notes members were content to **APPROVE** the minutes of the meeting held on 23rd March 2022.

22/23/04 Matters Arising and Action Log

Action Log

KB referred to Page 10 of the notes, with regards to mental health demand and capacity and associated non-recurrent funding. KB questioned whether discussion should take place at Trust Board to consider whether a BAF risk is needed in this regard. DJW advised that there is a need to be sighted on this issue. LC advised that there are risks on the Divisional Risk Register relating to capacity and demand. KB advised that it is referred to within the BAF strategic risk regarding access but is a separate risk needed?. LC clarified that funding is recurrent.

AB confirmed that there is a strategic risk regarding access, and stated that this is quite broad, and given the level of demand and challenges for Community & MH that there may be merit for offline discussion regarding whether there should be access for planned services and access for mental health services separated.

Resolved: offline discussion to be held with AB & LC, with update to be received at May 2022 meeting.

Transition Plan on a page update, SQAC noted that Quarter 4 Transition Report and Transition "plan on a page" is due to be presented at May 2022 meeting.

Update on Medical Examiner current position; ABa advised that a meeting had been arranged with the Regional ME, with AH Mortality Lead and Mortality Leads from Manchester Children's NHS Foundation Trust for 17th May 2022. It is hoped that the MEwill be able to apply some pressure to colleagues at Liverpool University Hospital Foundation Trust (LUFT), in order to assist Alder Hey with regards to a Medical Examiner, given that the previous request to LUFT for ME support had been refused. ABa advised that he had been in discussions with the incoming LUFT Medical Director who is due to commence in post at the end of June/early July 2022. ABa advised that should the discussion on 17th May 2022 not result in positive support, that ABa and the CMO at Manchester Children's NHS Foundation Trust would attempt to create a ME joint post with an appropriate rota to support the ME role. Deadline for creation of the ME post has been extended from April 2022 to September 2022. ABa confirmed that a further update would be provided at the July SQAC meeting, or earlier should the discussion on 17th May 2022 enable an appropriate solution.

Resolved: SQAC to receive a ME update at July 2022 meeting.

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

Ockenden Report phase one

NA presented the Ockenden Review Report, which related to the outcome of the independent review of maternity services provided by the Royal Shrewsbury and Telford (RST) NHS Trust. NA advised that a trust-wide action plan will be developed which would be monitored through SQAC, and presented to Trust Board for information and approval at the June 2022 meeting. 20 recommendations would be incorporated into the Action Plan, with 6 main themes – staffing levels, a well trained workforce, learning from incidents, listening to families, neonatal, and additional learning. NA advised that Trust Board would receive a 1 page summary at the May 2022 meeting.

DJW thanked NA for thoughtful and rigorous process which had been undertaken in creating the Ockenden update. DJW stated that she was surprised by the number of actions that are required for the Trust. NA advised that many of the actions within the action plan should be relatively swift and that our approach would be to fully review the report findings that may be applicable to Alder Hey.

JG referred to improvements/learning/patient safety and experience and highlighted the importance of this.

KB referred to the culture across the organisation and questioned whether further work across the organisation is required in order to understand variables across the organisation in terms of culture. NA advised that both NA and ABa had discussed this issue; NA advised that this would be within the Patient Safety Workplan, NA and ABa would review and discuss offline.
KB welcomed review of the full Action Plan at June 2022 SQAC meeting.

Resolved: offline discussion to take place with NA & ABa

Resolved: SQAC received and **NOTED** the content of the Ockenden Phase 1 Update and approved the suggested approach to learning from the Ockenden report, and the onward development of a Trust level action plan.
SQAC would monitor the Action Plan and welcomed review of the Action Plan at the June 2022 meeting.

Quality Improvement Progress Reports

22/23/05 Quality Priorities Monthly update

JW presented the Quality Priorities Monthly update, which included highlight summary progress reports, and a deep dive on Medication Safety.

Deteriorating patients – progress had been limited due to the absence of operational team's members due to Covid and leave. Data collection and trial of the pathway is in progress. Team are radically amending the data collection to support the ease of reporting and to align into the new surveillance model to ensure real time data collection. Steering Group agreed a refresh to the project plan and this work will be monitored through the Patient Safety Board.

Parity of Esteem – Good progress had been made with regards to purchasing the training package through partners 'We can talk'.

- MH Champions had been reinvigorated.
- Team are liaising with L&D colleagues to ascertain whether there is an opportunity to make this training mandatory for all staff; team are awaiting a decision from L&D.
- Re-advertised for Nurse Consultant role, due to the previous recruitment process being unsuccessful.

Medication Safety

- Quality improvement work is progressing locally, with scoping and observations continuing.
- Medication safety training, newsletters are disseminated
- Colleagues are awaiting feedback from Investment Review Group regarding the business case for Band 7 and Band 8A posts, following submission in in March

2022. NA advised that this needed to be followed up with colleagues offline, in order to obtain position statement.

- SQAC **NOTED** that the target regarding the reduction of 20% since 2021 had successfully been achieved.

LC thanked colleagues for excellent update and queried whether Community & MH had been included in the data gathering. BR confirmed that Community & MH had been included.

DJW, thanked team for detailed presentation, and referred to the use of red aprons, and questioned how SQAC could support clinical teams to highlight the use of red aprons.

NA suggested that the Medication Safety Team reinforce the messaging around this and ensure leadership at ward level, with the need for a reset, with Ward Managers. This would be addressed within Phase 2 of the programme.

KB welcomed the positive move to mandatory training, SQAC noted the caution that completion statistics for this would commence at zero.

NA advised that going forward the projects would be set up within the Brilliant Basics format, with appropriate project management and leadership support, with each of the safety projects being led and owned by the Associate Chief Nurses within the Divisions.

Resolved: SQAC **NOTED** the significant achievements with regards to the positive achievement of the 20% reduction in the overall medication errors.

SQAC **NOTED** that although the team do not have the full SPC data, SQAC **NOTED** the gradual decline is being represented.

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

Safe

22/23/06 DIPC Exception Report

SQAC received and **NOTED** the DIPC exception report.

KB queried whether the DIPC 2022/23 targets had been set; BL confirmed that there is a meeting scheduled with IT to review and set targets; BL would include an update within May 2022 DIPC report.

Resolved: SQAC to receive update on 2022/23 targets within May DIPC report.

22/23/07 Assurance ED Activity Monthly Update

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

JW referred to the patients who leave ED before being seen and return at another time, and sought clarity whether colleagues are requesting feedback from parents in order to understand why they are leaving and returning, and questioned whether the Trust are examining the reasons patients had left and returned. SB advised that from feedback received, there are a combination of reasons for leaving, - including issues relating to the display board in ED not updating to reflect the waiting time, a number of parents advising that they had felt that their child had improved, and parents had checked other ED's in the area and had presented at other EDs as they had shorter waiting times. SB advised that the notes of the patients who had left prior to

be being seen are reviewed by Consultants, and are followed up as appropriate, with outcome recorded on Meditech.

NA advised that there had been a decline in patient/parent satisfaction within ED, whilst also receiving an increased number of PALS. NA advised that he suspected that parents are leaving as they do not want to wait for longer periods, with further work to do, in order to improve patient satisfaction and improve on waiting times. NA advised that there is a meeting scheduled to take place on 5th May 2022 chaired by JG, with ED and Exec colleagues, in order to discuss how the organisation has an ED that is fit for the future, to enable treatment in a timely way.

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

22/23/08 Quality Assurance Rounds themes and risks

CU presented the Quality Assurance Rounds themes and risks update, key issues as follows:-

- Quality Assurance Round had identified people issues and associated risks which was identified in 4 of the themes, with 2 BAF risks relating to this theme - 2.1 workforce sustainability and development, and 2.2. employee wellbeing, with Trust Board being well sighted on these risks. CU advised that these risks are being managed.
- In addition, there is 1 key operational risk associated with this theme – risk 2100 – risk of inability to provide safe staffing levels which is currently scoring 16. This risk is being monitored by Workforce & Organisation Development Committee, with several controls in place including rigorous staff application of the policy, SALS service which is well utilised by staff and Business Partner support.
- CU advised on another high risk relating to this theme - risk 2415 regarding significant vacancies in key services across Trust. Due to the implementation of the TRAC system, and additional recruitment to the recruitment team, and the achievement of all of the KPI's this risk had been closed.
- Approximately 25-30% of services have no identified risks on risk register, which is clearly a risk for the Trust that requires addressing, and it is highly unlikely that any of those services are risk free.

Recommendation, it would be positive to adopt risk based focus regarding quality at local level, which could be achieved by supporting staff to identify and reports risks as routine, including assessing and mitigating through SMART actions to prevent those risks being realised. KB advised that this was discussed at the previous Audit & Risk Committee meeting, (ARC), and that ARC had requested for additional oversight on risk management training that is provided across the organisation, to ensure assurance. KB referred to the 25-30% of services that don't have risks, and requested CU to share the list of teams that don't have risks to all of the Divisions/Corporate Services and for divisions to review and confirm to the Risk Management Forum (RMF) the outcome of that review.

Resolved: CU to follow up with Divisions to ensure a formal statement of review/scrutiny

KB highlighted the importance of a positive culture regarding the reporting of risks like that in place for reporting incidents and near misses, and that this would be discussed at RMF and ARC, with regards to changing the culture to ensure raising of risks is viewed positively.

DJW advised that it is important for colleagues to receive updates in relation to risks which are reported. This will be reviewed within the divisional governance teams.

Resolved: Action regarding a review of services reporting no risks to be referred to the RMF for delivery. Action regarding the discussion to encourage a positive risk reporting function to be referred to ARC.

KB thanked CU for detailed update.

Resolved: SQAC received and **NOTED** the Quality Assurance Rounds themes and risk update.

22/23/09 Patient Safety Strategy

NA presented the Patient Safety Strategy update .NA advised on the formation of a Patient Safety Board to oversee the various workstreams that are required to deliver the Patient Safety Strategy. Patient Safety Board would meet on a monthly basis, and would report into SQAC. The aim is to move all safety related activity into the Patient Safety Board. The 18 workstreams have been prioritised and will initially focus on review of safety metrics, NPSA alerting processes, education & training, appointment of patient safety specialists, deteriorating patients and sepsis.

Projects would require rapid working groups to be established, with senior leadership that would enable development of improvement plans, and this would form the focus of the Patient Safety Board for the first 6 months. ABa stated that the creation of Patient Safety Board would ensure streamlined information and pathways, and advised that there will be relatively prompt improvements made, however there are some issues which may take longer to address, up to a 2 year period to resolve, with ongoing work required. ABa stated that the Patient Safety Board would reduce silo working and improve efficiency across the organisation.

NA expressed thanks to W Weston & C Talbot for ongoing work to support patient safety and ongoing support provided to NA & Aba.

LC highlighted the importance of ensuring that the Patient Safety Board meetings are clear, concise and very action focussed, whilst thought is required regarding ensuring who are the most appropriate colleagues within divisions to attend, to ensure that the meetings are action focussed. NA agreed that the attendance list would be reviewed to ensure appropriate representation.

KB referred to one of the priorities “children and young people and the families as safety partners” and stated that this is currently recorded as priority 3. KB stated that this did not feel correct, and queried whether the voice of children and young people should be made at the start of the process, in order to inform all of the other priorities. NA agreed and stated that it is complex interlinking with our CYP involvement approach being developed as part of the quality strategy.

KB thanked for NA & ABa for comprehensive Patient Safety Strategy update.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy update, and supported the establishment of a Patient Safety Board, which would report into SQAC.

22/23/10 Sepsis Update

SB presented the Sepsis Update; key issues as follows:-

- Division are awaiting the Sepsis Nurse to commence in post, colleagues are currently monitoring sepsis information within the BI dashboard on a daily basis, given that the validation has not been able to take place. Following daily review no patients had been identified as not receiving antibiotics within 1 hour period, patients had received antibiotics, or had been excluded from the data during the

validation process.

- Risk is still included on the Risk Register, as the Sepsis Nurse had not yet commenced in post.
- Within ED, the Sepsis Nurse is monitoring the data, and had reported that any antibiotic delays are due to difficulty in IV access or undertaking lumbar punctures, and any such delays are being reported on Ulysses, and are being reviewed as incidents, to gain any understanding and learning, with reminders also being issued regarding importance of IV access and detailing next steps for staff experiencing difficulty in administering IV access.

KB referred to a step change improvement within KPI's approx. two years ago, and since then difficulty obtaining IV access regularly provided as a reason for not meeting the KPIs. KB asked whether, as the Trust is not regularly achieving KPI's, are there are fundamental issues that require addressing to ensure a further step change improvement.

Discussion took place regarding the current difficulties with the absence of data validation due to the lack of a Sepsis Nurse. KB stated that not achieving the data validation should not be dependent on one member of staff and queried whether there was another colleague who could complete the validation. The team stated there were on going challenges with the current process.

NA advised that there is a requirement for a refocus to ensure that focus is given on providing children with appropriate antibiotics within the 60 minute target, in order to achieve lifesaving drugs in sufficient timeframe. NA advised that this would be addressed offline, in order to agree a step change regarding culture, with SQAC receiving an update on outcome of discussions at May 2022 meeting, with a Sepsis Monitoring Plan to be presented to SQAC at June 2022 meeting.

Resolved: Offline discussion to take place between ABa and UD
Resolved: SQAC to receive update following offline discussion at May 2022 meeting. SQAC to receive Sepsis Monitoring Plan at June 2022 meeting.

Resolved: SQAC received and **NOTED** the Sepsis update

Clinical Governance Effectiveness

22/23/11 CQSG Key issues update

NA advised that CQSG had focussed on a range of governance metrics and targets.

- Phenomenal work had taken place regarding policies, guidelines and information leaflets.
- Progress had been made with regards to NICE guidelines, with further work still required.

KB thanked NA for CQSG Key issues update.

Resolved: SQAC received and **NOTED** CQSG verbal CQSG key issues update.

22/2312 CQSG Annual Report, including CQSG Terms of Reference

SQAC received the CQSG Annual Report, including CQSG Terms of Reference.

Resolved SQAC received and **NOTED** the CQSG Annual Report

22/23/13 NICE Compliance summary position

CU presented the NICE Compliance summary position for the period 1st March – 31st March 2022. CU reported that staff are working extremely hard to address NICE Compliance.

- 51 NICE publications open, including 9 technology appraisals within the Division of Medicine
- 0 assessments had been completed and closed, and 0 with substantial progress
- 4 had made minimal progress
- 7 had made no progress
- Technical appraisals in Medicine – no progress made in month

KB requested clarification regarding Technology Appraisals and sought further detail regarding the terminology. CT advised that these usually relate to a new device, medication or surgical procedure and that there are recommendations made by NICE which are required to be reviewed.

KB requested assurance from Divisions with regards to lack of progress made during March 2022 and sought assurance that refocus had been provided during April 2022 to review improved progress for the May 2022 update.

CT advised that all assessments had been undertaken within the Division of Surgery, with continued progress being made within the Division, CT stated that a number of actions would take a longer time period to implement. CT provided assurance that progress is being made within Division of Surgery, and that the Division would continue to strive to make sustained improvements.

KB queried whether there was a nuance required within the report and referred to longer term actions and how this is reflected. KB suggested that rather than stating no progress, it would be more useful to detail whether the action is on track/target, SB would liaise with Jo Gwilliams to ensure improved reporting to reflect the current status. UD referred to assurance being Trust-wide, and not just the Medicine Division. UD questioned whether there could be standardised working across the Divisions with regards to Technology Assessments, in order to improve reporting and ensure that the divisions are consistently reporting. It was agreed this should be worked on collectively by the divisions.

JG stated that on review of the NICE update it is unclear what risks the organisation currently has in terms of compliance re NICE guidelines. NA advised that the Divisional teams need to meet with Governance Team to reflect the important points made in this discussion. NA acknowledged the phenomenal work which had taken place to address NICE compliance, with further improvements to be made.

Resolved: CU and Governance Team would follow up with Divisions, to ensure that Divisions are consistently reporting, and ensure any improved reporting is reflected within the current status, to ensure an accurate report is shared at SQAC, whilst acknowledging and addressing JG's comments regarding clarity on themes and risks across the organisation.

Resolved: SB would liaise with Jo Gwilliams to ensure improved reporting to reflect current status.

Resolved: SQAC received and **NOTED** the NICE Compliance summary position.

KB thanked CU for NICE Compliance summary position.

22/23/14 Board Assurance Framework

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

KB referred to MH and her comments earlier regarding whether there is a need for a separate BAF risk.

23/23/15 Divisional Report/Quality Metrics update

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

- Division had zero serious incidents resulting in harm
- Division had zero grade 3 or grade 4 pressure ulcers
- Continued admission of patients to Ward 4C
- 1 young person detained under Section 3 of the Mental Health Act
- Increase in reporting of incidents relating to self-harm and provided assurance those incidents are being reported in a timely manner and being responded to appropriately
- FFT scores remain over 90%
- Slight increase in PALS, regarding waiting times for assessment for ASD/ADHD appointments
- 4 formal complaints
- Division recorded the highest number of referrals for ASD/ADHD – 1724 referrals in total during March 2022. This had been escalated to CCG and to Local Authority. LC advised on a Liverpool SEND inspection during w/c 2nd May 2022.
- The Division had recruited to a number of key roles, Children in Care Lead Named Nurse had commenced in post in early April 2022, and the Associate Director of Safeguarding had been appointed, and is due to commence in post in May 2022.

KB acknowledged that within the Community & Mental Health Division there are significant ongoing challenges with regards to continuing increase in demand for services.
DJW highlighted the importance and clear need to escalate as a national issue across C&M, the importance of CCG escalating to NHSE. LC stated that a new pathway had been launched within Alder Hey and advised that the demand for services within the Division had been escalated regularly to the CCG, Local Authority, and Social Care and to NHSE nationally.

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

- UD advised that good progress is being made by Governance Team within the Division
- 20 complaints received from 1st January 2022
- 1 breach over the 25 day period, which is currently being investigated
- Good engagement within teams within the Division to address risks and complaints
- Locum Consultant commenced in post on 1st April 2022 to reduce waiting lists within General Paediatrics with a Second Consultant due to commence in post in June 2022

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

- CT commended the Division for 1 year of no never events, work continues on STAT programme and “Stop before you block”.
- Division are preparing to implement the new national guidance on prep stop block, with dissemination completed to anaesthetists and surgeons.
- Mandatory training is almost at 90%
- There had been a decrease in PALS and complaints

- Theatre utilisation had increased, almost at 90%
- Waiting lists continue to increase, with ongoing work across the Division. CT commended the Division on ongoing work to address safe waiting lists within the Division, and the additional work being undertaken by colleagues in order to reduce waiting lists.

PB advised that the Trust had recently met with NHSI with regards to progress regarding the never event. NHSE were extremely pleased with the work undertaken by Theatre Team and had stood down this case. NHSI continue to monitor the action plan through CQRM which is routine process.

NHSI are keen to arrange a Quality Summit to share exemplar work of organisations and are keen for Alder Hey to present.

KB thanked the Divisional Leads for the Divisional Updates.

Committee **NOTED** the pressures across each of the Divisions within services, resulting from high clinical workload, coupled with staffing issues.

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

22/23/16 SQAC Annual Report

SQAC received, **NOTED** and supported the 2022 SQAC Annual Report

22/23/17 Clinical Ethics Committee Annual Report

AD presented the Clinical Ethics Committee Annual Report and provided an overview of background of the Clinical Ethics Committee and main functions of the Committee.

- Committee continues to approach individual case discussions with a structured approach utilising differing models of ethical consideration; the mainstay of this approach being the IDEA framework. Processes and deliberations leading to outcome of support of clinicians and families is responsive, inclusive, reasonable, open and transparent and accountable.
- Alder Hey Clinical Ethics had participated in the RESTORE ethics research project to review aspects of pandemic ethics and moral distress from a paediatric perspective.
- Clinical Ethics is to present the work of both the Clinical Ethics Committee and Clinical Decision-Making Committee on 29th April to inform the wider organisation of the work. Clinical Ethics Chair is also due to present at Grand Round on 29th April, in order to raise Clinical Ethics profile.
- Committee had commenced work towards education and training support of both committee members and staff, as a valuable contribution for caring for staff who may face ethics dilemmas or moral distress in the course of their work.
- Challenges regarding improving the profile of the clinical ethics support and raising awareness/ and integrated with Clinical Decision making committee.
- AD acknowledged the ongoing dedication and support of all members of the Committee who work on a voluntary basis and give up their time so generously to support its work. AD also acknowledged the admin support provided for the Committee.

DJW expressed huge thanks to AD and Clinical Ethics Committee members and stated that expenses should be paid for those incurred for Clinical Ethics Committee members.

KB asked that a review be undertaken into the issues, challenges and recommendations presented in this report with a report back to SQAC. It was advised that this will be led by JG, liaising with AD, ABa and AH to agree a reasonable timeframe for review. JG would

undertake an offline discussion with AD/ABa and AH and SQAC to receive an update in July 2022 with a formal plan.

Resolved: SQAC received and **NOTED** the Clinical Ethics reports and **NOTED** the recommendations, offline discussion to take place led by JG, ahead of SQAC receiving an update at July 2022 meeting with a formal Clinical Ethics plan.

22/23/18 External Visits/Accreditation Report

SQAC received and **NOTED** the External Visits/Accreditation Report.

22/23/19 Research Annual Report

HC presented the Research Annual Report and reminded colleagues that the Research Division has a very different role to other divisions and that the core business is setting up research studies which are commissioned either within the Trust or from external partners. The Division are focussed on ensuring that studies take place safely, reporting to a number of regulatory bodies - MHRA, Research Ethics Committee, Health Research Authority, Human Tissue Authority, Gene Therapy Advisory Committee.

HC advised that there is significant pressure regarding staff turnover, and that staff replacement will be a challenge. The team leading the clinical research facility had achieved funding of £2M for a five year period. HC reported that Prof M Beresford had stepped down and Dan Hawcutt & Jo Blair would lead on this.

KB thanked HC for informative update, together with the level of detail and referred to the statistics within the caring section which were helpful.

KB requested that any risks regarding staffing be included on the Risk Register.
Resolved: SQAC, received and **NOTED** the Research Annual Report.

22/23/20 High Profile Patients and Visitors Policy RM69

SQAC received and **RATIFIED** the High Profile Patients and Visitors Policy RM69

External Communication Policy – M23

SQAC received and **RATIFIED** the External Communication Policy – M23

22/23/21 Any other business

NA advised that this was Cathy Umbers last SQAC meeting, ahead of Cathy moving to her new role at the Countess of Chester. NA formally thanked CU for her continued support to date.

On behalf of SQAC, KB thanked CU for continued support provided to SQAC and the organisation.

KB advised that ARC had received the Clinical Audit Annual Plan, and that it should be shared at SQAC at May 2022 meeting.

Resolved: Clinical Audit Annual Plan to be included on Workplan for May 2022 meeting.

22/23/22 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- SQAC received Ockenden Report
- Quality Priorities – updates received
- Patient Safety Strategy received and establishing a Patient Safety Board
- Good discussion held regarding sepsis, and agreement to address cultural aspects

- Clinical Ethics, review how this is performed more formally
- Research Annual Report
- SQAC received divisional updates, and recognised pressures which all of the Divisions are under, with good progress being made.

21/22/225 Date and Time of Next meeting

18th May 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Approved Minutes of the last meeting held on 25th April 2022
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Melissa Swindell	Chief People Officer
	Adam Bateman	Chief Operating Officer
	Nathan Askew	Chief Nurse
	Erica Saunders	Director of Corporate Affairs
	Rachel Greer	ACOO – Community & Mental Health
	Mark Carmichael	Associate COO – Medicine
In attendance:	Sharon Owen	Deputy Chief People Officer
	Pauline Brown	Director of Nursing
	Phil O'Connor	Deputy Director of Nursing
	Jo Potier	Associate Director of Organisational Development
	Katherine Birch	Director – Alder Hey Academy
	Maria Salcedo	HRBP - Surgery
	Clare Shelley	Associate Director of Operational Finance
	Jason Taylor	Acting Associate COO – Research
	Dot Brannigan	Governor
	Amanda Graham	Executive Assistant (Minutes)
Apologies:	Fiona Beveridge	Non-Executive Director
	Ian Quinlan	Non-Executive Director
	Mark Flannagan	Director of Communications & Marketing
	Alfie Bass	Acting Chief Medical Officer
	John Chester	Director of Research & Innovation
	Urmi Das	Director, Division of Medicine
	Lisa Cooper	Director of Community & Mental Health Services
	Claire Liddy	Managing Director, Innovation
	Rachel Hanger	Associate Chief Nurse - Surgery
	Cath Wardell	Associate Chief Nurse – Medicine
	Jacqui Lyons-Killey	Associate Chief Nurse – Research
	Ayo Barley	Head of Equality, Diversity & Inclusion
	Adrian Hughes	Deputy Medical Director

22/23/001 **Declarations of Interest**
Fiona Marston – Liverpool School of Tropical Medicine

Introductions
None received.

22/23/002 **Minutes of the previous meeting held on 22nd March 2022**
Resolved : The minutes of the last meeting were approved as an accurate record.

22/23/003 Matters Arising and Action Log

No matters arising. The action log was updated accordingly.

22/23/004 People Plan Report

MKS advised that the update report on the Trust's People Plan was included in the pack and would be taken as read. SO noted that an update on sickness absence & trends will be brought to the May meeting.

Resolved: PAWC received and noted the update of the People Plan

22/23/005 Communications Update

MKS advised that the Communications report was included in the pack and would be taken as read, noting that website & intranet development are moving ahead and a full update will be brought to the next meeting.

Resolved: PAWC received and noted the Communications Update

22/23/006 Staff Survey Action Plan

MKS shared slides detailing the high-level actions following publication of the Staff Survey results. These will focus on:

- Quality of appraisals – work ongoing for 2022/23 with full review for 2023/24
- Health & wellbeing (burnout) – HWB framework being developed & will be launched through refreshed HWB Group
- Equality Diversity & Inclusion – EDI Steering Group now in place with an update to follow

FM asked that all seen and unseen disabilities are included within the remit of the Group; MKS responded that staff have been very clear on what they would like to see, which is a network in line with the BAME taskforce.

Resolved: PAWC received and noted the update on Staff Survey

22/23/007 'Flowers – Average Pay During Leave' Report Update

ND shared slides giving an overview of the 'Flowers' report, detailing the background and work undertaken to implement the National Agreement made in 2021 and noting those activities which are not centrally funded by NHSE.

NA noted the large amount of work that has been done and asked whether it would be simpler to stop overtime and for staff to go onto NHSP for bank shifts; ND replied that while in theory it would be easier, that would not take into account payments for any on-call or additional hours undertaken by staff. It would also be quite difficult to impose, would take a lot of work to implement and would need agreement from all staff. NA responded that he would be keen to explore this alongside having auto enrolment onto bank at time of joining with all additional hours paid that way.

MC asked whether annual leave should be added onto E-Roster for those staff not yet using it; ND replied that in theory yes, but everyone would have to be on E-Roster at

the same time otherwise there will be potentially some imbalances created based on length of service. There will need to be assurance that everyone is on the system before implementation and it needs to be taken through JCNC because of the impact on staff of the changes.

MKS noted concurrence that life would be simpler if all staff were on NHSP but that there is still some work to be done and would like to formally thank ND for all the work done on this. Next steps will be to take to JCNC and progress with the trade unions, then to bring this back in three months for an update.

Action: 22/23/007.1 – 'Flowers' work to update in 3 months (ND)

Resolved: PAWC received the report on 'Flowers' and its implications

22/23/008 EDI Steering Group Update

MKS gave a brief update on progress with the newly-formed Equality, Diversity & Inclusion (EDI) Steering Group, noting that it will be chaired by Garth Dallas and the first meeting is expected to take place in May. Focus will predominantly be on race, disability and LGBTQ issues with possible exploration of some gender issues. Membership and Terms of reference are to be drawn up and agreed.

ES offered to have a conversation offline around support for staff to ensure membership was drawn from all levels of the organisation and participation enabled.

FM asked how the Group would link into PAWC; MKS confirmed this would be by AB who would bring regular reports from the Group, with delegation when required.

Resolved: PAWC received an update on the EDI Steering Group

Governance

22/23/009 Corporate Report Metrics – March 2022

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

Trust Metrics

Community & Mental Health – RG shared highlights, noting that focus for the last month has been on the new process for PDRs and the wider window. It is expected that reporting may need to change to show compliance as a result of the longer period. There has been a slight increase in sickness absence through March which has dropped again as at last week and work has been ongoing with HRBP on return to work compliance, which has seen positive results. There has been a deep-dive into why staff have been leaving with a significant number due to the end of FTCs and an increase in those leaving for personal reasons, relocation or taking on other responsibilities elsewhere. There is no immediate cause for concern but the number of FTC positions ending will have an impact on capacity and with 106 posts within the whole recruitment process there is naturally a focus on time to hire within the Division.

FM asked how the PDR targets will be managed with the new process coming in; MKS responded that there are staged targets, starting with senior staff having their appraisals by end of July and it is expected that monitoring will take place on a 12-

monthly basis but HRBPs will be speaking to their Divisions to discuss how they wish measure and monitor compliance. One aim of the refresh is to improve the quality of PDRs by giving more time to consider and plan for them.

FM asked whether PDRs will be on the anniversary of joining the Trust; MKS advised that Medical staff now have their appraisal in their birth month, the rest of the staff will have theirs at some point across the 12-month window of April to March, ideally planned so they don't all happen at the end of the period.

Corporate – AB noted a real focus on mandatory training within Facilities with an improvement in compliance and determination to get to 90%. Domestic staff have also been undertaking water safety training to address a risk and concern. Also within Facilities there is currently a piece of work preparing facility functions for the new Sunflower House and Community Cluster, with a TUPE process ongoing for OCS staff working at the Dewi Jones unit that is absorbing HR support and management time to ensure completion in the correct way.

Medicine Division – MC shared highlights, noting that the Division's focus on mandatory training has shown some improvement to get to 89% but there is still work to be done with over 100 staff still designated red. Clinical leads have been asked to provide a plan of approach to bring those into compliance. In sickness absence the Division has one of the highest absence rates with very high rates around Ward 4B due to COVID but that is moderated by noting that following progress with long term absences some long term sickness absentees are expected to return in May. Staff retention is not where is should be in some areas, particularly ED and some ward areas but work is ongoing to try and improve that along with feeding into to the Staff Survey response work on reasons for leaving. Time to hire has slipped slightly whilst feeling much slicker so this will be picked up to ensure Divisional delays are not impacting the metric.

Research & Development Division – JTR gave a brief summary, noting that mandatory training remains above 90%. Sickness absence is showing red although only two staff were off with short term sickness in March, with four staff being supported by HR on long term absence and RTW is going in the right direction following support from HR. Two members of staff left in March which has impacted the turnover figures.

Surgery Division – CC shared highlights, observing that the PDR plan will be really useful and that senior staff in the Division have a trajectory that they will have had their PDR by the end of July. Mandatory training is almost at 90% with an approach within the Division for managers to report on their lowest three compliance levels with a plan for improvement. Sickness is being managed well with monthly meetings with HR, however RTW has been challenging as when staff are absent managers will step in which impacts on their management time for completion of RTW. However the Matrons are now supporting with this as it is a real focus. Analysis of staff turnover is being undertaken to understand any underlying issues and time to hire has slipped slightly due to waiting for sign-off causing delays in the process.

FM noted positive views on the changing PDR process and a possible plateau in short term sickness absence which is a continuing concern along with RTW; MKS responded that there will be a detailed sickness update brought to the next meeting. While we are seeing COVID going down we are not seeing other elements of absence going down, suggesting outside influences are impacting on people's working lives, so support for staff to keep them well and in work is an ongoing focus for the HR team.

FM noted that the Time to Hire target is to be reduced to 30 days from 1st May 2022.

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

22/23/010 Board Assurance Framework – March 2022

ES noted that the risks continue to be regularly reviewed and updated, with a gap in assurance identified within the EDI risk. This is being addressed with the new EDI Task Force and will show an impact in coming months as that profile begins to shift.

FM asked for assurance that DBS checks are not a risk for the Trust, in terms of staff who have not had a DBS check; SO responded that there has been a large piece of work undertaken to ensure that is done as part of pre-employment checks. However the next step would be to consider whether to mandate the update service for all staff. ES added that while the CQC had raised an action around DBS checks they did close it following this work so they are happy with the process, but given our risk profile and appetite as a Board for something to go wrong perhaps there is a need to bring something back in more detail. MKS noted that this is ongoing with discussion being held with Staff Side colleagues and it is planned to bring a paper to the Committee.

Action: 22/23/010.1 – DBS to be standing item, with a paper on the update service to be brought to the Committee (SO)

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

22/23/011 Approve Annual Committee Report

FM queried whether having taken over as Chair in November the previous Chair should also be reviewing the Committee's Annual Report; MKS responded that would not be necessary and was confirmed by ES noting that there are other Non-Executive Directors who have had the opportunity to provide assurance on the report's accuracy.

FM noted that there was one point to clarify, that upon being appointed Chair of PAWC, her seat on Audit & Risk Committee was relinquished. ES noted this and confirmed this would be amended.

Action: 22/23/011.1 – Annual report to be amended to reflect FM's relinquishment of seat on Audit & Risk Committee (ES / JP)

Resolved: PAWC received and approved the Annual Committee Report subject to the amendment noted above and attached email confirmation.

22/23/012 Approve Committee Terms of Reference and Workplan for 2022/23

MKS gave a brief overview of the Terms of Reference, noting a refresh of language in line with the NHS National People Plan and of some job titles.

KB asked whether her position on the Committee should be an Invited Member and in terms of the Education Governance Committee, which is noted as a Steering Group but is constituted as a Committee; MKS responded that KB would be a

Member and apologised for the omission and noted the amendment for the Education Governance Committee.

FM asked for groups listed as acronyms to be listed in full for clarity; MKS agreed that this would happen.

MKS gave a brief overview of the Workplan for 2022/23, advising that the focus has been refined to take account of the four major strategic areas around the People Plan which reflects the Terms of Reference. There will be some adjustments made around timing of reports but this is ready for comment.

ES asked whether there should be an annual update on employee relations issues; MKS added that there is a quarterly report to trust Board but nothing formally to PAWC and agreed that this should be discussed outside the meeting.

NB: Due to the meeting not being quorate, approval of these documents will be supported by email confirmation from at least one absentee Non-Executive Director.

Action: 22/23/012.1 – KB to be listed as a Member of the Committee (MKS)

Action: 22/23/012.2 – Annual report on Employee Relations Issues to be added to workplan following discussions outside the Committee (MKS / ES / SO)

Resolved: PAWC received and approved the Committee Terms of Reference and Workplan for 2022/23 subject to the amendment noted above and attached email confirmation.

22/23/013 Policies

There were no policies presented for approval.

22/23/014 Board of Directors Summary

- Staff Stories are to be heard quarterly from June 2022
- Focus on the health & wellbeing of both staff and the organization through the People Plan work; the Staff Survey action plan was shared; and the Health & Wellbeing Group is to be refreshed
- Chair of the EDI Steering Group confirmed as Garth Dallas; ToR are being drafted & membership to be confirmed with first meeting in May 2022
- Absence rates stay concerning with external influences impacting; PDR metrics are expected to be reviewed following changes to the PDR system; there is to be a deep-dive into *Return To Work*; *Time to Hire* target was confirmed as being reduced to 30 days from 40 days from 1st May 2022
- Annual Report, Terms of Reference & Workplan to be approved by offline confirmation as the meeting was not quorate
- Further internal discussions are needed on the impact of the *'Flowers'* report as there is potentially significant impact for some staff
- DBS update / renewals to be a standing item on Action Log

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

22/23/015 The Committee received the approved minutes for the following for information, noted as read.

- Local Negotiating Committee – 28.02.2022

Resolved: PAWC noted the content of the minutes.

22/23/016 Any other business

There were no items raised under Any Other Business

22/23/017 Review of Meeting

FM reviewed the meeting and hoped the Committee found it productive, noting that while not quorate it did finish in record time. FM reflected on points raised within the People Plan item and on the Staff Survey results, noting the good discussions throughout, added that the Committee covered a lot of information and thanked everyone for their input.

22/23/018 Date and Time of Next meeting
23rd May 2022, 9am