Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 28th April, commencing at 9:00am

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**22/23/01**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/02**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/03**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 31st March 2022.**	**D**	Read enclosure
4.	**22/23/04**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/05**	**9:25 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**22/23/06**	**9:35 (30 mins)**	**Operational Plan for 2022/23:** • **Look back at 2021/22;** - **National Paediatric Accelerator: Evaluation.**	A Bateman	To receive and approve the Operational Plan for 2022/23. To receive a year-end overview of operational performance in 2021/22.	**D**	Read report
Strategic Update							
7.	**22/23/07**	**10:05 (10 mins)**	**ICS Development Update.**	D. Jones	To receive an update on the development of ICSs.	**N**	Verbal
8.	**22/23/08**	**10:15 (15 mins)**	**Next Steps in Developing the Trust Strategy.**	L. Shepherd/ J. Grinnell/	To launch the proposed evidence based approach to strategic planning towards the Trust's 2030	**N**	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
				D. Jones	vision.		
9.	**22/23/09**	**10:30 (10 mins)**	**Digital and Information Technology Year-End Update.**	K. Warriner	To provide a digital and information technology update.	**A**	Read report
10.	**22/23/10**	**10:40 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To provide an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
11.	**22/23/11**	**10:50 (10 mins)**	**Alder Hey's Green Plan Progress Report.**	M. Flannagan/ A. Pitman	To receive a progress report on the Trust's Green Plan.	**D**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
12.	**22/23/12**	**11:00 (10 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
13.	**22/23/13**	**11:10 (10 mins)**	**Ockenden Review Update - 2022.**	N. Askew	To receive a briefing on the content of the 2022 Ockenden report and the implications for Alder Hey.	**D**	Read report
14.	**22/23/14**	**11:20 (10 mins)**	**Mental Health Units Use of Force Act (2018).**	L. Cooper	To receive an update on the changes to the Use of Force Act (2018) which came into effect in April 2022.	**N**	Read report
15.	**22/23/15**	**11:30 (10 mins)**	**IPC Update.**	B. Larru	To receive an update on IPC.	**A**	Presentation
16.	**22/23/16**	**11:40 (20 mins)**	**Corporate Report; including an operational update and Divisional updates:** • **Medicine.** • **Community & Mental Health.** • **Surgery.**	A. Bateman U. Das L. Cooper C. Lee	To receive a report on the Trust's performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
Lunch (12:00pm-12:20pm)							

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The Best People Doing Their Best Work							
17.	**22/23/17**	**12:20 (10 mins)**	**People and Wellbeing Update; including:** • **EDI Steering Group update.**	M. Swindell G. Dallas/ M. Swindell	To receive the People and Wellbeing Report. To receive an update on progress.	**A** **N**	Read report Verbal
Strong Foundations (Board Assurance)							
18.	**22/23/18**	**12:30 (10 mins)**	**Recognition of the Trust as a Going Concern.**	R. Lea	For assurance and approval.	**D**	Read report
19.	**22/23/19**	**12:40 (10 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
20.	**22/23/20**	**12:50 (10 mins)**	**Financial Update for Month 12 - 2021/22.**	R. Lea	To provide an update on the position for Month 12 – 2021/22.	**A**	Read report
21.	**22/23/21**	**13:00 (25 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's verbal update from the meeting held on the 21.4.22.** - **Approved minutes from the meeting held on the 20.1.22.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 25.4.22.** - **Approved minutes from the meeting held on the 28.3.22** • **Safety and Quality**	K. Byrne I Quinlan	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
			Assurance Committee: - **Chair's verbal update from the meeting held on the 27.4.22.** - **Approved minutes from the meeting held on the 23.3.22.** • **People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 25.4.22.** - **Approved minutes from the meeting held on the 22.3.22.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 19.4.22.** - **Approved minutes from the meeting held on the 7.2.22.**	F. Beveridge F. Marston S. Arora			
Items for information							
22.	**22/23/22**	**13:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**22/23/23**	**13:29 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 26th May 2022, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in March and April 2022 383: Ainsdale Centre Lease Agreement – Hill Dickinson 384: Southport Centre Lease Agreement – Hill Dickinson 385: Southport Centre Lease Agreement – Hill Dickinson 386: Lease of Land at Ronald McDonald House and Alder Lodge – Hill Dickinson

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M12, 2021/22	R. Lea
DIPC Report	B. Larru

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 31st March 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)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Ms. L. Cooper	Director of Community Services	(LC)
	Mr. R. Craig	Acting Director of Surgery	(RC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. R. Lea	Deputy Director of 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)
	Ms. L. Smith	Public Governor, North Wales	(LS)
	Ms. J. Preece	Governance Manager	(JP)
Apologies:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Dr. F. Marston	Non-Executive Director	(FM)
Patient Story	Ms. J. Thurston	Parent	(JT)
Item 21/22/304	Ms. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 21/22/306	Ms. A. Bedford-Russell	Liverpool Neonatal Partnership	(ABR)
Item 21/22/306	Ms. J. Deeney	Liverpool Neonatal Partnership	(JD)
Item 21/22/308	Mrs. C. Dove	Chair of the BAME Taskforce Group	(CD)

Patient Story

The Chair welcomed Jenny Thurston, who had been invited to March's Trust Board to share her daughter's journey with the Trust. Jessica was born with a heart condition and had open heart surgery at Alder Hey when she was five years of age. Jessica is now 15 and is still under the care of the Trust.

Jenny provided an overview of Jessica's condition from the time she was born to date, the treatment that she received and the challenges that she has had to deal with. The Board was

advised of the anxieties that Jessica had due to having a needle phobia and the support that she received from Lorna O'Brien, Play Therapist, who helped alleviate some of these anxieties through distraction techniques and familiarisation of the different stages of the pre-op, having blood taken and recovery. It was pointed out that all of this preparation helped immensely with Jessica's prolonged stay in hospital and made the whole family feel supported.

Following discharge from hospital Jenny was worried about the long-term effects Jessica's anxieties would have as result of her stay in hospital. The Trust arranged for an appointment to take place with Emma Twigg, Paediatric Psychologist, who offered advice on how to talk to Jessica about her time in hospital and focus on all the good points. This technique worked as Jessica only has positive thoughts of her stay in hospital.

Jenny praised Lorna and Emma for the amazing support that they gave Jessica and drew attention to the Cardiac Liaison Nurses who have provided support throughout the different stages of Jessica's life and are helping her prepare for the transition into adult care. It was reported that Jessica has been referred back to the Play Therapy service as part of this preparation.

Jenny felt that it would be beneficial for the Play Therapy service to be available to all children who have a planned procedure to help things run smoothly. Jenny also raised a point about having more staff on duty over the weekend to reduce a delay in the decision-making process if a patient becomes really unwell during this period of time. Jenny thanked all those involved in the care of her daughter, during what was a very stressful time, and advised that the all-round package of care and support received from Alder Hey made a huge difference.

The Chair thanked Jenny for sharing Jessica's story with the Board and advised that the Trust will reflect upon the points that were raised.

21/22/294 Welcome and Apologies

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

21/22/295 Declarations of Interest

There were none to declare.

21/22/296 Minutes of the previous meetings held on Thursday 24th February 2022
Resolved:
The minutes from the meeting held on the 24th of February 2022 were agreed as an accurate record of the meeting.

21/22/297 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 21/22/218.1: *Q2 Mortality Report (New Medical Examiner process - Follow-up on the meeting that took place between Nicki Murdock and the CEO of LHCH to confirm as to whether Alder Hey is able to share LHCH's Medical Examiner resource from April 2022 onwards.)* – An update on this action will be provided during April's meeting. **ACTION TO REMAIN OPEN**

Action 21/22/267.1: *Recovery Plan 2021/22 (Include data/standards in the Corporate Report to monitor and demonstrate the Trust's progress against the National Delivery Plan)* - It has been proposed to report on a new score card from Month 2 onwards with enhanced metrics being included in May's Corporate Report. **ACTION CLOSED**

Action 21/22/272.1 - *Q2 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 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**

Action 21/22/272.2: *Q3 Mortality Report (Concerns raised about alerts on the Meditech System - Provide assurance that the alerts that have been raised as difficult to achieve on the current system have been captured, have actions against them and are being tracked)* – As part of the development of the Meditech system a solution will be rolled out to address the notifications of challenging problems for particular patients. **ACTION CLOSED**

21/22/298 Chair's and CEO's Update

The Chair advised the Board of the recent NED development session that took place to look at the ICS system and the implications for NEDs. It was reported that the session was very useful and highlighted the importance of focussing on assurance, strategy and culture. The outcome of the session will be fed back to Louise Shepherd, John Grinnell and Erica Saunders for further thought and discussion.

Louise Shepherd drew attention to the pressures that are being experienced across the System as a result of Omicron, staff absences, national recovery and the serious issues around emergency care and the ambulance service. It was reported that Alder Hey has reviewed its ambulance turnaround/handover times and it was confirmed that the outcome was positive. The Board was informed that staff at the Trust are being really flexible in terms of responding to pressures and attention was drawn to the importance of ensuring the health and wellbeing of the workforce.

The Trust has received a formal request from the region for specific assistance during the second quarter of the year in terms of supporting Manchester with a group of patients who have been waiting a long time for treatment and will breach the two-year target if not addressed. Gastro and Plastics are assisting with this request, but it was pointed out that strategic discussions will have to take place with Manchester to agree a joint working plan.

The Board was advised that the ICS has asked Alder Hey to lead on recovery across the System and it was pointed out that a balanced plan is required to address the significant deficit across Cheshire and Merseyside (C&M). It was reported that the two senior ICS teams will be in place once an announcement has been made on the appointment of the Chair and the Chief Nurse. Nine Place Directors for the C&M Integrated Care Board (ICB) have also been appointed with Jan Ledward having statutory responsibilities in both the ICB and Liverpool Local Authority.

The Chair acknowledged the contribution that staff are making by being so flexible at Alder Hey, across C&M and supporting Manchester.

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

21/22/299 Operational Plan for 2022/23; including an update on activity, finance and workforce

The Board received a briefing on the draft Annual Plan for 2022/23. A number of slides were shared which provided information on the following areas:

- 2021/22 key highlights.
- The five priorities of the Operational Plan for 2022/23;
  - Recovery.
  - Outstanding safety.
  - Great place to work.
  - Financial sustainability.
  - Safe systems.
- Summary of the provisional plan;
  - 3% expansion in the workforce.
  - 3.2% increase in activity.
  - 1% increase in CIP to achieve a £1.9m surplus control total.
- Overview of the provisional activity plan.
- Provisional key investments in 2022/23 to support delivery;
  - Theatre management system - £0.5m.
  - Staffing and workforce for quality and recovery – c£5m.
  - Mental Health - £1m.
  - Innovation projects – c£2m.
  - Digital transformation – c£3m.
- Digital futures and transformation;
  - Digital models of care for CYP and families.
  - Divisional digital programmes.
  - Healthier populations through digital, data and analysis.
  - Alder Care EPPR upgrade – Improved digital experience for staff

Draft Financial Plan for 2022/23

It was reported that the initial draft plan had a deficit of £12.5m based on a 2% CIP, no ERF, a continuation run rate and new pressures relating to energy and the Emergency Department. As a result of discussions taking place across C&M and internal work being conducted by the Trust changes were made to the draft submission; £8.4m ERF funding was allocated to achieve activity levels of 104%, increase in CIP to a minimum of 3% as per the request from C&M, and a review of provisions/accruals that may not be required, including annual leave, amounted to a saving of c£3m recurrent funding. The impact of these changes will enable a breakeven position for 2022/23 but attention was drawn to the challenges and significant risks in the plan which will require action to ensure its success.

The Board was advised of the assumptions in the plan;

- £12m CIP target (£8.4m recurrent and £3.6m non recurrent).
- A minimum of 104% activity recovery to retain an £8.4m income.
- No deterioration in the current run rate.
- Mental Health investment funded with no gap.
- No changes to income allocation from C&M.

The Chair acknowledged the challenges and risks that may affect the Trust in terms of achieving a breakeven position in 2022/23.

It was pointed out that one of the main risks for the Trust is meeting the 3% CIP target that has been set across the System. Work is taking place on the Divisional plans to understand the opportunities, along with the benefits of the large investments made by the Trust. The Board was advised of the discussion that took place at RABD about the organisation's cost improvement challenge and it was concluded that it is imperative to reduce the level of cost that the Trust is carrying over subject to evaluating that it doesn't have an adverse effect on safety. In terms of activity, there are risks that could derail the plan, the Board noted the challenge Alder Hey is facing.

Shalni Arora referred to the £11.5m key investments for 2022/23 and queried as to when these investments will be made and when will benefits be realised. The Board was advised that the majority of the investments have been secured and have started to be implemented with benefits coming through in phases. An overview was provided in terms of digital/innovation investments, projects and the forthcoming work that will take place to identify the benefits realisation of these investments. A discussion took place around the reintroduction of the reporting process for key transformation and improvement projects in order to monitor progress in 2022/23. It was agreed that further discussions should take place regarding this matter and that the reporting process should include metrics on innovation.

21/22/299.1 Action: LS/JG

Operational Update

The Board was provided with an operational update which included information on winter pressures, the recovery of services and Omicron. It was reported that staffing levels are reduced at the present time as a result of Omicron but simultaneously attendances in ED have surged over the last two weeks with the Trust receiving up to 50 additional patients per day via the front door in comparison to earlier in the month. As a result of this the Trust has been challenged for assessment space therefore action has been taken to deliver more of the urgent care services outside of the department to help reduce pressures in ED. A meeting has taken place with Liverpool CCG to raise a concern about the volume of attendances at Alder Hey's Emergency Department and post code data has been shared to enable the CCG to explore local access to alternative urgent care services. The Trust has submitted a request for financial support for its on-site primary care service to help manage the increase in the level of attendances that are currently being seen.

The Board was advised of an expected CQC inspection of urgent care services that is taking place across C&M. It was reported that the inspections are taking place to explore as to whether the urgent care system is working.

The Chair thanked all those involved in the work that is taking place across the Trust and those who are preparing for the imminent CQC inspection.

Resolved:
The Board noted the updates under the Operational Plan for 2022/23.

21/22/300 ICS Development Update

This item was deferred until April.

21/22/301 Next Steps in Developing the Trust Strategy

This item was deferred until April.

21/22/302 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:

- *Park Reinstatement (Phase 2 and 3)* – Vacation of the old Catkin Building is planned to be completed in spring 2022 ready for decommissioning and demolition. Phase 3A will commence in May ahead of demolition. It was reported that a lease has been signed for Liverpool Innovation Park 2 and work has commenced on site to enable the last of the CAMHS teams to vacate the old Catkin Building by June 2022.
- *Schemes* – The site of the Neonatal development is being cleared ahead of construction and the Trust is working with Galliford Try to ensure that the construction of Sunflower House is completed by the 29th of April 2022.

  It was reported that there are a number of commercial discussions taking place around the land buy back from Step Places and the construction of the Neonatal scheme which are effecting the overall planning for the Campus

Louise Shepherd advised of the positive meeting that has taken place with colleagues from Liverpool City Council (LCC). Council members have visited the park and are looking at the quickest solution for handover. A joint paper is being submitted to the LCC Board and will be shared with the Trust Board following approval by LCC.

The Chair thanked all those involved for driving the work of the Campus forward.

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

21/22/303 Serious Incident Report

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.2.22 to the 28.2.22. The following key points were highlighted:

- The Trust declared one StEIS reportable incident requiring investigation (*reference number - 2020/2634*) that related to a missed opportunity to diagnose a patient.
- There was one serious incident investigation closed in February that related to a person who had taken an overdose. The investigation confirmed that there were no additional steps that could have been taken by the Trust, but the organisation has taken on board some learning from a systems and processes perspective as a result of this incident.
- *Progress position of action plans* – It was reported that a lot of work has taken place to address the open action plans that are past their expected date of completion. It was proposed that a number of the residual actions relating to expanse, development, etc. should be transferred to business as usual to enable the respective action plans to be closed.

The Chair pointed out that the thematic review identified communication issues as one of the key themes contributing to serious incidents and queried as to how this is being addressed. It was reported that communications is the biggest category for PALS in terms of sub-categories and it was agreed that the Chief Nurse, Nathan Askew, would discuss this matter with the PALS and Complaints team.

21/22/303.1 Action: NA

Louise Shepherd referred to the Ockenden 2022 review and queried as to whether the recommendations are being addressed via the Trust's process. It was confirmed that the Ockenden report will be submitted to the Board during April's meeting.

21/22/303.2 Action: NA

Resolved:
The Board received and noted the contents of the Serious Incident report for period from the 1.2.22 to the 28.2.22.

21/22/304 Q3 DIPC Report

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:

- The number of respiratory viruses reported by North West laboratories for the latest 10 weeks.
- The Board was advised of the increase in flu cases reported over the last two weeks.
- Update on the Omicron variant and its sublineage in the UK.
- Update on the BA.2 variant which is now the predominant sublineage in the UK. It was reported that BA.2 behaves similarly to BA.1 but is more transmissible. From a vaccine effectiveness perspective, if a person has had Omicron it is unlikely that they will be infected with BA.2
- Update on patient and staff testing.
- Roadmap for the living with Covid 19 response;
    - 1.4 22: Educational activities and outpatient visiting guidance.
    - 1.5.22: Meetings with food and sibling visitation.
    - 1.6.22: Removal of masks in non-clinical areas.
- Changes to testing guidance following publication of new guidance on the 30.3.22. It was pointed out that the Trust will have to consider the amount of testing that it needs to do as funding will reduce.

Louise Shepherd thanked Beatriz Larru for her leadership and approach which has kept the Trust safe. It was felt that this area of work needs to be monitored as it has financial and operational implications for Alder Hey. The Trust also needs to be clear with its partners that the organisation is still experiencing real challenges as a result of Covid. The Chair highlighted the need for Trust wide communications to ensure the changes are understood and embraced.

Resolved:
The Board noted the Q3 DIPC update and the roadmap for Alder Hey.

21/22/305 Corporate Report

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

Medicine

Attention was drawn to the increase in rates for Was Not Brought (WNB) patients. It was reported that General Paediatrics are taking part in a pilot using a WNB predictor tool during March/April. The Chair highlighted the importance of understanding the WNB data in order to be more effective going forward.

The Board was informed of the small quality improvement project that is taking place to identify the reasons for the increase in WNB figures. One of the changes that are being made is to provide clinic appointments for patients 16+ outside of school hours around exam times. If patient feedback is positive this recommendation will be rolled out to other teams across the Trust. Work is also going to take place with the Divisions to look at resolving this matter.

There are a significant number of staff who are in the red for mandatory compliance. It was reported that the Division of Medicine has been working closely with the Director of Surgery and the training lead to address this area of work, which has helped.

Surgery

The Board was advised that the central themes for the Division of Surgery is staff sickness due to Covid which has been disruptive in terms of short notice cancellations.

There has been an increased number of complaints that relate to alleged failures in the care of complex patients, there have also been 45 enquiries to PALS during February relating to access issues.

It was reported that there has been an increase in referrals and waiting list size with 11,949 patients waiting for surgery. Attention was drawn to the national modelling which anticipates an upsurge in referrals for surgery, with 60% of missed referrals being re-submitted over the next two years. It was felt that this assumption is important in terms of planning and therefore it is imperative to keep track of this area of work. Louise Shepherd thanked Richard Craig for taking on the interim role of Director of Surgery and leading the Division.

Community

The Division is concentrating on reducing WNB rates and is in agreement to participate in the forthcoming Divisional work across the Trust to address WNB patients.

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

21/22/306 Liverpool Neonatal Partnership (LNP) Update

The Board received an update from the LNP team. The following information was shared:

- Recruitment;

  - A consultant with a strong research background in nutrition has recently been appointed, and a new Psychologist will be commencing in post shortly.
  - A number of trained ANPs will joining the service which brings the cohort to 35. This is the largest cohort of Neonatal Practitioners in the country.
  - Two trainee places have been secured with HEE for January 2023.
- It was reported that both neonatal units have minimal vacancies and are running at a turnover of 8% in the partnership, with the national average being 13%.
- The Board was advised of the changes to the Leadership team. It was reported that an away day is scheduled for the 16th of April in order to regroup as a new team and a further stakeholder session will take place in June.
- Achievements;
  - A new governance structure was implemented in December 2021 and is providing much more clarity and definition.
  - The LNP MoU has been refreshed and updated.
  - It has been agreed to routinely attend HDU seven days a week to care for the surgical babies and review them regularly in a co-managed way. Two additional consultants are being appointed in order to extend weekend coverage from 2:30pm onwards.
  - ANPs are on site seven days per week, twelve hours per day and work is taking place to extend this.
  - Nurse rotation is continuing successfully with teams starting to feel inclusive.
  - 12% of the LNP workforce are now qualified in neonatal surgery and work is taking place to increase the QIS level at Alder Hey from 40% to 60%.
  - The team was successful in winning a bid for national critical care money; 420k to help improve the nursing workforce on 1C in line with present day activity.
  - Work is taking place to achieve accreditation for 1C on family integrated car and UNICEF accreditation for breast feeding.
- The Board was advised of the challenges that are being experienced in terms of the construction of the new Neonatal Unit and the commissioner risk relating to the recruitment of nursing staff to facilitate the future of the unit in a timely manner.
- Attention was drawn to the amount of work that is required to streamline the support services around microbiology, radiology, pathology.
- It was reported that the LNP team has been awarded the 'Women Working in the NHS' award.
- On behalf of the LNP team, Jen Deeney thanked the Charity for their support.

Adam Bateman thanked Jen Deeney and Alison Bedford-Russell for their leadership and the work that has taken place whilst looking after the neonatal patients on 1C. Adam Bateman emphasised the commissioner risk relating to the £2m gap in terms of funding that is being released to staff the unit and pointed out that the Ockendon review will play a crucial factor in supporting the recruitment business case.

Alison Bedford-Russell drew attention to a number of governance related risks that have only just been identified and advised that this information will be shared with the Board during the next update.

Louise Shepherd referred to the positive discussions that have taken place between Alder Hey and LWH in terms of reconnecting with Wirral and working in partnership with them on a Level 2 unit. It was pointed out that granular level discussions will need to take place with Wirral to review figures and devise a plan that fits.

The Chair thanked the team for the work that has taken place to progress the LNP and offered congratulations to the team on winning the 'Women Working in the NHS' award.

Resolved:
The Board noted the LNP update.

21/22/307 2021 Staff Survey Results

The Board was provided with the headlines of the 2021 Staff Survey and the actions that are taking place as a result of the survey.

- *Overview* – Alder Hey is above average on all of the measures in the People Promise, staff engagement and morale in a comparator group of 150 acute and community trusts. It was reported that the overall message is positive with good feedback received from staff.
- 89.5% of staff recommending Alder Hey as a place for treatment.
- 70.5% of staff recommended Alder Hey as a place to work. It was reported that this was the highest score in relation to this question across all of the trusts in the North West
- Staff feeling confident in terms of raising concerns has risen to from 74.5% to 81%.
- *My organisation takes positive action on health and wellbeing* – 66.1% of staff agreed with this
- *How often, if at all, do you feel burnt because of your work* – It was reported that a third of all those who responded to this question said they were feeling tired. The Board was advised that significant attention will be paid to this over the next 12 months.
- *WRES and DES Indicators* – The Board was advised that twice as many staff with a disability, than without a disability, have stated that they have experienced some form of harassment, bullying and abuse from managers and colleagues. It was confirmed that work will take place to respond to this matter.
- It was reported that the Trust has received the local data for the Divisions and staff groups and attention was drawn to the areas that will require focus where People Promise scores are lower than the rest of the organisation and across all domains.
- The Board was advised of the areas to further understand and improve; discrimination especially disability, unpaid hours, staff thinking about leaving, burnout and wellbeing, morale, reward and recognition, appraisals and learning.
- *Next Steps* – Share the Staff Survey, share the Divisional/departmental data w/c 4.4.22,develop the action plan in response to staff feedback.

The Chair felt that the outcome of the 2021 Staff Survey was positive but pointed out that there are a number of issues that require attention.

Resolved:
The Board noted the update on the 2021 Staff Survey results.

21/22/308 People and Wellbeing Update
Resolved:
The Board received and noted the contents of the People and Wellbeing report.

BAME Inclusion Taskforce update

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

Claire Dove pointed out that many of the actions from the Taskforce were identified as a direct result of the feedback that was received from BAME staff via the listening events. The most significant step that was taken at the very start of the process was to create a space to listen to BAME colleagues and hear, for the first time from many, their experiences of working in the NHS at Alder Hey. Claire Dove offered some recommendations on the back of the achievements of the taskforce:

- *Volunteers* – Implement an Employability Programme to support volunteers who wish to seek employment with the Trust.
- *Governance* - The Trust engaged with a new search agency, Green Park, known for its success in helping organisations secure appointments from candidates from diverse backgrounds who may not have traditionally considered senior NHS appointments. It was pointed out that the Charity is interested in acquiring information on Green Park therefore it was recommended that the trust share this knowledge with the Charity.
- *Recruitment* – It was pointed out that interview panels need to be diverse, and a suggestion was made about having career roadshows and positive action programmes. It was queried as to whether a fast track approach could be Implemented to provide workplaces for young people with the Trust.
- *Training and Development* – The Trust needs to look at leadership programmes for staff and revisit training.
- *Staff Support* – It is imperative that staff in the SALS service are from a diverse background.
- Exit Interviews – It was felt that more exit interviews need to be conducted to find out why staff are leaving the Trust.
- *Publicity* – more images are required of Alder Hey in its diverse state.
- *Resources* – Ensure play and educational equipment reflect the Trust's patients.
- *NHS Observatory Report* – It was recommended that the Trust digest this report and confirm its response.
- *Audit trail* – It was suggested that an annual summit take place to review the recommendations and take stock.

The Chair thanked Claire Dove for her leadership and work to help remove processes and barriers in the organisation that sustain systemic racism. It was confirmed that the work of the BAME Taskforce will be embedded across the organisation and progressed. Louise Shepherd reiterated the Chair's sentiments and pointed out that the Trust would not have made the progress it has without the leadership of Claire Dove.

On behalf of the Board, the Chair wished Claire Dove all the very best for the future.

Resolved:
The Board noted BAME Inclusion Taskforce update and approved the recommendations.

21/22/309 Gender Pay Gap Report, 2021

The Trust Board noted the contents of the 2021 Gender Pay Gap report and approved it to enable it to be published on the Trust's website and the Government's website in line with statutory reporting guidelines.

It was pointed out that the gender pay gap is not an equality issue but the difference between male and female pay. The report demonstrates that the Trust gender pay gap remains mainly within the organisation's Medical and Dental staff groups and is reflective of an ageing male workforce within this staff group. The criteria for Clinical Excellence Awards has changed to be more inclusive and accessible. The Trust is conducting a review of this area of work and the actions/outcome will be driven by the EDI Steering Group.

Resolved:
The Board approved the 2021 Gender Pay Gap report.

21/22/310 Board Assurance Framework

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

- It was reported that Alder Hey received an excellent review from MIAA for the Trust's assurance framework and it was commended for being best on the patch for coverage and scrutiny.
- It was confirmed that a new risk (3.1) relating to buildings has been included in February's version of the BAF.

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

21/22/311 Board Assurance Committees

RABD – The approved minutes from the meetings that took place on the 24.1.22 and the 18.2.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 28.3.22 there was a focus on the risks that will impact the Trust going forward; inflation, increase in prices, lack of specific commodities. It was also pointed out that there are contractors who can't meet budgets/deadlines and the financial environment at the present time is very uncertain.

SQAC – The Board received the Chair's highlight report from the meeting that took place on the 23.3.22 and noted the approved minutes from the 16.2.22.

PAWC – The Board received the Chair's highlight report from the meeting that took place on the 22.3.22 and noted the approved minutes from the 15.2.22.

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

21/22/312 Any Other Business

There was none to discuss.

21/22/313 Review of the Meeting

The Chair felt that March's agenda covered some important issues and highlighted the wonderful work that is being conducted by the LNP. Plans are in place to progress the BAME Taskforce with Garth Dallas leading on this work. The Chair thanked all those involved in the operational side of the organisation and drew attention to the plan that is in place to address this area of work in 2022/23.

Date and Time of Next Meeting: Thursday the 28th April 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 April 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	On track Apr-22	22.4.22 - An update will be provide on the 28.4.22.
Actions for May 2022							
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	May-22	22.4.22 - This action has been deferred to May 2022.
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.	Nicki Murdock/ 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	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
16.12.21	21/22/218.1	Q2 Mortality Report	Follow-up on the meeting that took place between Nicki Murdock and the CEO of LHCH to confirm as to whether Alder Hey is able to share LHCH's Medical Examiner resource from April 2022 onwards.	J. Grinnell	28.4.22	Closed	**22.2.22** - An update will be provided on the 31.3.22 **31.3.22** - An update on this action will be provided during April's meeting. **25.4.22** - This action has been superseded by action 21/22/272.1 **ACTION CLOSED**
24.2.22	21/22/267.1	Recovery Plan 2021/22	Include data/standards in the Corporate Report to monitor and demonstrate the Trust's progress against the National Delivery Plan.	A Bateman	31.3.22	Closed	**31.3.22** - It has been proposed to report on a new score card from Month 2 onwards with enhanced metrics being included in May's Corporate Report. **ACTION CLOSED**
24.2.22	21/22/272.2	Q3 Mortality Report	*Concerns raised about alerts on the Meditech System (refer to page 3 of the M&M report)* - Provide assurance that the alerts that have been raised as difficult to achieve on the current system have been captured, have actions against them and are being tracked.	A. Bass	31.3.22	Closed	**31.3.22** - As part of the development of the Meditech system a solution will be rolled out to address the notifications of challenging problems for particular patients. **ACTION CLOSED**
24.2.22	21/22/276.1	BAME Inclusion Taskforce Update	Send a letter of thanks to the team who are responsible for volunteers to congratulate them on the successful work that has taken place to encourage volunteers from a BAME background to join the Trust.	Dame Jo Williams/ L. Shepherd	31.3.22	Closed	**22.4.22** - This action has been addressed. **ACTION CLOSED**
24.2.22	21/22/279.1	2022 Review of Risk Appetite Statement and Proposed Risk Tolerances	Discuss the implications in greater detail of having a nil risk appetite for risks relating to quality and safety, during an Exec team meeting in March.	N. Askew/ E. Saunders	31.3.22	Closed	**31.3.22** - A discussion took place regarding this action and it was agreed that Nathan Askew will progress this matter and feed back during a future Executive Team meeting. **ACTION CLOSED**

24.2.22	21/22/282.1	Any Other Business	*Green Plan* - Submit an interim report during April's Trust Board meeting.	A. Pitman	28.4.22	Closed	**22.4.22** - This item has been included on April's agenda. **ACTION CLOSED**
31.3.22	21/22/299.1	Operational Plan for 2022/23; including an update on activity, finance and workforce	*Draft Financial Plan for 2022/23* - Discuss the possibility of reintroducing the reporting process for key transformation and improvement projects, including innovation, in order to monitor progress in 2022/23.	L. Shepherd/ J. Grinnell	28.4.22	Closed	**22.4.22** - Following the submission of the 2021/22 Programme Annual Assurance Report to the Audit and Risk Committee it was reported that one of the next steps for 2022/23 is for each project to report regularly into Strategic Execs as per a proposed work plan via the BB A3 reporting template to update on progress. This reporting template will also be used for transformational change programmes and will become the reporting mechanism for all operational improvements to create consistency of reporting across the Trust at all levels and in all forums. **ACTION CLOSED**
31.3.22	21/22/303.2	Serious Incident Report	Submit the 2022 Ockenden Report to the Trust Board in April.	N. Askew	28.4.22	Closed	**22.4.22** - This item has been included on April's agenda. **ACTION CLOSED**
31.3.22	21/22/303.1	Serious Incident Report	*Thematic Review* - Discuss the communications issues with the PALS/Complaints Team as it has been identified that this is one of the key themes contributing to serious incidents and is the biggest category for PALS in terms of sub-categories.	N. Askew	28.4.22	On track Apr-22	**22.4.22** - The patient experience group has been asked to look at this as an area for improvement as part of their work plan. **ACTION CLOSED**

BOARD OF DIRECTORS

28 April 2022

Paper Title:	**2022- 23 Operational Plan**
Report of:	Adam Bateman, Chief Operating Officer
Paper Prepared by:	Adam Bateman, Chief Operating Officer Nathan Askew, Chief Nursing Officer Rachel Lea, Deputy Director of Finance Melissa Swindell, Chief People Officer Erica Saunders, Director of Corporate Affairs

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. Background

The 2022-23 operational plan sets out our priorities for the year. We are 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 our staff; and achieving financial sustainability. It is a plan that integrates and interconnects our plans for activity, quality, workforce, finance and risk.

This plan is guided by our vision for a healthier future for children and young people and is underpinned by the following principles:

- understand and focus on the needs of children and young people
- keep staff safe and well
- be a great partner
- improve care by seizing the opportunities that innovation and digital advancement bring
- to provide care that is preventative and is at, or as close to, home where possible

This operational plan will be supplemented by the following detailed plans and strategies, which are to follow, and will be submitted to Trust Board, in May 2022:

- Quality and safety strategy
- Digital strategy
- Innovation strategy
- Research, education and innovation framework
- People Plan

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2. Reflections on 2021-22

Strategic aim	Key achievements
	• The opening of The Alder Centre – the UK's only purpose-built bereavement centre for the loss of a child • 20% reduction in medication errors • Delivered 5,299 Covid-19 vaccinations to patients and staff • New Neutralising Monoclonal Antibody (nMABS) treatment given to high-risk children and young people with Covid-19 • Delivered over 400 all-age congenital cardiac operations • 300 staff undertook RSV clinical training to support RSV surge • Voluntary deployment of staff into PICU to maintain capacity to treat in-region critically unwell children • Provided cancer treatment to children from Ukraine • Launched a new digital symptom checker to support parents and families in managing common symptoms • Awarded, by NHS England and Youth Justice Services, a 3 year programme to work with the most vulnerable young people in accessing mental health services • Strong recovery of planned services in year two of the pandemic: 108% outpatient recovery and 100% elective recovery • Launched a digital 'One Stop Shop' platform for CYP with mental health needs and their families, enabling easy tracking of referral and useful information & support • Achieved international accreditation for our level of digital maturity and safety (HIMSS Level 7) • Expanded the Mental Health Support Teams in schools to provide seven teams across Liverpool and Sefton • Safe Waiting List Management programme delivered improvements in access to care and reduced waiting times • Vascular access team given Silver Award at British Journal of Nursing Awards 2022

	• Leading the C&M Children & Young People's Transformation programme and investing a £2M transformation fund to establish:
	  ○ A new Obesity Tier 3 service (North West collaborative model)
	  ○ Autism Friendly Wards
	  ○ Long Covid service (North West collaborative model)
	• Alder Hey, together with Royal Manchester Children's Hospital is one of the two quaternary centres nationally designated for managing the rare condition, congenital hyperinsulinism (CHI). In 2021, the service received 'Centre of Excellence' recognition by CHI international.
	• Established a partnership with Liverpool City Council Public Health and jointly appointed a Senior Public Health Practitioner
	• Successful bid to Health Education England for a Population Health Fellow
	• Partnership bids approved for ASD services, including the delivery of autism training in schools and provision of a post diagnostic support pilot for children and young people receiving an ASD diagnosis
	• Lottery funding bid approved for a two-year programme delivering the "Calm and Connected" group for children and young people experiencing anxiety
	• Our Liverpool Neonatal Partnership with the Liverpool Women's NHS Trust is enhancing neonatal care in the region and planning is secured for the new state-of-the-art NICU facility
	• Hosting the Cheshire & Merseyside digital leadership & programme team

	• Alder Hey was proud to be awarded 'Freedom of Sefton' by Sefton Council in July. At a meeting of Full Council, the decision was made to recognise Alder Hey and our staff, along with three other Merseyside trusts, for their hard work and dedication during the Covid 19 pandemic. • Volunteers received The Queen's Award for Voluntary service

	• Awarded Radiology Academy training status to train the Radiologists and Advanced Practitioner Radiographers of the future • Established a wellbeing programme in ED to support the staff responding to the significant impact on Urgent Care services following lockdown • Prince's Trust BAME "Get into the NHS" scheme provided eight-week placements for 8 young people • Staff Advice & Liaison Service (SALS) won the HSJ Staff Engagement Award 2021 • Single point of access through SALS for all staff support at Alder Hey – over 4,000 contacts since March 2020 • Expanded the Specialist Mental Health Services team by 20 staff to meet the complex mental health needs of C&YP • HPMA Browne Jacobson Award for Excellence in Employee Engagement (2021) • Staff engagement work recognised through NHS Employers annual conference and in a dedicated podcast featuring the Alder Hey staff engagement story and successes • Ranked number 1 in the North West in the staff survey: 72% of staff recommending Alder Hey as a place to work and 90% as a place for friends and family to receive care. • Strong Foundations leadership programme delivered to 400 leaders and managers • Schwartz Rounds running monthly with doubling of trained facilitators in 2021
	• 13,166 participants were recruited to research studies making Alder Hey the highest NHS recruiter overall in the North West region • 94 health care professionals from 28 specialities acted as Principal Investigators for 189 clinical research studies • The Alder Hey Clinical Research Facility (CRF) was awarded a further £2M in funding from the National Institute for Health and Care Research (NIHR) for enabling vital delivery of early-stage clinical research to continue until 2027

	• Deployed five Ai tools into our hospital to help augment and enhance our process including our homegrown WNB AI product that will tackle healthcare inequalities and has been spread and adopted in 11 Children's Trusts in England • Taken two home-grown digital platforms to clinical pilot with our industry partners and innovation centre capability, including 'Little Hearts at Home' remote monitoring platform • Used 3D printing to develop and implant titanium bones, a first in the UK that has helped a patient being treated in oncology • Invented a transparent mask and worked with a UK manufacturer to take to market and give those that need it a right to communication whilst improving infection prevention controls • Co-developed with families and staff a new video monitoring technology with an SME to support neonates and family centred care models of the future • Raised material inward investment through grants (£3m) and industry investment (£1m) and asked to apply to the LCR combined authority innovation development fund • Research grant allocated with Alder Hey as a partner, entitled: "Arts for the Blues: Towards integrating the use of the arts in health and cultural settings to tackle depression and improve wellbeing in the North West"

Impact of partnership working in Cheshire & Merseyside

Alder Hey played a leading role in co-ordinating acute paediatric services in Cheshire & Merseyside (C&M). A Paediatric Gold Command arrangement was established, chaired by the Chief Operating Officer of Alder Hey, to manage acute paediatric services during Respiratory Syncytial Virus (RSV), Covid-19 and winter pressures. Paediatric providers in the region have worked effectively to deliver the following:

- **C&M paediatric escalation framework:** this supported mutual aid was to be agreed and enacted when a paediatric ward was full, meaning C&YP could still get access to inpatient care through transfer arrangement

- **Recovery and mutual aid:** Alder Hey targeted investment in surgical services in C&M to help reduce waiting times for services with the biggest backlog. Alder Hey has provided mutual aid to Wirral Community Health & Care Trust by supporting additional dental surgery.

- **Paediatric Clinical Assessment Service (NHS 111):** staffed collaboratively with trained paediatric specialists

- **Supporting C&YP with complex behaviours:** agreed a shared standard for training staff and made available additional education resources

- **Paediatric Transport Service:** dedicated vehicle and service established over winter to support patient transfers and mutual aid

Achievements of the Children's Hospital Alliance

Alder Hey is one of ten paediatric Trusts that form the Children's Hospital Alliance. In 2021-22 we collectively secured £20 m in national investment to fund a paediatric accelerator programme. Over the last 12 months the programme has:

- **Invested £1m in an innovation programme** to roll out Ai technology that identifies children at risk of not being brought to their appointment (now live, 80% accuracy)
- **Delivered more elective activity** than pre-Covid (103%), as one of the best performing Accelerators, supported by transformation of care and shared learning
- **Developed a programme of inequalities interventions**
- **Developed data and benchmarking** (NHSE now use our numbers in preference to their own)

Withing this programme Alder Hey has:

- in Spinal Surgery, Paediatric Surgery, Dentistry and ENT carried out over 3,000 more outpatient consultations and 300 more operations. This was achieved through additional staff and equipment funded from accelerator investment.
- developed an Artificial Intelligence Was Not Brought Predictor, through Alder Hey Innovation, which identifies families at risk of not attending appointments. This technology has been rolled out to all Trusts in the Alliance.
- co-chaired the Paediatric Accelerator Steering Group and provided leadership to host the investment fund, set the accelerator strategy and spread innovation.

3. Operational plan for 2022-23

3.1 Our priorities

We have set 5 operational priorities for delivery in 2022-23:

i. Recover access to services

ii. Outstanding for safe care

iii. A great place to work

iv. Deliver financial sustainability

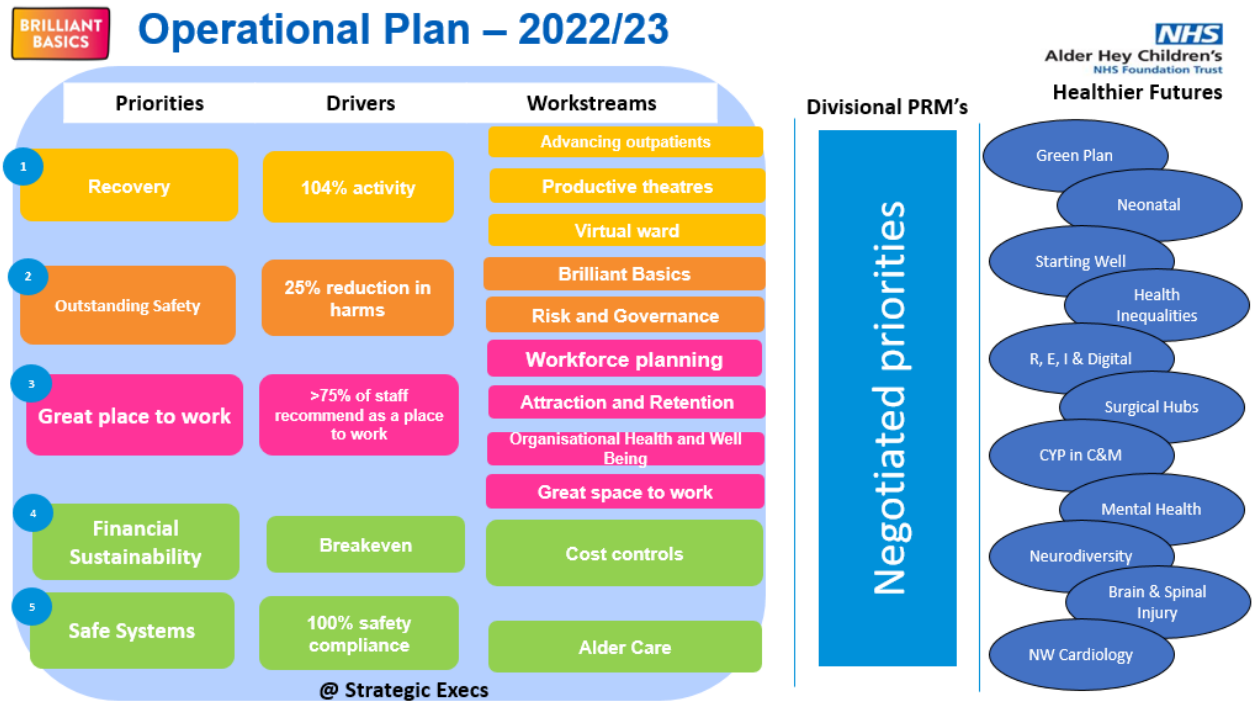
v. Safely digital systems

Each of the five priorities has a driver metric to enable measurement of progress and impact. Furthermore, we have identified the key workstreams that will support the achievement of the five priorities. The diagram below summarises how we will organise activities to deliver our operational plan *and* strategic healthier futures changes. There are three groups of changes:

i. Cross-cutting workstreams to achieve the 5 priorities

ii. Divisional projects and performance review meetings aligned to the five priorities

iii. Strategic changes to deliver healthier futures



The table below summarises the case for change and the metrics that will be used to monitor progress and impact:

Summary of operational plan and metrics

What are we going to do?	Why it's important?	How will we achieve it?	Driver metric	Watch metrics
Recovery: We will grow our services and increase productivity to clear the waiting list backlog and reduce waiting times for treatment for children and young people.	To meet the needs of C&YP by improving access to care and treatment Improve children & young people's experience of care by reducing waiting times.	**Advancing Outpatient care** **Productive Theatres** **Virtual ward**	**104% Activity**	**Inpatient Care** 1. Avr pts per Session (DC) 2. Avr pts per Session (Elec) 3. Avr pts /working day (DC) 4. Avr pts /working day (Elec) 5. # Theatre sessions/ week 6. # Pts >52ww (Elec + DC) **Outpatient Care** 7. OPN + OPPROC >104% 8. OPFU Reduction (85%) 9. Virtual OP >25% 10. No Harm whilst on waiting list (OP) **Urgent Care** 11. % ED < 4hrs
Outstanding safety: We will improve how we learn, how we treat staff and how we involve children and young people and their families.	**We will work to eliminate preventable harm to patients** To be rated as 'outstanding' for safety	**Risk and Governance** **Patient Safety strategy**	**25% reduction in Harms**	1. % Mandatory Training Compliance 2. FFT % recommend the Trust 3. % Complaints response within 25 working days

Great place to work: We will continue to respond to what our people are telling us to prioritise health and well-being, equality, diversity and inclusion, workforce planning and provide great places to work.	**The post-covid environment has resulted in some colleagues experiencing burnout, and we have also seen the impact of challenges facing staff outside of the workplace.** The trust has experienced higher absence rates among staff due to Covid 19 sickness/isolation, and higher rates of non-covid absence overall. There are skills shortages in specific staff groups/roles across the NHS; and difficulty recruiting for paediatrics given the extra complexity of patients clinically	**Attraction and Retention** **Organisation health and well being** **Great space to work** **Workforce planning**	**>75% of staff recommend as a place to work**	1. Absence – LTS 2. Absence – STS 3. Absence – Covid Related 4. % PDR completed (YTD) 5. % Medical Appraisals (YTD) 6. % Staff Turnover
Financial sustainability: We will enhance the efficiency and effective financial monitoring and management.	**The increasing challenging** constraints of the NHS financial architecture, and future income certainty for 22/23 beyond and CIP requirements.	**Cost control**	**I&E Breakeven** **Financial governance and accountability** **Financial benefits**	1. I&E vs Plan (YTD) 2. Expenditure Run Rate (Pay & Non Pay) 3. CIP Forecast 4. CIP Delivered (YTD) 5. Capital Plan (vs CDEL) 6. Cash
Safe Systems: We will use digital to ensure that we are safer and that we deliver the best possible care at every step.	We deliver world class services to children and young people. Building on our digital technology and developments is pivotal to support our staff to deliver reliable safe care.	**Alder Care** **Website and Intranet**	**100% safety compliance** (all agreed safety "red lines" are compliant prior to implementation of Alder Care)	1. % system build completion 2. % specialty sign off 3. # staff involved in prototype testing 4. # staff trained in Alder Care

Divisional plans for delivering the 5 priorities

Aligning divisional focus and projects is critical to successfully realising our five priorities. The tables below summarise the Divisions' driver metrics and key projects for 2022-23:

Division of Community & Mental Health: operational driver metrics and key projects

Trust priority	Driver Metrics	Project to Deliver Improvement
Recovery	Number of CYP waiting >52 weeks for care and treatment	Access and Waiting Times improvement project
Safety	Reduce the number of incidents where staff report abuse or aggression	'Zero tolerance' project
Great place to work	Workforce availability rate above 90%	Mental Health workforce plan
Great place to work	Number of community bases with a lease agreement in place	Development of clear community estates strategy
Safe systems	Number of referrals accepted as 'right first time'	Digital platform for Neurodevelopmental paediatric pathways

Division of Medicine: operational driver metrics and key projects

Trust priority	Driver Metrics	Project to Deliver Improvement
Recovery	99% of diagnostic procedures performed within 6 weeks	▪ Expansion of MRI services ▪ Gastroenterology recruitment ▪ Home VT for Sleep and Epilepsy
Safety	60 minutes time to clinical assessment	Urgent Care Improvement Group
Great place to work	Staff availability and vacancy rate in Radiology	Radiology workforce review
Financial sustainability	Reduce non-pay overspend	ASU service growth
Safe systems	Faster diagnosis (> 80%)	Digital cancer pathways tracker system

Division of Surgery: Operational driver metrics and key projects

Trust priority	Driver Metrics	Project to Deliver Improvement
Recovery	Zero patients waiting over 52 weeks for treatment by March 2023	Productive theatres Advancing outpatient care in Surgery
Safety	Reduction in incidents leading to harm	Safer Theatres at Alder Hey (STAT)
Great place to work	Staff availability in theatres and critical care	Theatres' workforce plan Critical care workforce plan
Financial sustainability	Deliver cost improvement target	Cost improvement delivery group
Safe systems	100% compliance with safety criteria for new theatre management system	Theatre management system

3.2 Quality

Alder Hey has a strong focus on patient safety, patient experience and clinical effectiveness. This year sees continued developments in all three areas as we continue to 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 healthier futures for the children, young people and their families that we serve. 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.

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. 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.

Patient safety

This year will see the next stage and implementation of a patient safety strategy. A Patient Safety Board will be formed and will report directly to the Safety and Quality Assurance Committee which will be chaired jointly by the CMO & CNO. The Patient Safety Board will ensure that all work programmes from the patient safety strategy have clear implementation plans and demonstrate improvement in those areas.

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.

Clinical effectiveness

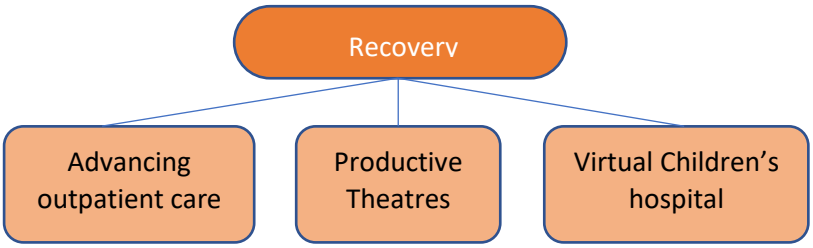
We will undertake a systematic review of systems, processes and application on a range of areas related to clinical effectiveness. This review will ensure that we are able to demonstrate compliance with national and local targets and will facilitate a robust and safe management system within the organisation leading to clear demonstration of learning from when things go wrong and embracing good practice when things go well.

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.

3.3 Activity & recovery

The recovery programme will be driven by 3 workstreams:



Summary of planned activity numbers

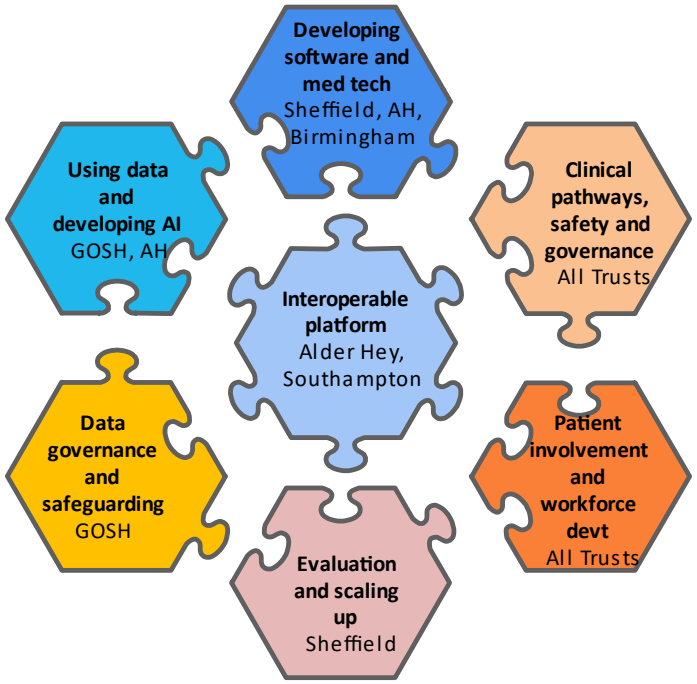
Section	Requirement	Pre-pandemic Baseline (19/20)	Current Run Rate (2021/22)	Proposed Plan (2022/23)	% vs Baseline	National Standard	RAG
Outpatients	Consultant-led first outpatient attendances (Spec acute)	72,302	68,431	74,925	104%	104%	
	Consultant-led follow-up outpatient attendances (Spec acute)	156,655	167,420	148,019	94%	<85%	
Elective	Total number of specific acute elective day case spells in the period	22,169	21,821	23,272	105%	104%	
	Total number of specific acute elective ordinary spells in the period	5,168	4,843	5,300	103%	104%	
Urgent Care / ED	Total number of attendances at all A&E departments, excluding planned follow-up attendances (Types 1 & 2 + Types 3 & 4)	62,098	69,420	70,080	113%	100%	
Non Elective	Number of specific acute non-elective spells in the period	15,713	15,247	16,189	103%	100%	
Diagnostics	Diagnostic Tests	22,736	20,376	23,418	103%	120%	

Productive theatres

Project title	Productive theatres
Aim	To deliver 104% elective activity
Key Outputs of Project	1. Increase the number of day case procedures to 104% 2. Increase the number of eligible patients receiving a pre-op assessment to 90% 3. Improve experience for patients with a learning disability 4. Improve day case staff experience
Proposed Workstreams / Change Ideas	 • Most efficient list orders • Expand pre-op assessment offer • Problems caused by pre-med pathways understood (A3 analysis) • Addition LD nurse to support day case is viable • Further implement key GIRFT principles • Implement Theatre Dashboard to improve care and visibility of LOS, and utilisation

Outpatients

<table>
<tr><td>Project title:</td><td>Advancing outpatient care</td></tr>
<tr><td>Aim</td><td>Reduce OPFU appointments by a minimum of 15% compared to 2019/20 baseline activity</td></tr>
<tr><td>Key Outputs of Project</td><td>1. Ensure no CYP experience harm as a result of sub-optimal waiting list management
2. Reduce the waiting times for patients waiting for a new outpatient appointment or a follow-up appointment
3. Empower families to self-care and initiate follow-up care
4. Implement WNB predictor tool (trialled only once at AH)
5. Improve patient and staff experience of outpatient experiences</td></tr>
<tr><td>Proposed Workstreams / Change Ideas</td><td>We are developing how we provide outpatient care at Alder Hey:
Patient portal
Advancing outpatient care models (including PIFU)
High data accuracy through administrative and AI validation of the waiting list (all 34,000 patients overdue will be validated)
Improve room booking, scheduling of appointments and clinic utilisation
We will manage this work through three key workstreams:
<table><tr><td>1) Advancing care models</td><td>▪ Develop new approaches to follow-up care, including PIFU
▪ Advice & guidance
▪ Self-management information on patient portal</td></tr><tr><td>2) Booking & scheduling</td><td>▪ New outpatient scheduling system
▪ Better processes and performance management to deliver high clinic utilisation</td></tr><tr><td>3) Digital and innovation</td><td>• Increase use of virtual consultations in specialties with less than 25% usage
• Roll out of Was Not Brought predictor
• Clinical letters available on patient portal
• Appointments to be arranged and booked flexibly through the patient portal</td></tr></table></td></tr>
</table>

Project: Virtual Children's Hospital	
Aim: To create a model for the provision of Alder Hey care anywhere so children and young people's needs can be met, and outcomes reported	
Reason for action	It is considered that a cohort of children or young people could receive care virtually to: 1. Reduced A&E admissions / attendances, 2. Reduced length of stay 3. Reduced unnecessary outpatient appointments • There is a lack of a shared definition of what a virtual ward is for Alder Hey • National guidance on 'virtual wards' does not reference or apply to children and young people • There is no defined list of conditions that be treated appropriately in a community setting • There is no oversight of services provided virtually within the Trust
Key Outputs of Project	1. 20 virtual care beds 2. Safety protocols 3. Patients access their results and care plan information in a single place: Alder Hey anywhere 4. Remote monitoring data is viewable in one place for clinicians and patients
Proposed Workstreams / Change Ideas	We see value in developing this model through the CHA to pool expertise and achieve scale. The building blocks to a national virtual children's hospital, and which Trust would lead on that component, is set out below:  The Alder Hey Anywhere platform will 'power' the virtual children's hospital and subsequently elicit the following impact and benefits:

@nywhere Digital Platform ™ Impact

Benefits/Impact

1. **Better patient outcomes** and earlier invention and prevention of chronic conditions and acute illness
2. **Equality of access to care** (tackling healthcare inequalities)
3. **Empowerment** of **self management** via digital devices and technology
4. **increased** hospital **optimization and efficiency.** Better use of resources and value for the NHS £. **New revolutionary care models.**
5. Collates **unique data set** across multiple conditions enabling AI, individualised **predictive use of digital biomarkers**

Resource	Efficiency
Occupied bed days	Reduction
Outpatient appointments	Reduction
A&E attendance	Reduction

Outcomes: Tackle healthcare inequalities
Life expectancy increases ▲
Educational attainment improvement ▲
Reduce variation in outcomes – chronic conditions ▼

3.4 People

In 2021-22, as a result of the ongoing pandemic, we continued our focus on three key areas: staff wellbeing, agile/flexible working and equality, diversity and inclusion. In keeping focused on what mattered to staff during this time, we ensured colleagues were safe, looked after and supported; evidence from the Staff Survey results for 2021 demonstrated that, overall, staff remained positive about their experiences of working in the organisation.

As we move forward into 2022-23, it is now time to review and refresh our People Plan and priorities. The publication of the national People Plan[1] has provided a helpful framework on which to build our local Plan, which centres around four key pillars:

- Looking after our People (People Promises)
- Belonging in the NHS
- New ways of working

[1] https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

- Growing for the Future

Our key actions around the four pillars are set out in the table below:

Theme	Key actions
Looking after our People (People Promise elements)	▪ Implement Organisational Health & Wellbeing Plan, managed via the refreshed Wellbeing Steering Group ▪ Identification of actions to address the People Promises ▪ Ensure all of our spaces, offices and clinical areas; are great spaces in which to work, for all colleagues
Belonging in the NHS (Diversity and inclusion)	▪ Establish new EDI Steering Group, ensuring continuity from the BAME Taskforce ▪ Establish the BAME, LGBTQIA+ and Disability Staff Networks ▪ Refresh of Leadership approach; inclusive and compassionate leadership ▪ Overhaul of recruitment processes to ensure inclusion, access and engagement from all demographic groups
New ways of Working (e.g. upskilling / new role development)	▪ Education strategy development including technology enhanced learning, CPD ▪ Focus on volunteering and pathways into employment ▪ Apprenticeship Planning ▪ New role development in line with operational priorities ▪ Fully implement e-rostering
Growing the Future (apprenticeships / career development / leadership development)	▪ 'Inspiring Futures' - focus on our role as an anchor institution within the city region; partnerships and collaborations with schools, FE, HEI and third sector ▪ Overhaul of recruitment processes to widen the pool locally, nationally and internationally ▪ Trust wide workforce planning process aligned with the emerging strategy ▪ Induction and 'onboarding' review

Staff Numbers 22-23

	Year end 31 Mar 22 WTE	Year End 31 Mar 23 WTE	Difference WTE
Medical and Dental	476	518	42
Non-Medical - Non-Clinical	1003	1,112	109
Registered Nurses	1135	1,160	25
Scientific, Therapeutic and Technical	732	732	0
Support To Clinical Staff	421	403	- 18
Grand Total	**3,767**	**3,925**	**158**

There will be a focus on workforce planning and development in the following areas:

- Radiology and Emergency Departments
- Psychology & Dietetics workforce
- Paediatric Intensive Care Unit workforce
- Theatres
- AHP workforce development

Increases in workforce numbers will be driven primarily through recruitment campaigns. The Trust in engaging in International Recruitment for nurses with 17 candidates due to start in May 2022 with an additional recruitment round scheduled for October 2022. In addition, the Trust is working with the national team, supporting 3 international diagnostic radiographer candidates to start with the Trust in July 2022.

As part of the Brilliant Basics activity across the Trust, Divisions are developing workforce plans using the A3 plan on a page framework which outlines the vision, priorities, dependencies, challenges and risks for each area. There is also a Trust wide AHP workforce plan underway as part of the national programme.

3.5 Financial Planning

Overview

The financial framework for 2022/23 has been set for the full financial year following the interim 6-month regime that we have seen since 20/21 and during the pandemic. The key areas to note in the 22/23 framework are:

- Expectation remains that at C&M system level, systems achieve financial balance and remain within their allocation.
- Requirement for system to achieve a breakeven
- Continuation of block income payments, rolled over from H2, adjusted for inflation.
- System tops up no longer a separate payment and included in base allocations.
- Continuation of national Elective Recovery Fund (ERF) with min target of 104% activity recovery compared to pre pandemic levels.
- Requirement for signed commissioner contracts for all activity provided

- Reduction in COVID funding top ups by 53%
- Efficiency requirement min 3% recurrently
- Car parking charges to resume for all staff on 1st April
- Capital spend (CDEL) in 2022/23 will continue to be managed through the ICS at system level with allocation of spend distributed to each provider.

The internal 22/23 plan has been built upon these key headlines and following a period of detailed analysis focusing on ensuring that the budgets set are reflective of the `true` cost to delivering the operational priorities set out above, whilst also recognising the affordability constraints that remain.

2022/23 Income & Expenditure Plan

The following table summarises the proposed 22/23 financial plan as a comparison to our performance in 21/22 with an overall expected system performance of £2.5m surplus by the end of March 23.

At the time of preparing this report, discussions are continuing across C&M on achieving financial balance as a system and therefore the numbers below are still provisional and could result in further changes once the C&M position is finalised and the final version will be updated once confirmed.

	21/22 Actual £`000	22/23 Plan £`000
Income		
Clinical Income	301,089	311,235
System Top Up	10,419	1,892
COVID Funding	9,592	2,847
ERF Income	9,490	7,620
Accelerator Hosting	16,405	-
Other Operating Income	31,248	36,295
Total Income	**378,243**	**359,889**
Expenditure		
Pay Expenditure	- 211,016	- 215,253
Non Pay Expenditure	- 130,805	- 118,528
Accelerator Hosting	- 16,405	-
EBITDA	*20,017*	*26,108*
Finance Costs	- 8,472	- 8,297
Depreciation	- 10,295	- 14,233
PDC	- 1,113	- 1,078
Total Expenditure	**- 378,106**	**- 357,389**
Adjusted Financial Performance for System	**137**	**2,500**

The key principles that have been adopted in the development of the 2022/23 I&E plan include:

- Block income levels rolled over for all activity based on H2*2 and uplifted by inflation and growth as per national guidance.
- Pay award changes based on 3% as per the national guidance although this has not yet been awarded.

- The depreciation charge includes £2.4m relating to assets that are hosted by Alder Hey on behalf of the C&M system and is funded by a corresponding increase in income.
- Cost associated with deliver of 104% activity has been included at a margin of c50% of the income generated.
- 65% of legacy cost pressures funded within divisional budgets with the remaining expected to be mitigated through switch of or repurpose and will be monitored through the Sustainability Deliver Group.
- Investment prioritised into the Emergency Department to directly increase the clinical workforce, recognising the significant increase in activity since 19/20.
- Further investment asks have been quantified by divisions, however given the financial risks that remain in the plan, a pause has been actioned on new investment not directly linked to delivery of the 104% recovery.
- A recurrent CIP for the year of £9.7m (3%) with a further £4.8m non recurrent CIP expected to be delivered.
- Reinstatement of car parking charges for staff from 1st May in line with national policy.
- A full planning exercise has been undertaken on the Mental Health Investment required to deliver the standards and included in the plan is an assumed £3.1m new recurrent investment that has not yet been confirmed.

A set of financial parameters have been agreed as part of the 22/23 plan which will form part of the Financial Sustainability priority project:

i. 19/20 cost base will deliver 19/20 activity levels
ii. Achievement of the 104% activity target to secure additional ERF income allocated
iii. Reduction of COVID spend by 57% to align national expectation.
iv. No increase in corporate overhead - spend 19/20 plus inflation
v. Restriction in new investments unless deemed necessary due to safety/quality risks.

2022/23 Efficiency Programme

A key factor of the 22/23 plan is a highly ambitious CIP target driven by a 3% minimum target set nationally. This must be achieved through a combination of cost reduction, productivity and collaboration and further work is ongoing as part of the Financial Sustainability priority project to ensure appropriate resource is available to drive forward the programme of works required.

- CIP target for 2022/23 has been set at 3% recurrently (£9.7m) with a further 1.5% to be delivered non recurrently (£4.8m)
- The CIP target has bene phased with higher weighting in H2 to allow for schemes to be developed and implemented.
- The target has been distributed equally across clinical and non-clinical areas at this stage. As transformation areas and projects are agreed the targets may move to reflect the area of most opportunity.
- The overarching themes that are in development for the 22/23 plan include:

  - Workforce
  - Increase activity to achieve min 104% and above
  - Data capture and coding
  - Procurement
  - Infrastructure including Green and Net Zero
  - Medicine Optimisation
  - Commercial initiative
  - Corporate Services
  - Collaboration and Partnerships
- We will also continue to have a progressive and inclusive approach to identification of CIP utilising tools such as Model Hospital, GIRFT, in addition to the trusts internal intelligence such as Service Line Reporting and Reference Costs.
- The Cost Improvement Programme for 2022/23 will continue to be governed through the Trust's Programme Assurance Framework and embedded within the Assurance Committees of the Board governance structure. CIP will also be monitored on through the Sustainability Delivery Board, which is also attended by the Divisions ensuring collective ownership of the programme and related decision making.

Key risks and Mitigations to the 22/23 Financial Plan:

Risks:

- Delivery of a highly ambitious CIP programme of £14m assumed in the plan with c50% identified to date.
- Delivery of activity programme to retain the ERF income assumed in plans
- Deterioration of current expenditure run rate above the pressures and investments agreed, to meet peaks in urgent care demand and elective recovery plans.
- Mental Health investment not yet secured in the plans
- Commissioner investments for service developments is not secured in the new environment.

Mitigations and Opportunities:

- ERF funding available if exceed 104% and deliver at marginal cost.
- Shift in productivity across Trust improving access and costs.
- New opportunities from national funding to support emerging pressures and investments (Urgent Care, Accelerator, Virtual Ward, Diagnostics, Digital/Innovation, Mental Health)

2022/23 Capital Planning

Capital is an increasing scarce resource in the NHS and the level of spend is controlled by a Capital Resource Limit (CDEL) set nationally by treasury and then allocated to each ICS by way of a system CDEL envelope that must not be exceeded.

As a Foundation Trust, Alder Hey has previously had the autonomy to develop a capital plan that utilised internally generated cash with the approval of own Trust governance. The move to a system capital resource limit (CDEL) with allocations to each provider, removes this autonomy to ensure that the capital spend for the ICS is within the limits set nationally. The CDEL allocation is a 'permission to spend' our own cash reserves and not necessarily an additional cash allocation although, new national capital investments will take the form of new cash in addition to an increase in CDEL to spend it.

Capital limits have been provided for the next 3 years, however, focus within C&M has been on agreeing the 22/23 capital plans with further work required on the following years.

The table below sets out the summary of the capital requirements for 22/23 based on a prioritisation process that has been undertaken, along with the confirmed CDEL and charitable allocations, resulting in a residual gap of £9.5m at this stage.

	£`000
Capital Scheme:	
Neonatal Development	8,570
Medical Equipment Replacement	6,052
Other campus works	3,500
H&S/Small Works	1,298
Total capital requirement	**19,420**
Confirmed funding sources	
CDEL Allocation	6,900
Charitable donations	3,000
Residual gap	**9,520**

A capital bid of £5m has been put forward for the national capital allocation and if successful this will reduce the gap to £4.5m with further mitigation to come from delay and postponement of spend where appropriate.

3.6 Risks

Top 5 Risks

Category of risk	Description of risk	Potential impact	Mitigating actions / contingency plans in place
Internal (BAF risk 1.2)	**Recovery**: Failure to deliver appropriate levels of access and activity to our CYP	Potential for: CYP waiting longer than national/acceptable standard; CYP experience harm as a result of sub-optimal waiting list management; lost opportunity to empower families to be at the centre of CYP care and improve patient and staff experience of outpatient experiences	Deployment of new models of care, supported by streamlined systems and process based on Brilliant Basics approach and supported by digital innovation.
Internal (BAF 1.1)	**Outstanding safety**:	Potential for: CYP to experience sub-optimal care if relevant safety metrics	Brilliant Basics model providing framework to ensure that CQC fundamental standards are met and

	Failure to deliver our ambition to deliver the safest possible care to our CYP and reduce preventable harm	do not sustainably improve; CQC ratings remain static	sustained across all services and staff are empowered to embrace our just learning culture.
Internal (BAF risks 2.1 & 2.2)	**Great place to work:** Failure to take steps to address known workforce issues, including learning from the pandemic about staff wellbeing and our obligations to our staff to support them deliver outstanding services to our CYP	Potential for: Staff to continue to experience unacceptable pressure leading to burnout and absence; inability to fill critical vacancies or develop appropriate new roles where skills shortages cannot be addressed locally	Full suite of staff satisfaction metrics are monitored, analysed and timely action taken to address issues; future workforce models and approaches, including equality, diversity and inclusion, agreed and implemented at Trust and Divisional level
External (BAF risk 3.4)	**Financial sustainability**: Failure to optimize efficiency and effectiveness challenges presented by new financial architecture	Potential for: Financial vulnerability as a result of system wide pressures, inability to reduce cost and improve run rate	Focus on realistic financial horizon scanning and planning coupled with robust stewardship, monitoring and governance
External (BAF risk 4.2)	**Safe systems:** Failure to deliver our digital ambitions to benefit effective patient care	Potential for: Alder c@re not meeting its delivery requirements for clinicians to enable them to enhance quality and safety	Robust processes for clinical engagement and governance of the critical phases of sign off and roll out of the new system.

4. Regional & national partnerships

4.1 Cheshire & Merseyside Integrated Care System

We will work with partners to advance and co-ordinate paediatric care and address inequalities. This will be progressed through both the Children & Young People's Transformation programme and in new collaborations between providers of paediatric services in the region. Our work will focus on:

- **Recovery:** We will review the waiting list across providers and specialties so that we can address inequalities in access through targeted support and mutual aid. We are also prioritising the development of a paediatric elective hub.
- **Clinical standards of care:** will be work as a network of providers to improve standards & address gaps in service
- **Transformation:** our work on transformation will include a virtual children's hospital, digital symptom checker and new models of care (such as integration NHS, Local Authority and VCSE services).
- **Digital:** Alder Hey are actively engaged in developing the C&M ICS digital strategy. We will develop the iDigital service that supports Alder Hey and Liverpool Heart and Chest. Our shared infrastructure and system opportunities will continue to be expanded with partners across C&M. The CYP As One Platform will be further developed and deployed across Cheshire and Merseyside supporting children and young people access to mental health services across the system.

4.2 Children's Hospital Alliance (national)

The 2022-23 work plan for the CHA has been agreed as follows:

Workstream	Key actions
Transformation for elective recovery	▪ Developing models of surgical hubs ▪ Community Diagnostic Centres for C&YP
Innovation	▪ Completing rollout of WNB innovation tool ▪ Developing a 'national virtual children's hospital'
Health inequalities	▪ Develop 10 collective 'pledges' for Trusts to sign-up to ▪ Research into health inequalities in our Trusts
Insight and metrics	▪ Develop data and benchmarking
Advocacy	▪ Raising profile of issues around paediatrics care nationally
Communications	▪ Developing information sharing between Trusts ▪ Develop our brand

National Paediatric Accelerator: Evaluation

7 April 2022

How the Accelerator was formed

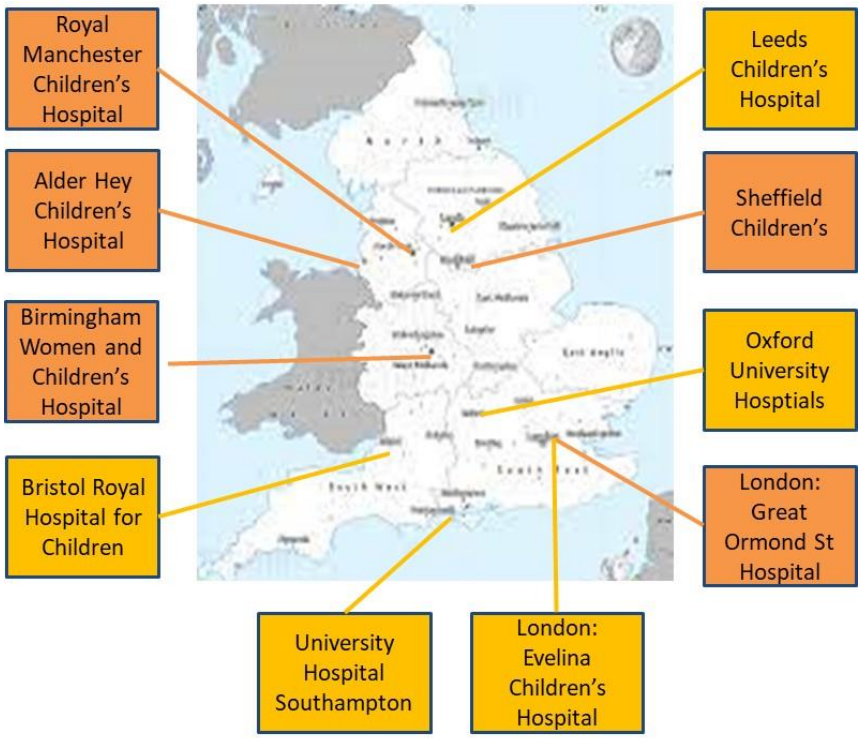
- **April 2021: NHS England announced £200m of ICS-level 'Accelerator' funding** for adult Covid recovery

- **The national lead of the Children and Young People Transformation Programme successfully lobbied on behalf of the CHA for £20m** additional funding for children

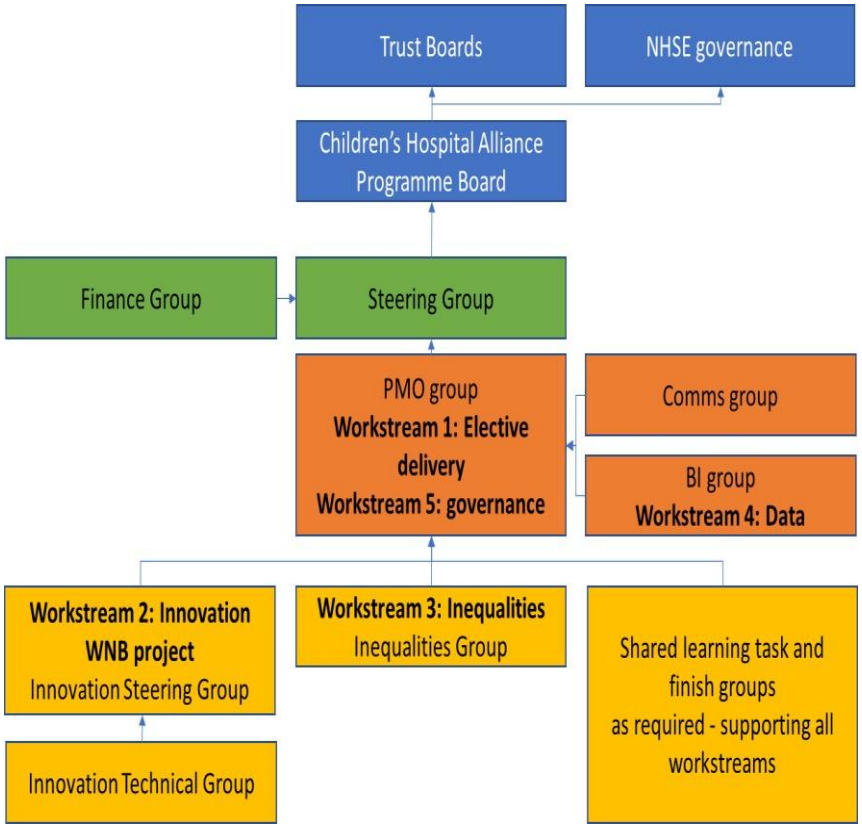
- **The business case and the work programme** were drafted by a PMO assembled from the 10 Trusts:
  - £1m for a joint innovation project
  - £2.7m each for transformation in the larger Trusts who were part of the initial £15m bid (Alder Hey, Birmingham, GOSH, Manchester, Sheffield)
  - £1m each for transformation in the smaller Trusts following a successful second £5m bid (Bristol, Evelina, Leeds, Oxford, Southampton)
  - £0.5m for a joint PMO

Members and governance

Geography



Governance



The 5 objectives of the programme were:

1) Delivery of national elective recovery target: 120% of 2019/20 activity for the 5 core Trusts (105% for the 5 additional Trusts). The CHA revised this in September to delivery of over 100% for the core Trusts, when it became evident that few Accelerators nationally would manage even 100%.

2) Transforming care longer term through innovation. There was a commitment to deliver longlasting change at scale, by rolling out an existing cutting-edge innovation.

3) Reduction in variation of care and tackling inequalities, across national footprint and across ICSs

4) Embedding best practice and shared learning

5) Establish clear governance and accountability structure

This translated into 6 main workstreams

Workstream 1: Activity

Objective:

- Originally, to deliver 120% of 2019/20 activity on average May-November 2021; revised to **deliver more than 100 % of 2019-20 activity**

Delivered:

- **The core Trusts delivered 103.8% of baseline and the additional Trusts delivered 94.7% of baseline between May and November 2021, for an overall of 101.6%.** The Accelerator officially ended in November but activity continued until end March

How this was delivered:

Transformational activity e.g.

- Walk-in-walk out models
- High intensity theatre lists
- Estates changes to speed flow
- Use of VAR in theatres

Additional activity / capacity e.g.

- Additional lists
- Independent sector activity
- Additional staff
- New procedure rooms / OP spaces

Table 1: Activity as a percent of baseline for the priority specialties

Month	All activity	Elective activity	Outpatient activity
		Core trusts	
May	114%	101%	118%
June	106%	91%	111%
July	100%	83%	105%
August	100%	84%	105%
September	100%	86%	105%
October	99%	87%	103%
November	104%	86%	109%
Total	**104%**	**89%**	**107%**
		Additional trusts*	
May	99%	94%	100%
June	97%	96%	97%
July	90%	90%	93%
August	90%	94%	90%
September	94%	91%	97%
October	98%	90%	103%
November	98%	95%	102%
Total	**95%**	**93%**	**97%**
Grand Total	**102%**	**90%**	**103%**

Workstream 2: Innovation

Objective:

- **To deliver a £1m innovation project, rolling out an Artificial Intelligence tool across 10 Trusts to identify children at risk of not attending their appointments**

Delivered:

- **All Trusts are participating in** and rolling out the AI tool which was originally developed by Alder Hey
- **7 Trusts have shared data** as at end March and are able to identify and target those children who are most at risk of not being brought. The remaining 3 will go live shortly
- **Did Not Attends are one of the top 10 causes of avoidable child death** and cost the Trusts £13.4m per annum
- **The programme aims to reduce DNAs by 50%** once up and running in all Trusts

What we have done:

- All Trusts have signed Data Protection Contracts and Impact Assessments supported by a DPO working group, Jan 22
- Standard Operating Procedures developed and the data specification refinements delivered through the Technical working group during Jan –Mar 22
- 7 Trusts are now sharing data which is being run through the WNB predictor tool, led by the Alder Hey Innovation Technical Team by March 22
- An Innovation Programme Board developed a shortlist from staff feedback and PSG approved the final five pilot schemes to reduce WNB rates
- Commitment from all trusts to use the WNB AI output data to identify patients at risk of WNB, with an 80% accuracy, £60k allocated to each Trust
- Standardised evaluation framework developed in conjunction with the Intervention and Innovation Programme Leads to be phase 1 completed June 22

Workstream 3: Inequalities

Objective:

- **To better understand and reduce the impact of health inequalities in our Trusts**

Delivered:

- **Established 10 pilot projects to reduce WNB** by tackling inequalities
- **Awarded funding for an evaluation** in 2022-23 of Trust policies and clinical engagement with Health Inequalities.
- **Data analysis of inequalities** to understand impact of deprivation and neurodiversity (autism and ADHD) on attendance
- **Benchmarking of inequalities data** across the Trusts eg Trusts' performance on data collection.
- **Created tools** to support setting up outpatient services and to assess the impact of services, Equality and Health Inequality Impact Assessment (EHIA) tool .

Inequalities pilot projects

Schools – Leeds, Southampton and Oxford:

- To test the concept of introducing 3-way virtual outpatient appointments that will address some of the potential barriers to attendance. In conjunction with clinicians, families and schools.

Transport – Birmingham and Sheffield:

- To test contacting patients prior to their outpatient appointments and offering free public transport; taxi or parking for Children.

Focussed Support – Manchester:

- Provide a range of bespoke services for children and young people with either Neurodiverse, Learning Difficulties and/or Mental Health conditions to support families to pre, during and post elective procedures.

Clinician-led calls – Alder Hey and Evelina:

- To test methods of communication with a clinician, to see if they could possibly have a more proactive discussion and reduce WNB rates.

Patient portal – Bristol and GOSH

- Use the AI data to target their most vulnerable patients, support sign up, better understand usage, risk and through feedback refine systems and processes to better meet patient and family needs.

Workstream 4: Shared learning and shared delivery

Objective:

- **To share learning between the Trusts to jointly improve delivery**
- **To raise staff morale and recognise the contribution of the children's workforce nationally**

Delivered:

- **Shared learning**: 11 best practice sessions attended by ops / clinical staff from across Trusts. Several of these led to further shared / bilateral projects

- **Shared delivery**: 2 'Super Saturdays' delivering >2000 additional procedures and trialling innovative approaches. E.g. VAR in theatres as an alternative to GA for minor procedures (Leeds); Health Bus reaching deprived populations (Sheffield); theatre and pharmacy tours (GOSH)

- **Workforce**: the Super Saturdays were also a celebration of staff eg patients invited to write messages of thanks to staff

What we did:

Workstream 5: Data and benchmarking

Objective:

- **Provide evidence-base to support Trusts' service changes and quality improvement.**

Delivered:

- **Finance and activity monitoring** for the Accelerator: NHSE used this in preference to their own
- **Demand modelling** for future waitlist growth, future activity requirements, and future financial gaps across accelerator Trusts
- **Benchmarking outpatients follow-up use across Trusts by specialty**
- **Benchmarking outpatients access for patients** based on deprivation, ethnicity, and learning disability status
- **Benchmarking ethnicity data quality**

What we did:

Analysed data from national sources and from Trusts to understand the variation in access to elective services and expectations for the elective waiting list in the future.

Some key findings:

- Was not brought rates for outpatients appointments were
  - highest for patients with Caribbean and African ethnicities
  - more than twice as high for patients in the most deprived decile compared to the least deprived decile
- Patients with ADHD were more likely to not be brought to their appointments and patients with ASD were more likely to not be brought to in person appointments
- There is a 15% variation between Trusts in the number of outpatients appointments where the ethnicity of the patient is unknown

Findings of demand modelling are in next steps below

Workstream 6: PMO and governance

Objective: to establish clear governance and decision making

Delivered:

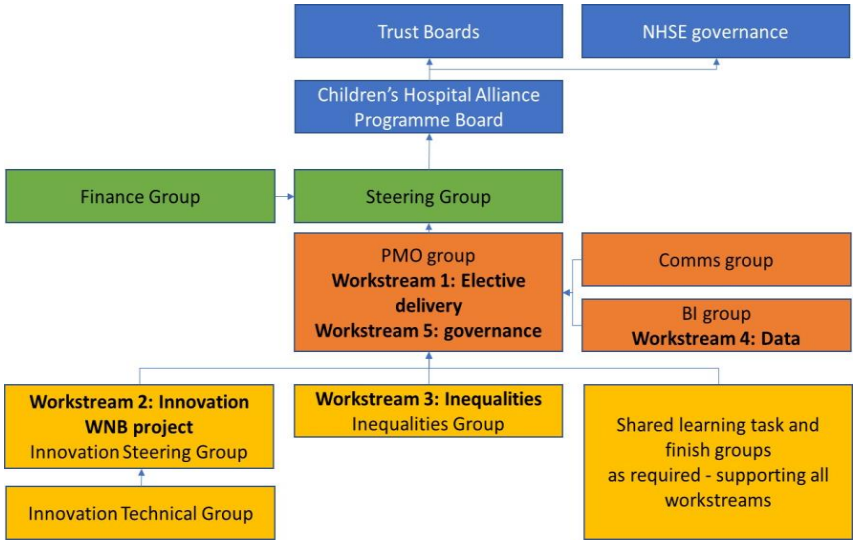
Programme overseen by 3 main groups:

- **Steering Group**: COOs from all Trusts. Decision making on all operational issues, met fortnightly
- **Finance Group**: DoFs from all Trusts. Decision making on all financial issues, met fortnightly, then monthly
- **PMO group**: Programme lead from each Trust, delivering the project at operational level, met fortnightly

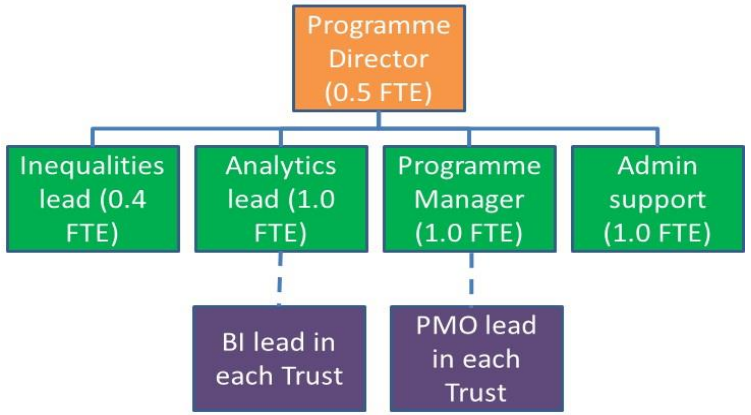
Highly effective streamlined decision making

Supported by PMO with dedicated programme director, programme manager, inequalities lead and admin support

Governance structure:



PMO structure:



National profile and media coverage

- **Objective**: to raise the profile of the Accelerator, with NHSE and our patients - strengthening our ability to advocate for children and recognising the achievements of our staff

- **Successful engagement with NHSE:**
  - contributed 4 case studies to national best practice database
  - Sheffield was filmed for NHSE's programme of media coverage of the Accelerator
  - at national seminar in November we were one of the top performing Accelerators

- **Media coverage focused around the Super Saturdays**
  - Widespread coverage in national and local media (The Independent, Evening Standard, Yorkshire Evening Post, Sheffield Star)
  - Broad reach on social media from participating Trusts
  - Engagement from clinicians and the families of patients – > 120 tweets using #NHSSuperSatuday around the March event

Video clips and links

- **Birmingham: Super Saturday 16 October:**
  https://www.youtube.com/watch?v=avYiEwN7uuk

- **Birmingham: Super Saturday 5 March:**
  https://www.youtube.com/watch?v=lQ9Bvg0yekw

- **Leeds: Super Saturday 16 October:**
  https://www.youtube.com/watch?v=veXE1xB5Ju4

- **Sheffield: BBC Look North coverage of the Accelerator:**
  https://www.youtube.com/watch?v=FlwXgk4wr6A

- **Sheffield: Super Saturday 5 March:**
  https://www.youtube.com/watch?v=DpQx3yTxP-w

- **Sheffield: Matilda's Story:**
  https://www.youtube.com/watch?v=EoNi9bhNucQ

Finance – we managed our allocation within the financial year

Spending plans for paediatric accelerator Trusts, February 2022*

*(end year finances being finalised as at 12th April)

	Updated planned spend (H1 and H2)	Actual spend (April to February 2021)	Percent of spending completed to date	Underspend including reprofiling
Alder Hey	£2,755,974	£1,955,551	71%	£0
BWCH	£2,749,000	£2,068,005	75%	£0
GOSH	£1,626,920	£1,384,120	85%	£0
Manchester	£2,856,512	£2,809,378	98%	£0
Sheffield Children's	£2,900,394	£2,214,622	76%	£9,023
Bristol	£1,048,000	£824,009	79%	
Leeds	£1,075,959	£922,198	86%	£2,000
Oxford	£999,188	£918,708	92%	£0
Southampton	£995,000	£980,000	98%	
Evelina*	£1,099,780		0%	
Total	**£18,106,727**	**£14,076,591**	**78%**	**£11,023**

Spending on topsliced / shared programmes:

Cost category	Allocation	Spending to date	Forecasted spend
PMO	£700,000	£464,283	£ 710,602
WNB – Alder Hey	£270,000	£174,936	£280,056
WNB – Other trusts	£730,000	£0	£755,000
Inequalities	£200,000	£0	£144,000
Total	**£1,900,000**	**£639,219**	**£1,889,658**

Lessons learned

- **Shared working has been energising** and has benefitted all Trusts; the Accelerator projects have been very positive and good for staff morale during a difficult year
- **We should be equitable going forward** in how we distribute funding. The split between the 'core' and 'additional' Trusts came about because of the way in which the project was set up, as NHSE funding became available, but in future years we will not follow this distinction. However future projects may also need to negotiate differences in gainshare, if Trusts are able to commit to projects at different rates
- **Recognise that not all Trusts can move at the same pace**; the smaller Trusts have fewer resources. Future projects may need to make provision for project support in the smaller Trusts where there is less capacity to support shared working
- **Transparency has been a great strength.** The benchmarking eg around equalities has been extremely helpful; going forward we should do more benchmarking eg of waiting lists
- **Senior and operational leadership very successful;** need more clinical voice for the future
- **Next step is to reach out more into our ICSs and regions, and the ODNs** – we need to take the benefits out to other Trusts. Some Trusts have been able to do this but this needs to be more systematic and navigate the tensions of working at ICS / regional / national level

What each Trust has delivered

Alder Hey

NHS
Alder Hey Children's
NHS Foundation Trust

Dental

- Procured additional handpieces which allowed us to treat more patients and put on weekend theatre lists
- Recruited a temporary Specialist Dentist who provided an additional 20 outpatient clinics and 10 theatre lists

ENT

- Recruited an ENT Consultant who helped to see an additional 670 outpatients and operated on a further 100 inpatients

Paediatric Surgery

- Regular Super Saturdays enabled the department to see an additional 1170 outpatients and undertake an additional 24 theatre lists

Orthopaedics & Spine

- Recruited a Spinal Nurse to support an increase in activity
- The specialities have jointly undertaken an additional 50 weekend theatre lists

Innovation

- AI tool that underpins the Was Not Brought intervention was developed originally by AH. The AH innovation team supported the development and rollout of this across all Trusts

Leadership

- Co-chaired the Steering Group and took an active role in helping to develop the programme.

Birmingham Women and Children's

NHS
Birmingham Women's and Children's
NHS Foundation Trust

Innovation growth

- Successful innovation pilot of a High Impact Intensity Theatre approach tested out in PS&U, offering surgery to an additional 57 patients with no additional theatre time; and reducing down time. Innovation now being reviewed for wider spread to other areas
- Established standby patient and patient call out processes; and used shared learning opportunities with Alder Hay to to maximise utilisation and complete a review of the 642 Theatre Utilisation process
- Shared learning from Sheffield and GOSH supported us with developing a pilot for reducing GA use in MRI through play therapy
- Was Not Brought Initiative offered Transport support to patients (from IMD1 areas), removing barriers to attendance & reducing WNB rates in those cohorts by around 4.5%*

Workforce

- Funding provided locum posts in PS&U, T&O and Cardiology which addressed WL challenges in those specialties
- Supported recruitment of 44 International Nurses

Activity

- Multiple specialties carried out over 200 additional surgical operations plus almost 2000 additional outpatient consultations
- An additional 43 sleep studies were carried out, along with over 100 additional therapy consultations
- 324 additional ultrasound scans completed

#NHSSuperSaturday

- ✓ Around 700 additional children seen for elective procedures or and outpatient consultations
- ✓ HIIT list pilots able to test & learn
- ✓ Online cooking demonstration aimed at young diabetes patients as part of an innovative community outreach initiative with a third sector partner

**Indicative figures – final pilot validation still underway*

Bristol Royal Hospital for Children

Bristol Royal Hospital For Children

Massive improvements driven through a comprehensive programme funded by the CHA Accelerator, including:

- Increased bed capacity on our medical ward
- Investments in our Children's Emergency Department (CED) to support improved flow
- Innovative new roles in our CED for early support and intervention for children with mental health presentations
- Funding of a new mental health lead post for the hospital, who has led a comprehensive programme of work in this area
- Improvements to our allergy service
- Launching an outpatient neuro-rehabilitation service, freeing up inpatient ward beds
- Supporting flow through general paediatrics investment for earlier discharge
- Investment in our gastrostomy nursing team
- Investment in outpatients capacity

This programme has brought huge benefits to patients and staff through this challenging period. In combination with our local accelerator schemes, the investment enabled us to increase outpatient, and elective inpatient and day case activity in 21/22 by around 10% on 20/21 levels

Evelina

Neurosciences – TANDeM and Improvement Management

- Accelerator funding has provided an additional 42 new slots and 66 follow up slots so far to help care for patients with tics and neurodevelopmental movement difficulties. This has helped reduce waiting times to ensure patients are seen sooner. (impact on RTT as shown)

- Our new service improvement manager has streamlined our outpatient processes to improve waiting times for our follow ups. They have successfully reduced the follow up backlog by 24% since November 21

Urology Fellow

- Post holder helped to run 20 outpatient clinics and provide cross cover for theatres allowing our clinical team to pick up additional theatre lists in other hospitals

Endocrine Consultant

- Helped to see an additional 570 patients, reducing the follow up backlog by 20% and an improvement on the new patients waiting times by 25%

Additional Inpatient Lists & Equipment

- Total of 106 additional patients treated since the start of the programme. Specialties included Orthopaedics, Gastroenterology, Urology and Cleft
- Additional Orthopaedic sets allowed for higher volumes of lists

My Pre-Op Software

- Accelerator funding facilitated the purchase of a new pre assessment software which allows for a reduction in the need for patients to visit face to face

Great Ormond Street

Successfully Completed Projects under the GOSH Accelerator Programme

Enhanced Theatre Cleaning Project – reducing cleaning process by 2 hours to allow for better flow and utilisation

Integration of Rostering and Electronic Patient Record systems – Producing better objective information for the operational management of patient placement and nurse allocation using live data in the GOSH EPR system

Nurse Call System Improvements – Increasing theatre efficiency by linking the call system across all theatres

Capital Equipment Investment – Purchasing of two flow metres, a rapid Covid testing machine and a Manometry unit for Gastro leading to successful increase in patient activity, and reduced delays and disruption in theatres due to better and more convenient Covid testing

Royal Free Mutual Aid – Shared resource and capacity led to increased numbers being seen in general surgery and urology for the Royal Free

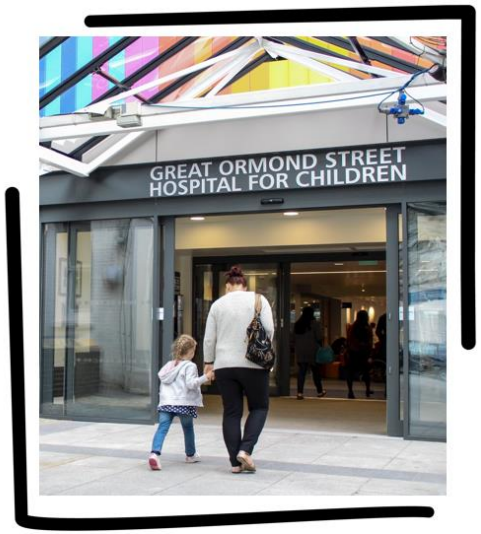
Tiva Pumps – Purchase and utilisation of Tiva pumps created an additional theatre list per day

Additional Administrative Capacity – Additional hours agreed and released increased capacity in validation and clinical support processes

AHU Upgrades – Increased air flow allowed for more spaces to remain accessible for patients

Impact of Projects: May 2021 – Feb 2022

- **42,616 Elective and day case appointments**
  - 1,093 above the Accelerator target, 109 average per month
- **170,149 Outpatient Appointments undertaken**
  - 6,769 above the Accelerator target, 677 average per month
- **Reduction in >52 week waiting list numbers by 54%**
- **Increased patient numbers against the 2019/20 baseline of:**
  - 13% - Daycase and Elective procedures
  - 9% - Outpatients



Leeds Children's Hospital

Two incredibly successful Super Saturday events in Oct 2021, March 2022 including:

- Trial of virtual reality distraction therapy for surgical procedures
- High intensity theatre lists
- Hospital passports for children with additional needs
- Community hub clinics
- Learning disability signage
- Bespoke clinics for children with additional needs
- Blood drop-in/tablet taking clinics

Watch our Super Saturday feedback film from October 2021!

Transformation Schemes Supported by Accelerator:

- New Outreach Team for deteriorating children
- New 'Accelerator' Matron
- Introduction of Complex Needs Team
- Additional LTV capacity
- Digital OPD room booking system
- Digitalising NSSA and fluid balance charts
- Workforce modernisation of Physicians Associates
- Advice and guidance facility within General Paediatrics
- Healthier at Home pilot
- New Eating Disorders Service
- New Discharge Co-ordinator

What difference did this make to patients?

710 more children had their operation completed in 2021/22 vs 2020/21
1628 more children had outpatient appointments in 2021/22 vs 2020/21

Oxford Children's Hospital

Oxford University Hospitals NHS
NHS Trust

- **Activity levels increased:**
  - **20 Paediatric Spinal Cases** undertaken within the independent sector, close collaboration with Trust and Independent Sector staff. Small in number, but huge in impact. Fantastic patient experience, and seamless care between providers meant that these children had their surgery much earlier than would have otherwise been possible. Has set a precedent for an ongoing relationship with this provider for future initiatives
  - **Additional Outpatient activity** undertaken in specialties within long waits, resulted in a 7% increase in activity. Supported the Children's Hospital to deliver 106% of 19/20 outpatient activity
- **The Accelerator programme has provided a framework for closer working with other Children's Centres**, sharing the unique challenges that Children's Services face, and facilitate discussion around solutions and the potential to transform future models of care.

Sheffield Children's

Sheffield Children's NHS
NHS Foundation Trust

SCFT has led on a range of Paediatric Accelerator pieces of work, reducing waiting times whilst improving colleague engagement. We are proud to have achieved:

Innovation

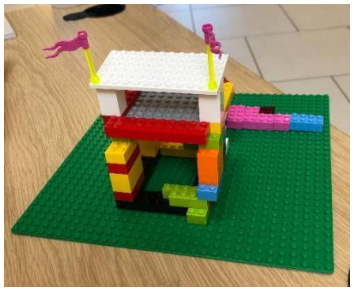
- First Trust to have live data for WNB Predictor tool, testing and refining the process for other Trusts in the CHA
- First Trust to implement WNB interventions (targeted patient Transport project)
- Leader on the evaluation of WNB innovation pilots for the CHA
- Implemented high intensity theatre lists in ENT and direct theatre pathways

Shared Learning

- Frequent and active contributor to all shared learning sessions, especially around Health Inequalities
- Led learning session on WNB interventions, and shared ideas for WNB pilots (e.g., appointments in schools)

Super Saturday

- Led on the development of the Super Saturday concept
- Delivered two Super Saturday events (Oct 2021 and Apr 2022) with over 1000 family contacts to improve oral health
- Permanently increased Trust capacity for theatres for oral health interventions
- Tested and made room for innovative ways of working, joint clinics



Health inequalities

- Supported families of inpatients with Staycation Packs and access to affordable meals
- Developed a coproduction approach with a social enterprise (Co-Create)
- Called >400 families as part of our WNB Project (Collaborated with BWC to test interventions to reduce barriers to attendance)

Accelerator Interventions

- Over 210 projects approved, with a total value of c.£8M
- Delivered an additional five outpatient rooms, permanently increasing outpatient space capacity
- Improved the usability of our theatre spaces (through an upgrade of the Procedure Room)
- 130 new colleagues joined the organisation on a range of permanent and temporary contracts

Southampton Children's Hospital

- **Accelerator funding has enabled us to purchase equipment and recruit staff to expand our home sleep study service** and start a home video-telemetry service. This resource-efficient, family-centred model has enabled us to increase activity without a requirement for additional inpatient capacity. It is also much less disruptive for children and families and often results in better quality results
- **It also enabled us to run regular Saturday operating lists,** resulting in an additional 188 elective procedures across paediatric surgery and paediatric orthopaedics between April 2021 and January 2022
- **It supported us to trial an 'Intelligent Triage' model** for referrals to paediatric dermatology.
- **It enabled us to trial different models of working by investing in non-medical roles** – e.g. pharmacy-led clinics in paediatric neurology and paediatric endocrinology

Next steps

Levels of need next year

- **The Accelerator has helped us control our WL much better than non-Accelerator Trusts** (14% growth overall compared with 22% in 2021*)
- **But 91,000+ children are currently waiting** for care across our Trusts**
- **And another 112,000 weren't referred for services** as we would have expected during Covid – about 67,000 of those are likely to return (based on NHSE assumptions of 60%)
- **We expect WL to rise to 174,000 (more than a 40% rise)** by the end of the year even if we meet all of our waiting list targets AND deliver 104% of activity in 2022-23
- **We will need to deliver more than 130% of activity by 2024-25** to get the WL down to 2019-20 levels

*22% increase in 7 months of 2021: Nuffield Trust 2021
**All other figures on this slide taken from internal CHA modelling

Working together going forward

- **Given the success of the Accelerator we have agreed to take forward the Children's Hospital Alliance** as a self-funded organisation

- **We will continue to work together** to tackle waiting lists and our other challenges

- **We have bid for £30m additional funding** from NHSE, to help us build on momentum and tackle the gap in need following the end of the Accelerator funding. There is a known £30m shortfall in funding for specialist children's services in 2022-23, and paediatrics has very little access to the £1.2bn being made available to adult services for Covid recovery in this current year.

- **With or without the NHSE funding we will take forward a work programme** that builds on successes to date while focusing more on advocacy for children and engagement with other national partners going forward

Objectives of the CHA going forward

The purpose of the Children's Hospital Alliance is to bring together its member Trusts to:

1. **Improve access to high quality care for children and young people by tackling health inequalities, driving improvements in our local systems and working in partnership above and beyond regional boundaries;**
2. **Improve quality of paediatric care across the system by sharing learning and spreading innovation;**
3. **Support a national focus on paediatrics, advocating on behalf of our staff, children, young people and families to help secure the resources they need.**

Our objectives…

Develop the structure, governance and function of the CHA

Support recovery and strengthen delivery through innovation

Engage with national stakeholders to advocate for CYP

Support education on paediatric care

Develop shared approaches to data and benchmarking for quality and value

Provide leadership to improve care for complex CYP

Reduce health inequalities for CYP

The work programme for 2022-23

1. **Transformation for elective recovery**
   - Rolling out transformations that we know work
   - Developing models of surgical hubs and Community Diagnostic Centres for paeds

2. **Innovation**
   - Completing rollout of WNB innovation tool
   - Developing a 'national virtual children's hospital'

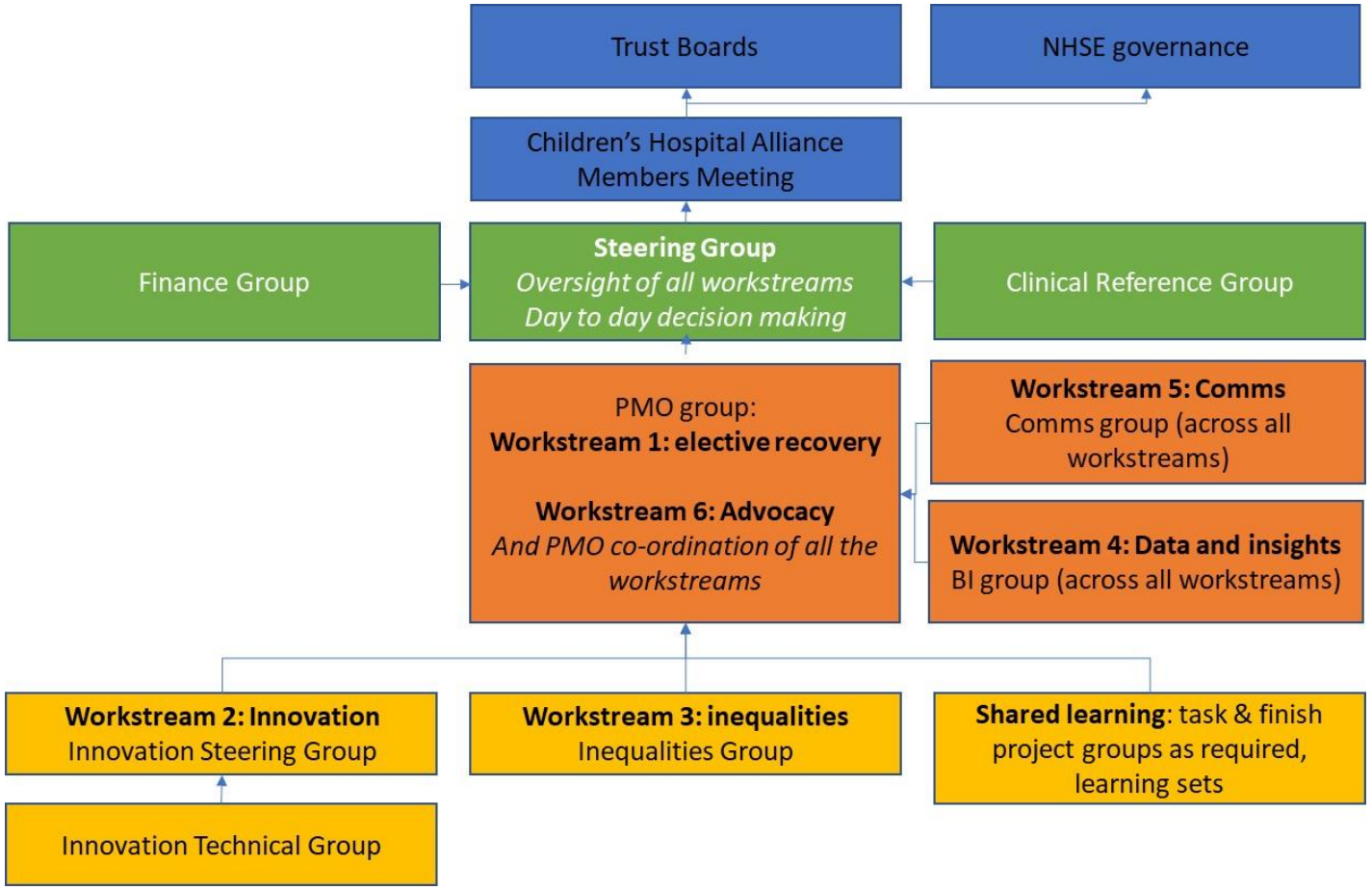
3. **Health inequalities**
   - Develop 10 'pledges' for Trusts
   - Research into health inequalities in our Trusts

4. **Insight and metrics**
   - Develop data and benchmarking partic on inequalities

5. **Advocacy**:
   - Raising profile of issues around paediatrics care nationally

6. **Communications:**
- Developing information sharing between Trusts
- Develop our brand

The governance will be largely as now with the addition of a clinical reference group



Acknowledgements

The programme is the sum of a year of hard work and enormous effort from staff across all of the 10 Trusts. Each of the transformation projects above represents hours of commitment from executive, clinical, managerial, operational, financial, HR, estates, and admin colleagues.

The PMO would like to extend huge thanks to everyone who has helped to make the Accelerator such a success; and in particular, to the leads at each of the Trusts who have worked together with such commitment, good humour and mutual support.

Thank you all.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	Digital and Information Technology Update
Report of:	Kate Warriner, Chief Digital and Information Officer
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer; Ian Gilbertson, Deputy Chief Digital and Information Officer

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

Alder Hey Digital and Information Technology Update

1. Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress against the Digital Futures Strategy. It reports on the overall service, key areas of transformation and operational performance.

Key headlines include:

- Good progress with Digital Futures delivery
- Good Operational performance
- Progress and plans for Digital Futures 2022
- Changes to iDigital Service Model

The Board of Directors is asked to receive the report and note good progress to date.

2. National and Regional Digital Update

Nationally, there have been some significant developments with structures and ways of working. A weekly CIO touch base is in place which includes updates and input to emerging national changes.

Following the publication of the What Good Looks Like (WGLL) Framework for ICS and Provider organisations, NHSX have published a tailored version, specifically for Nursing. This future vision for nursing, enabled by WGLL, is a vision where, Nurses are empowered to practice and lead in a digitally enabled health system and their practice is fully supported using digital technology and data science.

The framework is based around seven success measures aligned to the top line themes of digitise, connect, transform:

What Good Looks Like Success Measures:

1. Well, led
2. Ensure smart foundations
3. Safe practice
4. Support Nurses
5. Empower citizens
6. Improve care
7. Healthy populations

The Digital and Nursing Teams have commenced a detailed assessment into how Alder Hey is performing against the framework, which will be submitted to the next Digital Oversight Collaborative.

Regionally, the refresh of the Digital Strategy for Cheshire and Merseyside ICS is underway, following the appointment of a new Chief Digital and Information Officer late last year. The Trust are actively engaged with the regional teams and will ensure their contributions are captured and portrayed in the refreshed strategy and that the refreshed Trust strategy is well aligned.

3. Digital Partnership – iDigital Service Update

Further progress has been made regarding the iDigital integrated service. Some leadership changes have afforded the opportunity to review the effectiveness of the current service model and whether it is fit for the future priorities of both Alder Hey and Liverpool Heart and Chest.

The new model is based on a streamlined professional digital portfolio model underpinned by a single operating model. The portfolio model proposed responds to the current priorities of Alder Hey and would be the next stage of the evolution of iDigital. The model would see further integration of teams, whilst maintaining the integrity and priorities of each Trust.

The model will predominantly operate within 2 core functions:

- **Data & Change** function will have significant transformation priorities for 2022 for both trusts. These priorities include taking data and analytics to the next level both operationally and strategically, HIMSS 7 at LHCH.
- **Delivery and Assurance** has a major role in ensuring operational excellence in core delivery across a range of areas critical to the day to day running of services in both trusts. Delivery and assurance should be highly visible working with front line teams supporting clinical care delivery to be effective with a great digital experience for staff.

The model was approved by both Trusts Executive Committees with mobilisation underway. Finally, the iDigital Partnership Group recently met to review the Partnership Agreement. The group noted the huge amount of progress that has been made in 21/22 and the benefits the model has delivered for both organisations.

4. Digital Futures

4.1 Digital Children, Young People and Families

The Website & Intranet project is approaching the end of the ‘Discovery’ phase which has involved stakeholder engagement through surveys, content auditing, and workshops. The next steps will involve further, more in-depth engagement with named departmental leads which will help produce a clear design vision and prototype for the intranet. The intranet is expected to Go Live in August 2022 and the external website Go Live is planned in for October 2022.

The build for the remaining symptoms for the Symptom Checker is underway, with clinical leads collating content for anxiety, infant feeding, constipation, and a diabetes page. In addition, the Communications team are in discussions regarding the potential for further regional and national promotion of the symptom checker, following wider interest from CCGs.

There are currently 19 specialities across the Trust engaged with the imminent roll out of the ISLA platform. Governance has been established and the pipeline priorities have been planned in, with a target to have the specialities with a lower uptake of virtual clinics to go live in the early stages of roll out. Aiming to Go Live with Neurology in April and Sefton Community Physio in early May. A further engagement and communication campaign is to be conducted to capture any additional specialities

4.2 Digital Quality and Safety Improvement

Following the successful Stage 7 EMRAM accreditation of In November, the Trust continue to work closely with the HIMSS assessment team ahead of the publication of a new set of accreditation criteria.

The electronic anaesthetic record continues to support several benefits for the Trust, including improved quality and access to the anaesthetic data. Since go live there have been over 7500 electronic anaesthetic records captured. Feedback has been gathered from the Theatre & Anaesthetic department and the results indicate the implementation has transformed the way the department works.

Medisight, the bespoke Ophthalmology EPR, went live department at the end of January 2022, with positive feedback from the team following implementation. The solution will enable the department to transition to a paperless workflow and improve data quality by integration with specialist clinical equipment. The system will now be handed over to BAU and benefits will continue to be monitored.

A successful upgrade of the Electronic Consent system was completed in March 2022, which included some key safety features which will enable a Trust wide deployment. A plan is being developed to completely remove the paper from circulation by May 2022.

4.3 Digital Futures 2022

Digital Futures was launched in 2019 and plans are now underway to develop a refreshed version for 2022 - 2025. A proposed, high level overview of the refreshed strategy has been presented and provisionally supported by the Digital Oversight Collaborative and the Trusts Executive Team.

To support the development of the new strategy and to ensure it is co-designed by the wider hospital a Board Strategy Development session was held in April with the Board of Directors. The session reflected on the successes of Digital Futures since 2019, gathered contributions and input from key stakeholders and identified how the Board could further support the digital agenda.

Compounding this, the Digital Team have facilitated discussions with Divisional Leads to obtain their input and ideas, again ensuring the strategy is reflective of the wider Trust needs. Both the Divisional and Board Development feedback will help shape the final version.

The first draft of Digital Futures 2022 is scheduled for submission to RABD and the Board of Direcrtors in May 2022.

5. AlderC@re

One of the key priority programmes for 2022 is the Alderc@re programme. Alderc@re is the programme which will see a major upgrade to the Trust’s core electronic patient record system – Meditech. This upgrade will impact all staff who utilise Meditech and is a major change programme for Alder Hey.

While the Alder Hey deployment is a first of type deployment in the UK, there are other Trusts locally and nationally who are planning to go live with Expanse over the next few

years. We have reach out to some of these organisations with a view to sharing resources and where possible engaging in joint activities.

The programme team is working towards the agreed September/October Go Live. The governance and leadership of the programme has recently been reviewed and refreshed. The operational positions within the governance structure have been filled. This will enable additional contributions to the deployment from clinical and operational colleagues. The revised team structure is on track to provide a schedule of deployment for key activities, which is supported by controlled, regularly updated data from the related workstream leads. The Development and Training teams are working closely together to ensure workshops and training can be planned in with the appropriate staff groups.

The programme Go Live is subject to the successful mitigation of IT resource issues, and the resolution of a number of key risks, primarily in relation to electronic prescribing, resolution of agreed go live 'red line' criteria and clinical / operational sign off.

The delivery of solutions for the programme showstoppers from Meditech continues steadily. A concern remains regarding the long lead times for some items, and others without clear dates for resolution. Clinical safety hazard logs continue to be received from Meditech and allocated to staff within the Trust where mitigation is required.

6. Analytics and Data Engineering

The Analytics and Data Engineering teams have continued to maintain the data warehouse, submit 400 individual submissions per month and deliver ad hoc data requests throughout March.

The teams have supported numerous projects throughout the month including LD Benchmarking, a comprehensive review of Was Not Brought (WNB) reporting, Patient Care Platform, National Theatre Productivity Data exercise and launch of new accessible CAMHS PTLs.

Progress continues to be made with the current work plans including:

- Access to Care – New content and fixes
- Expanse Project – work is continuing data migration work for Expanse
- Radiology Power BI Dashboard
- Contribution to Recovery Plan
- 2022/2023 Quality and Performance Planning
- National RTT Switch Off

7. Operational IT Performance

Key operational targets continue to be delivered or improved upon. 95% of incidents or requests are resolved within target, reducing average response and fix times and improving customer satisfaction.

This report provides performance to the end of March 2022. Key highlights include:

- Continue with downward trend for overall Ticket resolution. Slight increase over the past couple of months though which is being investigated.
- Ticket resolutions at 95% target SLA

- Resolutions within 1 Day remain high and above SLA.

Monthly tickets hovering at the 3000 mark with the Drop-in clinic resolving nearly 500 tickets in the last 3 months.

8. Summary and Recommendations

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

2022 is a year with a range of significant developments for Alder Hey, notably with the upgrade of Meditech planned for September/October subject to sign off of key risks, operational and clinical readiness etc.

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

The Board of Directors is asked to receive the report and note good progress to date.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 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

April 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 4 in Quarter 2 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. 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 Tendering and Design **COMPLETE**								
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								

3. 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 and awaiting handover. 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. 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. 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 15th May 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.	Budget for furniture is inadequate.	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.	Complete legal agreements. Reviewing asbestos report (obtained 21/04/22)

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Phase 1 of the park is now operational. A planning application for the Multi-Use Games Area (MUGA) has now been submitted. The application is set to be determined by delegated powers by 22nd April 22.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9)	Planning decision expected 22/04/22. LCC liaison officer tasked with chasing decision if not provide on due date.

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 on plan for 28/04/22; 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. Delay being reported due to fire stopping within existing building.	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.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 28th April 2022.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**Alder Hey Green Plan report of progress**
Report of:	**Green Plan delivery team**
Paper Prepared by:	Mark Flannagan, SRO (Director of Marketing and Communications) Alex Pitman, Green Project Director

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

1. Introduction

This paper sets out for the Board the next phases of our Green Plan.

The goal of a Net Zero Alder Hey was agreed by the Trust Board in March 2020 and in February 2022 Alex Pitman started on contract as Green Project Director to provide the expertise we require to advise what we need to do operationally to achieve this goal.

This paper sets out what we are now proposing to do to move us forward to Net Zero, beginning with "low hanging fruit" of energy, waste and, to an extent, travel. The Board is asked to support this approach, recognising that regular reports on progress will be provided to RABD and then brought back to The Board as appropriate.

2. Background

The NHS has developed Greener NHS programme with the key objective being carbon reduction and a move to Net Zero. There is, therefore, a requirement on all NHS bodies to make their own progress towards this goal, reporting through the ICS. It should be noted that delivering Net Zero will require a large amount of organisational change over some years and we recognise that this will need the right resources directed to this purpose. It is also recognised that there may be financial savings through delivering net zero, but these aren't yet identified or certain.

3. Phasing the Plan

We have identified three initial phases to our Plan.

Phase 1 is what we are now working on beginning to deliver with the immediate goals of energy, waste and travel within a governance framework. We aim to embed Phase 1 within the next four to six months and start wider engagement and communication across Alder Hey.

Phase 2 will be about locking in the continued measurement of our journey alongside a programme working with staff to illustrate the need for net zero, both in Alder Hey and in their own lives, in addition to continuing with the elements of Phase 1. As part of this we will publish our carbon footprint. Phase 2 will be the next six months of our journey.

Phase 3 will be about implementing the remaining areas with a fully operationalised approach, but also include a heavy focus on delivering net zero procurement working with the multi-Trust team led by Richard Jolley.

These phases and elements may adjust or change significantly as we progress and learn more, but this will be reported to RABD.

Alongside each of these phases will be closer working with NHS colleagues across the ICS to identify opportunities for shared activity, such as the possibility of working as one on a Green NHS Travel Plan that engages with public transport providers to radically improve provision and, thus, notably reduce car travel by NHS staff across the region.

4. Work being done now: Phase 1 activity

Initial scoping showed three key areas of opportunity that we either must or could engage with:

- Energy – The main hospital building does not work as designed leading to increased carbon emissions and costs.
- Waste – We create over 1,000 m^3 of waste a month and recycle only 25% of this.

- Green travel – 80% of our staff drive to work, public and active travel options are poor.

- We also now have data on the carbon emissions from our medical gases and these make up 9% of our buildings emissions with the majority coming from nitrous oxide. This is an area where we have consistently improved year on year and are doing well vs NHS best practice.

The next phases of our plan have been documented in a draft Project Initiation document (PID) attached at Appendix 1.

The first phase of our work is targeted to:

- ENERGY: Save £1m in energy costs and reduce energy related carbon emissions by 10%.
    - We achieve this by getting the building to operate as designed.
        - Key savings come from reinstating the Combined Heat and Power plant.
        - Further savings come from energy savings in the heating system.

NOTE: *To deliver the initial energy savings we need to have the hospital to work in the way it was designed to. The SPV have outlined a series of technical problems that need to be resolved but have not yet agreed a plan to resolve these. This has been escalated along with a number of other SPV technical issues and we are waiting for a response.*

To deliver at pace and help mitigate the large energy price rises we expect on our new contract in October we need an improved way of working. We have suggested a week-by-week implementation plan needs to be developed by the SPV and then reported against weekly.

To ensure this is done we suggest Executive Team meeting reporting and oversight and, where needed, intervention to ensure the SPV delivers as needed.

- WASTE: Double our recycling rate and save £40k per year by.
    - Reinstating cardboard collections.
    - Adding a third compactor to reduce the 1,000 bin collections a month.

- TRAVEL: Carefully develop a revised and realistic Green Travel Plan that will include:
    - A focus on items such as the impacts of:
        - Working from home.
        - Changing work locations.
        - New buildings.
        - Digital outpatients.
    - External partnership working with Merseytravel, local government and the ICS.
    - Staff engagement and behaviour change.
    - Identifying the Capital needs, e.g., for more and improved cycle facilities.

- GASES: Develop a medical gas plan using external benchmarking versus industries with expertise in gas leakage.

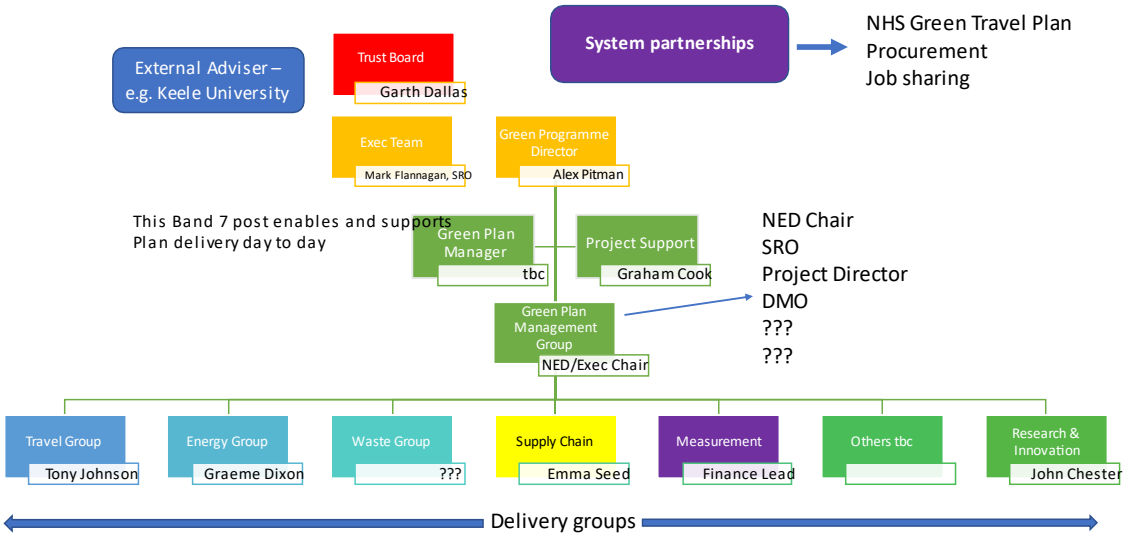
To aid Phase 1 and the subsequent move to net zero we will create a Communications Plan to explain our goals, to recruit support for activities, to inform staff about the actions they can take in support and to set the scene for further work in Phases 2 and 3.

5. Governance

The project is being managed through Garth Dallas as Non-Executive Director and Mark Flannagan as Senior Responsible Officer. Wider engagement has started with clinical teams and the Youth Forum.

The project team will provide monthly updates to RABD and the Executive Team. A project steering team will meet monthly starting in May to provide governance and assurance. The project initiation document will be finalised once completion dates are agreed with the SPV on energy.

Management information for waste, carbon and energy have been developed and will be used at steering team level. Further work is needed to embed these at the right level in other scorecards by workstream.



Delivering our Green Plan – structure

6. Recommendation

The Board is asked to support this approach.

APPENDIX 1

Project Initiation Document (PID)

Title of the Project/Scheme:	Green Alder Hey
Strategic Driver Metric	
Executive Sponsor:	Mark Flannagan
Clinical SRO:	
Operational SRO	
Clinical Lead:	
Senior Project Manager:	Alex Pitman, Graham Cook
Finance Lead:	
Information Lead:	
Consulted in the development of the project brief	
Function and name	Estates team - Graeme Dixon, Mark Deveraux, Jean Hutfield Clinical team – Ian Sinha, Sarah Mayell, James Holmes, Charlotte Berwick, Avram Mihaela Estates suppliers – Cliff Bathgate, Jason Pryor, Mark Cade, Mark Finnegan, Daniel Rowlands Development team – Philip Morgan Pharmacy team – Paul Sanderson Youth forum

Reporting arrangements	Monthly green steering team meeting RABD
Brilliant Basics, Trust value and Strategic driver	

Objectives (SMART)

1. £ 1m saving in annual energy consumption by Oct '22. Delivered through consuming less and generating more electricity through the CHPs.
2. Increase recycling rate from 25% to 50% by July '22
3. Strategic travel plan agreed by Aug. '22
4. Improvement plan in place for Nitrous oxide

Analysis of root cause of problem

1. Energy. Building does not work as designed to increased energy use and more expensive energy being used.
2. Waste. Cardboard compactor does not work. Poor use of bins and recycling procedures.

3. Current travel plan is compliant with NHS practice but does not address strategic issues.
4. Nitrous oxide management system

Change ideas / workstreams (*What are seeking to change, in terms of processes, systems etc.)*

Concern (problem / area)	**Change ideas** (High level areas of focus / project delivery requirements)
Energy	1. CHPs returned to operation
	2. Hot water losses fixed
Waste	3. Restore the cardboard compactor
Waste (phase 2)	4. Add a third compactor. Remove double handling of waste
Waste (phase 2)	5. Improve the hospital side of waste system including training, communications and bin positioning.
Nitrous (phase 2)	6. Eliminate current leaks. Put in place leak management system

Benefits and Measures

	Benefit	Baseline	Target	Captured how
Watch	Lower energy costs	£ 5.750m FY 21-22 electrical consumption. FY 21-22 gas consumption with weather impacts Prices for gas and electricity at new contract estimates.	£ 1m saving	Changes in monthly energy vs 21/22 base.
Driver	Lower carbon	7,263 tonnes CO2e Data source as above combined with 2021 emission factors	10% saving	Changes in monthly energy vs 21/22 base.
Watch	Waste cost saving	£ 130k (TBC) FY 21-22 waste volumes at 22 prices	£ 30k saving	
Driver	Increase recycling rate	25% 21-22 environment report	Increase to 50%	
Watch	Nitrous cost saving	TBC		
Driver	Nitrous carbon CO2e reduced	TBC		
Watch				

Watch				

Scope

In scope (What the programme / project will change)	**Out of scope** (What the programme / project won't do)
Phase 1 delivery Energy and Waste reduction Phase 1 build capability Comms and engagement plan Join ICS networks Embed in business metrics and key dashboards Phase 1 – plan for phase 2 Green travel, nitrous oxide reduction Energy and waste procurement Phase 2 Green travel delivery Staff training and addition of compactor Nitrous reductions Energy improvements from base including CHPQA Define medium term carbon targets Define model of care scope e.g. air quality New build specification Phase 3	

Water efficiency Climate adaptation Food and menu choices Bio-diversity Research strategy Embed Sustainability in permanent structure	

Programme milestones

High Level Project Milestones	**Start**	**Finish**
1. Energy back to base line plan agreed	**April**	**May**
2. Energy plan delivered	**April**	**Aug**
3. Compactor 2 working	**April**	**May**
4.		
5.		

Financial impact (+/-)

Impact	**PYE £'000**		**FYE £'000**	
	Investment	Benefit	Investment	Benefit

Pay				
Non-pay			**Low TBC**	**>£ 1m**
Income				

Dependencies (internal / external system and projects)

Dependency (area)	**Type of dependency (tick)**			
	Start to finish *(can't start until)*	**Start to start** (both must start at the same time)	**Finish to finish** (Both tasks must finish at the same time)	**Start to finish** (Cannot start until task has finished)

Complexity Profile: Summaries the challenges of the project, to ensure the strategic risk is understood

Factor	**Low**	**Medium**	**High**
Strategic Importance			Trust priority, large £ impact,

			reputationally important
Stakeholders / influencers			Relationship with SPV
Stability of overall context		Long term direction fairly clear	
Financial impact and value for money			High
Execution complexity			High. Energy problems complex and long standing.
Interfaces / relationships		Relationship with SPV ICS Green travel work	
Dependencies		Capacity of SPV	
Extent of change		Defined impacts in phase 1. Not extensive teams involved.	

Initial Risks to Project Delivery (To be transferred to Project Risk Register Template once approved)

Priority	Risks	Likelihood	Impact	Score
1	Energy problems are commercially slow and complex to solve	5	4	20

2	Energy problems are technically slow and complex to solve	5	3	15
3	ICS travel plans conflict with ours	2	2	4
4				
5				

Please note, Milestone Plan, Risk Register and EA/QIA are also required; the templates are enclosed below:	
Milestone Plan: See milestone plan within project workbook  3. Milestone Plan Template.xls	**EA/QIA:**  Equality%20and%20 Quality%20Assessmer - template  Equality%20and%20 Quality%20Impact%20 - guidance

Initiation Checklist

Confirmation Initiation Criteria has been met	
1. Is their adequate project resource to deliver the project requirements?	Yes
2. Have the time commitments of the project leaders been considered, and capacity to deliver the benefits?	Yes
3. Are the desired trust behaviours and culture being promoted through the project?	Yes
4. Has the project set realistic and transparent targets?	Yes
5. Are the financial impacts and potential savings detailed?	Yes
6. Are there any change management, challenges within the project?	Yes
7. Are there any HR / IT / Estate impacts?	Yes
8. Does the project support the Trust's Greener agenda?	Yes
9. Does the project support Equality, Diversity and Inclusion?	Not directly

Comments	

Approved by name:	
Executive meeting date:	

Project Team **Will change as project moves through programme stages*

Project Team	Name	Time *(resource / per week)	Responsibilities
Exec Sponsor / Senior Responsible Officer (SRO)	**Mark Flannagan**		- Accountable for the project deliver - Approves changes to scope - Provides resources to support requirements of the project - Lead decision maker for the project
Clinical SRO	**N/A**		- Chairs the Project Steering Group - Provides Clinical resources to support requirements of the project - Ensure that the clinical requirements is embedded - Clinical stakeholders are engaged and involved in the delivery and development
Operational SRO	**N/A**		- Responsible for the operational delivery of the programme - Review and monitoring progress inline the key deliverables of the project - To resolve internal barriers to delivering improvement
Clinical lead	**N/A**		- Responsible for clinical leadership into the project - Supporting the engagement and involvement of clinical stakeholders - Providing leadership to support the implementation of improvements - Assigning clinical resource into the project work streams

Project Team	Name	Time *(resource / per week)*	Responsibilities
			- To support the completion of the Equality and Quality Impact assessment - To resolve barriers to embedding improvements as business as usual
Operational lead	**N/A**		- Responsible for the operational leadership into the project - Ensuring that operational risks associated with the project are detailed as appropriate on the risk register - To support the data collection as part of the improvement project
Nursing lead	**N/A**		- Responsible for the nurse leadership into the project - To ensure the effective engagement of Nursing and AHP colleagues into the improvement project - Provide leadership to support the implementation of improvements - To assign nurse resources into the project work streams - To escalate risk and issues to the Work streams group and Project Lead
Senior Project Manager	**Alex Pitman/Graham Cook**		- Responsible for the project delivery; providing guidance and stewardship - Reporting of progress and escalation of concerns to SRO - To undertake checkpoint reviews - Provide coaching support and improvement advice

Project Team	Name	Time *(resource / per week)*	Responsibilities
Project Support			- Responsible for providing project support to all stages of the project - Update progress against delivery plan - Ensure the effective engagement of project stakeholders
Information Lead	**N/A**		- Responsible for providing improvement analytical support to the project; reviewing current performance and presenting the data driven evidence base for change - Identify relevant improvement measures and track impact of the project actions - Ensure access to data tools to support the continuous review and improvement of service delivery
Financial lead	**TBC**		- Identification and support financial analysis - Supporting identification and tracking of financial efficiencies

Appendices

#	Useful documentation - Title	Document

1	**What is an A3 summary**	What is an A3 Summary.pptx
2	**A3 reporting template**	A3 Summary Reporting Template.p
3	**Quality Improvement Tools by Project Stage**	QI tools by project stage.docx

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 28th April 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st March 2022 – 30th March 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Chief Nursing Officer & Associate Director of Nursing and Governance

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

1 Introduction

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

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

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

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

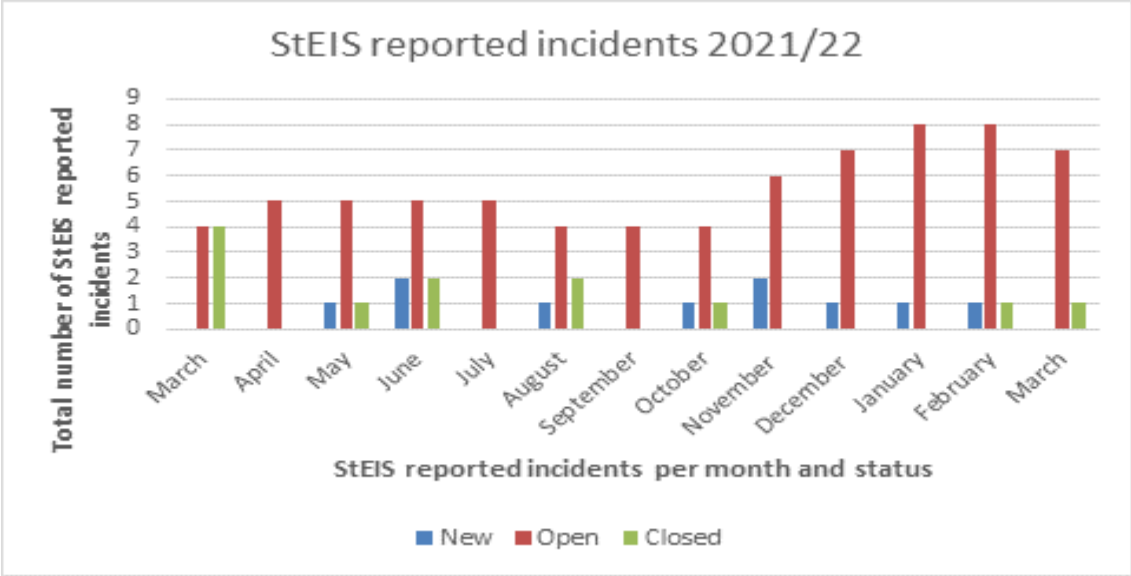
Serious incidents that do not meet the StEIS criteria are discussed at the weekly patient safety meeting and where appropriate an RCA level 2 is instigated.

2. Serious Incidents activity March 2021 – March 2022

During 1ST March 2021 – 31st March 2022, the Trust reported as follows

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

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



Graph 1 – StEIS reported incident status by month

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

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

Table 1: StEIS reported serious incident March 2022

4. Never Events

Zero 'never events' were declared in March 2022.

5. Serious incident reports completed in March 2022

One serious incident' investigations was closed in March 2022

StEIS Reference	Date reported	Incident	Summary
2021/20934	06/10/2021	Delay in treatment	Refer to appendix 1

Table 2: *SI investigation report completed March 2022*

6. Learning from serious incidents

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

6.1. Serious Incident action plans

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

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

Table 3 below provides an overview of progress position of open action plans, past expected date of completion. The Division of Surgery currently have three action plans past expected date of completion. Two of the action plans have one action each that require developments via Meditech 'expanse', i.e., ref. 46313: 'inclusion of care plan for patients in Halo traction', to minimise the risk currently an RCN paper-based care plan is being used until electronic solution in place, ref. 44571: 'discharge information for dental patients' needs to be available for general dental practitioners', waiting for 'expanse' to add general dental details to discharge summaries. To mitigate risk families are provided with a printed summary and a copy of the printed summary is manually sent to the dental practice. The third action plan, ref: 49559, is an outstanding action relating to documentation audit, the action date was extended, and the audit is in now in progress as a Trust wide audit. The Head of Nursing is meeting with the auditor - the ANP, DETECT for update on the Divisions position and the plan for ongoing monitoring. The Division of Medicine have two action plans past expected date of completion. The first action plan, ref: 39858, has one outstanding action relating to sharing lessons learned and recommendations for improvement with two Trusts who were involved in the patients care. Head of governance and risk has contacted all staff aligned to this action to ensure progressing to completion. The second plan, ref: 46716, has five outstanding actions. Meeting arranged with consultant lead to provide update to all outstanding actions. Meeting has been delayed due to leave, arranged for April 2022. There are no identified risks from the overdue actions, as mitigations are in place to minimise risk to patient safety.

Division	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Total
Surgery	11	4	4	5	5	5	3	6	6	0	3	3	55
Medicine	3	1	3	1	1	1	3	4	4	6	2	2	31
CMH	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
Total	14	5	7	6	6	6	6	10	10	6	5	5	86

Table 3: *SI action plans past expected date of completion*

6.2 Measuring the effectiveness of serious incident actions

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

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

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

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

- Clinical staff with digital team support reviewed the process for copying clinic letters and discharge summaries to colleagues in district general hospitals, where there are shared care arrangements in place. There is now a new automated system that enables staff to email copies of discharge summaries to shared care providers. This will be rolled out across the Trust with Neurology taking priority.
- A Serious Incident highlighted that where advice given to tertiary centres was not routinely recorded, therefore both digital and clinicians staff have been working together to develop solution. An App in currently in development in which advice can be recorded and then downloaded into patient notes.
- Staff training sessions completed for the care of children and young people in traction. In addition, training session recorded, so staff can access at times to suit their needs.
- Patient and family's information leaflet developed, approved and available for patients who require emergency dental treatment in the Emergency Department.
- Revised resuscitation policy clearly outlines the responsibilities for the resuscitation lead during a cardiac arrest. Communicated widely across the Trust and easily available for staff to access via the Trust document management system.

7. Quality Improvement

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

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

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

8. Thematic Review

Serious incident investigations explore problems in care (Why?). the contributory factors to such problems (how?) and the root causes /fundamental issues (Why?).

To support understanding a process of theming across these areas has been undertaken to identify commonalities across StEIS reported incidents submitted to commissioners since April 2021.

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

Since the 1st of April 2021, there were eight investigation reports submitted to commissioners and 48 themes were identified. Key themes contributing to the serious incidents included:

- Communication issues (8/8)
- Guidelines, Policies, Procedures not adhered to/not followed/lack clarity (4/8)
- Documentation not clearly visible/not completed (7/8)
- Escalation processes not followed (4/8)

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

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

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

9. Conclusion

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

Appendix 1

Precise for completed StEIS (ref: 2021/20934)investigation report. (Ulysses references: 52819, 52978, 53009)

Background

This investigation consisted of an aggregate review of three incidents relating to Urology outpatients Department. The three incidents relate to the booking and scheduling process for appointments and follow ups.

Root Cause's

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

- The outpatient department is a complex system, with complex interactions between people and technology. Many aspects of the systems are open to individual interpretation and perception with no standardisation across departments.
- There is a lack of mapping of highest risk aspects of pathways enabling audit/ analysis directed toward high-risk areas.
- There is a lack of risk analysis of highest risk aspects of pathways when rapid change is required; as with the COVID pandemic.
- There is a reliance on people doing the right thing rather than using technology to support/ enhance performance.

Lessons learned

- When moving from paper to paperless referral, practices changed without understanding best practice and safety practice in the old and new systems. The move to the paperless referral system changed the electronic record process but clinical practice has not altered in line with this.
- The work towards creating a single validated version of the truth when considering various waiting lists will improve visibility of patients and their waiting times.
- Once created the rules to identify outliers and high-risk patients will enhance identification of those requiring review.
- The management of cancelled appointments needs to mirror that for those not bought to their appointments. This should be true of those cancelled by parents through the bidirectional system as well as those cancelled by the trust. This needs to be linked, with an understanding of high-risk groups to make sure those at risk are highlighted, such as children with specific conditions or those with time critical reviews.

- 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.
-
- Understanding of safety netting processes built into the any outpatient pathway needs to take place prior to any change to that system design or process. When rapid change is required, this will enable safety critical tasks to be understood and considered as part of any change to the system.

Recommendations

1. Services need to understand their codes, review these, remove redundant codes and make sure they are specific to the clinic to which they are attached.
2. Understand tolerances, high risk groups of patients and create a safe waiting list management/ prioritization method. Once understood audit and quality analysis tools can be created to monitor this data.
3. Understand what information clinicians require to complete the ePPF accurately and understand how and in what circumstances the receptionists cash up these ePPF's. Understand when and how errors in this translation occur to target these instructions to make more specific.
4. Review roles and responsibilities through the outpatient pathway and determine who should complete each step/ when they should interact with a patient's pathway.
5. Review the referral process – streamline to a single system with direction and forcing functions to reduce unnecessary traffic, create an auditable trail and create prompts for review of referral.
6. When patients cancel, the hospital cancels or patients are not bought to clinics, create pathway to check patient information, and review earlier than the current triggers, if determined to be high risk.

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

END

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**Ockenden Review 2022 Update**
Report of:	Acting Chief Medical Officer and Chief Nurse
Paper Prepared by:	Acting Chief Medical Officer and Chief Nurse

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:	
Associated risk (s)	

Ockenden Review 2022 update to Trust Board

Introduction

The Ockenden report is the outcome of an independent review of the maternity services provided by the Royal Shrewsbury and Telford (RST) NHS Trust. This paper presents an overview of learning and recommendations for Alder Hey Children's NHS Foundation Trust.

Whilst the reports focus is on the maternity care of women at the RST Trust the report also covers neonatal care and highlights some wider learning points for organisations. This paper has considered the report in totality as some of the themes and learning require consideration for the Alder Hey.

This paper presents the Ockenden report to the trust board. An initial assessment has been conducted in relation to the recommendations of the final report. The trust board will be presented with the trust wide action plan at the board meeting in June once this has been fully developed and approved by the safety and quality assurance committee (SQAC).

The report is extensive at 250 pages, a copy of the executive summary is included in appendix 1. An assessment of applicable actions is included in appendix 2. A full copy of the report can be accessed here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064302/Final-Ockenden-Report-web-accessible.pdf

Background

The Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust commenced in the summer of 2017. It was originally requested by Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned, it has grown considerably. The independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

The report considers clinical care, culture, staffing, governance, and a range of other aspects which impact on the outcomes for the women and infants. It can be summarised in 6 main themes:

1. Staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families
5. Neonatal
6. Additional learning

Summary

This paper provides a summary of the key themes of the report which are considered applicable to Alder Hey. The report contains local actions for Royal Shrewsbury and Telford NHS Trust but also importantly Immediate and Essential Actions (IEA) for all trusts to consider in respect of maternity and neonatal services. Whilst Alder Hey is not responsible for maternity care the recommendations are worthy of consideration in respect to our clinical services.

An analysis of the IEA's is included in appendix 2. A trust wide action plan will be developed which will be monitored through safety and quality assurance committee and presented to trust board for information and approval in June.

1 – Staffing Levels

The report notes for medical and nursing staff that several aspects of safe staffing recommendations were not fully implemented at the RST Trust. These included labour ward coordinators not being supernumerary, lack of consultant cover on labour ward and neonatal medical staff covering neonates and general paediatrics. All key actions from central and royal college guidance had not been implemented.

Action- Alder Hey should:

1. Undertake a review of staffing models to provide assurance that they meet national recommendations, and any deficits are addressed urgently through business planning.
2. Develop a method of safe staffing assurance, like the nursing framework, which gives assurance and oversight of the staffing of services.

2 – A well-trained workforce

2.1 - Supervision of Midwives

Clear guidance relating to the supervision of midwives was in place and not adhered to. Recent introduction of the Professional Nurse Advocate (PNA) role has a similar expectation in how staff access PNA.

Action – Alder Hey should:

3. Finalise the PNA framework for the Trust and associated training and development plan for the role.

2.2 - Escalation of concerns

In many of the cases timely escalation to a senior clinician and appropriate response and review would have led to a different outcome.

Action - Alder Hey should, through the deteriorating patient group:

4. Review current escalation processes and where needed strengthen them to ensure that concerns raised about patients are acted upon.
5. Ensure an SBAR style tool should be used for conversations relating to escalation of concerns and staff are trained in its use.

2.3 - Team Culture

A culture of bullying and poor processes for raising concerns was sighted as a contributory factor in the length of time concerns have existed as the RST Trust

Action - Alder Hey should:

6. Undertake a review of our raising concerns mechanisms to provide assurance these are fit for purpose and that staff who raise a concern have feedback on the outcome.

3 – Learning from incidents

Several aspects of the governance processes were identified as part of the review. Primarily these fall into the categories below and associated actions:

3.1 - Investigation

Poor and protracted investigations with little evidence of change resulting from action plans. The governance process was not in line with national recommendations, particularly relating to serious incidents.

Action - Alder Hey should:

7. Review the current governance policy in line with national recommendations
8. Ensure that reports on time scales of investigations are presented monthly to CQSG
9. Action plans are SMART and achievable before signing off
10. Overdue actions are monitored
11. Learning is implemented within 6 months and has clear evidence of change associated with the outcomes of the investigations

3.2 - Guidelines

Poor MDT involvement in the development and ratification of guidelines, and timely review of guidelines

Action - Alder Hey should:

12. Ensure that each clinical division has nominated leads for policy and guidelines development which is reflective of the MDT.
13. That guidelines and polices (including patient information) is reviewed in time or removed from the system

3.3 - Clinical Audit

Clinical audit had a lack of MDT support and audits were not always completed in a timely manner

Action - Alder Hey should:

14. Review the current clinical audit process, including approval / registration of audits.

3.4 - External and invited reviews

Several invited external reviews were conducted at RST Trust, however there was a lack of evidence that these had been accepted and acted upon by the Trust.

Action - Alder Hey should:

15. Undertake a review of external and invited reviews from the last 10 years to assess clear evidence of implementation of recommendations.

3.5 – Downgrade of incidents

Several incidents were downgraded at RST to prevent external scrutiny. This led to ineffective or lower levels of investigation outside of national guidance.

Actions – Alder Hey should:

16. Ensure that an effective process is in place where divisional reviews suggest a down grade that this is objectively considered by the Chief Nursing Officer and / or Chief Medical Officer for ratification

4 – Listening to families

Complaints were not empathetic and were not delivered in the time frames of the trust complaint policy. Staff were also lacking in formal training for responding to complaints.

Action - Alder Hey should:

17. Ensure compliance with its complaint time frames, and the current reporting of complaints be revised, including increased frequency at SQAC.
18. Training should be available for all staff involved in the handling of complaints

5- Neonates

Overall, the neonatal care was described as good as part of the review, with few cases where a change in management would have resulted in an improved outcome. There are several neonatal actions in the IEA's.

Action - Alder hey should:

19. Receive an assessment and any associated action plan from the LNP in relation to neonatal specific actions from the review.

6 - Additional Learning

6.1 - Assurance

It was found through several aspects of the review that the RST Trust Board were receiving reassurance rather than assurance. For example, not receiving sufficient patient safety data in respect of the maternity service.

Action - Alder Hey should:

20. Review the Trust dashboard to be assured that the metrics are appropriate, and that where indicated they are in line with national requirements. For example, sepsis standard in 60 minutes, not 90 minutes.

6.2 - Patient demographics

The RST NHS Trust was criticised in relation to completeness of data, particularly relating to patient demographics. The recording of a minimum dataset also is helpful when looking at health inequalities across the population that we serve.

Action - Alder Hey should:

21. Review the mandated fields in respect of patient demographics and have in place a system that provides assurance on data quality.

6.3-Documentation

Medical records were not always contemporaneous as medical and nursing notes were separate

Action - Alder Hey should:

22. Review the existing system and plans for expanse to ensure that medical and nursing notes are visible to all in the care record.

6.4 outcomes

The report indicates there was reduced visibility of clinical outcomes and patient reported outcome measures across a range of vitality interventions.

Action – order he should:

23. Develop a system of clinical outcomes that give sufficient oversight through relevant reporting structures at service level.
24. Develop a process for patient reported outcome measures that give sufficient oversight to relevant reporting structures at service level

It is recognised that the issues highlighted within the report particularly relating to culture, family and patient experience, and the safety of the organisation are all main themes within the national and trust patient safety strategy. This strategy is monitored through safety and quality assurance committee and as it continues its implementation in this year particular emphasis will be placed on addressing the issues raised in the Ockenden report through this process.

These actions, and specific IEA's that are applicable to the trust Will now be developed into a trust wide action plan that will provide assurance to the board that the learnings from the Ockenden report will be translated into improvements in practice and will be reported through the safety and quality assurance committee.

Recommendations

- The Trust board are asked to note the content of this report
- The Trust board are asked to approve the suggested approach to learning from the Ockenden report and the onward development of a trust level action plan.
- The Trust board are asked to approve the monitoring of the action plan through SQAC

Nathan Askew, Chief Nurse
Alf Bass, Chief Medical Officer

Appendix 1

Executive summary

This Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust ("the Trust") commenced in the summer of 2017. It was originally requested by the Rt Hon Jeremy Hunt, MP, when he was Secretary of State for Health and Social Care and commissioned by NHS Improvement (NHSI), to examine 23 cases of concern collated by the tireless efforts of the parents of Kate Stanton-Davies and Pippa Griffiths, who both died after birth at the Trust in 2009 and 2016 respectively.

Since the review was commissioned it has grown considerably. Our independent and multi-professional team of midwives and doctors reviewed the maternity care of 1,486 families, the majority of which were patients at the Trust between the years 2000 and 2019. It has previously been reported that this review was considering 1,862 family cases. However after removing duplication of recording, and excluding cases where there were missing hospital records or consent for participation in the review could not be obtained, the final number of families included in this review is 1,486. Some families had multiple clinical incidents therefore a total of 1,592 clinical incidents involving mothers and babies have been reviewed with the earliest case from 1973 and the latest from 2020.

In line with the terms of reference, the review examined the Trust's internal investigations where they occurred. In addition, the review team has considered external reports into the Trust's maternity services over these years (national regulatory reports and locally commissioned reports) and examined local clinical governance processes, policies and procedures, as well as ombudsman and coroner's reports.

Throughout this process our priority has been to ensure that the families impacted by the maternity services at the Trust are heard. They wanted to understand what had happened to them, as well as ensure that finally lessons are learned so that no further families experience the same harm and distress that they did. Families were offered a variety of methods to engage with the review team and share accounts of their care and treatment. Throughout this report we have included vignettes of the care received by families either through our review of their maternity care considering the documentation that was received from the Trust, or by quoting family members directly from their communication with the chair of the review or team members.

As well as listening to families, the review team wanted to ensure that staff had an opportunity to be heard as well. In 2021 the review team interviewed 60 present and former members of staff about their opinions on the maternity services they worked within. We also offered staff the opportunity to complete a questionnaire for the review, which 84 staff did. We have included vignettes of these interviews and questionnaires throughout this report in order to ensure that staff voices are clearly heard. In the final weeks leading up to publication of the report, a number of staff withdrew their cooperation from the report and therefore their content (or "voice") was lost from the report. The main reason for withdrawing from the report as cited by staff was fear of being identified. This was despite our reassurance that staff would only ever be identified as 'a staff member told the review team...'

Within this report we have included a timeline of events which led up to the commissioning of this independent review (see chapter 1). This highlights a number of cases that became known of, many in the public domain between 2001 and 2016, as well as a number of external reviews from the various commissioning and regulatory bodies which took place during the period under review. It would be expected that the number of incidents featured in this timeline would have warranted closer scrutiny of maternity services at an earlier point than we are at now. However, in our opinion due to concerns around other clinical areas within the Trust and also due to the significant turnover at Executive and Board level, issues within maternity services remained largely unseen. This was to the detriment of the families receiving care.

Patterns of repeated poor care

Through the review of 1,486 family cases, the review team has been able to identify thematic patterns in the quality of care and investigation procedures carried out by the Trust, and identify where opportunities for learning and improving quality of care have been missed.

For example, in the nine months preceding the avoidable death of Kate Stanton-Davies in March 2009, the review team has identified two further incidents of baby deaths which occurred under similar circumstances.

In May 2008 Baby Joshua was born in poor condition at Ludlow midwifery-led unit, and was transferred by air ambulance to the Royal Shrewsbury Hospital Neonatal Unit. Joshua's mother was considered to have a low risk pregnancy, and even after she reported episodes of severe uterine tenderness and tightening at 31 weeks this risk profile was not changed. She reported reduced baby movements the day before her labour at 37+5 weeks gestation, but on her admission the baby's heart rate was not monitored appropriately. Joshua was delivered with no signs of life and died at six days old, when care was withdrawn.

In January 2009 Baby Thomas was born following his mother's long, slow labour stretching over more than a day. His mother, who had given birth to a large baby during a previous pregnancy, had been treated as a low risk case throughout this pregnancy, and no check for gestational diabetes was conducted. She had been due to give birth in a midwifery-led unit, but was admitted to the antenatal ward in the consultant-led unit. The review team found that despite abnormal heart rate readings, a high dose of oxytocin infusion was used, and his mother was infrequently monitored. In the hour before birth, examinations showed signs of obstructed labour and uterine rupture, as well as difficulties establishing the baby's heart rate, but despite this a ventouse delivery was attempted before an emergency caesarean was conducted. Thomas briefly had a heartbeat but at 34 minutes of age resuscitation was stopped.

Then on 1 March 2009 Rhiannon Davies gave birth to Kate Stanton-Davies at the Ludlow midwifery-led unit, despite reporting a reduction in her baby's movements in the two weeks before the birth. There was a lack of appropriate heart rate monitoring during labour and missed opportunities to manage Kate's health as she was born severely anaemic. Kate suffered a cardiopulmonary collapse at 90 minutes of life and was transferred by air ambulance to a tertiary neonatal unit, where she died shortly after arrival at six hours of age.

The review team found evidence of poor investigation into all three of these cases which took place within less than a year of each other, as well as a lack of transparency and dialogue with families. This resulted in missed opportunities for learning, and a lost opportunity to prevent further baby deaths from occurring at the Trust.

Unfortunately these three cases were not isolated incidents and throughout this review we have found repeated errors in care, which led to injury to either mothers or their babies. During our work we have considered all aspects of clinical care in maternity services including antenatal, intrapartum, postnatal, obstetric anaesthesia and neonatal care.

In total 12 cases of maternal death were considered by the review team. They concluded that none of the mothers had received care in line with best practice at the time and in three-quarters of cases the care could have been significantly improved. Only one maternal death investigation was conducted by external clinicians, and the internal reviews were rated as poor by our review team. These internal investigations frequently did not, recognise system and service-wide failings to follow appropriate procedures and guidance. As a result significant omissions in care were not identified and in some incidents women themselves were also held responsible for the outcomes.

As part of the review 498 cases of stillbirth were reviewed and graded. One in four cases were found to have significant or major concerns in maternity care which if managed appropriately might, or

would have, resulted in a different outcome. Hypoxic ischaemic encephalopathy (HIE) is a newborn brain injury caused by oxygen deprivation to the brain. There were significant and major concerns in the care provided to the mother in two thirds (65.9 per cent) of all HIE cases. After the baby had been born, most of the neonatal care provided was considered appropriate or included minor concerns, however these were unlikely to influence the outcome observed.

Most of the neonatal deaths occurred in the first 7 days of life. Nearly a third of all incidents reviewed (27.9 per cent) were identified to have significant or major concerns in the maternity care provided which might or would have resulted in a different outcome.

The review team found that throughout the review period staff were overly-confident in their ability to manage complex pregnancies and babies diagnosed with fetal abnormalities during pregnancy. There was sometimes a reluctance to refer to a tertiary unit to involve specialists such as paediatric surgeons and geneticists in care. For example, the neonatal unit at Royal Shrewsbury Hospital continued to work as a neonatal intensive care unit for many years after it had been re-designated as a local neonatal unit. Although the review team noted that care provided by staff in the unit was generally good, it was operating beyond its designated scope. Staff suggested this was due to a lack of capacity within the surrounding services, but this view has been rejected by the neonatal network.

Internally, within maternity services at the Trust women were frequently not referred to or discussed with colleagues from the wider multidisciplinary team. It has been observed that there were repeated failures to escalate concerns in both antenatal and postnatal environments. There are also multiple examples within this report, where there were delays in women being admitted to the labour ward during induction of labour, being assessed for emergency intervention during labour or reviewed by consultants in the postnatal environment. On occasion this resulted in families being discharged from hospital but later readmitted for emergency procedures due to becoming extremely unwell through the lack of earlier appropriate review of care. Other examples of a lack of appropriate escalation are of obstetric anaesthetists involved at the last minute, not enabling them to assess women appropriately for urgent obstetric interventions.

Failure in governance and leadership

Throughout the various stages of care the review team has identified a failing to follow national clinical guidelines whether it be for the monitoring of fetal heart rate, maternal blood pressure, management of gestational diabetes or resuscitation. This, combined with delays in escalation and failure to work collaboratively across disciplines, resulted in the many poor outcomes experienced by mothers or their babies, such as sepsis, hypoxic ischaemic encephalopathy and unfortunately death.

Some of the causes of these delays were due to the culture amongst the Trust's workforce. The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear amongst midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace, and limited the ability of the service to make positive changes.

Unfortunately these poor working relationships were also witnessed by families, and in some cases mothers have described the additional stress these interactions had on them at one of the most vulnerable moments in their lives. In addition, repeatedly throughout this review we have heard from parents about a lack of compassion expressed by staff either while they were still receiving care or in follow-up appointments and during complaints processes. Examples include clinicians being unprepared for follow-up briefings with families, and response letters to complaints including inaccurate information, justifying actions or omissions in care and in some cases even including explanations which laid blame on the family themselves for the particular outcome.

As summarised earlier, there were often delays in escalation of care to appropriate clinicians, in part these delays in care could be attributed to staffing and training gaps at the Trust. The review team found there were significant staffing and training gaps within both the midwifery and medical workforce, which negatively affected the operational running of the service. The review team identified

how it was widely accepted that the labour ward coordinator did not have supernumerary status, often having their own clinical caseload, preventing them from being readily accessible to junior staff and the wider midwifery team for clinical advice, care planning and support.

Similarly, the medical staff rotas have been overstretched throughout the time period covered by the review. Inadequate support from consultant obstetric and anaesthetic services caused a consistent lack of clinical expertise to be available. Where locum doctors filled in rota gaps, there is evidence of them being unsupported and on occasions unsafe clinical practice was not addressed or challenged. Staff also cited suboptimal staffing levels and unsafe inpatient to staffing ratios to the review team, and said they often felt fearful and stressed at work due to poor staffing levels.

The review has found the Trust leadership team up to Board level to be in a constant state of churn and change. Therefore it failed to foster a positive environment to support and encourage service improvement at all levels. In addition the Trust Board did not have oversight, or a full understanding of issues and concerns within the maternity service, resulting in a lack of strategic direction and effective change, nor the development of accountable implementation plans.

Our consideration of clinical governance processes and documents at the Trust has shown that investigatory processes were not followed to a standard that would have been expected for the particular time the incident occurred. The reviews were often cursory, not multidisciplinary and did not identify the underlying systemic failings and some significant cases of concern were not investigated at all. In fact, the maternity governance team inappropriately downgraded serious incidents to a local investigation methodology in order to avoid external scrutiny, so that the true scale of serious incidents at the Trust went unknown until this review was undertaken.

Where investigations took place there was a lack of oversight by the Trust Board, unfortunately the review believes this has persisted in some incident investigations as late as 2018/2019 considered as part of this review.

This meant that consistently throughout the review period lessons were not learned, mistakes in care were repeated and the safety of mothers and babies was unnecessarily compromised as a result.

There were a number of external reviews carried out by external bodies including local Clinical Commissioning Groups and the Care Quality Commission during the last decade. The review team is concerned that some of the findings from these reviews gave false reassurance about maternity services at the Trust, despite repeated concerns being raised by families. It is the review team's view that opportunities were lost to have improved maternity services at the Trust sooner.

Local Actions for Learning and Immediate and Essential Actions

This review has considered all aspects of maternity care at Shrewsbury and Telford Hospital NHS Trust and as a result has made a significant number of recommendations for improvement of care across each of the maternity disciplines.

In total more than 60 Local Actions for Learning have been identified specifically for the Trust in light of the care received by the 1,486 families featured in the review. The review team are encouraged by staff reports that following our first report in December 2020 there does seem to have been a recent improvement in maternity services at the Trust with increased numbers of senior clinicians employed.

It is recognised that many of the issues highlighted in this report are not unique to Shrewsbury and Telford Hospitals NHS Trust and have been highlighted in other local and national reports into maternity services in recent years. This is why the review team has also identified 15 areas as Immediate and Essential Actions which should be considered by all trusts in England providing maternity services. Some of these include: the need for significant investment in the maternity workforce and multi-professional training; suspension of the Midwifery Continuity of Carer model until, and unless, safe staffing is shown to be present; strengthened accountability for improvements in care amongst senior maternity staff, with timely implementation of changes in practice and improved investigations involving families.

It is absolutely clear that there is an urgent need for a robust and funded maternity-wide workforce plan, starting right now, without delay and continuing over multiple years. This has already been highlighted on a number of occasions but is essential to address the present and future requirements for midwives, obstetricians, anaesthetists, neonatal teams and associated staff working in and around maternity services. Without this maternity services cannot provide safe and effective care for women and babies. In addition, this workforce plan must also focus on significantly reducing the attrition of midwives and doctors since increases in workforce numbers are of limited use if those already within the maternity workforce continue to leave. Only with a robustly funded, well-staffed and trained workforce will we be able to ensure delivery of safe, and compassionate, maternity care locally and across England.

Not applicable to Alder Hey	
Indirectly applicable to Alder Hey	
Directly applicable to Alder Hey	

IEA		Action	AH Applicable?	Comment
1: WORKFORCE PLANNING AND SUSTAINABILITY				
The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented.	1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England.		
	2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. Thismust encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.		National safe staffing levels should be implemented across the entire trust
	3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.		A review of the staffing uplift should be undertaken
	4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These bodies must include as a minimum NHSE, RCOG, RCM, RCPCH.		
We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented.	5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.		A review of the preceptorship program for newly qualified nurses should be undertaken
	6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe willensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife.		
	7	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.		A review of the coordinator role should be undertaken an appropriate training and resources put into place
	8	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.		
	9	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience.		
	10	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable training programme across the country must be established, to ensure the appropriate workforce long term.		
2: SAFE STAFFING				
All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	11	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.		There should be a review of the staff staffing escalation process to ensure that there is executive oversight of any deficiency
	12	In trusts with no separate consultant rotas for obstetrics and gynaecology theremust be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.sultant rotas for obstetrics and gynaecology there		
	13	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.		There should be a review of the coordinator role description
	14	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.		
	15	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction		
	16	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.		
	17	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.		The trust should review the current model of clinical education
	18	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.		The support for newly appointed ward managers should be reviewed
	19	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication		
	20	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction.		
3: ESCALATION AND ACCOUNTABILITY				
Staff must be able to escalate concerns if necessary	21	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.		A conflict of clinical opinion and associated escalation process should be developed
There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.	22	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.		
If not resident there must be clear guidelines for when a consultant obstetrician should attend.	23	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.		
	24	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit.		
	25	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit		
4: CLINICAL GOVERNANCE-LEADERSHIP				
Trust boards must have oversight of the quality and performance of their maternity services.	26	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans.		
In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.	27	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.		
	28	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.		
	29	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities		A review should be undertaken to ensure those responsible for clinical governance activities have time in their job plan dedicated to this
	30	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.		The trust should review the education and training for leads of clinical governance
	31	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.		Each division should have allocated MDT leads for the development of guidelines policies and patient information
	32	All maternity services must ensure they have midwifery and obstetric co-leads for audits.		The trust clinical audit process should be reviewed
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS				
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	33	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.		The trust should ensure that complaints and investigations are responded to in easy to understand language
	34	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.		
	35	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.		Evidence that the change in clinical practice has occurred should be included in the action plan for clinical incidents
	36	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.		The trust should develop a process to demonstrate changes from SI investigations have occurred within six months
	37	All trusts must ensure that complaints which meet SI threshold must be investigated as such		A process should be in place that identifies complaints that meet the SI threshold
	38	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.		The trust should involve children young people and their families in a review of the complaints process
	39	Complaints themes and trends must be monitored by the maternity governance team		Complaints themes and trends should be reported on a regular basis to the trust board
6: LEARNING FROM MATERNAL DEATHS				
Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies.	40	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to ensure that this is provided in any case of a maternal death.		
In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable hospitals/clinical settings.	41	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required		
	42	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.		
7: MULTIDISCIPLINARY TRAINING				
Staff who work together must train together	43	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored.		
Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend.	44	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.		The trust should ensure that the SBAR tool is used in practice and staff receive training on induction
Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	45	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS		The development of patient safety training should include human factors training as well as principles in this action
	46	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.		Simulation training for clinical emergencies should be in place

	47	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.		The trust should review emotional and psychological support mechanisms within the organisation
	48	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.		
	49	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory.		
8: COMPLEX ANTENATAL CARE				
Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care.	50	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.		
Trusts must provide services for women with multiple pregnancy in line with national guidance	51	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019.		
Trusts must follow national guidance for managing women with diabetes and hypertension in pregnancy	52	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes.		
	53	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.		
	54	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation		
9: PRETERM BIRTH				
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth.	55	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.		
Trusts must implement NHS Saving Babies Lives Version 2 (2019)	56	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.		
	57	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability		The trust will seek assurance from the LNP but neonatal teams are routinely involved in such discussions
	58	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.		
10: LABOUR AND BIRTH				
Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary.	59	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made		
Centralised CTG monitoring systems should be mandatory in obstetric units	60	Midwifery-led units must complete yearly operational risk assessments.		
	61	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.		
	62	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.		
	63	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.		
	64	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.		
11: OBSTETRIC ANAESTHESIA				
In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm.	65	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.		
Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events.	66	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences		
Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed.	67	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC		
	68	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance.		
	69	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.		
	70	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity.		
	71	The competency required for consultant staff who cover obstetric services out-of- hours, but who have no regular obstetric commitments.		
	72	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommended in the first report		
12: POSTNATAL CARE				
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review.	73	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non- maternity ward.		
Postnatal wards must be adequately staffed at all times	74	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.		
	75	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary.		
	76	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.		
13. BEREAVEMENT CARE				
Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	77	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday.		The current bereavement arrangements will be reviewed
	78	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.		The number of staff who are trained in obtaining consent for post-mortem will be reviewed
	79	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.		The LNP will provide assurance that routine follow-up appointments are provided following neonatal death
	80	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.		Bereavement care will be reviewed in line with national best practice guidance
14: NEONATAL CARE				
There must be clear pathways of care for provision of neonatal care.	81	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.		The LNP will provide assurance with compliance with this recommendation
This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	82	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly.		The LNP will provide assurance with compliance with this recommendation
	83	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.		
	84	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.		The LNP will provide assurance with compliance with this recommendation
	85	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.		The LNP will provide assurance with compliance with this recommendation
	86	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.		The LNP will provide assurance with compliance with this recommendation
	87	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.		The LNP will provide assurance with compliance with this recommendation
	88	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications		The LNP will provide assurance with compliance with this recommendation
15: SUPPORTING FAMILIES				
Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision	89	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.		The trust will ensure that psychological support is available to the families on the neonatal unit
Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	90	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.		The LNP will provide assurance with compliance with this recommendation
	91	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care.		The LNP will provide assurance with compliance with this recommendation

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England**
Report of:	**Lisa Cooper, Director Community & Mental Health Services**
Paper Prepared by:	**Lisa Cooper, Director Community & Mental Health Services** **Jacqui Pointon, Associate Chief Nurse** **Andrea O'Donnell, Clinical Lead, Tier 4 Inpatient Unit** **Dr Andrew Kevern, Consultant Psychiatrist, Tier 4 Inpatient Unit**

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:	To be determined	
Links to risk register		

1. Introduction

The purpose of this paper is to update Trust Board regarding changes made to the Mental Health Units (Use of Force) Act 2018: statutory guidance for NHS organisations in England, which came into effect on 31 March 2022.

2. Background

Olaseni "Seni" Lewis was a 23-year-old black man from South London, who died following the use of prolonged restraint by police officers at the Bethlem Royal Hospital in Beckenham on 31 August 2010. Investigations following Seni's death were critical of how the restraint was carried out and in response to the case a private members bill in Parliament was raised and subsequently developed into law.

The Mental Health Units (Use of Force) Act 2018 ('the Act') was enacted on 01 November 2018. Guidance on the implementation of the Act was issued in December 2021 with an aim to commence implementation from 31 March 2022.

Full details of the Act can be found at Mental Health Units (Use of Force) Act 2018 (legislation.gov.uk) Departures from the guidance could lead to legal challenge. The CQC will also have regard to the guidance when considering whether providers meet its regulatory requirements and commissioners will look to ensure that the services, they commission are consistent with it.

'Use of force' under these provisions includes restraint (whether physical, mechanical or chemical) and isolation (including seclusion and segregation). The requirements will apply to all patients in mental health units, whether detained or not. The Act also applies to children and young people detained under the Mental Health Act within an acute paediatric setting.

The main purpose of the Act is to make provision about the oversight and management of the appropriate use of force in relation to people in mental health units, with the objectives being to:

- To reduce the use of force in mental health units
- To ensure accountability and transparency about the use of force in mental health units

The Act's objectives of reducing and ensuring accountability and transparency about the use of force in mental health units should be achieved by:

- Bringing an end to the disproportionate use of force on people sharing protected characteristics, particularly race, sex, age, and disability
- Providing services which meet the needs of the individual and are preventative in their approach to stop situations reaching crisis point
- Services understanding the negative impact of the use of force on patients with histories of trauma and abuse
- Services involving the individual, their families and Carers in the planning and delivery of their care

- Ensuring that there are positive relationships between those receiving care and those providing it

3. Actions for Alder Hey

The following actions have been taken by Alder Hey to ensure compliance with the Act:

Appoint a 'responsible person'

One of the central provisions in the Act is an obligation on organisations that run inpatient mental health units to appoint a 'responsible person' whose role will be to ensure compliance with the use of force requirements. For Alder Hey the "responsible person" is the Chief Nursing Officer who is supported in this function by the Director of Community & Mental Health Services.

Additional clinical expertise is also provided by the Clinical Lead (RNLD), Tier 4 Children's Inpatient Unit; Consultant Nurse Learning Disabilities (RNLD); Consultant Psychiatrist, Tier 4 Children's Inpatient Unit and Associate Chief Nurse (RMN), Community and Mental Health Division.

Review relevant policies and procedures to ensure they meet new requirements

The Act requires organisations running inpatient mental health units to publish a policy on use of force by staff who work on those units, setting out the steps being taken to reduce and minimise the use of force. The guidance states that, where an organisation has an existing policy on use of force, this may be updated to ensure that it complies with the requirements in the Act and guidance.

Current Trust policy has been updated to include the relevant components of the Act and is in draft format awaiting the approval process. The section on training requires some further minor clarification in relation to what should be provided, when and how often they are repeated, but standards are met in relation to current provision within the Trust's Tier 4 Children's Inpatient Unit. Policy will be reviewed at the Community & Mental Health Division's policy and procedures subcommittee on 03 May 2022.

Provide information to patients about use of force

The Act requires that, as soon as reasonably practicable after admission to a mental health unit, each patient must be given information about their rights in relation to the use of force by staff who work in that unit.

The guidance is clear regarding what information should be provided to patients. For example, which staff may use force in what limited circumstances and what approaches will be taken to avoid it.

An appropriate leaflet for children and young people 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

The Act provides that mental health unit staff must be provided with training on the appropriate use of force. It lists 11 topics that must be covered as part of this training - for example, techniques for avoiding/reducing use of force and the impact of use of force on a patient's mental and physical health.

The guidance indicates that training which is certified to comply with RRN (Restraint Reduction Network) standards should meet the requirements in the Act/Guidance.

Within the Trust there is a tiered system to approaching the skill development of staff in relation to responding to disturbed behaviour and reducing the use of restrictive interventions:

Level 1 – All Trust staff receive conflict resolution training which includes a basic introduction to Positive Behavioural Support principles. This is currently delivered as online sessions.

Level 2 - Defined clinical Trust staff and Tier 4 Children's Inpatient Unit clinical staff complete Clinical Holding training.

Level 3 - Defined Trust clinical staff complete the CALMS Core Theory. This is an online session for which staff must meet assessment of competencies to pass. All Tier 4 Children's Inpatient Unit staff undertake this and key Trust areas where there are more likelihood of children and young people being admitted to an acute ward area with presentations requiring these skills. The training is a prerequisite for completion of the full Physical intervention training programme (as either trainers or to become trained staff)

Level 4 - Defined Trust clinical staff and Tier 4 Children's Inpatient Unit clinical staff complete the Physical intervention training and receive annual refresher training to enable safe and proactive physical restrictive interventions where risk requires this.

Level 5 – Train the Trainer in CALMS Physical intervention approaches. There are currently 10 trainers across the Trust, including 3 x Tier 4 Children's Inpatient Unit trainers who able to provide theory and practical training in Physical interventions and updates via refresher training. The Train the Trainer presence allows for additional consultation/advice and responsive additional bespoke sessions across the trust.

Level 6 – This is work in progress with recruitment to an RMN Consultant Nurse post. The post holder will support the trust wide physical intervention and clinical holding strategy and provide additional consultation and support to the paediatric workforce. Liaison with Tier 4 Children's Inpatient Unit clinical leads and trainers supporting development, training and appropriate support systems will also form part of this role.

Training will be complete for staff on the Tier 4 Children's Inpatient Unit by 30 April 2022, (due to the number of new recent starters) and a "Train the Trainer" approach

is now fully in place in the unit to ensure staff continue to receive accredited training on an annual basis and are able to cascade training across the service.

The Tier 4 Children's Inpatient Unit is implementing the Safewards programme and has established Positive Behavioural Support Plans as part of day-to-day care approaches which support the overall requirement on the reduction of force.

In addition, Tier 4 Children's Inpatient Unit staff are completing a 2-session training on human rights training with The British institute of human Rights (BIHR) as part of the Tier 4 Inpatient NHS England/Improvement GIRFT programme.

Systems for recording use of force

Under the Act, a record must be kept (for 3 years) of any use of force by staff that is more than 'negligible'.

The Act also gives a list of information which must be recorded in each case, such as the reason for the use of force, whether it formed part of the patient's care plan and efforts made to avoid it. The guidance builds on this by providing further details about what needs to be recorded.

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.

7. Next Steps

The Trust Board are asked to note the content of this report.

Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report March 2022

How Did We Do?

Executive Summary **Month: March** **Year: 2022**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- We have had 0 Hospital acquired MRSA for a full 12-month period
- Very high clinical incident reporting in month resulting in near miss, minor or no harm.
- 95% of patients in AED treated for sepsis within an hour. Best performance of the year.

Highlight

- 0 clinical incidents resulting in severe harm
- 0 MRSA or 0 Difficile in month
- 0 pressure ulcers category 3 and above

Challenges

- Two errors involved minor harm in **March**. One patient was given medication containing a flavouring they were allergic to and required a dose of antihistamine - no reaction was observed. Another patient received 4 times more intravenous paracetamol than prescribed due to an infusion pump programming error. Blood tests were checked but no abnormalities seen.
- 1 clinical incident resulting in moderate harm. This incident occurred in Surgery and in summary related to a delay in acting on blood test results, resulting in the patient requiring an unplanned admission to PICU. Rapid review has been undertaken; duty of candour completed. RCA 1 in progress.
- 1 MSSA in March relating to a patient on PICU who had tested positive for staphylococcus in both gastrostomy and tracheostomy swabs and also peripheral blood cultures. Awaiting outcome of review.

The Best People Doing their Best Work

Caring

- Overall Friends and Family score is below 90% reflecting the challenging position in AED
- Many issues are being addressed informally at ward and departmental level to prevent escalation to PALS or complaints

Highlight

- Friends and family scores remain well above 90% across Community, CAMHS and In Patient areas

Challenges

- Friends and family score in AED is the lowest of the year at 59.3%. Work continues within AED and with the Divisional team to address the issues highlighted.
- A high number of PALS and complaints were reported in March. All were responded to by the Divisions within the agreed timeframes whilst working to positive agreed outcomes.

Delivery of Outstanding Care

Effective

The biggest operational performance challenge in March related to the number of patients waiting over 4 hours for treatment in the Emergency Department. Attendances were up 13% on 2019 levels and we experienced very high staff absence levels which affected the levels of medical and nursing cover. In response, from April, we are changing our model to see more green stream patients in a clinic setting, away from the main ED. We are also recruiting additional nursing and medical staff. Moreover, we will be discussing with the senior team more radical improvements to address crowding and delays to assessment.

Highlight

- Zero 12 hour waits in ED for patients requiring admission to a bed

Challenges

- Timeliness of care in the Emergency Department

Delivery of Outstanding Care

Responsive

The number of patients waiting over 52 weeks increased to 271 patients. In February and March capacity contracted as the number of theatre sessions scheduled reduced due to absence associated with Covid-19. Nonetheless, there is a significant underlying capacity challenge in paediatric dentistry which we are working through with the department and Division of Surgery.

In diagnostics, equipment issues are hindering our recovery programme. In MRI and DEXA equipment issues are disrupting service delivery and capacity. Business continuity plans and recovery plans are in place to redress this and are being monitored at Divisional Board and corporate Access to Care meetings.

Highlight

- Access to cancer care

Challenges

- Elective waiting times for treatment
- Diagnostic waiting times

The Best People Doing their Best Work

Well Led

Finance

For the Month of March (Month 12), the Trust is reporting a deficit of £0.9m which is £0.9m away from plan.

However, the draft full year financial position is a small surplus of £71k which is slightly ahead of the break-even target. It should be noted that this closing full year position is subject to a full external audit; as such it remains provisional at this stage.

Cash in the bank at the end of March was £91.5m.

The overall capital expenditure year to date to March was £30.2m.

Mandatory Training

Work continues with all staff to encourage compliance across the Trust. Recent areas of focus; Resus Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen significant compliance drops due to the impact of COVID on face-to-face training. Estates and Ancillary staff compliance continues to improve and has increased to 78% this month. Medical Education and Senior leaders have worked to promote Mandatory Training compliance in the Medic staff group, compliance has risen from 75.75% in Feb to 78.71% as of 4th of April.

Sickness

Sickness levels have remained high through March and is therefore a significant focus across all divisions. The HR team continue to provide dedicated support and guidance, along with weekly reports to assist with effective and proactive management of sickness. As of 31st March, Covid related absences accounted for 2% of the Trust overall sickness absence figure. A number of interventions are in place to support staff, which are promoted across the Trust to ensure staff are aware of how to access the support they require.

Sickness Absence training will launch in May 2022, which will support our Leaders across the Trust to effectively manage sickness absence, in line with Trust policies and procedures.

Highlight

Challenges

- Complete Year End Audit
- Focus on CIP challenges and delivery as we head into the 2022 – 23 financial year

Turnover Staff turnover remains slightly higher than previous months, therefore the HR team have provided a detailed report to show the reasons for staff leaving the Trust and analysed Exit Interview responses. The Senior HR team are conducting a full review on turnover, based on this report and are in the process of implementing next steps, including renewing the Exit Interview process.	

Game Changing Research and Innovation

Research and Development

Month 12 Research Activity:

- 190 research studies currently open
- 1,160 patients recruited to research studies (13,166 in 21/22)

Divisional Participation:

- Division of Medicine – 153 open studies
- Division of Surgical Care – 33 open studies
- Division of Community & Mental Health – 4 open studies

Research Assurance:

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

Highlight

NIHR Clinical Research Facility
Research patient story featured on BBC News North West Tonight

Challenges

National request to close research studies that are not viable in the current context to provide capacity for studies that are.

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Alder Hey Children's NHS
NHS Foundation Trust

Leading Metrics

SAFE

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

Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
95.08 %
Mar 2022

CARING

Friends & Family: Overall Percentage Recommended Trust
86.68 %
Mar 2022

EFFECTIVE

ED: 95% Treated within 4 Hours
64.79 %
Mar 2022

RESPONSIVE

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	All Cancers: 31 day wait until subsequent treatments	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	Diagnostics: % Completed Within 6 Weeks
100 %	100 %	100 %	56.90 %
Mar 2022	Mar 2022	Mar 2022	Mar 2022

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks - Incomplete Pathways	Waiting List Size
100 %	61.29 %	271	20612
Mar 2022	Mar 2022	Mar 2022	Mar 2022

WELL LED

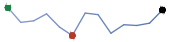
Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	Safer Staffing (Shift Fill Rate)	Sickness
91464	-1000.04	89.81 %	81.72 %	7.41 %
Mar 2022	Mar 2022	Mar 2022	Mar 2022	Mar 2022

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.8%	99.8%	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%	99.6%	99.8%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	D	98	79	81	90	73	62	91	89	65	76	75	78	95		No Threshold	✔
Clinical Incidents resulting in No Harm	D	401	395	363	321	332	298	313	276	273	250	237	276	305		No Threshold	✔
Clinical Incidents resulting in minor, non permanent harm	D	95	91	80	72	94	88	74	86	136	76	99	92	145		No Threshold	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	1	4	1	1	1	0	1	1	0	1	2	1		No Threshold	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	1	0	0	0	0	1	1	0	1	1	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	D	4	4	2	2	2	6	4	2	4	5	3	2	2		<=4 N/A >4	✔
Pressure Ulcers (Category 3)	W	1	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0	✔
Never Events	W	1	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	D P	100.0%	85.0%	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%	83.7%	95.1%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	88.9%	83.3%	89.7%	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%	75.9%					>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	1	0	0	0	1	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	D	0	0	1	0	2	0	0	1	3	1	0	0	1		No Threshold	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust W	92.9%	94.0%	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%	89.2%	86.7%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust D	88.0%	88.0%	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%	69.5%	59.3%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust D	93.0%	95.9%	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%	90.5%	94.4%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust D	89.8%	96.4%	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%	93.9%	95.7%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust D	87.9%	90.6%	85.7%	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%	100.0%	96.2%	95.5%	94.1%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust D P	95.1%	95.3%	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%	94.1%	93.3%		>=95 % >=90 % <90 %	✔
Complaints W	23	5	9	15	10	12	13	13	14	9	16	20	20		No Threshold	
PALS W	110	101	119	149	122	88	148	136	141	106	99	133	135		No Threshold	

D Drive W Watch P Programme

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	W	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%			No Threshold	✔
ED: 95% Treated within 4 Hours	D	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%		>=95 % N/A <95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	12	13	7	13	13	12	32	23	56	23	22	16	23		<=20 N/A >20	✔
28 Day Breaches	W	2	4	3	0	3	8	5	11	12	25	7	3	9		0 N/A >0	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	95.6%	96.0%	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%	93.0%	95.3%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	94.7%	98.5%	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%	96.7%	97.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	94.2%	98.5%	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%	67.6%	66.1%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	96.1%	98.5%	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%	97.1%	98.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D	78.2%	81.1%	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%	80.9%	87.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D	90.9%	91.0%	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%	91.9%	93.0%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	68.1%	68.6%	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%	61.5%	61.3%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	11,892	11,110	11,564	11,414	12,096	13,286	13,092	18,495	18,976	19,127	19,098	19,731	20,612		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	W	361	283	235	204	187	195	263	318	250	218	237	246	271		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	97.5%	95.2%	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%	63.3%	56.9%		>=99 % N/A <99 %	
PFI: PPM%		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	97.0%	99.0%	99.0%	96.0%				>=98 % N/A <98 %	✔

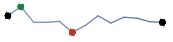
The Best People doing their best Work

WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	W	3,825	-954	593	392	-588	-50	836	-853	382	166	2,123	-725	-1,000		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-5,794	-910	974	13	162	234	-339	-221	-159	406	964	403	-5,413		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	92,708	92,708	88,440	82,001	82,006	82,121	88,514	94,111	91,971	90,450	87,781	92,978	91,464		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	18,172	-494	716	1,598	2,981	-1,713	2,767	-2,609	149	1,475	1,048	274	19,562		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-13,171	-308	-370	-545	553	71	-2,466	2,477	676	-16	6	9	608		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	-1,176	-153	247	-661	-4,122	1,591	534	-720	-443	-1,293	1,068	-1,008	-21,170		>=-5% >=-20% <-20%	✔
AvP: IP - Non-Elective	W	1,066	-97	-100	1,292	-184	-142	-66	1,374	1,365	1,259	1,272	1,293	1,352		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W	455	-88	-61	453	-20	-112	-79	402	387	323	320	357	432		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W	2,098	208	31	2,153	316	-84	232	1,985	2,186	1,851	1,853	1,812	2,125		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W	27,554	2,384	5,038	28,172	6,170	1,882	6,739	26,050	29,620	23,661	24,810	23,785	27,421		>=0 N/A <0	✔
PDR	W	74.4%	0.9%	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%	72.2%	72.0%		No Threshold	
Medical Appraisal	W	95.9%	21.9%	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%	0.4%	12.3%		No Threshold	
Mandatory Training	W	86.8%	88.4%	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%	88.4%	89.8%		>=90 % >=80 % <80 %	✔
Sickness	D	4.7%	4.6%	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.3%	7.4%	8.1%	6.7%	7.4%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.2%	1.1%	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.7%	3.7%	2.3%	3.0%		<=1 % N/A >1 %	✔
Long Term Sickness	D	3.6%	3.5%	3.9%	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.7%	4.4%	4.4%	4.4%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	2,272	1,071	1,040	960	1,130	1,096	1,368	1,137	1,590	1,521	1,385	1,620	2,079		No Threshold	
Staff Turnover	D	8.7%	9.3%	9.7%	9.3%	9.6%	9.7%	10.2%	10.8%	11.2%	11.0%	11.4%	12.1%	12.5%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	94.0%	97.7%	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%	84.0%	81.7%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	97.7%	97.7%	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%	100.0%	100.0%		>=85 % N/A <85 %	✔
NHS Oversight Framework	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

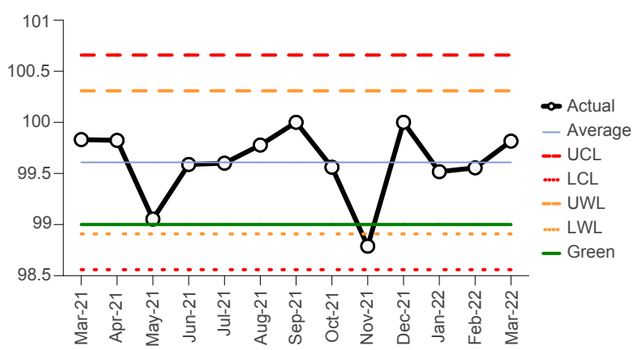
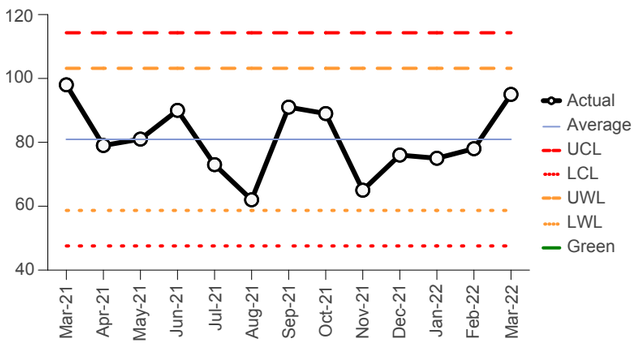
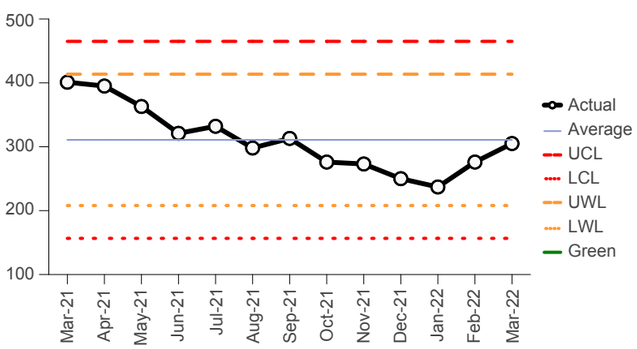
R&D

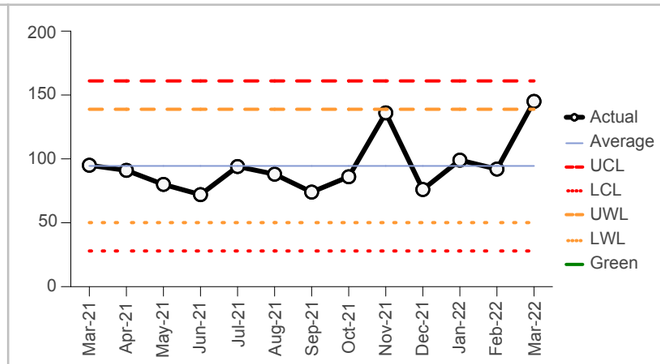
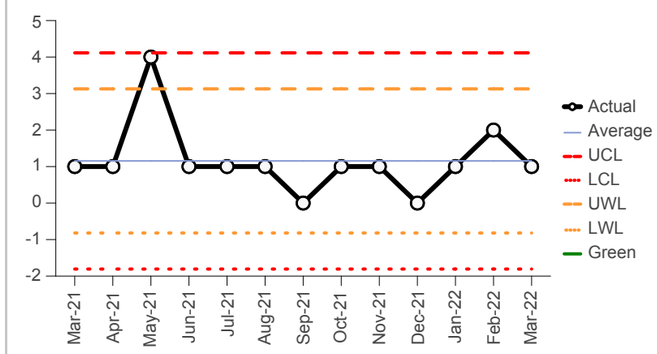
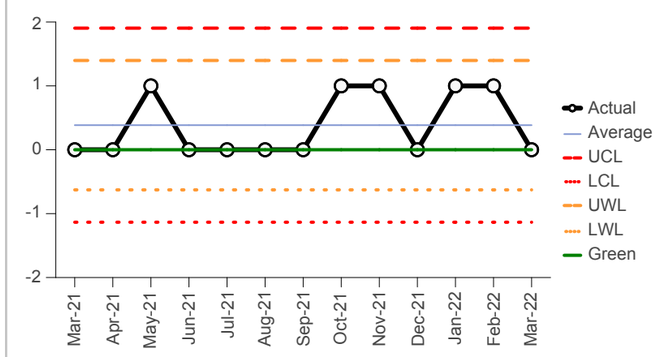
Alder Hey Children's NHS Foundation Trust

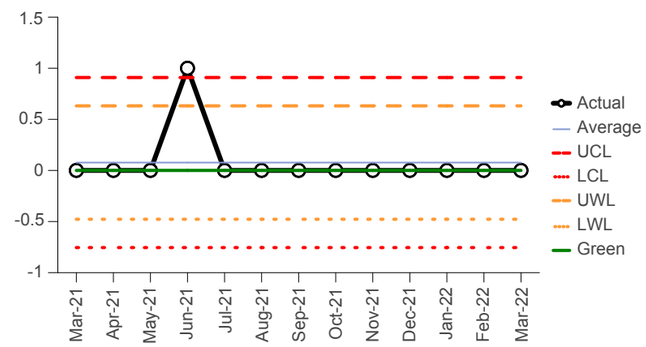
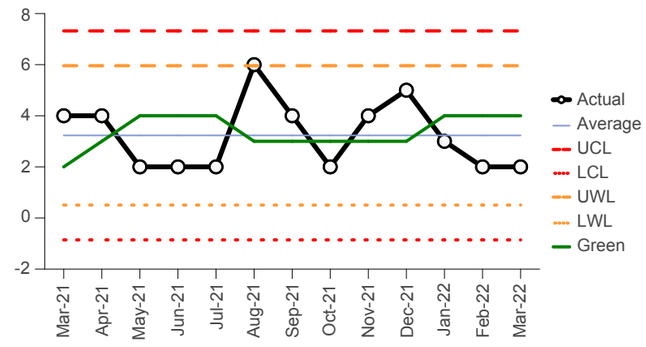
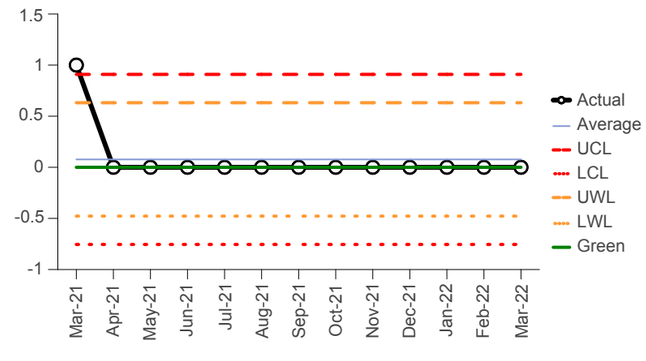
GROW THE FUTURE

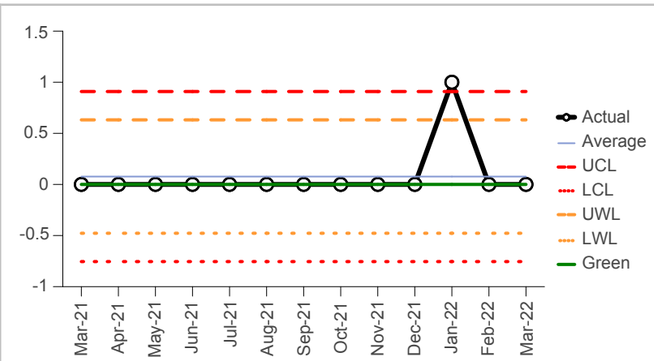
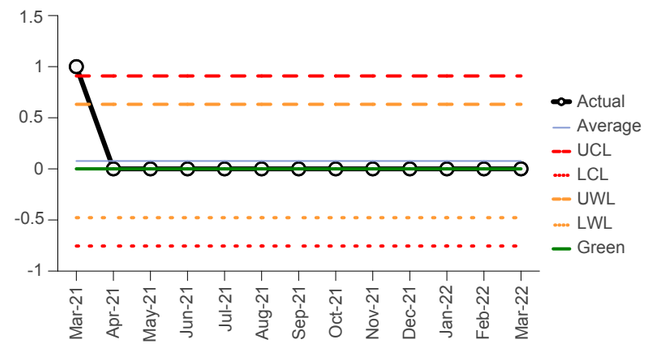
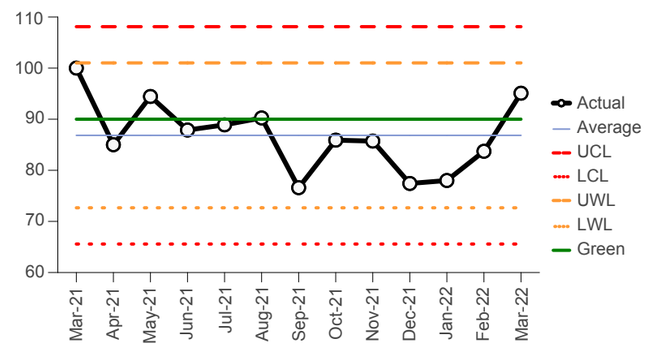
D Drive W Watch P Programme

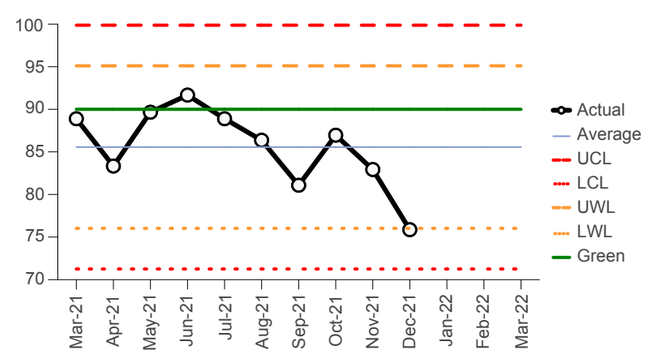
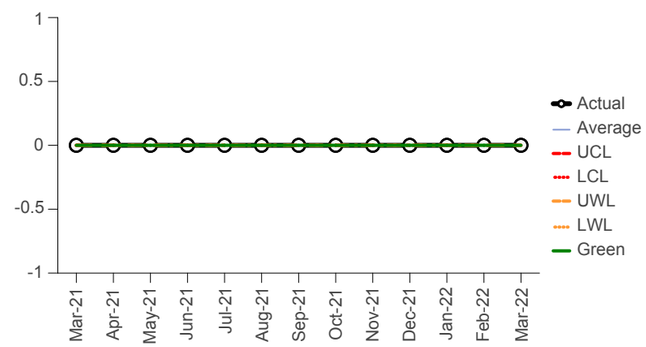
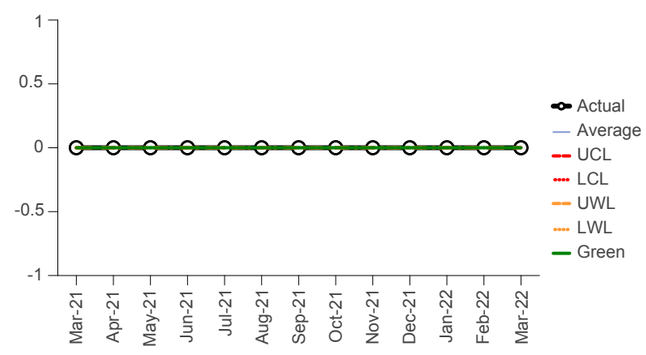
		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	90	100	103	108	117	125	132	139	142	145	148	150	153		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	36	34	36	38	37	38	40	43	44	42	43	44	38		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	6	7	2	3	7	3	7	7	4	1	3	0	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	2	0	3	1	1	0	2	3	3	0	3	0	0		>=1	N/A	<1	
Number of patients recruited	W	105	1,055	1,039	896	439	1,060	983	931	1,038	816	978	937	1,157		>=100	>=86	<86	✔

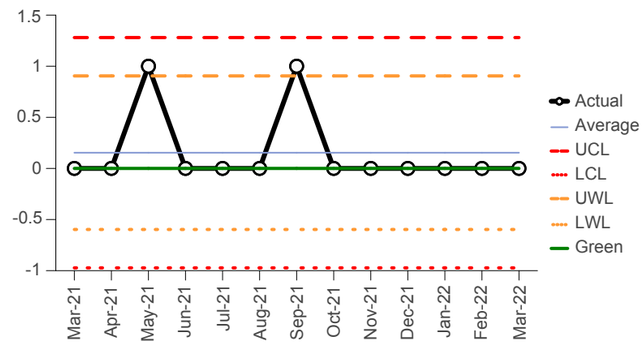
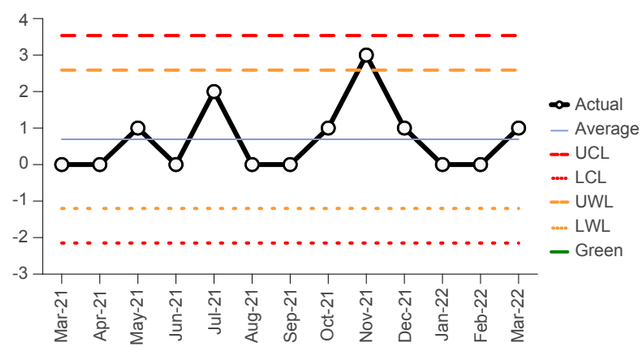
	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Nathan Askew **Committee:** SQAC	99.82 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported **Exec Lead:** Nathan Askew **Committee:** SQAC	95	No Threshold		
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. **Exec Lead:** Nathan Askew **Committee:** SQAC	305	No Threshold		

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. **Exec Lead:** Nathan Askew **Committee:** SQAC	145	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. **Exec Lead:** Nathan Askew **Committee:** SQAC	1	No Threshold		
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 20 - Mar 21. 21/22 aim is less than 52 annually for the trust. **Exec Lead:** Nathan Askew **Committee:** SQAC	2	R >4 A N/A G <=4		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 21/22 aim is 90%. **Exec Lead:** Nathan Askew **Committee:** SQAC	95.08 %	R <90 % A N/A G >=90 %		No Action Required

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

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 21/22 Aim is zero annually. **Exec Lead:** Nathan Askew **Committee:** SQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** D Hospital Acquired Organisms - MSSA . 20/21 aim is to reduce by 10% or more. **Exec Lead:** Nathan Askew **Committee:** SQAC	1	No Threshold		Complex baby known to colonised with STAU in Tracheostomy and PEG site. Developed STAU sepsis unclear source Action to introduce Tissue viability pathway for PEG including the use of Flaminal antimicrobial product in theatre

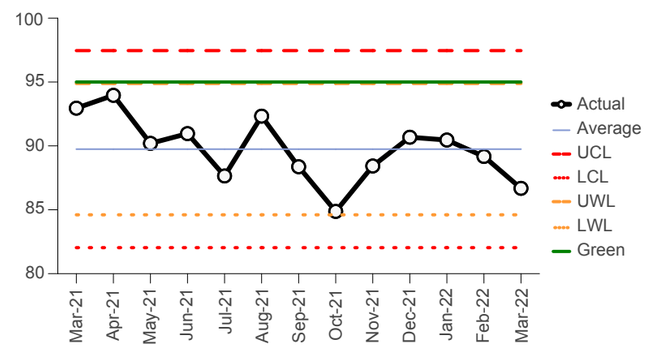
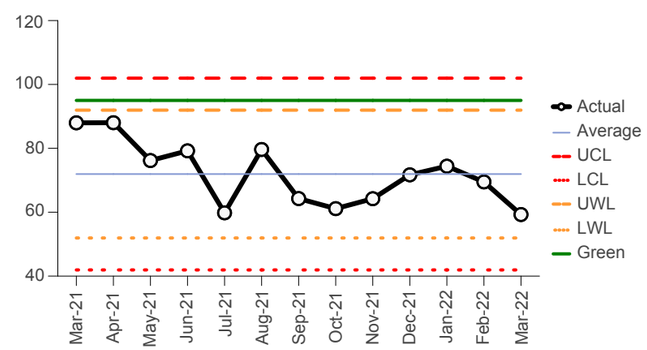
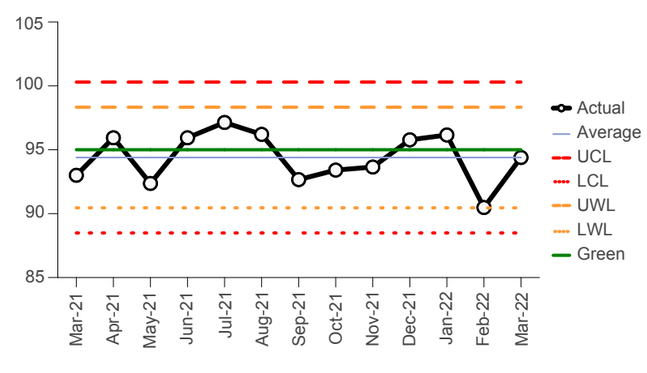
The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	86.68 %	R <90 % A >=90 % G >=95 %		March has 1535 responses from a possible 37,725 (March 2022). This gave an overall Trust FFT percentage of 86.7% who found their experience to be either good or very good. This is a 2.5% decrease compared to February. By Division, Community has had an increase from the previous month of 2%. Surgery had a slight decrease of 0.6% and Medicine a decrease of 4.4%. 71% of responses came via SMS message, this is a decrease of 7% by this method.
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	59.26 %	R <90 % A >=90 % G >=95 %		From the responses from March 2022; 192 found their experience to be either good or very good, giving a FFT percentage of 59.3%. This is a 10% decrease compared to February. 31% responded their experience was very poor or very poor (100). From these 100 responses, waiting time was the most common, followed by recuring comments regarding triage/reception staff attitude.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	94.39 %	R <90 % A >=90 % G >=95 %		During March Community Division received 189 responses in total. 94.4% had a good/very good experience which was a 4% increase compared to February (90.4%). The highest % of poor/very poor came from Phlebotomy clinic, this is an area of ongoing improvements and additional clinics are being offered to reduce waiting time

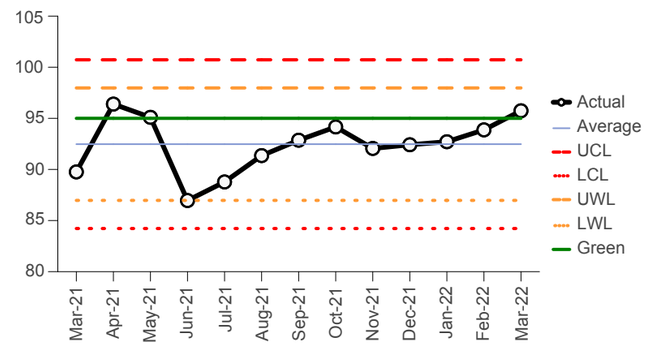
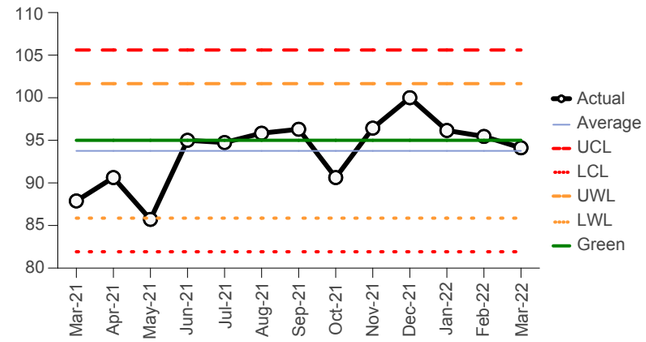
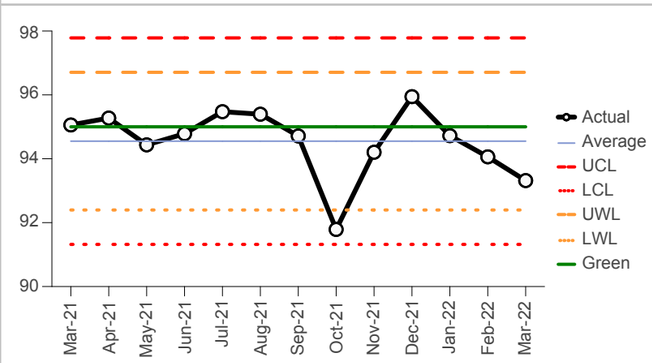
The Best People doing their best Work

8.2 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	95.74 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	94.12 %	R <90 % A >=90 % G >=95 %		During March, Mental Health has 17 responses. From these responses 16 found their experience to be either good or very good, giving a FFT percentage of 94.12%. This is a 1.3% decrease compared to February. There was 1 poor response for Liverpool CAMHS from the 6 very good responses this service received. All responses came via SMS.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Nathan Askew **Committee:** SQAC	93.32 %	R <90 % A >=90 % G >=95 %		From the responses in March 726 found their experience to be either good/very good, giving a FFT score of 93.3%. 31 responses were poor/very poor. Increase of collection within OPD to start during April.

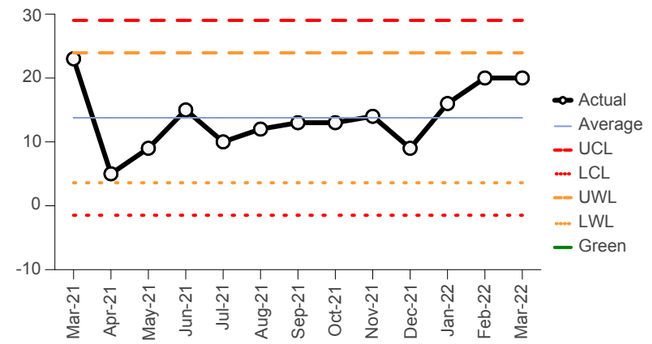
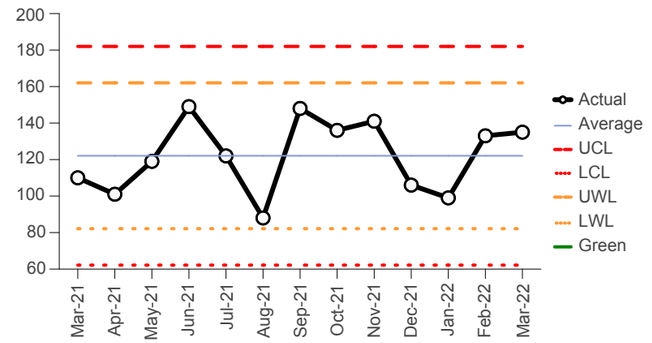
The Best People doing their best Work

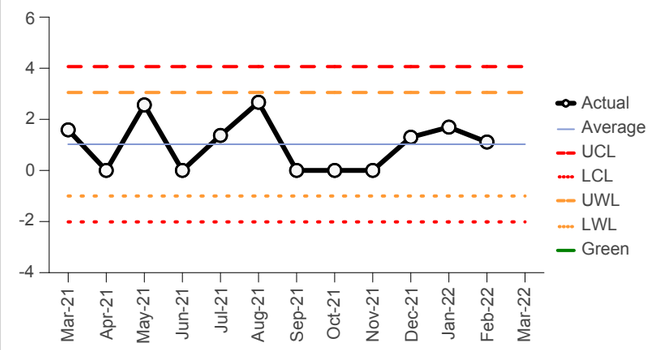
8.3 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Nathan Askew **Committee:** SQAC	20	No Threshold		
PALS	**PALS** W Total number of PALS contacts. **Exec Lead:** Nathan Askew **Committee:** SQAC	135	No Threshold		

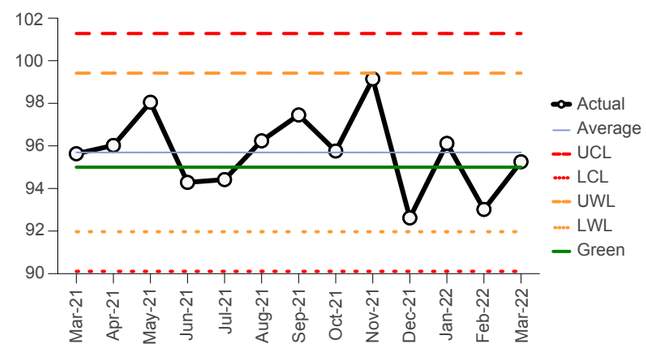
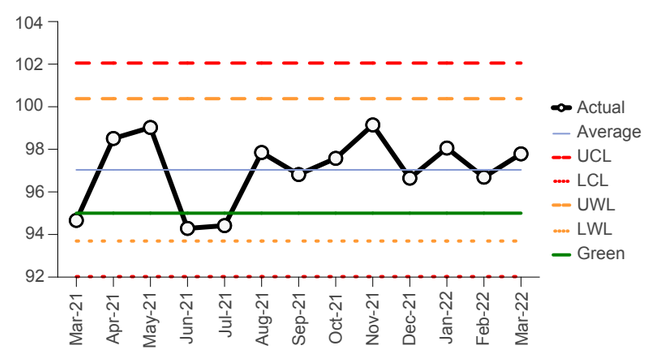
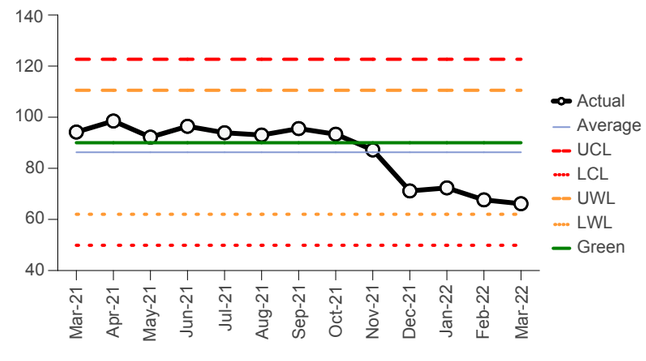
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Nathan Askew **Committee:** SQAC		No Threshold		March 2022 position currently unavailable. National system used is offline as precaution due to national cyber attacks. Postion will be backdated once system accessible again.

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

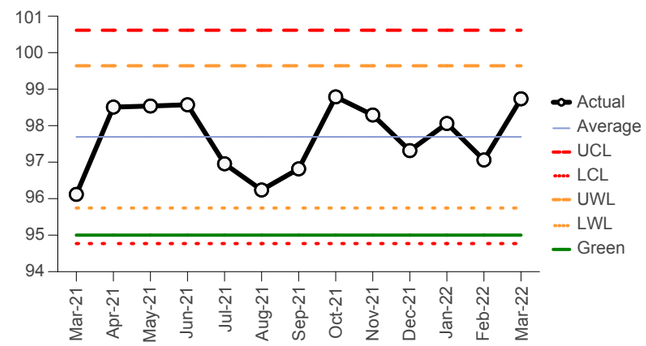
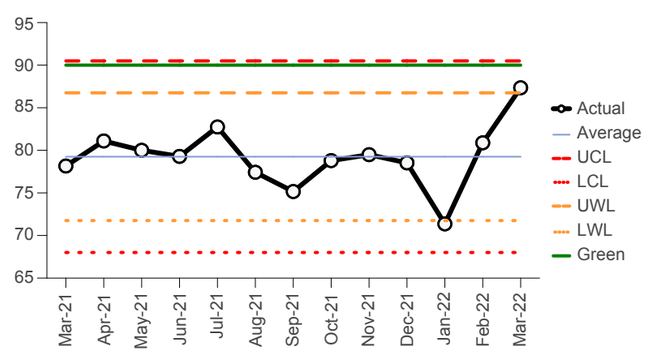
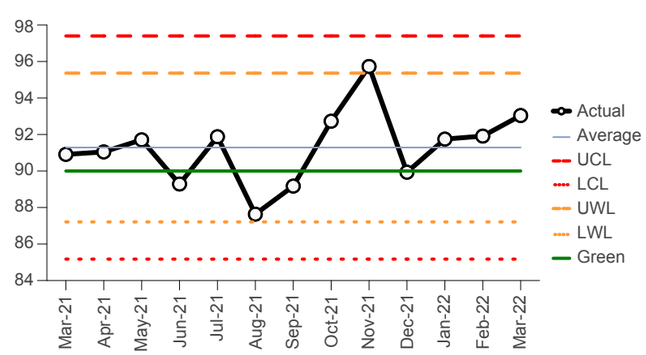
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	95.25 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 21/22 is 100%. **Exec Lead:** Nathan Askew **Committee:** SQAC	97.78 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	66.14 %	R <85 % A >=85 % G >=90 %		During March there was a 1.5% decrease in the number of responses that knew their expected date of discharge – 66%. Improvement work continues through the Emergency Care and collaborative programme to improve timely discharges and information to children, young people and families.

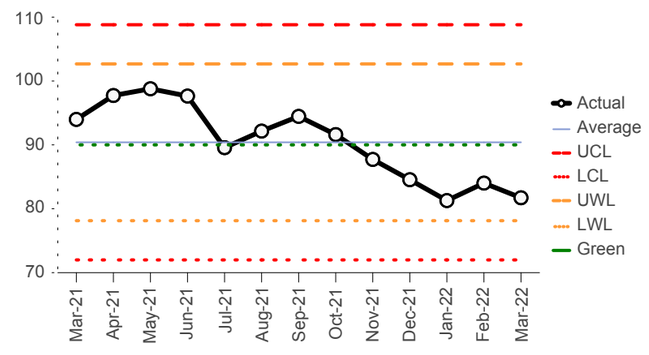
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 21/22 aim is 95% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	98.73 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	87.34 %	R <85 % A >=85 % G >=90 %		87.3% responded that they had engaged with play during March an increase of 6.5% since February and a total increase of 16% in 2022. There has been further provision of play due to recruitment and volunteer support in these areas and return of staff following COVID isolation and sickness absence
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 21/22 aim is 90% or above. **Exec Lead:** Nathan Askew **Committee:** SQAC	93.04 %	R <85 % A >=85 % G >=90 %		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** SQAC	81.72 %	R <90 % A N/A G >=90 %		Safer Staffing meeting is Chaired by an Associate Chief Nurse in hours or Patient Flow (weekends). Senior nursing staff review staffing for their Division, making plans to maintain safe staffing levels. Due to sickness, staff availability has been reduced. All staffing has been maintained with the Green, Amber, Red model and agreed to manage staffing at times of winter pressure or surge. Any incident reported related to staffing is reviewed and investigated. New Senior Nurse/AHP on Site role (SNOS) commences May 2023 which will provide an additional layer of support to wards and teams.

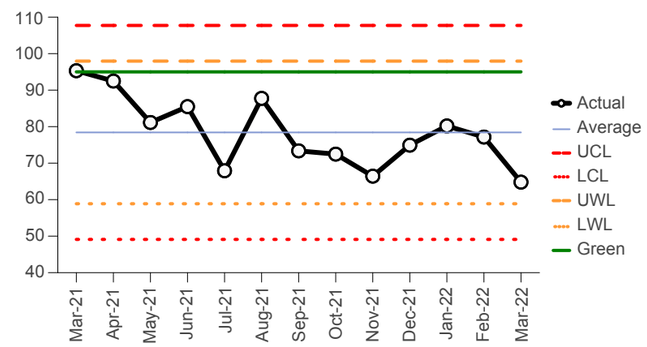
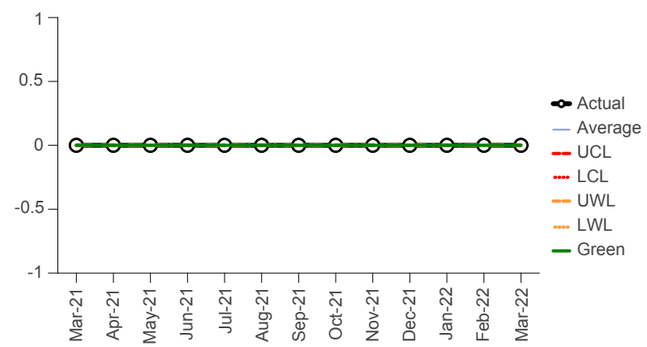
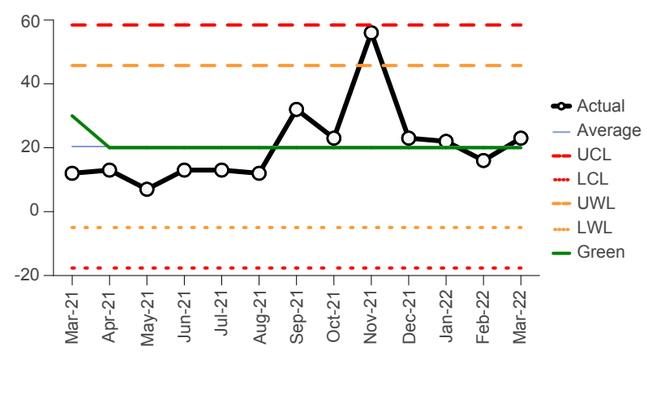
Delivery of Outstanding Care

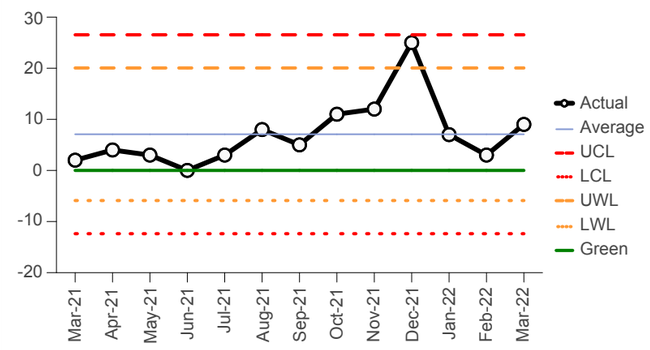
12.1 - PERFORMANCE - EFFECTIVE

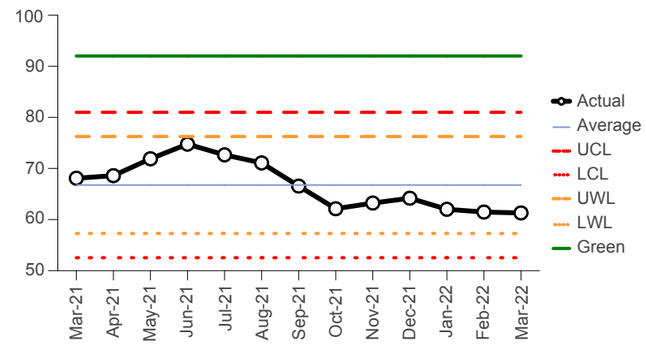
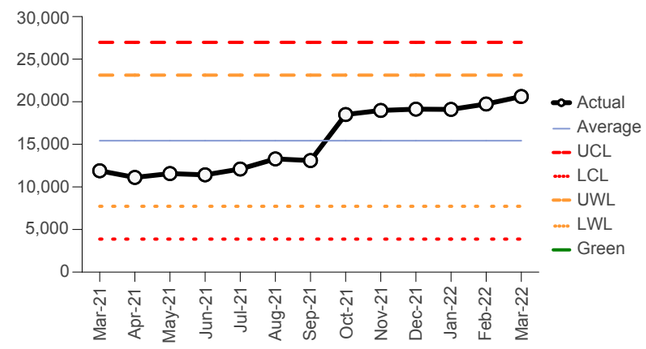
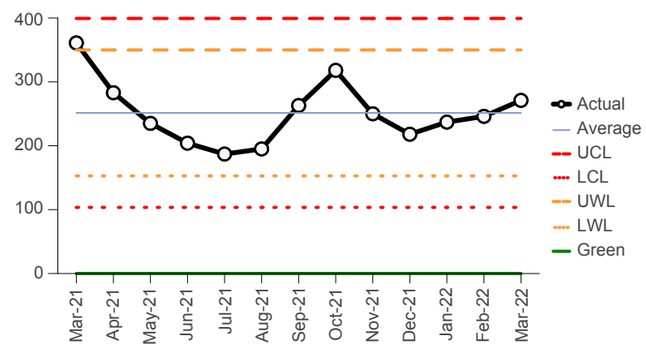
Alder Hey Children's NHS Foundation Trust

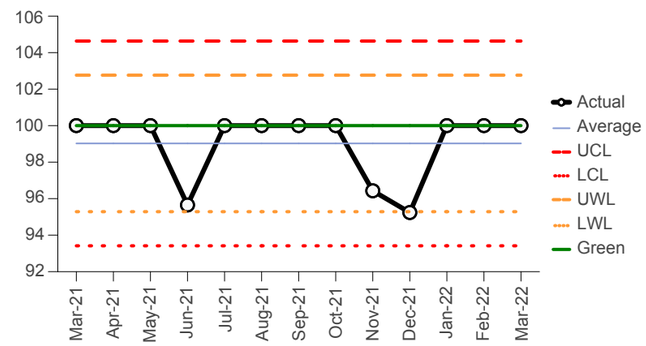
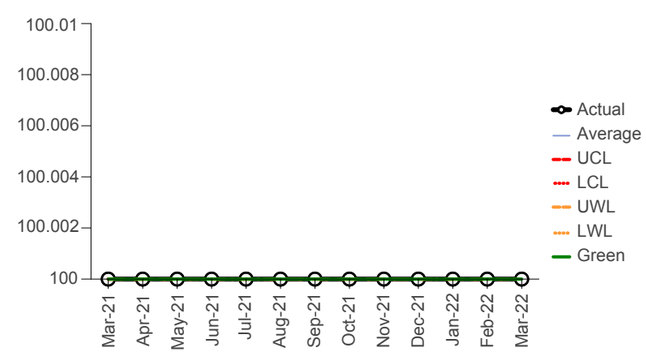
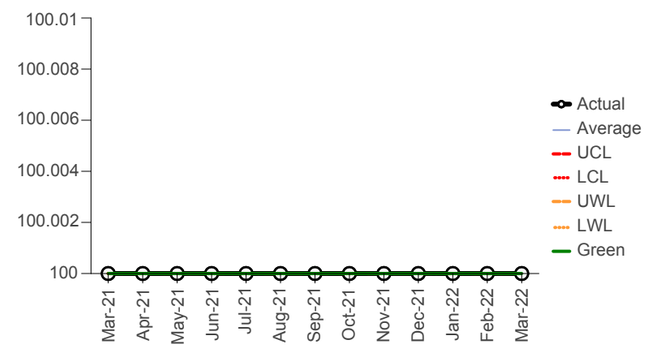
BRILLIANT BASICS

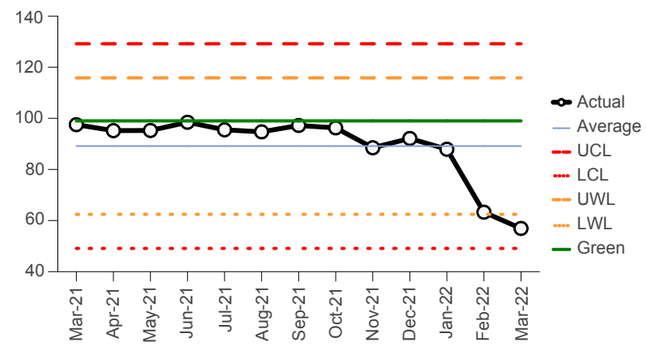
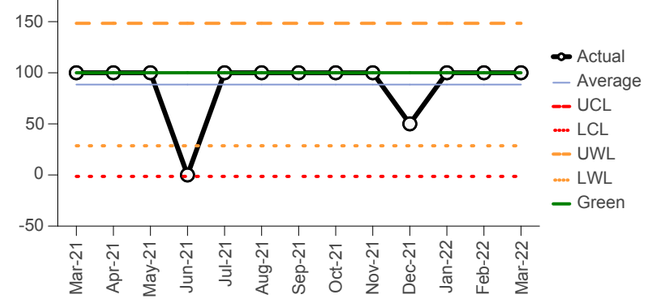
D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	64.79 %	R <95 % A N/A G >=95 %		March attendances increased to over 6000 which is 1500 more than the same period in 2021. Acuity remained constant at around 66% low acuity attenders. GP presence has continued in ED, but significant Covid and non-Covid related sickness absence in ED has meant that waits to be seen by a doctor was a median of 2 hours for March.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	23	R >20 A N/A G <=20		On the day cancellations increased in March. We are still experiencing a high volume of on the day cancellations due to Covid positive patients & staff. Cancellations are tracked in a weekly theatre performance meeting.

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	9	R >0 A N/A G 0		Breaches are tracked weekly via a theatre performance meeting to ensure patients are rebooked. Due to the volume of cancellations, recent sickness and urgent cases taking priority, we have been unable to redate all cancelled patients within 28 days. It is important to note that some patients have not been well enough to rebook their procedure within the timeframe.

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	61.29 %	R <90 % A >=90 % G >=92 %		RTT performance has remained fairly static through March which was expected due to ongoing capacity challenges. There is ongoing improvement work for most challenged specialities and further work underway to realign capacity/planned additional activity.
Waiting Times	**Waiting List Size** W Total waiting list size of Inpatient and Outpatient RTT incomplete pathways **Exec Lead:** Adam Bateman **Committee:** RABD	20612	No Threshold		
Waiting Times	**Waiting Greater than 52 weeks - Incomplete Pathways** W Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 21/22 aim is zero annually. **Exec Lead:** Adam Bateman **Committee:** RABD	271	R >0 A N/A G 0		RTT performance has remained fairly static through March which was expected due to ongoing capacity challenges. There is ongoing improvement work for most challenged specialities and further work underway to realign capacity/planned additional activity.

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

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	56.90 %	R <99 % A N/A G >=99 %		The inclusion of our sleep studies continues to impact on the overall trust performance negatively. The team has identified the best product available to be able to carry our the full studies at home which will support our recovery. We are going through the capital process to purchase this kit and hope to have it in place for June 2022.
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

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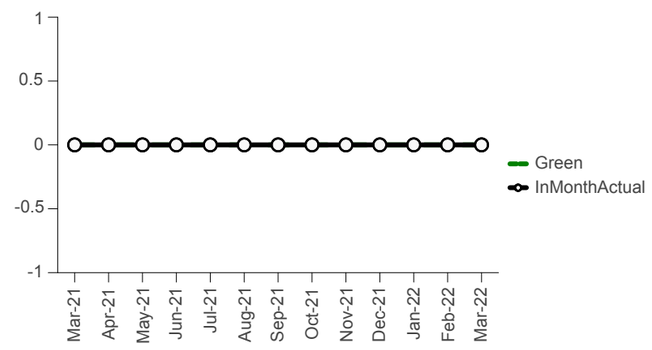
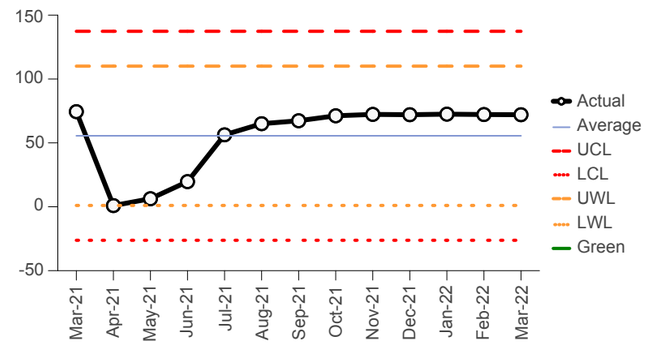
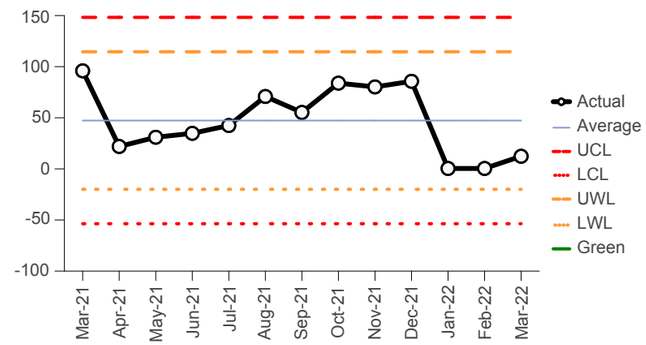
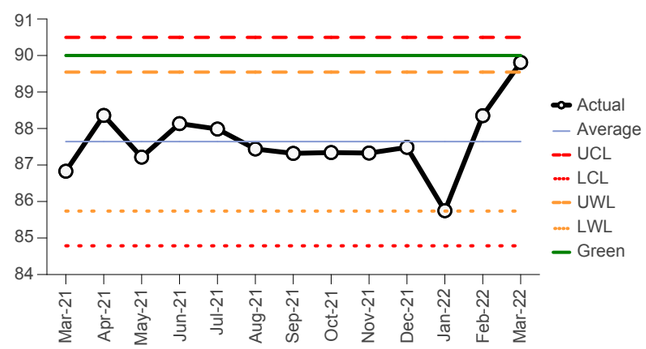
14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**NHS Oversight Framework** W Five themes against which trusts' performance is assessed and the indicators that trigger consideration of a potential support need: Quality, Finance and UOR, Operational performance, strategic change and Leadership and improvement capability (well led). **Exec Lead:** Erica Saunders **Committee:** SQAC	0	R >1 A <=1 G 0		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** PAWC	72.03 %	No Threshold		
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** PAWC	12.32 %	No Threshold		
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** PAWC	89.81 %	R <80 % A >=80 % G >=90 %		Work continues with all staff to encourage compliance across the Trust. Recent areas of focus; Resus Training, Estates and Ancillary staff and Moving and Handling Level 2 which had all seen significant compliance drops due to the impact of COVID on face-to-face training. Estates and Ancillary staff compliance continues to improve and has increased to 78% this month. Medical Education and Senior leaders have worked to promote Mandatory Training compliance in the Medic staff group, compliance has risen from 75.75% in Feb to 78.71% as of 4th of April.

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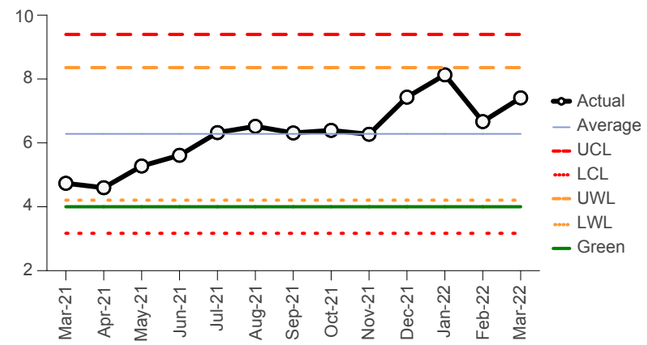
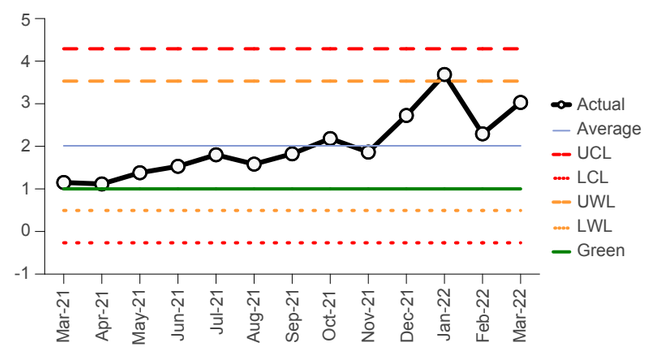
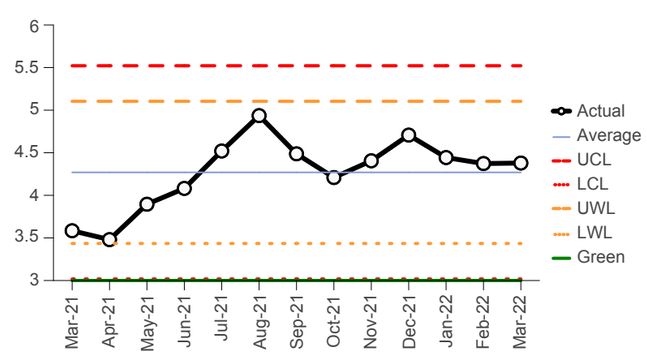
15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** PAWC	7.41 %	R >4.5 % A <=4.5 % G <=4 %		Sickness levels have remained high through March and is therefore a significant focus across all divisions. The HR team continue to provide dedicated support and guidance, along with weekly reports to assist with effective and proactive management of sickness. As of 31st March, Covid related absences accounted for 2% of the Trust overall sickness absence figure. A number of interventions are in place to support staff, which are promoted across the Trust to ensure staff are aware of how to access the support they require. Continued below.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** PAWC	3.03 %	R >1 % A N/A G <=1 %		Sickness Absence training will launch in May 2022, which will support our Leaders across the Trust to effectively manage sickness absence, in line with Trust policies and procedures.
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** PAWC	4.38 %	R >3 % A N/A G <=3 %		See Above Comments

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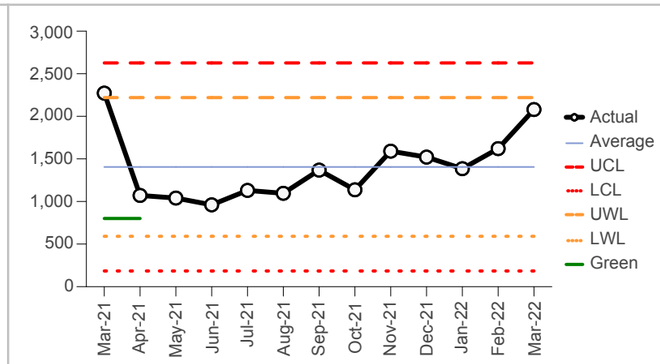
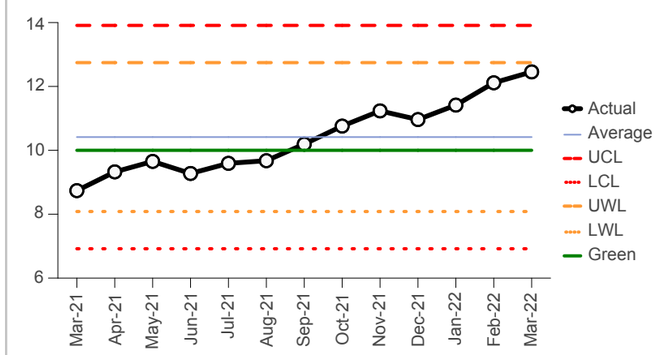
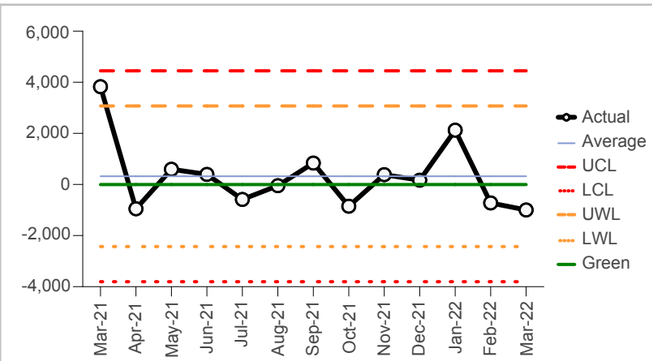
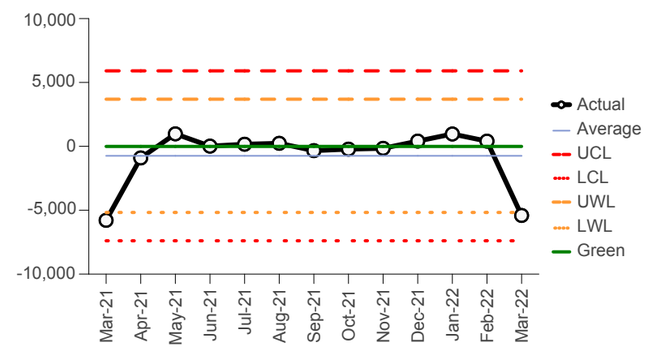
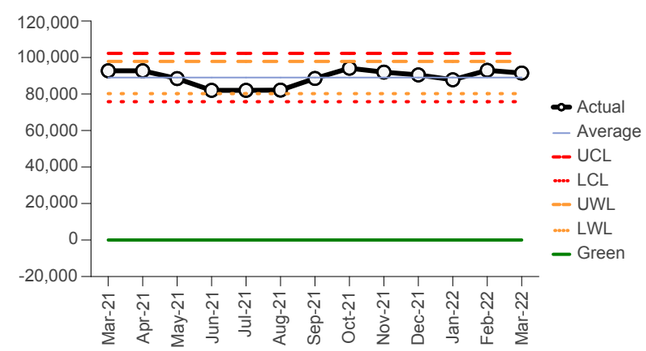
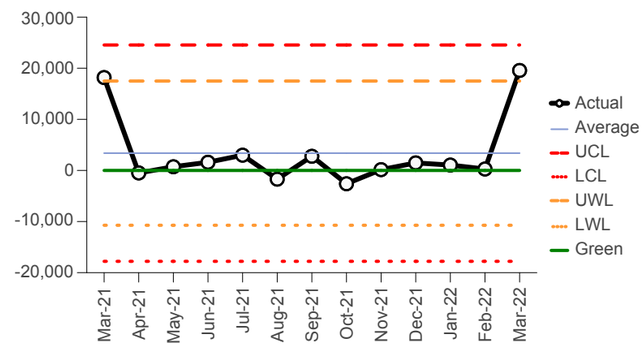
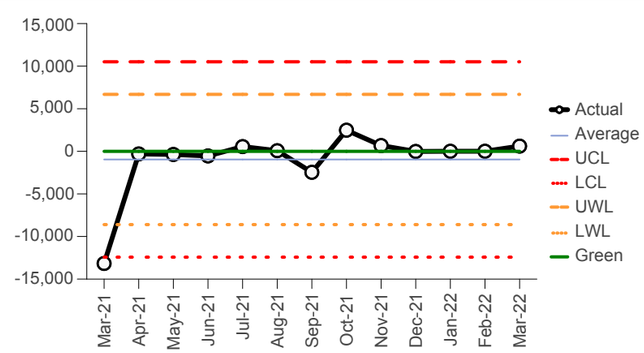
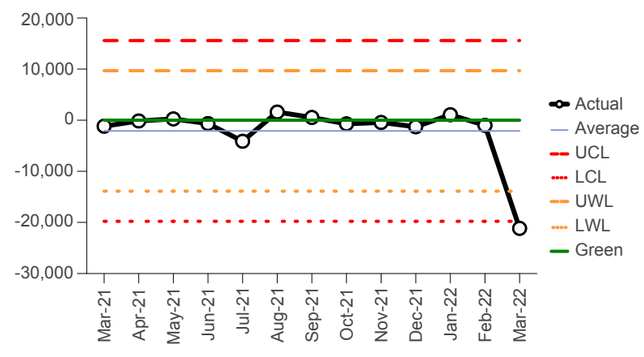
15.3 - PEOPLE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** PAWC	2079.23	No Threshold		
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** PAWC	12.46 %	R >11 % A <=11 % G <=10 %		Staff turnover remains slightly higher than previous months, therefore the HR team have provided a detailed report to show the reasons for staff leaving the Trust and analysed Exit Interview responses. The Senior HR team are conducting a full review on turnover, based on this report and are in the process of implementing next steps, including renewing the Exit Interview process.

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-1,000	R <-20% A >=-20% G >=-5%		
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-5,413	R <-10% A >=-10% G >=-5%		
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	91,464	R <-20% A >=-20% G >=-5%		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	19,562	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	608	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-21,170	R <-20% A >=-20% G >=-5%		

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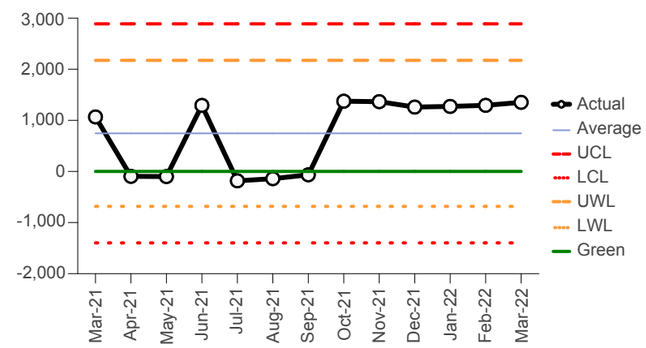
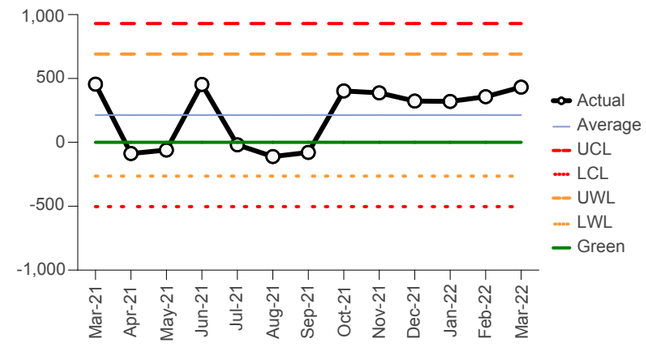
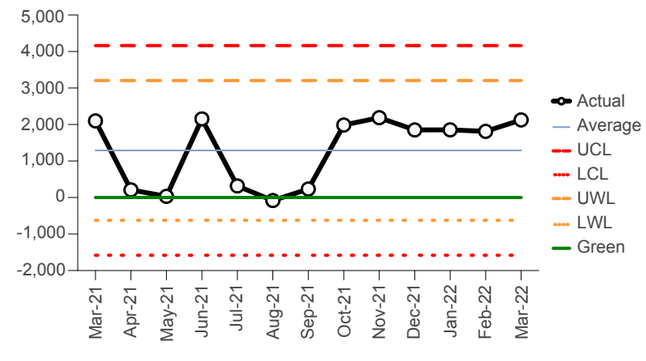
6.3 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1352	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	431.81	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	2124.71	R <0 A N/A G >=0		No Action Required

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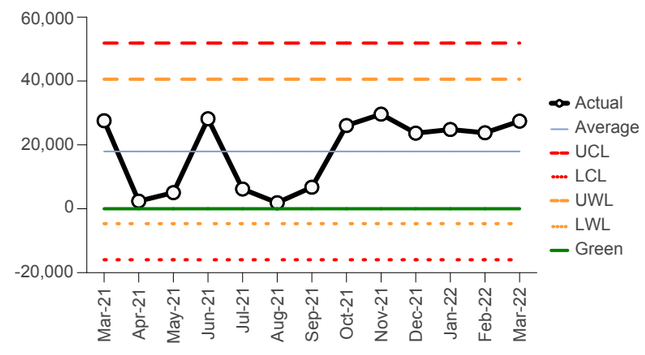
6.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	27420.69	R <0 A N/A G >=0		No Action Required

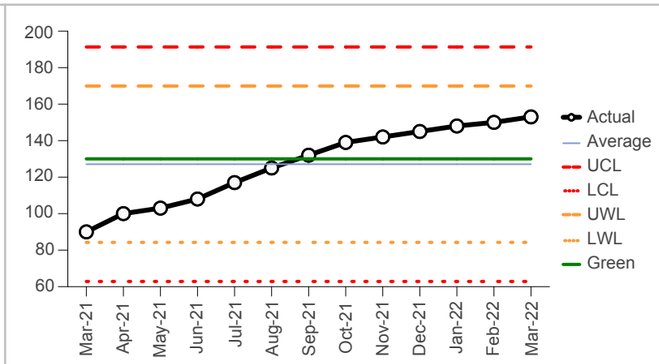
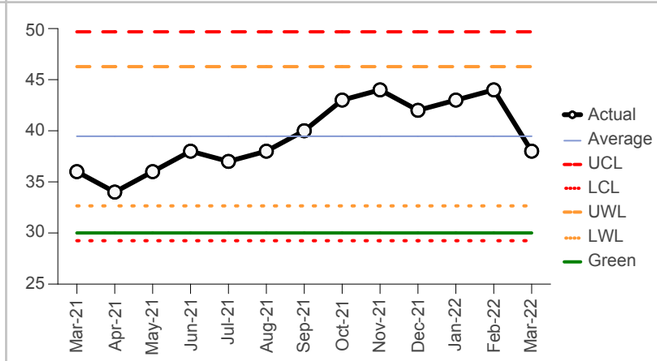
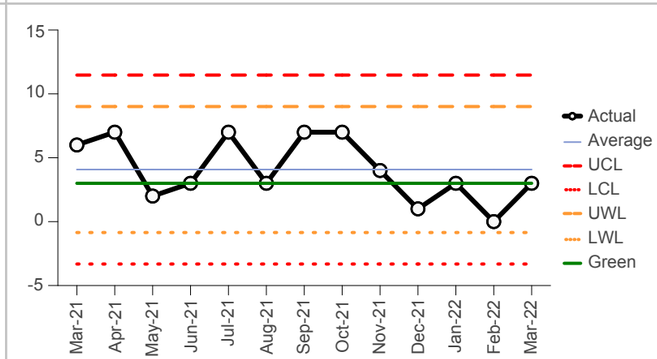
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	153	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Jo Blair **Committee:** RMB	38	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	3	R <2 A >=2 G >=3		No Action Required

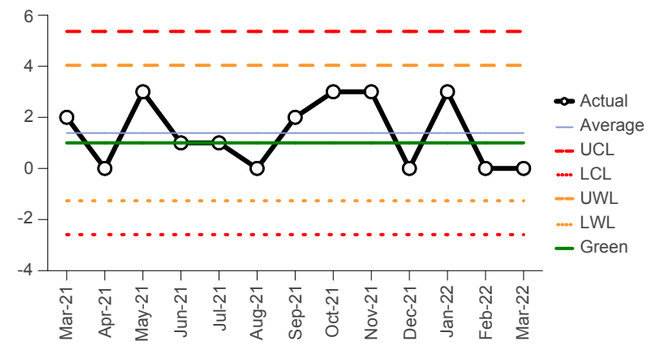
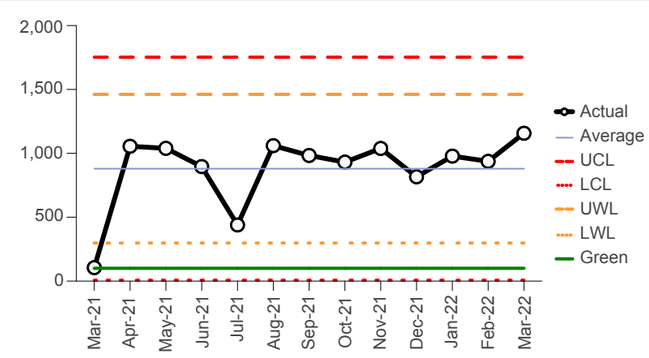
Game Changing Research & Innovation

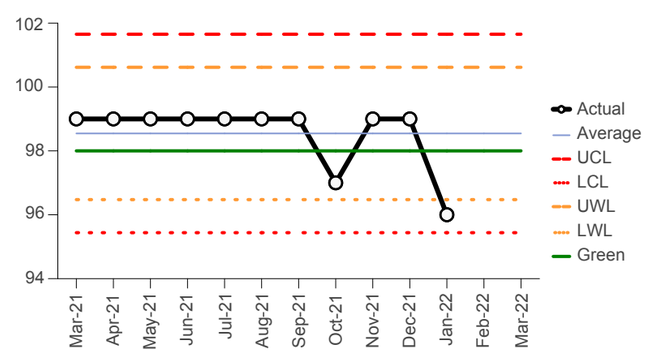
17.2 - RESEARCH & DEVELOPMENT - WELL LED

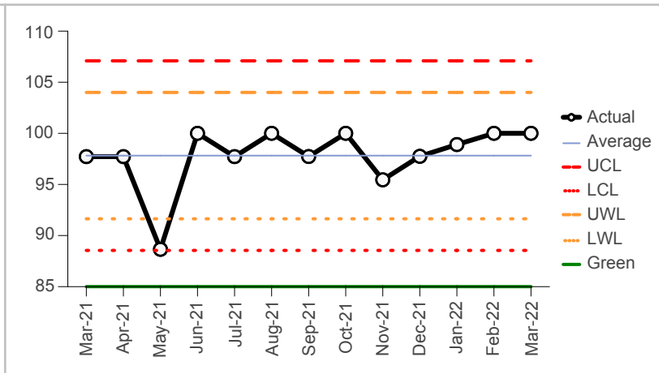
Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Jo Blair **Committee:** RMB	0	R <1 A N/A G >=1		
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Jo Blair **Committee:** RMB	1157	R <86 A >=86 G >=100		No Action Required

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

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Nathan Askew **Committee:** SQAC	100 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG		
Clinical Incidents resulting in Near Miss	D	12	39	34	No Threshold		
Clinical Incidents resulting in No Harm	D	63	86	132	No Threshold		
Clinical Incidents resulting in minor, non permanent harm	D	64	17	42	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	1	No Threshold		
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	N/A	>0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	N/A	>0
Medication errors resulting in harm	D	0	0	2	No Threshold		
Pressure Ulcers (Category 3)	W	0	0	0	0	N/A	>0
Pressure Ulcers (Category 4)	W	0	0	0	0	N/A	>0
Never Events	W	0	0	0	0	N/A	>0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		83.3%	75.0%	>=90 %	N/A	<90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MSSA	D	0	0	1	No Threshold		

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	4	6	9	No Threshold
PALS	W	34	52	43	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
% Readmissions to PICU within 48 hrs	W			1.1%	No Threshold		
ED: 95% Treated within 4 Hours	D		64.8%		>=95 %	N/A	<95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0	N/A	>0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	5	18	No Threshold
28 Day Breaches	W	0	2	7	0 N/A >0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care	W		93.4%	96.4%	>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W		95.9%	99.0%	>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P		53.7%	73.8%	>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W		97.5%	99.5%	>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D		89.3%	86.2%	>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D		96.7%	90.8%	>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	52.0%	62.8%	61.9%	>=92 % >=90 % <90 %
Waiting List Size	W	1,788	6,411	12,413	No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	W	1	3	267	0 N/A >0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks	W		59.6%	35.4%	>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 % N/A <100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	96	-344	-581	No Threshold
Income In Month Variance (£'000s)	W	78	273	131	No Threshold
Pay In Month Variance (£'000s)	W	-112	-376	-196	No Threshold
Non Pay In Month Variance (£'000s)	W	130	-241	-516	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG
PDR	W	82.6%	74.0%	61.1%	No Threshold
Medical Appraisal	W	8.6%	10.2%	14.4%	No Threshold
Mandatory Training	W	93.3%	88.9%	89.4%	>=90 % >=80 % <80 %
Sickness	D	6.6%	8.7%	6.8%	<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	2.1%	4.2%	3.2%	<=1 % N/A >1 %
Long Term Sickness	D	4.5%	4.6%	3.7%	<=3 % N/A >3 %
Temporary Spend ('000s)	D	493	614	824	No Threshold
Staff Turnover	D	12.3%	12.6%	12.4%	<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.4%	81.3%	80.5%	>=90 % >=80 % <90 %

Medicine Division

SAFE	Daily incident meetings are allowing timely review and progress of incidents. Daily review of sepsis dashboard is allowing validation of sepsis patients and compliance with Abx.	**Highlight** • 2 RCAs completed and submitted to CCG. 3rd RCA to go for Exec sign off. 4th RCA ongoing. • During the daily reviews of sepsis patients on the BI dashboard no failures of compliance with 1hr target have been identified following review by Matron. **Challenges** • National shortages of ventilation equipment is delaying set up of patients for NIV. Currently have 18 patients waiting set up. Regional discussions taking place through ODN to assess managing waiting list and potential to suspend routine services.
CARING	20 complaints received since 1st Jan 2022. Only one complaint since 1 Jan 2022 has breached 25 working day. Breach was by 2 days – review of process for this complaint to take place to identify why breach occurred.	**Highlight** • Engagement from teams to respond to complaints response requests is **Challenges** • PALS process has points of failure of admin procedures – trust wide review undertaken with Director of Nursing and changes to the process identified to help improve.
EFFECTIVE	ED Performance has further deteriorated in month; the department has been significantly impacted by absenteeism in nursing and medicine including Consultant level staffing resulting in on-call staffing levels during weekdays; recruitment is underway to fill outstanding vacancies with consultant interviews planned for the end of April. March 2022 saw 6430 attendances through ED compared to 5008 in February representing a 30% increase in month. WEF 11th April the GP stream is being diverted via OPD Monday to Friday as part of a PDSA program; evaluation will be presented in late May.	**Highlight** • No breaches of 28-day standard for rebooking cancelled surgery. • Progress on demonstrating an improvement in NICE assessments completion has been made with input from Clinical Director for Governance. **Challenges** • Theatre Utilisation remains at 79.3%, far short of the 90% minimum standard; work continues to review areas for improvement in Rheumatology and Respiratory where performance is lowest. • Appointments cancelled < 6 weeks for non-clinical reasons are under review. • NICE position reporting due to unplanned leave.
RESPONSIVE	Locum consultants appointed for Gen Paediatrics as part of plans to reduce waiting times. Starting in April and July. Work progressing on BI reports for Radiology and Cancer waiting lists to improve visibility for specialty teams.	**Highlight** • Cancer targets all achieved. • All patients over 52 weeks have planned appointment dates and teams now working to resolve for all patients over 40 weeks. **Challenges** ▪ Reporting of Cross-Sectional Imaging remains a challenge in meeting the 2-week target. 2nd outsourcing company identified that is in use across NW and with procurement for sign off. ▪ DM01 continues to be challenged due to pressures in MRI, suspension of the DEXA service and new reporting

		processes that are capturing services not previously reported with historic long waits. Recovery plans for MR, Sleep and VT are being developed to support the Diagnostics recovery submission. ▪ RTT Performance deteriorated further in month to 62.8% against the 92% standard; plans are being developed to support recovery and the Division has submitted ambitious recovery plans in terms of activity and performance for 22/23
WELL LED	Overall Sickness absence rates have deteriorated in month with a sharp increase in STS; ED, Pharmacy and the wards continue to be hot spots. The division have ended the year with a deficit of £1.4m against the plan. The overall pay over spend (£0.6m) has largely been due to the current pressures within ED which have resulted in additional junior doctors and nursing staff to meet demand. Other significant pay pressures include nursing 1-2-1 and sickness cover at premium cost. The non-pay overspend (£1m) has contributed significantly to the overall deficit position. The main drivers of the overspend are Clinical supplies costs, which are significantly overspent across ED and the core wards and represent the increased activity levels.	**Highlight** • Mandatory training compliance showed a 2.9% improvement in month to 88.9%, just 1.1% short of the minimum compliance standard; clinical and operational leads continue to monitor compliance. • The 21/22 CIP target of £0.9m has been achieved within the year. • The PDR approach for 22/23 has been refreshed to remove the short window for activity, based around a framework. **Challenges** • Maintain monthly risk reviews in all areas. • There are a significant number of staff who are in the red for mandatory training compliance, the Division are actively contacting individuals to remind them of the requirement to comply. Some technical issues have been identified that may be a contributing factor and these have been highlighted for resolution. • As at 13th April 22 sickness absence has increased to 9.07%, COVID related absence equates to 2.56% of the total. • PDR compliance is not improving, managers are being encouraged to undertake PDRs ahead of the formal PDR window in April. • The overall pay overspend is largely understated due to slippage, vacancies and external funding (Accelerator, UEC winter funding) that may not be available in 22/23. • Aseptic Unit outsourcing continues to be a challenge, with the level of overspend remaining consistent due to increased volume of patient activity. Work is ongoing and plans are in place to repatriate this service in-house which will see this cost pressure reduced in 2022/23.

Medicine

D Drive W Watch P Programme

SAFE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	33	42	32	36	29	28	33	39	24	49	32	38	39		No Threshold
Clinical Incidents resulting in No Harm D	125	123	125	89	101	99	133	93	87	100	104	103	86		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	19	23	24	17	18	17	14	28	25	18	19	18	17		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	1	0	2	1	1	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	1	0	0	0	0	0	0	0	0	1	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm D	2	0	0	1	0	2	3	1	0	1	1	0	0		No Threshold
Medication Errors (Incidents)	39	29	42	26	14	20	35	24	20	30	28	18	20		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	4	1	3	2	0	2	1	6	7	4	1	4	2		No Threshold
Never Events W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	87.5%	90.9%	88.2%	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%	83.3%					>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile D	0	0	1	0	0	0	1	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	5	0	0	2	3	3	4	2	1	0	1	3		No Threshold
Hospital Acquired Organisms - MSSA D	0	0	0	0	0	0	0	1	1	0	0	0	0		No Threshold
Cleanliness Scores	98.6%	98.7%	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%	98.8%	99.4%		No Threshold

CARING

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Complaints W	12	4	5	2	4	4	3	5	7	2	5	5	6		No Threshold
PALS W	37	24	23	39	43	26	49	50	45	42	34	50	52		No Threshold

EFFECTIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Referrals Received (Total)	2,249	2,148	2,251	2,427	2,268	1,930	2,479	2,627	2,697	3,067	2,914	2,506	3,367		No Threshold
ED: 95% Treated within 4 Hours D	95.3%	92.5%	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%		>=95 % N/A <95 %
ED: Percentage Left without being seen W	2.2%	3.8%	7.4%	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%	6.1%	4.0%	5.9%	10.6%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes W	0	0	0	0	0	0	1	0	1	4	0	1	1		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes W	0	0	0	0	0	0	1	0	0	3	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%) W	7.5%	8.3%	9.5%	8.6%	9.8%	9.7%	8.4%	9.2%	9.6%	9.9%	9.1%	8.8%	9.5%		No Threshold
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	86.3%	74.7%	76.9%	73.9%	74.2%	72.2%	78.5%	76.6%	76.7%	73.7%	70.8%	74.9%	79.3%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	1	2	0	1	0	3	2	3	5	0	4	0	5		No Threshold
28 Day Breaches W	0	0	0	0	0	0	1	1	2	2	0	0	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	18	21	19	21	37	42	30	43	45	40	33	37	26		No Threshold

Medicine

D Drive W Watch P Programme

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
OP Appointments Cancelled by Hospital %	11.4%	10.0%	10.9%	11.4%	14.3%	14.3%	13.5%	15.0%	12.3%	12.0%	12.2%	13.0%	12.5%		<=5 % N/A >10 %
Was Not Brought Rate W P	8.3%	8.6%	8.2%	9.2%	9.9%	10.7%	9.2%	9.0%	8.7%	8.8%	8.5%	7.6%	7.5%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	8.8%	12.0%	9.1%	10.8%	10.3%	10.9%	8.7%	9.2%	8.6%	8.7%	10.3%	7.3%	8.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	8.2%	7.9%	8.0%	8.8%	9.8%	10.7%	9.4%	9.0%	8.7%	8.7%	8.2%	7.7%	7.3%		<=14 % <=16 % >16 %
Coding average comorbidities	5.41	5.14	5.17	5.58	5.47	5.58	5.50	5.68	5.57	5.49	5.50	5.41	5.54		No Threshold

RESPONSIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care W	95.2%	96.2%	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%	92.1%	93.4%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	95.2%	98.1%	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%	97.0%	95.9%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	91.9%	96.2%	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%	58.4%	53.7%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	95.2%	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 % >=90 % <90 %
IP Survey: % Patients involved in Play D	85.5%	84.9%	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%	80.2%	89.3%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D	80.0%	90.6%	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%	92.1%	96.7%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	92.9%	92.0%	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%	63.4%	62.8%		>=92 % >=90 % <90 %
Waiting List Size W	2,280	2,509	2,819	3,122	3,338	3,507	3,565	5,605	5,842	5,943	5,955	6,136	6,411		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	4	4	3	6	11	7	13	23	10	15	5	2	3		0 N/A >0
Waiting Times - 40 weeks and above	10	24	12	15											No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	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. W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks W	97.7%	95.5%	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%	88.5%	66.7%	59.6%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	91.9%	91.1%	92.6%	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%	88.2%	89.8%	90.4%	88.9%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	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	100.0%	89.0%	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%	99.0%	99.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	99.0%	89.0%	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%	82.0%	89.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	58.0%	65.0%	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%	64.0%	67.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	98.0%	98.7%	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%	72.5%	77.1%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	100.0%	100.0%	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%	93.5%	91.2%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	98.9%	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	-586	263	200	-1,036	-347	-58	253	-127	-199	87	144	-261	-344		
Income In Month Variance (£'000s) W	170	37	-26	-1	209	-490	201	-184	1,138	829	-308	135	273		
Pay In Month Variance (£'000s) W	-148	-64	60	-150	48	47	121	-35	15	70	-96	-218	-376		

Medicine

D Drive W Watch P Programme

		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG		
PDR	W	74.2%	2.6%	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%	74.2%	74.0%				
Medical Appraisal	W	94.1%	23.4%	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%	0.0%	10.2%				
Mandatory Training	W	88.5%	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 %	>=80 %	<80 %
Sickness	D	4.2%	4.5%	5.5%	5.3%	6.4%	7.1%	6.3%	6.5%	7.4%	9.3%	9.8%	8.0%	8.7%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.1%	1.2%	1.5%	1.5%	2.0%	1.9%	1.8%	2.3%	2.2%	3.5%	4.5%	2.9%	4.2%		<=1 %	N/A	>1 %
Long Term Sickness	D	3.1%	3.4%	4.0%	3.7%	4.4%	5.2%	4.5%	4.3%	5.2%	5.8%	5.3%	5.1%	4.6%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	261	210	262	230	265	263	292	311	373	370	452	495	614				
Staff Turnover	D	6.0%	6.5%	6.8%	7.3%	7.5%	8.3%	9.4%	9.6%	9.9%	10.0%	11.2%	12.1%	12.6%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	93.9%	101.7%	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%	77.0%	81.3%		>=90 %	>=80 %	<90 %

Surgery Division

SAFE	• Cleanliness scores continue to improve (99.1% March)	**Highlight** • 0 Never events for 12 months consecutively • 0 CLABSI (ICU) since December **Challenges** • 1 Hospital acquired organism in March- MSSA • Increase in clinical incidents (Near miss/no harm) • Increase in medication errors (21 < 26)
CARING	• All monthly PALS/complaints sent via monthly divisional governance report, discussed at Integrated Governance meeting	**Highlight** • Reduction in both PALS and formal complaints in March **Challenges**
EFFECTIVE	• Referrals continue to increase (4160 in March compared to 3438 in Feb, 3274 in Jan) • Increase in hospital cancelled appointments- reflective of our sickness levels	**Highlight** • Elective and NEL LOS reduced in March • Theatre utilisation increased at 88.7%. Paediatric Dentistry significant improvement in month at 85.1% • WNB rate decreased for 4th consecutive month **Challenges** • On the day cancellations increased slightly due to high volume of Covid related sickness- staff & patients. • Increase in 28 day breaches- focus on re-dating patients within 28 days where possible but proving a challenge due to capacity/long waiters
RESPONSIVE	• Waiting list size continues to grow (12,413)	**Highlight** • Increase in % patients who felt they received information enabling choices about their care **Challenges** • Increase in patients waiting > 52 weeks – experienced a high volume of cxd. Ops for long waiters in March due to covid (staff & patients) Paediatric Dental continues to be a challenge and a weekly action plan is in place to improve • Ongoing challenge with validation of overdue follow ups- a number of these are being added to the live PTL
WELL LED	•	**Highlight** • Mandatory training increased and just under 90% target **Challenges** • Sickness increased in March, reflective of operational challenges

Surgery

D Drive W Watch P Programme

SAFE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	46	23	32	43	27	25	42	33	33	21	26	21	34		No Threshold
Clinical Incidents resulting in No Harm D	174	166	165	164	120	114	107	103	117	117	77	114	132		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	33	35	28	38	31	49	39	43	82	40	40	43	42		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	0	1	2	0	0	1	0	1	1	0	1	1	1		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	0	0	0	0	0	1	1	0	1	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm D	2	4	2	1	2	3	1	1	3	4	1	2	2		No Threshold
Medication Errors (Incidents)	45	43	36	29	24	27	26	20	28	29	20	21	26		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Never Events W	1	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients D P	90.9%	76.9%	91.7%	88.9%	66.7%	100.0%	75.0%	82.6%	82.4%	75.0%					>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA D	0	0	1	0	2	0	0	0	2	1	0	0	1		No Threshold
Cleanliness Scores	97.9%	98.9%	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%	98.7%	99.1%		No Threshold

CARING

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Complaints W	7	0	4	5	3	4	6	4	5	4	4	10	9		No Threshold
PALS W	27	34	42	43	33	25	30	29	42	33	28	45	43		No Threshold

EFFECTIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Readmissions to PICU within 48 hrs D	1	0	2	0	1	2	0	0	0	1	1	1	0		No Threshold
% Readmissions to PICU within 48 hrs W	1.6%	0.0%	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%			No Threshold
Referrals Received (Total)	4,049	3,964	4,120	4,375	3,768	3,240	3,934	3,580	3,935	3,114	3,279	3,438	4,209		No Threshold
Theatre Utilisation - % of Session Utilised W	89.5%	77.0%	83.0%	78.4%	79.5%	81.0%	83.8%	86.7%	79.4%	81.5%	77.2%	85.9%	88.7%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	11	11	7	12	13	9	30	20	51	23	18	16	18		No Threshold
28 Day Breaches W	2	4	3	0	3	8	4	10	10	23	7	3	7		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	37	47	46	59	63	74	54	78	43	51	48	34	50		No Threshold
OP Appointments Cancelled by Hospital %	11.5%	10.0%	10.0%	11.2%	9.6%	11.3%	11.3%	10.5%	8.8%	10.5%	12.8%	12.4%	14.0%		<=5 % <=10 % >10 %
Was Not Brought Rate W P	7.9%	6.6%	7.3%	7.9%	9.5%	10.1%	8.6%	7.8%	8.3%	9.2%	9.3%	8.1%	8.0%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	9.1%	7.6%	9.8%	9.3%	12.1%	12.0%	9.9%	9.3%	10.2%	10.6%	11.0%	9.6%	8.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	7.4%	6.2%	6.3%	7.3%	8.5%	9.4%	8.1%	7.3%	7.6%	8.7%	8.6%	7.6%	7.8%		<=14 % <=16 % >16 %
Coding average comorbidities	4.54	4.63	4.40	4.49	4.62	4.57	4.51	4.50	4.28	4.51	4.57	4.62	4.50		No Threshold
CCAD Cases	34	34	31	39	28	19	23	29	24	33	20	22			No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care W	95.8%	95.9%	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%	93.6%	96.4%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect W	94.4%	98.6%	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%	96.5%	99.0%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge D P	95.1%	99.3%	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%	73.1%	73.8%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care W	96.5%	100.0%	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%	98.2%	99.5%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play D	75.0%	79.7%	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%	81.3%	86.2%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning D	95.8%	91.2%	92.5%	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%	88.5%	91.6%	91.8%	90.8%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	61.8%	61.6%	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%	61.5%	61.9%		>=92 % / >=90 % / <90 %
Waiting List Size W	8,701	7,773	7,980	7,484	7,787	8,632	8,319	11,360	11,505	11,621	11,567	11,949	12,413		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways W	357	276	232	197	174	186	249	294	239	202	231	244	267		0 / N/A / >0
Diagnostics: % Completed Within 6 Weeks W	94.1%	91.3%	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%	66.7%	32.5%	35.4%		>=99 % / N/A / <99 %

WELL LED

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	-708	-716	217	108	583	-5	-137	-349	-598	-657	-130	-232	-581		
Income In Month Variance (£'000s) W	152	47	49	209	223	28	-144	-43	68	59	-16	23	131		
Pay In Month Variance (£'000s) W	-526	-599	28	-116	541	-64	-158	-82	-452	-331	-85	-358	-196		
PDR W	66.1%	0.1%	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%	61.3%	61.1%		
Medical Appraisal W	96.8%	24.0%	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%	0.8%	14.4%		
Mandatory Training W	87.8%	89.0%	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%	88.5%	89.4%		>=90 % / >=80 % / <80 %
Sickness D	5.4%	5.2%	5.7%	5.8%	6.7%	6.2%	6.3%	5.9%	5.6%	7.2%	8.4%	6.1%	6.8%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness D	1.5%	1.5%	1.6%	1.6%	2.2%	1.6%	2.3%	2.5%	1.8%	3.2%	4.5%	2.6%	3.2%		<=1 % / N/A / >1 %
Long Term Sickness D	3.9%	3.7%	4.1%	4.2%	4.5%	4.5%	4.1%	3.4%	3.8%	4.1%	3.9%	3.5%	3.7%		<=3 % / N/A / >3 %
Temporary Spend ('000s) D	542	515	457	332	445	469	532	363	631	535	474	535	824		
Staff Turnover D	7.5%	7.9%	9.0%	9.0%	9.7%	10.3%	10.5%	11.2%	11.4%	11.3%	11.8%	12.2%	12.4%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate) W	93.7%	95.8%	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%	86.6%	80.5%		>=90 % / >=80 % / <90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 56146 (**Children's Community Nursing) Skin integrity concern raised by parent **Improvement** – Audit introduced to monitor correct documentation has been completed for all skin integrity incidents and pressure sores. **Incident 56017** (Phlebotomy) Incorrect volume of blood collected **Improvement** – Staff to ensure that only one set of labels/paperwork to be taken to phlebotomy room at a time to avoid error. **Incident 56061** (ASD/ADHD) Assessments did not take place as clinician was absent, but the service and families were not aware. **Improvement** – Process improved to ensure any absence is reported to all services that staff members work in so that schedule changes can be made.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 166 incidents reported (140 clinical, 26 non-clinical) **Challenges** • Continued admissions to acute medical beds for young people with an eating disorder who are medically compromised • Increase in incidents reporting self-harm from young person in Tier 4 impatient Unit – review undertaken to ensure all support is being offered to staff and young person
CARING	Improvement changes from complaints includes: **SO19975** – Complaint related to waiting time for ASD assessment and requirement for a face-to-face appointment. **Improvement** – Content of ASD letters to be reviewed to ensure care plans are clear including who is required to attend appointments. **SO20179**– Complaint related to journey through ED, inpatient ward, and input from CAMHS. **Improvement** – Car parking charges to be clearly communicated to families, and improvement made to ensure communication is provided between Trust services when a young person is on their way to the emergency department.	**Highlight** • 8 Excellence Reports submitted in March • 14 Compliments submitted in March • 94% FFT Scores for Community • 94% FFT Scores for Mental Health • 93% FFT Scores for Outpatients **Challenges** • 34 PALS recorded in March; this is a small increase compared to February (32 PALS). The main themes relate to waiting time for assessments/appointments and communication. • 4 formal complaints logged in March. Complaints relate to parental concerns of treatment provided by CAMHS and a complaint regarding occupational therapy input for a young person.
EFFECTIVE	Sensory Occupational Therapy service commenced following investment agreement from Sefton CCGs. Education Health Care Plan internal quality assurance panel established with leads from each service providing a drop in for staff to access advice and support	**Highlight** • Reduction in WNB Rate for the division to 11% for new appointments and 11.6% for follow-up appointments. Continued improvement plan in place **Challenges** • Increase in hospital-initiated clinic cancellations <6 weeks' notice (13 in March, compared to 8 in February). Whilst this remains lower than in 2021, further investigation is underway with specialty teams to ensure there are no avoidable short notice cancellations.

RESPONSIVE	Access times remain challenging in the division due to a continued increase in demand and workforce pressures. Specialities not meeting their agreed local or national waiting time targets include Community Paediatrics, CAMHS, ASD, Eating Disorders and Speech & Language Therapy Access is one of the divisional priorities and the brilliant basics methodology utilising an A3 has been completed to support improvement.	**Highlight** • No breaches in the eating disorder urgent waiting time standard **Challenges** • Highest number of referrals recorded in March for ASD and ADHD diagnostic pathways (724 referrals). Further analysis is underway to understand impact on the improvement plan shared with Liverpool and Sefton CCGs. Recruitment to new posts is taking place to increase capacity.
WELL LED	Successful external recruitment to a number of key roles within Division including Lead Nurse for Children in Care, Associate Director for Safeguarding and Assistant Clinical Lead Eating Disorders	**Highlight** • Mandatory training remains above Trust target at 93.3% **Challenges** • Increase in staff turnover to 12.3% in March. An A3 for workforce availability has been completed for Mental Health Services and will be completed by all challenged services in the division. • Increase in sickness absence levels to 6.6% in March. Weekly drop ins are provided to managers to support sickness management.

Community

D Drive W Watch P Programme

SAFE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss D	9	7	12	7	11	4	8	4	2	4	13	14	12		No Threshold
Clinical Incidents resulting in No Harm D	84	74	54	51	92	65	50	63	56	29	40	51	63		No Threshold
Clinical Incidents resulting in minor, non permanent harm D	35	28	19	11	20	10	14	8	9	4	7	17	64		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm D	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death D	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	23	17	9	9	10	8	12	18	13	5	6	5	14		No Threshold
Pressure Ulcers (Category 3) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores	100.0%		99.0%	97.5%		86.8%				98.6%	98.5%	98.2%	97.3%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

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

EFFECTIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Referrals Received (Total)	1,109	912	1,319	1,325	1,063	729	1,022	1,116	1,230	1,057	1,139	1,142	1,358		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	7	11	5	9	21	22	17	25	41	17	12	8	13		No Threshold
OP Appointments Cancelled by Hospital %	14.2%	12.9%	10.2%	11.9%	13.6%	15.7%	12.2%	16.9%	9.6%	13.8%	13.5%	13.9%	16.5%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) W	16.1%	15.6%	17.8%	13.8%	19.0%	13.6%	15.7%	17.2%	16.4%	15.8%	16.6%	12.1%	11.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	13.4%	14.2%	13.6%	12.5%	16.0%	16.1%	13.8%	13.4%	14.0%	13.1%	12.2%	13.2%	11.6%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	18.8%	18.2%	22.7%	17.1%	19.8%	17.1%	19.9%	16.7%	16.7%	18.0%	18.5%	11.1%	12.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	17.7%	17.4%	16.9%	18.5%	21.9%	24.3%	24.0%	20.1%	19.0%	15.8%	15.4%	14.9%	14.2%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	15.1%	6.9%	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%	18.2%	16.2%	13.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	12.7%	14.0%	13.3%	12.0%	15.7%	15.2%	10.9%	12.0%	13.8%	14.0%	12.4%	13.7%	12.2%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	114.3%	113.3%	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%	128.6%	128.6%		No Threshold
CAMHS: Tier 4 DJU Bed Days	248	239	248	237	217	216	214	267	217	198	219	252	279		No Threshold
Coding average comorbidities	4.00	9.00		2.00		8.00			4.50	7.00	3.50				No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1					1	1	1		4				No Threshold
CAMHS: Referrals Received	469	396	536	638	374	297	475	526	567	433	534	483	621		No Threshold
CAMHS: Referrals Accepted By The Service	251	197	254	316	173	141	233	302	307	219	274	233	316		No Threshold

Community

D Drive W Watch P Programme

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	53.5%	49.7%	47.4%	49.5%	46.3%	47.5%	49.1%	57.4%	54.1%	50.6%	51.3%	48.2%	50.9%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks (W)	66.0%	63.3%	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%	54.1%	52.0%		>=92 % / >=90 % / <90 %
Waiting List Size (W)	911	828	765	808	971	1,147	1,208	1,530	1,629	1,563	1,576	1,646	1,788		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways (W)	0	3	0	1	2	2	1	1	1	1	1	0	1		0 / N/A / >0
CAMHS: Crisis / Duty Call Activity	808	746	757	718	573	367	675	563	766	629	687	618	751		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks (W)	67.3%	65.6%	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%	67.2%	70.6%		>=92 % / >=90 % / <88 %
ASD: Completed Pathways	112	107	145	134	97	228	49	63	84	60	77	51	38		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	66.1%	24.3%	25.5%	16.4%	9.3%	4.4%	12.2%	7.9%	11.9%	15.0%	10.4%	7.8%	2.6%		>=92 % / >=90 % / <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) (P)			23.5%	28.6%	6.7%	21.4%	10.5%	23.8%	21.7%	25.0%	16.7%	15.0%	12.0%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) (P)			25.0%	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 (W)	169	120	135	150	582	144	143	165	168	177	150	140	157		No Threshold
CCNS: Number of Contacts (D)	896	791	821	835	959	809	736	931	959	951	740	823	904		No Threshold

WELL LED

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s) (W)	-41	14	212	-11	287	250	540	16	60	185	346	-77	96		
Income In Month Variance (£'000s) (W)	150	94	88	50	154	75	118	-78	59	118	-112	-106	78		
Pay In Month Variance (£'000s) (W)	137	5	-49	-87	260	167	15	142	319	-9	248	228	-112		
PDR (W)	83.1%	0.0%	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%	82.5%	82.6%		
Medical Appraisal (W)	100.0%	6.2%	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%	0.0%	8.6%		
Mandatory Training (W)	89.3%	91.8%	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%	92.4%	93.3%		>=90 % / >=80 % / <80 %
Sickness (D)	3.9%	3.1%	3.9%	4.9%	5.6%	6.4%	5.8%	5.9%	5.5%	5.8%	6.3%	5.8%	6.6%		<=4 % / <=4.5 % / >4.5 %
Short Term Sickness (D)	1.0%	0.9%	1.2%	1.5%	1.4%	1.5%	1.6%	2.1%	1.7%	1.8%	2.5%	1.4%	2.1%		<=1 % / N/A / >1 %
Long Term Sickness (D)	2.9%	2.2%	2.7%	3.5%	4.2%	4.9%	4.3%	3.8%	3.7%	4.0%	3.8%	4.4%	4.5%		<=3 % / N/A / >3 %
Temporary Spend ('000s) (D)	141	183	192	229	171	127	168	192	166	273	168	278	493		
Staff Turnover (D)	9.8%	10.7%	9.6%	9.8%	9.8%	9.9%	10.1%	10.9%	12.1%	11.1%	10.4%	11.2%	12.3%		<=10 % / <=11 % / >11 %
Safer Staffing (Shift Fill Rate) (W)	100.2%	97.2%	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%	99.1%	99.4%		>=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 • New incident bulletin shared with CRD team to increase shared learning following incident reviews • Safe staffing levels supported across the trust with research nurses being released to support ward areas	**Highlight** • Mandatory Training > 90% • GCP training 97% • SOP compliance 74.7% (dropped due to SOP review window) • ANTT compliance 100% • CRD ICP compliant • Research staff supported clinical wards when trust fell into red staffing **Challenges** • PDR Target of has reduced to under TT due to an increase in leavers • Out of hours research blood samples for oncology trials • X9 incidents reported in month (7 covid sickness reporting)
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	**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	• Commenced 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. • Research skills training continues with excellent feedback from staff. • Clinical skills days are well attended and has improved some MT compliance. • 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	**Highlight** • Important Covid 19 studies remain open within Trust AH one of chosen sites nationally to continue with UPH studies (Recovery) • Trust participating in extension COV09 vaccine study with LSTM. • AH sponsoring flagship Asymptomatic Study • Stop RSV trial. (one of two national sites) now actively recruiting. • Portfolio growth in line with plans **Challenges**

		• CRD working with local system partners to improve research participation.
RESPONSIVE	• New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave. • Coordinated and partnership working with local providers to offer joint training programmes. • Targeted training TBA for new managers in the department for risk reporting. • Top items from CRD staff survey for improvement being actioned- i.e. Archiving event planned for next month.	**Highlight** • Agile working implemented to reduce footfall • Collaborative working with external partners continues • Team fund has been utilised and is on track • 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 supporting Trust vaccine programme. • Trust has been accepted as Pic for new RSV vaccine trial
WELL LED	• LTS numbers are now reducing as staff RTW • 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	**Highlight** • Division supporting staff with Flexible working (hybrid model) • CRD engaging staff with SALS • Extra-ordinary team brief completed in March with detailed updates and opportunities for staff engagement. **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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

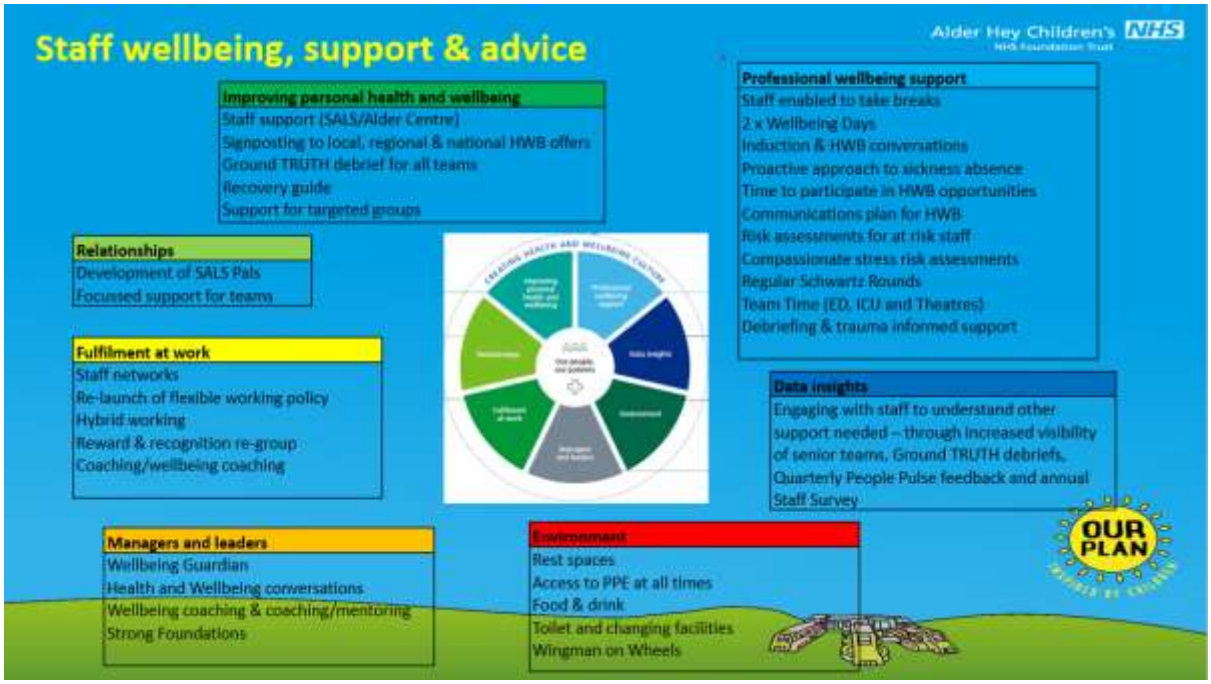
Paper Title:	**People and Wellbeing update**
Report of:	**HR and OD Department**
Paper Prepared by:	Deputy Director of HR & OD/Associate Director of OD

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

1. Purpose

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

2 Health & Wellbeing



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

Improving personal health and wellbeing

SALS continues to be extremely busy seeing 397 contacts (95 new and 302 follow up) in March. Financial pressures have been a key issue for staff leading to the development of a new resource pack for staff being developed to promote financial wellbeing. This resource is being finalised by the SALS team and will be available to staff over the coming few weeks.

Professional wellbeing support

The Health and Wellbeing Steering group has recently been paused to enable a refocus and refresh of the agenda. The meeting will reconvene on the 16th May to agree a new agenda based on the Organisational Health and Wellbeing Framework (above) and to agree attendance and a revised terms of reference.

There is also work underway on a comprehensive communications plan which brings together all elements of staff feedback through Ground TRUTH debriefs, People Pulse surveys and as a vehicle for ongoing staff survey feedback. This will form a monthly Ground TRUTH Bulletin and will accompany a monthly slot at the execs meeting which focusses on People.

Schwartz Rounds are continuing monthly with the latest Round in April having been on the theme "You'll Never Walk Alone". The next Round will be on the 25th May on the theme "Behind your Mask" with a focus on seen and unseen disabilities. This has been an agreed action from the Disability Listening events which have been taking place over the past few months and led by SALS.

Fulfilment at Work

The disability listening events for staff with seen and unseen disabilities have been well attended and have led to the following actions (in addition to the Schwartz Round outlined above): there is a plan to develop and expand the Strong Foundations leadership programme to develop additional training for managers on 'Supporting Others' focused on increasing understandings of Reasonable Adjustments, mental health awareness and supportive Interventions; there is also a plan to develop the disability network with the EDI Lead (Ayo Barley) and launch more awareness activities and a learning event in November-December 2022 coinciding with disability awareness month.

Data insights

Staff Survey - divisional packs out and service packs being sent out to all teams over 11 people.

3 Equality, Diversity & Inclusion

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

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

4 Staff Availability

Table 4.1- Sickness position as of 11th April 2022

Division	Total Workforce	Total Absent	Total Covid Related	Total Non Covid Related	Covid Related (Sickness)	Non Covid Related (Sickness)	Covid Related (Special Leave)	Non Covid Related (Special	Total Absent %	Covid Related %	Non Covid Related %	Covid Sickness %	Non Covid Sickness %
Community	767	46	6	40	5	40	1	0	6.00%	0.78%	5.22%	0.65%	5.22%
Corporate	755	65	19	46	17	46	2	0	8.61%	2.52%	6.09%	2.25%	6.09%
Medicine	1214	104	32	72	31	68	1	4	8.57%	2.64%	5.93%	2.55%	5.60%
Research	67	4	1	3	1	3	0	0	5.97%	1.49%	4.48%	1.49%	4.48%
Surgery	1295	102	34	68	24	63	10	5	7.88%	2.63%	5.25%	1.85%	4.86%
Total	**4098**	**321**	**92**	**229**	**78**	**220**	**14**	**9**	**7.83%**	**2.24%**	**5.59%**	**1.90%**	**5.37%**

Total sickness absence as of 11th April 2022 is 7.83%, which is a slight increase from the previous reporting period (7.54%). General sickness absence accounts for a total of 5.59% with 2.24% of absence attributed to covid related absence. There 78 staff members who are absent with covid related sickness, which is another monthly increase compared to 73 people last month and 61 staff in February 2022.

The general sickness absence position has remain relatively static at 5.37% compared to the previous months of 5.35%.

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

5. Governance and Ongoing Business

All cases continue to be managed on a case-by-case basis in partnership with staff side colleagues from all of our recognised Unions with appropriate measures and risk assessments put in place to ensure staff health and wellbeing continue to be prioritised

Table 5.1- Employee Relations Activity and Stage 3 Sickness Management Per Division as of the 11th April 2022

Division	MHPS	Disciplinary	Grievance	B&H	Appeal	ET	Stage 3	Total
Surgery H/C 1326	1	3	3	0	1	2	5	**15**
Medicine H/C 1223	1	2	0	0	0	0	3	**6**
Community H/C 687	0	0	1	0	0	1	3	**5**
Corporate & Research H/C 695/65	0	2	0	0	1	0	0	**3**
Grand Total	**2**	**7**	**4**	**0**	**2**	**3**	**11**	**29**

Overall activity in terms of MHPS, disciplinary, Grievance, B&H, Appeal and ET has increased by 1 case overall. This month reporting a total of 18 cases compared to 17 cases in March 2022. There has been no change to ER activity in Medicine, which remains the same, Surgery has seen a decrease of 3 cases, Community has an increase of 1 case and there has been a reduction of 2 cases in corporate and Research

Overall stage three sickness cases have reduced in April 2022 to 11cases, compared to 17 in April, with a reduction of cases in all divisions with the exception of Medicine where the position remains static.

6. Training

As of the 4th April, Mandatory Training was at 89.48% overall, 0.52% below the Trust target of 90% and up 1.13% from last month. We continue to work with staff, managers and SMEs to encourage improvements in compliance across the Trust.

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

In terms of Resuscitation training, we have worked closely with the Resus team who have rolled out Basic Life Support via e-Learning on ESR and allocated additional resources to Paediatric Life Support update sessions. This had seen a consistent improvement in Resus compliance to a high of 81% in February but has seen slight drop to 78% overall this month. Feedback from the Resus team is that staff non - attendance on face-to-face courses has impacted on their recovery plan. Moving & Handling Level 2, has seen a small increase this month of 1% to 73% following the large jump from 59% in February. We will continue to work with Moving and Handling leads to further improve this figure.

The L&D team continue to work with SMEs and mangers to review local data and to support agreed actions.

Table 6.1 Mandatory Training by Topic

	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Trend
Overall Mandatory Training	87.34%	87.34%	87.94%	87.64%	88.44%	89.48%	
Overall Resus	76.46%	79.03%	79.42%	80.24%	80.16%	78.86%	
Advanced Paediatric Life Support (4 Years)	89.91%	90.14%	88.04%	88.41%	86.11%	86.70%	
Basic Life Support (Annual)	68.09%	75.51%	82.18%	83.82%	83.90%	78.63%	
PLS/APLS Annual Update	73.75%	74.37%	73.17%	73.73%	73.14%	74.24%	
Paediatric Life Support (4 Years)	87.81%	87.96%	83.37%	83.49%	84.66%	84.36%	
Positive Behavioural Support - (3 Years)	89.25%	90.48%	91.59%	91.52%	92.66%	93.50%	
Sepsis (Annual)	78.31%	77.83%	77.11%	77.15%	75.98%	78.91%	
Equality, Diversity and Human Rights (3 Years)	90.21%	90.75%	92.25%	92.20%	93.53%	94.80%	
Fire Safety (2 Years)	90.75%	89.73%	84.50%	84.45%	85.73%	89.03%	
Health, Safety and Welfare (3 Years)	89.27%	89.23%	90.18%	90.13%	91.53%	92.40%	
Infection Prevention and Control (Level 1 - 3 Years)	87.82%	88.33%	90.22%	89.82%	90.66%	91.71%	
Infection Prevention and Control (Level 2 - 2 Years)	88.59%	87.09%	83.86%	84.14%	86.09%	89.00%	
Information Governance and Data Security (Annual)	82.35%	82.13%	80.80%	80.93%	80.35%	84.07%	
Moving and Handling (Level 1 - 3 Years)	90.01%	90.91%	92.52%	92.53%	93.85%	94.83%	
NHS|CSTF|Moving and Handling (Level 2 - Annual)	59.33%	55.90%	60.39%	59.94%	72.10%	73.07%	
NHS Conflict Resolution (England) (3 Years)	91.21%	91.66%	92.08%	92.07%	93.46%	94.82%	
Preventing Radicalisation - Basic Prevent Awr (3 Years)	90.59%	90.25%	91.11%	90.02%	90.31%	90.49%	
Safeguarding Adults (Version 2) (Level 1 - 1 Year)	91.96%	92.13%	92.79%	91.68%	90.90%	91.08%	
Safeguarding Adults (Version 2) (Level 2 - 3 Years)	91.85%	91.60%	91.66%	90.15%	89.09%	89.01%	
Safeguarding Children (Version 2) (Level 1 - 1 Year)	91.85%	92.07%	92.33%	91.33%	91.53%	92.29%	
Safeguarding Children (Version 2) (Level 2 - 3 Years)	92.05%	91.50%	90.87%	89.25%	90.19%	90.95%	
Safeguarding Children (Version 2) (Level 3 - 3 Years)	86.59%	86.78%	87.87%	86.58%	85.10%	84.85%	
Fraud Awareness (No Renewal)	88.26%	89.98%	90.73%	90.78%	91.23%	91.97%	
Major Incidents (3 Years)	89.66%	90.58%	91.68%	91.57%	92.42%	93.05%	

Estates and Ancillary staff compliance continues to improve and has increased 1% this month to 78%. We will continue to push mandatory training within this staff group.

There has also been a lot of work done by Medical Education and Senior leaders to promote Mandatory Training compliance in the Medic staff group which has seen compliance rise from 75.75% in Feb to 78.71% as of 4th of April.

Table 6.2 Mandatory Training by Staff Group

Staff Group	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Trend
Add Prof Scientific and Technic	91.51%	92.05%	93.58%	93.44%	94.13%	93.47%	
Additional Clinical Services	90.02%	88.80%	89.57%	89.47%	90.18%	92.20%	
Administrative and Clerical	88.35%	88.42%	87.57%	87.42%	88.52%	90.38%	
Allied Health Professionals	91.61%	91.29%	90.07%	89.84%	91.09%	91.47%	
Estates and Ancillary	69.19%	73.87%	76.89%	76.37%	76.82%	77.91%	
Healthcare Scientists	88.95%	91.53%	91.26%	90.57%	93.11%	92.52%	
Medical and Dental	80.08%	78.79%	76.79%	75.75%	77.26%	78.71%	
Nursing and Midwifery Registered	87.96%	87.68%	89.62%	89.35%	89.61%	90.54%	

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

Table 6.3 Mandatory Training compliance – 4th April 2022

Trust	Overall Mandatory Training	Change (Since Last Report)
Trust	89.48%	+1.13%
Division	**Overall Mandatory Training**	**Change (Since Last Report)**
411 Alder Hey in the Park	80.19%	+1.71%
411 Capital	90.91%	+27.27
411 Community	92.95%	+0.54%
411 Corporate Other Department	66.67%	-9.09%
411 Executive	90.07%	+0.48%
411 Facilities	78.15%	+1.12%
411 Finance	85.37%	-1.62%
411 Human Resources	92.00%	-1.53%
411 IM&T	96.22%	+8.36%
411 Innovation	94.48%	+8.85%
411 Medicine	88.52%	+1.52%
411 Nursing & Quality	89.84%	-0.32%
411 Research & Development	91.72%	-1.30%
411 Surgery	89.26%	+0.75%

Table 6.4 – PDR Compliance as of 28th February 2022

As of the 31st of March 2022, our Trust appraisal rate was 68.03%, the 2021 PDR window is closed and due to the way the window works compliance will slowly fall throughout the rest of the year due to staff turnover.

Division	Reviews Completed %
411 Alder Hey in the Park L2	57.89%
411 Capital L2	100%
411 Community L2	73.87%
411 Corporate Other Department L2	66.67%
411 Executive L2	100%
411 Facilities L2	72.45%
411 Finance L2	84.31%
411 Human Resources L2	72.22%
411 IM&T L2	79.78%
411 Innovation L2	46.15%
411 Medicine L2	69.13%
411 Nursing & Quality L2	70.59%
411 Research & Development L2	80%
411 Surgical Care L2	60.18%
Grand Total	68.03%

The new appraisal process for 2022/23 has now launched with several changes as below, effectively resetting appraisal compliance to 0% for all staff:

Changes to the appraisal window:

This year we are moving away from the usual appraisal window that required all appraisals to be completed between April and July.

Instead, we are introducing three simple concepts that will allow managers the flexibility to spread out their team's appraisals across the year and dedicate time to have meaningful conversations.

1. All band 7 and above appraisals must be done by no later than 31st July 2022.
2. Reviewers should have had their appraisal before reviewing other staff.
3. All staff must have had an appraisal before the 31st of March 2023

Changes to the paperwork:

In order to ensure staff and managers get the most out of their appraisal conversations we have made some small tweaks to the paperwork to ensure the process makes staff feel valued as well as helping them to do their job.

Changes to the training offer:

For 22/23 as well as our usual offer of reviewer training for managers, for the first time we will also be offering support for reviewees who want to know more about the appraisal process and getting the best out of it for them.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	Discussion Paper to support the assessment of Going Concern for 2021/22 Annual accounts
Report of:	Deputy Director of Finance
Paper Prepared by:	Ken Jones

Purpose of Paper:	Decision ■ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	This paper is to recommend to the Trust Board that the 2021/22 annual accounts and associated financial statements should be prepared on a going concern basis following the agreement at Audit & Risk Committee to support this recommendation.
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
Associated risk (s)	Minimal

1. Purpose

This paper is to recommend to the Trust Board that the 2021/22 annual accounts and associated financial statements should be prepared on a going concern basis following the agreement at Audit & Risk Committee to support this recommendation.

2. Background

The Trust is compliant with the Department of Health and Social Care (DHSC) guidelines preparing the 2021/22 financial accounts on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due for the foreseeable future. For these purposes, 'foreseeable future' is considered to be twelve months from the date of signing of the annual accounts.

International Accounting Standard 1 – presentation of financial statements (IAS 1) requires the Trust directors to assess and satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. The 2021/22 DHSC Group Accounting Manual (GAM) sets out the interpretation of going concern in the public sector context.

Directors' assessment of going concern

The specific factors that the Directors should consider in respect of their assessment of going concern are:

- Financial conditions
- Operating conditions
- Other conditions such as serious non-compliance with regulatory or statutory requirements

Having considered the above the Trust directors have a reasonable expectation that the Trust will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last 5 years has delivered within these targets often making significant surpluses to support the sustainability of the Trust.

As a specialist provider of children's services, the Trust is commissioned to provide services across the North West Region and nationally for highly specialised services and it is expected that NHS funding will flow from commissioners, at similar levels to that previously provided for all of these specialist services. There remains a firm requirement to still provide the services.

The Trust currently has a significant level of its own cash resource available demonstrating strong liquidity.

The block funding arrangements put in place early in 2020/21 are set to continue with some minor amendments around incentives for the delivery of elective care and these arrangements are expected to continue for at least the 2022/23 financial year.

Initial draft plans for 2022/23 have been compiled upon this basis and whilst these are still yet to be approved, it is expected this will be achieved prior to the anticipated sign-off of the 2021/22 financial statements in June. These draft plans for 2022/23 have recently been submitted on this basis at both an organisation and Cheshire & Merseyside ICS level.

As such the Trust board can take assurance that it is reasonable to expect that the 2022/23 funding levels will be maintained based upon these plans as the actual income streams are not expected to be materially different. Arrangements beyond 2022/23 are yet to be confirmed and the Trust assumes similar arrangements to those in place for 2022/23 will be adopted, especially as the Cheshire & Merseyside ICS becomes a statutory body in July this year.

The Trust has calculated a number of liquidity ratios based upon is provisional closing Statement of Financial Position as at 31st March 2022 and these are as follows –

Quick Ratio	Cash & Receivables Current Liabilities	115,696		(98,676)	1.17
Current Ratio	Current Assets Current Liabilities	119,447		(98,676)	1.21

Generally the higher the ratios are the greater the margin of safety
An ideal ratio is considered to be between 1 & 1.5

The Trust has also completed a scenario analysis to assess operational liquidity for the next 18 months to September 2023 and consider what level of cash the Trust could close H2 23/24 with, expressed as a percentage of current levels and this is shown in Appendix A.

The outcome of this analysis demonstrates that in all scenarios, the level of cash available at the end of next financial year is likely to remain significant therefore all examples fully support the Directors assessment that a Going Concern basis should be adopted.

3. Conclusion

The Trust Directors have a reasonable expectation that Alder Hey Children's NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

Appendix A – Liquidity Scenario Analysis

Going Concern Liquidity Scenario Testing for 22/23 & H1 23/24 - 30th September 2023

	Base Case		Upside Case - Capital Restraint		Downside Case - CIP not delivered	
	£'000	£'000	£'000	£'000	£'000	£'000
Bank & cash balance per 31st March (Draft Close)		**91,463**		**91,463**		**91,463**
Trust Operations 22/23 :						
Draft Planned Income	355,536		355,536		355,536	
Draft Planned Expenditure	(367,572)		(367,572)		(367,572)	
Draft CIP Target	12,036		12,036		12,036	
Draft Plan Capital Expenditure April - March 23	(12,000)		(12,000)		(12,000)	
(Non-cash backed CDEL element)		(12,000)		(12,000)		(12,000)
Downsides:						
CIP Not delivered @ 50%						(6,018)
Mitigations:						
Capital restraint 22/23 - uncommitted capital spend				4,000		
Projected Cash Balance 31/3/23		**79,463**		**83,463**		**73,445**
Trust Operations H1 23/24:						
Projected Planned Income (3% Growth)	183,101		183,101		183,101	
Projected Planned Expenditure (Incl Inflation)	(189,300)		(189,300)		(189,300)	
CIP Target - H1	6,199		6,199		6,199	
Indicative Capital Expenditure April - September 23	(6,000)		(6,000)		(6,000)	
		(6,000)		(6,000)		(6,000)
Downsides:						
CIP Not delivered						(3,099)
Mitigations:						
Capital restraint 22/23 - 1/3rd of indicative capital spend				2,000		
Projected Cash Balance 30/9/23		**73,463**		**79,463**		**64,346**
% of current cash balance		**80%**		**87%**		**70%**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**Board Assurance Framework Year-end Report 2021/22 (March)**
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 2021/22

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) and year-end review for 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	Safety & Quality Assurance Committee Resources and Business Development Committee
1.3	Failure to address building deficits with Project Co.	Resources and Business Development Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	Trust Board
3.6	Risk of partnership failures due to robustness of partnership governance	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Innovation Committee

3. Comparison of the BAF at the start and the end of 2021/22

BAF March 2021 overview

BAF Risk Register - Overview at 13 April 2021
1.2: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVI (S)
3.4: Financial Environment (S) 1.3: Keeping children, young people, families and staff safe during the COVID-19 pandemic (S)
2.3: Workforce Equality, Diversity & Inclusion (S)
3.2: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)
4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)
1.1: Inability to deliver safe and high quality services (S) 2.1: Workforce Sustainability and Development (S)
2.2: Employee Wellbeing (S)
4.2: Digital Strategic Development & Delivery (S)

BAF March 2022 overview

BAF Risk Register - Overview at 13 April 2022
3.4: Financial Environment (S)
3.5: ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system comp) (S)
1.2: Children and young people waiting beyond the national standard to access planned care and urgent care (S)
2.3: Workforce Equality, Diversity & Inclusion (S)
3.2: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of (S)
4.2: Digital Strategic Development & Delivery (W) 2.1: Workforce Sustainability and Development (S)
1.3: Failure to address ongoing building defects with Project Co. (S)
4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)
1.1: Inability to deliver safe and high quality services (S) 2.2: Employee Wellbeing (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)
3.6: Risk of partnership failures due to robustness of partnership governance (S)

Trend of risk rating indicated by: B - Better, S - Static, W – Worse (*Reports 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. Month-on-month overview of risk scores during 2021/22 (April 2021 to March 2022)

BAF Risk		2021									2022		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
STRATEGIC PILLAR: Delivery of Outstanding Care													
1.1	Inability to deliver safe and high-quality services	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	4x5	3x5 IMPROVED	3x5	3x5
1.3	Keeping children, young people, families and staff safe during COVID-19	5x3	4x3	4x3 CLOSED	-	-	-	-	-	-	-	-	-
1.3	Failure to address building deficits with Project Co.	-	-	-	-	-	-	-	-	-	-	4x3 NEW	4x3
1.4	Sustaining operational delivery following the UK's exit from the European Union	4x3 CLOSED	-	-	-	-	-	-	-	-	-	-	-
1.6	CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID.	-	-	4x5 NEW	4x5	4x5	4x5	4x5	4x5	4x5	4x5 CLOSED	-	-
STRATEGIC PILLAR: The Best People doing their Best Work													
2.1	Workforce Sustainability and Development	3x3	3x3	3x3	3x3	4x4 INCREASED	4x4	4x4	4x4	4x4	4x4	3x4 IMPROVED	3x4
2.2	Employee Wellbeing	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
2.3	Workforce Equality, Diversity & Inclusion	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
STRATEGIC PILLAR: Sustainability through External Partnerships													
3.1	Failure to fully realise the Trust's Vision for the Park	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
3.2	Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3	4x3
3.4	Financial Environment	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	4x4	5x4

BAF Risk		2021									2022		
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.	-	-	4x3 NEW	4x3	4x3	4x4 INCREASED	4x4	4x4	4x4	4x4	4x4	4x4
3.6	Risk of partnership failures due to robustness of partnership governance.	-	-	3x3 NEW	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
STRATEGIC PILLAR: Game-Changing Research and Innovation													
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3	3x3
4.2	Digital Strategic Development and Delivery	4x1	4x1	4x1	4x1	4x1	4x1	4x1	4x1	4x1	4x1	4x1	4x3

5. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower-level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

- Of the 16 risks on the BAF during the course of the year eight didn't change their risk rating
- Financial Environment and New Integrated Care System NHS legislation/system architecture both present the biggest risks to the Trust currently scoring 16 (*major x likely)*.
- Children and young people waiting beyond the national standard to access planned care and urgent care has reduced from a score of 20 (*major x almost certain*) to 15 (*moderate x almost certain*).
- Workforce Sustainability and Development saw an increase in score from 9 (*moderate x possible*) during Aug 2021-Jan 2022 and was reduced to a 12 *(moderate x likely)* in Feb 2022.
- New risks in year:
    - ADDED June 2021: (3.5) ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.
    - ADDED June 2021: (3.6) Risk of partnership failures due to robustness of partnership governance.
    - ADDED Feb 2022: (1.3) Failure to address building deficits with Project Co.
- Risks closed in year:
    - CLOSED April 2021: (1.4) Sustaining operational delivery following the UK's exit from the European Union (April 2021). *NOTE: agreed to monitor via the appropriate operational risk register*
    - CLOSED June 2021: (1.3) Keeping children, young people, families and staff safe during COVID-19. *NOTE: superseded by BAF risk 1.6*
    - CLOSED Jan 2022: (1.6) CYP services under extreme pressure due to historically high urgent care demand, predicted RSV surge, mental health crisis and further impacts of COVID. *NOTE: residual risk managed through other existing BAF risks.*

6. Summary of BAF - at 13th April 2022

The diagram below shows that all risks remained static in-month except for risk 4.2 which has increased due to some staffing gaps in IT Teams coupled with high turnover; this is being mitigated with a new service model and recruitment.

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**	SQAC & RABD	**3x5**	3x3	STATIC	STATIC
1.3 DP	**Failure to address building deficits with Project Co.**	RABD	4x3	2x3	**NEW**	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development.**	PAWC	3x4	3x2	IMPROVED	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	**5x4**	4x3	STATIC	STATIC
3.5 DJ	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.**	Board	**4x4**	3x3	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	4x3	4x1	STATIC	**INCREASED**

7. Summary of March 2022 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. 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.

- ***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 - 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.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month - expected update end April in line with scheduled LNP pilot run of partnership assurance round.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed and actions updated - all actions taken forward by the Trust Head of EDI.

- ***Failure to address building deficits with Project Co. (DP)***
  Risk reviewed and no change to risk score. Detailed report to be shared at Trust Board on the latest actions and status.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  Risk rating maintained due to volatile attendances and high absence rates***.***

- ***Inability to deliver safe and high-quality services (NA).***
  The risk has been reviewed and the controls and actions in place continue to progress.

- ***Financial Environment (JG).***
  Risk reviewed and actions updated accordingly. No change to overall score.

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

Risk reviewed prior to April Board.

- ***Digital Strategic Development and Delivery (KW).***
  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.

- ***Workforce Sustainability and Development (MS).***
  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.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions closed or updated where appropriate. No change to current 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).***
  April review – no change.

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)

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) (2501) Risk of not being able to safely staff (nursing) waiting lists initiative (WLI) Clinics in OPD, caused by COVID 19 pandemic (Linked to 1.1 & 2.1) (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)

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

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

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

Board Assurance Framework 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, 2230, 2501, 2589, 2597, 2410, 2326, 2535, 1902, 2415		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. SQAC will receive on going monthly updates on this program of work and improvements will be monitored through this process.	01/09/2022	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

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.
September 2021 - Nathan Askew the risk as been reviewed and updates undertaken of some control actions. Work continues in relation to gaps in assurance relating to medication safety. Other controls remain in place

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, 2517, 2383, 2246, 2497, 2578, 2528, 2463, 2501, 2501, 2597, 2410, 2326, 2535, 1902		
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 - pending 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 shifts Symptom checker has gone live

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.

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

March 2022 - Adam Bateman
Our levels of planned care in February were good in the context of Omicron and staff absence levels in excess of 7%. We achieved 93% recovery of elective and day case services, 98% for outpatient services and 101% in Radiology. Nonetheless, this is lower than pre-Omicron levels and the reduction has stalled our progress in reducing the number of children and young people waiting over 52 weeks for treatment; this fell only slightly from 237 patients to 232. We are now working to fully restore the theatre schedule and review improvement plans for workforce expansion and productivity.

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

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

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, 2517, 2516, 2497, 2383, 2536, 2246, 2578, 2497, 2100, 2528, 2501, 2589, 2597, 2535, 1902		
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
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	28/04/2022	Overall Mandatory Training still at 88% overall as of 1st March 2022. Key hot spots are vastly improved from the start of the focus: Resus: 81% Estates: 77% M&H Level 2: 72%

		We will continue to promote and work with SMEs to further improve compliance across all topics and staff groups.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	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
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.
February 2022 - Sharon Owen Risk scores remains high. Absence rates remain high across the Trust, recruitment activity also remains high. Action plans in place to address and the situation is monitored through gold command weekly. Absence position reported on daily

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

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.	15/04/2022	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	30/04/2022	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.	30/04/2022	
Executive Leads Assessment		
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		
January 2022 - Jo Potier Risk review and all controls and actions reviewed and updated. 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	30/04/2022	

Executive Leads Assessment

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

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

March 2022 - Melissa Swindell
risk reviewed, actions updated

Board Assurance Framework 2022-23

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	

Executive Leads Assessment

April 2022 - David Powell
Prior to April Board

March 2022 - David Powell
Prior to March Board

February 2022 - David Powell
Review prior to February 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 vision and strategic objectives refresh - Q4 21/22	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - 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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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.

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

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: 5x4	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	30/04/2022	Part of business planning for 22/23 will be to develop an internal 3-5 year LTFM for Alder Hey. First draft to be presented alongside plans to RABD and Trust Board
2. Five Year capital plan	30/04/2022	22/23 proposed capital plan to be approved at RABD on 24th and will prioritise those investments that are either already underway or are business critical to ensure remain within the current CDEL and funding envelope. Continued work required on securing further CDEL to allow for all schemes to progress.
1. Uncertainty of income for 22/23 and beyond	30/04/2022	Further changes have been made to income allocations for 22/23 and significant challenge and risk in being able to meet the national target of breakeven. CIP has increased to above 3%. Final plan due to be submitted on 25th April.

Executive Leads Assessment

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.

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

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
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete
C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)
Maintain effective existing relationships with key system leaders and regulators	
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	15/12/2022	

Executive Leads Assessment

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

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

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

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Agreement to pilot Pship Assurance Round approach with LWH and Liverpool Neonatal Partnership. Pack development to be undertaken during Feb & March, for presentation to LNP Board in April. Learning to be shared and co-design to pack to be incorporated	28/04/2022	

Executive Leads Assessment

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

February 2022 - Dani Jones
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: 2427		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

April 2022 - Claire Liddy
April review - no change

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

February 2022 - Claire Liddy
February review - no change

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: INCREASED

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	28/04/2022	Engagement with stakeholders underway. Board development session with NHS Providers scheduled for 12th April.
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

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.

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**Finance Report as at Month 12/Full Year (Provisional) – March 2021/22**
Report of:	Deputy Director of Finance
Paper Prepared by:	Rachel Lea, Deputy Director of Finance

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:	
Associated risk (s)	

Alder Hey Children's NHS Foundation Trust

Finance Report

As at
Month 12 / Full Year (Provisional)
March 2021/22

Date of issue: 22nd April 2022

Rachel Lea
Deputy Director of Finance

Executive Summary

Key Metrics	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Income £000 (Exclude ERF)	31,514	50,472	18,958	341,581	368,880	27,300
Pay Expenditure £000 (Exclude ERF)	(14,731)	(13,770)	961	(207,939)	(207,879)	59
Non Pay Expenditure £000 (Exclude ERF)	(16,949)	(38,044)	(21,095)	(139,112)	(167,217)	(28,105)
Expenditure £000 (Exclude ERF)	(31,681)	(51,814)	(20,133)	(347,051)	(375,097)	(28,046)
Trading Position £000	(167)	(1,342)	(1,175)	(5,470)	(6,216)	(746)
ERF Income £000	167	406	240	11,470	9,490	(1,980)
ERF Expenditure £000	0	0	0	(6,000)	(3,137)	2,863
Revised Trading Position £000	0	(935)	(935)	()	137	137
WTE	3,775	4,247	(472)	3,775	4,247	(472)
Cash £000		91,463			91,463	
CAPEX FCT £000	3,579	8,992	(5,413)	26,309	30,178	(3,869)

The Trust has achieved an in-month trading deficit of £935k in March with the draft year end position for 21/22 a £137k surplus against the breakeven plan, a positive achievement given the risks that was inherit with the plan at the start of H2. Delivery of the plan has relied on robust cost control and high activity recovery generating generate additional income under the Elective incentive model.

Included in the year end position are several areas to highlight:

- **Income £26.9m favourable variance to plan**
  - As host for the Paediatric Accelerator programme, we received £19.1m of additional income and of this £16.5m was distributed to other providers.
  - £4.2m additional system funding received to cover hosting costs for the HSLI digital programme and to offset provisions required as detailed below.
  - ERF indicative income for Q4 of £906k based on recovery achievement. This is at a lower level than Q3 due to the reduced theatre schedule that was in place in January and February as a direct response to the Omicron surge.

- **Non-Pay £28.1m adverse variance to plan**
  - Includes £16.5m of funding distributed to 9 providers as part of Paediatric Accelerator costs.
  - £2.7m paediatric accelerator costs spent within Alder Hey with investments in Anaesthetics, Radiology, Dental services, Spinal services, and the running of regular super Saturdays to support elective and day case recovery.
  - Provision included relating to the Trust legal obligations on completing the infrastructure, demolition, and reinstatement of the Alder Hey Campus.

- **Capital spend of £30.1m**
    - Capital spend for the year is in line with the agreed CDEL limit set by C&M of £22.1m
    - In addition a further £7.6m of capital spend that has been funded by additional Public Dividend Capital (PDC) through successful bids and grants during the year. This includes funding for digital (Cyber, IT devices and infrastructure, Theatre Management System), Innovation (RPA Centre of Excellence, Islacare) and smaller estates schemes.

- **CIP achievement in year of £6m against the £7m target, recurrent gap of £2.8m**

- **Cash at the year end of £91.5m**

It is anticipated that the C & M system will achieve a breakeven position overall for the 21/22 financial year largely due to the system overall meeting the threshold for activity recovery and as a result additional income earned across Q4.

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 20th January 2022**

Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mr G Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bass	Acting Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Ken Jones	Associate Finance Director	(KJ)
	Mrs R Lea	Acting Director of Finance	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Ms. C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Observing:	Mr. J. Wilcox	Divisional Accountant	(JW)
Apologies:	Mr. J. Grinnell	Acting CEO	(JG)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
Item 107	Mr. P. Grimes	Cyber Security Manager	(PG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 109	Mr. P. Grimes	Cyber Security Manager	(PG)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)

21/22/98 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies that were received. A special welcome was given to a new member of the Committee, Garth Dallas, and introductions were made.

21/22/99 Declarations of Interest

There were none to declare.

21/22/100 Minutes from the Meeting held on the 18th November 2021

Resolved:

The minutes from the meeting that took place on the 18th of November were agreed as an accurate record of meeting.

21/22/101 Matters Arising and Action Log

Action 19/20/50.6: *MIAA Progress Report (suggest a mechanism to review the effectiveness of External Audit for the 2019/20 accounts)* - This item has been included on the agenda. **ACTION CLOSED**

Action 20/21/36.1: *Internal Audit Progress Report (conduct a repeat of the Project Management Audit with a focus on non-construction projects, in 2021/22)* – This item will be addressed via the draft Internal Audit Plan for 2022/23 which has been included on the agenda. **ACTION TO REMAIN OPEN**

Action 20/21/71.2: *Progress against actions from the Audit and Risk Committee Self-Assessment (submit a questionnaire to enable the Audit and Risk Committee to conduct a self-assessment)* - It was confirmed that the questionnaire will be circulated in the next couple of days. **ACTION CLOSED**

Action 21/22/35.2: *Trust's Nil Net Assets Review (submit an update to provide assurance that the ongoing process for nil assets is being managed)* – The main focus of this work has been on medical devices due to the volume. It was confirmed that 25% of the items on the ledger have been disposed of and will be removed from the asset register ahead of the year end. In terms of items that are still being used, 25% have been identified as still being used and therefore will remain on the asset register. From an Estates perspective, buildings will only be removed from the register if they are demolished before the end of the current financial year. It was confirmed that work will continue to address the remaining items, with a focus on medical devices. In order to monitor this area of work, a report is produced on a monthly basis by the Medical Devices Team to provide an update on items that have been disposed of. **ACTION CLOSED**

Following discussion, it was agreed to compile guidance to support the management of the process for nil net assets.

21/22/101.1 Action: KJ

Action 21/22/74.1: *Alder Hey Innovation Company Structure; including Acorn Action Plan (discuss the reporting structure for the Innovation Committee and RABD. Review the oversight of both committees in terms of the submission of appropriate information, expertise and decision making)* - The RABD Terms of Reference (ToR) have been revised slightly and have been submitted to RABD for approval. Claire is going to review the ToR for the Innovation Committee as the work of the Committee has moved on. The revised ToR will be submitted to the Innovation Committee for approval in February. **ACTION CLOSED**

Action 21/22/77.1: *Information Governance Policies (review the suite of policies that used to be submitted to the IGC and share it with the Audit and Risk Committee to enable the Committee to streamline this area of work)* – Following the disbandment of the Integrated Governance Committee a piece of work took place to ensure that there is a process is in place to approve the Trust's policies and that there are there are no gaps. The Committee was advised that the Document Control Policy has been revised and reflects the changes to the approval process and includes all relevant information. Kate Warriner confirmed that a review of the Trust's Information Governance (IG) policies has been conducted and all are in date. The Chair requested a list of all policies, including IG

policies, that will require ratifying by the Audit and Risk Committee to enable a submission schedule for 2022/23 to be compiled. Cathy Umbers agreed to address this matter.

Action 21/22/78.1: *Corporate Governance Manual (arrange for MIAA to review the Corporate Governance Manual prior to ratification in January 2022 and include a summary sheet at the front of the document to highlight the changes that have been made)* – It was confirmed that MIAA reviewed the Corporate Governance Manual as part of their key financial control review.
ACTION CLOSED

Action 21/22/85.1: *Board Assurance Framework (conduct a sense check of the linkage from the BAF risks to those on the CRR to ensure that no high level risks have been overlooked (15+)* – The Ulysses risk management system now incorporates an additional function to enable Divisions and Corporate services to link risks to strategic risks, in addition to principal objectives. This additional function applies to the Corporate Risk Register and will ensure that the diagram at the front of the BAF report is aligned accurately. **ACTION CLOSED**

Action 21/22/86.1: *Risk Management Forum update; including Corporate Risk Register (provide narrative in the CRR of the likely timescale to resolve each risk)* – Work has taken place to look at this action, but it was felt that it would be difficult to be time specific taking into account the current risk register. It was pointed out that some risks have a number of dependencies which make it hard to pinpoint a specific timeframe in terms of mitigation. It was agreed that this area of work should be monitored. **ACTION CLOSED**

Action 21/22/87.1: *Trust Risk Management Analysis (conduct a piece of work to confirm that the information being reported in terms of services / functions reporting that they have zero or a low number of risks is correct)* – It was confirmed that the Division of Surgery has reported back on this action to SQAC during January's meeting. Lisa Cooper advised that a piece of work has been carried out with the teams in the Community Division and one risk has been identified that wasn't on the CRR. Urmi Das reported that a meeting is taking place on the 25.1.22 with the Governance Leads for the Division of Medicine to discuss this action. **ACTION TO REMAIN OPEN**

Action 21/22/87.2: *Trust Risk Management Analysis (look at a governance structure for the risks of services that sit under the remit of an Executive Lead, rather than a Division)* - Adam Bateman has agreed to look at this action from a performance lens with Corporate teams. It was confirmed that an update would be provided during the next meeting on the agreed reporting structure for Corporate Services. **ACTION TO REMAIN OPEN**

Action 21/22/94.1: *Audit and Risk Committee Terms of Reference/Workplan for 2022/23 (re-circulate the Audit and Risk Committee Terms of Reference/Workplan for 2022/23 once the minor amendments that Committee members put forward have been made)* – The Terms of Reference and Work Plan will be circulated following the meeting.
ACTION CLOSED

Action 21/22/95.1: *Waiver Activity Report (discussion to take place, as part of the draft Internal Audit Plan preparation, with Dani Jones to confirm as to whether there are any specific collaborations/partnerships that need to be thought about more urgently than others from an assurance perspective)* - This item will be addressed via the draft Internal Audit Plan for 2022/23 which has been included on the agenda. **ACTION CLOSED**

21/22/102 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF as at the <date> 2021. The following points were highlighted:

- It was pointed out that some of the external risks that are being reported to the Board by the Director of Strategy and Partnership will warrant a deep dive by the Committee later on in the year.
- The Committee was advised that the new Head of EDI, Ayo Barley, has commenced in post. A meeting has been scheduled for the 1.2.21 to review the EDI risk and identify gaps in control.
- It has been agreed to incorporate a risk on the BAF around the PFI issues. The risks relating to digital will be presented to the Board in January and will continue to be monitored by the Resources and Business Development Committee (RABD). The workforce sustainability issue was discussed during January's People and Wellbeing Committee (PAWC) and it was felt that this is one of the Trust's main concerns due to staff absence and the timeliness of recruitment. It was confirmed that the timeliness of recruitment is going to be reviewed to ensure that people are being put in post as quickly as possible.

The Chair felt that the BAF reflects the organisation's strategic risks and noted the new risks that have been included in the document.

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

21/22/103 Risk Management Forum (RMF) Update; including Corporate Risk Register (CRR)

The Committee received an overview of the RMF meeting that took place on the 10th of January 2022. It was felt that the Forum set aside the necessary time to discuss areas of concern, including deep dives, the Trust Risk Report, the CRR and issues highlighted by the Divisions/Services. It was reported that there were three key discussion points and issues to escalate to the Audit and Risk Committee; Access to Services, Medicines Management and People.

Attention was drawn to the significant work that is required on the longstanding high moderate risks and risks with no action plans. The Committee was advised that there hasn't been as much movement as expected, particularly in terms of reviewing the older risks that are still graded as high moderate. It was confirmed that the Chair of the RMF has requested that risk owners address this matter ahead of March's meeting.

It was reported that the three deep dives that took place during the meeting were of a high quality and that lots of work had taken place to provide assurance in terms of mitigating risks relating to the Resuscitation Service, Major Trauma and Community and Mental Health Division. The two deep dives for March are yet to be agreed but the emergence of the risk profile ahead of the next RMF will help with this decision.

Anita Marsland raised concerns around the 10x Medication Errors and queried as to

whether there was anything that the Committee could do to support this area of work. The Chair advised that Medication Errors is one of SQAC's three Quality Priorities (projects) for which a formal update is provided to SQAC at each meeting. Reduction in all medication errors is the key focus of this project. It was reported that a 10x medication summit was held in 2021/22 which resulted in a wide ranging improvement plan for this particular error type. As SQAC oversees this project on a monthly basis, it was felt that the Audit and Risk Committee does not need to do anything additional at this stage. If the Committee continues to question whether sufficient progress is being made the Committee will ask the project team to submit a report to the Audit and Risk Committee.

Corporate Risk Register

The Committee received the Corporate Risk Register for the period from the 1.10.21 to the 12.1.22. The following points were highlighted:

- Progress has been made across the majority of high risks but there are concerns about the increase in the number of long standing high risks. It was confirmed that a focus will be maintained on this area of work.
- Attention was drawn to the risk relating to 2100 (*risk of inability to provide safe staffing levels)* caused by high level of sickness and absence. It was reported that the risk rating will be reduced shortly as a result of the additional mitigations that have been implemented.

The Chair referred to risk 2235 (*risk that patients won't get an outpatient (OP) appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list)* and queried the timeframe for the business case that is being compiled for validating follow-up waiting lists. It was confirmed that this will be concluded as part of the annual planning process in March 2022. An initial paper has been submitted to the Executive Team and it has been agreed that Outpatients will be one of the Trust's three step change projects.

Resolved:
The Audit and Risk Committee noted the update from the RMF meeting that took place on the 10.1.22, and the contents of the Corporate Risk Register.

21/22/104 Trust Risk Register Analysis

The Audit and Risk Committee received the Trust Risk Register Report for the period from the 1.10.21 to the 19.12.21 in order to scrutinise the effectiveness of risk management in the Trust. The Committee was advised that the assurance presented in this report is a direct reflection of evidence available on the electronic Ulysses risk management system. The following points were highlighted:

The Committee was advised that there were concerns raised during January's RMF in relation to the number of risks past their review date, but it was confirmed that this has since improved. It was reported that this information has been incorporated in the dashboard that is submitted to Gold Command on a weekly basis and is being monitored by the Executive Team from a performance/compliance perspective.

- It was also pointed out that there were concerns raised around risks with no action plans. It was confirmed that work is taking place to improve the current position.

The Chair felt that the information that is submitted to the various Committees/groups is aligned and that in itself offers assurance.

Resolved:
The Audit and Risk Committee received and noted the Trust Risk Register Report.

21/22/105 CQC Action Plan 2020/21
Resolved:
The Audit and Risk Committee received the CQC Action Plan and noted that recommendation 8 which was allocated to the Audit and Risk Committee for monitoring purposes has been closed.

21/22/106 Update on Risk Management Process within the Community Division

The Audit and Risk Committee received a presentation on the risk management process within the Community Division. A number of slides were shared which provided information on the following areas:

- Key standards.
- Divisional governance structure.
- Processes in place to address risk at Divisional and service levels.
- Priorities for 2022/23
  - Additional resource to be identified for the Governance Team.
  - Increase frequency of annual 'Deep Dive' review of risk register to six-monthly.
  - Collaboration between services to look at risk.
  - Collaboration across Divisions to look at risk.
  - Embed named support from Corporate Services.
  - Trust new risk management system.
- The Committee was advised that a monthly quality report is shared during the Quality and Governance Committee that includes an overview of all incidents. This provides an opportunity for challenge and constructive discussions to take place. Time is also set aside to discuss the Divisions' top risks to ensure that Community staff have an awareness of the top risks and whether they have increased/ decreased in month.
- It was reported that spotlight sessions (Deep Dives) take place during each Governance Meeting. The Committee received an example of the Lone Working deep dive that took place in November 2021.

The Chair felt that the update was really comprehensive, offered assurance and highlighted the clear structure and good practice within the Division.

The Chair referred to the Ulysses Risk Management system that is in place at the present time and the challenges that the Trust has experienced with the system. The Committee was advised that there is a piece of work being undertaken to review this matter and test the market for alternative systems that might be more cost effective, intuitive and easier to use.

Resolved:
The Audit and Risk Committee noted the update provided on the risk management process within the Community Division

21/22/107 Cyber Security Report

The Audit and Risk Committee received an update on cyber security assurance with an overview of the key controls, developments and performance against standards. The following points were highlighted:

- It was reported that there has been lots of progress in terms of investment, deployment of cyber security tools, resources and compliance standards such as the national Data Security and Protection Toolkit.
- Attention was drawn to the challenges of cyber security for the Trust, the developments and the key controls that are in place to address this area of work. It was pointed out that there will always be challenges in relation to cyber security but work is taking place to ensure that staff are adequately trained and educated in this field and that digital colleagues have the skills and leadership to be able to be both proactive and reactive.
- The Committee was advised that NHSX produced a list of 6 national cyber security priorities in 2020. The priorities highlighted nationally are consistent with cyber priorities and processes in place at Alder Hey which are monitored through the subgroups of the Digital Excellence Committee. It was reported that the Trust's current performance against national priorities is green.
- The Trust received funding for immutability following a recommendation from NHSX after conducting work on the Trust's backup systems. It was also pointed out that Trust is looking to achieve Cyber Essentials Plus accreditation in the next few months.
- Kate Warriner referred to the global cyber issue that occurred over the Christmas period on a Friday evening. It was pointed out that this matter was dealt with by the Trust in an efficient manner as a result of the investment in tools and resources that Alder Hey has made. The on call system also helped the Trust react quickly to this incident.

The Chair advised that the Committee has received an update on this area of work as it was a key risk to the organisation.

Resolved:
The Audit and Risk Committee noted the contents of the cyber security update.

21/22/108 Update on the Matter Relating to Stolen iPads.

The Committee was advised of the theft of a number of iPads that had been ordered by the Trust to support a project for deprived families to give them access to services as part of Alder Hey's digital inclusion work that was funded by NHS Digital. This incident was identified when the team commenced the mobilisation of the project and the devices were not where the asset tracker had indicated. A thorough search of the Trust's on-site and off-site storage facilities took place all to no avail which led to the reporting of a potential theft to Merseyside Police.

Following the theft of the devices the Trust reviewed all of its processes which culminated in additional controls being implemented in terms of managing stock control, asset management processes and security. Alder Hey has also commissioned MIAA to conduct an advisory review and a formal HR investigation will take place internally. Both pieces of work will provide further information/recommendations and are due to conclude by the end of January 2022.

The Committee was informed that the Police were able to make an arrest in December following a lead that they received. The latest update from the Police is that further questioning of the individual is taking place prior to the matter being referred to the CPS. Kate Warriner agreed to submit a formal report to the Committee once the commissioned work has concluded and a final update has been received from Merseyside Police.

21/22/108.1 Action: KW

Resolved:
The Audit and Risk Committee noted the update on the matter relating to stolen iPads.

21/22/109 Data Security and Protection Toolkit Update.

The Audit and Risk Committee received an update on the Trust's DSPT submission for 2020/21, the improvement actions identified during completion of the self-assessment and the independent audit undertaken by MIAA. The following points were highlighted:

- The Committee was advised that all Standards were met with the exception of information governance training. There were ten areas of review by MIAA with eight receiving substantial assurance and two receiving moderate assurance. It was reported that there is an action place in place for the 2021/22 submission.
- It was pointed out that the Trust has strengthened its information governance (IG) leadership with the shared appointment of the Head of IG and administration at Liverpool Heart and Chest Hospital, Wyn Taylor, who is also the Data Protection Officer for Alder Hey. Work is taking place ahead of the next review; Terms of Reference have been drafted and are under review, a forensic view of data is being conducted to try and address IG training and meetings are taking place to deal with general IG issues, develop the Tool Kit and focus on implementing actions.

The Chair queried as to whether assurance will improve if the actions in the plan are implemented. It was confirmed that this will be the case.

Resolved:
The Audit and Risk Committee noted the Data Security and Protection Toolkit Update.

21/22/110 Review and approve Draft Internal Audit Plan for 2022/23.

The Audit and Risk Committee received the draft Internal Audit Plan for 2022/23. It was reported that there are a number of reviews which are mandated; Assurance Framework, Data Security and Protection Toolkit. Four reviews have been included in the Plan from a good practice perspective; Risk Management, Key Financial Controls, Data Quality and Cyber. Partnership Governance has been included following a request by the Committee

and Consent, Mortality and Morbidity were areas of discussion in 2021. Project Management of Non-Building Projects has been included for discussion and Workforce Planning is to be reviewed in 2022/23 due to being deferred previously.

A discussion took place and the following points were raised:

- It was queried as to whether Payroll or Conflicts of Interest could be deferred to 2023/24 to enable an audit to take place that is more pertinent to the Trust at the present time. It was agreed to look at the scope for Conflicts of Interest with the view to postponing it. In terms of Payroll, it is felt that it is best practice to conduct this review due to the volume of expenditure that goes through the Trust's payroll system. It was pointed out that third party assurance could be requested from ELFS for the element of this service that they provide. Ken Jones agreed to formally request this information.

21/22/110.1 **Action: KJ**

- The Committee was advised that the Trust is looking to commission an external advisory review of Risk Management in order to benchmark itself against non-NHS organisations from a good practice/continuing improvement perspective. This will free another slot on the plan.
- It was felt that the audit relating to Project Management for Non-Buildings Projects should take place later on in the year in order to gain the appropriate level of assurance, for example, Brilliant Basics and the sub-projects that are driving clinical, safety and quality changes.
- It was reported that a discussion will take place between the Chief People Officer and MIAA around the detail of the Workforce Planning review.

21/22/110.2 **Action: KS**

- The Chair referred to the Morbidity and Mortality (M&M) review and queried the driver behind it. The Committee was advised that this review was included in the Plan following a discussion with the previous Medical Director. It was reported that the audit will focus on the M&M review process and the lessons learnt/changes to practice following the outcome of reviews. It was pointed out that reporting is strong on this area of work, but it was felt that there would be value in conducting an audit. It was suggested that a meeting take place between MIAA and Alfie Bass to discuss this matter in more detail.

21/22/110.3 **Action: KS/AB**

The Chair provided a summary of the conversation that took the place on draft plan and advised that;

- Workforce Planning, ESR Payroll and M&M will be discussed outside of the meeting with an update provided during April's meeting.
- Further thought needs to be given to health inequalities in terms of looking at how the Committee gains assurance on this area of work as presently it isn't a definable audit.
- Risk Management slot to remain open.
- Project Management for Non-Buildings Projects review to take place later on in 2022/23.
- Draft plan to be submitted to the Committee for formal approval following off line discussions with the respective Executive Directors.
- MIAA to commence scheduling the agreed audits.

Resolved:
The Audit and Risk Committee approved the draft Internal Audit Plan for 2022/23 subject to discussions taking place on Workforce Planning, ESR Payroll and M&M.

21/22/111 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the Internal Audit Plan for 2021/22 during the period of November 2021 to January 2022. The following points were highlighted:

- It was reported that four reports have been finalised;
  - Key Financial Controls with a deep dive into accounts payable - (*high assurance*).
  - Risk Management Thematic review - (*substantial assurance*).
  - Complaints and PALS - (limited assurance).
  - Lessons Learnt from Covid-19 - (*substantial assurance*).
- Four reviews are currently in progress and will be completed by March 2022 ahead of the Audit Opinion.
- The two high risk areas relate to PALS and Complaints in terms of lessons learnt actions and the monitoring of follow up actions. It was confirmed that the Trust has compiled a robust action plan to address these two areas of work.

Anita Marsland raised concerns about the limited assurance that was given following the review of PALS and Complaints and felt that the Trust should be in a better position, especially as this is an area that CQC monitor. The Committee was advised that some of the delays are as a result of the devolved governance model not working as it was intended. It was reported that Nathan Askew and Erica Saunders are actively revisiting this matter at the present moment in terms of the balance of the Divisions and their autonomy, and also to make sure that the Trust is safe from a corporate perspective. In terms of assurance, it was confirmed that there are active conversations taking place to look at what needs to be done to improve the function.

The Chair raised a couple of points;

- In the event the Risk Management report is to be monitored by the RMF it won't need to be submitted to the Audit and Risk Committee.
- The link on page 5 of the progress report 'CQC inspections through the Audit Committee lens' doesn't work when the document is converted to a PDF.

21/22/111.1 **Action: KS**

- Review appendix B of the progress report as the status is ranked as green but only one of the eleven actions has been implemented.

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

21/22/112 Internal Audit Follow Up Report

The Audit and Risk Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made during the period November 2021 to January 2022. The following points were highlighted:

- There are four reviews where the dates have been extended; Consultant Job Planning, Project Management, PFI Compliance and Mandatory Training. The Chair felt that in the event these recommendations are delayed any further the respective owners should be invited to the Audit and Risk Committee to provide an update.
- It was felt that a more formal update is required in terms of PFI Compliance as the original action was raised in a follow-up report in 2016/17. The Committee was advised that things have moved on since the new hospital was constructed therefore it was agreed to have a discussion outside of the meeting to look at the scope of the recommendations, agree new actions that will be useful and provide assurance, whilst recognising that time has moved on. A date for implementation will also be agreed.

21/22/112.1 Action: KS/RL

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

21/22/113 Local Counter Fraud Progress Report.

The Audit and Risk Committee received a progress update on the work undertaken during the period from the 15.9.21 to the 13.1.22. The following points were highlighted:

- The Trust's Fraud Champion nomination has been processed by the NHSCFA and it was confirmed that Ken Jones is the official Counter Fraud Champion for Alder Hey. The Committee was advised that the Fraud Champion role was renamed by consensus to the Counter Fraud Champion. NHSCFA have indicated that there will be a relaunch of the CFC role.
- Clarification has been sought from NHSCFA in relation to the RAG scorings for component 12 (Conflict of Interest). NHSCFA confirmed that there is no formal guidance, although they advised that a reasonable target to attain a Green rating for this area of work would be an 80% compliance rate. A meeting took place between MIAA and the Trust and it was agreed that this would be the target for 2021/22 with the potential for increasing it for 2022/23.
- It was reported that work is underway on the new Fraud Risk Assessment which all NHS organisations have to conduct in compliance with component three of the Government Functional Standard. The Committee was advised that Alder Hey is amber on this rating, as are many trusts at the present moment, therefore once the initial assessment has been completed work will take place to move this component to green by the 31.5.22.
- There is one referral that remains open from 2019 (reference: IMO/18/00332).

The Chair queried as to whether the Committee would receive an update on the outcome of the Fraud Risk Assessment due to the substantial changes. It was confirmed that this report will be submitted during the meeting in September/November.

21/22/113.1 Action: KJ

The Chair asked if any changes had been made to the Accounts Payable system, taking into account the five duplicate payments that had been identified. Rachel Lea agreed to look into this matter and provide an update during April's meeting.

21/22/113.2 Action: RL

21/22/114 External Audit Update

It was reported that Ernst and Young (E&Y) is in the process of planning an approach to conduct audits for seven NHS organisations and is looking to arrange meetings with respective Trusts to commence discussions. Attention was drawn to the challenges that are being experienced by E&Y in terms of the pressures on the audit market and staff capacity due to ongoing Government work. As a result of this E&Y are looking to combine resources via a hub to enable staff to be more efficient in terms of working across multiple files during the audit period. The portal for the submission of information is being updated and requests for information will be received by the Trust towards the end of January. It was confirmed that E&Y staff will continue to work remotely if that is the Trust's preference.

Resolved:
The Audit and Committee noted the update from E&Y.

21/22/115 Corporate Governance Manual
Resolved:
The Audit and Risk Committee approved the changes to the Corporate Governance Manual.

21/22/116 External Audit Effectiveness

Following numerous discussions at previous Committee meetings around how the Trust should look to assess the effectiveness of its External Audit function, colleagues have attempted to source examples of how other NHS organisations have approached and carried out this exercise. Unfortunately, despite exploring numerous avenues colleagues have been unable to source examples from within an NHS context.

In light of this, example documents were sourced from a number of the "Big 4" audit firms and although these essentially have a more "commercial spin" they have been adapted to suit an NHS setting. The report that was shared with the Committee provided information on the purpose of the framework, the framework structure and the approach.

Following feedback from Committee members on their views in terms of the approach that should be taken and implemented, it was agreed to progress with the full version of the framework rather than the abridged version, taking into account the practicalities and capacity of resources to conduct this piece of work.

Resolved:

The Audit and Risk Committee noted the report on External Audit effectiveness and agreed to progress with the full version approach with it being the first time that this piece of work has been conducted.

21/22/117 Update on progress against actions from the Audit and Risk Committee Self-Assessment.

The Chair advised that most of the actions on the Audit and Risk Committee self-assessment have been completed, and it was proposed that any outstanding actions will be carried forward and incorporated into the action plan following the new self-assessment exercise that will be undertaken in 2022/23. It was pointed out that one of the key areas that influenced a lot of updates was the review of the Audit and Risk Committee and the RMF in terms of how they work together and independently. It was concluded that they function well and there weren't any major changes other than to reduce the attendance of Divisional directors at future Committee meetings.

Resolved:
The Audit and Risk Committee noted the progress update that was provided on the Committee self-assessment.

21/22/118 Any Other Business

There was none to discuss.

21/22/119 Meeting Review

It was felt that the Committee had a number of beneficial discussions with a focus on the RMF, the Corporate Risk Register and the draft Internal Audit Plan for 2022/23.

Date and Time of the Next Meeting: Thursday 21st April 2022, 2:00pm-5:00pm, via Teams.

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 28th March 2022 at 13:00, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Kerry Byrne	Non-Executive Director	(KB)
	Melissa Swindell	Director of HR & OD	(MS)
	Claire Liddy	Managing Director of Innovation	(CL)
	Kate Warriner	Chief Digital & Information Officer	(KW)
	Rachel Lea	Acting Director of Finance	(RL)
	Adam Bateman	Chief Operating Officer	(AB)
In attendance:	Sue Brown	Associate Development Director (Campus)	(SB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Mark Flannagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director for Development	
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Catherine Kilcoyne	Deputy Director of Business Development	(CK)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:			
396	Richard Jolley	Procurement and Contract Manager	
401	Alex Pitman	Green Project Director	

20/21/385 Apologies:

Apologies were received from:

John Grinnell	Director of Finance	(JG)
Anita Marsland	Non-Executive Director	(AM)
Mark Carmichael	Associate Chief Operating Officer	
Dani Jones	Director of Strategy and Partnerships	(DJ)
Erica Saunders	Director of Corporate Affairs	(ES)

20/21/386 Minutes from the meeting held on 18th February 2022

The minutes were approved as a true and accurate record.

20/21/387 Matters Arising and Action log

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

20/21/388 Declarations of Interest

There were no declarations of interest.

20/21/389 RABD Workplan

To Agree the five top risks for 2022/23

RABD agreed: CIP, Capital/Cash and Campus would remain within the top 5 risks for 22/23. A discussion would be held to agree the 2 other top risks for the new financial year.

In relation to workplan the Chair asked for a benefits realisation quarterly update to be included.

Action: JT/RL

Resolved:
RABD Approved the work plan with inclusion of a quarterly benefit realisation update and agreed to approve the top five risks at the April RABD.

20/21/390 **Finance Report**
Month 11 Financial Position
CS said the in-month position for February is a £0.7m deficit but remains in a year to date surplus of £1.0m. A divisional update was received. The chair asked if it would be helpful to hold a deep dive divisional session. It was agreed this would be organised following completion of the budget setting.

Resolved:
RABD received and noted the M11 Finance report.

20/21/391 **2022-23 Plan**
RL presented slides on the latest position noting submissions that had been made, the final submission is due on 28th April 2022. The deficit position was discussed noting 4 assumptions.

A slide on 22/23 financial approach was discussed noting plans to overachieve on the 104% activity target and weekly SDG meetings that will monitor progress.

Resolved:
RABD received details of the 2022-23 Financial Plan. The final plan will be presented to RABD at the April meeting prior to submission.

20/21/392 **Write Off's**
Resolved:
RABD APPROVED the write off from November 2019 in relation to an overpayment of salary for £257.12. RABD noted this had been pursued and was uneconomical to pursue any further.

20/21/393 **Capital Update**
KJ went through the update noting phasing of Catkin/Sunflower development and associated Charity funding may now be received in 2022/23. RG provided background into the delays as well as noting a shortfall in insurance for the Knotty Ash Care Home. RG advised that due to this a review of buildings insured and rebuilding prices was to be completed.

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

20/21/394 **Cost Improvement Plan**
Resolved:
The CIP target for 2021/22 is outstanding of £1m. CS went through the plans for the target to be achieved.

20/21/395 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
SB went through the phases and timescales for the park site clearance.

Following a contractual dispute with Laing O'Rourke confirmation was awaited on compensation of £1.6m in relation to the current PFI contract. RABD APPROVED the request for the compensation to be re-allocated to secure the Modular office accommodation.

CL referred to the future strategy and reference to Digital and Innovation. CL asked that collaboration with Industry partners was added as this was being worked towards.
Action: SB – Completed

RABD discussed the hybrid model being used at the Innovation Park and whether it was being used to full capacity. It was noted that this would be monitored under the space planning review.

Resolved:
RABD received details on the park site clearance and APPROVED for the compensation to be re-allocated to secure the Modular Office accommodation.

20/21/396 **Procurement**
Following a 2 month delay due to staff pressures relating to Covid phase 2 of the Specialist Trust Collaboration consultation process had commenced on 1st March and will close on 31st March 2022. RJ provided details of the TUPE transfer date that will start in April and will continue for serval months.

Resolved:
RABD received the paper noting the procurement team had been heavily involved in collaborative work, via the HPL specialist Trust's procurement alliance and with the wider Cheshire & Merseyside Trust's. A number of Alder Hey specific projects had also been undertaken.

20/21/397 **Business Development**
CK went through her bi-monthly update highlighting:

- Priorities for 2022/23 including the Telehealth pilot
- Business development pipeline
- Review pricing policy

A query was raised around the Second Opinion project and whether it was still on target. CL agreed to bring a reforecast of the project to the next RABD and an evaluation to assess if there is still a requirement for the project.
Action: CL/CK/EK

Resolved:
RABD received and noted the business development update.

20/21/398 **Inequalities to Care**
Following a review of waiting list data AB shared the findings noting inequalities relating to deprivation and learning disabilities was found. As a pilot two extra appointments have been assigned to dental services for patients with learning disabilities as well as the development of a number of staff training programmes.

AB reported on a Trust in Yorkshire who had taken the decision to prioritise patients with learning disabilities due to their shorter life expectancy and whether this should also be actioned at Alder Hey.

KW noted a Board Development session taking place in April on data noting this would be an opportunity to develop data captured in relation to deprivation and learning disabilities.

Resolved:
RABD received the Inequalities to Care update noting further updates would be presented in due course.

20/21/399 **Month 11 Corporate Report (starred item – only questions/answers will be noted)**
Resolved:
RABD received and noted the M11 Corporate report.

20/21/400 **Communications update (starred item – only questions/answers will be noted)**
Resolved:
RABD received and noted the communications paper.

20/21/401 **Green Plan update**
AP presented plans in place to move forward with the following three workstreams:
Energy
Green Travel
Waste

Resolved:
RABD received the Green Plan update agreeing regular updates are to be added to the workplan.

20/21/403 **PFI Report**
Update on Commercial position
Resolved:
RABD received and noted the M11 PFI report as well as the current commercial position.

20/21/404 **Board Assurance Framework**
Resolved:
This item was deferred until the April meeting.

20/21/405 **Any Other Business**
Russell Gates, last meeting
The Chair thanked RG for his support over the years and wished him well going forward. It was noted that RG may still support AH on an interim basis.

20/21/406 **Review of Meeting**
The Chair noted challenges moving forward and positive mitigations.

Date and Time of Next Meeting: Monday 25th April 2022, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 23rd March 2022
Via Microsoft Teams

Present:	Prof Fiona Beveridge	Non Executive Director (SQAC Chair)	(FB)
	Adam Bateman	Chief Operating Officer	(AB)
	Kerry Byrne	Non-Executive Director	(KB)
	Urmi Das	Director – Medicine Division	(UD)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Dame Jo Williams	Trust Chair	(DJW)
	Dani Jones	Director of Strategy, Partnerships & Transformation	(DJ)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Jacqui Pointon	Associate Chief Nurse, Community & Mental Health Division	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Alfie Bass	Acting Chief Medical Officer, Divisional Director For Surgery Division	(AB)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Christopher Talbot	Safety Lead – Surgery Division	(CT)

In attendance:

Mo Azar	Chief Pharmacist	(MA)
Lauren Elliott	Assistant Service Manager, Cancer Services	(LE)
Julie Grice	Hospital Mortality Lead	(JG)
David Reilly	Associate Director – Digital Systems	(DR)
Julie Creevy	Executive Assistant (Minutes)	(JC)
Jill Preece	Governance Manager	(JP)
Steve Riley	Clinical Audit Manager	(SR)
Cathy Umbers	Associate Director of Nursing & Governance	(CU)
Jennie Williams		

21/21/208 Apologies:

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)
Adrian Hughes	Deputy Chief Medical Officer	(AH)

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

21/22/209 Declarations of Interest
SQAC noted that there were none to declare.

21/21/210 Minutes of the previous meeting held on 16TH February 2022 –
Resolved: FB alluded to item 21/22/191 regarding CQC Action plan and advised that the CQC Action plan had been closed as all actions had been completed. Committee

members were content to **APPROVE** the minutes of the meeting held on 16th February 2022.

21/21/211 Matters Arising and Action Log

Action Log

The action log was updated accordingly.

FB reminded members that the Committee is still operating under the 'governance lite' approach, and as such those starred items would be taken as read only with any questions addressed as required.

Aggregated Analysis - ABass advised that within the Division of Surgery the entire risk register had been fully reviewed with the risk managers and the risk owners. As a result of the detailed review, a substantial number of risks had been closed, with 36 risks currently open within the Division of Surgery. Next steps with the process is to identify any new risks within the Division that are required to be included within the Risk Register. A meeting will be arranged to review these risks with the risk owner. Major trauma remained a high risk; however, given that a substantial amount of work had taken place to mitigate this, AB's expectation is that the risk rating would reduce. The other major group of risks related to the appointment of substantive posts within the Division of Surgery, as there are a significant number of temporary posts – this risk has both a service and financial aspect. There is a risk relating to the interface between Meditech and Badger, particularly on the Neonatal Unit, which is included on the Neonatal Partnership Board Risk register.

AB also referenced process issues which the review had highlighted in relation to Ulysses, which mandates that each risk is updated on a monthly basis; AB commented that there are a number of risks which do not require review on a monthly basis e.g. a Business Case that may take a number of months to resolve, and that if colleagues do not find value in updating risks simply because the system demands it, it detracts from the purpose of the Risk Register and the risk management process. AB advised that risk management training for service managers is required to be strengthened to ensure they have sufficient knowledge to describe a risk and have clear knowledge regarding mitigation and actions. Governance teams have established training for service managers within the Division via the training module within ESR, however AB queried whether more formal training should be initiated across the organisation.

FB thanked AB for undertaking the focussed work, resulting in a number of redundant risks to be closed. FB welcomed comments from colleagues regarding regular review of the system and establishing correct timelines. UD echoed AB's comments and advised that not all risks require review every month. UD felt that the Medical Leads/Governance Leads should also receive risk management training; this has commenced within the Division with the new Governance Lead but she agreed with AB that there should be trust-wide training.

MA queried whether the risk owner, together with the risk team, could determine the frequency of reviews and queried whether this could be built into the Ulysses system. FB welcomed this approach. KB queried the process change and stated that this should be via the Risk Management Forum.

Dame JW requested a lead be identified to enable the three divisions to think about how this is completed in a different way to ensure improved ownership from colleagues.

ES advised as Chair of Risk Management Forum, that a significant amount of work had taken place within the Forum to align risks and streamline the process, most recently to address long standing risks including high moderate risks (scored 12 to 15). ES advised that the Trust is due to go through the process of procurement for a new system, although there are limited choices, with the alternative to look for a bespoke system. ES advised that discussions are ongoing through divisional and corporate level, with significant work taking place to address challenges and also 'cleanse' the system.

FB welcomed any 'quick wins' regarding whether there are ways identified to provide risk owners with some choice regarding the review frequency.

Resolved: Discussions to take place at Risk Management Forum regarding the process issues, ensuring corporate services are included in discussions in Risk Management Forum.

Resolved: ES to undertake offline discussion with CU with regard to requirement for Risk Management training for Service Managers and Medical/Governance Leads.

Risk 2312 – AB provided an update on Risk 2312 which related to a concern from the neurosurgery and cranio facial team regarding sub optimal general paediatric cover due to lack of capacity. At present the risk had not been reduced, however two mitigations had been agreed relating to escalation protocols and participation in the neurosurgery MDT. This would be tracked on the risk register regarding timely implementation, and the risk score could then be adjusted. FB queried whether the risk should continue on SQAC action log. AB advised that the DIG meeting should review this in 4 weeks to ensure that the actions had been completed. UD advised that discussions had taken place with the leads within General Paeds and that the consultant of the week prioritises all surgical or neurosurgical cases. The team are reviewing requests to join appropriate meetings which need to be balanced against busy ward rounds.

Resolved: Action to be closed and removed from SQAC action log, with the Divisional governance group reviewing in 4 weeks' time to assess progress.

Transition Update

LE provided a Transition update highlight report, which included an overview of current position, impacts on transition, associated issues and barriers, proposed solutions and next steps.

- Current position – during 2021 the Trust had 2560 outpatient attendances by 16-17 year olds; to date during 2022 the Trust has had 293 outpatient attendances by patients aged 16&17. Medicine inpatient attendances aged 16 & 17 – 2021 – 1411, 2022 – 302; Medicine outpatient attendances aged 18 and over 2021 – 632, 2022 – 69; Medicine inpatient attendances aged 18 and over 2021 – 418, in 2022 – 88.
- Breakdown of specialties 2021 - Endocrinology and Oncology have the highest number of outpatients aged 18 plus; in terms of inpatients Endocrinology have a high number of patients aged 18 plus , together with nephrology, with an increasing number within Rheumatology. During 2022 Dermatology and Nephrology have a high number of inpatients patients over the age of 18.
- Impacts – services are already overstretched, increase in waiting times for outpatients and inpatients, costs on workforce, young adults being treated in a paediatric setting.

- Issues - not knowing the volume of patients within the specialties who are ready for transition, administration process currently being undertaken by clinical staff and some patients who are not ready for transition.
- Barriers - the impact of Covid 19: because of long waiting lists, Adult Services are not keen for patients to transfer; metabolic bone adult consultant has left the Trust – no further interest in the post. There are also a number of Welsh patients but not sufficient numbers to make a big group to enable a transition.
- Reality of transition - patients are due to transition at 18 years however adult services don't accept patients, in joint transition clinics with adult services, patients under Alder Hey may not be discharged until 19 years old, as they are reviewed jointly by adult services.
- Proposals – Transition dictionary to be developed capturing all relevant information required to transition patients by specialty; employ dedicated admin support for transition; support worker post for patients who may find the transition difficult; live dashboard/reporting/app to show patients within service who should be in transition or are approaching transition.

UD advised on the non engagement of patients, given that these patients are increasingly reliant on Alder Hey and are reluctant to transition to adult services. UD commented that this is evident within the diabetes team, which has a youth worker to liaise within the community to address any barriers preventing transition.

Dame JW thanked LE for update and highlighted the need to discuss transition at the age of 13/14 with individuals/families and referred to potential cultural issues in terms of medical staff transitioning long term patients. Dame JW queried patients who are not ready to transition and sought clarity on this. UD advised that this could relate to medical issues that adult services have no expertise in e.g. growth hormone; she added that there are patients within the system with nowhere to transition to. UD also advised that adult services do not feel comfortable accepting patients with complex conditions i.e., autism, ADHD and that there are a number of factors which prevent transition to adult services. DJW stated that there is an opportunity to undertake strategic discussions with adult sector to increase engagement.

KB referred to the different processes across specialties and stated that a central team would be able to highlight themes; she echoed Dame JW comments on the need for earlier discussions with individuals and families regarding transition and advised that a business case could be made to demonstrate increased throughput and efficiency with a central resource. AB queried whether this is included within the annual plan with regards to time and resource to increase the number of patients who are due to transition. FB stated that this should be addressed offline.

DJ echoed KB comments regarding the need for a centralised team to increase efficiency and assisting with throughput of transition. DJ referred to the impact the complex community team have had regarding reducing the number of complex cases ensuring a centralised focus approach, which is well evidenced. DJ referred to data and how it is presented, to show as a comparator across the years, and ensure that this is modelled and projected forward, detailing what the impact would be by the end of 2022 and the following years based on the numbers.

UD referred to metabolic bone patients and that Salford Royal had refused to accept Alder Hey patients as they do not have capacity. UD stated that where anadult services' clinician is performing joint clinics with Alder Hey those patients remain in the system, and that if a patient is poorly an ambulance would take them to adult services; however these patients are adding to Alder Hey data. FB stated that it was clear that in some cases either the Trust have no choice, or it is best for the patient

to remain at Alder Hey; however there should be a mechanism to separate these patients out within the data. UD stated that within some of the services this could be clearly detailed, however in other services it is not well developed.

UD stated that Transition should be in Job plans for every nurse specialist and that a process is underway in the Division to enable this.

Resolved: SQAC to receive a 'plan on a page' to capture workstreams resulting from this discussion at its May 2021 meeting to ensure that the Trust is providing the best Transition of Services for all patients, whilst not taking up valuable Alder Hey resources and ensuring system level discussions.

Devolved Governance improvement report – CU advised that NA had previously reported that the governance structure within each of the divisions had organically evolved and this had caused some issues regarding understanding the structure, roles and remit, systems and processes. The senior nursing and governance team are working on a number of 'quick wins' to ensure similar/same approach across the divisions. NA & Execs had sourced an external consultant to undertake a clinical governance review which is scheduled to commence for a two month period and is currently at data gathering stage.

Quality Improvement Progress Reports

21/22/212 Quality Priorities Monthly update

JW presented the Quality Priorities Monthly update, which included highlight summary progress reports, and a deep dive on Parity of Esteem.

Medication Safety – significant progress with regard to process observation on all of the ward areas across the Trust. The findings are consistent with work required regarding standardisation of processes, followed by continuation of process observations. The team are using the data to inform the prioritisation of those ward areas.

JW advised that IRG had verbally approved the Pharmacy Business Case and that the pharmacy team had commenced the recruitment process. The Quality Improvement Team is supporting Pharmacy to ensure a more structured project plan, with clear milestones, benefits realisation and timescales for implementation. MA stated that he had not yet received any confirmation of approval, JW/MA agreed to discuss offline, and would follow up with appropriate teams to confirm IRG approval.

Resolved: Offline discussion to be held with MA & JW to obtain clarity re Business case approval

Deteriorating patients - the team are aiming to ensure that the governance is in place prior to transition from project status into business as usual, whilst using the learning to roll out and scale up the implementation of the pathway and the data. There had been challenges regarding data and significant manual work; Quality Improvement Team are working with the BI team to automate data. JW advised that the remodelling of the ACT team is ongoing; the Quality Improvement Team are working extremely closely with operational team to ensure successful delivery.

Parity of Esteem - JP advised that progress against plan had been made, Programme Board had been paused during Covid, however work had continued. Tangible progress had been made with regard to the training element - MH

Champions had been established and a plan is in place to reinvigorate over the coming weeks. JP advised that the previous recruitment process for a nurse consultant had been unsuccessful. This post is going back out to recruitment. The team are also looking to recruit nursing associates as a pilot to support patients on wards 4C & 3A and support patients with eating disorders. The suicide prevention workstream is due to recommence over the coming weeks.

KB referred to Medication Safety and stated that the vision is to reduce to 0 by Quarter 4 this year for medication errors and referred to the second goal regarding the training for staff, which does not conclude until 2023. KB questioned whether 2023 is a sufficiently challenging goal and queried whether the training should be delivered and completed earlier than 2023.

JW responded that there is a need to review the goals and vision, particularly given the potential for the pharmacy resource, which would result in a more robust project plan. JW referred to broader training plans within the medicine safety committee, stating that she would review this and would include an update within the Deep Dive at April 2022 SQAC meeting.

KB stated that she did not feel assured regarding achievement of the Deterioration Patients project, ahead of the plan to move to business as usual and welcomed a clear overview of project delivery. A Bass echoed KB comments and stated that on review of the report the operational work required ownership, ensuring workstreams areas are brought together/aligned and 'operationalised'. SQAC agreed that this project will not at present be moving to 'business as usual' and would require a refocus/reset to be followed up offline with Executives. SQAC would receive an update at April 2022 meeting.

Resolved: SQAC to receive update on Deteriorating Patient position at April 2022 meeting following Executive Team discussion.

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

21/22/213 Sepsis Update

SQAC received the sepsis update. KB commented that the highlight report was extremely brief and that it did not provide assurance in relation to performance against the 60 minute target. KB felt that it would be helpful for SQAC to refocus on sepsis at future meetings to understand the clinical complexities. UD advised that the report shared at today's meeting was to provide reassurance on the interim staffing measures, given that the Sepsis lead nurse had recently changed; currently the matron of the day, and the sepsis lead within ED review performance daily and should there be any lapses or delays in treatment that these delays are being reported and reviewed. Dame JW supported KB comments, and welcomed review of enhanced data within future Sepsis reports.

FB queried whether the risk had increased within the interim period with no lead nurse, or whether the mitigation in place is appropriately managing the risk, and keeping any risk at the existing level. UD advised that reported risk had not increased, and the current arrangements were robust. JG, as ED lead for sepsis provided assurance that the Sepsis Steering Group continue to meet and discuss any incidents; she advised the team are working extremely hard to maintain standards.

Resolved: SQAC to receive detailed Sepsis update at April 2022 meeting

Safe

21/22/214 Quarter 3 DIPC Report

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

21/22/215 Assurance ED Activity Monthly Update

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

21/22//216 Safe Waiting List update

AB provided an update on the Safe Waiting List Management programme current position; key issues were outlined as follows:-

- 3 of the 4 phases of work had been completed, with continued ongoing focus regarding the follow-up waiting list.
- Following benchmarking against other specialist children's hospitals in England, data analysis showed that Alder Hey has the lowest percentage of patients waiting over 52 weeks for treatment and has the third lowest of overall numbers; the Trust had been approached by RMCH with a request to provide mutual aid.
- Clinical Prioritisation (admitted patients) – total number of patients with a prioritisation (p) code – 96%, aiming to reach 100%.
- Root cause analysis had been signed off w/c 21st March 2022, which related to three incidents relating to patients on a waiting list for the Department of Paediatric Surgery & Urology experiencing harm in October 2021.
- Root cause analysis identified 4 key causes: a complex system, with many aspects having been open to individual interpretation and perception; lack of mapping of highest risk aspects of pathways enabling audit/analysis directed towards these areas; lack of risk analysis of pathways when rapid change required as with pandemic; and reliance on people doing the right thing rather than using technology to support/enhance performance.
- Next steps – a detailed action plan would now be implemented to take forward the recommendations contained in the RCA, to address high impact changes; classification of high risk patients in outpatients: a safer system, focus on the follow up waiting list, patient portal, data quality dashboard and training.
- Over 100,000 records are to be reviewed using robotic review, aim to complete review of records by the end of June 2022.

FB thanked AB for the detailed updated.

Resolved: SQAC received and **NOTED** the Safe Waiting List update.

21/22/217 Quarter 3 Mortality Report

JG presented the Quarter 3 Mortality Report, key issues as follows:-

- JG referred to the increase in deaths during Q3 which had been reviewed and that there were no concerning trends. During November 2021, 3 deaths had occurred within 1 month relating to oncology cases, all cases had been discussed at HMRG, colleagues had noted they were very late presentations. Following discussions oncology team advised that there were no further actions that the Trust could have undertaken in order to prevent these patient deaths, given that these patients

were extremely unwell at diagnosos and oncology colleagues have raised this nationally.

- JG referred to ED activity and referred to increasing numbers of gastroenteritis with sepsis, as well as Covid cases in a number of younger children who are not vaccinated, and with the different strains this appears far more infectious, with pressure across the system, and whether this may potentially impact on mortality in the future.
- JG advised that the national requirement for a medical examiner role in every trust had been delayed from 1st April 2022. JG thanked ABass for continued support provided to try to address this issue. AB advised that there is a planned meeting with the Regional Medical Examiner, together with Medical Director and colleagues at Manchester and Alder Hey with the aim to progress ME support. AB advised that he is hoping/anticipating that the Regional Medical Examiner may apply some pressure on other organisations to assist Alder Hey. AB had approached the Medical Directors at four other local trusts but had received negative responses from all. AB advised that numbers at Alder Hey are extremely small (20-25) per year which makes it unviable for Alder Hey to have its own Medical Examiner. FB stated that although numbers of dealths within the Trust are small, approximately 360-400 post-mortems per year are conducted when you include cases coming into the Trust from elsewhere. She asked, for information, whether it is thought to be better to have dedicated focus on children due to scientific issues, or whether it is better to have someone who examines adults and children. JG advised that the process was very much set up for adults. She stated that following a child death, due to the data and how data is collected that there is only a short amount of time to register a child's death to obtain the medical certificate, which has to be reviewed before it can be signed off and that it would therefore be helpful to not be reliant on one person, to ensure that there are no delays to processes. AB advised that an update would be provided following discussions with Regional Medical Examiner together with an update within the next quarterly mortality report.

Resolved: SQAC to receive verbal update regarding Medical Examiner position at April SQAC meeting. Further Update to be included within Quarterly Mortality Report at June 2022.

FB thanked JG for Quarter 3 Mortality Report

SQAC received and NOTED the Quarter 3 Mortality Report.

21/22/218 Clinical Audit & Effectiveness Report

SR presented the Clinical Audit & Effectiveness Report, key issues as follows:-

- Quality Account this year would be reporting on 37 National audits and confidential enquiries. NCPOD Transition confidential enquiry is a project that the audit team are fully involved in with substantial progress made.
- 30 audits are on trajectory in terms of data collection and are due to be completed by the end of March 2022, to be reported within the Quality Account.
- 1 audit had made minimal progress reported, due to delays due to Covid which related to IV dressing audit. 6 additional audits are on the plan which are Trust priority audits.
- Overall position within the Trust audit plan - 4 completed which are the National Comparative Audit of Blood transfusion audit, management and toxicity in high risk medulloblastoma audit, audit on consent, which is currently ongoing, reports had been received, with a wider audit planned to include medicine and community divisions. There is also a Royal College Pain in Children Audit, data collection had been completed and audit team are awaiting report and publication. SR

advised that with regards to national audits the Trust is bound by publication of reports resulting in a delay, and clinical audit team are not able to provide recommendation until reports are published.

- 24 audits reported as substantial progress, currently at data collection stage, and on trajectory to be completed by the 31 March 2022.
- 74 audits in total on the audit plan at the end of February 2022, 25 had been completed, 44 had made substantial progress, 2 had made minimal progress, and 3 had made no progress, those that had made no progress those audits had been cancelled by the teams involved, these were all surgery audits.
- Recommendation that CQSG continue to receive and scrutinise the detailed plans monthly and provide assurance to SQAC with monthly exception reports.
- SR advised on an audit amnesty announced at February 2022 CQSG and Divisions had been informed that all of the audits on the system are to be reviewed and closed if they are not progressing, and if they are to be continued the condition is for those audits to be completed, and that there would be senior members of staff responsible for those audits to accelerate progress.

FB sought clarity regarding the audit amnesty and questioned whether this included the action plans associated with the audits, SR confirmed that this was correct. FB queried how and who would decide that it is acceptable to close an existing action plan that had not been implemented. SR advised that this is shared with Divisions to enable them to provide assurance to the audit team that the action plan could be closed.

KB welcomed the new reporting style within the report which provided improved assurance regarding audit throughput and action plans. KB queried whether in Quarter 1 that the Audit team are able to summarise any specific themes arising, and queried how these are dealt with within the action plan. KB sought clarity regarding timeline for process and production of next year's plan and queried whether SQAC would be involved and have any input into the plan. SR advised that he produces a year-end report which would be available in April 2022. In terms of next year's plan the Clinical Audit Team is requesting divisions to advise on priorities for audit plans for the year. The Trust's priorities would be those items within the Quality Account and mandated audits, National Confidential Enquiries and CCG Quality Contract audits.

FB thanked SR for detailed Clinical Audit & Effectiveness update and welcomed review of the Clinical Audit year-end Report in April 2022.

Resolved: SQAC received and **NOTED** the Clinical Audit & Effectiveness update and welcomed Clinical Audit year-end review in April 2022.

Clinical Governance Effectiveness

22/22/219 CQSG Key issues update

POC advised that the Clinical Quality Steering Group had met on 8th March 2022, the meeting had focussed on key issues as follows:-

- Guidelines – in the last reporting period 284 guidelines were in date, which reflected an improved position. From the 19 guidelines that had extended past the review date 7 are awaiting approval at various committees, 2 had been presented to committees and are awaiting incorporation of recommendations prior to upload to DMS.
- Policies - 210 policies in date which reflected an improved position; 5% of policies are past the expected date of review, 3 awaiting approval by various committees.

- Patient information leaflets – compliance rate is 84% across the Trust. Excellent progress had been made within medicine and corporate Divisions with some further improvement required across Surgery and Community Divisions to enable further assurance.

FB welcomed the improved position, as a result of continued focussed work

21/22/220 NICE Compliance summary report

CU provided an update on NICE guidance compliance for the reporting period.

CU referred to the 20 guidelines at assessment stage, of which 15 had made no or minimal progress in month; there is concerted work ongoing within divisions to improve this position. Good progress is evident in relation to 37 guidelines at recommendation stage.

UD advised that the information within the report for the Division of Medicine did not reflect the current position which had further improved.

Resolved SQAC received and **NOTED** the National Institute for Health & Care Excellence update and **NOTED** the ongoing improvements.

FB thanked CU for NICE Compliance update and welcomed continued focus.

Well Led

21/22/221 Board Assurance Framework

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

AB provided an update on the rationale for the closure of risk 1.6 which related to services under extreme pressure due to high urgent care demand, anticipated RSV Surge, Covid and the Mental Health crisis. AB advised that the risk had been closed as there had begun to be duplication with actions attached to risk 1.2 regarding access challenges and risk 2.2 with regards to workforce and health and wellbeing. AB advised that the RSV epidemic did not occur at the severity anticipated, and given that there is no end date for Covid this factor would remain an issue within 1.2.

AB referred to MH demand and stated that that this may need to be identified as a separate strategic risk, or the Trust could at least ensure that it is adequately referenced in some of the other risks. ES advised that this is included on the corporate risk register. KB welcomed discussion offline regarding the interface, acknowledging volume and severity of challenges. AB to discuss further with ES & LC.

KB advised that she felt assured with regards to the closure of Risk 1.6.

KB referred to risk 1.2 which was previously aligned to SQAC and had changed to RABD, and stated that previously SQAC had oversight of 3 clinical related risks, and there is currently 1 global clinical risk which did not feel correct. FB referred to the rationale of moving risk 1.2 from SQAC to RABD, as sometimes resource is the issue, however this is not always the case; she reflected that a lot of good safety and quality assurance work is ongoing that aligns to that risk and which is reported to SQAC.

ES advised that whilst there had been a discipline of only one assurance committee prescribed to oversee each risk, it was possible to involve both committees in gaining assurance against the risk. ES advised that she would annotate the document to reflect requirements.

ES advised that the CQC is undertaking a system wide inspection of Urgent & Emergency Care in North Mersey before the end of April 2022, to include all partners across health and social care, primary care and mental health services. ES advised that internal plans are in place to ensure that the team is briefed and prepared.

Resolved: SQAC received and **NOTED** the Board Assurance Framework, **NOTED** the update regarding closure of Risk 1.6 and **NOTED** verbal update regarding CQC Urgent & Emergency Care System-wide Inspection.

21/22/222 Divisional Reports by exception/Quality Metrics

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

- Division had 1 category 4 pressure ulcer; patient was admitted from Whiston Hospital, child was known to Alder Hey prior. The review process highlighted that part of the tissue viability assessment and documentation which is mandated for ward staff, and not also mandated for community staff, which highlighted a gap, this had since been corrected and is now mandated for community staff.
- Division had launched a training and Education group to centralise oversight of mandatory training and professional registration and centralise learning offer for inhouse teaching and training, and to develop a strategic workforce development alongside the workforce in preparation for the annual TNA, which would align with the workforce strategy.

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

- UD advised that all open incidents had been reviewed within the Division and that weekly monitoring is in place.
- Locum interventional radiology consultant had been appointed and has commenced in post, enabling the closure of one of the highest risks within the Division.
- Locum consultants had been appointed in general paediatrics and will result in a reduction in waiting times.
- Sickness absence had improved, currently at 8.5%, with absences related to covid
- Mandatory training – UD advised that she had requested biweekly updates from Consultants within the Division in order to improve mandatory training compliance within the Division.

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

- Despite inpatient waiting list size theatre utilisation had been increased
- Reduction of 28 day breaches
- 52 week waiting list remained static
- The Division had 0 hospital acquired infections
- The Division are reaching a 12 month period of no never events
- Despite ongoing efforts to increase mandatory training, compliance remains static, with review at Divisional Board meeting.
- Division had an increase in PALS, complaints and clinical incidents. Clinical incidents reported all had low harm or no harm, with increased reporting.

FB thanked the Divisional Leads for the Divisional Updates.

SQAC **NOTED** the pressures across each of the Divisions within services, resulting from high clinical workload, coupled with staffing issues.

Resolved: SQAC **NOTED** the Divisional updates; SQAC **NOTED** comments regarding mandatory training compliance and ongoing challenges, feedback to be provided to K Birch to consider and address the requirement for a Trust-wide unified response to increase mandatory training compliance.

21/22/223 SQAC workplan

SQAC received and noted the 2022 SQAC workplan. ES requested any feedback, comments or amendments to be shared with her.

SQAC received, **NOTED** and supported the SQAC Workplan

21/22/224 Any other business

None

21/22/225 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Quality Priorities – updates received, including a deep dive on Parity of Esteem, with a focus on the coherence between the vision and the training roll out. Update also received on Deteriorating patients - this project would not be moving to 'business as usual' until further work had been undertaken particularly with regard to sepsis. SQAC would receive an update in due course.
- Discussion held regarding risk review, with actions agreed to review how those risks are managed, with discussion required at Risk Management Forum.
- Q3 DIPC Report
- Monthly ED Activity Update
- Clinical Quality Steering Group verbal update
- Quarter 3 Mortality Report was received, which included an update on the Medical Examiner current position, together with the statistics.
- Safe Waiting List update received, detailing key issues from the RCA, with focus on follow up appointments.
- Clinical Audit and Effectiveness Report received, SQAC are looking forward to being able to identify any emerging themes, and how the audits are aligned to strategic priorities going forward.
- Discussion held regarding Transition Update, identifying key issues and agreeing that a 'plan on a page', is required to capture the various strands and to aid continued progress.
- Board Assurance Framework
- NICE Compliance highlight report, which highlighted progress in terms of assurance with regards to NICE guidelines.
- SQAC Metrics and Divisional Reports
- SQAC 2022/23 Workplan received and supported

21/22/225 Date and Time of Next meeting

27th April 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 28th April 2022

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	25th April 2022 – Summary 22nd March 2022 - Approved Minutes
Report of:	Fiona Marston, Chair
Paper Prepared by:	Amanda Graham, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 25th April 2022 along with the approved minutes from the 22nd March 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** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 - Workforce Sustainability – current risk IxL: 3x3 BAF 2.2 - Employee Wellbeing – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. **Introduction**

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

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

2. **Agenda items received, discussed / approved at the meeting)**
   - People Plan
   - Staff Survey Action Plan
   - EDI Steering Group Update
   - Impact on '*Flowers'* Tribunal on Agenda for Change pay
   - Corporate Report Metrics/Workforce KPIs – March 2022
   - Board Assurance Framework/Key Workforce Risks – March 2022
   - PAWC Annual Report, Terms of Reference & Workplan for 2022/23
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 15.02.22

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - To note – this 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

4. **Positive highlights of note**
   - Staff Stories are to be heard quarterly from June 2022
   - There is a 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 was confirmed as Garth Dallas; Terms of reference 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

5. **Issues for other committees**

None

6. **Recommendations**

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

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on 22nd March 2022
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Fiona Beveridge	Non-Executive Director (Deputy Chair)
	Melissa Swindell	Chief People Officer
	Adam Bateman	Chief Operating Officer
	Mark Flannagan	Director of Communications & Marketing
	Erica Saunders (left 10.45am)	Director of Corporate Affairs
	Ian Quinlan	Non-Executive Director
	Rachel Greer	ACOO – Community & Mental Health
	Mark Carmichael	Associate COO – Medicine
	Jacqui Lyons-Killey	General Manager – Research (deputy)
In attendance:	Sharon Owen	Deputy Chief People Officer
	Alfie Bass	Acting Chief Medical Officer
	Pauline Brown	Director of Nursing
	Phil O'Connor	Deputy Director of Nursing
	Jo Potier	Associate Director of Organisational Development
	Ayo Barley	Head of Equality, Diversity & Inclusion
	Maria Salcedo	HRBP - Surgery
	Clare Shelley	Associate Director of Operational Finance
	Jason Taylor	Acting Associate COO – Research
	Claire Liddy	Managing Director, Innovation
	Urmi Das	Director, Division of Medicine
	Lisa Cooper	Director of Community & Mental Health Services
	Amanda Kinsella	Head of Health & Safety
	Amanda Graham	Executive Assistant (Minutes)
Apologies:	Nathan Askew	Chief Nurse
	Dot Brannigan	Governor
	Claire Dove	Non-Executive Director
	Rachel Hanger	Associate Chief Nurse - Surgery
	Cath Wardell	Associate Chief Nurse – Medicine
	John Chester	Director of Research & Innovation
	Katherine Birch	Director – Alder Hey Academy
	Adrian Hughes	Deputy Medical Director

21/22/108 **Declarations of Interest**
Fiona Marston – Liverpool School of Tropical Medicine

Introductions
None received.

21/22/109 **Minutes of the previous meeting held on 15th February 2022**
Resolved : The minutes of the last meeting were approved as an accurate record.

21/22/110 Matters Arising and Action Log

No matters Arising. The action log was updated accordingly.

21/22/111 People Plan Report

SO shared a presentation of updates on the Trust's People Plan, noting that while sickness absence levels are dropping, they are higher than seasonally normal. It is proposed to bring a separate item to the Committee on sickness absence to look into this in more depth. MS added that Covid-related absences are beginning to increase. JP noted that there is a growing piece of work around menopause with absences being recorded as stress / mental health. A policy is being developed and there is an active group in the organisation.

FM asked what plans are in place for the end of free Covid testing; MS responded that this will continue for NHS staff, with tests being obtained by ordering online.

FM commented that with stress / mental health related absences increasing there needs to be a big focus on this trend; MS responded that while there are numbers in that group who are off with menopause there are also numbers who are off because of what is happening in their home lives rather than work lives. JP noted that there are alarmingly high rates of domestic abuse in the region, and this is expected to rise with increasing financial pressures on families. Work is ongoing with the Wellbeing Guardian meetings to develop more support. ES asked whether this could be brought back to the Committee following the impact of increased costs of living & fuel on staff. JP advised that this has been raised at JCNC with a task & finish group with staff side representation set up to look at this and an outcome is that a series of resources will be released soon with collaboration from the Citizen's Advice Bureau (CAB) to provide information & support for staff. FM asked that this is regularly reported on.

Action: 21/22/111.1 – Item on sickness absence to be brought to future meeting (SO)
Action: 21/22/111.2 – Financial Wellbeing to be regularly reported (JP)

Resolved: PAWC received and noted the update of the People Plan

21/22/112 Communications Update

MF noted three main points from the Communications report: the Key Messages calendar is approaching sign-off and will be brought to a future meeting, adding that the weekly broadcast is one of a suite of tools to share Comms messages with staff. Work on the new intranet is ongoing and a progress update is within the paper, with a further update to be brought to the Committee in due course; and that the Charity actively tracks press & social media coverage of Alder Hey, with the Echo giving some very positive coverage recently.

FM asked how an external view is gained when developing a website; MF responded that when the project was established surveys to users were undertaken and that a lot of views were sought. It is important to keep consultation customer focused but also to bear in mind the overarching vision and that the purpose for ourselves is for this to be more than just a hospital website. An update on the website can be brought back to the Committee in the future.

AyB noted appreciation for the support and assistance given by the Comms team to the Teams session for the UN day for the Elimination of Racial Discrimination which helped this session go smoothly and also added that MF has been in touch to ensure ED&I is reflected within the key messages plan and the new intranet.

Action: 21/22/112.1 – Update on new website development to be brought to a future meeting (MF)

Resolved: PAWC received and noted the Communications Update

21/22/113 Staff Survey

JP shared slides detailing the 2021 Staff Survey results, noting that these are very helpful indicators for progress against the seven Promises within the NHS People Plan, along with other staff morale and engagement themes. Overall, the Trust performs higher than average with the Raising Concerns scores being the most improved of all questions. However, within some specific areas there are lower than average scores, notably the two questions on harassment / bullying (although at very low levels) and the question on experiencing stress / burnout, at 32% of the 52% response rate. The overall NHS scores for recommending as a place to work has gone down by 6.4 percentage points from 2020, with Alder Hey's score dropping by 7.5 percentage points. JP noted the next steps will be to share the data internally; to share divisional / departmental data measured against the Trust; and to develop an action plan in response to staff feedback on what they want to improve which will be brought to a future meeting.

MF asked whether trends & improvements could be broken down by staff group, to pinpoint areas needing support; JP responded that work was ongoing with some areas.

FB asked what level of response was expected from teams at lower levels; JP responded that for teams of eleven or more would get a specific pack of results benchmarked against the Trust as a whole. There will be an expectation of a "Big Conversation" feeding into an action plan, which with HR support will be fed back through the Divisional leadership team and into the Trust's action plan. MS added that this is a process that's been developed over the last few years although not quite so focused for the previous two years during Covid. It is used as a way of looking at what is making the high-scoring teams successful and learning from that. JP noted that the aim is for packs to be shared by the beginning of April.

AB asked whether there is data on the level of uptake in areas where leadership development programs such as Strong Foundations have been running and would it be possible to generate appropriate responses in those areas where there has been a low uptake; JP responded that once the more fine-level data is available that should be possible, and the questions about managers can also be reviewed. There will be more focus on appraisals and learning, and also on more vulnerable staff groups to ensure understanding and support.

FM noted that the metric for Bullying & Harassment stood out at circa 10%, and while that is fairly consistent and low, should we as an organisation state there is zero tolerance; MS responded that yes that is what is being aspired to and there has been a Zero Tolerance policy issued around discriminatory, homophobic, racist behaviours. FB noted that Alder Hey is low compared to other organisations but there is a question of how low the level can be, particularly as there can be perceived bullying or harassment when there are performance issues which are being managed or

linked to stress. Some of this will be about attitudes and behaviours which are reflected more broadly across society. MF commented that there has been work around zero tolerance in specific areas such as ED in terms of aggressive behaviour, and there needs to be a fine balance between getting the message across that it is not tolerated and being child-friendly and inclusive, to assure people that the issue is being acknowledged. JP added that perception of bullying is just that and can be subjective, and the survey data also indicates compassionate behaviours.

JP continued by noting that data from the most recent People Pulse report shows that staff feel well informed, thanking MF and the Communications team for their work to achieve the 70% level which is 16% higher than the NHS overall figure. Staff also feel that the Trust proactively supports health & wellbeing, with a figure of 69%, 15% ahead of the NHS overall figure. Health & Wellbeing (HWB) conversations were found to be very useful by 82% of the staff who had them in the previous 3 months.

FM thanked JP for the detailed analysis of the survey results.

Resolved: PAWC received and noted the update on Staff Survey

21/22/114 Appraisal System Update

MS shared highlights of the Appraisal System paper, noting that a review of the process has taken place and after discussions with the Executive team the following recommendations have been made; that there is a wider window for appraisals to be completed by a cascade process from senior staff down over the whole year; and also for a refresh of the paperwork for 2022/23, which will include the HWB conversation but also a return to more structured career development discussions and objective setting. There is also a longer-term piece of work to look at an electronic appraisal system and how it would want to look.

AyB commented that some staff may have negative PDR experiences and they can be a weak spot in terms of career development where bias can creep in, but this is an area where increased support for minority staff groups could be integrated into the process; MS noted that currently this isn't part of the PDR process but that AyB's input and involvement would be welcomed.

FB commented that PDRs need to be meaningful for both the individual and the reviewer, team and organisational perspective, in the context of Alder Hey being a listening culture. There are also learning points for the organisation from the reflections of the reviewers. MS noted that currently there is not a mechanism to feedback & check-in on challenges and expectations, but as part of the wider piece of work this can be incorporated to become more thoughtful and sophisticated in gathering information. Appraiser training is currently offered, but a review of that can also fall within the context of the piece of work.

MF asked whether it would be beneficial to undertake a reflective review of the process for this year and use that to shape the new system; MS noted that there is not as yet and it would take some resource to undertake that. MC asked whether there is an opportunity while redesigning the process to obtain feedback from staff around what they feel would be useful; MS responded that within the wider piece of work there will be the chance to incorporate this.

Action: 21/22/114.1 – Update on appraisal process to be brought to a future meeting (MS)

Action: 21/22/114.2 – Consideration to be given to a reflective review on 2022/23 appraisal process (MS)

Resolved: PAWC received and approved the proposed Appraisal System for 2022/23

21/22/115 Gender Pay Gap Report

AyB presented slides detailing the Gender Pay Gap Report for 2021. This report is a statutory requirement based on organisational size and covers data up to 31st March 2021 which identifies the average difference in pay between male and female staff doing different jobs – not the same jobs. Data is collected via ESR and is analysed by hourly rate; median gap; bonus pay; and at different levels.

Overall, the data is in line with the previous report presented in October 2021, with the gender profile remaining static at 17% male / 83% female staff. On average female staff earn 28% less than male staff within the organisation, reflecting society in general and the predominance of lower banded roles being occupied by female staff.

In previous years bonus payments to medical and dental consultants which are made under the Clinical Excellence Award scheme have had a gender gap of 30% less females being awarded; however the scheme has recently been revised and payments are now equally divided between all eligible consultants, with some organisational flexibility on criteria to ensure equity of impact.

The gender pay gap is most prominent within Medical & Dental staffing at 9%, predominantly due to male staff having a longer length of service compared to female staff. When looking at AFC staffing there is an average gender pay gap for males of 0.42%.

AyB concluded by noting the recommendations that the promotion & support for flexible working arrangements will continue alongside development & promotion of the Trust's leadership strategy, adding that as the ED&I strategy develops, gender will become a protected characteristic of that strategy.

Resolved: PAWC received the Gender Pay Gap Report and approved the proposed recommendations.

Governance

21/22/116 Corporate Report Metrics – February 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 there has been a slight improvement on mandatory training figures and that while sickness levels overall have reduced for February and into early March, there are some significant increases in absence over the last 10 days.
AB asked whether the Time to Hire metric could now be locked in as 40 days, with an aspiration to work to 30 days and also noted that Return to Work (RTW) interview numbers would benefit from exploring further improvement; RG responded that the Division have been working with the HR team around RTWs, and that it is an aim to further reduce Time to Hire. SO noted that realistically it would be May when any

reduction to the Time to Hire KPI could reasonably be applied, to ensure changes within the Recruitment team are fully embedded.

Corporate – MS noted that Time to Hire is looking OK within Corporate Services and that sickness within Corporate is quite high but without more detailed data it is not possible to see which specific areas and suggested reporting by exception at the next meeting to give a better sense of which departments are affected.

Medicine Division –MC shared highlights, noting that over 100 staff are showing as red for mandatory training, but they are all being contacted and it is hoped there will be an improvement next month. Sickness is still high, but HR colleagues are working hard with clinical colleagues to reduce the numbers. RTWs are low with particular hotspots being addressed locally. Staff turnover remains high and more work is planned on this while Time to Hire is once again on an improving trajectory, with divisional recruitment process being reviewed to ensure it is as smooth as possible.

Research & Development Division – JTR gave highlights, noting that while sickness in month is higher than target, in context this is five people out of seventy-two with ongoing conversations and interventions with HR support. RTWs are beginning to improve again. Staff turnover has increased, noting that this is a rolling twelve months figure and not in-month.

Surgery Division – MS shared highlights, noting that there are similar themes to the other Divisions with sickness and RTW levels, despite a recent local initiative involving the Divisional ACN raising the issue at KPI meetings. Staff turnover remains high with analysis ongoing of staff movements out of the Trust to understand the background. Time to Hire is reducing and while there are eight formal sickness reviews ongoing four will come off that number as they have been concluded over the last fortnight.

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

20/22/117 Board Assurance Framework – February 2022

MS noted that the risks continue to be regularly reviewed and updated; there is still work to do on the EDI risk which ES has discussed with AyB.

FM noted the improved position in respect of workforce sustainability and development.

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

20/22/118 Health & Safety Dashboard

MS noted that this is a new item following robust discussions around developing a suite of metrics for Health & Safety.

AK gave an overview of the new dashboard, noting that it is in its infancy and will require some refinement going forward. Metrics have been drawn from regulations and guidance and the list is not intended to be exhaustive, allowing additional metrics or drill-down into data as required.

FB asked whether the dashboard will be shared on a monthly basis with trends, and if so would the targets shown then become rolling 12-month compliance targets; AK

responded that the initial thought was to share on a quarterly basis as that would show changes within the metrics and would demonstrate any trends.

FB asked if it would be possible to show a split for non-clinical claims between staff and non-staff, noting that it would also be useful from an SQAC perspective; AK noted that this is relatively easy to do and the breakdown can be added.

Resolved: PAWC received and noted the Health & Safety Dashboard

21/22/119 Policies

There were no policies presented for approval.

21/22/1 Board of Directors Summary

- People Plan – good focus on menopause, underlying issues around mental health absence, levels of domestic abuse and the financial wellbeing work
- Communications – timetable for Comms items being addressed by MF
- Staff Survey– Clear analysis of data, good discussion around tolerance and next steps
- People Pulse report – a view on what is impacting staff three times a year
- Appraisal Process – changes approved, with updates in six months and review & reflection in one year
- Workforce Metrics – Time to Hire metric to be reviewed in April with potential reduction in May
- Gender Pay Gap Report – approved the actions detailed
- Health & Safety Dashboard – received first iteration with quarterly reviews and potential cross-review from SQAC

Resolved: PAWC agreed the Board of Directors Summary

Sub Committee/ Working Groups reporting to Committee

21/22/1 The Committee received the approved minutes for the following for information, noted as read.

- Local Negotiating Committee – 08.12.21
- Joint Consultation & Negotiation Committee (JCNC) – 25.01.2022

Resolved: PAWC noted the content of the minutes.

21/22/1 Any other business

There were no items raised under Any Other Business

21/22/1 Review of Meeting

FM reviewed the meeting and hoped the Committee found it productive. 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.

21/22/1 Date and Time of Next meeting

22nd March 2022, 10am

Minute Reference	Action	Who	When	Status
Trust People Plan 2019-24				
21/22/60-1	Non Agenda for Change (AFC) Pay Update • Deferred increase to on-call payments to be included in overall review of on-call arrangements	NA/AB	March 2022	Complete
21/22/60-2	Non Agenda for Change (AFC) Pay Update • Pay Review – small anomalies across the Trust – to also include review of approach for Non-AFC practices	MKS/SO	Spring 2022	Noted 23.03.2022: To be undertaken March / April & review at April meeting
21/22/96	• Staff Story – think about how we may capture this going forward	SO/JP	June 2022	Noted 23.03.2022: To be agenda item at April meeting
21/22/97/1 21/22/97/2	Staff Survey • Produce overarching Trust wide action plan • Disability Network – look to establish the Network and reflect in Staff Survey Comms rollout	MKS MKS/AB	April 2022 March 2022	Noted 23.03.2022: To be agenda item at April meeting Noted 23.03.2022: Work ongoing to establish this
21/22/111.1 21/22/111.2	People Plan • Item on sickness absence to be brought to future meeting • Financial Wellbeing to be regularly reported	SO JP	May 2022 TBC	
21/22/112.1	Communications Update • Update on new website development to be brought to a future meeting	MF	May 2022	
21/22/114.1 21/22/114.2	Appraisal Process • Update on appraisal process to be brought to a future meeting • Consideration to be given to a reflective review of 2022/23 appraisal process	MKS	July 2022	
Governance				
21/22/80-1	Trust Metrics - Medicine Division	CW	April 2022	Noted 23.03.2022:

	Increased staff turnover – feedback following review of data.			To be agenda item at April meeting
21/22/80-3	Trust Metrics – Corporate Services Discuss and agree the right performance framework for Corporate Services	AB	April 2022 tbc	Noted 23.03.2022: To review at April meeting
21/22/80-4	Trust Metrics Look at producing a 1/4ly report with year-on-year comparisons in the metrics in relation to turnover	SO/MKS	May 2022 (1st quarterly report)	
21/22/66	Health & Safety • To produce a current status dashboard for Health & Safety to inform the Board	MKS/AK	March 2022	Complete
Equality, Diversity & Inclusion				
21/22/58	• Monitor 3 action Plans WRES/WDES/BAME Taskforce		Ongoing	
Sub-Committee / Working Groups reporting to PAWC				
21/22/104	Request Chairs of reporting Committees to provide a summary guide/precis outlining what was agreed and discussed at the meeting (1 page – bullet points)	MKS	ASAP	Complete

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 7th February 2022**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Ms. R. Lea	Acting Director of Finance	(RL)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Dr. F Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
In Attendance:	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mrs. K. Warriner	Chief Information Officer	(KW)
Observing:	Ms. F. Ashcroft	CEO of the Trust's Charity	(FA)
Apologies:	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
Item 21/22/56	Mr. K. Bell	Business Intelligence Lead	(KB)
Item 21/22/56	Ms. S. Johnson	Innovation Consultant	(SJ)
Item 21/22/63	Mr. J. Kinsella	CEO of Blue Tree Medical Group	(JK)

21/22/49 Introductions and Apologies

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

21/22/50 Declarations of Interest

The Innovation Committee noted the following declarations:

- Fiona Marston declared her association with the Liverpool School of Tropical Medicine.
- Marc d'Abbadie declared his association with LCR ventures.

21/22/51 Minutes from the Meeting held on the 11.10.21 and the 24.1.22 .
Resolved:
The minutes from the meetings that took place on the 11.10.21 and the 24.1.22 were agreed as an accurate record.

21/22/52 Matters Arising and Action Log

Action 21/22/26.1: *Commercial Partnerships (Further clarity to be included in the report on the materiality level and decision-making process which defines whether an agreement will be submitted to the Innovation Committee or RABD, for approval)* – It was confirmed that once the Corporate Governance Manual is complete this action will be addressed. **ACTION TO REMAIN OPEN**

Action 21/22/21.3: *Health Tech Seed Fund Proposal (Submit a report on a pre-seed fund approach and product pipeline, during August's meeting)* – A mock pitch day took place in partnership with MSIF to look at ten of the Innovation Centre's most mature projects from a business case perspective. It was concluded that these projects are still in the early stage of commercial development therefore it was agreed to cease an Alder Hey pre-seed fund approach. It was reported that this work links in with the new Liverpool City initiative, Liverpool Ventures, which is looking to support early stage projects financially. MSIF has confirmed that it still wants to work with the Innovation Centre on specific ask pitches and seed funds. **ACTION CLOSED**

Action 21/22/35.1: *Q2 Performance Report (circulate the Trust's elevator pitch which is in draft form with the view to receiving constructive feedback from Committee members)* – It was confirmed that the final version of the elevator pitch will be ready for circulation approximately two weeks after the strategy has progressed to copy write status with Strat House. **ACTION TO REMAIN OPEN**

Action 21/22/36.1: *Research and Innovation Vision (Discuss the governance element of the Research and Innovation Strategy and agree which Committee the strategy will sit under)* - This action will be progressed once a discussion has taken place on the positioning of the Innovation Strategy in terms of the framework. **ACTION TO REMAIN OPEN**

Action 21/22/41.1: *Draft Intellectual Property Policy (Refine the draft Intellectual Property Policy based on the comments made during the meeting and submit a further version of the policy during the next Committee meeting)* – The draft policy has been updated and reflects the feedback provided by Committee members. Further work is required prior to completion therefore it was agreed to circulate the final version of the document w/c the 21.2.22 for virtual approval. Further discussions will take place during April's meeting with regard to the process for implementing the policy.
ACTION TO REMAIN OPEN

21/22/53 Draft Innovation Strategy (final version)

The Innovation Committee received the final version of the Innovation Strategy and was advised of the amendments that have been made to the document following feedback at the previous meeting. The Committee was asked to approve the strategy in order to produce a published document and submit it to the Trust Board on the 24.2.22. It was pointed out that further work is required before it can be submitted to the publishers therefore delegated responsibility was requested to enable a sub-set of the Committee to address the final amendments.

The Committee was asked to provide comments on the final draft of the strategy. The following pointes were raised:

- Kate Warriner felt that the narrative in the document needs to be more explicit on external opportunities, particularly in terms of ICS/Children's Transformation Programme opportunities. It was also felt that engagement should take place with the leads of the Children's Transformation Programme and the Digital Programme. Attention was drawn to the importance of developing the existing relationship that the Trust has with the Children's Health Alliance in order to link in with forthcoming opportunities. The Committee was advised that the Trust is in the process of refreshing its Digital Strategy and it was felt that both strategies should be aligned. It was agreed that a discussion will take place between Kate Warriner and Claire Liddy regarding this matter.

21/22/53.1 **Action: CL/KW**.

- Fiona Marston raised three points that she felt requires attention; 1. The USP of the Innovation Centre needs to be better articulated. 2. It was felt that KPIs should measure quality and impact and not be driven solely by the number of projects. It was felt that by having a mechanism in place for the sign-off of projects by the Committee will produce data on quality, impact and benefits. 3. Assurance is required to ensure that there aren't any gaps in the governance process due to it being split between two Committees; RABD and the Innovation Committee.

  A discussion took place around the blockages that would occur if all of the major decisions were funnelled up to the Innovation Committee for approval. Iain Hennessey highlighted the importance of having the agility to progress an innovative opportunity without having to wait for Committee approval The Committee agreed that it is imperative to have a clear operational plan supported by KPIs so that the Committee can monitor the agreed work and have an understanding of the quality criteria, along with a yearly budget that feeds into a financial forecast on returns/investments that is clearly stated in the strategy document. This process will enable the Committee to support projects or review them.

- John Chester felt that the document has progressed immensely and is at a stage where it can be shared with Strat House to be worked up. In terms of approval, it was felt that this should be done once the final amendments have been made to the strategy by the assigned group.
- Mark Flannagan drew attention to the importance of publicising the Innovation Strategy and new brand as soon as possible and felt that design work could commence prior to the final approval of the document.
- The Chair suggested that pending amendments the Committee should approve the strategy and then compile an operational plan that has a twelve month set of performance targets which have impact and drivers sat behind them.

Actions/Next Steps:

- Small working group to be established to finalise the strategy. Group to include JC/FM/SA/MF/CL/EH. Once the strategy has been finalised it was agreed to circulate the document to Committee members.

21/22/53.2 **Action: CL/EH**

- Small working group to be established to address governance. Group to include SA/ES/IQ/FM/JC/CL/EH

21/22/53.3 **Action: CL/EH**

- Work to take place on the operational plan.
- It was agreed to approve the Innovation Strategy, following the amendments to the document.

The Chair informed the Committee that the Innovation Strategy will feed into the Research and Innovation Framework from a reporting perspective.

Resolved:
The Innovation Committee approved the Innovation Strategy pending amendments and scrutiny of the document by the working group.

21/22/54 Q3 Performance Report

The Committee was provided with an update on performance for the period from October 2021 to December 2021. A number of slides were shared, and information was provided on the following areas:

- *Innovation KPIs;*
  It was reported that there has been an increase in grant funding and new projects into the pipeline. Projects are being progressed through the pipeline and are going to pilot and being deployed. It was pointed out that the number of projects into the pipeline is one of the Innovation Centre's impact measures.
- *New project delivery highlights;*
  - Two projects have gone into pilot.
  - Four projects have been deployed.
- *Impact to Care Story;*
  - Little Hearts at Home App.
  - Robotic Process Automation.
- *Branding and Reputation*
  - Winners of the Mental Health Innovation HTN awards.
  - Highly commended for Positive Practice Mental Health awards.
  - Guest speakers at a number of events.
  - First Innovation Lab Pitch day in partnership.
  - A replica of the impossible tumour is displayed at the Science and Industry Museum.
  - Participated in the BBC Bitesize school tour.
  - An overview of the Innovation Centre's successes in 2021 was provided.
- The Committee received an update on partnerships and funding success from bids submitted in Q3.

CYP As One KPI Update

It was reported that since the launch of the CYP As One platform in May 2021 77% of referrals have been submitted via this route. In Q3 there were 3450 visitors new to the As One site and a total of 1522 referrals, of which, 76% came via the As One platform. Work has also commenced to calculate the reduction of admin hours that have been saved as a

result of being able to automate referrals, and it was confirmed that 86 hours per month been saved based on current figures. The Innovation Centre is also looking to improve staff experience for those processing CAMHS referrals through the implementation of the Rapid Process Automation. The Committee was advised that the CYP As On Platform has been rated by users as 4*.

John Grinnell pointed out that some of the work that the Innovation Centre is conducting fits with national policy and felt that it would be beneficial to horizon scan these areas, particularly the hospital at home model, and dedicate time to this going forward. In terms of the CYP As One Platform, John Grinnell queried as to whether the data that is being collected around referrals could reflect outcomes to enable the Trust to plan ahead in terms of the required healthcare support for patients.

In light of the new technologies that are being implemented to improve patient care, Kate Warriner felt that a piece of work needs to be conducted on the mainstreaming of metrics to think about capturing benefits realisation and evidencing the impact to productivity from a financial perspective. It was agreed that a meeting will take place to discuss this matter further and look at whether this information can be captured in one report.

21/22/54.1 Action: KW/CL/EH

Kate Warriner drew attention to the opportunities that are taking place regionally and felt that this is something that the Innovation Centre should look into from a strategic perspective.

Resolved:
The Innovation Committee noted the Q3 Performance Report and the CYP As One KPI update.

21/22/55 Innovation Management Accounts

The Committee received an overview of the Innovation Management Accounts for Month 9. A number of slides were shared which provided information on income, expenditure, forecast, accelerator funded spend and the capital position. It was confirmed that an update on the management accounts will be provided on a quarterly basis.

Resolved:
The Innovation Committee received and noted the Innovation Management Accounts for M9.

21/22/56 Alder Hey Anywhere Platform and Roadmap Update

The Committee received an update on the Alder Hey Anywhere Digital Platform. A number of slides were shared which provided the following information:

- The work that has taken place in partnership to collect data, build a framework and to develop a product.
- An update on the Roadmap position.
- Programme progress.
- An overview of the Anywhere Portal Landing page.
- Future commercial ideas.

- Challenges.

The Committee was advised of the learning that has taken place in partnership to help support the Trust with its concept of the Anywhere Portal. It was confirmed that a workshop has been scheduled for March 2022 to enable the Trust's Clinical Directors to think about the practicalities of bringing this together in terms of clinical areas and the cohorts of patients that will benefit most.

The Chair asked as to whether the Committee will need to monitor any risks as the platform develops. It was confirmed that that a data impact assessment of the programme will be conducted which will be supported via the Trust's Data Protection Officer and the SIRO. The Trust will also adhere to the national standards that exist.

A discussion took place around the importance of the platform and the Trust's website complimenting each other in terms of providing the right information in the appropriate place, and the possibility of developing a segmentation analysis in the Commercial Strategy to look at a children's Anywhere Platform offer locally, nationally and globally. It was agreed to compile a segmentation analysis report to identify market segment opportunities locally and nationally, but it was pointed out that identifying global gaps will take longer. A section in the report will be dedicated to data opportunities.

21/22/56.1 **Action: KB**

Resolved:
The Innovation Committee noted the Alder Hey Anywhere Platform and roadmap update

21/22/57 **Commercial and Partnership Agreements Log.**
Resolved:
The Innovation Committee received and noted the quarterly update and the contents of the Commercial Partnership Agreement schedule.

21/22/58 **Draft Intellectual Property Policy Update (IP)**
Resolved:
The Innovation Committee agreed to approve the Intellectual Property Policy virtually, but in the event there are a large number of queries the policy will have to be re-submitted to the Committee in April 2022 for further discussion.

21/22/59 **Board Assurance Framework Update**
Resolved:
The Innovation Committee received and noted the contents of the Board Assurance Framework Report for December 2021.

21/22/60 **Innovation Committee Terms of Reference**
Resolved:
This item was deferred to April's meeting.

21/22/61 **Any Other Business**

Following an issue that was raised about the circulation of Committee papers in a timely manner, it was confirmed that members will receive documentation for future meetings a two clear days ahead of scheduled meetings.

21/22/62 Review of Meeting

The Chair thanked everyone for their contributions during the meeting and summarised the actions that were agreed.

21/22/63 Blue Tree Medical Group

The Committee received a presentation from the co-CEO of the Blue Tree Medical Group who provided an update on the BrillianSee project. A discussion took place around manufacturing capacity, cost to produce the product, primary factors that is driving potential success and the design rights position. Following the update, the Committee advised that it felt more assured on the potential opportunity of the product.

Resolved:
The Innovation Committee noted the update on the BrillianSee project.

Date and Time of the Next Meeting: Tuesday 19th April 2022, 1:00pm-4:00pm, via Teams