BOARD OF DIRECTORS PUBLIC MEETING

Thursday 28th July, commencing at 11:00am

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	22/23/99	11:00 (1 min)	**Apologies.**	Chair	To note apologies.	N	For noting
2.	22/23/100	11:01 (1 min)	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	R	For noting
3.	22/23/101	11:02 (3 min)	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meetings held on: **20th of June 2022 and the 30th of June 2022.**	D	Read enclosure
4.	22/23/102	11:05 (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.	22/23/103	11:10 (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.	22/23/104	11:20 (50 mins)	• **Integrated Performance Report Proposal.** • **Operational Progress Report, Q1 2022/23.** • **M3 Integrated Performance Report.**	K. Warriner/ A. Bateman Exec Leads Exec Leads/ Divisional Leads	To receive the Integrated Performance report proposal. To receive an operational progress update for Q1, 2022/23. To receive a report on the Trust's performance for scrutiny and discussion, highlighting any critical issues.	D A A	Read report Read report Read report
Lunch (12:10pm-12:30pm)							
Strategic Update							
7.	22/23/105	12:30 (10 mins)	**ICS Development Update.**	D. Jones	To receive an update on the development of ICSs.	N	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	22/23/106	12:40 (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
9.	22/23/107	12:50 (10 mins)	**Digital and Information Technology Update.**	K. Warriner	To provide a digital and information technology update.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
10.	22/23/108	13:00 (5 mins)	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
Sustainability through External Partnerships							
11.	22/23/109	13:05 (15 mins)	**LNP Update.**	LNP Team	To receive an update.	**A**	Presentation
The Best People Doing Their Best Work							
12.	22/23/110	13:20 (5 mins)	**Medical Revalidation Update.**	A. Bass	To receive an update on the current position.	**A**	Read report
13.	22/23/111	13:25 (5 mins)	**EDI Steering Group Update.**	G. Dallas	To receive an update on the inaugural meeting.	**A**	Verbal
Strong Foundations (Board Assurance)							
14.	22/23/112	13:30 (15 mins)	**Monthly Financial Update for M3, 2022/23.**	C. Shelley	To provide an update on the current position for Month 3, 2022/23.	**A**	Presentation
15.	22/23/113	13:45 (5 mins)	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
16.	22/23/114	13:50 (15 mins)	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 14.7.22.**	K. Byrne	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Approved minutes from the meeting held on the 16.6.22.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 25.7.22.** - **Approved minutes from the meeting held on the 27.6.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 20.7.22.** - **Approved minutes from the meeting held on the 22.6.22.**	I Quinlan F. Beveridge			
Items for information							
17.	**22/23/115**	**14:05 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
18.	**22/23/116**	**14:09 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal

Date and Time of Next Meeting: Board Strategy Session **-** Thursday 8th September 2022, 9:00am-12:00pm, via Microsoft Teams.

REGISTER OF TRUST SEAL
The Trust Seal wasn’t used in July 2022

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M3, 2021/22	C. Shelley
IPC Report	B. Larru

EXTRAORDINARY PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Monday 20th June 2022 at 9:03am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Acting Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. J. Grinnell	Deputy Chief Executive/CFO	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/60	Mr. D. Spiller	E&Y Accounts Manager	(DS)
Item 22/23/68	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mr. D. Powell	Development Director	(DP)

22/23/58 Welcome and Apologies

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

22/23/59 Declarations of Interest

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

22/23/60 Draft Annual Report and Accounts for 2021/22

The Trust Board received the draft Annual Report and Accounts for 2021/22. The Board was advised that the Accounts Manager from Ernst and Young (E&Y), Dan Spiller, has been invited to the meeting to present the draft external Audit Results Report and provide an overview of the work that has been completed by E&Y as part of the audit. John Grinnell stated that the draft set of reports were submitted to the Audit and Risk Committee on the 16.6.22, this included a supplemental finance report to bring the accounts to life. It was reported that the Chair of the Resources

and Business Development Committee (RABD), Ian Quinlan, attended June's Audit and Risk Committee to offer assurance on the consistency of the information/data that is included in the draft 2021/22 Financial Accounts, from a RABD perspective.

Annual Report, 2021/22

Erica Saunders provided the Board with an overview of the contents of the 2021/22 Annual Report which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Board was advised that the Quality Account has been removed on a permanent basis from the body of the Annual Report and will be submitted separately going forward.

The Annual Report has been checked for consistency by E&Y along with the Annual Governance Statement, of which, it was confirmed that there were no material differences found. The date of submission to NHSI/E is the 23.6.22 and thereafter the Trust will lay the Annual Report and Accounts before Parliament on the 8.7.22.

The Chair of the Audit and Risk Committee, Kerry Byrne, advised that the Committee reviewed the draft Annual Report and Accounts in detail during June's meeting and also had an in depth discussion on a number of areas to gain further clarity on queries that were raised. Kerry Byrne drew attention to the Going Concern disclosure which it was felt was a very thorough and comprehensive report, and thanked Ian Quinlan for his support during June's Audit and Risk Committee meeting.

Annual Accounts, 2021/22

John Grinnell provided the Board with an overview of the contents of the 2021/22 Annual Accounts and the supplemental finance report which was included to bridge the more technical areas. It was reported that the Trust's year end position for 2021/22 remains at a surplus of £137k against a national breakeven plan, which the Trust achieved. A number of categorisation changes have been made following discussions with E&Y, but this has not affected the overall position.

A number of key highlights were shared with the Board in terms of performance; it was reported that the Trust delivered its Capital Plan with a total spend of £32m. This included areas of hosted capital and a number of new capital investments received via national money. Alder Hey also hosted the National Paediatric Accelerator Programme on behalf of ten specialist trusts which brought an additional income of £20m. It was confirmed that an element of the income from the Accelerator Programme was invested to support digital and innovation projects.

The Trust's cash balance as at the 31.3.22 informed the outcome of the organisation's liquidity assessment in terms of fully supporting that a Going Concern basis should be adopted for preparing the financial accounts. Attention was drawn to the increase in the organisation's provisions which relates to the Trust's liability for the reinstatement of the park.

Resolved:
The Board approved the Annual Report and Financial Accounts for 2021/22.

External Audit 'ISA260', 2021/22

The Board received the draft External Audit Year-end Report for 2021/22. It was reported that E&Y is planning to issue a clean opinion on the Trust's 'Value for Money' (VFM) and 'Financial Statements'. The Accounts Manager for E&Y, Dan

Spiller, felt that the outcome of the audit was really positive with only minor items raised in the report.

Resolved:
The Board approved the external Audit Results Report for 2021/22 (ISA260).

Draft Letter of Representations
Resolved:
The Board received and noted the draft letter of representation which is to be signed by the Chair of the Audit and Risk Committee and the Chief Finance Officer.

On behalf of the Board, the Chair congratulated and thanked all those involved in achieving an outstanding outcome in what has been a demanding year. Louise Shepherd reiterated the Chair's comments and pointed out that it is extraordinary in terms of what has been achieved across the organisation, as detailed in the Annual Report and Accounts for 2021/22.

22/23/61 Committee Annual Reports, 2021/22

The Board received the following Committee Annual Reports for 2021/22, noting that each Committee had fulfilled its Terms of Reference and managed its governance processes during the year; it also acknowledged the 2022/23 priorities for each Committee:

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

The Chair thanked each of the Assurance Committee Chairs for their leadership during the year. The Chair pointed out that there is some excellent work taking place across all of the Assurance Committees and felt that the level of scrutiny and debate provides the Board with assurance that actions are being progressed and substantiated with evidence/data.

Resolved:
The Board received and noted the contents of the 2021/22 Annual Reports for each of the Assurance Committees.

22/23/62 Board Self-Certification of Compliance with the Provider Licence

The Board received the 2022 Board Self-Certification of Compliance with the Provider Licence. Erica Saunders confirmed that the Trust is able to declare full compliance with the exception of the Major Trauma service which has a derogation in place.

Kerry Byrne queried the timeline for the removal of the derogation and asked as to whether this matter should be monitored via SQAC. It was agreed to gain further detail and address this matter outside of the meeting.

22/23/62.1 Action: ES

Resolved:
The Board received and approved:
- NHS Improvement Provider Licence Self-Assessment

- The declarations in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training.
- The declaration in relation to general condition 6 (systems for compliance with licence conditions) and service condition 7 of the provider licence (continuity of services).

22/23/63 Directors' Register of Interest 2021/22

Resolved:
The Board received and noted the Directors' Register of Interest for 2021/22.

22/23/64 Use of the Mental Health Act Annual Report – 2021/22

Lisa Cooper provided the Board with an update on the activity relating to the use of the Mental Health Act (1983) for the reporting period from the 1.4.21 to the 31.3.22. The following points were highlighted:

- There have been 12 children and young people detained under a section of the Mental Health Act during the reporting period. This is an increase compared to 2020/2021 when 7 CYP were detained. It was reported that the increase is due to the use of the community treatment order for 2 young people who had been detained due to an eating disorder. This is seen as a positive step for the organisation as the community treatment order enable patients to return home whilst continuing to receive care/ treatment.
- There has been a slight increase in the use of Section 136 of the Mental Health Act, and 3 young people with eating disorders have been detained on the Paediatric Ward during 2021/22.
- *Mental Health Act Training;*
  - Specialist Mental Health Services – 97%
  - Ward 4C – 95%
  - Emergency Department – 80%

It was reported that compliance in ED continues to increase and there is a plan in place to achieve compliance by the 30.6.22. The Board was advised that Mental Health Act training is to become mandatory for particular staff groups and work is taking place to roll this out across the Trust.

Resolved:
The Board noted and approved the Use of the Mental Health Act Annual Report for 2021/22.

22/23/65 Use of Restrictive Physical Interventions Annual Report – 2021/22

The Board was provided with an update on the activity relating to the use of restrictive physical interventions across the Trust for the reporting period from the 1.4.21 to the 31.3.22. The following points were highlighted:

- Narrative has been included in the report on legislative and national guidance regarding the Use of Force Act on Mental Health Units which applies to Alder Hey's Tier 4 Children's Inpatient Unit. The Chief Nurse is the Executive Lead for the Trust with delegated responsibility to the Director of Community and Mental Health Services.
- The Trust reported 152 incidents regarding the use of restrictive physical interventions of children and young people accessing services at Alder Hey. This is a decrease in comparison to 175 incidents reported during 2020/2021. It was pointed out that the increase in recorded incidents involving restrictive

interventions in the Community and Mental Health Division related to one young person who was detained under the Mental Health Act on the Trust's Tier 4 Children's Inpatient Unit.

- A total of 21 incidents were reported in 2021/22 in comparison to 52 reported in the previous year. The Board was advised that the training and education provided by the Trust has given staff the skills to reduce harm when having to use restrictive practice. The Trust is continuing to roll out the Train the Trainer model for the CALM technique and improvements are on-going in terms of recording and reporting incidents.
- It was confirmed that work is taking place on a reduction programme. This should be completed by the end of August and will be submitted to the Trust Board in due course.
- The Trust's Tier 4 Children's Inpatient Unit is currently participating in the 'Safe Wards' project as part of NHSEI's 'Getting it Right First time' (2018) programme and the National Quality Improvement programme that is supporting best practice and guidance on the use of restrictive physical interventions.

Resolved:
The Trust Board noted the contents of the Use of Restrictive Physical Interventions Annual Report for 2021/22.

22/23/66 Complaints and PALS Report, Q4

The Board was provided with an overview of formal complaints and informal PALS concerns received and completed between 1.1.22 to the 31.3.22 (Q4). The report also provided an overarching year-end report for 2021/22. The following points were highlighted:

- The Board was informed that a huge amount of improvement work took place at the end of Q4 to increase the organisation's responsiveness to complaints within a 25 day period. It was confirmed that compliance in Q4 was above 85% and is continuing to increase during Q1 of 2022/23.
- Responding to concerns within a 5-day timeframe remains at 65%. The Board was informed that the Divisions have reviewed their processes for Q1 and an increase in responsiveness to concerns is expected to be seen going forward.
- Attention was drawn to the examples of complaints, concerns and compliments that are detailed in the report.

Kerry Byrne informed the Board of the internal audit that took place on complaints which received a limited opinion. The Board was advised that management responses were really positive and proactive in terms of the actions that had been agreed to address the outcome of the review. Week commencing the 13.6.22 MIAA confirmed that all bar one of the eleven recommendations had been implemented on time with one minor issue outstanding. Kerry Byrne shared this information with Board members to highlight the good work that has taken place to deal with this matter. The Board was advised that the next phase of work will focus on organisational learning. The Chair thanked Nathan Askew and Pauline Brown for the work that has taken place.

Resolved:
The Board received and noted the contents of the Complaints and PALS Report for Q4.

22/23/67 Mortality Report, Q4

The Board received the Mortality Report for Q4, 2021/22. The following points were highlighted:

- It was reported that there had been 55 deaths in the year against a figure of 52 expected deaths.
- *Medical Examiner Process* – The Medical Examiner (ME) at LUFT has been very receptive to the request made for support for Alder Hey on the new ME process therefore the Trust is looking at how this can be done collaboratively.
- *Notification in the New System* – A more effective process has been established for notifying clinicians of particular clinical conditions that patients suffer from, for example, difficult airways, whilst in the care of Alder Hey.
- The Board was informed of the two RCAs relating to trauma deaths that were reported to StEIS. One RCA has been completed and it was confirmed that it was an unavoidable death, but it was found that learning is required to improve the care that Alder Hey provides as a Trust. The second RCA is due to be completed.

Resolved:
The Board received and noted the contents of the Mortality Report for Q4.

22/23/68 Director of Infection, Prevention and Control (DIPC) Report, Q4

The Board received an update on infection, prevention and control (IPC) for Q4, 2021/22. A number of slides were shared which provided information on the following areas:

- It was reported that there are six patients with Gram-Negative BSI hospital acquired infections (HAI) on Ward 3C.
- There were zero patients with Covid-19 HAI during the reporting period.
- There are two cases of Carbapenemase-Producing Enterobacterales HAI in HDU. It was confirmed that these cases weren't linked.
- Two patients were identified within one week with Pseudomonas after negative screens and visits to theatre 3 and 7. The Trust received the results of the water sampling tests on the 17.6.22 and it was confirmed that there were no positive outlets identified in either theatre. It was pointed out that the Trust has a more robust system in place to respond to colonised patients, but it was acknowledged that further work is required in terms of water safety on critical care units.
- On the 16.6.22 the Royal College of Paediatrics and Child Health published guidance advising that pre-op Covid-19 testing is not required going forward. It was confirmed that the Track and Trace team are still in situ.
- It was reported that the Trust is preparing for the 2022/23 staff Flu and Covid Vaccination programme and is looking to achieve a target of 90% in terms of uptake.
- The Board was informed of the increase in Covid-19 cases reported in the UK during May along with an increase of positive testing among staff.
- An overview of the updated national guidance on masks was provided and it was confirmed that the Trust has advocated to continue with the wearing of masks in clinical areas and when staff have contact with patients/families. Visitors are still being asked to wear masks but in none-public areas the organisation has agreed to lift the mandate for masking.

Clarity was requested on the guidelines for holding future Board/Committee meetings on a face to face basis. Following discussion it was felt that a stepped approach is required in terms of removing measures at Alder Hey especially in light of the rise in Covid cases and an increase in staff absences. Staff communications will need to be clear in terms of the Trust's position following the recent publication of NHSE guidance.

The Chair advised that the Board recognises the work that has been done by the DIPC and her team to keep patients, families and staff safe, and felt that the Trust should proceed cautiously in terms of any changes to the removal of measures. With regard to future face to face Board/Committee meetings it was agreed to review this on a month by month basis.

Resolved:
The Board noted the DIPC report for Q4, 2022/23.

22/23/69 Any Other Business

There was none to discuss.

22/23/70 Review of the Meeting

The Chair thanked everyone involved in delivering what has been a fantastic year's work.

Date and Time of Next Meeting: Thursday the 30th June 2022 at 12.30pm via Teams.

PUBLIC MEETING OF THE BOARD OF DIRECTORS
Confirmed Minutes of the meeting held on **Thursday 30th June 2022 at 12:30pm**
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)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Deputy Chief Executive/CFO	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Observing	Kate Brizell	Head of Operations, LUFT	(KB)
	Josh Golblatt	Shadowing Nathan Askew	(JG)
	Prof. J. Jankowski	Member of the public	(JJ)
	Ms. C. Shelley	Assoc. Director of Operational Finance	(CS)
Apologies	Mr. A. Bass	Acting Chief Medical Officer	(ABASS)
	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Mrs. K. Byrne	Non-Executive Director	(KB)

Patient Story

The Chair welcomed Georgia, who had been invited to June's Trust Board to share her son's journey with the Trust.

The Board was advised that James was admitted to Alder Hey on the 4.1.22 on life support fighting sepsis and seizures. After four weeks he was transferred to 4B but had to be put back on life support three days later. The second time his heart stopped but he kept fighting. In total, James has been on life support three times in a short space of time following diagnosis.

James is still at Alder Hey and is having to learn everything all over again, for example; walking, talking and eating. Georgia paid tribute to her son who she feels is an incredibly, strong, young man who never gave up and through his determination is still here today. Georgia thanked everybody who was involved in James' care that helped him back on the road to recovery. Georgia informed the Board of the incredible families that she has met during James' stay at Alder Hey who support each other, and the staff who became familiar faces who kept her strong

through James' ordeal. Georgia pointed out that all of these amazing people look after you like one of their own and treat you with such kindness and generosity.

On behalf of the Board, the Chair thanked Georgia for sharing James' story.

22/23/71 Welcome and Apologies

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

22/23/72 Declarations of Interest

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

22/23/73 Minutes of the previous meetings held on Thursday 26th May 2022
Resolved:
The minutes from the meeting held on the 26th of May 2022 were agreed as an accurate record of the meeting.

22/23/74 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 22/23/46.1: *EDI Steering Group (EDISG) Update (Discuss the possibility of connecting the EDI Steering Group agenda with the health inequalities and prevention work that is taking place)* – Reference has been made in the EDISG ToR from a strategic perspective in terms of dovetailing the Trust's Partnership Strategy. **ACTION CLOSED**

22/23/75 Chair's and CEO's Update

It was reported that Integrated Care Systems (ICSs) will be fully operational as of the 1.7.22. The Board was advised that the Trust will have the opportunity to share its vision for joining children's services up across Cheshire and Merseyside (C&M) with the Chair of the Integrated Care Board, Raj Jain, and the CEO of the Integrated Care Board, Graham Urwin, when they visit Alder Hey in July. It was pointed out that Raj Jain is also the ICS Executive Lead for children and young people (CYP).

The NHS set a target date of the 30.6.22 to ensure that all patients waiting over two years for treatment receive their treatment within the agreed timescale as part of the Recovery Programme. The Trust was asked to work with Manchester Children's Hospital to make sure the target was met across the whole of the North West and it was confirmed that all patients received their treatment within the set timescale. Louise Shepherd paid tribute to the teams at Alder Hey who drove this work forward and offered thanks to the partnership which will continue to work together on the roadmap to recovery.

It was reported that the CEO of the NHS, Amanda Pritchard, visited the Trust's Innovation Hub in June along with the new Head of Transformation and Innovation at NHSE, Tim Ferris. The Innovation team showcased their work to highlight what it is that the Trust is trying to do for CYP. Amanda Pritchard recognised that there are some real challenges facing CYP in this country and felt that the opportunities that

will arise via the ICS and working collaboratively will help address these problems. After the event the Trust received really helpful advice from Amanda Pritchard's office and senior members at the Centre which it was pointed out will help with the national initiatives that the Trust is trying to progress. Attention was also drawn to the meeting that took place with the senior team from NHSE to discuss the platform for the Virtual Ward model. Louise Shepherd asked that her thanks be relayed to the Innovation Team and all those who participated in the innovation event.

The Chair provided an overview of the visit of the Children's Commissioner that took place on the 29.6.22. During the visit the Children's Commissioner, Dame Rachel de Souza, listened to twenty young people who were able to articulate the things that are important to them and she undertook to make sure their ideas and frustrations are fed into the right places in Central Government. The young people were also invited to go and meet with their MPs and Ministers in the Department of Education.

It was reported that a regional meeting took place w/c 27.6.22 which was Chaired by Richard Barker who is covering the North and the North West as Regional Director. The headlines from the meeting related to the increase of Covid cases across the country and the worrying financial situation in the NHS.

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

22/23/76 Operational Update and Performance

The Board received an operational update on the recovery of services for children and young people for the month of May. The following points were raised:

- *Elective Recovery* – It was reported that the Trust achieved 110% elective recovery in May.
- *Outpatient Recovery* – The Trust achieved 106% outpatient recovery in May, and delivered 119% follow-up recovery, which is in excess of the 85% financial payment that the organisation will receive. It was reported that the Trust is seeking to balance a reduction in face-to-face follow-up activity, with a need to reduce overdue follow-ups. In order to do this, the Trust is testing safe alternatives to manage follow-ups, such as patient initiated follow-ups.
- *Was Not Brought (WNB)* – In order to support recovery, efficiency and reduce waiting times, the Trust has delivered a number of initiatives to support families to attend outpatient appointments. In May the percentage of appointments that were lost to WNB was 9.6%, which is below the 11% rate that the organisation had in 2019/20.
- *Waiting Times* - The Trust is challenged in reducing the number of patients waiting 52 weeks for treatment due to significant pressures and imbalance between demand and capacity in paediatric dentistry, with two thirds of the total number of long wait patients awaiting dental treatment. Actions are being taken by the Division of Surgery to support this area of work, but it was pointed out that it is not straight forward as the team is small and therefore it is difficult to increase capacity.

  Attention was also drawn to the ASD Service (Neuro Developmental Pathway) where access is challenged due to a continued surge in referrals which are presently experiencing an 82% increase. It was confirmed that a number of actions are taking place to address this issue; additional investment, recruitment and educational work in schools. If the service continues to experience challenges it was suggested that a deep dive may take place going forward.

Lisa Cooper advised of the proposal that has been compiled which the Trust is currently discussing with the local education authority and the CCG to try and address the 60% increase in referrals from schools. The Trust is also working with partners and schools and is part of the autism initiative that was funded by the local authority. It was confirmed that a pilot has commenced in Liverpool which focuses on education and training. It was confirmed that it is progressing well.

- *Diagnostics* - Diagnostic performance remains below the 99% target, reporting with particular challenges in MRI, gastroscopy, sleep studies, DEXA and urodynamics. A diagnostic recovery plan was submitted to RABD in June and a workforce recovery plan has been implemented to improve resilience and numbers in the Radiology team. It was reported that investment has been approved for home sleep study equipment which will help towards the reduction in waiting times for diagnosis.

On behalf of the Board, the Chair thanked all those involved for the commendable work that is taking place on the recovery of services.

Resolved:
The Board received the operational update for May 2022.

22/23/77 Integrated Care System (ICS) Development Update

The Board was provided with an update on the development of the ICS. A number of slides were shared that provided information on the following areas:

- What's new since May?
- Legislative changes and guidance for the CYP Executive Lead and the ICB.
- ICS Roadmap for integrating Specialist Services;
- Update on CMAST (Acute and Specialist).
- Update on LDMHC (LD, Mental Health, and Community).

C&M Latest Financial Update

- The final version of the 2022/23 plan was submitted as a £30m deficit.
- A significant risk was built into the plan which related to CIP, Elective Recovery Fund and COVID costs.
- A peer review of deficits is underway for organisations.
- The CCG finance teams are due to transition into ICB. It was reported that the structure is not yet known.
- The governance and reporting route is unclear at the present time in terms of transitioning from CCG to ICB.
- Chief Financial Officers (CFO) are working collaboratively and workstreams are being developed to understand drivers, deficits and the actions that are required.

Digital update

Attention was drawn to a number of colleagues who developed and progressed the Share to Care Programme whilst they were part of Alder Hey's Digital team. It was reported that the ICS is taking responsibility for this programme going forward therefore these team members will be transitioning into the ICS to continue with this work. It was felt that the Share to Care Programme was a fantastic success story

and it was agreed to write to these staff members to formally thank them for the work that they conducted to embed this programme.

22/23/77.1 Action: DJW

It was pointed out that the risks relating to the integration of specialist services are enormous especially the one appertaining to specialised commissioning. It was reported that the North West has already established a roadmap as a result of working collaboratively for children across the North West and it was felt that this will be the footprint that will be used going forward. Working with Manchester and colleagues in the three Transformational Boards will provide real opportunities to work in collaboration. Funding needs to be addressed and it was confirmed that discussions have commenced with the ICB's Finance Directors.

Fiona Marston queried the positives and benefits of being part of the ICS in terms of the Trust's emerging Vision 2030 Strategy. It was felt that there are two offers in terms of the business model that was discussed during the earlier strategy session:
1. Working in partnerships across the North West to improve specialist services.
2. Aligning with Place in terms of the population health model.

It was also pointed out that there are formal partnerships in place now with local authorities, education, social care and the third sector that will bring about different opportunities. It was pointed out that the Children's Transformation Board has brought a real sense of collaboration in respect to the work that is taking place on the programme, and it was felt it will help immensely if the right culture can be created across C&M, especially with Raj Jain sponsoring CYP.

Resolved:
The Board noted the update on the development of the ICS.

22/23/78 Alder Hey in the Park Campus Development Update.

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

- *Catkin Centre and Sunflower House Construction* - The completion date for the construction of the Catkin Centre and Sunflower House has been delayed until he 1.7.22. This is due to the quality issues being experienced on site with finish of the building. An architectural advisor has been engaged to review and set a quality improvement plan.
- *Neonatal and Urgent Care Development* – The Trust has received information from the developers, Morgan Sindall. Further discussions will need to take place with regard to the specification.
- *Park Clearance* – It was pointed out that the delay in the completion of the new Catkin Building will have an effect on the park clearance as the demolition of the old Catkin Centre can't commence until staff have been rehoused. The Trust has been working with the planners at Liverpool City Council to agree planning permission for temporary portacabin accommodation. Positive feedback has been received in respect to the planning permission for the portacabin to house staff from the old Police Station; the Trust is still awaiting a response in relation to the main portacabin accommodation.
- *Liverpool Innovation Park* - This project has been delayed due to the requirement of additional fire stopping within the existing building.

The Chair informed the Board that the Trust is working very hard to keep the local community updated on the reinstatement of the park.

Resolved
The Board received and noted the Campus Development update.

22/23/79 Serious Incident Report

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.5.22 to the 31.5.22. The following key points were highlighted:

- The Trust declared 1 StEIS reportable incident that met the serious incident criteria. This incident related to the unexpected death of a young person who deteriorated and died in PICU whilst in the care of the Trust. In line with protocol, an internal 72 hour rapid review of this case was undertaken but the review did not identify any learning for the Trust. The post-mortem has also been concluded but unfortunately no cause of death was identified. The Trust is awaiting the result of histology and toxicology reports which may take some time to come back. It was confirmed that the Board would be provided with an update on this incident in due course.
- The new Associate Director of Risk and Governance, Jackie Rooney, is working with the Divisions to close down the open action plans as quickly as possible.

Resolved:
The Board received and noted the contents of the Serious Incident report for reporting timeframe from the 1.5.22 to the 31.5.22. .

22/23/80 Nurse Workforce Annual Report 2021/22.

The Nurse Workforce Annual Report for 2021/22 was submitted to the Board to provide assurance that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff. An overview of the report was provided, and the following highlights were pointed out:

- The Trust has developed its first 5-year Nursing Workforce Plan and achieved all of the outcomes/targets set out for year one of the plan.
- It was reported that the Trust is not compliant with the standard that relates to the 24/7 Supernumerary Clinical Co-Ordinator, but the organisation is looking to address this issue in the next four to five months by funding these roles via the recruitment of 14 wte nurses.
- Alder Hey has maintained 90% of its fill rate throughout the year for safe staffing, with less than 10% of shifts being based on a red model. It was felt that this was a great achievement taking into consideration the challenges that have been experienced during the year as a result of Covid-19, etc.
- It was confirmed that the Trust has completed the bi-annual establishment reviews following the publication of the Nurse Workforce Annual Report. Work is taking place to look at increases/adjustments to the baseline that might be required following the review against activity, acuity, independence and professional judgment.

The Board was advised that the Trust now has dedicated digital nurses embedded in the Divisions to support the Chief Nursing Information Officer and the Digital Programme going forward. It was reported that the new regional Chief Nurse and Information Officer at NHSE has commended the Trust for the actions it has taken on this area of work.

The Chair queried the Trust's position in terms of the use of bank and agency staff. The Board was advised that the majority of shifts are covered by staff, via the Bank, in their respective clinical areas therefore the Trust is able to maintain flexibility and expertise whilst having a safe ward environment. In terms of agency staff usage, it was confirmed that this is minimal. The Board was provided with the detail of the two challenges that need to be addressed in 2022; request versus fill rates and the level of one to one care.

Louise Shepherd pointed out that the vacancy rates look good overall but felt that the averages belie potential pockets of staffing pressures and asked as to whether there are real challenges/problems that need addressing ahead of the winter period and whether there is a correlation between vacancies and sickness levels. It was reported that the Trust has a nursing vacancy rate of 2.6% against a national average of 12% to 15%. The biggest issue for Alder Hey at the present time is the unavailability of nursing staff which is at 15%; maternity leave (5%), long-term sick (5%), secondment/HR issues (5%). It was confirmed that a piece of work needs to take place to reduce unavailability.

It was reported that there are twenty-two Band 5 vacancies on ICU, however the team have conducted a robust recruitment programme which covers new graduates and experienced ITU staff, of which, there are seven new members joining ICU imminently. A national recruitment open day specific to ITU is also due to take place in July 2022 and currently 77 people have confirmed their attendance. It was pointed out that there will be challenges going into the winter period in terms of the mix of staff on ICU, but the Chief Nurse felt assured that the organisation will have the appropriate numbers of nursing staff in place to run ICU safely.

Resolved:
The Board approved the 2021/22 Nurse Workforce Annual Report.

22/23/81 Ockenden Review Trust-wide Action Plan.

The Board received the Ockenden Report Action Plan for May 2022. It was reported that action plan has been split into Alder Hey specific actions and those that relate to the Liverpool Neonatal Partnership. A baseline assessment has been conducted with the outcome determining that a phenomenal amount of recommendations from the original report are already in place of have been achieved at Alder Hey. There is a workstream in place to address the recommendations that the Trust is not currently compliant with, which will be monitored via the Safety and Quality Assurance Committee (SQAC). SQAC have requested that Alder Hey and the Liverpool Women's Hospital (LWH) share their action plans so that they can be dovetailed to ensure that both organisations are sighted on the level of risk.

Nathan Askew offered thanks to the Director of Nursing, Pauline Brown for the work that has taken place on the action plan.

Resolved:
The Board received and noted the contents of the Ockenden Review Trust Wide Action Plan.

22/23/82 Corporate Report

The Divisions 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

A query was raised about the reason behind the dramatic reduction in diagnostic performance. It was reported that the Director of Medicine, Urmi Das, is having regular meetings with the Division about the actions that need to be taken to address this matter. It was confirmed that an update will be provided during July's meeting.

22/23/82.1 Action: UD

Surgery

There were no queries raised in relation to the update.

Community

A discussion took place on the increase in referrals to the ASD and ADHD diagnostic pathway which has challenged service recovery plans. It was queried as to whether the time is appropriate to have a deeper look at the referral trends across mental health to identify the sources/drivers. It was confirmed that the Trust has a breakdown of data for ASD/ADHD referrals, but it was pointed out the mental health referrals are done via self-referral. A request has been made for data in terms of the general numbers of CYP accessing the CYP As One platform, the number of self-referrals and the number of referrals converted into referrals for the Trust and other partners. It was agreed to discuss this matter further outside of the meeting.

22/23/82.2 Action: LC/JG

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

22/23/83 Growing Great Partnerships

The Board received a report on growing great partnerships which provided an update/assurance on progress and risk management within the Trust's established health and care partnerships, along with an update on the Trust's emergent health and care partnerships. It has been proposed that this report be submitted to the Board on a quarterly basis going forward.

It was reported that the drive for collaboration and partnership across health and care services has grown in recent years. During the Covid-19 pandemic (2019-22) huge strides were made in system collaborations, though the priority focus of this collaborative working was on operational mutual aid and real-time pandemic management. Emerging from the pandemic, strategic partnership working has come once again to the forefront as a result of the implementation of integrated care systems (ICSs) via the Health and Care Act (2022).

There is currently no formal framework for the breadth of health and care partnerships to follow. As such, Alder Hey has undertaken a range of activities that have enabled broad categorisation of the Trust's health and care partnerships into established partnerships and emergent partnerships. It was pointed out that there is a lot more that can be done in terms of categorising, and the Board was advised that the report brings together the leadership for each of the established partnerships and highlights the key aspects of any given partnership that the Trust needs to remain sighted on.

Attention was drawn to the work that has commenced to devise an innovative new approach; partnership quality assurance rounds (PQAR). It was reported that a PQAR framework has been developed, taking the positive learning from service-level quality assurance rounds, and shaping the lines of enquiry to be appropriate for a partnership setting. This approach has been piloted with the Liverpool Neonatal Partnership (LNP) team who reflected very positively on the PQAR process.

Fiona Beveridge felt that as this area of work progresses it would be beneficial for the Trust and respective partners to think about the aspirations of the partnership. It was confirmed that this discussion takes place during the PQAR in terms of; What is our joint vision? What are our joint aspirations? Dani Jones invited Non-Executive Directors to attend the Neonatal PQAR that is taking place at LWH in July.

Kate Warriner drew attention to the non-clinical partnerships and developments that are in place for a number of years, for example, iDigital and Health Procurement Liverpool, etc. and felt that it is important to think about these collaborations at scale through partnership as well. In terms of PQARs, it was confirmed that the partnerships would welcome the methodology.

Resolved:
The Board:

- Noted the content of the report.
- Agreed to receive a quarterly update of this assurance report.
- Noted the Partnership Quality Assurance Round framework and agreed to receive assurance updates from partnerships as they are deployed.

22/23/84 EDI Steering Group Terms of Reference

The Board received the final version of the draft Terms of Reference (ToR) for the Equality Diversity and Inclusion Steering Group (EDISG). The ToR have been shared with various groups for consultation purposes and feedback has been received from the People and Wellbeing Group (PAWC) about the size of the membership, therefore this will be reviewed via a membership versus attendance lens. Recruitment is ongoing to replace the previous Head of Equality, Diversity and Inclusion (EDI), Ayo Barley, who recently left the organisation. The Board was advised that progress has stalled due to gaps in service, but it was confirmed that the inaugural meeting of the EDISG will take place on the 21.7.22.

Garth Dallas voiced his disappointment about progress being delayed but assured the Board that it is a temporary situation. It was confirmed that a reference has been made in the ToR from a strategic perspective in terms of dovetailing the Trust's Partnership Strategy. Garth Dallas advised of the proactive work that he has been conducting and the strategic links that he has made in order to learn from others and share good practice; NHSEI EDR Strategic Group and the Equality and Diversity Lead at LWH.

The Board was informed that the Walton Centre has decided to exit the partnership that was established to share EDI resources. It was confirmed that the partnership will continue and will include the Trust and Clatterbridge going forward.

Fiona Marston requested that the ToR be approved subject to providing Garth Dallas with Committee feedback following June's PAWC meeting.

Resolved:
The Board received and approved the ToR subject to feedback being provided to Garth Dallas following June's PAWC meeting.

22/23/85 Board Assurance Framework (BAF)

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

- *BAF Risk 1.4* (*Access to Children & Young People's Mental Health)* - It was confirmed that a strategic risk relating to mental health and investment levels has been included in May's BAF and includes all relevant details.
- *BAF Risk 1.3 (failure to address building deficits with Project Co) and 3.1 (failure to fully realise the Trust's Vision for the Park)* - It was pointed out that there are some adjustments in controls and assurance required to ensure the detail reflects the current position of both risks.
- *BAF risk 4.2 (Digital Strategic Development and Delivery)* – The Alder Care Programme has been identified as one of the top six risks at RABD due to the challenges being experienced. It was confirmed that the current proposed go live date of October is not possible therefore a review is underway at the present time which will provide an indication of a proposed revised time scale.

  The Board was informed that when the Trust set out on this programme it was advised that it was an EPR upgrade and therefore was resourced and approached in that way but as the organisation moved forward on this basis it became apparent that it was not an upgrade but actually a first of its type implementation in the UK. It was confirmed that the Trust has made a number of internal changes since early June which are now in place, and a team from Meditech are coming to the UK this week to participate in a joint Exec to Exec meeting to discuss this matter further.

  The Trust has made the ICS, regional and national colleagues aware of the issues that are being experienced with the programme and will share any critical learning in due course. From an internal perspective there is a lot of key learning underway as a result of the review, including a deep dive into benefits with clinicians and business change colleagues.

- *BAF Risk 3.6 (Risk of partnership failures due to robustness of partnership governance)* – A deep dive into this area of work took place during June's Risk Management Forum in order to raise awareness at operational level.

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

22/23/86 Monthly Financial Update for M2, 2022/23.

The Trust reported an in month deficit of £0.5m against a plan of £274k, with an adverse variance of £265k in month. YTD deficit position is £1.3m against an adverse plan of £745k. Cash in the bank is £85.3m and Capital Spend YTD is slightly under £1m.

Attention was drawn to key drivers for the M2 position:

- Divisional position
  - Medicine £1m adverse YTD (*Junior doctors, non-pay including drugs*).
  - Surgery £1m adverse YTD (*WLI claims, non-pay, CIP*).
- *Key risk* - Anticipated £0.2m risk on the ERF not met 104% threshold overall.
- *Key risk* - CIP target achieved in Month 2 however YTD target not met (£0.6m).

2022/23 Plan

- *Cost Improvement Programme (CIP)* - The Trust is forecasting £11m against a £17m target which leaves a gap of £6m that is yet to be identified. This was an improvement of £1.5m from M1.
- *Actions Underway*;
  - 8 sprint areas with a weekly focus. It was reported that £1.5m of the £4m target has been identified following initial work.
  - The Trust is in discussion with MIAA around some additional resources and expertise on CIP.
  - Alder Hey is looking to bring in some shared learning from C&M to help bolster the CIP programme.

2022/23 Plan Latest Position

- Alder Hey has submitted a control total surplus of £4.6m. This was driven by an additional 0.7% tariff inflation and agreed brokerage with the ICS, that will be returned to the Trust in 2023/24, which contributed to the ICS hitting a £30m deficit. It was pointed out that all of the specialist trusts achieved a surplus position, with LWH achieving a breakeven position.

Shalni Arora queried as to why the money doesn't meet the threshold and yet the recovery target is above the 104% threshold. It was reported that that an 85% follow-up target has been set. If this is not achieved the Trust is penalised financially and therefore it becomes harder to achieve 104% activity funding. It was confirmed that work is taking place to try and reduce follow-ups to ensure that the Trust isn't penalised in the way that it is presently. A discussion took place around driving costs out and it was felt that there is a fundamental flaw in the system which needs to be highlighted collectively. It was pointed out that over performance on follow-ups is inappropriate in comparison to expectation and the finance model.

Attention was drawn to the focus on the Divisional position for Medicine and Surgery and the work that is taking place to address the adverse figures. It was felt that some of the real delivery of this work needs to come via the organisation's transformation work in terms of the sprints that are underway; it was also proposed to re-instate the reporting process for the Transformation Programme via the organisation's Assurance Committees and Board. It was agreed to commence this reporting process from September 2022 on a quarterly basis.

22/23/86.1 Action: JG/NP

Resolved:
The Board noted the operational update which included a financial update for M2, 2022/23

22/23/87 Board Assurance Committees

Audit and Risk Committee – The approved minutes from the meeting held on the 21.4.22 were submitted to the Board for information and assurance purposes.

RABD – The approved minutes from the meeting held on the 23.5.22 were submitted to the Board for information and assurance purposes.

SQAC – The approved minutes from the meeting held on the 18.5.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 22.6.22 there was a focus on the Ockenden Review Trust-wide Action Plan, sepsis, the updating of out of date information leaflets and the improvement of response times to complaints and concerns.

Louise Shepherd referred to the Trust's role in the System in terms of supporting other trusts with presentations of children with sepsis and queried the shared learning/support across C&M. It was agreed to look into this matter outside of the meeting.

22/23/87.1 Action: NA/ABASS

PAWC – The approved minutes from the meeting held on the 23.5.22 were submitted to the Board for information and assurance purposes. An overview was provided on some of the items that were discussed during the meeting that took place on the 29.6.22; staff story, financial wellbeing, the Apprenticeship Plan, sickness absence due to Covid, and PDR compliance.

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

22/23/88 Any Other Business

On behalf of the Board, the Chair thanked Anita Marsland for her hard work, contribution and leadership as the Senior Independent Director on Freedom to Speak Up during her time with the Trust as a Non-Executive Director and wished her all the best for the future.

22/23/89 Review of the Meeting

The Chair felt that the discussions that had taken place during the meeting were relative and important and thanked everyone for the work that has been conducted to produce the reports for June's Board.

Date and Time of Next Meeting: Thursday the 28th of July 2022 at 12:30pm via Teams.

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for July 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.	A. Hughes	28.7.22	July-22	
20.6.22	22/23/62.1	Board Self-Certification of Compliance with the Provider Licence	Confirm the timeline for the removal of the Major Trauma service derogation and advise as to whether this matter should be monitored via SQAC.	E. Saunders	28.7.22	On track July-22	
30.6.22	22/23/82.1	Corporate Report	*Medicine* - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance.	U. Das	28.7.22	On track July-22	
Actions for September 2022							
28.4.22	22/23/15.1	IPC Update	*PCR Testing for Patients Ahead of Surgery* - Look towards progressing a model, if possible, based on local testing for patients and share this information via the network.	B. Larru	29.9.22	Sep-22	
30.6.22	22/23/82.2	Corporate Report	Have a deeper look into referral trends across the Mental Health service to identify the source/drivers behind the surge in referrals.	L. Cooper/ J. Grinnell	29.9.22	On track Sep-22	
30.6.22	22/23/86.1	Monthly Financial Update for M2, 2022/23.	Re-instate the reporting process for the Transformation Programme via the organisation’s Assurance Committees and Board	J. Grinnell/ N. Palin	29.9.22	On track Sep-22	
30.6.22	22/23/87.1	Board Assurance Committees.	*SQAC* - Look into the shared learning and support that is available across C&M, for example, Alder Hey has been supporting other trusts in the system with presentations of children with sepsis.	N. Askew/ A. Bass	29.9.22	On track Sep-22	
Actions for October 2022							
16.12.21	21/22/214.1	Chair's/CEO's Update	Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.	K. McKeown	28.7.22	Oct-22	**22.7.22** - Dr. Fulya Mehta has agreed to attend October's Trust Board meeting to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.

Status	
Overdue	(red)
On Track	(green)
Closed	(blue)

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
26.5.22	22/23/46.1	EDI Steering Group Update	Discuss the possibility of connecting the EDI Steering Group agenda with the health inequalities and prevention work that is taking place.	D. Jones/ G. Dallas	30.6.22	Closed	**30.6.22** - Reference has been made in the EDISG ToR from a strategic perspective in terms of dovetailing the Trust's Partnership Strategy. **ACTION CLOSED**
30.6.22	22/23/77.1	ICS Development Update	Write to the members of the Digital team who developed and progressed the Share to Care Programme, to formally thank them for the work that they conducted to embed the programme and to wish them well in their transition to the ICS.	Dame Jo Williams	28.7.22	Closed	**27.7.22** - This action has been completed. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	**Integrated Performance Report Proposal**
Report Of:	John Grinnell, Deputy CEO
Paper Prepared by:	Andy McColl, ACOO Kate Warriner, Chief Digital and Information Officer

Purpose of Paper:	Decision X Assurance Information Regulation
Background Papers and/or supporting information:	None
Action/Decision Required:	To note To approve **X**
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **X** **The best people** doing their best work **X** Sustainability through **external partnerships** **X** Game-changing **research and innovation** **X** **Strong Foundations** **X**
Resource Impact:	N/A

Integrated Performance Report Proposal

1. Purpose of Report

The purpose of this report is to outline a proposal and progress with the development of a revised approach to the Trust Integrated Performance Report. The report outlines progress to date with early changes in place and future development plans.

2. Background

Being data driven, with clear visual management of performance across all domains is essential to delivering all strategic objectives in the Trust annual plan and providing assurance to the Trust Board. This is an ambition as part of the Brilliant Basics programme aligned to the Leading for Improvement and Delivering Improvement workstreams.

It is proposed that the Corporate Report is replaced with an Integrated Performance Report. This will align to the Brilliant Basics standards implemented across the Trust and meet the best practice recommendations from the NHS E/I 'Making Data Count' standards.

Some initial changes have been made to the Corporate Report from May 2022, aligning reporting to Trust priorities in the Annual Plan, and refining format. A further phase of developments are proposed as identified in this report.

3. Vision and Goal

The vision is for the Board of Directors to receive an Integrated Performance Report on a monthly basis, with NHSE/I 'Making Data Count' principles applied in line with best practice. This will enable:

- A focus on agreed priorities linked to the Operational Plan
- Clearer reporting of performance trends to more easily identify areas of concern
- Stronger emphasis on an improvement trajectory and actions
- A wider look at a Strategic Scorecard in the future

The report should be comprehensive and not require duplication with separate reporting of performance in key areas.

4. Current Position

The current corporate report was last reviewed prior to Covid therefore this review and development is timely. The proposed new arrangements will also support reduced duplication in reporting and a more streamlined process with the Board and Sub Committees.

Due to the lack of clarity on some key metrics, there is often a reactive rather than pro-active culture responding to multiple performance issues which hinders the Brilliant Basics approach of focussing on fewer priorities to optimise improvement.

An observational analysis indicates:

- Current Corporate Report can be up to 60 pages long, and does not differentiate relative importance of metrics (eg statutory, national guidance, local targets etc)
- Run rate graphs typically have 12 data points which is insufficient for proper Statistical Process Chart (SPC) trend analysis
- RAG ratings do not give clear indication of trend and deterioration
- Metrics and performance of corporate services are omitted from current report
- Executive Directors produce additional reports which duplicate metrics and narrative in the Corporate Report

5. Integrated Performance Report Proposal

It is proposed that the new Integrated Performance Report will include distinct sections, each with a clear purpose and perspective on Trust performance as follows:

Executive Summary – succinct narrative on key issues

Part 1 – Priorities from Annual Plan: Executive lead for each priority area will identify a "Drive metric" and small number of "Watch metrics". Each metric will all be reported in graphical format using SPC chart if statistically appropriate, with technical analysis and description of actions

Part 2 – Performance against CQC Domains at Trust wide level: Each domain will include space for overarching commentary and actions, with a succinct table summarising performance of metrics, using icons to demonstrate trends of improvement/deterioration and comparison of performance against targets

Part 3 – Divisional and Departmental Performance: Each Clinical Division will produce 1 page of summary narrative and actions, supported by 1 page of metrics consistent in format to CQC metrics in Part 2. Future development will also incorporate narrative, actions and KPIs from the newly established Corporate Services Collaborative.

Part 4 – Potential for future development Impact Reports, eg may include reporting on other strategic initiatives (eg Green Plan, Clinical Outcomes, addressing Health Inequalities, etc) and the development of a Strategic Scorecard

In addition to changing content and format, this provides opportunity to improve process for producing the report on a monthly basis. Key steps include:

- Data used to populate metrics
- Technical analysis undertaken to highlight statistical changes in performance
- Executive led completion of narratives, with focus on improvement actions

- Collective review of full report at Executive team meeting
- Use of report at Sub Committees
- Circulation of final report to Trust Board members

6. Timeline

Whilst some changes in the current Corporate Report have commenced since April including the introduction of Drive and Watch metrics for agreed priorities, the timeline and milestones below are proposed for formal implementation of this proposal.

Date	Milestones
July	• Agreement from Board of Directors to introduce new Integrated Performance Report • Information Team to commence report design and proper use of dynamic SPC charts, and collecting data from April 21 for sufficient trend analysis
August	• Executives to meet individually with operational leads to formally review and agree metrics for Part 1 and Part 2 of the report • Engagement with Divisional teams to shape content of Part 3 (completing work commenced by KPMG through Brilliant Basics)
September	• Prototype report presented to Executive team for review, feedback and sign off
October	• Full report, with Parts 1-3 to be produced for Trust Board meeting in October (incorporating performance up to and including September). This will include Board sign off of metrics
Q4 22/23	• Commence formal review of reporting in line with development of 2023/24 annual plan and agreed priorities. This will also take into consideration the refreshed Trust Strategic Objectives • Development of Part 4 of the Integrated Report, for inclusion from 23/24 onwards

7. Risks

Dedicated analytics and data resource and capacity to deliver all planned improvements. This will be mitigated by reducing additional and ad hoc requests to the analytics and data team and other key stakeholders.

Changing priorities and metrics during development, with impact that deadlines are not met due to re-work. This will be mitigated by full executive engagement to review and formally sign off metrics for Annual Plan priorities (Drive and Watch) as well as metrics for reporting against the CQC Domains.

8. Governance Arrangements

The Integrated Performance Report covers all areas of performance and domains across the Trust, so all Executive Directors have an interest and ownership in the governance of this report.

It is proposed that the process and leadership arrangements are established with Executive Leads, the Chief Digital & Information Officer and Deputy CEO .

The leadership arrangements will ensure the Integrated Performance Report is produced monthly in line with the timeframes and standards agreed by the Board of Directors.

A pro-active review of the report should take place every six months (as part of annual planning, and end of Q2). Ideally any changes to the report will be limited to these time windows to maximise consistency of reporting to the Board of Directors and support planned allocation of resources. It is recognised that 'urgent' changes may occasionally be required if performance in a key area deteriorates rapidly, but this is considered to be an exception to normal governance process.

It is proposed that there will be a gateway process to make changes to the report, to ensure clear authorisation and documentation for audit trail:

1. Proposal by an Executive Director at Exec team meeting
2. Ratification of changes agreed by Board of Directors
3. CDIO to ensure implementation of agreed changes

9. Summary and Recommendation

In summary, the changes to the Corporate Report to an Integrated Performance report provides a number of benefits to align to our Brilliant Basics work and gives us an opportunity to present our performance in a clear and visual way aligned to key NHSE/I Making Data Count standards.

It is recommended that a new Integrated Performance Report is developed, with appropriate analytics and operational resource allocated to deliver this improvement in line with the timescales outlined in this report.

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	**Q1 22/23 Operational Plan Update**
Report of:	Chief Operating Officer
Paper Prepared by:	Andy McColl, ACOO Nathan Askew, Chief Nurse Melissa Swindell, Chief People Officer Rachel Lea, Deputy Director of Finance Kate Warriner, Chief Digital and Information Officer

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

Q1 22/23 Operational Plan Update

1. Purpose of Report

The purpose of this report is to provide an Executive Lead update to the Board of Directors on Q1 progress with the priorities as set out within the Operational Plan 22/23.

The report is a high level overview of the improvement journey we have commenced in each of these areas during Quarter 1, describing progress and achievements to date along with current areas of concern and a look ahead to actions planned in Quarter 2.

2. 22/23 Operational Plan

The 2022/23 Annual Plan identified 5 priorities which align to the Trust strategy and to the national guidance and ICB objectives. Within the priority areas, a set of driver and watch metrics and a delivery workstreams / programmes were identified. These are highlighted in the diagram below.

3. Workstream Executive Reports

3.1 Recovery

Priority	**Recovery**
Driver Metric	**>104% Activity** (above 19/20 Baseline)
SRO	**Adam Bateman, Chief Operating Officer**
Q1 Progress	• Above 104% recovery standard for volume of inpatient activity every month with peak of 115% in June; driven by Day Case activity. • Strong progress reducing longest waits during Q1, eliminating waits >104wks, and providing mutual aid to other Trusts (eg RMCH). • Recruitment of 7 Consultant Anaesthetists, and appointment to Clinical Director for Theatres – which will drive recovery and enable additional theatre capacity (increase to 141 sessions per week). • Defined scope and secured engagement for Transformation across Theatres, Outpatients and ED; emphasis on psychological safety as key foundation for transformational change. • Consistent compliance with national Cancer Standards.
Areas of Concern	• ED performance against 4 hours is improving but remains below national standards. 'ED at its Best focuses on areas such as triage, communication with patients and staff, pathways and processes and importantly training and role redesign and development. • ASD has only 51% of incomplete pathways <30wks and high level of referrals. Recruitment to additional posts ongoing (6 new staff to start by Sept). Launch of new ASD/ADHD referral platform to improve process and Brilliant Basics improvement project underway. • Paediatric Dentistry represents c.70% of Trust total long waits (>52wks) with fully developed action and improvement plan. • Achieving the Outpatient Follow Up reduction target is challenging due to volume of overdue follow up appointments and increase in commissioned activity in Community and Mental Health services. Surgical specialities <25% Virtual due to standardised post-op pathways, to provide assurance virtual appointments are optimised.
Look Ahead to Q2	• Driving ERF delivery by increasing activity recovery target to 110% for selected "high value" specialties. • Clear milestones set for reducing long waits: OP<46wks, IP<60wks. • Diagnostic wait times to improve further, with increased capacity in Sleep Studies (+100%) and Urodynamics (+75%) planned from September 2022.

	• Comprehensive analysis on growth in referrals and impact on total waiting list size; with actions to be developed at specialty level in response to associated capacity and demand pressures. • Complete Programme Brief for Virtual Ward, with work in place to support service delivery through winter. • Re-introduce the "Safe Waiting List Management" group, with clinically led assurance on safety for CYP awaiting their care.

3.2 Outstanding Safety

Priority	**Outstanding Safety**
Driver Metric	**25% Reduction in Harms** (compared to 21/22, minor harm and above)
SRO	**Nathan Askew, Chief Nursing Officer**
Q1 Progress	• There has been a sustained improvement in mandatory training requirements over Q1. • There continues to be a low number of cardiac arrests and a significant reduction in the unplanned admission to critical care – demonstrating the impact of early detection and stabilisation of the deteriorating patient. • The patient safety strategy board is now formed, with all safety workstreams coming together to drive forward improvements.
Areas of Concern	• Compliance with the sepsis target in ED remains a significant challenge. The sepsis steering group will be developing an improvement plan to address this • Pressure ulcers continue to be made of grade 2 ulcers relating mostly to medical devices. The TVN team have a targeted action plan to further reduce the number of grade 2 ulcers.
Look Ahead to Q2 (with actions)	• Further development of the patient safety board • A robust action plan to address the challenges with meeting sepsis performance to be developed.

3.3 Great Place to Work

Priority	**Great Place to Work**
Driver Metric	**>80% Recommend as a place to work**
SRO	**Melissa Swindell, Chief People Officer**
Q1 Progress	• Establishment control project underway and progressing at pace • Great Space to work programme progressing; support from OD in place to focus on staff welfare elements of project • 'Time to Hire' metrics now <30 day target • Financial wellbeing support for staff implemented • Induction review project underway

Areas of Concern	• Lack of progress with the Attraction & Retention project due to resourcing issues – currently under review • Sickness and retention rates increasing across the organisation; requires a more thorough review • Poor take up of the Pulse Check
Look Ahead to Q2 (with actions)	• Further develop the Attraction and Retention project scope • Development of Wellbeing Steering group priorities and actions • Promotion and communication about the Pulse Check to improve completion rates • Review of approach to sickness absence management and retention

3.4 Financial Sustainability

Priority	**Financial Sustainability**
Driver Metric	**Achievement of 22/23 Control Total**
SRO	**Rachel Lea, Deputy Director of Finance**
Q1 Progress	• Reported Q1 position in line with the plan control total • Confirmation of the 22/23 capital spending limits which allow continuation of the campus and other capital projects in year. • Launch of new financial dashboards and financial statements to budget holders. • Positive feedback on national bids for capital funding for both Elective Hub and Eating Disorder Day Case
Areas of Concern	• Q1 forecast for year showing significant challenge in achievement of control total with number adverse variances • Cost Improvement Programme remains a challenge with £4m (30%) with no identified opportunity or plans in progress • Continuing impact of excessive inflationary rises across non pay expenditure in particular energy, drugs and clinical supplies. • Increasing temporary workforce spend in areas predominately Junior Doctors and WLI.
Look Ahead to Q2 (with actions)	• Financial awareness programme to be launched Q2 across organisation. • Acceleration of CIP sprints by SRO with accountability through strategic executive meeting. • Increased scrutiny on drivers of the divisional variances through divisional finance reviews. • Implement financial governance and controls framework. • Agree financial measures of success for each division/department

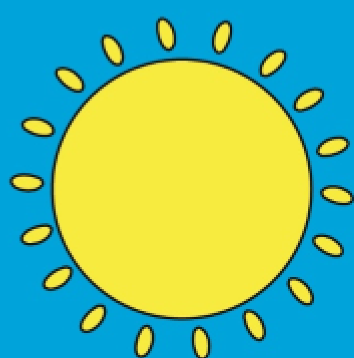
3.5 Safe Digital Systems

Priority	Safe Digital Systems
Driver Metric	**100% Safety Compliance**
SRO	**Kate Warriner, Chief Information Officer**
Q1 Progress	• Good progress throughout Q1 with Digital and Data Futures strategy developed and supported by Board of Directors. The refreshed strategy sets a clear vision for improving experience and outcomes and puts greater emphasis on data and analytics, safe digital systems for staff, new models of care and service excellence • Progress continues with digitally connecting with CYP and families with the deployment of digital letters and progress with new website and intranet project • Good progress with implementation of several system improvements to support safety and transformation including the Islacare platform
Areas of Concern	• The Aldercare programme has been delayed due to a number of component parts including functionality gaps, system build and the programme encountering issues due to being a UK first of type • A programme review is underway to establish the gaps and requirements for a new go live date which is likely to be in 2023 • A reset of the vision, ambition and benefits realisation is underway with Meditech and clinical teams. The vision of creating an amazing system that is 'safe, fast and easy' to use is in developing
Look Ahead to Q2 (with actions)	• Close down of Digital Futures and initiation of Digital and Data Futures programmes of work • Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint • Mapping workshop in place to scope out New Models of Care programmes and projects

4. Summary

In summary, there has been good progress with the delivery of the Operational Plan priorities within Q1. There are some areas of concern as highlighted within this report and key actions to further progress delivery during Q2.

The Board of Directors is asked to note the contents of this report.



Integrated Performance Report June 2022

BRILLIANT BASICS

GROW THE FUTURE

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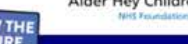
How Did We Do?

Executive Summary Month: June Year: 2022



Delivery of Outstanding Care

Safe

- There continues to be a good reporting culture of no harm and near miss incidents in the organisation.
- There has been a reduction in medication safety incidents in month and work continues within high reporting units with bespoke programmes of medication incident reduction
- There continues to be no grade 3 or 4 pressure ulcers in the organisation and targeted work to reduce grade 2 device related pressure ulcers.
- Sepsis compliance in ED has dipped slightly, the sepsis nurse is now in post and will be reviewing the in patient data as well as continuing to support the ED staff in achieving compliance.
- IPC metrics continue to be in line with targets.

Highlight

- Continued reduction in unplanned admission to critical care
- Improvements in reducing the number of out of hours critical care step downs
- Improved responsiveness in pals and complaints

Challenges

- Sepsis compliance with the 60 minute standard
- Continued focus on reducing medication errors

The Best People Doing their Best Work

Caring

- Sepsis compliance with the 60 minute standard
- Continued focus on reducing medication errors

Highlight

- Improvements in responsiveness to families who riase a pals or complaint

Challenges

- ED FFT performance

Effective

Our ED department continues to see high volume of attendances, in excess of 2019 baseline. Performance against the 4 hour standard rose to 77.9% in June, with 3 consecutive months of upward trend (although technically within parameters of standard variation.

ED continue to achieve <15minutes median triage time, but waiting for clinician is 101 minutes (>60 min standard). There remains a small number of patients spending >12 hours in the department.

ED Programme Board established led by Deputy CEO provide executive oversight of the overarching trust wide improvement workstreams including the scoping of additional physical capacity in advance of the Neonatal building coming on line in 2024.

Highlight

- Clinical Triage in ED remains under 15minutes

Challenges

- Overall waiting times in ED, and patients waiting >12 hours in the ED department

Delivery of Outstanding Care

Responsive

At the end of June, 331 patients were on a RTT pathway >52weeks, which is an increase compared to the previous month. Of these 230 (69%) are paediatric dentistry and a specific action plan is being monitored by COO. There are no patients >104ww, and only 12 patients >78ww which benchmarks well against our peers.

To achieve our goal of zero patients >52wks by March 2023, we are working towards milestones for end of Q2:

- OP maximum wait of 46 weeks
- IP maximum wait of 60 weeks.

Specialties will model their waiting list demand and capacity required to achieve these milestones.

Highlight

- High level of recovery volume in Elective and Day Case
- 100% compliance with Cancer standards

Challenges

- Number of patients waiting >52weeks, particularly in Dentistry
- Volume of Out patient Follow Up appointments exceeding the 85% national standard, with factors including patients overdue for follow-up care and increase in commissioned activity (above 2019 levels) in Community and Mental Health services.

There has been some improvement in Diagnostic waiting times, but we remain offtrack following the validation work completed. The actions in the three challenged modalities are: • MRI: extended working days and regular Saturdays have increased capacity, leading to significant improvement with 96% now within 6 week standard. • Sleep Studies: Implement home based sleep studies which will double volume of activity each week (subject to clinical suitability). • Urodynamics: agreed extra session every week to commence from 7 Sept, growing capacity by 75%.	

The Best People Doing their Best Work

Well Led

Finance

For the month of June (Month 3), the Trust is reporting a surplus of £0.5m which is £0.7m ahead of plan.
For the year to date position Q1, the Trust is reporting a deficit of £0.7m which is in line with the planned position at this stage of the year as we expect CIP schemes to be further progressed after Q1.
The main drivers for the YTD position includes CIP non-delivery and continued pay and non-pay cost pressures including Junior Doctor pressures, clinical supplies, offset in part with slippage in investments.
Internally, the Trust would not be achieving Elective Recovery Funding threshold due to EL value of activity compared to 19/20 (not count of activity) and Outpatient Follow Up reduction targets not being met. However, the instruction from NHSEI on ERF is to report to plan until the national position is known.
Cash in the bank at the end of June was £81.1m.
The overall capital expenditure for the year to date is £1.3m which is largely in line with plan.
The external audit for 2021/22 is now successfully complete.

Highlight

Challenges

- Significant challenge with regards to the CIP requirement in year which is £17m in total
- Significant challenge to achieve the £4.6m control total surplus plan by the end of the financial year
- Achievement of ERF threshold

Sickness Levels of sickness absence are currently back on an upward trajectory, with particular reference to COVID related absence. This is being closely monitored by the HR team and IPC. Strategies to support people to return to work or remain in work, are in place and kept under close scrutiny and review. Absence training for staff has launched across the trust and additional sessions are being facilitated due to the level of interest. **Staff Turnover** Turnover across the trust remains in excess of the 10% KPI target. This is reported to divisional management teams on a regular basis to allow deep dives into key areas. The approach undertaken to ascertain why people are leaving the trust is being strengthened to aid information gathering and help identify next steps.	

Research and Development

Academic:

- Awarded £1M by National Institute for Health and Care Research (NIHR) for a 4-year paediatric rheumatology trial **to compare effectiveness, safety and cost-effectiveness of intravenous versus oral corticosteroid induction regimens for children and young people with juvenile idiopathic arthritis.**

Commercial:

- **Alder Hey selected by global healthcare company Sanofi as site for HARMONIE trial,** a Phase IIIb randomized open label study aimed at preventing hospitalisations due to respiratory syncytial virus in infants.

Research Activity:

- 188 research studies currently open
- 565 patients recruited to research studies (2426 in 22/23)

Research Assurance:

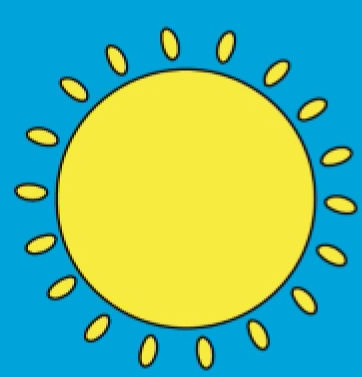
- GCP training compliance – 94%
- Research SOP compliance – 88%

Highlight

- Highest recruiter of patients to STOP RSV trial.

Challenges

- Post-pandemic recovery of clinical research capacity.



Part 1 - Executive Scorecard

BRILLIANT BASICS

GROW THE FUTURE

Dashboard refreshed 20 Jul 2022 11:14 (although individual metrics may be older)

Home > Detailed Scorecard

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

Metric — Recovery

104% Activity - Elective and Daycase

Jun 2022: 115% | Trend: ▲ | Target: >=104 %

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

99%, 93%, 95%, 106%, 104%, 109%, 102%, 94%, 98%, 104%, 110%, 115%

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
Actual performance of 115% represents forth month of consecutive increase, and third month above 104% target. This is positive trend, although technically remains within standard parameters. This is driven by additional DC activity.

Priority Actions
Utilise new model to monitor corelation between activity recovery and ERF value. This includes identification of 9 "high value" specialties required to achieve 110% recovery to drive ERF delivery. Ensure all specialties are clear on their weekly activity target (volume) to drive delivery. Implementation of actions from Theatre Improvement Board will improve productivity and support recovery.

Average Patients per Working Day (DC Spells)

Jun 2022: 99.4 | Trend: ▲ | Target: >=92

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

82.4, 78.8, 84.8, 90.7, 95.9, 93.2, 93.5, 86.9, 89.4, 96.0, 94.8, 99.4

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
June performance of 99.4 is highest figure in last 12 months, and exceeds target of 92. Three consecutive months above target. This is significant contribution to overall recovery of 115% in June.

Priority Actions
Theatre Improvement Board focus on maximising activity through Surgical Day Case, to exceed 40 surgical patients per day.

Average patients per working day (Elective Spells)

Jun 2022: 20.0 | Trend: ▼ | Target: >=22

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

19.5, 18.0, 17.4, 19.7, 18.5, 18.0, 17.5, 18.7, 19.4, 19.7, 21.7, 20.0

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
Four points above the average is positive and the last 3 months have been the highest 3 points in the last year. However, performance is still below the target of 22 Elective patients per working day.

Priority Actions
Additional theatre lists per week will support increased volume. Drive selected "high value" specialties to achieve 110% recovery, with additional elective activity (primarily in surgery).

Theatre Sessions per week

Jun 2022: 139 | Trend: ▲ | Target: >=139

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

134, 133, 139

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
Target of 139 sessions per week achieved in June

Priority Actions
Implement increase to 141 theatre sessions per week, to maximise activity recovery in line with additional Anaesthetic recovery.

Number of Patients > 52 ww

Jun 2022: 331 | Trend: ▲ | Target: 0

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

187, 195, 263, 318, 250, 218, 237, 246, 249, 290, 282, 331

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
Number of patients waiting >52wks rose to 331 in June which is the highest point in the last 12 months. Whilst within the standard range this is a concern.

Priority Actions
Dental represents 69% of total 52 week breaches and has a specific action plan which is reviewed weekly by COO. All other specialties are working towards milestones for end of Q2: OP maximum wait of 46 weeks, IP maximum wait of 60 weeks. Specialities will model their waiting list demand and capacity required to achieve these milestones.

Outpatient New + Outpatient Procedure 104%

Jun 2022: 102% | Trend: ▼ | Target: >=104 %

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

92%, 96%, 99%, 95%, 102%, 102%, 88%, 88%, 84%, 91%, 106%, 102%

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
June performance of 102% is less than 104% target, but is consistent with trend and demonstrates natural variation

Priority Actions
Summary relates to all OPD metrics: WNB AI: Pilot of 3 specialities completed at end of June 5 new specialities identified to go on next, working on roll out plan. Meetings beginning to be scheduled with respective areas. Roll out of letters via text link Sub workstreams to start for joint clinics and redesign of diagnostic pathway

Outpatient Follow Up 85%

Jun 2022: 112% | Trend: ▼ | Target: <=85 %

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

112%, 112%, 109%, 106%, 119%, 125%, 108%, 104%, 110%, 110%, 119%, 112%

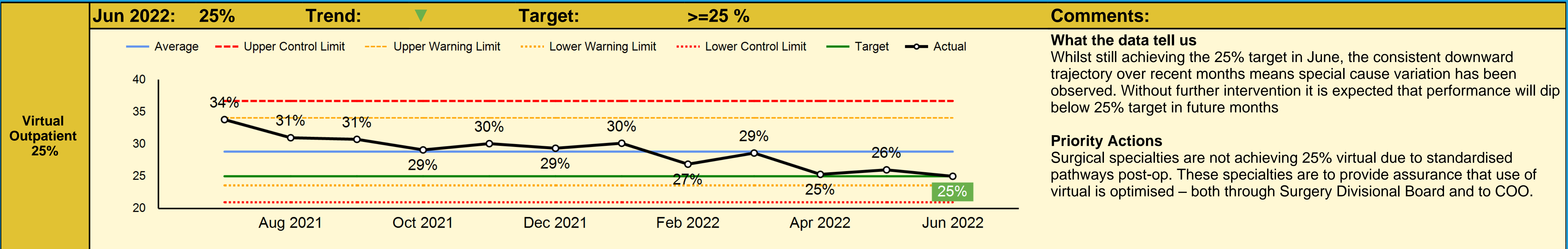
Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
June performance of 112% is less than previous month, but remains significantly in excess of 85% target and is consistent with trend and demonstrates natural variation

Priority Actions
PIFU: Added 4 new specialities (total of 7 now), plan to add 4 specialities each month. Next cohort for 1st week in Aug.

Virtual Outpatient 25%



Jun 2022: 25% | Trend: ▼ | Target: >=25 %

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

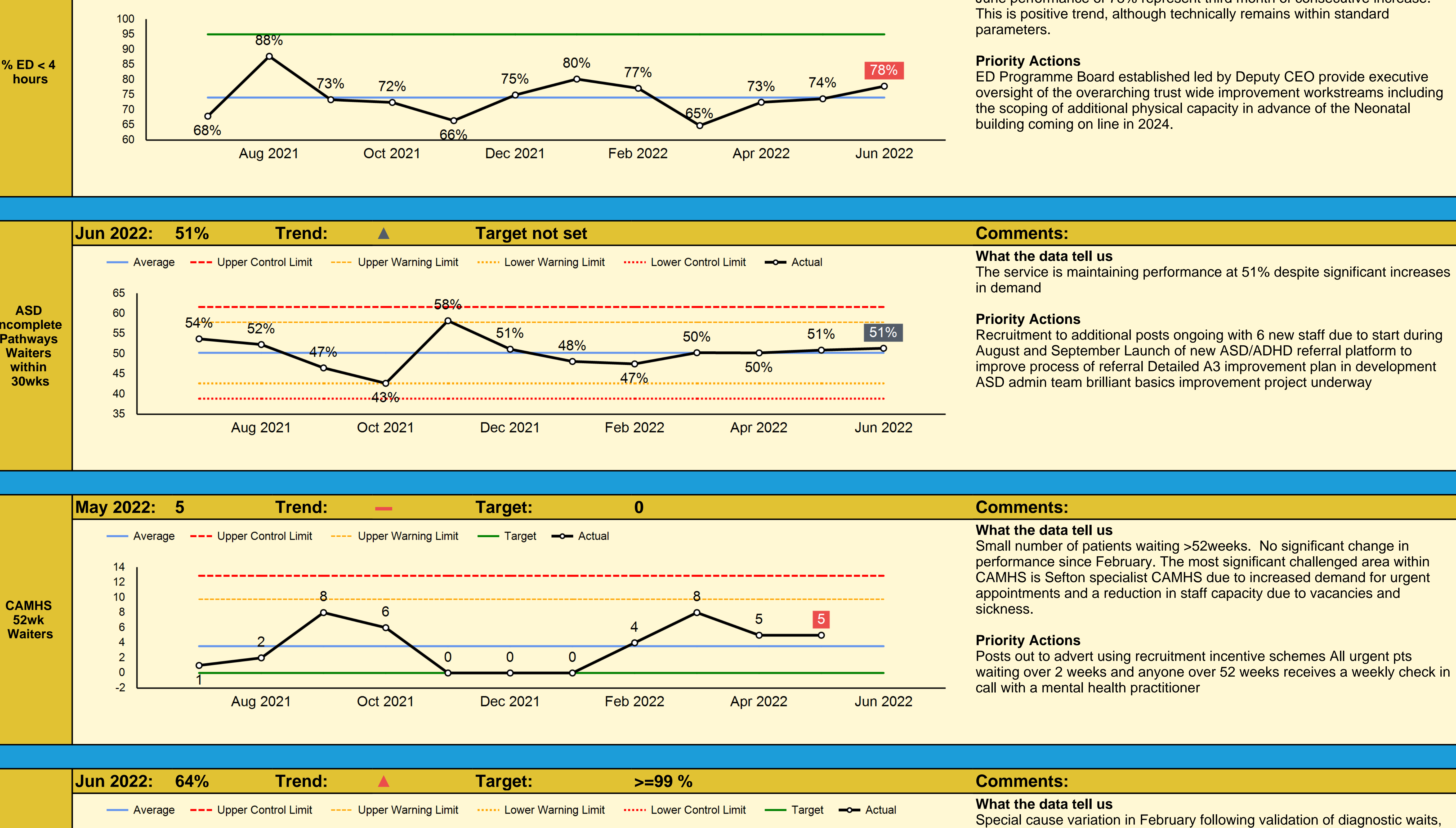
34%, 31%, 31%, 29%, 30%, 29%, 30%, 27%, 29%, 25%, 26%, 25%

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

What the data tell us
Whilst still achieving the 25% target in June, the consistent downward trajectory over recent months means special cause variation has been observed. Without further intervention it is expected that performance will dip below 25% target in future months

Priority Actions
Surgical specialties are not achieving 25% virtual due to standardised pathways post-op. These specialties are to provide assurance that use of virtual is optimised – both through Surgery Divisional Board and to COO.



Comments:

What the data tell us
June performance of 78% represent third month of consecutive increase. This is positive trend, although technically remains within standard parameters.

Priority Actions
ED Programme Board established led by Deputy CEO provide executive oversight of the overarching trust wide improvement workstreams including the scoping of additional physical capacity in advance of the Neonatal building coming on line in 2024.

Comments:

What the data tell us
The service is maintaining performance at 51% despite significant increases in demand

Priority Actions
Recruitment to additional posts ongoing with 6 new staff due to start during August and September Launch of new ASD/ADHD referral platform to improve process of referral Detailed A3 improvement plan in development ASD admin team brilliant basics improvement project underway

Comments:

What the data tell us
Small number of patients waiting >52weeks. No significant change in performance since February. The most significant challenged area within CAMHS is Sefton specialist CAMHS due to increased demand for urgent appointments and a reduction in staff capacity due to vacancies and sickness.

Priority Actions
Posts out to advert using recruitment incentive schemes All urgent pts waiting over 2 weeks and anyone over 52 weeks receives a weekly check in call with a mental health practitioner

Diagnostic Wait Time Performance (DM01)

Jun 2022: 64% Trend: Target: >=99 %

Average Upper Control Limit Upper Warning Limit Lower Warning Limit Lower Control Limit Target Actual

96% 95% 97% 96% 88% 92% 88% 63% 57% 52% 59% 64%

Aug 2021 Oct 2021 Dec 2021 Feb 2022 Apr 2022 Jun 2022

Comments:

What the data tell us
Special cause variation in February following validation of diagnostic waits, as reported to Trust Board.

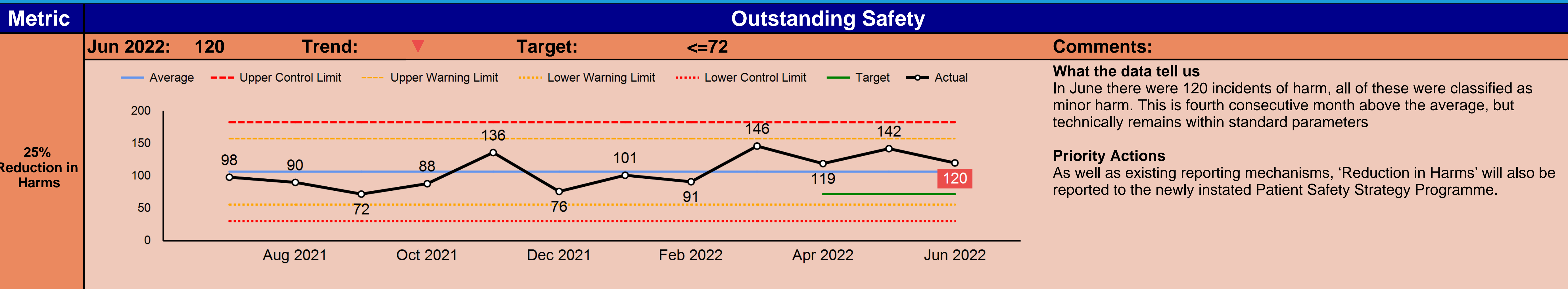
Priority Actions
MRI: extended working days and regular Saturdays have increased capacity, leading to significant improvement with 96% now within 6 week standard. Sleep Studies: Implement home based sleep studies which will double volume of activity each week (subject to clinical suitability). Urodynamics: agreed extra session every week to commence from 7 Sept, growing capacity by 75%.

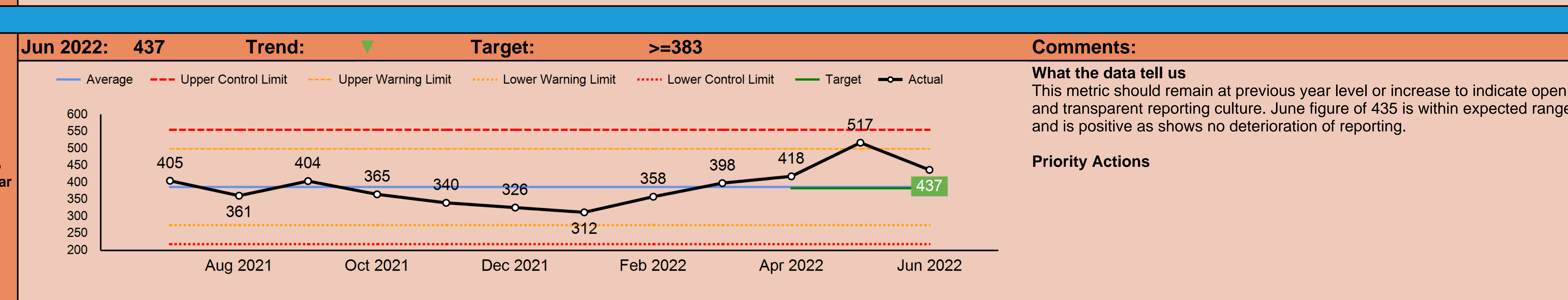
Dashboard refreshed 20 Jul 2022 11:14 (although individual metrics may be older)

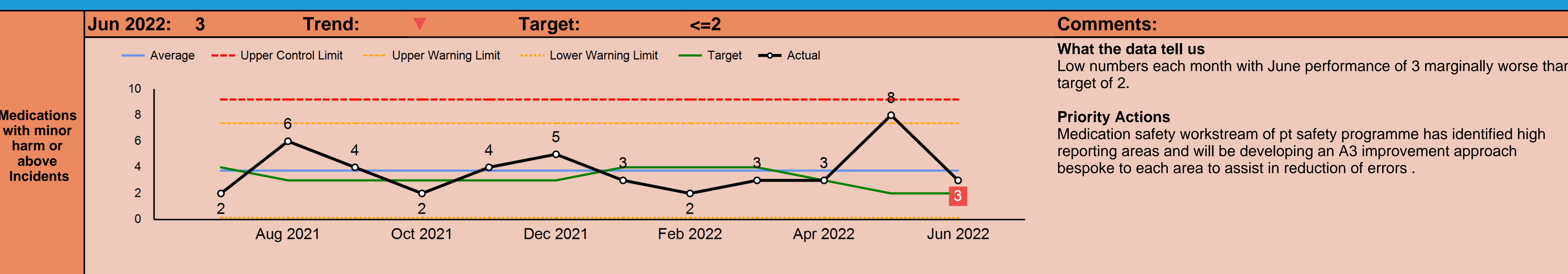
Home > Detailed Scorecard

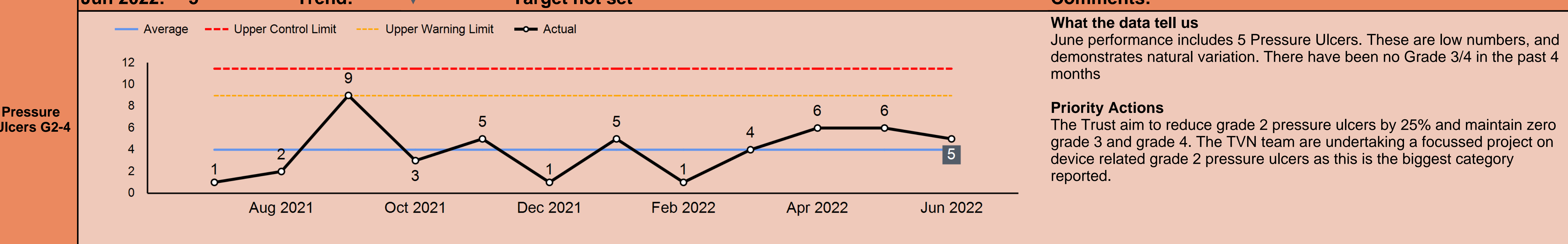
Please click on the word 'Home' to navigate back to the summary page

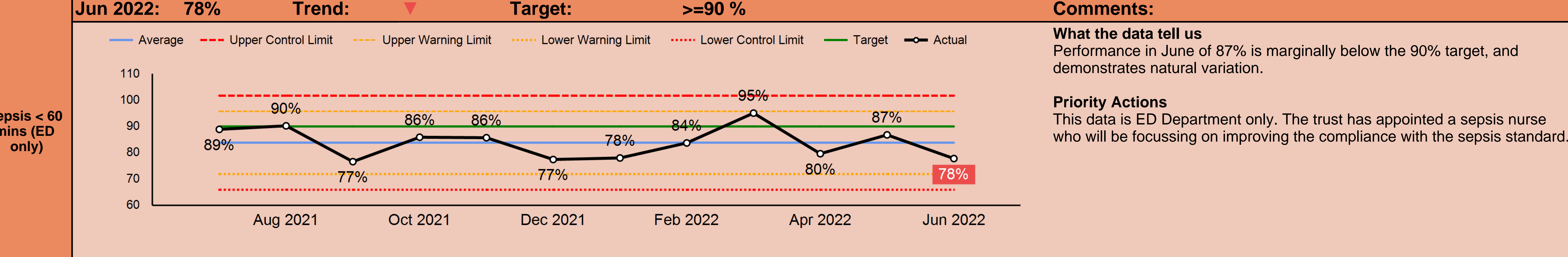
Metric | **Outstanding Safety**

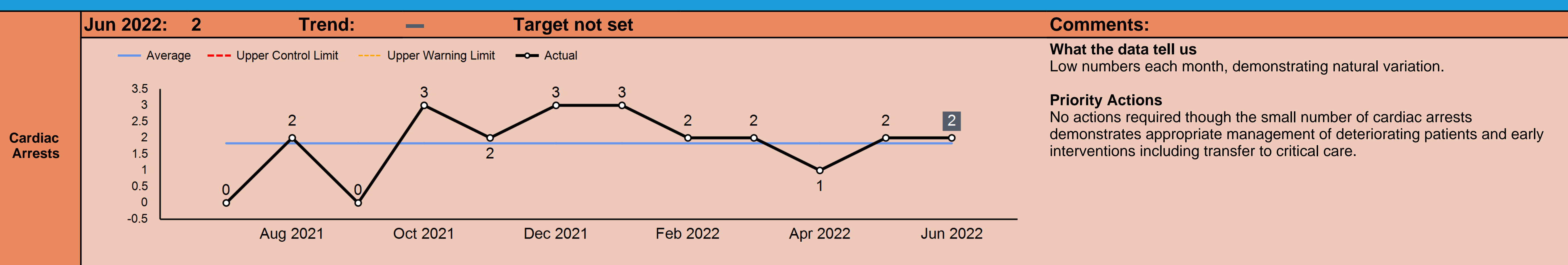


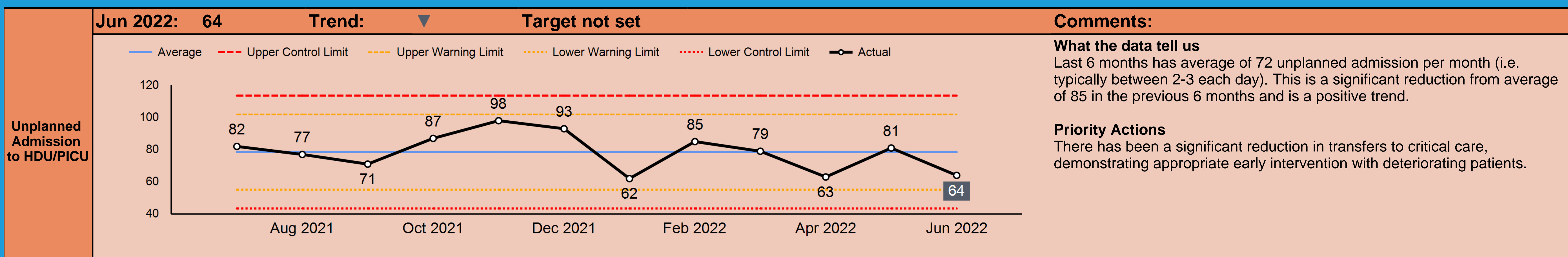


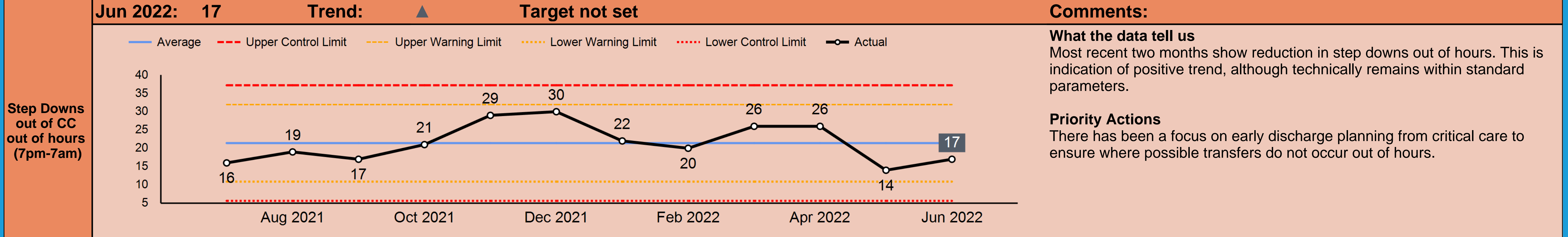


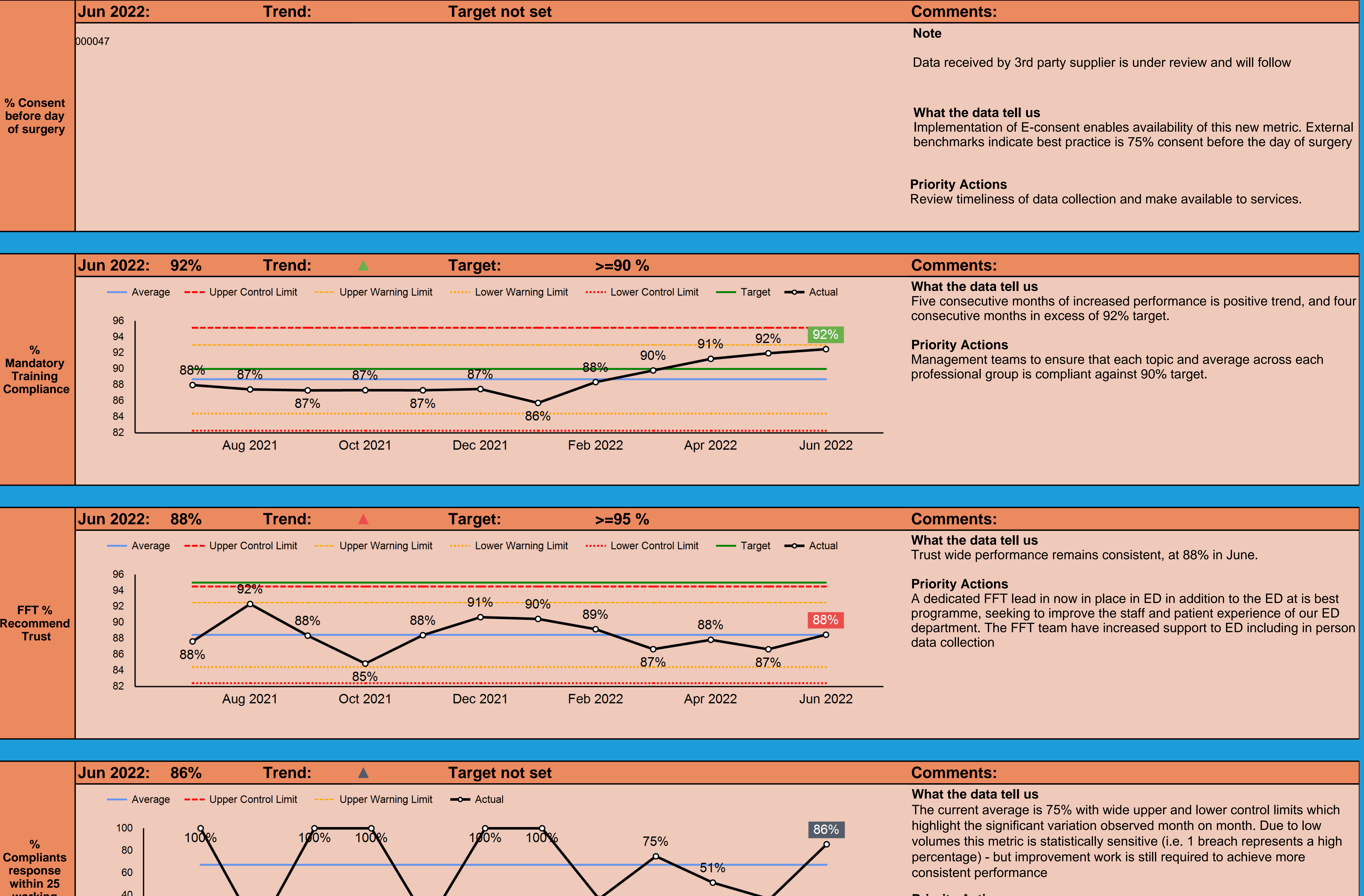












% Consent before day of surgery

Jun 2022: | **Trend:** | **Target not set**

000047

Comments:

Note

Data received by 3rd party supplier is under review and will follow

What the data tell us
Implementation of E-consent enables availability of this new metric. External benchmarks indicate best practice is 75% consent before the day of surgery

Priority Actions
Review timeliness of data collection and make available to services.

% Mandatory Training Compliance

Jun 2022: 92% | **Trend:** ▲ | **Target: >=90 %**

Comments:

What the data tell us
Five consecutive months of increased performance is positive trend, and four consecutive months in excess of 92% target.

Priority Actions
Management teams to ensure that each topic and average across each professional group is compliant against 90% target.

FFT % Recommend Trust

Jun 2022: 88% | **Trend:** ▲ | **Target: >=95 %**

Comments:

What the data tell us
Trust wide performance remains consistent, at 88% in June.

Priority Actions
A dedicated FFT lead in now in place in ED in addition to the ED at is best programme, seeking to improve the staff and patient experience of our ED department. The FFT team have increased support to ED including in person data collection

% Compliants response within 25 working days

Jun 2022: 86% | **Trend:** ▲ | **Target not set**

Average — Upper Control Limit — Upper Warning Limit — Actual

100% 8% 100% 100% 15% 100% 100% 37% 75% 51% 37% 86%

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

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

Priority Actions

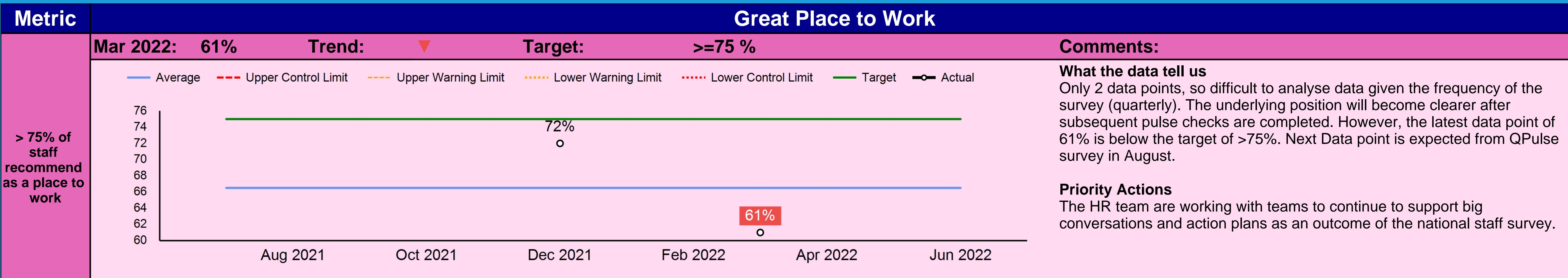
There has been an increased level of responsiveness in our complaints management in line with the patient experience improvement plan. Current actions are in place to further improve the position.

Dashboard refreshed 20 Jul 2022 11:14 (although individual metrics may be older)

Home > Detailed Scorecard

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

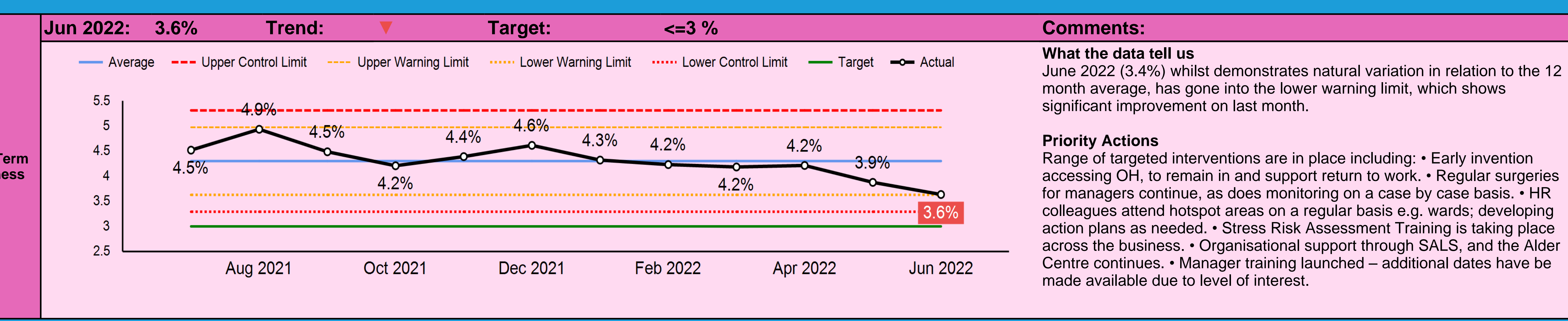
Metric — Great Place to Work



Comments:

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

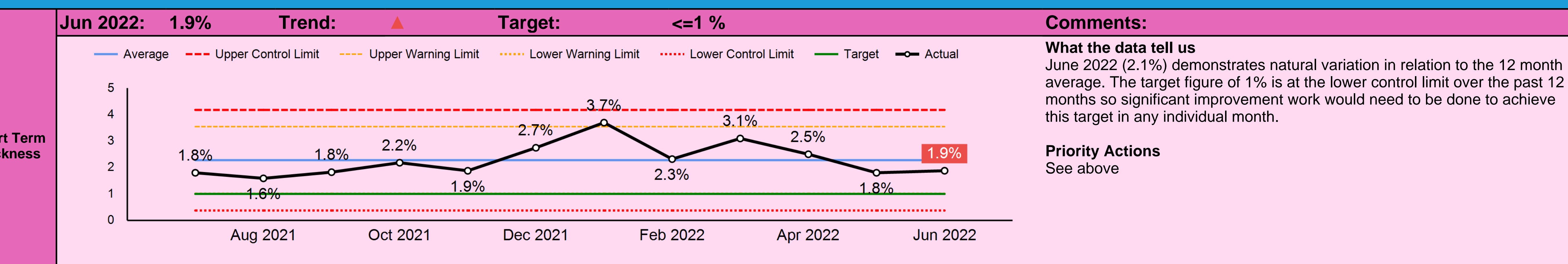
Priority Actions
The HR team are working with teams to continue to support big conversations and action plans as an outcome of the national staff survey.



Comments:

What the data tell us
June 2022 (3.4%) whilst demonstrates natural variation in relation to the 12 month average, has gone into the lower warning limit, which shows significant improvement on last month.

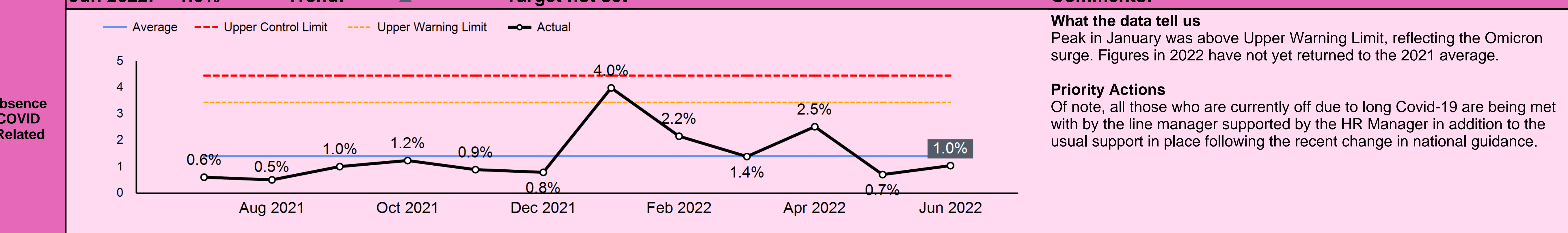
Priority Actions
Range of targeted interventions are in place including: • Early invention accessing OH, to remain in and support return to work. • Regular surgeries for managers continue, as does monitoring on a case by case basis. • HR colleagues attend hotspot areas on a regular basis e.g. wards; developing action plans as needed. • Stress Risk Assessment Training is taking place across the business. • Organisational support through SALS, and the Alder Centre continues. • Manager training launched – additional dates have be made available due to level of interest.



Comments:

What the data tell us
June 2022 (2.1%) demonstrates natural variation in relation to the 12 month average. The target figure of 1% is at the lower control limit over the past 12 months so significant improvement work would need to be done to achieve this target in any individual month.

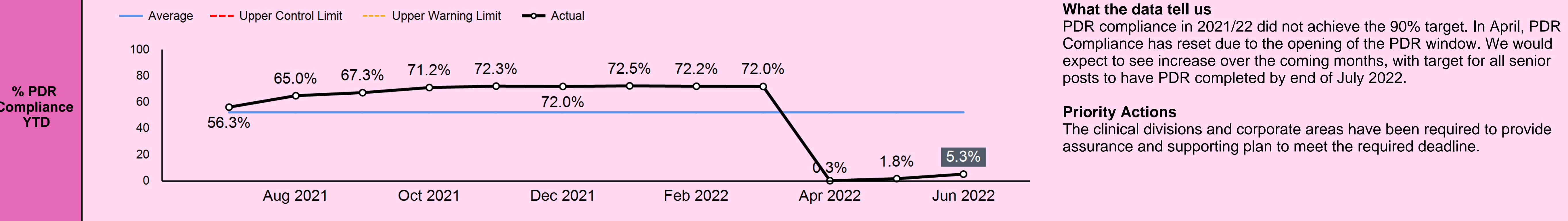
Priority Actions
See above



Comments:

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

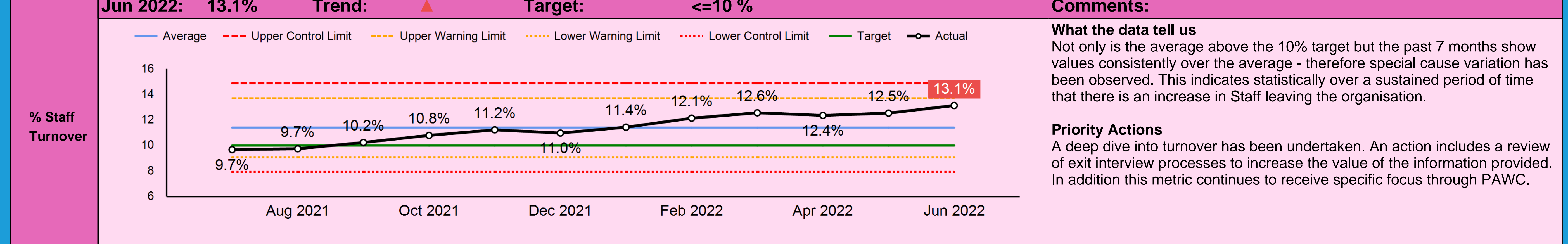
Priority Actions
Of note, all those who are currently off due to long Covid-19 are being met with by the line manager supported by the HR Manager in addition to the usual support in place following the recent change in national guidance.



Comments:

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

Priority Actions
The clinical divisions and corporate areas have been required to provide assurance and supporting plan to meet the required deadline.



Comments:

What the data tell us
Not only is the average above the 10% target but the past 7 months show values consistently over the average - therefore special cause variation has been observed. This indicates statistically over a sustained period of time that there is an increase in Staff leaving the organisation.

Priority Actions
A deep dive into turnover has been undertaken. An action includes a review of exit interview processes to increase the value of the information provided. In addition this metric continues to receive specific focus through PAWC.

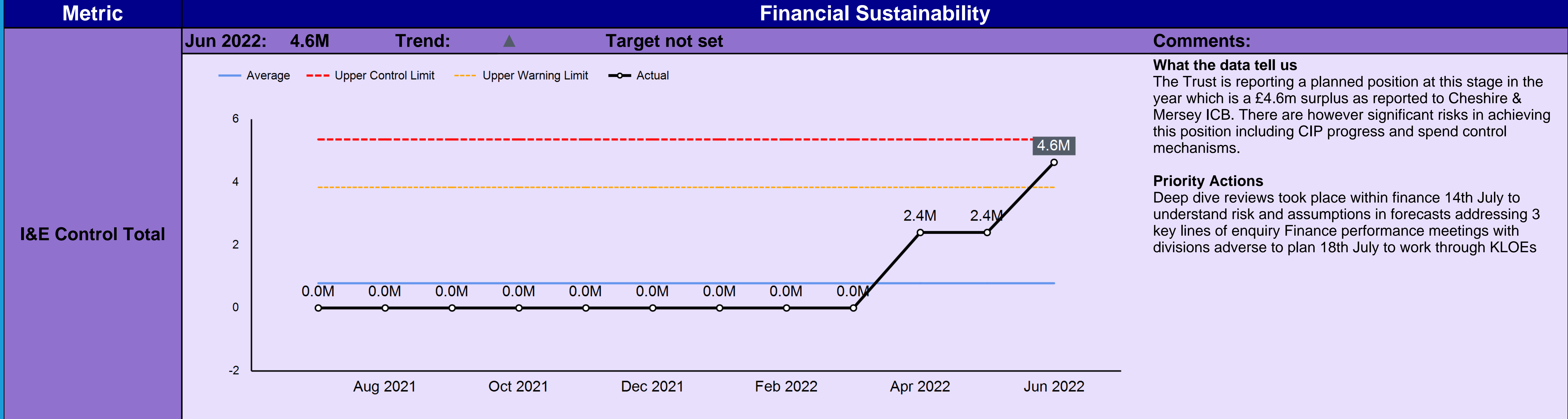
My Alder Hey Executive Scorecard

Dashboard refreshed 21 Jul 2022 16:40 (although individual metrics may be older)

Metric	Financial Sustainability

I&E Control Total

Jun 2022: 4.6M **Trend:** ▲ **Target not set**

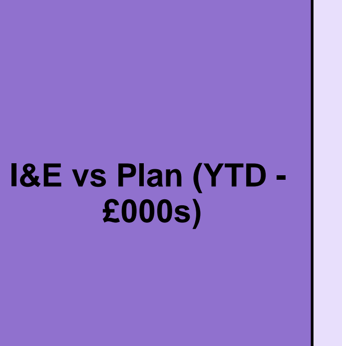


Comments:

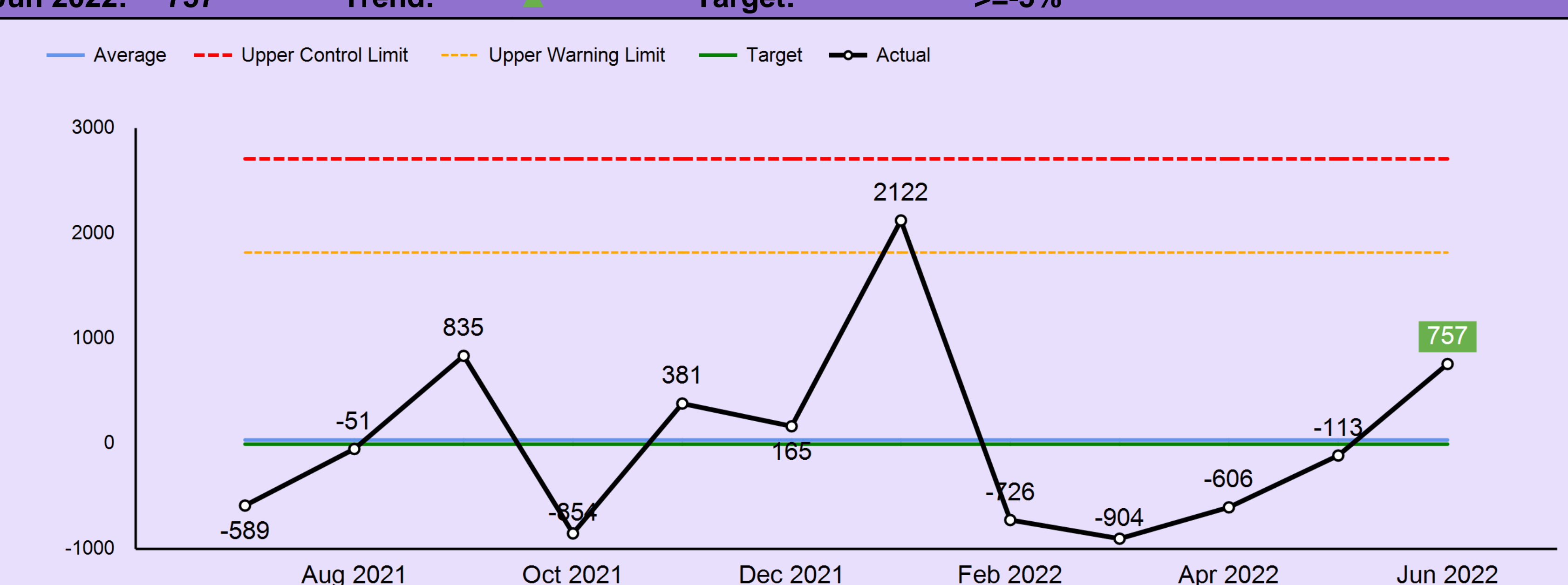
What the data tell us
The Trust is reporting a planned position at this stage in the year which is a £4.6m surplus as reported to Cheshire & Mersey ICB. There are however significant risks in achieving this position including CIP progress and spend control mechanisms.

Priority Actions
Deep dive reviews took place within finance 14th July to understand risk and assumptions in forecasts addressing 3 key lines of enquiry Finance performance meetings with divisions adverse to plan 18th July to work through KLOEs

I&E vs Plan (YTD - £000s)



Jun 2022: 757 **Trend:** ▲ **Target: >=-5%**



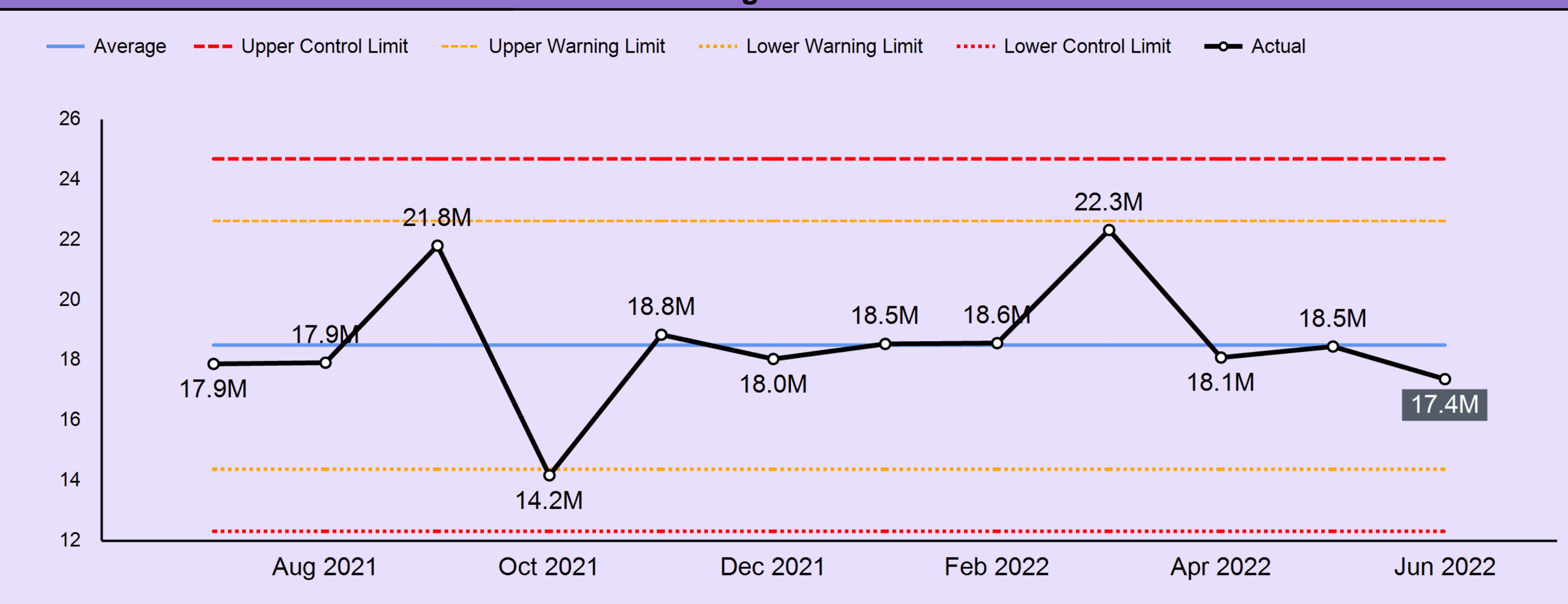
Comments:

What the data tell us
Year to date the Trust is reporting a deficit of £0.7m which is in line with plan for Q1 as we anticipate CIP schemes to mobilise further after Q1. Main drivers for the ytd position includes CIP non-delivery and continued pay and non-pay cost pressures including Junior Doctors, clinical supplies, offset in part with slippage in investments. Internally, the Trust would not be achieving the Elective Recovery Funding threshold due to EL value of activity compared to 19/20 (not count of activity) and Outpatient Follow Up reduction targets not being met. However, the instruction from NHSEI on ERF is to report to plan until the national position is known.

Priority Actions
Deep dive reviews took place within finance 14th July to understand risk and assumptions in year to date position Finance performance meetings with divisions adverse to plan 18th July to work through financial performance as at Q1.

Expenditure Run Rate (Pay)

Jun 2022: 17.4M **Trend:** ▼ **Target not set**



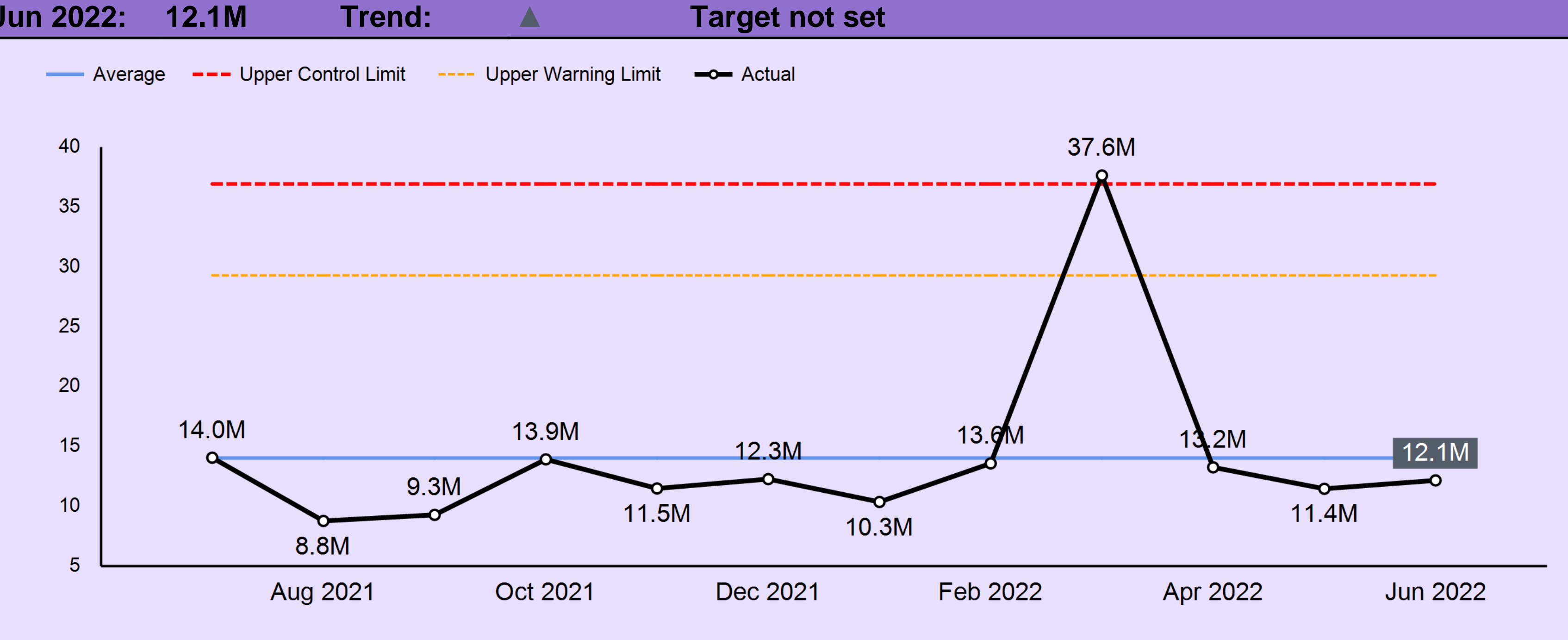
Comments:

What the data tell us
Run rate for pay is £17.5m which is lower than the previous month. This is largely through an adjustment as a result of the financial plan submission which moved an element of CIP assumption from non-pay to pay. The remainder of spend is largely in line with previous months. When compared to plan, pay is showing an adverse to plan position of £0.4m. This predominantly due to pressures within Medicine and Surgery medical staffing.

Priority Actions
As above – deep dives within finance and divisional finance performance review meetings.

Expenditure Run Rate (Non Pay)

Jun 2022: 12.1M **Trend:** ▲ **Target not set**



Comments:

What the data tell us
Run rate for non-pay is £11.7m which is higher than last month. This is largely through an adjustment as a result of the financial plan submission which moved an element of CIP assumption from non-pay to pay. The remainder of spend is largely in line with previous months. Non Pay is showing an adverse to plan position of £1.4m of which £2.4m is largely offset with income. The remainder is associated with CIP non delivery and non pay pressures including clinical supplies

Priority Actions
As above – deep dives within finance and divisional finance performance review meetings.

CIP Forecast

Jun 2022: 13.3M **Trend:** ▲ **Target not set**

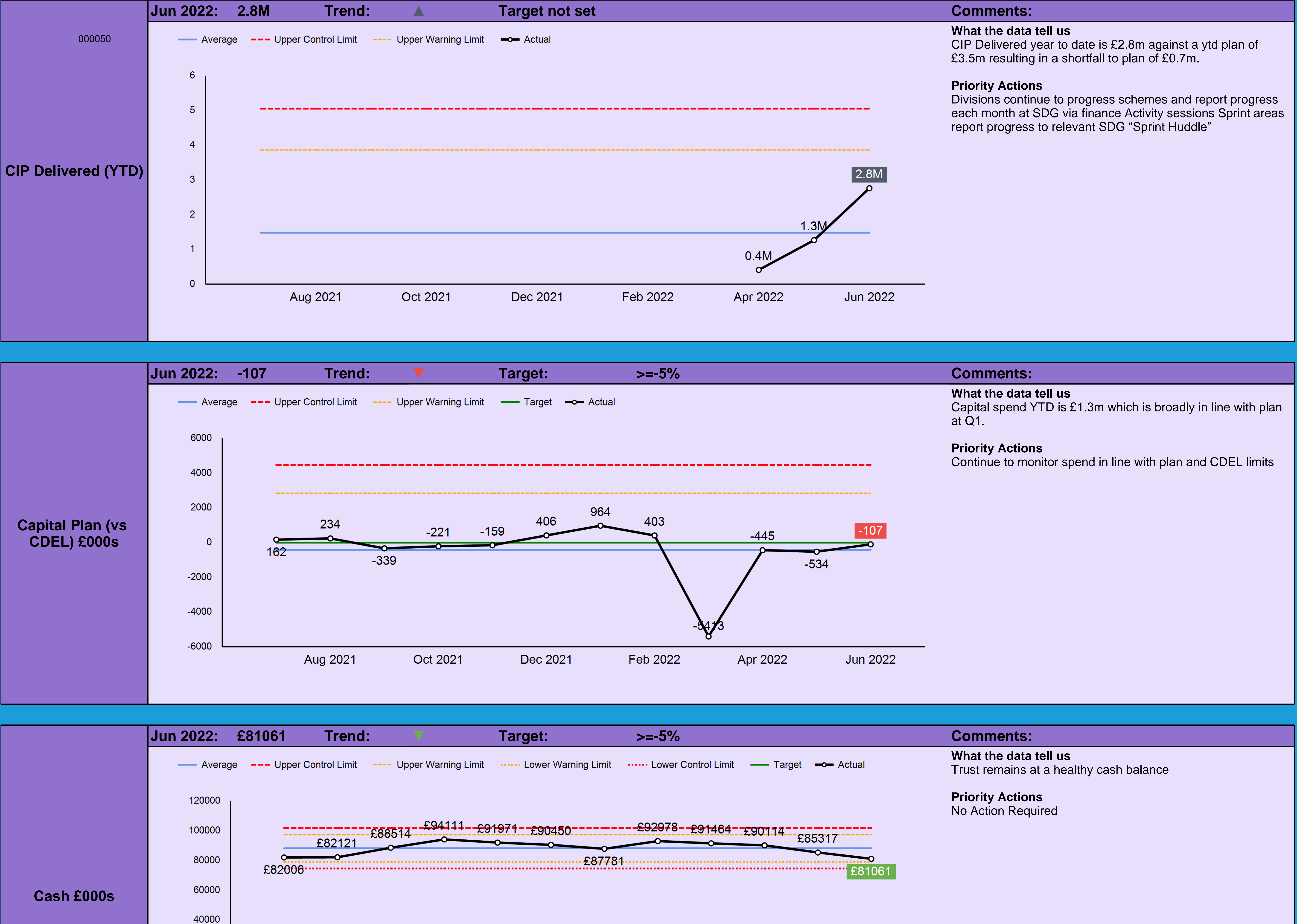
Comments:

Note

Visual is under developement

What the data tell us
The Trust is forecasting to deliver £13.3m savings. Improvement of £2.4m compared to month 2 as red (opportunity) are being progressed and included within forecast. However there remains a gap of £4.0m to achieve the £17.3m target.

Priority Actions
Divisions continue to progress schemes and report progress each month at SDG via finance Activity sessions highlighting any area of risk to forecasts. Red schemes now to be included in forecast as these are recognised opportunities which should be progressed. Sprint areas report progress to relevant SDG "Sprint Huddle"



Cash £000s

Jun 2022: £81061 **Trend:** **Target: >=-5%**

Average | Upper Control Limit | Upper Warning Limit | Lower Warning Limit | Lower Control Limit | Target | Actual

£82006, £82121, £88514, £94111, £91971, £90450, £87781, £92978, £91464, £90114, £85317, £81061

Aug 2021 | Oct 2021 | Dec 2021 | Feb 2022 | Apr 2022 | Jun 2022

Comments:

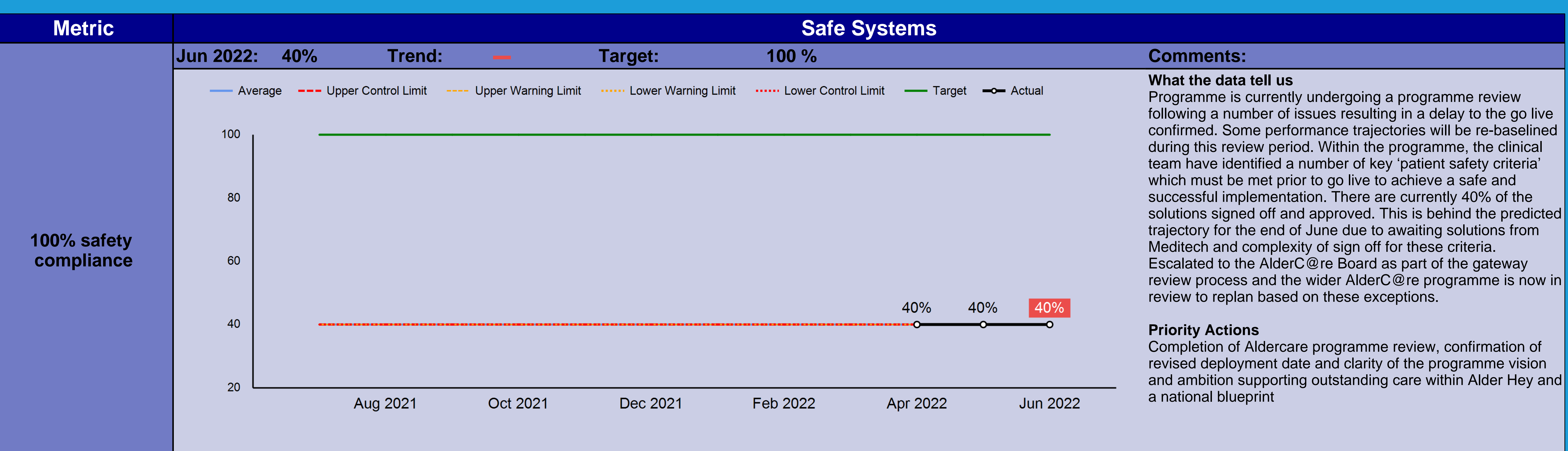
What the data tell us
Trust remains at a healthy cash balance

Priority Actions
No Action Required

Home > Detailed Scorecard

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

Metric	Safe Systems



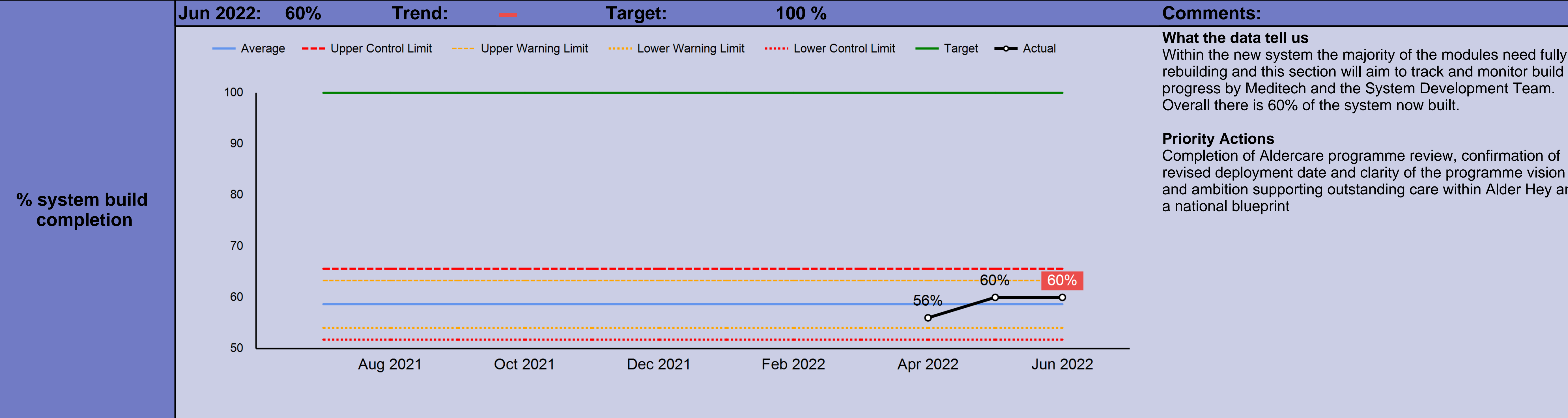
100% safety compliance

Jun 2022: 40% **Trend:** **Target: 100 %**

Comments:

What the data tell us
Programme is currently undergoing a programme review following a number of issues resulting in a delay to the go live confirmed. Some performance trajectories will be re-baselined during this review period. Within the programme, the clinical team have identified a number of key 'patient safety criteria' which must be met prior to go live to achieve a safe and successful implementation. There are currently 40% of the solutions signed off and approved. This is behind the predicted trajectory for the end of June due to awaiting solutions from Meditech and complexity of sign off for these criteria. Escalated to the AlderC@re Board as part of the gateway review process and the wider AlderC@re programme is now in review to replan based on these exceptions.

Priority Actions
Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint



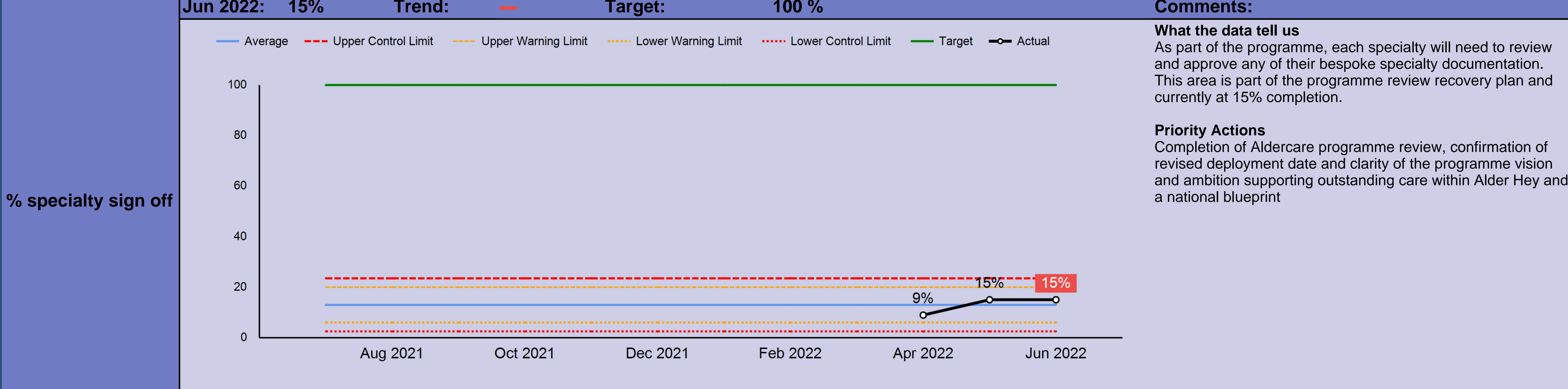
% system build completion

Jun 2022: 60% **Trend:** **Target: 100 %**

Comments:

What the data tell us
Within the new system the majority of the modules need fully rebuilding and this section will aim to track and monitor build progress by Meditech and the System Development Team. Overall there is 60% of the system now built.

Priority Actions
Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint



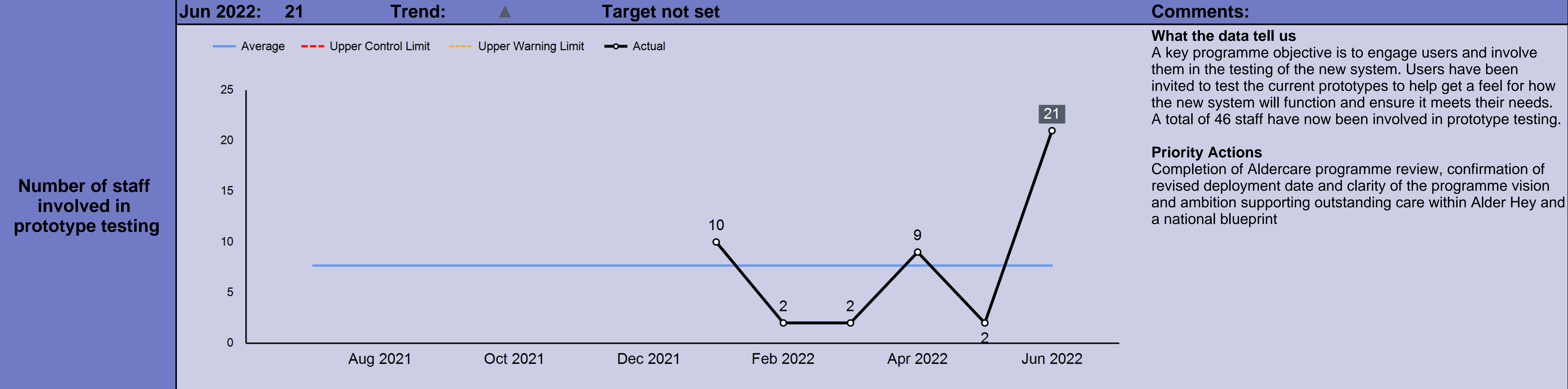
% specialty sign off

Jun 2022: 15% **Trend:** **Target: 100 %**

Comments:

What the data tell us
As part of the programme, each specialty will need to review and approve any of their bespoke specialty documentation. This area is part of the programme review recovery plan and currently at 15% completion.

Priority Actions
Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint



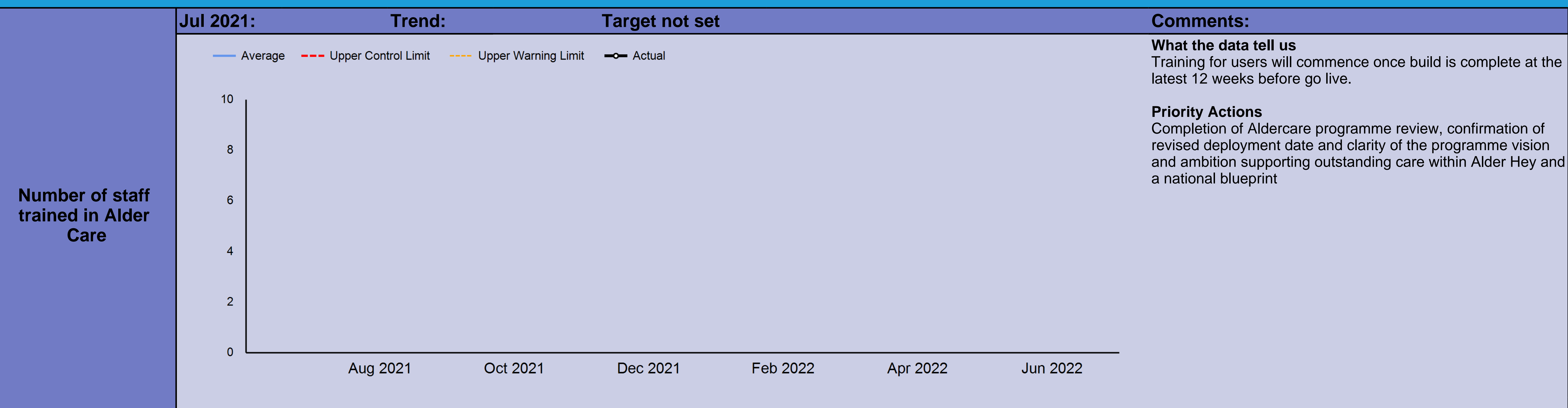
Number of staff involved in prototype testing

Jun 2022: 21 **Trend:** ▲ **Target not set**

Comments:

What the data tell us
A key programme objective is to engage users and involve them in the testing of the new system. Users have been invited to test the current prototypes to help get a feel for how the new system will function and ensure it meets their needs. A total of 46 staff have now been involved in prototype testing.

Priority Actions
Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint



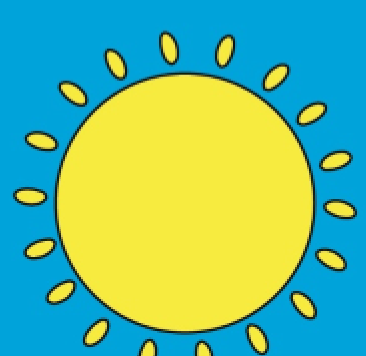
Number of staff trained in Alder Care

Jul 2021: **Trend:** **Target not set**

Comments:

What the data tell us
Training for users will commence once build is complete at the latest 12 weeks before go live.

Priority Actions
Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint



Part 2 - Dashboard of Metrics

BRILLIANT BASICS

GROW THE FUTURE

Delivery of Outstanding Care

SAFE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG			Comments Available
Proportion of Near Miss, No Harm & Minor Harm	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%	99.6%	99.8%	99.6%	100.0%	100.0%		>=99 %	N/A	<99 %	✔
Clinical Incidents resulting in Near Miss	90	73	62	91	89	65	76	73	79	91	97	111	85		No Threshold			
Clinical Incidents resulting in No Harm	321	332	299	313	276	275	250	239	279	307	321	406	352		No Threshold			
Clinical Incidents resulting in minor, non permanent harm	73	94	88	72	86	134	76	99	89	144	117	142	117		No Threshold			
Clinical Incidents resulting in moderate, semi permanent harm	1	1	1	0	1	1	0	2	1	1	2	0	0		No Threshold			
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	1	1	0	0	1	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	2	2	6	4	2	4	5	3	2	3	3	8	3		<=2	N/A	>2	
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%	83.7%	95.1%	79.6%	86.8%	77.8%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%	75.9%								>=90 %	N/A	<90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	0	2	0	0	1	3	1	0	0	1	1	0	0		No Threshold			

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%	89.2%	86.7%	87.8%	86.7%	88.5%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%	69.5%	59.3%	60.3%	59.6%	73.4%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%	90.5%	94.4%	100.0%	92.4%	90.6%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%	93.9%	95.7%	96.5%	95.3%	97.6%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%	100.0%	96.2%	95.5%	94.1%	96.4%	100.0%	90.9%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%	94.1%	93.3%	93.9%	93.3%	91.7%		>=95 % >=90 % <90 %	✔
Complaints	15	10	12	13	13	14	9	16	20	19	15	15	17		No Threshold	
PALS	149	122	88	148	136	141	106	100	135	136	102	148	163		No Threshold	

Delivery of Outstanding Care

EFFECTIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	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	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%	77.8%		>=95 % N/A <95 %	✔
ED: Patients In Department >12 Hours	2	17	0	14	47	46	26	11	23	70	19	10	23		0 N/A >0	✔
ED: Median Time to Triage (Mins)	1	8	10	14	17	17	13	10	12	20	12	14	11		<=15 N/A >15	✔
ED: Median Time to Clinical Assessment (Mins)	117	158	76	100	108	129	87	83	102	125	106	104	101		<=60 N/A >60	✔
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	13	13	12	32	23	56	23	22	16	23	21	22	26		<=11 N/A >11	✔
28 Day Breaches	0	3	8	5	11	12	25	7	3	9	10	9	8		0 N/A >0	✔
Clinic Letters Completed within 10 Days	56.1%	60.4%	60.5%	64.7%	60.7%	67.9%	55.1%	70.3%	63.4%	66.4%	58.5%	62.6%	65.0%		>=95 % N/A <95 %	✔

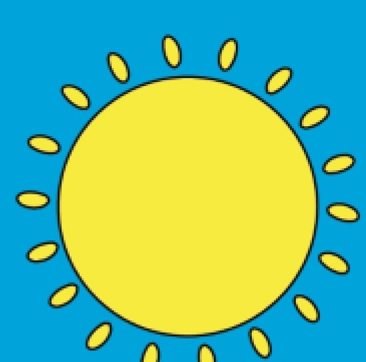
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG			Comments Available
IP Survey: % Received information enabling choices about their care	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%	93.0%	95.3%	95.7%	97.8%	98.8%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%	96.7%	97.8%	99.3%	97.8%	98.2%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Know their planned date of discharge	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%	67.6%	66.1%	66.4%	66.9%	85.3%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%	97.1%	98.7%	97.1%	98.9%	97.6%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in Play	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%	80.9%	87.3%	78.7%	78.6%	82.1%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Patients involved in Learning	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%	91.9%	93.0%	95.3%	90.8%	90.5%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%	61.5%	61.3%	60.1%	61.8%	59.2%		>=92 %	>=90 %	<90 %	✔
Waiting List Size	11,414	12,096	13,286	13,092	18,495	18,976	19,127	19,098	19,731	20,612	21,894	22,885	23,735		No Threshold			
Waiting Greater than 52 weeks - Incomplete Pathways	204	187	195	263	318	250	218	237	246	249	290	282	331		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%	63.3%	56.9%	51.9%	58.9%	63.8%		>=99 %	N/A	<99 %	
PFI: PPM%	99.0%	99.0%	99.0%	99.0%	97.0%	99.0%	99.0%	96.0%	92.0%	99.0%	98.0%	99.0%	97.0%		>=98 %	N/A	<98 %	

The Best People doing their best Work

WELL LED

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	391	-589	-51	835	-854	381	165	2,122	-726	-904	-606	-113	757		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	13	162	234	-339	-221	-159	406	964	403	-5,413	-445	-534	-107		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	82,001	82,006	82,121	88,514	94,111	91,971	90,450	87,781	92,978	91,464	90,114	85,317	81,061		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	1,597	2,980	-1,713	2,766	-2,610	149	1,474	1,047	273	27,774	1,210	204	291		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-545	553	71	-2,466	2,477	676	-16	6	9	-7,579	-121	406	-585		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	-661	-4,122	1,591	534	-720	-443	-1,293	1,068	-1,008	-21,099	-1,694	-723	1,051		>=-5% >=-20% <-20%	✔
PDR	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%	72.2%	72.0%	0.3%	1.8%	5.3%		No Threshold	
Medical Appraisal	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%	0.4%	12.3%	16.4%	23.7%	28.0%		No Threshold	
Mandatory Training	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%	88.4%	89.8%	91.3%	92.0%	92.5%		>=90 % >=80 % <80 %	✔
Sickness	5.6%	6.3%	6.5%	6.3%	6.4%	6.3%	7.4%	8.0%	6.6%	7.3%	6.7%	5.7%	5.5%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.7%	3.7%	2.3%	3.1%	2.5%	1.8%	1.9%		<=1 % N/A >1 %	✔
Long Term Sickness	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.6%	4.3%	4.2%	4.2%	4.2%	3.9%	3.6%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	960	1,132	1,096	1,367	1,137	1,592	1,523	1,387	1,620	2,080	1,570	1,375	1,172		No Threshold	
Staff Turnover	9.4%	9.7%	9.7%	10.2%	10.8%	11.2%	11.0%	11.4%	12.1%	12.6%	12.4%	12.5%	13.1%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%	84.0%	81.7%	83.7%	86.4%	85.1%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%	100.0%	100.0%	97.5%	97.0%	99.0%		>=85 % N/A <85 %	✔

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	108	117	125	132	139	142	145	148	150	153	154	148	143		>=130	>=111	<111	✔
Number of Open Studies - Commercial	38	37	38	40	43	44	42	43	44	38	40	39	35		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	3	7	3	7	7	4	1	3	0	3	3	1	0		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	1	1	0	2	3	3	0	3	0	0	1	1	0		>=1	N/A	<1	✔
Number of patients recruited	896	439	1,060	983	931	1,038	816	978	937	1,157	917	944	565		>=100	>=86	<86	✔



Part 3 - Divisional Performance

BRILLIANT BASICS

GROW THE FUTURE

Medicine Division

SAFE	Ongoing staffing issues - there is a risk to out of hours neurology and haematology services due to the ongoing staff shortages. Audit reporting and action plans – division are working with Clinical Audit manager to provide support to escalation of incomplete audits and action plans.	**Highlight** • June data – no moderate harm or above incidents reported. Increase in no harm reporting indicates good reporting culture. 0 medication incidents resulted in harm. **Challenges** • To complete RCA investigations within the 60-day target and not require an extension to ensure families receive the feedback in a timely way. • Increase in hospital acquired infections.
CARING	Increase in the number of complaints in month (14 in June) with emerging themes: • **6 Alleged failure in medical care** • 1 attitude of staff – nursing • 2 communication failure – medical • 2 conflicting information • 1 delay in receiving test results 2 diagnosis delayed.	**Highlight** • We have improved the compliance with trust targets to respond. • 6 complaints closed in June – no breaches of 25 working day target. **Challenges** • Ongoing work to achieve higher compliance with trust targets. • PALS numbers have increased in numbers and complexity
EFFECTIVE	Incremental improvement against the 4-hour standard in ED, 4.2% improvement in month Improvement in the number of children leaving ED before being seen, 2.4% improvement in month.	**Highlight** • Time to Triage in ED continues to improve **Challenges** • Theatre utilisation deteriorated further in month, GM for Medicine to undertake a detailed review.
RESPONSIVE	Incremental improvement across the majority indicators in relation to the IP survey.	**Highlight** ▪ 100% of CYP diagnosed within 28 days (Cancer FDS) **Challenges** ▪ 52 week waits deterioration in month; challenges in Neurology due to consultant shortage – review of the Paediatric Botox service is underway with AHP colleagues, these CYP are the bulk of long waits in Neurology. ▪ Gastroenterology team are developing a recovery plan to mitigate their long OP and DC waits. New Consultant joins September 2022.

WELL LED	Increasing COVID absence has impacted the Divisions improving short term sickness rates in month.	**Highlight** • Mandatory training is above 90% for 3rd month, continued scrutiny to improve is in place. **Challenges** • Divisions financial position is incredibly challenged at M3 at £2m deficit. Significant underlying pressures relating to non-pay consumables, drugs and blood products; further analysis required in collaboration with Pharmacy and Procurement underway firstly to understand the impact of inflation and opportunities to mitigate. • Miscellaneous expenditure review underway, additional divisional controls being developed. • Pay pressures in relation to junior doctors in ED and Medicine; further review underway by ACOO/GM's to be completed. • Historic pressures in relation to specialist nursing; review commissioned, Head of Nursing Medicine to undertake. • Other significant pressures relate to CIP non delivery against a £3.6m target. To date £0.4m of CIP has been achieved. • Mandatory Training hotspots / topics for non-compliance are being targeted.

Medicine

SAFE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	36	29	28	33	39	24	49	32	40	36	42	45	28		No Threshold
Clinical Incidents resulting in No Harm	89	101	101	133	93	87	100	104	104	89	109	105	115		No Threshold
Clinical Incidents resulting in minor, non permanent harm	17	18	17	12	28	25	18	19	15	15	18	28	29		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	1	1	0	0	0	0	0	0	0	0	1	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	1	0	2	3	1	0	1	1	0	0	1	2	0		No Threshold
Medication Errors (Incidents)	26	14	20	35	24	20	30	28	18	20	31	29	21		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	2	0	2	1	6	7	4	1	4	2	0	4	5		No Threshold
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%	83.3%								>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	0	2	3	3	4	2	1	0	1	3	7	7	4		No Threshold
Hospital Acquired Organisms - MSSA	0	0	0	0	1	1	0	0	0	0	1	0	0		No Threshold
Cleanliness Scores	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%	98.8%	99.4%	99.7%	99.4%	98.5%		No Threshold

CARING

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Complaints	2	4	4	3	5	7	2	5	5	4	6	7	8		No Threshold
PALS	40	43	26	49	50	45	42	35	50	52	34	45	45		No Threshold

EFFECTIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Referrals Received (Total)	2,481	2,342	1,997	2,559	2,742	2,823	3,179	3,052	2,651	3,438	2,557	2,459	2,381		No Threshold
ED: 95% Treated within 4 Hours	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%	77.8%		>=95 % N/A <95 %
ED: Patients In Department >12 Hours	2	17	0	14	47	46	26	11	23	70	19	10	23		0 N/A >0
ED: Median Time to Triage (Mins)	1	8	10	14	17	17	13	10	12	20	12	14	11		No Threshold
ED: Median Time to Clinical Assessment (Mins)	117	158	76	100	108	129	87	83	102	125	106	104	101		No Threshold
ED: Percentage Left without being seen	4.9%	12.5%	4.3%	9.1%	9.5%	8.7%	6.1%	4.0%	5.9%	10.6%	7.6%	7.8%	5.4%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	0	0	0	1	0	1	4	0	1	1	0	1	1		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	0	0	0	1	0	0	3	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	8.6%	9.8%	9.7%	8.4%	9.2%	9.6%	9.9%	9.1%	8.8%	9.5%	9.4%	8.4%	8.9%		No Threshold
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised	73.9%	74.2%	72.2%	78.5%	76.6%	76.7%	73.7%	70.8%	74.9%	79.3%	79.1%	82.4%	75.8%		>=90 % >=80 % <80 %

Medicine

000063

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
On the day Elective Cancelled Operations for Non Clinical Reasons	1	0	3	2	3	5	0	4	0	5	9	0	2		No Threshold
28 Day Breaches	0	0	0	1	1	2	2	0	0	2	1	6	1		0 / N/A / >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	21	37	42	30	43	45	40	33	37	26	36	27	15		No Threshold
OP Appointments Cancelled by Hospital %	11.6%	15.0%	14.9%	13.9%	15.3%	12.4%	12.3%	12.5%	13.3%	13.0%	15.3%	15.9%	13.4%		<=5 % / N/A / >10 %
Was Not Brought Rate	9.3%	10.0%	10.7%	9.2%	9.1%	8.8%	8.8%	8.6%	7.8%	8.0%	8.9%	8.7%	9.5%		<=12 % / <=14 % / >14 %
Was Not Brought Rate (New Appts)	10.8%	10.3%	10.9%	8.6%	9.3%	8.6%	8.7%	10.4%	7.4%	9.0%	8.8%	8.4%	9.0%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	9.0%	9.9%	10.8%	9.4%	9.1%	8.9%	8.8%	8.3%	7.9%	7.8%	9.0%	8.7%	9.6%		<=14 % / <=16 % / >16 %
Coding average comorbidities	5.58	5.47	5.58	5.50	5.68	5.57	5.49	5.51	5.41	5.54	5.73	5.70	5.51		No Threshold

RESPONSIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%	92.1%	93.4%	92.2%	98.0%	98.0%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%	97.0%	95.9%	98.0%	96.0%	96.0%		>=95 % / >=90 % / <90 %
IP Survey: % Know their planned date of discharge	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%	58.4%	53.7%	51.0%	55.0%	62.0%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	97.8%	93.1%	87.2%	90.2%	100.0%	94.9%	96.2%	97.3%	95.0%	97.5%	95.1%	98.7%	96.0%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%	80.2%	89.3%	80.4%	79.2%	82.0%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%	92.1%	96.7%	95.1%	90.6%	90.0%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%	63.4%	62.8%	61.5%	62.0%	59.6%		>=92 % / >=90 % / <90 %
Waiting List Size	3,122	3,338	3,507	3,565	5,605	5,842	5,943	5,955	6,136	6,411	6,922	7,266	7,445		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	6	11	7	13	23	10	15	5	2	2	5	8	10		0 / N/A / >0
Waiting Times - 40 weeks and above	15														No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Diagnostics: % Completed Within 6 Weeks	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%	88.5%	66.7%	59.6%	55.2%	62.0%	69.5%		>=99 % / N/A / <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100.0%		100 % / N/A / <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%	88.2%	89.8%	90.4%	88.9%	89.9%	90.2%	91.4%		>=90 % / >=85 % / <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=90 % / >=85 % / <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % / >=90 % / <95 %
Imaging - % Reporting Turnaround Times - ED	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%	99.0%	99.0%	97.0%	96.0%	93.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Inpatients	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%	82.0%	89.0%	83.0%	80.0%	84.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Outpatients	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%	64.0%	67.0%	61.0%	62.0%	71.0%		>=85 % / N/A / <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%	72.5%	77.1%	73.2%	84.1%	96.0%		>=99 % / N/A / <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%	93.5%	91.2%	87.1%	95.7%	97.3%		>=99 % / N/A / <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % / N/A / <99 %

Medicine 000064

WELL LED

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-1,036	-347	-58	253	-127	-199	87	144	-261	-344	-343	-653	-1,030		No Threshold
Income In Month Variance (£'000s)	-1	209	-490	201	-184	1,138	829	-308	135	273	1,294	638	16		No Threshold
Pay In Month Variance (£'000s)	-150	48	47	121	-35	15	70	-96	-218	-376	-151	-160	-234		No Threshold
AvP: IP - Non-Elective	808	822	694	826	1,008	956	860	892	913	902	-32	-5	12		>=0 N/A <0
AvP: IP Elective vs Plan	162	132	134	112	125	125	95	120	136	165	7	9	14		>=0 N/A <0
AvP: OP New	1,562.00	1,454.00	1,214.00	1,628.00	1,601.00	1,804.00	1,205.00	1,323.00	1,277.00	1,517.00	-154.87	219.49	276.98		>=0 N/A <0
AvP: OP FollowUp	6,811.00	5,747.00	5,179.00	6,031.00	5,375.00	6,067.00	4,861.00	5,622.00	5,229.00	6,312.00	1,179.18	1,348.02	1,309.02		>=0 N/A <0
AvP: Daycase Activity vs Plan	1,371	1,240	1,139	1,276	1,276	1,377	1,166	1,203	1,231	1,471	239	309	344		>=0 N/A <0
AvP: Outpatient Activity vs Plan	9,462	8,168	7,386	8,671	8,047	9,044	7,100	7,863	7,478	9,002	843	1,472	1,269		>=0 N/A <0
PDR	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%	74.2%	74.0%	0.0%	1.6%	4.0%		No Threshold
Medical Appraisal	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%	0.0%	10.2%	13.5%	22.1%	27.7%		No Threshold
Mandatory Training	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%	86.7%	85.9%	87.0%	88.9%	90.2%	91.5%	91.9%		>=90 % >=80 % <80 %
Sickness	5.3%	6.4%	7.1%	6.3%	6.6%	7.4%	9.3%	9.8%	8.0%	9.0%	8.4%	6.6%	6.7%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.5%	2.0%	1.9%	1.8%	2.3%	2.2%	3.6%	4.5%	2.9%	4.2%	3.2%	1.9%	2.2%		<=1 % N/A >1 %
Long Term Sickness	3.7%	4.4%	5.2%	4.5%	4.3%	5.2%	5.8%	5.3%	5.1%	4.8%	5.2%	4.7%	4.5%		<=3 % N/A >3 %
Temporary Spend ('000s)	230	265	263	292	311	373	370	452	495	614	484	508	383		No Threshold
Staff Turnover	7.3%	7.5%	8.3%	9.3%	9.5%	9.7%	9.9%	11.2%	12.1%	12.8%	12.8%	13.6%	14.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%	77.0%	81.3%	76.3%	78.2%	78.7%		>=90 % >=80 % <90 %

Surgery Division

SAFE	Incident reporting continues to improve within the division which is supported by a daily rapid review process to allow timely review and response/escalation. Currently CLABSI data is only available on ICU- this is under review with BI and IPC to look at developing reporting for CLABSI's across the trust.	**Highlight** • 0 Never events for over 12 months consecutively • Continued increase in near miss/no harm reporting • Cleanliness scores remains at 99% **Challenges** • Sepsis data is still not readily available
CARING	The division continue to receive a high volume of PALs (May – 59, June – 52). The overarching theme is waiting times in our RTT pressure areas however there has been a rise in PALs being used to gain information which highlights a potential issue with communication. The leadership team are undertaking a deep dive to identify any areas where families are struggling to communicate with departments. We have seen an improved turnaround time for PALS/complaints response ensuring that patients and families are receiving contact from the relevant teams in a timely manner.	**Highlight** • 100% of PALs in June were responded to within the 5-day timeframe **Challenges** • High volume of PALs in relation to waiting times and communication
EFFECTIVE	Readmissions to PICU within 48 hrs have been 0 for 4 months Theatre utilisation remains slightly below the 90% target. Continued focus on recovery, theatre performance and throughput of cases. Start times for theatre have improved in daycase	**Highlight** • Readmissions to PICU within 48 hrs have been 0 for 4 months • WNB remains under 10% • Start times for theatre have improved in daycase **Challenges** • Increase (24) in on the day elective cancellations- 50% were due to staff sickness (covid-19) • Decrease in 28 day breaches (6). Breaches are tracked via weekly performance meeting, a number of urgent cases have recently taken priority.
RESPONSIVE	Our waiting list size has decreased in month (12487) The RTT position remains similar to the previous month, challenges remain and is predominantly in Paediatric Dentistry in terms of both OP & IP. A weekly action plan is in place to improve the position and discussions are ongoing with the divisional director and ACOO. We have a number of posts out to recruitment but available workforce is a significant constraint. We still have some challenges in a few areas affected by Radiology workforce constraints: Spinal surgery, Orthopaedics and Urodynamics.	**Highlight** • RTT position improved at 59.8% **Challenges** • Waiting times in dentistry & Spinal surgery • Radiology workforce constraints: Spinal surgery, Orthopaedics and Urodynamics.

<table>
<tr><td rowspan="4">WELL LED</td><td rowspan="4">Overall Sickness absence rates have improved in month for both long and short term sickness.

Our mandatory training position continues to be compliant with the 90% target. This is a result of focused work via a weekly challenge boards approach and through the monthly Divisional Governance Meeting.</td><td>Highlight</td></tr>
<tr><td>• Mandatory training remains over target at 90.9%
• Sickness absence rates improved in month at 5.2%</td></tr>
<tr><td>Challenges</td></tr>
<tr><td>• Although sickness absence rates improved they remain above trust targets
• Although an improvement in month the division are still facing a significant financial challenge and remain focused on recovery and CIP work</td></tr>
</table>

Surgery

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SAFE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	43	27	25	42	33	33	21	24	21	35	36	40	35		No Threshold
Clinical Incidents resulting in No Harm	164	120	113	107	103	119	117	79	114	133	111	142	132		No Threshold
Clinical Incidents resulting in minor, non permanent harm	38	31	49	39	43	80	40	40	43	42	45	63	51		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	1	0	1	1	0	2	1	1	1	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	1	1	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	1	2	3	1	1	3	4	1	2	2	1	6	2		No Threshold
Medication Errors (Incidents)	29	24	27	26	20	28	29	21	21	26	26	39	23		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	88.9%	66.7%	100.0%	75.0%	82.6%	82.4%	75.0%								>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	0	2	0	0	0	2	1	0	0	1	0	0	0		No Threshold
Cleanliness Scores	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%	98.7%	99.1%	98.5%	99.5%	99.2%		No Threshold

CARING

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Complaints	5	3	4	6	4	5	4	4	10	10	8	5	5		No Threshold
PALS	43	33	25	29	29	42	33	28	45	43	32	59	55		No Threshold

EFFECTIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	0	1	2	0	0	0	1	1	1	0	0	0	0		No Threshold
% Readmissions to PICU within 48 hrs	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%						No Threshold
Referrals Received (Total)	4,398	3,781	3,251	3,958	3,617	4,017	3,178	3,390	3,680	4,299	3,424	4,249	3,887		No Threshold
Theatre Utilisation - % of Session Utilised	78.4%	79.5%	81.0%	83.8%	86.7%	79.4%	81.5%	77.5%	85.9%	88.7%	87.6%	96.9%	87.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	12	13	9	30	20	51	23	18	16	18	12	22	24		No Threshold
28 Day Breaches	0	3	8	4	10	10	23	7	3	7	9	3	7		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	59	63	74	54	78	43	51	48	34	50	39	28	44		No Threshold
OP Appointments Cancelled by Hospital %	11.2%	9.6%	11.3%	11.3%	10.5%	8.8%	10.5%	12.8%	12.4%	13.7%	14.4%	12.1%	11.3%		<=5 % <=10 % >10 %
Was Not Brought Rate	7.9%	9.5%	10.1%	8.6%	7.8%	8.3%	9.1%	9.3%	8.1%	7.9%	9.3%	8.8%	9.0%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	9.3%	12.1%	12.0%	9.9%	9.3%	10.2%	10.6%	11.0%	9.7%	8.6%	11.7%	9.9%	10.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	7.3%	8.5%	9.4%	8.1%	7.3%	7.6%	8.6%	8.6%	7.6%	7.7%	8.5%	8.4%	8.5%		<=14 % <=16 % >16 %
Coding average comorbidities	4.49	4.62	4.57	4.51	4.50	4.28	4.51	4.57	4.65	4.58	4.47	4.48	4.32		No Threshold
CCAD Cases	39	28	19	23	29	24	33	20	22	27	29	26	30		No Threshold

Surgery

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RESPONSIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG		
IP Survey: % Received information enabling choices about their care	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%	93.6%	96.4%	97.7%	97.6%	99.2%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%	96.5%	99.0%	100.0%	99.0%	99.2%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%	73.1%	73.8%	75.4%	75.2%	97.0%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%	98.2%	99.5%	98.3%	99.0%	98.3%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%	81.3%	86.2%	77.7%	78.1%	82.2%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	93.6%	93.5%	92.1%	90.5%	95.5%	94.9%	88.5%	91.6%	91.8%	90.8%	95.4%	91.0%	90.7%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%	61.5%	61.9%	61.0%	62.7%	59.8%		>=92 %	>=90 %	<90 %
Waiting List Size	7,484	7,787	8,632	8,319	11,360	11,505	11,621	11,567	11,949	12,413	13,085	13,640	14,220			No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	197	174	186	249	294	239	202	231	244	246	282	265	314		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%	66.7%	32.5%	35.4%	29.6%	38.3%	23.9%		>=99 %	N/A	<99 %

WELL LED

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	108	583	-5	-137	-349	-598	-657	-130	-232	-581	-603	-353	-270			No Threshold	
Income In Month Variance (£'000s)	209	223	28	-144	-43	68	59	-16	23	131	10	10	115			No Threshold	
Pay In Month Variance (£'000s)	-116	541	-64	-158	-82	-452	-331	-85	-358	-196	-218	5	-256			No Threshold	
AvP: IP - Non-Elective	485	406	386	421	371	411	404	386	385	452	6	-15	-70		>=0	N/A	<0
AvP: IP Elective vs Plan	299	298	243	270	288	278	247	213	237	281	-17	-19	-34		>=0	N/A	<0
AvP: OP New	2,587.00	2,516.00	2,170.00	2,824.00	2,451.00	2,481.00	1,958.00	2,053.00	1,925.00	2,350.00	-564.43	-241.53	-120.79		>=0	N/A	<0
AvP: OP FollowUp	7,104.00	6,919.00	5,726.00	6,665.00	7,096.00	8,280.00	5,912.00	6,136.00	6,275.00	7,681.00	723.52	858.91	65.68		>=0	N/A	<0
AvP: Daycase Activity vs Plan	795	711	622	710	732	837	696	672	611	720	-22	-52	0		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	11,316	11,094	9,330	11,091	11,077	12,584	9,232	9,382	9,513	11,323	221	746	-54		>=0	N/A	<0
PDR	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%	61.3%	61.1%	0.3%	0.5%	0.6%			No Threshold	
Medical Appraisal	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%	0.8%	14.4%	19.8%	26.7%	29.6%			No Threshold	
Mandatory Training	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%	88.5%	89.4%	91.1%	90.9%	91.8%		>=90 %	>=80 %	<80 %
Sickness	5.8%	6.7%	6.2%	6.3%	6.0%	5.6%	7.1%	8.2%	5.9%	6.8%	6.2%	5.3%	5.2%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	1.6%	2.2%	1.6%	2.3%	2.5%	1.9%	3.2%	4.5%	2.6%	3.3%	2.8%	2.2%	2.4%		<=1 %	N/A	>1 %
Long Term Sickness	4.2%	4.5%	4.5%	4.1%	3.5%	3.8%	3.9%	3.7%	3.2%	3.5%	3.4%	3.1%	2.9%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	332	445	469	532	363	631	535	474	535	824	621	341	482			No Threshold	
Staff Turnover	9.0%	9.7%	10.2%	10.4%	11.2%	11.4%	11.3%	11.9%	12.2%	12.3%	12.1%	11.3%	11.3%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%	86.6%	80.5%	86.8%	90.4%	87.5%		>=90 %	>=80 %	<90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 58453:** Audit data with patient identifiable information emailed to external account. **Improvement:** Reminder provided to all staff that when analysing or writing up audit data to use Trust IT systems and if audit information needs to be sent outside the organisation, ensure all patient identifiers are removed prior to sending. **Incident 58202:** Child had two outpatient appointments in one day, however one appointment was cancelled. Staff did not see 2nd appointment and told parent there was no appointment at all. **Improvement:** Details to be checked thoroughly for all children attending clinic, so as to ensure nothing is missed and that they are directed to the appropriate clinic area.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 124 incidents reported (97 clinical, 27 non-clinical) **Challenges** Continued number of self-harm incidents reported from Tier 4 Unit (1 child). This is reducing May (76) June (27)
CARING	Improvement changes from complaints includes: **SO20746:** Complaint related to communication regarding a referral to social care and attendance at meetings by Alder Hey professionals. **Improvement:** New Associate Director for Safeguarding & Statutory Services reviewing the current Safeguarding process and procedures in line with the latest Royal College of Paediatrics and Child Health (RCPCH) guidance on Perplexing Presentations and will disseminate any changes.	**Highlight** • 16 Excellence Reports submitted in June • 32 Compliments submitted in June • 91% FFT Scores for Community • 91% FFT Scores for Mental Health • 92% FFT Scores for Outpatients **Challenges** • 2 formal complaints received in June. These complaints relate to waiting times in Developmental Paediatrics. • 58 PALs recorded in June; this is an increase compared to May (38 PALs). Main themes relate to waiting times for appointments.
EFFECTIVE	Referral Platform launched for Community Paediatrics, ASD and ADHD services	**Highlight** • Division met the 104% elective recovery target for new outpatient appointments in June **Challenges** • WNB rates for the Division remain higher than the Trust target. A process for utilising the WNB predictor tool has been agreed for Mental Health Services and Community Paediatrics to contact young people who are most likely not to attend and remind them of their appointment time.

RESPONSIVE	Digital innovation launched to send appointment letters and link to online portal directly to parent/guardian mobile phones	**Highlight** • Eating Disorder routine waiting times compliance has increased to 71% and assessments are now available within the 28-day target. • Eating Disorder urgent waiting times compliance remains at 100% **Challenges** • Waiting times remain challenged for the ASD and ADHD diagnostic pathways. Discussions are taking place with system wide partners to identify actions required to support education and health partners whilst reducing waiting times. • RTT for Community Paediatrics has deteriorated slightly to 53% in June. All young people waiting over 45 weeks for an appointment have been booked.
WELL LED	Divisional CIP plan agreed for 2022/2023 and reduction in temporary spend by £100k by June.	**Highlight** • Mandatory training remains above Trust target at 95%. Action plan in place to address individual staff with non-compliance. • Return to work interviews at 91% • Staff survey conversations have taken place in teams **Challenges** • PDR completion rates for Band 7 and above at 38% with all dates booked before 31 July 2022.

Community

000071

SAFE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	7	11	4	8	4	2	4	13	14	10	12	18	14		No Threshold
Clinical Incidents resulting in No Harm	51	92	65	50	63	56	29	40	51	64	88	147	67		No Threshold
Clinical Incidents resulting in minor, non permanent harm	12	20	10	14	8	9	4	7	17	65	39	42	18		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	9	10	8	12	18	13	5	6	5	15	5	4	4		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores	97.5%		86.8%				98.6%	98.5%	98.2%	97.3%	100.0%	100.0%			No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Complaints	8	0	3	4	2	2	3	7	4	4	1	3	2		No Threshold
PALS	55	39	34	63	51	48	25	31	31	36	29	36	50		No Threshold

EFFECTIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Referrals Received (Total)	1,327	1,061	729	1,022	1,116	1,234	1,065	1,146	1,157	1,409	898	1,336	1,132		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	9	21	22	17	25	41	17	12	8	13	2	0	11		No Threshold
OP Appointments Cancelled by Hospital %	11.8%	13.7%	15.0%	12.2%	17.0%	9.7%	13.9%	13.7%	14.0%	17.0%	14.1%	11.0%	15.5%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	13.2%	17.9%	12.1%	16.0%	17.6%	16.8%	16.5%	16.2%	12.1%	10.9%	16.3%	10.7%	15.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	12.5%	16.0%	16.2%	13.8%	13.4%	14.0%	13.1%	12.2%	13.2%	11.8%	14.9%	14.5%	14.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	16.4%	17.6%	14.3%	21.6%	17.6%	17.7%	19.9%	18.8%	10.9%	13.9%	16.3%	11.1%	14.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	18.4%	22.0%	24.4%	24.0%	20.1%	19.1%	15.7%	15.6%	14.8%	14.5%	17.7%	12.9%	17.6%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%	18.3%	16.2%	13.4%	22.6%	13.6%	19.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	12.0%	15.8%	15.2%	10.9%	12.0%	13.8%	14.0%	12.4%	13.8%	12.3%	15.1%	16.7%	15.6%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%	128.6%	128.6%	128.6%	124.9%	114.3%		No Threshold
CAMHS: Tier 4 DJU Bed Days	237	217	216	214	267	217	198	219	252	279	270	270	240		No Threshold
Coding average comorbidities	2.00		8.00			4.50	7.00	3.50			15.00	2.00	2.00		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU				1	1	1		4							No Threshold
CAMHS: Referrals Received	638	374	297	476	526	567	434	536	484	622	350	567	490		No Threshold
CAMHS: Referrals Accepted By The Service	316	173	141	234	302	306	220	277	233	317	171	276	229		No Threshold

Community 000072

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	49.5%	46.3%	47.5%	49.2%	57.4%	54.0%	50.7%	51.7%	48.1%	51.0%	48.9%	48.7%	46.7%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%	54.1%	52.0%	49.7%	54.3%	53.0%		>=92 % >=90 % <90 %
Waiting List Size	808	971	1,147	1,208	1,530	1,629	1,563	1,576	1,646	1,788	1,887	1,979	2,070		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	1	2	2	1	1	1	1	1	0	1	3	9	7		0 N/A >0
CAMHS: Crisis / Duty Call Activity	718	573	367	675	563	766	629	687	619	751	652	800	664		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%	67.2%	70.6%	69.2%	69.6%	64.9%		>=92 % >=90 % <88 %
ASD: Completed Pathways	136	109	237	57	67	115	77	90	78	54	52	64	57		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	18.4%	11.0%	4.2%	10.5%	7.5%	16.5%	18.2%	15.6%	7.7%	1.9%	9.6%	20.3%	5.3%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)			21.4%	10.5%	23.8%	21.7%	25.0%	16.7%	15.0%	12.0%	15.0%	57.1%	71.4%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)			100.0%	66.7%	100.0%	100.0%	50.0%	100.0%	50.0%	100.0%		0.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	150	582	144	143	165	168	177	150	140	157	134	165	171		No Threshold
CCNS: Number of Contacts	835	959	809	736	931	959	951	740	823	904	800	928	914		No Threshold

WELL LED

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-11	287	250	540	16	60	185	346	-77	93	36	297	160		No Threshold
Income In Month Variance (£'000s)	50	154	75	118	-78	59	118	-112	-106	78	53	0	20		No Threshold
Pay In Month Variance (£'000s)	-87	260	167	15	142	319	-9	248	228	-112	17	90	204		No Threshold
AvP: OP New	651.00	570.00	518.00	586.00	593.00	662.00	533.00	543.00	592.00	672.00	125.00	323.00	68.00		>=0 N/A <0
AvP: OP FollowUp	4,220.00	3,732.00	3,069.00	3,804.00	3,423.00	4,157.00	3,414.00	3,757.00	3,600.00	4,091.00	1,152.00	1,539.00	1,147.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan	4,871	4,302	3,587	4,391	4,016	4,825	3,961	4,313	4,204	4,782	1,285	1,867	1,219		>=0 N/A <0
PDR	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%	82.5%	82.6%	0.0%	1.6%	8.2%		No Threshold
Medical Appraisal	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%	0.0%	8.6%	10.8%	9.1%	21.1%		No Threshold
Mandatory Training	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%	92.4%	93.3%	94.4%	95.3%	95.0%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	229	171	127	168	192	166	273	168	278	493	202	254	153		No Threshold
Safer Staffing (Shift Fill Rate)		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%	99.1%	99.4%	96.9%	96.9%	98.5%		>=90 % >=80 % <90 %

Research Division

<table>
<tr><td rowspan="4">SAFE</td><td rowspan="4">Divisional Mandatory training demonstrates good compliance
All Incidents reported onto Ulysses system and thematic reviews conducted periodically.
Quarterly incident bulletin shared with team.
Trust metrics discussed at monthly 121's with staff to encourage compliance.
PDRs underway for band 7 and above
Safe staffing levels supported across the trust with research nurses being released to support ward areas</td><td>Highlight</td></tr>
<tr><td>Mandatory Training > 90%
GCP training 94%
SOP compliance 88% (dropped due to SOP review window)
ANTT compliance 100%
CRD ICP compliant 97.6%
Research staff supported clinical wards when trust fell into red staffing model.</td></tr>
<tr><td>Challenges</td></tr>
<tr><td>X 8 incidents reported in month (6 covid sickness reporting)</td></tr>
<tr><td rowspan="4">CARING</td><td rowspan="4">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)
Held 2 big conversation events and an additional nursing/delivery team meeting to discuss key issues.</td><td>Highlight</td></tr>
<tr><td>X 0 Complaints or PALS concerns
Collaborative working with local services and teams are being established
Research participating in Trust PEG and presenting at July meeting.
PRES link and paper versions given to all families to capture feedback- awaiting response rate from CRN
Actively seeking patient research stories to share (supported by comms team)</td></tr>
<tr><td>Challenges</td></tr>
<tr><td>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.</td></tr>
<tr><td rowspan="4">EFFECTIVE</td><td rowspan="4">Continue with portfolio review.
Clinicians encourage children and young people to make informed decisions about participating in studies.
Research skills training continues with new appointment of education research nurse - excellent feedback from staff
Systems and processes are being reviewed as part of effective and efficient ways of working
Acting matron presented Matron Research awareness survey at June Matron forum and highlighted key points to chief nurse.
Review of commercial contracts completed to check that costings are being done correctly. This feeds into plan for quarterly financial forecasts for commercial activity.</td><td>Highlight</td></tr>
<tr><td>Important Covid 19 and other emerging public health studies (monkeypox) studies remain open within Trust
Trust participating in extension COV09 vaccine study with LSTM, preparing for follow up visits in July.
Stop RSV trial. Leading recruitment site and continuing through summer months as rates remain high</td></tr>
<tr><td>Challenges</td></tr>
<tr><td>CRD working with local system partners to improve research participation.</td></tr>
</table>

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. • Top items from CRD staff survey for improvement continuing- ie Archiving event continues	**Highlight** • Agile working continues to support flexibility for staff • Collaborative working with external partners continues • Team fund has been utilised and gifts (team hoodies) have been distributed. • 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
WELL LED	• LTS numbers have reduced with successful RTW for some staff members. • Internal staff survey results have been collated and shared. • CRF grant for £2m award from NIHR now confirmed • Acting Nursing manager and Acting Matron held extra Big conversation event for delivery team to explore staff retention and internal communication.	**Highlight** • Division supporting staff with Flexible working (hybrid model) • CRD engaging staff with SALS • Monthly team brief meetings continue- with plan for more F2F meetings. **Challenges** • Correct model for future working to be established • Recruitment and retention being monitored carefully due to increase in leavers • F2F exit interviews established with leavers with key questions focussed on retention

Board of Directors

Thursday, 28th July 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

July 2022

1. Introduction

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

As of Month 3 in Quarter 1 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Salient Points

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Programme and Cost Pressure Substantial cost increases expected due to market inflation, availability of labour and / or materials	Working closely with contractor to finalise and agree in preparation for presentation to Board, cost being presented WC 1st August 2022.
Sunflower House / Catkin	Programme delay; HO 25th July 2022 Quality issues	Weekly route to HO meetings held. Meetings held with GT Construction and Commercial Directors on Mondays and Fridays to review performance and delivery. Architectural advisor and specialist experts engaged to review and provide solutions. Early warnings under the contract issued.
Temporary Modular Office	Planning approval	Received for Former Police station module, Alder Centre expected on the 21st July 2022. Working with LCC liaison officer and LPA to agree route.
Main Park Reinstatement	Vacation of Catkin, linked to Sunflower House / Catkin and modulars projects and their programmes.	PM brought in to oversee the management of these works to coordinate and tie together.
Innovation Park 2	Programme delay; HO 15th October due to fire stopping issues.	PM brought in to manage project and ensure new HO date is hit.

3. Programme Delivery Timetable

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

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

4. Project updates

Neonatal and Urgent Care Development

Current status	Risks/issues	Actions
Phase 1 of the enabling works to create a temporary ED car park have completed. Phase 2 of the enabling works 90% complete, additional works identified; service investigations. Infrastructure enabling stopped to allow main contract programme to be reduced. Realignment of the Blue Light road being designed and costed. Finalising contractor selection and contract award. Developing costs and programme. NHSEI approval provided verbally for current stage.	Project delays in contractor selection and appointment. Programme delay due to contractor selection and pause of enabling works. Substantial cost increases expected due to market inflation, availability of labour and / or materials Project Co engagement extending the programme and increasing costs.	Fast tracking cost and programme elements. Establishing early works and enabling schemes to maintain momentum. LOI being agreed. Working closely with contractor to finalise and agree, challenging work package costs, VE and design. Continue working with Project Co to mitigate impact.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Completion date delayed until 25th July 2022. Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates. Furniture and interiors discussions have concluded and so furniture ordering has commenced.	Further programme delays. Quality issues being experienced on site.	Weekly route to HO meetings held. Meetings held with GT Construction and Commercial Directors on Mondays and Fridays to review performance and delivery. Architectural advisor and specialist experts engaged to review and provide solutions. Early warnings under the contract issued.

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. Planning expected on the 21st July 2022. Smaller unit in Police Station car park being provided by Portakabin; layouts agreed and signed off and programme agreed. Planning approval received.	Planning consent for large module.	Liaising with dedicated LCC liaison officer and LPA. Agreed with LPA they will approve under delegated authority unless 5 or more objections are received. Local councillors and residents advised of the plan to gain support.

Police Station

Current status	Risks/issues	Actions/next steps
Lease documents with lawyers for checking. Signatures delayed. 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) Cost increase due to additional asbestos and condition works.	Complete legal agreements. Reviewing works and costings, challenging the design. New PM engaged to manage process.

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Phase 1 of the park is now operational. Grassed area re-seeded and grass recovered. Planning application for the Multi-Use Games Area (MUGA) to be determined by delegated powers by 22nd April 22. Decision pushed back by LCC, who asked for an acoustic survey to be provided. Acoustic report and subsequent move of MUGA location completed and issued to LCC/LPA.	Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9)	Acoustic report and subsequent move of MUGA location completed and issued to LCC/LPA. Awaiting response. Deadline for response is the 28th July 2022.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Landscaping completed for Phase 2 with number of paths started. Phase 3A started within existing Springfield park.	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

Aiming to complete and seed the majority of this Phase in June 22, with a planned early hand back in Summer 2023. LCC engaged and supporting AH in these works.		and demolition. Phase 3A already commenced 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 August 2022. Commissioning workshops started and occupation being planned. Early occupation by Orthotics complete; only storage from Histo to be moved on completion of main works.	Project Co and sub-contractors do not manage the works efficiently.	Regular site meetings to monitor progress.

Innovation Park 2

Current status	Risks/Issues	Actions/next steps
Works commenced on site. Project delayed due to additional fire stopping within existing building. HO date of 15th October 2022	Delays to works delays the move from Catkin.	Regular site meetings to monitor progress.

North East Plot Development

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

Communications

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

5. Trust Board of Directors

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

BOARD OF DIRECTORS

Thursday, 28th July 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:

- Publication of the Digital Health and Care Plan
- Good Operational performance
- Progress and plans for Digital Futures 2022
- AlderC@re Update

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

2. National and Regional Digital Update

In June, NHS England published the Digital Health and Care Plan which is aiming to 'lay the foundations of a brighter digital future by 2025 and beyond. The plan comprises of 4 major goals:

1. Prevent people's health and social care needs from escalating
2. Personalise health and social care and reduce health disparities
3. Improve the experience and impact of people providing services
4. Transform performance

Top line headings form the plan include:

1. Equipping the system digitally for better care (digitising records, EPRs, shared records across systems including social care, diagnostics including clinical decision support based on AI)
2. Supporting independent healthy lives (including NHS App expansion/'NHS services in people's pockets', digital self-help and therapies)
3. Accelerating adoption of proven tech (tech R&D partnerships, buying better tech across health and social care)
4. Aligning oversight with accelerating digital transformation (using regulatory levers with NHSE and CQC, enforcing standards, supporting social care)

The plan has strong links to other national digital strategies, including 'What Good Look Likes Like, Data Strategy and the Year of the Digital Profession. Finally, there is a strong focus throughout on remote monitoring and virtual expansion alongside population health and reducing health inequalities.

Alder Hey currently perform well a number of the goals set out in in the above strategies and the themes in the revised 'Digital and Data Futures' strategy strongly align to the direction of travel set out in the Digital Health and Care Plan. Most notably, 'Healthier Populations through Digital, Data and Analytics' is a theme that will focus in part on Population Health, joining data up from multiple sources to help improve the overall health of the population and will see a switch to more preventative care models. Finally, our Tech Roadmap and

Operational Service Excellence' will contribute massively to '*Improve the experience and impact of people providing services'*

3. Updates to iDigital Service Model

The integrated service continues to evolve and is constantly looking at areas that could be enhanced through partnership working. In May 2022, a proposal was approved by both Trust Executive Committees to consolidate the Information Governance service through iDigital.

The Information Governance service will include the following areas:

- Information Governance
- Health Records
- Access to Health

The joint working will enable:

- Collaboration – performance improvement (FOI, DPIA, governance etc)
- Support for increased workloads – particularly DPIA, confidentiality auditing
- Improve IG process and culture – significant data protection challenges and potential risks
- Potential for integration and shared location of the team to provide cross cover (LHCH and AH)
- Development, career pathway, succession planning to align with iDigital service model aspirations

The TUPE is planned to formally conclude on 1st August 2022.

The iDigital Service is currently undertaking the Level 3 accreditation for Excellence in Informatics as part of the Skills Development Network professional framework.

4. Digital Futures Progress

4.1 Digital and Data Futures 2022

The new Digital and Data strategy is compelte, having been developed over the last 3-6 months. 'Digital and Data Futures' is the successor to 'Digital Futures', a three-year strategy launched in 2019. Delivery of Digital Futures has been incredibly successful for Alder Hey and has seen some major achievements and benefits, as set out in the refreshed strategy. This includes external awards, international accreditations and national recognition.

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

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

In August, the previous strategy will be formally closed through the Digital Oversight Collaborative, which will then enable the mobilisation of Digital and Data Futures. The

designed version of the Digital and Data Futures strategy is included as an appendix to this report.

4.1 Digital Children, Young People and Families

The new governance approach for the Website & Intranet project has been implemented, with departmental leads contributing through a weekly meeting and any points for escalation governed through a project board chaired by members of the Executive committee. The design and vision for the Intranet is nearly complete, with the 'Discovery' phase of the Website due to begin shortly. The Intranet is expected to Go Live in September 2022 and the external website Go Live is planned in for October 2022.

An additional communications campaign for the Symptom Checker is underway, following further interest from other services regionally. The project was recently presented to national colleagues with brilliant feedback and an ask for the Trust contribute to similar national projects following the success of the Symptom Checker.

There are currently 8 specialities live and using ISLA Care at the Trust. In the first week of June, Paediatric Neurology, Neuromuscular, Community Physio (Sefton), Community Nursing went live. This was in addition to the pilot specialities who are already live with the platform. Additional specialties continue to be engaged with the Trust-wide roll out, with over 10 more within the pipeline to be launched in the coming months.

4.2 Digital Quality and Safety Improvement

Following the successful Stage 7 EMRAM accreditation of In November 2021, the Trust continue to work closely with the HIMSS assessment team ahead of the publication of a new set of accreditation criteria.

Following the successful of SMS reminders, the Digital Communications portal has progressed significantly in the last period and the Trust are now live with Digital Appointment and reminder letters to patients. Initial feedback from patients has been really positive and the benefits will continue to be measured. The next phases of this project include digital solutions for clinic outcome letters, inpatient and referral reject letters and finally PIFU pathways.

The iDigital team have supported PICU with a Bedside Management Verification relaunch. Training has been delivered to over 120 staff across the unit and superusers have been identified to support and cascade training further. Hardware has now been relocated following installation of new shelves on the Drager units. The kit is now more conveniently located for usage at the patient's bedside.

Following the upgrade to enable key safety features and functionality, work continues with the surgical division to digitise all surgery consent forms by August 2022. Once rollout in Surgery is complete, the Trust will embark on phase 2 of the project, the introduction of digital consent within the Medicine division.

5. AlderC@re

The Aldercare programme was due to deploy in late September / early October 2022. In May 2022 it became clear that due to a number of risks the programme was unlikely to

deliver safely and effectively in October 2022 with the programme reporting a red delivery status. The delay to the programme was formally agreed by the Executive Team in July 22.

The programme, which is a UK First of Type deployment is currently under review to ascertain the key gaps, improvements and a establish a revised go live date.

The review has already identified some key learnings, notably recognising that the move to Meditech Expanse is not an upgrade as had been advised and therefore resourced for. The system requires an almost complete rebuild which has meant the level of work required to rebuild in the new version is significantly greater than that resourced for. Compounding this, there are still high priority functionality issues with Meditech that have no resolution date.

Early indications are signalling that the deployment date is now likely to be in 2023 due to the amount of remaining work and operational internal Trust pressures over the winter period.

The new system will deliver a much more intuitive system for staff and is much more modern than the system currently in place. In addition, it addresses a number of long standing issues with the current system.

It is recognised that the successful deployment of AlderC@re depends on a strong partnership between Alder Hey and Meditech. An Executive to Executive meeting has been held with Alder Hey and Meditech with a number of key actions and outcomes.

The programme review and revised plans are expected by the end of July 22 for consideration in August.

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 closed 105 ad hoc data requests throughout May.

The teams have supported numerous projects throughout the month including, Recovery Reporting, Executive Scorecard and Corporate Refresh. The team have also delivered ASD & ADHD Dashboards along with an ASD Pathway Dashboard.

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

- Recovery – New content and fixes
- Governance Dashboard
- Expanse Project – work is continuing data migration work for Expanse
- Surgery Data Quality
- Touch Time Utilisation
- Medication’s incident dashboard
- CSDS 1.6 rewrite
- ASD & ADHD Contract statement
- Corporate Report part 2

7. Operational IT Performance

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

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

- Continue with downward trend for overall Tickets raised. There have been 10% less tickets raised in first half of 2022 compared to the same period in 2021.
- Ticket resolutions continue to meet the 95% SLA target. We have hit our target of 95% or more for the last 23 months.
- Resolutions within 1 Day remain high and above SLA.

Average monthly tickets raised have reduced by 3% over the last 6 months compared to the last 6 months of 2021.

8. Summary and Recommendations

In summary, progress with digital developments and delivery at Alder Hey remain positive although as reported there have been significant challenges with the Aldercare programme.

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 and will be officially launched in August.

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.

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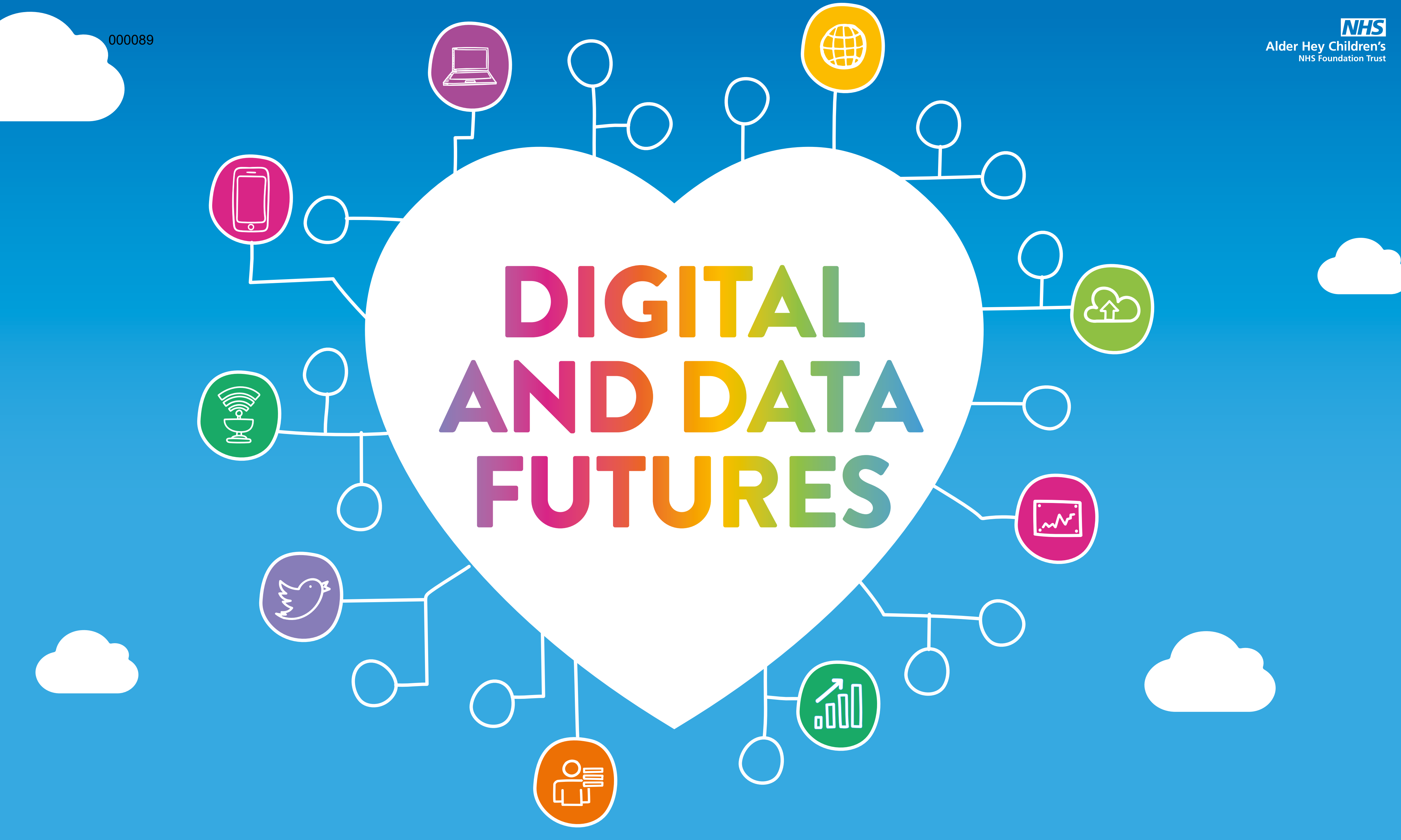
Alder Hey Children's NHS Foundation Trust



Alder Hey Children's NHS Foundation Trust Digital and Data Strategy
2022 – 2025

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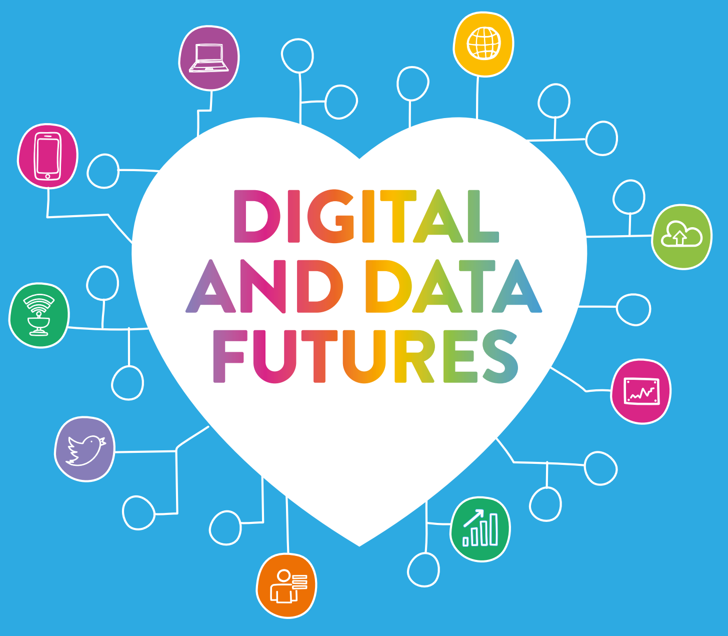


Foreword

Almost everything we do in healthcare is driven by our ability to do it backed by the power of digital technology. The care we provide can be enhanced and improved through the aide that digital technology provides to deliver that care effectively and efficiently. Alder Hey set out to make the digital power central to its care in its first Digital Futures strategy published in 2019.

The impact was game changing.
From the basics of delivering a high-quality user experience for Alder Hey staff to putting Electronic Patient Record delivery as the central goal of daily care we delivered a Trust-wide digital approach that provided confidence in our infrastructure and ambitions.

Today, we need to move to the next phase of our Digital Future with a strategy that locks in the benefits we have and moves forward to ensure that digital helps deliver our Vision: A healthier future for children and young people.

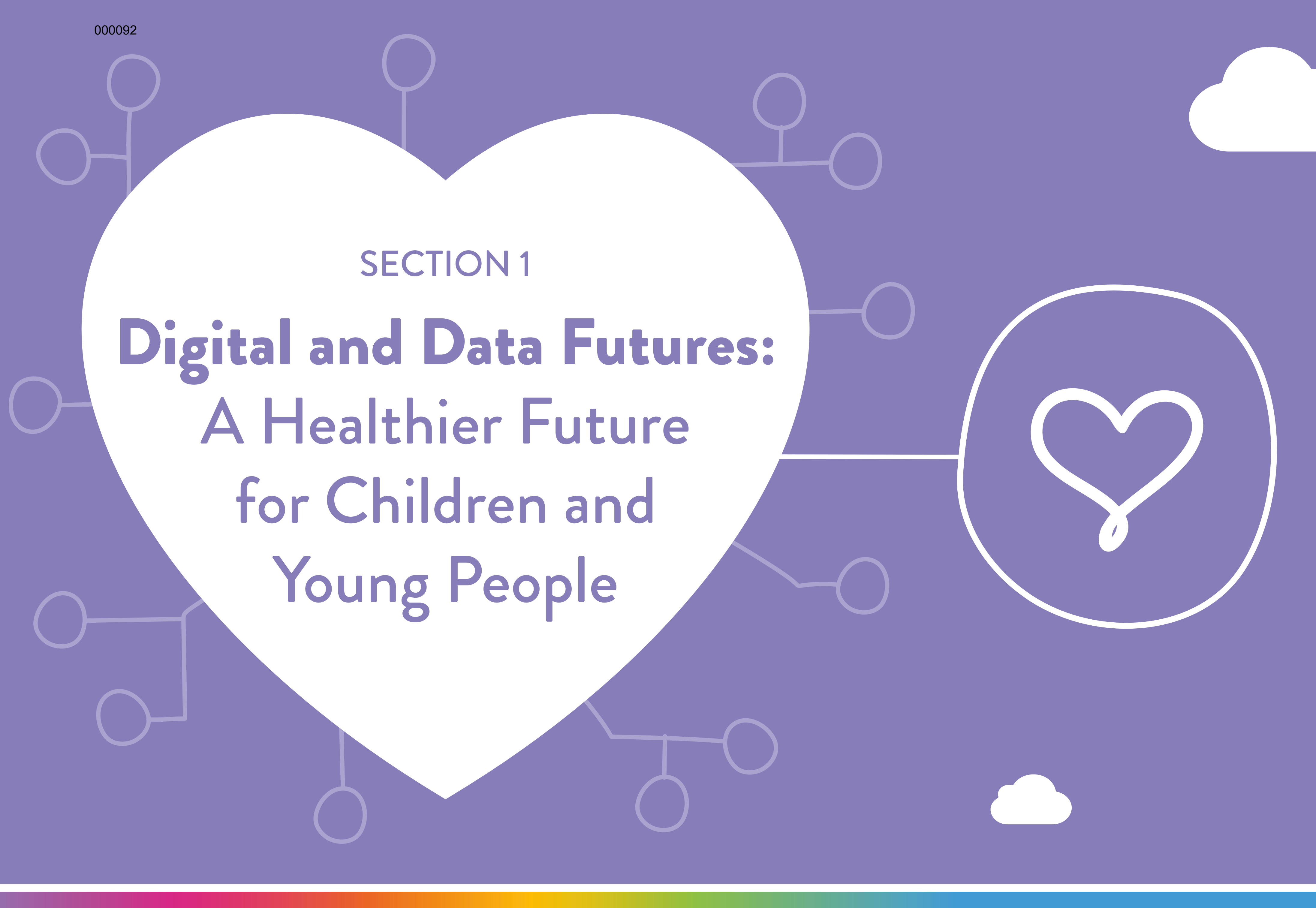
One key new element of that will be a focus on Data: delivering the information we need to analyse and improve upon what we do, on a day to day, minute by minute basis. This addition to our update strategy is a key commitment. It is a pledge to ensure that every interaction, every outcome, every decision will have the capacity to be informed by real time information from which we will learn and adapt.

Delivering this new strategy will not be easy. It requires the guarantee that the future infrastructure enhances staff experience, for example Alder Care must be a success with clinical staff if it is to retain the confidence of those who use it. The detailed work by the iDigital Team must be expertly delivered continuously. The adoption of new technology and approaches by Alder Hey staff has to be with their consent and full confidence. The resources in a tight NHS budget need to be applied efficiently and transparently.

This strategy is about setting the framework for doing all of this whilst keeping our eye on the future needs of our children and young people.

Dame Jo Williams
Chair

Louise Shepherd, CBE
Chief Executive



SECTION 1

Digital and Data Futures: A Healthier Future for Children and Young People

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

We are passionate about this vision which is a big part of why we do what we do each and every day.

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

1.1

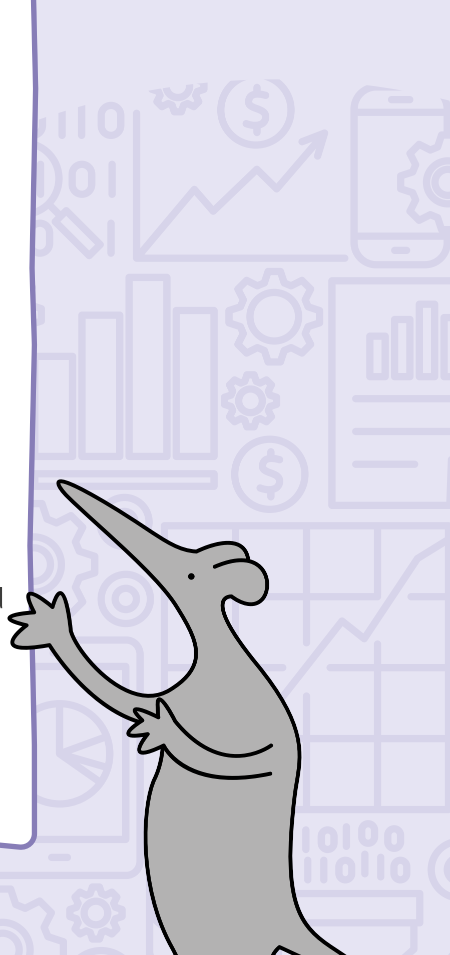
Digital and Data Futures Ambition

We live and work an era powered by digital and data in everything we do. Our ambition is to deliver **'Outstanding Digital and Data Excellence'.**

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

THROUGH THIS WE WILL STRIVE TO:

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

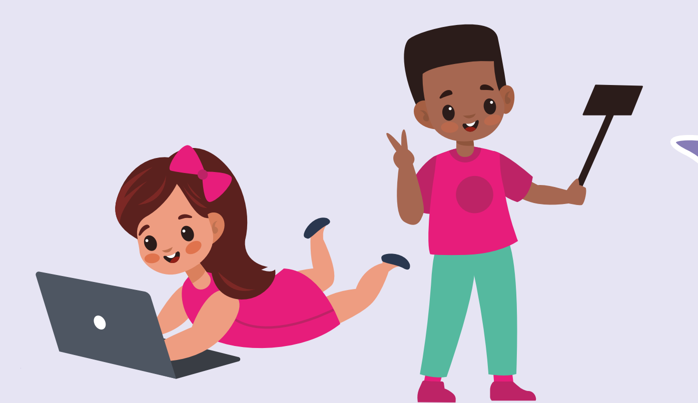


1.2

Feedback from Children, Young People and Families

In the development of Digital and Data Futures we have worked with children and young people to ensure their views are central to our plans.

We have undertaken extensive engagement with clinical and divisional colleagues and wider stakeholders internally and externally.



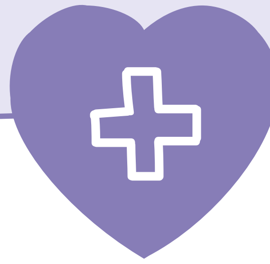
Our Children and Young people have told us that they want us to help them through giving them digital and innovative ways of accessing our services when they are at home. They want us to make sure that when they come to Alder Hey they can access our Wi-Fi easily on their own devices and that when they are waiting to be seen there are digital opportunities to distract them.

Our Families have told us that they want easy online access to Alder Hey services – making their experience of accessing health services as easy as other aspects of their lives. Our Families want their children and young people to have seamless care where all of our information and communications are joined up together.

1.3

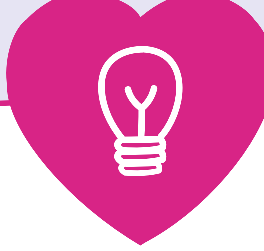
Outcomes and Benefits

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



Safety and Clinical Outcomes

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

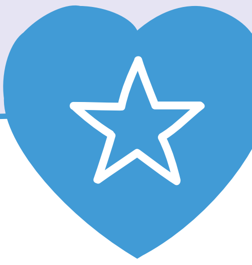


Experience and Empowerment

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

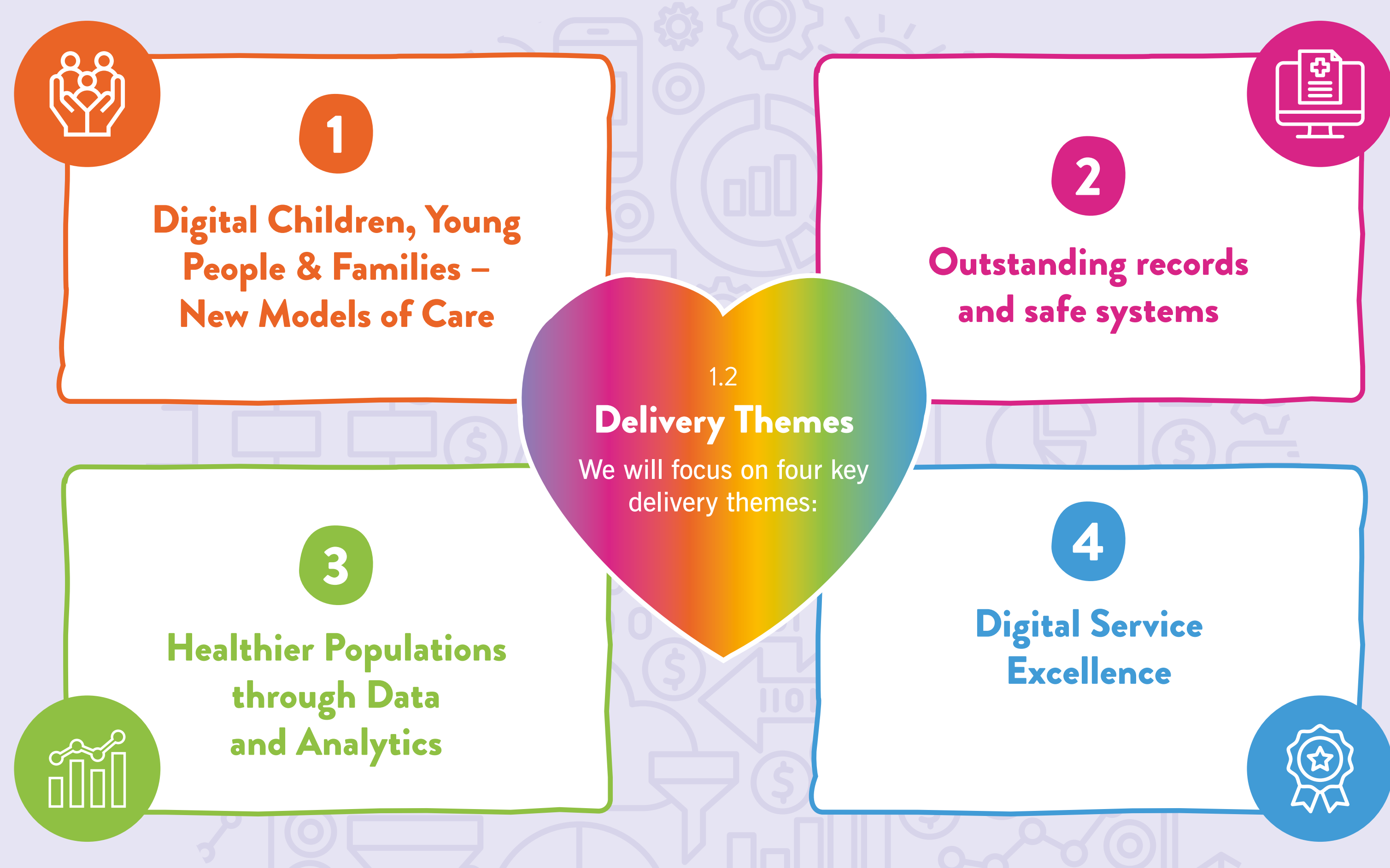
Population Health

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



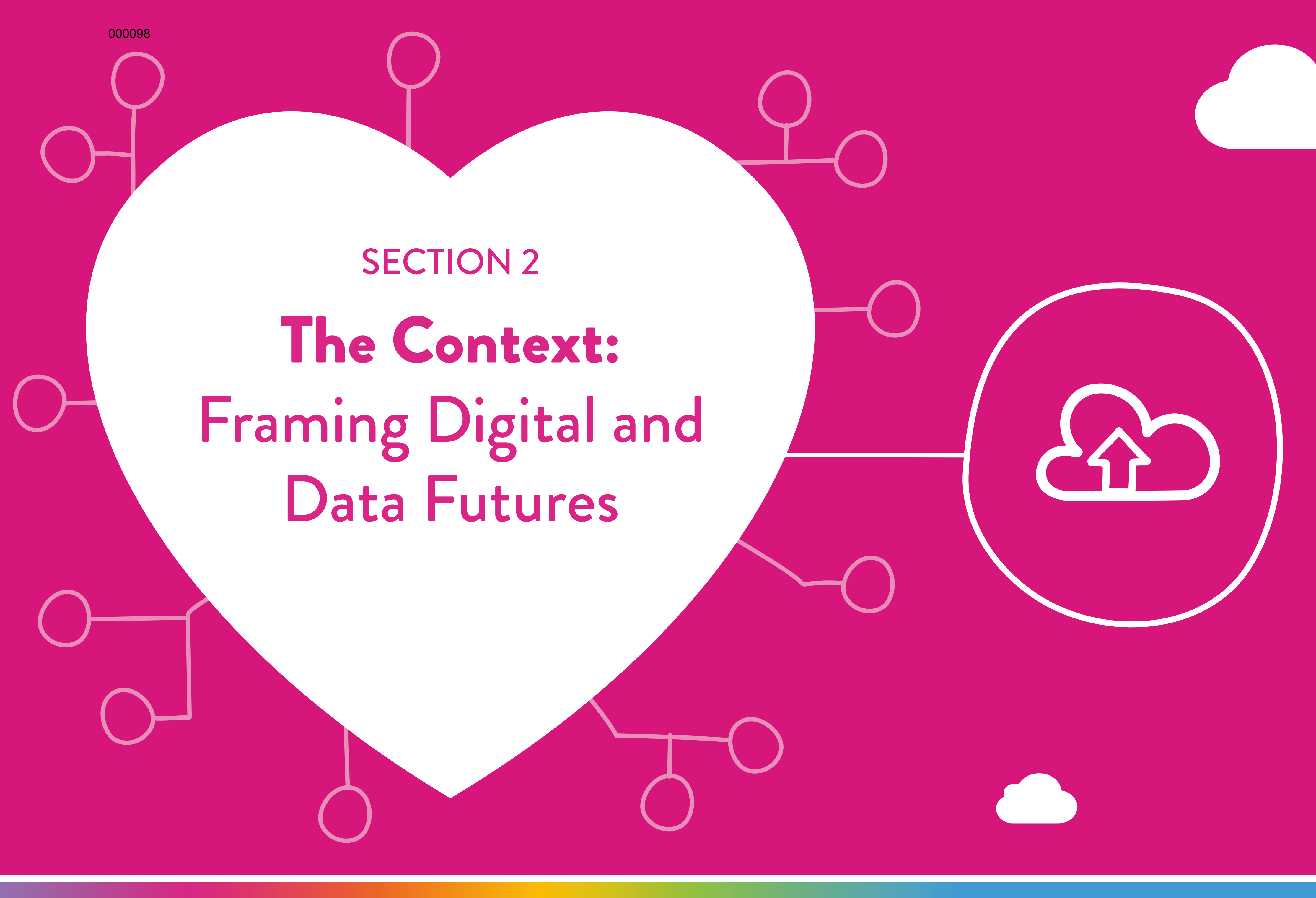
Efficiency

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



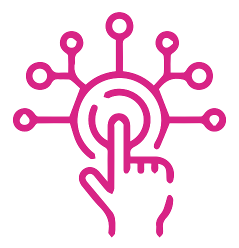
The opportunity of digital and data is immense for health and care services. It has developed exponentially over the past three years and is at the core of operational delivery, safety and innovation. The covid 19 pandemic has been a digital transformation catalyst for many businesses and health services across the globe.

This will grow and grow as we continue to innovate and deliver health and care services for the future.



SECTION 2

The Context: Framing Digital and Data Futures



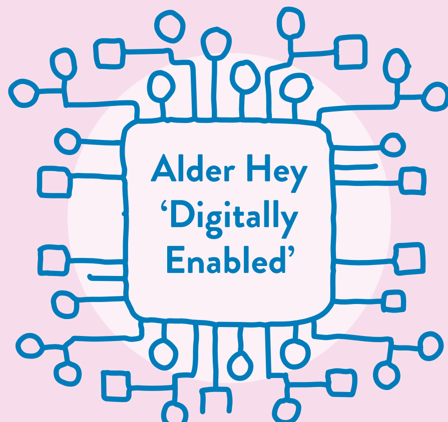
'Digitally Enabled' is identified as a strong foundation in Alder Hey's 'Our Plan' It is a core component of our strategy which runs through our whole strategy from Brilliant Basics and Outstanding Care, supporting our people to do their best work, through to growing the future with game changing research and innovation.

We expect and get a 'digital experience' every day and it isn't unusual, or even "digital". It just is what we do and get - from waking up to our phone alarm, to listening to music, to using 'sat nav' on way to work, online shopping, messaging family and friends on WhatsApp etc.

In health and care services, the use and development of digital, data and technology are critical factors prevalent in much of what we do, but has way more potential and opportunity to truly support and transform the way in which we provide, plan and deliver care.

Digital healthcare in the future is an area of rapid growth and development. We anticipate major changes linked to self care, digitally enabled precision healthcare and preventative medicine, however there are also expected changes to workforce behaviours and patterns. This will be continually reviewed as we set our Alder Hey Futures 2030 vision and strategy.

There is an opportunity for Alder Hey to lead the way with this pioneering thinking including the potential development of national peer networks and internationally working with other children's hospitals.



"the use and development of digital and technology are critical factors prevalent in much of what we do...

2.1

Alder Hey Children's NHS Foundation Trust

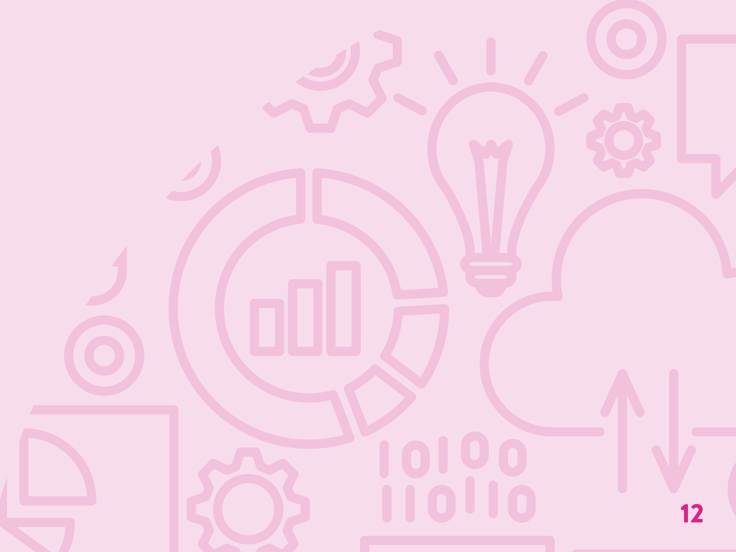
Digital and Data are key parts of our quality improvement Brilliant Basics approach and support all of our operational priorities.

Brilliant Basics aspires to provide care and treatment of the very highest safety and quality, in collaboration with the children, young people and their families who use our services. Each of the workstreams within the Digital & Data Strategy will align with Brilliant Basics to ensure any improvement has a big impact on our staff, children, young people and families.

The Digital and Innovation teams at Alder Hey have always worked closely together in delivering transformation through technology. The new Digital and Data Futures and Innovation strategies have been developed together to further build on this relationship, supporting the interdependencies across the two and harnessing expertise from both teams to improve the way healthcare is delivered for children, young people and families at Alder Hey.

Looking ahead to Alder Hey Futures, in concert with research, innovation and education, digital and data are part of the pioneering powerhouse to help us meet our 2030 ambitions for a healthier future for children and young people.

Brilliant Basics aspires to provide care and treatment of the very highest safety and quality in collaboration with the children...



2.2

Working with Partners

Alder Play plays an active role nationally, regionally and at Place. We work with many partners to deliver, improve and innovate how we care for children and young people. Our partners include local, regional, national and international experts in health, care, academic and industry fields. Working together in collaboration is a core part of how we deliver with impact, passion and energy.

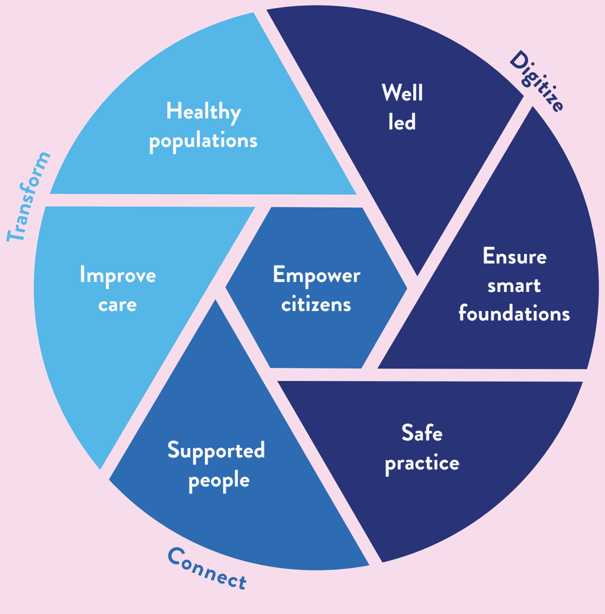
2.3

National and Regional Landscape

Nationally, there has been a significant change in the structure and priorities of digital and data. The Digital, Data and Technology (DDaT) approach, functions and profession have been significantly strengthened and integrated into NHS England / Improvement structures.

The NHS digital and data strategy is focussed into three interconnecting ambitions of Digitise, Connect and Transform. These ambitions are underpinned by the NHS data strategy and What Good Looks Like (WGLL) Framework. A more streamlined approach to investments is underway alongside the devolution of some areas to emerging integrated care systems and boards.

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



WGLL sets out a clear set of expectations for local systems and organisations with regards to good digital practice across health and care. Its aim is to provide clear guidance for leaders to digitise, connect and transform services safely and securely.

Sonia Patel, System CIO for NHE England and Improvement commented on WGLL at Alder Hey: "I'm overwhelmed by what I've seen, from the innovation work to implementing brilliant basics. The best way to describe it is 'awesome.' The standout for me has been looking at the user centric digital transformations. Alder Hey have developed a culture of understanding and trust with clinical and operational staff which has forged a foundation where digital transformation has been able to flourish whilst also keeping focussed on ensuring brilliant basics."

There is potential to work with national colleagues in trailblazing work on a paediatric minimum data set for an electronic patient record. This could include creating a blueprint for a national eRedbook making the best use of the national infrastructure to trial something locally.

Nationally, much work is ongoing with regards to the digital profession with a move to encourage professional registration and membership of digital and data professionals. 'The Year of the Digital Profession' has been launched in 2022.

"...Alder Hey have developed a culture of understanding and trust with clinical and operational staff which has forged a foundation where digital transformation has been able to flourish whilst also keeping focussed on ensuring brilliant basics."

2.4
Cheshire & Merseyside Digital and Data Strategy

Across Cheshire and Merseyside, there is a wealth of talent and expertise in relation to digital and data. Cheshire and Merseyside is one of the more digitally mature Integrated Care Systems with many of its members having well established, digitally mature systems.

Cheshire and Merseyside have been working together on digital developments for many years leveraging national investments and partnerships. Successes include a vibrant cyber security community, extensive sharing of records across boundaries and a shared system wide analytics platform. The development of the **Combined Intelligence for Population Health Action (CIPHA)** platform and the **System P** programme present opportunities for Cheshire and Merseyside to develop a system wide population health approach.

The Cheshire and Merseyside digital and data strategy is currently in the process of being refreshed. The core elements of the new strategy are referenced in the diagram below.

Strong Foundations

Reliable, seamless and secure digital and data infrastructure and associated support across the system

Strategic Data Platforms

Data platforms for strategic ICS digital and capabilities, e.g., for shared care records, population health management, BI, person held records and remote monitoring

System Wide Tools and Services

Digital and Data applications, tools and services that leverage the Strategic Data Platforms to support delivery of the ICS health and care objectives

Capabilities mainstreamed and embedded

2.5
Liverpool Place

Within Liverpool Place, a digital and data group has been established and strategy in the process of being developed for the City.

The Liverpool Digital and Data Strategy sets out 5 integrated themes, built around 4 main pillars, that together aim to deliver a digital and data transformation for Liverpool Place's health and care sector. It sets out a framework for pursuing, up to 2025, an ambitious but realistic approach to how digital and data solutions that align with WGLL standards can contribute to improving people's health, care and well-being, raising user satisfaction with health and care services, encouraging self-care, prevention and self-management of diseases whilst tackling the considerable challenges of an ageing population and increasing demands on a health and care sector that has human resource constraints and continuing financial pressures.

THE KEY THEMES, BUILT AROUND THE 4 PRIMARY PILLARS, ARE:

- **EMPOWERING CITIZENS:** Digital access to the NHS and digital tools to self-manage health, care and well-being
- **BOOSTING HEALTH** and care service quality, capability and efficiency
- **SUPPORTING HEALTH** and Social Care Professionals
- **EXPLOITING DATA** for business intelligence, research and innovation to improve population health
- **INNOVATION,** sustainable health and social care services, economic development and high-value jobs
- **IMPROVING** the digital and data infrastructure and cyber security resilience for Liverpool's health and care system

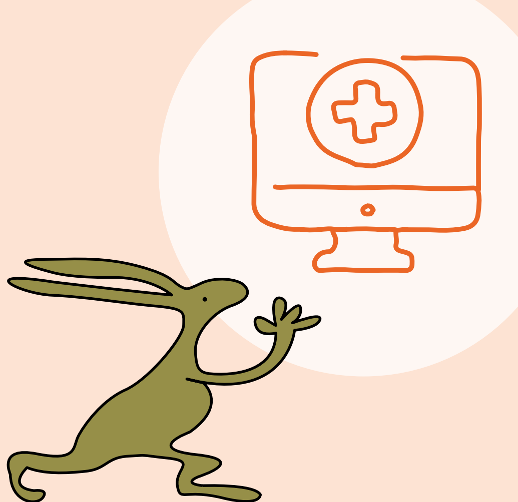
SECTION 3

What a Journey… Reflections on the Last 3 Years

Digital Futures was launched in Alder Hey in 2019. Digital Futures was built on a set of solid foundations.

Digital Futures strived to improve experiences for children and young people and for staff and to put Alder Hey firmly on the map with external kitemarking and endorsement of our digital developments.

Since 2019, major progress has been made with the delivery of a significant amount of digitally enabled change. To achieve this, whilst dealing with a global pandemic, typifies the culture at Alder Hey, which has embraced the technology and taken many leaps of faith along the way.



Dr Christopher Grime, Chief Clinical Information Officer reflected,

'When we looked back at the last 3 years and our previous digital strategy, none of us could have predicted the arrival of a world-wide pandemic.

While COVID-19 has been devastating for many and is a significant challenge for the NHS in general, it has become an opportunity to develop and expand. Never before have we in the NHS been given the opportunity to stop and 'reverse engineer' what we do.

Thanks to the efforts put in place by our team before pandemic and generous donation from the charity allowing us to purchase new hardware, we enabled virtual working on a scale we never thought possible before which allowed many of our services to continue uninterrupted.

Now that we are facing the recovery phase of the pandemic, we are reflecting on those new ways of working and acknowledging that many of them lead to more efficient processes and better care from patients.

With minor refinement, our new digital and data processes and pathways offer a great opportunity to improve the way we work. We are facing a very exciting future as a fully digitally enabled trust.'

Key achievements from Digital Futures include...

3.1

Safer care for children and young people

Digital Futures helped to enable much safer care through introducing a range of tools and technologies. Alder Hey staff developed a paperless programme with the increased adoption of the Electronic Patient Record and the introduction of many specialty packages through the Global Digital Exemplar programme, supporting specialties to capture key information digitally.

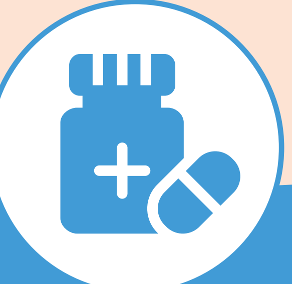
This enabled clinical records to be available from anywhere for staff, facilitating new and different models of care. Closed loop technologies were developed to support the safer administration of milk, blood and medicines and alerts and warnings were built into prescribing and clinical decision support systems.

Having achieved the prestigious **Healthcare Information and Management Systems Society (HIMSS)** Electronic Medical Record Adoption Model (EMRAM) Stage 6 in December 2019, as part of the national Global Digital Exemplar (GDE) Programme, we then become the first specialist Trust in the UK and the first paediatric hospital in Europe to have been awarded **HIMSS EMRAM Stage 7** in November 2021. This international accreditation really put Alder Hey on the global map for digital healthcare demonstrating a culmination of achievements and clearly showcasing the difference improving care and services through digital in Alder Hey has made to children and families lives.

A number of analytics case studies were presented by clinical and operational leads from across the Trust as part of the accreditation. Each outlined how they had used data to identify and resolve clinical, financial and operational problems across the Trust. Example case studies included:

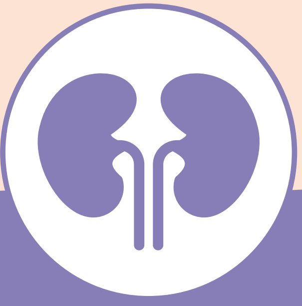
Asthma Mapping

Liverpool children and young people with asthma are 15 times more likely to be admitted to ED for a preventable asthma attack. It is evident that there are major socioeconomic determinants of health within Liverpool are present. In order to better understand the incidents of asthma attacks across Liverpool, the goal of this project was to track Emergency Department admissions in order to highlight areas within the region with higher admission rates. A heat map was produced to depict locations with high paediatric asthma morbidity and its related contributing factors, before implementing specific evidence-based interventions



Polypharmacy Ward Round

Adverse drug reactions are responsible for 3% of all paediatric admissions. In turn, adverse drug reactions lead to complications in 15% of inpatient stays. Reporting these adverse drug reactions to spontaneous reporting schemes in order to identify these suspected harms remains low. This project established a service to identify and monitor children and young people with potential problematic polypharmacy across Alder Hey and since the service began, there has been a significant reduction in children and young people taking more than 20 different medications



Acute Kidney Injury

At Alder Hey we see around 200 children and young people every year with severe AKI and just over half of these have exposure to nephrotoxic medication. This is a significant, preventable, problem locally, nationally and internationally. This project aimed to reduce avoidable harm and death for children with acute kidney injury, and to improve care for patients whether in hospital or at home. The implementation resulted in a reduction in medication errors and adverse drug reactions

The Cheshire and Merseyside Integrated Care System Digital Leadership

"HIMSS Stage 7 status is the highest level of digital accreditation a healthcare organisation can achieve and it is rare with only a few organisations globally achieving this level of digital maturity. Cheshire and Merseyside are truly honoured to have Alder Hey operating at this level, not only because they are in a continuous improvement cycle using digital and data to benefit our children and young people, but they also act as a beacon to others, sharing and supporting others in our NHS community with great humility".

Major clinical digital improvements delivered through Digital Futures include:

- **Introduction of an Electronic Anaesthetic Record:** the implementation of a digital platform, which fully digitised the anaesthetic process in Theatres, improving efficiencies and patient care
- **Cardiology Imaging System:** A solution for Cardiology, helping them manage and report on Echos in a safer more efficient manner improving cardiac and cardiology services for our children and young people
- **Online Symptom Checker:** the demand on our Emergency Department grew exponentially during COVID recovery, the development of an innovative online symptom checker integrated into our website has meant families can glean clinical advice for their children from the comfort of their own homes.

"The electronic anaesthetic record was implemented in early November 2021. It has already delivered several of the projected benefits including improved quality and detail of the anaesthetic record and provided instant availability of historical records at all times, both for clinical use and coding/audit. I believe features such as highlighting risk factors and clinical reminders for tasks have improved safety and quality of care. The implementation of this application has revolutionised the way the Theatre & Anaesthetic department work in Alder Hey"

Dr Harvey Livingstone, Clinical lead, Electronic Anaesthetic Record system

Alder Hey became one of the first Trusts in the UK to receive a formal Global Digital Exemplar accreditation from NHSX (now NHS England/ Improvement). The Trust are formally nationally recognised as national 'Digital Leaders' in healthcare.

3.2

Improved Experience for Staff:

In the development of digital futures, a key priority highlighted by colleagues was to work on a range of service improvements for staff. These included speed of access, access to modern equipment and digital tools to support colleagues in their day to day work. A major technology roadmap was developed to support this with significant levels of investment.

This work included a major shift to create a modern workspace for Alder Hey staff. This programme saw early migration to Office 365, which we did not know at the time would become so essential as a way of staying connected during covid times. Migrating all staff to Office 365 has garnered greater flexibility, security, access to key information enabling staff to work in a more agile manner. This was complimented with a huge device refresh programme ensuring staff have the best digital tools and equipment available to do their jobs.

Behind the scenes, a refresh of the core infrastructure was completed, providing greater resilience for our Digital Systems. There has also been some great work on keeping our information secure, with some major investments in Cyber Security. This has culminated in the Trust being accredited with the national Cyber Essentials kitemark.

3.3

Digital COVID Response

When the pandemic hit, the prevalence of digital technology catapulted into new heights across the globe. This was no different in Alder Hey where we embraced a 'digital first' approach using the technology that had been developed to keeping both patients and staff safe. Over 700 laptops were distributed to colleagues alongside a mass adoption of Microsoft Teams to ensure communication channels remained open amongst staff.

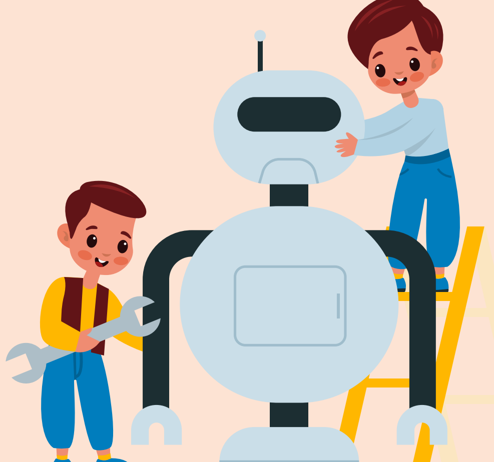
With over 700 clinicians trained in 3 weeks the Trust deployed Attend Anywhere enabling us to continue to care for our patients through virtual consultations. The Trust really embraced this and has performed over 50,000 virtual appointments to date. We are proud that no child or young person had their therapy appointments cancelled as we moved to new, virtual models of care.

We provided virtual visiting solution with the Patient Liaison Service enabling children and young people who were inpatients to communicate with their families during the national restrictions.

"I can't even begin to tell you what a difference such a small act has made to her. She was so low earlier today and this has enabled her to keep going during this difficult time."

Feedback from an Alder Hey family member

The deployment of the '**RoboDoc**', a telemedicine on wheels unit, meant shielding clinicians could still care and offer diagnosis for patients remotely, using high powered robotic camera technology. This was also deployed jointly across our partners at Liverpool Women's Hospital which enabled the neonatal teams to continue to provide safe care to their tiny patients and their families.



A mother of a premature baby said, "Under normal circumstances a surgeon would travel from Alder Hey to check on his wound regularly. A week following surgery his wound started to weep, but there was no way for a surgeon to jump in a car and go across the city like they normally do. That's where the telemedicine robots came in. We used it throughout our time in hospital, the surgeon could zoom in on the wound and you felt like they were in the room. I genuinely don't know what we would have done without the robots. During lockdown this became the norm and it saved so much time as the surgeons could see him immediately when they needed to."

3.4
Benefits Impact

The digital initiatives implemented within Alder Hey over the last three years have introduced significant benefits. Over 10,000 hours of efficiencies have been saved through the introduction of technology.

There has been a marked improvement in both staff and patient experience across a number of projects. The projects within the safety programme have seen a considerable reduction in errors, making a marked improvement to the care patients receive within the Trust.

Peter White, Chief Nursing Information Officer

Nurses in Alder Hey have benefited from continuous development to the EPR, safer medicines management and pioneering research from the DETECT study which enabled mobile observations and improvements in the management of deteriorating patients. Using data to improve care is the norm - dashboards displaying audits such as hygiene audits as well as Safe Staffing encourages staff to use data to continue delivering outstanding care to everyone. Nurses naturally have to evolve as medical practice develops. They also need to be current with the needs of their patients. For the Children and Young People accessing services within Alder Hey this involves an increasing reliance of digital solutions. Whether that is for entertainment, socialising or education, families expect the health service to keep pace and allow them to stay connected.

THE BENEFITS

A snapshot of benefits from various projects are highlighted below:

Telemedicine, virtual appointments and digitising height and weight have helped to achieve c.£115K in non cash releasing efficiencies saving patients having to travel to Alder Hey also contributing to our net zero ambitions

Approximately 11,000 hours have been saved through telemedicine, e-consent, electronic anaesthetic charts and surgery dashboard

Bedside verification, digital scales, econsent and ophthalmology digital records have helped to reduce harms by 59%

Attend Anywhere, virtual visiting and the ED symptom checker have supported an improvement in patient experience by 54%

An average £39k per month has been saved for patients not having to travel to site following the introduction of virtual consultations

Many programmes including better basic equipment, office 365, one drive have supported a 71% improvement in staff experience

3.5

Digital Service and the Birth of iDigital

The digital service has grown from strength to strength over the past 3 years. The service has grown in size and shape and has gone from being somewhat 'back office' to front and centre alongside our clinical teams and a true clinical support service. Some of the huge successes include:

- **The much valued Digital Drop** in Centre in Room 5 on the Mezzanine in the main hospital and in community sites. This provides a single point of access for staff to Digital Support enabling faster turnaround times and better results when solving technology issues
- **Business partnership** model with digital, clinical and analytics colleagues embedded in divisional structures
- **Digital staff** known, valued and respected across Alder Hey teams

In June 2021, Alder Hey collaborated with Liverpool Heart and Chest Hospital to form an integrated digital service; iDigital (Integrated Digital). The iDigital team now provide a joint digital service to the two Trusts and the model has brought significant benefits including collaboration, efficiencies and knowledge sharing, as well as development opportunities for staff. Feedback from the organisations has highlighted the positive impact the collaboration has had on delivery of digital initiatives.

Staff development is a key priority of the iDigital service and over the last three years, each Trust has achieved the Northwest Informatics Skills Development Network accreditation for Excellence in Informatics. This accreditation assesses staff development opportunities, governance, and leadership value.

3.6

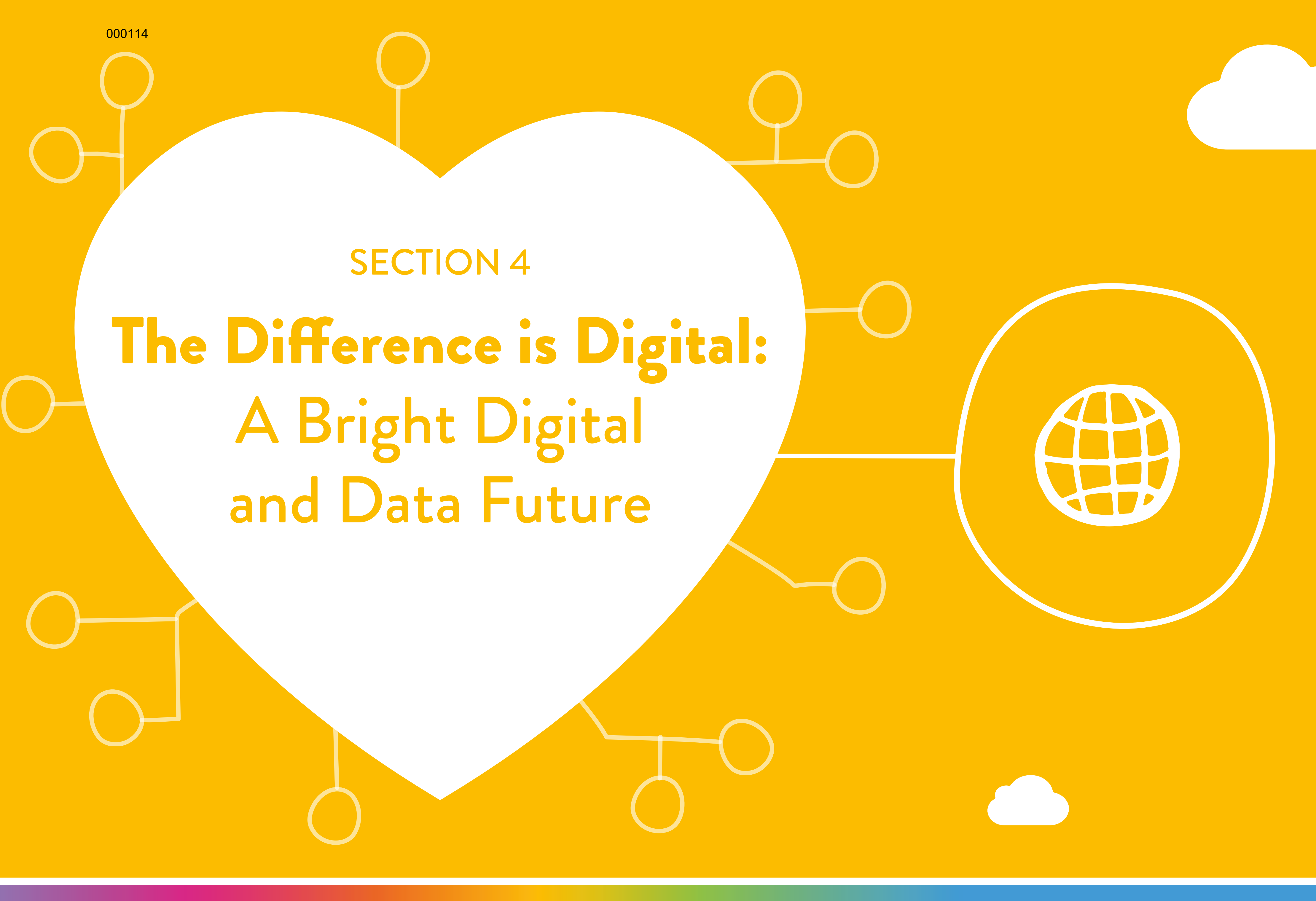
Celebration and Recognition

The Digital team were awarded a number of accolades for work in support of the pandemic response, and work more widely. This included a prestigious HSJ Award in the 'Digitising Patient Services Initiative Award'.

Chief Digital and Information Officer, Kate Warriner

"An extraordinary amount has been accomplished in the digital space at Alder Hey, and we are thrilled to achieve this award in recognition of that. In the face of unprecedented challenges, our Digital teams worked together with clinicians, innovation colleagues and other internal and external partners to achieve the seemingly impossible; delivering what was required to support our children and young people, their families and our staff."

In 2020, Alder Hey was named Overall Winner at the Health Tech Awards hosted by Health Tech News. The team were also nominated for the Tech Project of the Year Award and the Delivering at Pace Award and were highly commended within each category.



SECTION 4

The Difference is Digital: A Bright Digital and Data Future

4.1
Our Ambition

We live and work an era powered by digital and data in everything we do. Our ambition is to deliver ‘Outstanding Digital and Data Excellence’.

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

Through this we will strive to:

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

Our vision for data through our strategy refresh is to establish a world leading Digital, Data and Insight Service.

Our digital and data strategy will support us to use data and analytics not just as management information but at a personal level. The step change in strategy and approach will support our efforts in population and preventative health. We have never been at more risk of excluding people in our populations, a streamlined effort will help to minimise this risk and work in a system of inclusivity with a concerted effort to tackle health inequalities.

As part of the strategy, we will help citizens to improve their digital skills and remain mindful of digital inclusivity in all that we do.

Processes will be in place to ensure the strategy initiatives do not introduce digital exclusion through their delivery, whilst also embracing areas where digital and data can facilitate inclusion, for example digital letters allowing patients to translate into other languages or use screen readers.

The digital and data approach will support education and training coming together in a way that enables us to move forward, harnessing our data and intelligence to inform us where interventions and proactive support is needed. This will help with workforce skills, capability and capacity.

A real focus on data quality and data entry is vital including a move to automation and maximising the potential of innovation at scale leveraging all opportunities within our gift.

Integration with our research and innovation framework and research programmes is crucial, particularly in supporting the next generation of precision medicine and new therapies and treatments.

4.2

Digital and Data Futures Themes

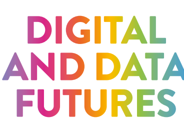
Digital Futures will be delivered through 4 core themes. Within each of these themes will be a number of distinct Programmes of work, which will each align and contribute to achieving overall outcomes of strategy.

Digital Children, Young People & Families – New Models of Care

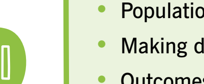
- Innovation into Digital – new models of care delivered at scale
- Alderhey Anywhere deployment inc portal
- OP transformation
- Virtual ED
- Symptom checker expansion
- Website and Intranet

Tech Roadmap & Operational Service Excellence

- Consistent high quality service delivery
- Cyber and resilience standards
- Tech & infrastructure programmes of work



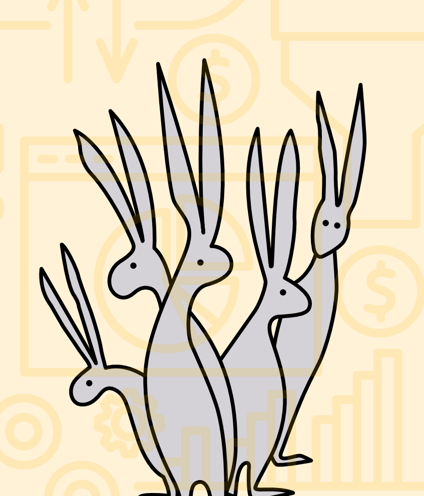
Healthier Populations through Digital, Data and Analytics



- Population health analytics
- Making data count
- Outcomes
- New BI portal implementation (maximising / streamlining Power BI)

Improved Digital Experience for Staff

- Successful Aldercare Go Live
- EPR maximisation and development programme
- Theatre management
- Bed management and Flow
- Digital Dewi



Theme 1:

Digital Children, Young People & Families – New Models of Care

At Alder Hey our Children, Young People and Families are at the heart of everything we do and this theme strongly supports that value.

When the pandemic hit, we delivered care differently in order to keep our Children and Young People safe. This was largely enabled by digital technology, which was rapidly adopted by clinical services, facilitating remote care through a number of different vehicles.

Post pandemic, we are now in a recovery phase and we need to build on some of the successful models, growing our capability to care for more patients virtually, creating physical capacity for those that need it most.

When the pandemic hit, we delivered care differently in order to keep our Children and Young People safe.

Through our virtual services, digital technology will support new models of care at scale including key priorities such as elective recovery and enable the reshaping of clinical services. Through solutions like remote monitoring and the expansion of our online symptom checker, children and young people can receive care and be kept safe remotely, reducing the need for unnecessary attendances or follow ups.

The main focus of this theme is providing patients with a portal; delivering one, central 'digital front door' to all of the virtual services within Alder Hey, improving access and modernising the way healthcare is delivered to children and young people.

Working alongside the Innovation Team, the successful delivery of **AlderHey@nywhere** platform will allow this portal to be developed. This solution will combine with the modernisation of the Trusts website and provide children and young people with a single point of access to a plethora of digital services and education. For clinicians, it will deliver an integrated platform, to monitor and patients' conditions in real time from any location enabling them to only bring patients to hospital when absolutely necessary.

Within Outpatient Transformation we will deliver a wide range of initiatives to improve the utilisation and efficiency of the service. This will support key priorities such as Patient Initiated Follow Ups, helping manage waiting lists more efficiently ensuring we see patients most in need more quickly.

Providing children, young people and families with greater access to clinical services, advice, guidance and subset of their medical record we will aim to empower our children, young people and their families to be able to take more ownership of their care and improve their experience and outcomes.

Programme	Deliverables / Projects	When
Virtual Services	Expansion of Online Symptom Checker	**22/23 – 23/24**
	New Intranet and Website	**22/23**
	Virtual Consultations for Emergency Care	**23/24 – 24/25**
	Advice & Guidance Consolidation	**22/23 – 23/24**
	Patient Portal/ Alderhey@nywhere	**22/23 – 24/25**
	Virtual Wards/Clinics	**22/23 – 24/25**
	Digital Community and Mental Health	**22/23 – 23/24**
Outpatient Transformation	Optimising Virtual Consultations	**22/23 – 23/24**
	Paperless Outpatients	**23/24 – 24/25**
	Remote monitoring	**22/23 – 23/24**
	Patient Initiated Follow Ups	**22/23 – 23/24**

Theme 2:

Outstanding Records and Safe Systems

This theme focusses on making a step change improvement in the usability of our digital systems and electronic patient records.

Our digital platforms support our staff to do their best work in delivering outstanding care to children and young people, so its vitally important they are optimised to meet the evolving needs of the Trust.

The theme will be delivered through 4 key programmes:

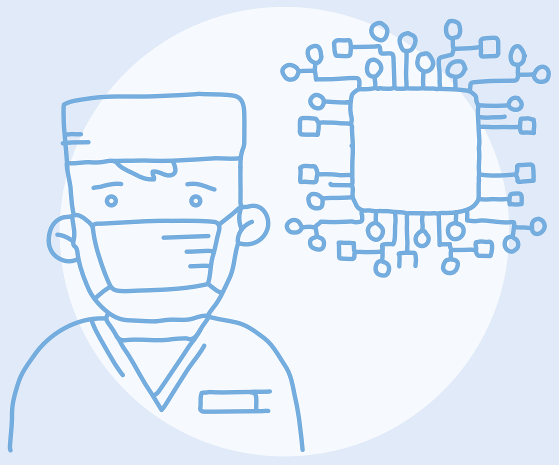
- **AlderC@re**
- **Digital Safety**
- **EPR Optimisation**
- **Divisional Digital Programme**

The successful delivery of **AlderC@re** is one of the main components of the strategy. This will see the move to the latest version of our Electronic Patient record which will provide a more modern and intuitive user interface along with improved functionality in key areas. We will work in partnership with clinical and divisional colleagues to ensure the transition is as seamless as possible.

Alongside this we will continue to develop and deliver our **Digital Safety Programme**. Reviewing and expanding on existing technologies, building on our current levels of clinical decision support and responding to divisional priorities will continue to contribute to a reduction in errors and improved outcomes.

Following the successful implementation of AlderC@re, a continuous optimisation programme will be established. We recognise that the needs of our services continuously evolve and our digital systems must be capable of responding to the changing needs. Through this programme we work collaboratively with the Divisions to create a mechanism for capturing and coordinating the delivery of prioritised system improvements.

It is pivotal that the digital and data strategy is shaped by the priorities of each of our clinical divisions. We will work together as 'one team' to provide a joined-up service to staff. Through our assigned Digital Divisional leads, we provide a single point of contact ensuring our service is fully integrated and aligned to clinical and operational needs.



Programme	Deliverables / Projects	When
AlderC@re	Go Live of Alderc@re programme	**22/23 – 24/25**
Digital Safety and Efficiency Programmes	Closed Loop Technology Phase 3	**23/24 – 24/25**
	Paperless Pharmacy and automation	**23/24 – 24/25**
	Digital ECGs	**23/24 – 24/25**
	Integrated observations	**23/24 – 24/25**
	E-Handover	**23/24 – 24/25**
	EMRAM HIMSS 7 Re-accreditation	**23/24 – 24/25**
	Facilities Improvement Projects	**22/23 – 24/25**
EPR Optimisation	Optimisation Strategy	**23/24 – 24/25**
	EPR Optimisation Group	**22/23 – 24/25**
Surgery Digital Programme	Digital Theatre Management Solution	**22/23 – 23/24**
	Digital Outpatient Room Booking and Utilisation	**22/23 – 23/24**
	Bed Management and Patient Flow	**23/24 – 24/25**
Medicine Digital Programme	Remote monitoring solutions	**23/24 – 24/25**
	Virtual Emergency Department	**22/23 – 23/24**
	Integration of Telederm with GP practices	**22/23 – 23/24**
	Expansion of symptom checker	**22/23 – 23/24**
Community and Mental Health Digital Programme	EMIS Optimisation	**23/24 – 24/25**
	Sunflower House	**22/23 – 23/24**
	Tier 4 In Patient Unit Digitisation	**22/23 – 23/24**

Theme 3:

Healthier Populations through Digital, Data and Analytics

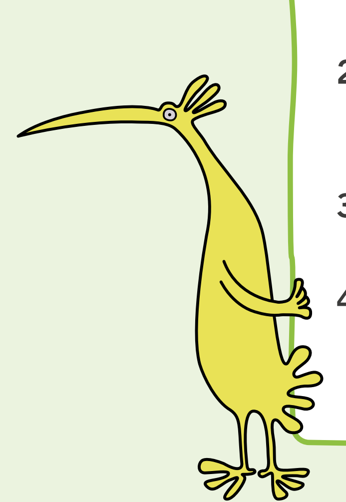
Data is an integral part of the NHS, effective use of data at all levels of the NHS, and beyond, can deliver better care for our children and young people. The reliance on data and analytics for our clinical and operational services at Alder Hey has never been greater. The use of data at Alder Hey Children's NHS Foundation Trust has increased dramatically over the past 2 years in line with the pandemic, the alignment of Digital and Data is key to taking the next steps.

It is important we empower our staff, children, young people and families by making information as accessible, digestible and accurate as possible, for them to make key decisions and transform service delivery. Working with education and children's services, this work has a huge role in supporting outreach and promoting better health and wellbeing for children and young people.

This theme will also stretch beyond our virtual walls and strengthen our impact on population health, connecting our data up with other providers and sectors, adding value to the rich data we already possess. The analysis of this combined data can lead to more targeted and preventative care across the region, improving the overall health of our population and reducing attendances and admissions to hospital.

The 4 key programmes to support this theme are:

1. **Clinical Outcomes:** our vision is to collect data that allows us to measure changes in health, function or quality of life that result from our care.
2. **Population Health Management:** we want to better understand our communities and the differing health and wellbeing needs of children and young people by analysing available data.
3. **Making Data Count:** we will implement the principles of Making Data Count for all relevant reports and update our performance reporting narrative
4. **Access to Data:** all staff members will have appropriate access to timely analysis or data that enables them to provide the best care to our children and young people



We will use the **HIMSS Adoption Model for Analytics Maturity (AMAM)** to provide an external kitemark assessment of our analytics capability and utilise the maturity model to govern the data aspect of the Digital Strategy.

Our approach to data and analytics will include a blend of internal developments and resources, working in partnership with universities and co-innovating with industry. We will play our part as a partner within our **Integrated Care System** linking into the **CIPHA** and **System Programmes** of work. With the Innovation Centre, we will exploit the benefits of artificial intelligence, automation, machine learning and digital twin opportunities.

Programme	Deliverables / Projects	When
Clinical Outcomes	Optimising data capture for clinicians	**22/23 – 24/25**
	Analyse our data and work with clinicians to improve outcomes	
	Benchmark ourselves nationally and globally using the HIMSS AMAM model	
	Establish a patient reported outcomes measures service	
	Enable and support research and innovation data priorities	
Population Health	Linking our data to the ICS, working with system programmes to advocate for children and young people	**23/24 – 24/25**
	Improving data collection to better understand our children and young people	
	Analysing data to identify and reduce health inequalities	
	Work with partners such as strasys to embed a population health approach for children's transformation	
	Develop a strategic intelligence function	

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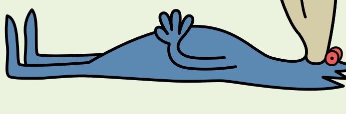

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Programme	Deliverables / Projects	When
Making Data Count	Redeveloping all corporate reporting	22/23 – 23/24
	Upskilling Analysts via ApHA	
	Developing the organisations understanding of SPC Corporate and Divisional Dashboards	
Access to Data	Implement a new Analytics Portal	22/23 – 23/24
	Enable self service	
	Widen the Analytics community within the organisation	
	Improve the breadth and standard of content	
	Data Warehouse Optimisation	

Theme 4:

Tech Roadmap & Operational Service Excellence

Our Digital Service Excellence theme builds on much work delivered to date and underpins our Brilliant Basics ethos. It focusses on ensuring the service maintains a consistent level of high-quality service delivery.

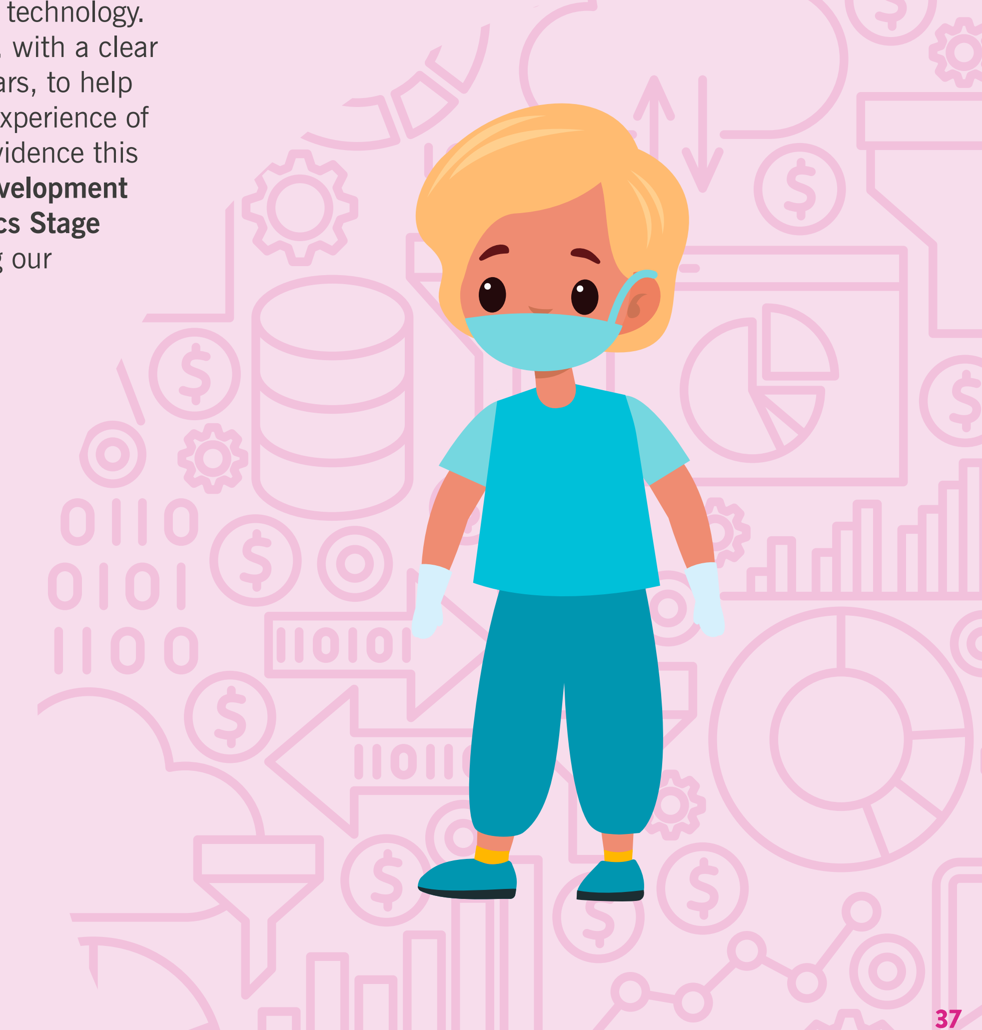
Our overall technology roadmap outlines a clear plan to improve our security, infrastructure and devices, providing our staff with the best tools to do their jobs. We will continue to take a proactive approach, through our device refresh programme, replacing ageing equipment on a rolling basis.

Learning from the successes of new support models such as the **'IT Drop in Clinic',** we will look to further expand our digital support services, making them more accessible, reducing response and resolution times for our staff across all locations and sites.

Cyber Security is a major focus of our **Delivery and Assurance** function. It is important we continue to invest and enhance our preventative solutions and seek independent assurance through accreditations such as **Cyber Essentials Plus.**

Within this theme will also be a focus on digital service excellence for our staff within iDigital, investing in our people as well as technology. Our staff forum will be revamped, with a clear set of initiatives for the next 3 years, to help create solutions, to improve the experience of working in our service. We will evidence this through our Informatics **Skills Development Network Excellence In Informatics Stage 3** accreditation and strengthening our connections with the British Computing Society.

Work is also required to fill a gap in the workforce with the required skills to support becoming 'digitally enabled'. This theme supports the growth of a sustainable and skilled digital, data, technology and informatics workforce



This theme will be delivered through 3 Programmes:

- Service Improvement
- Security and Resilience
- Digitally enabled staff

Programme	Deliverables / Projects	When
Service Improvement	Device strategy and refresh programme	22/23 – 23/24
	Maintenance of a robust network in line with KPIs	22/23-24/25
	Infrastructure Strategy	23/24
	Cloud data hosting	24/25
	Single Sign-On Optimisation	22/23
	Removal of historical technologies	23/24-24/25
Service Excellence	ISD Accreditation Stage 3	22/23
	Staff Forum Strategy	22/23
	Digital Professional Body	23/24
	Alignment to the national sustainable ICT Strategy	22/23-24/25
	Workforce skills development	22/23-24/25
	ISO Accreditations	24/25
Security and Resilience	Digital Theatre Management Solution	22/23 – 23/24
	Digital Outpatient Room Booking and Utilisation	22/23 – 23/24
	Bed Management and Patient Flow	23/24 – 24/25

SECTION 5

Our Approach: Making IT Work

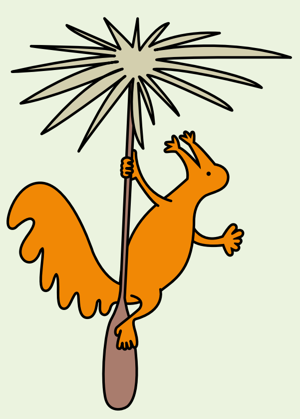
OUR APPROACH

Our approach or our 'how' are of crucial importance in delivering Digital and Data Futures. This includes our values, our team, our governance and how we work with colleagues and partners internally and externally to deliver our goal in creating a healthier future for children and young people.

5.1

Values Pledge

Our values and culture importantly set out how we will achieve our ambitions. We will commit to a digital pledge linked to the Alder Hey values in the delivery of Digital and Data Futures. We are proud to highlight this pledge (right):



Trust Value	Design Principle / Values Pledge
Excellence excellence	Simplify – we will create a great experience for staff and our population by keeping things simple and not unnecessarily overcomplicating our approaches or duplicating effort
	We will work with Empathy
	We will have a customer focussed service model with feedback loop and confidence in resolution
Innovation innovation	We will work in partnership with our Innovation Centre to deliver digital innovations at scale
	Licence to Succeed, Permission to Fail – we will create an environment and culture where we encourage innovation and learning and accept that with innovation there can be projects
	It's ok to be a geek or a nerd – unleash the inner nerd!
Respect respect	No 'Badges on Speedos' – we will not use our credentials or level of hierarchy to undermine the views of others, we will be respectful of all opinions and input, and work together for our population
	We are digitally responsible – for the Children and Young People we are here to serve, we will operate a digitally responsible environment
Together together	One Team Ethos – we will work together as 'one team' with our divisions in order to provide a joined up service to staff. We will work together, not in silos
	Will 'Do With not To' Co-Design and Co-Produce with the Person at the Centre – We will work with our population and staff to ensure that the services we develop are designed around people not organisations
	Work in Partnership – we will work together as a collaboration, build and lead our digital programmes together. Digital leaders will 'walk the walk' with their clinical colleagues and vice versa, to ensure a deep level of understanding of the impact of their work
	Pool efforts and assets – working together to leverage best value, drive economies of scale, avoid duplication and unnecessary competition
Openness openness	Share our Learning – We will share our work openly and transparently with one another and with external colleagues, creating learning from best practice approach. Where appropriate, we will share, co-commission or jointly procure systems

5.2

Service Model and Approach

Building on the early successes of iDigital, our service model and approach will have a focus on working together as one integrated service. The model has recently undergone significant changes, based on a more streamlined professional digital portfolio model, underpinned by a single operating model. It supports further integration of teams and responds to the current priorities of Alder Hey and is the next stage of the evolution of iDigital.

THE MODEL PREDOMINANTLY OPERATES WITHIN 2 CORE FUNCTIONS:

DATA & CHANGE

This function includes taking data and analytics to the next level both operationally and strategically.

DELIVERY AND ASSURANCE

This function 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.

Our approach will be one of creating a great experience for staff and delivering with a smile, positive and can do ‘how can I help’ service and culture.

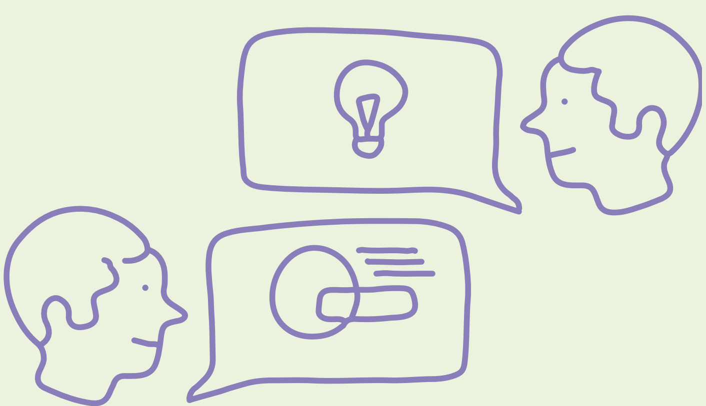
We will have an uncompromising approach to delivery models for staff. We will continue to strengthen our proactive support model with daily ward rounds and visits to clinical areas to ensure equipment, systems and technologies operate as per our ambition – and resolving issues quickly where there are issues that do not meet this standard.

We will work with staff, children, young people, families and other stakeholders to support the adoption of digital innovation and technology. We will also play our part in the wider City and system in relation to digital inclusion and digital skills.

5.3
Clinical Leadership

We will build on the fantastic leadership and expertise of the Alder Hey clinical digital team. This will include further developing and strengthening roles within this team including the **Chief Clinical Information Officer, Divisional Chief Clinical Information Officers, Chief Nursing Information Officer, Digital Nursing & AHP Team** and individuals working in Trust programmes with digital leadership or activities identified as part of job planning or objectives. This team will continue to work together supporting day to day activities across the Trust in terms of operations and advice on more strategic development.

Our iDigital team will support our clinical ambitions with expertise and specialist skills in their field.



5.4
Working in Collaboration

As digital is such a fast paced area, often with areas of scarce specialist skills, we will work with partners to develop services together, attracting and maintaining talent and expertise ensuring value.

We will also work with other partners locally, nationally and internationally including:

- Local Health and Social Care Organisations
- Cheshire and Merseyside Health and Care Integrated Care Board / System
- Academia / Higher Education Partners
- National Regulators
- NHS E/I Transformation Unit
- NHS Digital
- Industry Partners
- Small and Medium Enterprise organisations
- Public Health

5.5

Investment and Statement of Planned Benefits

A significant level of investment will be needed in order to effectively deliver the Digital & Data Futures strategy. A detailed piece of work around this investment is underway, including the identification of internal and external funding sources to progress proactively.

Planning around the Digital and Data Futures statement of planned benefits has also began, ensuring robust, measurable benefits realisation is in place for each deliverable proposed. All significant projects will have business cases drafted and approved through the relevant governance structures in place across Alder Hey.

5.6
Governance

A robust governance structure will continue to support the delivery of the strategy ensuring it continually meets the needs of the organisation and Children, Young People and Families.

The Digital Oversight Collaborative will remain the core function and will report into to the Board of Directors via the Resource and Business Development Committee.

Underneath the DOC, there are range of groups in place to support the day to day running of the different digital components in conjunction with providing assurance on performance, delivery, and benefits realisation.

More strategically Digital and Data Futures will align to the emerging Alder Hey Futures 2030 programmes of work and associated governance.

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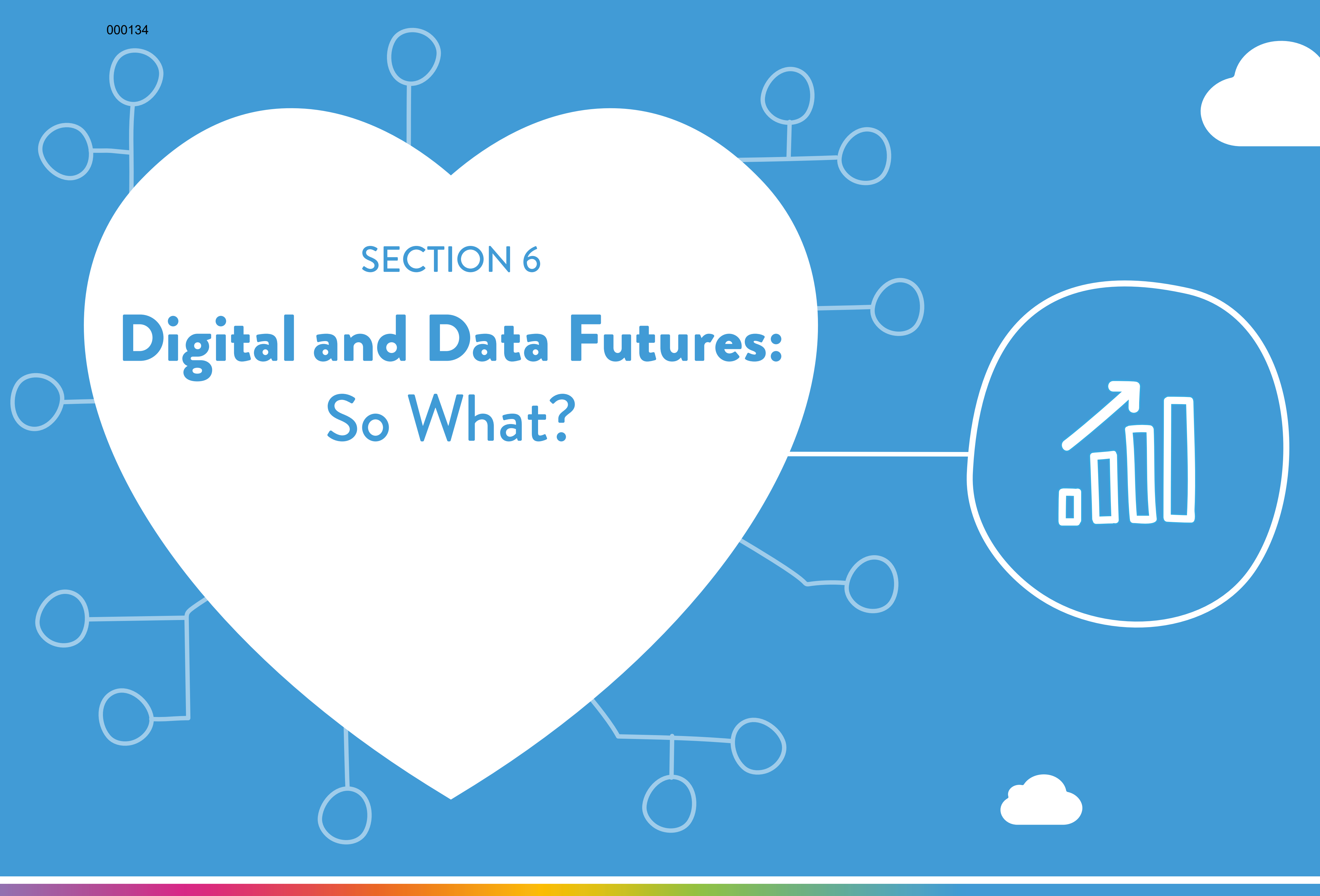
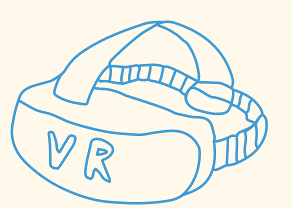


SECTION 6

Digital and Data Futures: So What?

We describe an exciting future with Digital and Data Futures, but what difference will all of this actually make…

Here we describe what 'A Day in the Life' could look like for our children, young people, families and staff in the future…



Young Person

*I have been a patient at Alder Hey for a number of years now. I used to have to come to site for every single appointment and phone up if I needed to rearrange or ask any questions. I can now do some of my appointments virtually, saving me and my family a huge amount of time! **I love my online video appointments with my Consultant, they save me so much time and I really like being able to see her on the screen. I can manage all of my appointments on my phone and communicate with my clinical team if I need advice.** I can record results remotely, giving my clinical team assurance that I'm okay between appointments.*

When I do need to go in for various procedures, the equipment in the rooms is just great and keeps me entertained. When I had to stay in critical care, the access to technology there made my stay pass much more quickly and I was pleased to be able to listen to my favourite music and see my family and friends whilst I was in hospital. **I feel so much more independent and in control of my condition thanks to the technologies that have been put in place.** *It is so much better than it used to be :-)*

Mother of Neonatal Baby

We have 2 children, a 5 year old and a tiny premature baby who is being cared for in the neonatal unit at Alder Hey. My husband and I are having to split our time between our new-born and his sibling which is so difficult for us. ***The neonatal virtual visiting solution has provided us with 24/7 access to see our baby which would have been impossible had it not been for the technology in place.*** *The concept is brilliant and is allowing us to bond with our baby and share the new-born with others during a really challenging time. The new unit is exceptional and the staff are fantastic. Even though we cant be there together, our experience has been incredible and we feel truly connected to each other, our baby and the staff at Alder Hey.*

NEONATAL UNIT

>>LIVE STREAM

Ward Sister

We used to record all referrals on paper, it was a nightmare. The process took a really long time and there was no record of the referral anywhere centrally, causing delays and safety concerns. The implementation of Alderc@re across Alder Hey has really benefitted us. It has meant that within the Burns unit receiving our referrals is much easier. It facilitates a far more robust process for our patients and is making life so much easier. It is saving staff significant amounts of time on writing referrals on paper forms. ***Our IT devices and equipment just work for us these days and families having access to their records really helps them to be involved in their care.*** *Safety is considerably improved for a particularly vulnerable group of patients - it's just brilliant!*

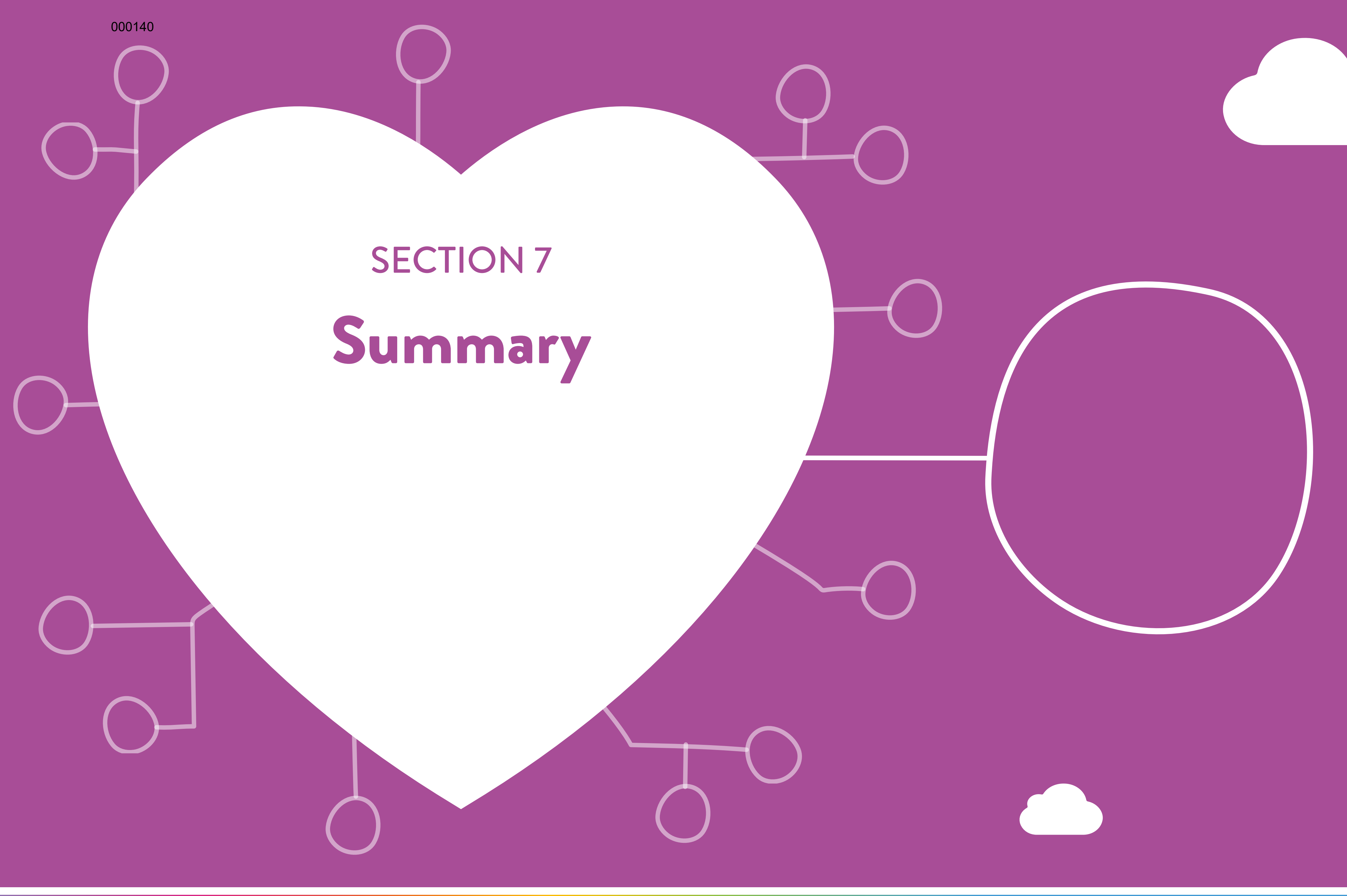
Community Speech and Language Therapist

When I started this role I could have never imagined the progress we have seen in such a short period of time. The digital infrastructure which has been developed means the Community & Mental Health division can now support hybrid working for nearly all staff within the division. They have been provided with the right equipment, use of virtual consultations and a single referral platform for all mental health referrals for CYP in Sefton & Liverpool, designed by young people for young people. ***The support from the iDigital team is brilliant, they are always one step ahead and willing to work together to problem solve.***

Consultant

It's incredible to see where we have come from and what we now have in place. I remember someone saying 'noone ever says they hate their iPhone' – and we really hoped our work systems would have the same approach. I never thought I would see the day where remote video consultations are largely the norm. I love having access to everything I need via my own device – far more usable than previous clunky processes of having to be at the hospital for everything! The systems are so intuitive, prescribing and clinical decision making are supported by the EPR with links to clinical resources, care pathways are implemented, and I have access to everything I need to care for my patients – wherever I am. Including our regional Share2Care Record. Everything is there, it is safe and secure and easy to access.

The implementation of the Digital and Data Futures strategy over the next three years will improve the safety of our children and young people, as well as their experience whilst under the care of Alder Hey. *Much of the focus also surrounds improving experience for staff, ensuring they have the right technology at their fingertips to deliver outstanding care at every opportunity. It will introduce efficiencies that will support staff in releasing time for direct patient care and enhance clinical outcomes through technology. Many of the deliverables are designed to support recovery following the pandemic, which is a main priority at a Trust and national level. It will ensure digital inclusivity is a common thread throughout implementation. Furthermore, aims to reduce health inequalities within the region, transforming the way the health of our population is managed.*



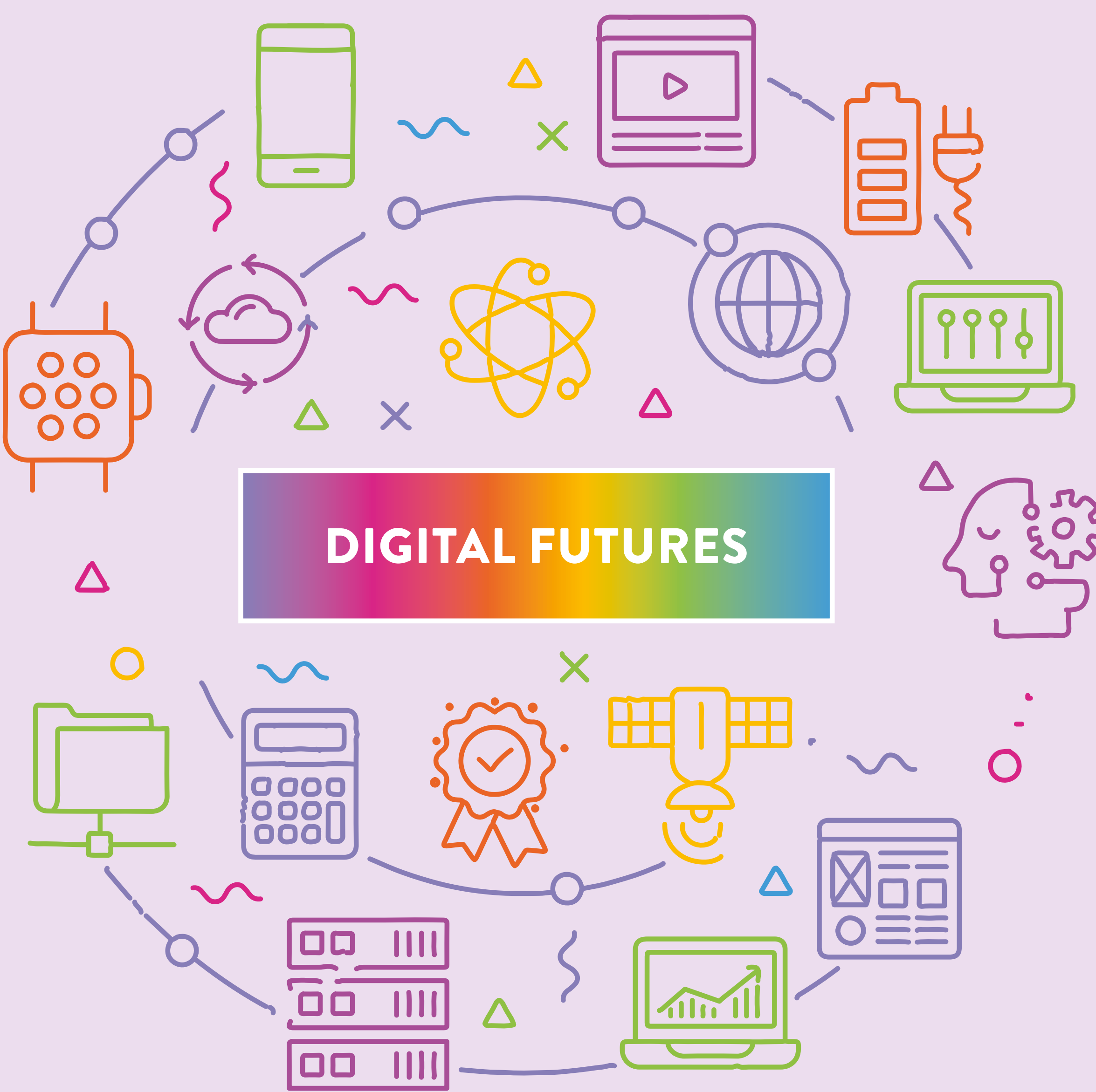
SECTION 7

Summary

Alder Hey is a wonderful place, a jewel in the crown of an iconic City. We deliver world class services to our Children and Young People. Building on our digital and technology developments and investments, it is a pivotal time for our next stage of delivery through Digital and Data Futures.

The alignment of key strands of work will ensure we maximise the sum of many parts working together playing to our talents and expertise. It will both liberate and disrupt our ways of working to improve the care we give to Children and Young People. It will put us at further at the forefront of global digital and data leadership. We believe that our relationships, support, leadership and talents of our staff will enable us to deliver our aspirations.

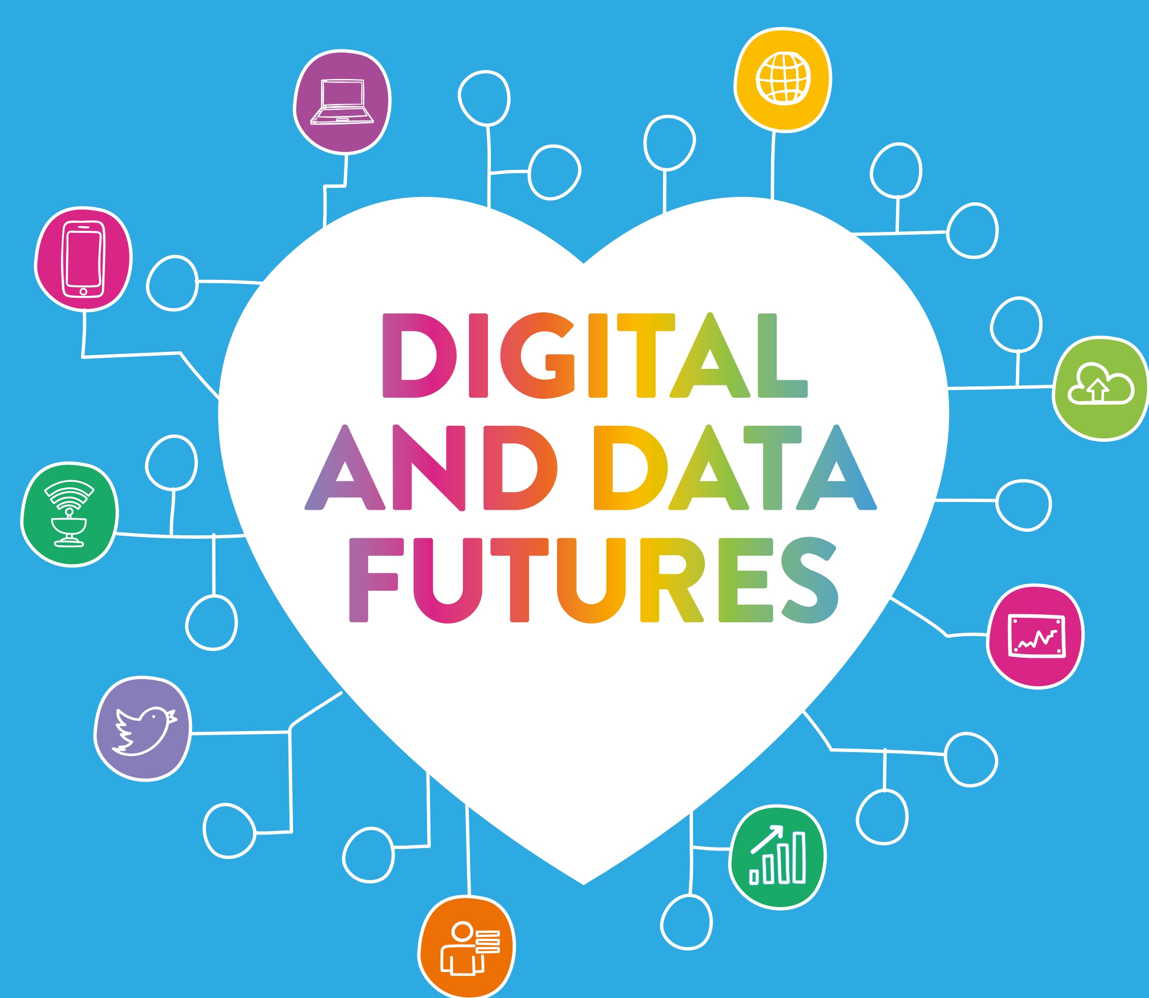
Our Digital and Data Futures is very bright and exciting.



Find out more...

You can download a copy of Digital Futures from our website www.alderhey.nhs.uk

Alder Hey Children's NHS Foundation Trust
Eaton Road
Liverpool L12 2AP



BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	Serious Incident, Learning and Improvement report 1 June-30 June 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director Nursing: Governance and Risk Trust Risk Manager

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

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidences that are considered as serious incidences following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st-30th June 2022.

2. Background

Serious Incidents (SIs) 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.

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, ensuring SIs are correctly identified, investigated and importantly, learning embedded to prevent the likelihood of the same or similar incidents happening again.

In line with National SI framework, the Trust is required to report SIs to the Strategic Executive Information System (StEIS) and share investigation reports with commissioners. SIs that does not meet the StEIS criteria are discussed at the Trusts weekly patient safety meeting and where appropriate a root cause analysis (RCA level 2) investigation is instigated.

Outcomes and oversight of SIs 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.

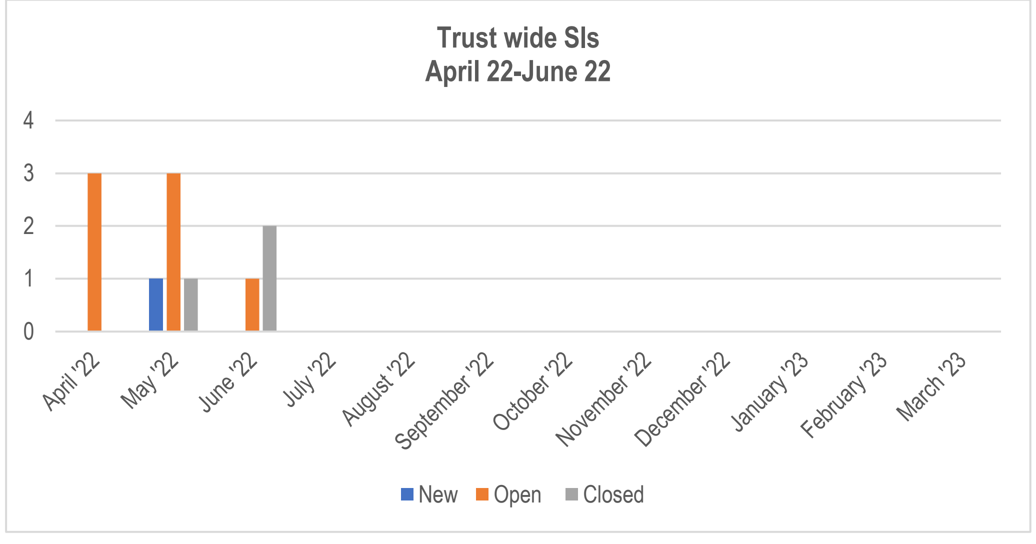
3. Local context

3.1 Never Events

The Trust declared **Zero** Never Events during the reporting time frame 1st-30th June 2022.

3.2. Serious Incidences

Graph 1 Trust wide StEIS reported SI status June 2022



3.2.1 Declared Serious Incidences

The Trust declared no StEIS reportable incidents that met the SI criteria during the reporting timeframe (1st-30th June 2022.)

3.2.2 Open Serious Incidences

There is **1** SI open during the reporting time frame 1st-30th June 2022 as outlined in table 1 below:

Table 1 Open SIs June 2022

StEIS reference	Date reported	Division	Incident	Summary
2021/24660	25/11/2021	Surgery	Near miss reported for potential for learning	Refer to appendix 1 for detail

3.2.3 Serious incident reports

3.2.4 SI action plans

At the time of reporting:

9 SI action plans are overdue their expected completion date.

4 SI action plans have been completed and closed.

1 SI action plan is to be sent to commissioners for review and closure.

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Date action plan due
2019/23494	24/10/2019	25/10/2019	Medicine	Outstanding laboratory test results identified	17 7 actions outstanding.	30/04/2020
2018/21323	02/08/2018	31/08/2018	Surgery	Never Event – wrong tooth extraction	18	30/11/2020 Completed and closed by CCG 29/6/22.
2019/21208	25/09/2019	26/09/2019	Surgery	Never Event – retained foreign object post-procedure	5 4 actions outstanding	19/12/2020
2020/608	08/01/2020	09/01/2020	Medicine	Misdiagnosis of tumour	6 All actions completed - action plan sent to CCG	30/06/2021

					pending closure.	
2020/18368	28/09/2020	29/09/2020	Surgery	Teeth replanted into incorrect sockets	4	30/06/2021 Completed and closed by CCG.
2020/19349	08/10/2020	12/10/2020	Medicine	Inappropriate clearance of C-Spine	0 Completed action plan sent to CCG for reviewed	30/06/2021
2020/16210	24/08/2020	26/08/2020	Medicine	Patient death following diagnosis of acute promyelocytic leukaemia (APML).	14	30/06/2021 Completed and closed by CCG.
2020/12954	09/07/2020	10/07/2020	Corporate Services	Incorrect settings on port-a-count machine resulting in staff being incorrectly passed on an FFP3 mask	11	20/12/2021
2020/23808	10/12/2020	11/12/2020	Surgery	Category 3 Pressure Ulcer	10	28/02/2022 Completed and closed by CCG.
2021/1919	03/01/2021	15/01/2021	Medicine	Transfer from Bangor. Treated according to advice, patient suffered raised intracranial pressure requiring shunt	11 6 actions outstanding.	30/04/2022
2021/12203	27/05/2021	10/06/2021	Medicine	Deteriorating patient requiring transfer to HDU	12 5 actions outstanding	01/06/2022
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	8 5 actions outstanding	30/06/2022 .
2020/23828	11/12/2020	18/12/2020	Corporate Services	Waiting list data quality issues with 52 week waits	23 7 actions outstanding.	30/06/2022

3.3 Internal level 2 RCA Investigations

The Trust declared **Zero** internal level 2 RCA investigations during the reporting time frame 1st-30th June 2022.

Duty of candour

The Trust is required to comply with Regulation 20 of the Health and Social Care Act 2008(Regulated activity), Duty of Candour.

2 Duty of Candour responses were required and issued within expected deadlines during the reporting timeframe.

However, a recent review of the Trusts Duty of Candour CQC Regulation 20 process has noted a disparity in the number of breaches reported; with 6 Duty of Candour breaches identified not the 2 initially reported to the commissioners during 2021/22. Predominantly, these relate to a delay in the final investigation report not being sent out within 10 days of final sign off by the division / executives.

This has been reported to commissioners and CQC and all internal processes with Duty of Candour have been addressed with compliance monitored by the corporate governance team.

4. Learning from serious incidents

Alder Hey Children's Hospital NHS Foundation Trust is committed to ensuring all our children, young people and their families receive the highest quality of care; responding appropriately when things go wrong, demonstrating its commitment to continually improve the safety of the services it provides.

The RCA methodology seeks to identify the causal factors associated with each event and action plans developed to address these factors.

SI action plan completion is monitored internal via CQSG, to ensure barriers to completion are addressed and learning is embedded across the organisation as required.

3 local SI action plans have been submitted to commissioners for review.

2 investigation reports have concluded and submitted to commissioners during the reporting timeframe 1st-30th June 2022.

The emerging themes and associated learning from completed reports in the reporting timeframe are:

- Clinical pathway review
- Service delivery review
- Education for staff and patients/families
- Improved clinical documentation
- Development of patient information leaflets
- Digital solutions ie improved electronic referral process

5. Next steps

- Ongoing review of open SIs with overdue actions plans being undertaken by Divisions as a matter of urgency

- Further support offered from the corporate governance team to support divisions with the timely completion of action plans.

- Review of Divisional internal governance and assurance processes to support improvements of timely sign off of SI action plans

- SI action plan completion to continue to be monitored internal via CQSG

- Ongoing collaboration between corporate governance team and divisions

- Themes and trends from SIs to be reported to Trust Board once outstanding RCAs have concluded.

Recommendation

The Trust Board is asked to:

- Note content of report
- Note emerging themes for completed SI reports
- Note actions to address open SI overdue action plans

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2021/24660	Traumatic death from penetrating neck injury - reported as per protocol (as Near Miss).	Incident was initially identified as catastrophic, however following in-depth review, incident reclassified as a near miss but StEIS reportable due to potential for learning.	A comprehensive level 2 investigation undertaken July 22: Draft RCA completed pending Exec approval and sign off

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	2021-2022 Annual Submission to NHS England North West: Appraisal and Revalidation and Medical Governance
Report of:	GMC Compliance and Assurance
Paper Prepared by:	Dr U Das, Responsible Officer, Dr Z Bassi, Appraisal Lead and Helen Blackburn, Appraisal and Revalidation Manager.

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

1. Introduction

The framework of quality assurance for responsible officers and revalidation report is required by the GMC to provide assurance that the Trust is managing appraisals for clinicians, ensuring that they have access to appropriate resources.

2. Background

The GMC has introduced a new appraisal model which allows for a more well-being focused meeting. Consultants will continue to demonstrate their professional development but the with less onus on uploading supporting evidence.

3. Conclusion

The re-introduction of appraisals combined with the birth month has been a challenge for some clinicians. Some appraisals were not completed before the March deadline, as they were only due in March. We will review this for the next AoA.
There was a higher number of revalidation deferrals as staff were unable to collect feedback or undertake an appraisal.

4. Recommendations

- Review collection of patient feedback is still under consideration, the GMC intend to provide some guidance soon. We will review their recommendations before any changes are implemented.
- Peer review to be undertaken in 2022, this will take place in late Autumn

2021-2022 Annual Submission to NHS England North West:

Appraisal and Revalidation and Medical Governance

Name of organisation:		
	Name	Contact information
Responsible Officer	Dr Urmi Das	urmi.das@alderhey.nhs.uk
Medical Director	Mr Alfie Bass (Interim)	alfie.bass@alderhey.nhs.uk
Medical Appraisal Lead	Dr Zahabiyah Bassi	zahabiyah.bassi@alderhey.nhs.uk
Appraisal & Revalidation Manager	Helen Blackburn	Helen.blackburn@alderhey.nhs.uk
Additional Useful Contacts	Admin team	appraisal@alderhey.nhs.uk

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Section 3 – Recommendations to the GMC 6
Section 4 – Medical governance 7
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Section 6 – Summary of comments, and overall conclusion 9
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Introduction:

The Annual Organisational Audit has been stood down again for the 2021/22 year. A refreshed approach is planned for 2022/23. It still remains a requirement for each Designated Body to provide assurance to their Board about the governance arrangements in place in relation to appraisal, revalidation and managing concerns. In addition, NHS England North West use information previously provided in the AOA to inform a plan for quality visits to Designated Bodies. These visits are now starting to be planned in again moving forwards.

Amendments have been made to Board Report template (Annex D) with the intention of making completion of the submission straightforward whilst retaining the goals of the previous report:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

This template for an Annual Submission to NHS England North West should be used as evidence for the Board (or equivalent management team) of compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) or appended to your own board report where a local template exists.

This completed document is required to be submitted to NHS England North West by the end of September 2022 and should be sent to england.nw.hlro@nhs.net

Annual Submission to NHS England North West

Section 1 – General:

The board of [*Alder Hey Children's NHS FT* can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> 2021/2022 update: Dr Urmi Das remains as the RO. She is a consultant endocrinologist and Director, Division of Medicine (Interim)
>
> Action for next year: N/A

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> 2021/2022 update including description of Appraisal & Revalidation support: The Team consists of RO, Appraisal Lead, Appraisal & Revalidation Manager and Appraisal administrator. The Team has continued to work together to support training updates and provide support for all staff. We have held 2 update training sessions and one new appraiser event.
>
> Action for next year: Organise 3 training events.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> 2021/2022 update: Yes, the L2P system is now embedded into the Trust. All staff with a contract of 1 year or more are given access to the system. This allows for better management and governance.
>
> Action for next year: N/A

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> List of relevant policies and date of last review October 2021, presented to Board December 2021.
>
> 2021/2022 update: Medical Appraisal and Revalidation Policy is reviewed in accordance with Trust guideline unless national events require an immediate change.
>
> Action for next year: Review policy to reflect national changes if required.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

2021/2022 update: This did not take place due to on-going Covid pressures. Action for next year: Peer review to be undertaken before the end of 2022.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

List of relevant policies and date of last review: Medical Appraisal and Revalidation Policy August 2021 2021/2022 update: All medical staff appraisals are recorded and managed using L2P. Exit reports are used for short term contracts of 6 months or less. Action for next year: Monitor and support short term Drs.

7. Where a Service Level Agreement for External Responsible Officer Services is in place –

Describe arrangements for Responsible Officer to report to the Board: N/A Date of last RO report to the Board: Action for next year:

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have

not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

2021/2022 update: We use the new Appraisal 2020 model; however, some consultants have used the previous model as they felt it was more appropriate for them. Action for next year: Fully implement the 2020 model for all appraisees.

8. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

2021/2022 update: Partial implementation has taken place. Full implementation will take place in 2023 Action for next year: Ensure that new model is communicated to all staff.

9. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

List of relevant policies and date of last review: August 2021 2021/2022 update: The policy complies with national guidelines and was presented to Board December 2021. It is available via the Trust DMS and Share Point site. Action for next year: N/A

10. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Number of available appraisers:62 2021/2022 update: We have sufficient appraisers to accommodate the requirements. We will have further training events to allow other consultants to participate as appraisees and increase the numbers for resilience. Action for next year: Organise appraiser training

11. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development

events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

> 2021/2022 update: Appraisers attend internal development events and are encouraged to attend external events. These events include RO network updates. They also receive feedback from the appraisees as part of the Trusts review process.
>
> Action for next year: N/A

12. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

> List of relevant policies and date of last review: Medical Appraisal and Revalidation Guidelines
>
> 2021/2022 update: The Appraisal Lead and Appraisal manager audit appraisals. The themes and outcomes are reported to the RO.
>
> Action for next year: Provide reports to Board

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Total number of doctors with a prescribed connection as at 31 March 2022	
Total number of appraisals undertaken between 1 April 2021 and 31 March 2022	387
Total number of appraisals not undertaken between 1 April 2021 and 31 March 2022	19
Total number of agreed exceptions	22

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 3 – Revalidation Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Recommendations to the GMC:	
Total number of positive recommendations submitted between 1 April 2021 and 31 March 2022	68
Total number of recommendations for deferral submitted between 1 April 2021 and 31 March 2022	39
Total number of recommendations for non-engagement submitted between 1 April 2021 and 31 March 2022	0
Total number of recommendations submitted after due date between 1 April 2021 and 31 March 2022	1

2.

2021/2022 update: There were a higher number of deferrals due to covid as staff were unable to collect patient data or due to insufficient number of appraisals

Action for next year: Ensure that all recommendations are made promptly.

3. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

List of relevant policies and date of last review: Medical Appraisal and Revalidation policy

2021/2022 update: Drs are contacted to discuss deferrals; we create action plans if required.

Action for next year: Continue to monitor recommendations to reduce deferrals.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors. This includes reporting and collation of, for example, complaints, safeguarding concerns and incidents to identify necessity for appropriate intervention at the earliest opportunity.

List of relevant policies and date of last review: Medical Appraisal and Revalidation Guidelines 2021/2022 update: We have robust processes in place to ensure that issues with Drs are reported and reviewed and action taken if required. Action for next year: Continue to follow Trust policy.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

2021/2022 update: There are processes in place to monitor Drs. Clinical Directors and Divisional Directors meet regularly to discuss issues. Drs are able to access relevant information to support their appraisals. Action for next year: Review access to information.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

2021/2022 update: List of relevant policies and date of last review: The ROAG meets bi-weekly to discuss appraisals and any issues or concerned. Concerns requiring escalation are discussed with the MD and GMC liaison officer. Action for next year: Continue to follow current practice.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the

Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Outline arrangements and frequency for reporting to the Board: 2021/2022 update: A professional standards group has been implemented to discuss concerns and provide assurance. Action for next year: Continue to monitor concerns for themes.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

2021/2022 update: The process for transferring information remains the same. We respond within 3 days to requests and ask for information regarding new employees. Action for next year: N/A

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

2021/2022 update: There are processes in place to ensure that clinical governance concerns are managed within the Trust's policies. Action for next year: N/A

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

List of relevant policies and date of last review: Recruitment and Selection Policy May 2022 2021/2022 update: The recruitment process is managed by the wider HR team and Clinical Directors. The processes follow national guidelines to ensure that all pre-employment checks are undertaken before employment contracts are issued. Action for next year: N/A

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail any additional information that you wish to highlight (the following provides a guide to information that you may wish to include): - **General review of actions since last Board report** - **Actions still outstanding Peer review either later in 2022 or early 2023.** - **Any reflections of impact of COVID 19 on delivering service to patients** - **Current Issues N/A** - **New Actions: Develop a local Mersey network with RO and Appraisal managers** **Overall conclusion: The year has been successful; the new system was well received. We will continue to train new appraisers and update them at internal events.**

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	**Board Assurance Framework 2022/23 (June)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

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

Board Assurance Framework 2022/23

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 14 principal risks aligned to the Trust's strategic objectives.

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

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

2. Review of the BAF

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

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

3. Overview at 12th July 2022

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

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

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

4. Summary of BAF – at 12th July 2022

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

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

5. Summary of June 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. Actions, controls and evidence updated.

- ***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. Actions and controls reviewed and updated.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk Reviewed; no change to score in month but progress with actions, controls and evidence.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  No change to risk score in month. All actions remain on track.

- ***Failure to address building deficits with Project Co. (DP)***
  Risk reviewed following discussion at RABD. Controls, assurances and actions updated. Exec Lead changed from David Powell to Adam Bateman.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  At the end of June 2022, there were 231 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment. This is an increase 43 patients. Paediatric dentistry remains. We are enhancing, including secuiring additional fixed theatre and clinic sessions with the team, and working on supporting a retired colleague to return and increase capacity. We expect this additional capacity to be in place from September 2022. We have modelled backlog clearance and in the good case scenario we project clearance by the end of December 2022. On recovery, provisional data for June indicates strong recovery in elective services at 115% (above the national target), 102% for new outpatients (a drop on May and below 104%) and 112% for outpatient follow-up (a reduction relative to May). In relation to urgent and emergency care, emergency department standards, Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 78% of patients within 4 hours, a third consecutive month of improvement. Through the ED at its best programme we have started a video communication briefing to staff; a move to appointments, rather than waiting, for patients who can be seen by a GP. We are working to open a new proof-of-concept urgent care facility in Q3.

- ***Inability to deliver safe and high-quality services (NA).***
  the risk has been reviewed and the assurance processes remain valid and in place. The three areas of gaps in assurance remain but the work to improve these is

currently under review and are actively being monitored through the patient safety board. No additional gaps in control have been identified.

- ***Financial Environment (JG).***
  A new risk has been added to the corporate risk register regarding the financial risk to the 22/23 plan. Relevant actions have been moved over and progress updated on both risks. No change to risk score on this.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Following Catkin and Sunflower review.

- ***Digital Strategic Development and Delivery (KW).***
  BAF Risk reviewed. Current scores remain in place. Aldercare programme currently in exception, formal review underway. Review has confirmed that October 22 go live is not viable, work in progress to establish revised go live date and associated required resources. Resourcing challenges are improving with recruitment of some key vacancies in some services. Mobilisation plans for Digital and Data Futures is in development.

- ***Workforce Sustainability and Development (MS).***
  No change to risk score in month. All actions remain on track

- ***Employee Wellbeing (MS).***
  Risk reviewed and controls amended and updated. Actions reviewed and updated. Unable to close overdue action so escalated to Chief People Officer.

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

- ***Access to Children and Young People's Mental Health (LC)***
  All actions reviewed and updated.

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)
(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (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
(2326) Delayed diagnosis and treatment for children and young people (Linked to 1.2)
(2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 2.1)
(2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 2.1)
(2564) There is a risk of delayed diagnosis and the inability to monitor ophthalmic , oncology and neurological conditions. there is a risk to life and of permanent harm to vision.
(2650) Unable to reprocess endoscopes .Delay in treatment due to list/procedure cancellations. Endoscopes not available for emergency procedures.
(2643) Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)
(2642) Inability to deliver 1-1 care where required
(2652) unregulated device (for intussusception emergencies) could fail leading the patient to need surgery
(2627) Not compliant with national guidance with transferring and transcribing patient records following adoption

BAF Risk

Strategic Aim

Related Corporate Risk(s)

1.2

Children and young people waiting beyond the national standard to access planned care and urgent care

(3x5=15)

Delivery of **outstanding care**

(2233) Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies (linked to 1.1)
(2501) Risk of inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 10 pandemic leading to a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments (linked to 1.1)
(2463) Risk that Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals during 2020 (linked to 1.1)
(2517) Risk of Children & Young People coming to harm whilst waiting for urgent treatment episodes, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS (linked to 1.1 & 2.1)
(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1 and 2.1)
(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)
(2326) Delayed diagnosis and treatment for children and young people (Linked to 2.1)

BAF Risk

Strategic Aim

Related Corporate Risk(s)

1.3

Failure to address ongoing building defects with Project Co.

(4x3=12)

None

Delivery of **outstanding care**

1.4

Access to Children and Young People's Mental Health

(3x5=15)

(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS)
(2517) Children and young people come to harm whilst waiting for urgent treatment episodes.
(2643) Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)

BAF Risk

Strategic Aim

Related Corporate Risk(s)

2.1

Workforce Sustainability & Capability

(3x4=12)

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)

(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)

(2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 1.2)

(2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 1.2)

(2642) Inability to deliver 1-1 care where required

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 (4x4=16)		(2663) Failure to deliver the 2022/23 control total set by Cheshire & Mersey ICS
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)

None

Game-changing **research and innovation**

4.2
Digital Strategic Development and Delivery

(4x3=12)

None

Board Assurance Framework 2022-23

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, 2312, 2229, 2332, 2383, 2536, 2570, 2578, 2100, 2501, 2597, 2326, 2415, 2020, 2617, 2410, 2246, 2230, 2497, 2589, 2516, 2535, 2528		
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

July 2022 - Nathan Askew
the risk has been reviewed and the assurance processes remain valid and in place. The three areas of gaps in assurance remain but the work to improve these is currently under review and are actively being monitored through the patient safety board. No additional gaps in control have been identified

Board Assurance Framework 2022-23

June 2022 - Nathan Askew the risk has been reviewed and the assurance processes remain valid and in place. The three areas of gaps in assurance remain but the work to improve these is currently under review and will be monitored through the patient safety board from July. No additional gaps in control have been identified
April 2022 - Nathan Askew this risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk
March 2022 - Nathan Askew this risk has been reviewed and current control remain in place.

Board Assurance Framework 2022-23

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2233, 2383, 2578, 2501, 2501, 2597, 2326, 2517, 1902, 2410, 2246, 2463, 2497, 2535, 2528

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

Urgent Care Improvement Group overseeing several improvement workstreams: PLACE - GP streaming relocation to OPD - complete FUNDING - business case submitted for approval to increase nursing and decision makers - Complete SUPPORT - external company engaged to support GP stream - complete; funding for 22/23 requested via CCG - pending WORKFORCE - subject to funding workforce required including out of hours - pending CAPACITY & DEMAND - review of demand and capacity by stream - pending EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	30/09/2022	Go 2 Doc now covering 7 days per week but still working toward 2 x GP/ACP cover 9am-9pm. OPD rooms still being utilised Mon-Fri whilst a longer term solution is sought for a location for streaming services. - update required before 30/5/22 Meeting with executive team Thurs 5/5/22 and ED senior team to discuss challenges in urgent care and create action plan for short and long term improvements. To reconvene in 2 weeks to discuss ideas. - deadline 19/5/22 'ED at it's Best' launched as listening event for ED staff supported by project management team. Reporting findings and recommendations to Urgent Care Improvement Board (UCIB) monthly. 4 new ED consultants appointed at interviews in April 2022. Anticipated start dates of September 2022. Nursing posts to be advertised following approval of business case for investment in 2022/23. Updates to be provided monthly to UCIB. Capacity and demand work ongoing alongside review of triage guidance to ensure all patients suitably streamed at point of attendance - target for completion 24/5/22 Task and finish groups to be arranged with support teams and medical/surgical specialties to improve pathways for patients that avoid inappropriate attendance at ED - target date of 20/5/22 for start PAU pilot scoping underway to test pathways ahead of implementation in 2024/25. Proposal to be put forward to PAU Project group and UCIB in June 2022.
The following actions are being undertaken to improve the RTT performance: Expand the criteria of patients who can be booked onto a weekend list - ongoing External dentist given priority weekend lists - complete Recruit new honorary contract dentist - complete, starting 28th May Additional weekend capacity has been granted in May - complete Additional weekend capacity to be identified in June Increase number of complex patients planned per list - ongoing Allocate a Consultant Anesthetist on all dental lists - ongoing Consideration of temporary job plan changes to increase capacity - meeting scheduled w/c 23rd May Trial use of VR for older patients to avoid GA and increase productivity - started	12/08/2022	The following actions are being undertaken to improve the RTT performance: Expand the criteria of patients who can be booked onto a weekend list - complete External dentist given priority weekend lists - complete Recruit new honorary contract dentist - complete Additional weekend capacity has been granted in May - complete Additional weekend capacity to be identified in June - complete Increase number of complex patients planned per list - complete Allocate a Consultant Anesthetist on all dental lists - ongoing Trial use of VR for older patients to avoid GA and increase productivity - started Consideration of job plan changes to increase daycase capacity - complete Arrange honorary contract for starter who can commence in September - ongoing Recruit the following positions - ongoing - locum specialty dentist - specialist dentists (1 x 10 PA & 1 x 1PA) Clinical team to confirm what additional sessions can be completed to clear OP / IP backlog - ongoing Create trajectory and plan that ensures no OP waits over >52 weeks by 31/12/22

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.

July 2022 - Adam Bateman
At the end of June 2022, there were 231 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment. This is an increase 43 patients. Paediatric dentistry remains. We are enhancing, including secuiring additional fixed theatre and clinic sessions with the team, and working on supporting a retired colleague to return and increase capacity. We expect this additional capacity to be in place from September 2022. We have modelled backlog clearance and in the good case scenario we project clearance by the end of December 2022. On recovery, provisional data for June indicates strong recovery in elective services at 115% (above the national target), 102% for new outpatients (a drop on May and below 104%) and 112% for outpatient follow-up (a reduction relative to May). In relation to urgent and emergency care, emergency department standards, Our

Board Assurance Framework 2022-23

Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 78% of patients within 4 hours, a third consecutive month of improvement. Through the ED at its best programme we have started a video communication briefing to staff; a move to appointments, rather than waiting, for patients who can be seen by a GP. We are working to open a new proof-of-concept urgent care facility in Q3.
June 2022 - Adam Bateman For the w/e 29 May 200, there were 288 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment. As sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry, a dedicated support plan is now in situ. Recovering services, to in turn reduce waiting times, is one of the 5 operational priorities for 22-23. Provisional data for May indicates recovery of 106% for new outpatients, 120% for outpatient follow-up and 110% for elective activity. Aside from the need to safely reduce follow-up activity, this is really strong performance. In relation to urgent and emergency care, emergency department standards, Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 73.7% of patients within 4 hours, a marginal improvement relative to April. The team are testing changes to managing flow and clinical pathways in the department, including scheduled appointments, for the following day, with our primary care service for low acuity patients. Ahead of winter we are designing two radical changes to the model for specialty assessment and the treatment of minor illness and injury patients.
May 2022 - Adam Bateman The current number of C&YP waiting over 52 weeks for treatment is 275. Over the past two months the number has plateaued. Sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry. A specialty recovery plan to address this is being finalised by the 6 May 2022. We also have a Trust wide plan to recover services to 104% this year. Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 72.4% of patients within 4 hours, an improvement relative to March (driven largely by a return from absent of a number of staff). Through the annual plan process we have agreed a significant increase in investment to increase staffing levels, and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place - ED at its best.
April 2022 - Mark Carmichael Risk rating maintained due to volatile attendances and high absence rates

Board Assurance Framework 2022-23

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: Adam Bateman		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 and identifies operational mitigations. 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.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance

Remedial Works not yet completed; lack of confidence in timescales being met.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Board to board meeting to take place on a regular basis and escalation of any issues	31/03/2023	
Undertake regular inspections on known issues/defects	31/03/2023	Inspections underway

Executive Leads Assessment

July 2022 - Rachel Lea
Risk reviewed following discussion at RABD. Controls, assurances and actions updated. Exec Lead changed from David Powell to Adam Bateman

June 2022 - Rachel Lea
Risk reviewed and no change made to risk score.

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

Board Assurance Framework 2022-23

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Access to Children and Young People's Mental Health		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led			Link to Corporate risk/s: 2517, 2497		
Exec Lead: Lisa Cooper		Type: Internal,	Current IxL: 3x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

There has been a significant increase in demand for Specialist Mental Health Services at Alder Hey following the COVID-19 pandemic which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks.

Existing Control Measures	Assurance Evidence (attach on system)
Weekly safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment.	Recent check in audit (attached)
Business case for investment submitted to Liverpool and Sefton CCG's. This is also included in the Cheshire & Merseyside ICB submission.	Business case (attached)
Weekly performance monitoring in place for operational teams which includes: Weekly Tuesday/Wednesday meeting with PCOs Divisional Waiting Times Meeting each Thursday Trust Access to Care Delivery Group each Friday This provides assurance on plans for urgent young people, long waiting routine young people (>46 weeks) and reallocations.	Minutes available for each meeting saved on Teams
Monthly performance information is communicated with commissioners to inform them of the latest position, provide assurance and request support where required.	Monthly assurance processes include: Monthly contract statements Waiting time position presented to Liverpool and Sefton Health Performance Meetings
Performance management system with strong joint working between Divisional management and Executives.	Bi-monthly Divisional Performance Review meetings with Executives
Weekly allocation process for children and young people waiting for treatment in place led by Assistant Clinical Leads to ensure the children and young people with the greatest need receive the earliest appointment dates possible.	Weekly allocation meetings
Continuous recruitment to existing vacancies. Opportunities are also present to retain staff by offering training courses and ability to move services through a transfer window.	Recruitment processes present through Trac software

Gaps in Controls / Assurance

1. Gaps in current trajectories to meet the Trust internal standard of 92% of children and young people waiting for treatment within 18 weeks due to outstanding confirmation on new investment.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Full validation of community mental health waiting list to remove data quality errors and identify any areas of risk. This will support future capacity and demand planning.	30/09/2022	All children and young people reported to be waiting >2 years overdue have been validated.
Actions for 4 Week Wait National Pilot Programme to continue which includes: -Audits to be completed, including welcome call, DNA audit and referral rejection audit -Scoping for automatic booking of locality mental health appointments to take place -Improvement plan with wider mental health (CAMHS) partnerships to be set following completion of process mapping	30/09/2022	Automatic booking of EDYS appointments in place. Process mapping sessions with Aqua completed and summary report expected.
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	31/07/2022	Date amended due to issues with Meditech
Review of job plans and clinic templates to ensure recommended activity levels are being achieved and available clinic room space is being optimised.	31/08/2022	Locality leeds meeting held 13th May 2022 and next steps agreed
Actions from mental health workforce plan to be delivered which includes: -Improving workforce availability rate to >90% -Task & Finish group with aim to increase headcount of external staff through marketing of services and the organisation and enhancing job roles and adverts -Delivery of staff wellbeing schemes -Staff retention to be improved through review of job plans and education/training opportunities	28/04/2023	Workforce plan A3 completed and shared with Senior Leadership team

Executive Leads Assessment

Board Assurance Framework 2022-23

July 2022 - Lisa Cooper
All actions reviewed and updated

Board Assurance Framework 2022-23

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, 2383, 2536, 2578, 2100, 2501, 2597, 2020, 2617, 2517, 1902, 2246, 2497, 2497, 2589, 2516, 2624, 2535, 2528	
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. COVID related sickness impacting upon service delivery

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	01/12/2022	as above
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	01/03/2023	Attraction and Retention Project identified as key project for 22/23
L&D team monitoring compliance on a weekly basis. Separate actions plans in place to support those f2f topics which dipped during the pandemci, incl resus and MH.	30/09/2022	MH training now above compliance.

Board Assurance Framework 2022-23

Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	30/11/2022	actions continue to be rolled out and monitored. sickness absence managed at local level with HR Advisers.

Executive Leads Assessment
July 2022 - Melissa Swindell No change to risk score in month. All actions remain on track
June 2022 - Melissa Swindell actions updated and risk reviewed
May 2022 - Sharon Owen Absence remains higher than expected for this time of year and continues to be monitored closely. Recruitment time to hire significantly reduced and meeting target. Stretch target to be put in place from 1st May 2022.

Board Assurance Framework 2022-23

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
NHSE Organisational Health and Wellbeing framework implemented	HWB 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
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin	Minutes of exec meetings
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment

Gaps in Controls / Assurance

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

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

Board Assurance Framework 2022-23

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.	30/06/2022	Still awaiting response from Melissa Swindell re this learning review. Email sent 6.7.22 requesting an update
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	30/09/2022	Progress to be reported at next HWB Steering group
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.	30/09/2022	Business case logged but awaiting confirmation of next steps
Mental Health training for line managers ("Strengthening Others") being developed by SALS/OD to be rolled out to all leaders and managers as a module of Strong Foundations and as stand-alone training available to all via recorded presentation and monthly drop ins run by SALS	08/08/2022	Progress update to be delivered at HWB Steering Group on 12th July

Executive Leads Assessment
July 2022 - Jo Potier Risk reviewed and controls amended and updated. Actions reviewed and updated. Unable to close overdue action so escalated to Chief People Officer.
June 2022 - Joanne Potier De La Risk reviewed and actions updated. All actions on track except for action relating to Learning Review to be escalated. No change to risk rating
May 2022 - Jo Potier Risk reviewed and actions updated. One control removed and one new control added. No change to risk rating.

Board Assurance Framework 2022-23

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
New Head of EDI will be develpping an action plan as a result of her audit of EDI, as part of her induction to the role	01/09/2022	

Executive Leads Assessment

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

July 2022 - Melissa Swindell
No change to risk score in month. All actions remain on track

June 2022 - Melissa Swindell
risk reviewed and 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.
Programme and plan agreed with LCC and LPA to return the park back by November 2023.	Works commenced on site and plans established, agreed, costed and signed off as approved.

Gaps in Controls / Assurance

1. Planning approvals for modular buildings to allow demo of Catkin and continuation of park works.
2. Successful handover of IP2 to allow temporary car park to be closed and continuation of park works.
3. Successful realisation of the moves plan.
4. Agreement to MUGA location and planning approval from LPA.
5. Funding availability and potential market inflation.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Review finishes and prepare remedial action plan	12/08/2022	Plan commenced
Set up Joint Planning meeting with community	12/08/2022	Planning Meeting established
Establish an Eaton Road Frontage Review to Prepare Delivery Plan	31/08/2022	Phase 1 implemented using CFS planting. Main review put back whilst issues on Catkin and Sunflower builds are resolved.
Establish temporary office accommodation to house staff within Catkin to allow the building to be demolished.	10/10/2022	Modulars ordered and delivery dates agreed. Planning approved for former police station modular, planning for three storey modular expected on the 21st July 2022

Executive Leads Assessment

June 2022 - David Powell
Following Campus Review Session

Board Assurance Framework 2022-23

May 2022 - David Powell Risk reviewed prior to May Board
April 2022 - David Powell Prior to April Board
March 2022 - David Powell Prior to March Board

Board Assurance Framework 2022-23

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 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH 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. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress
Coordinated system-wide action planning for predicted RSV surge	NW & C&M Surge Plans
ICPG led Refreshed One Liverpool Delivery Plan - under development	
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6.Develop Operational and Business Model to support International and Private Patients	30/09/2022	Target date updated to Q4 21/22 - International strategic plan to be developed in line with 2030 Vision refresh
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/09/2022	Workforce analysis will be a key part of Strasys analysis in developing 2030 Vision refresh. This will support the HRD and system with evidence base for wider workforce planning.
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	31/12/2022	Exec, Trust Board & Governor sessions on 2030 Vision / pop health strategy have all begun (April-May)

Executive Leads Assessment

July 2022 - Dani Jones
Risk reviewed; no change to score in month. Actions, controls and evidence updated.

June 2022 - Dani Jones
Risk reviewed; no change to score in month. Assurance evidence updated and control added.

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

Board Assurance Framework 2022-23

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: 2663		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to meet NHSI/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')
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.
6. Deliverability of 22/23 high risk CIP programme

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	30/09/2022	LTFM work delayed due to ongoing requirements of the 22/23 business planning and system requirements.
2. Five Year capital plan	30/09/2022	22/23 Capital plan approved based on current CDEL allocation. Awaiting confirmation of outcome of bids for any further allocation. Work underway with C&M regarding allocations for 23/24 and 24/25.

Executive Leads Assessment

July 2022 - Rachel Lea
A new risk has been added to the corporate risk register regarding the financial risk to the 22/23 plan. Relevant actions have been moved over and progress updated on both risks. No change to risk score on this.

June 2022 - Rachel Lea
Risk reviewed and added control gap on CIP programme and deliverability of the 22/23 targets.

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

Board Assurance Framework 2022-23

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

Assurance Committee: Trust Board

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

Existing Control Measures	Assurance Evidence (attach on system)
Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda	Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan
Specialist Trust Alliance membership of C&M ICS (HCP) Board - to ensure Specialist Trusts have a voice to influence	
C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22
C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)
Maintain effective existing relationships with key system leaders and regulators	
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development) C&M CMAST Provider Collaborative proposals (under development)

Gaps in Controls / Assurance
Uncertainty over future commissioning intentions (see BAF 3.4 re finance, and also new guidance re delegation of Specialist Commissioned services into ICSs)

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	
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/10/2022	X

Executive Leads Assessment
July 2022 - Dani Jones Risk reviewed; no change to score in month. Actions and controls reviewed and updated.
June 2022 - Dani Jones Risk reviewed; no change to score in month, Assurance evidence added
May 2022 - Dani Jones Risk reviewed; no change to score in month, updated actions and evidence. System shift ongoing, Alder Hey membership and CYP voice in all key groups confirmed.

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. Liverpool Neonatal Partnership and presented PQAR to LNP Board in June 22 - agreed next action to identify NED rep from both Trusts to do a full PQAR with LNP (under identification/scheduling)
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 Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - June 22

Gaps in Controls / Assurance

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Agreement to pilot Pship Assurance Round approach with LWH and Liverpool Neonatal Partnership. Pack development to be undertaken during March - initial plan with LWH for presentation to LNP Board in April - this has been moved to June (recognising current pressures in team). Learning to be shared and co-design to pack to be incorporated	31/08/2022	Initial presentation at LNP Board completed June 22. Next step to identify NED from both Trusts to undertake full PQAR with LNP team
MIAA Audit scheduled for Q2 2022	31/10/2022	Draft TOR for audit currently under agreement

Executive Leads Assessment
July 2022 - Dani Jones Risk Reviewed; no change to score in month but progress with actions, controls and evidence.
June 2022 - Dani Jones Risk reviewed; no change to score in month, additional control added
May 2022 - Dani Jones Risk reviewed; no change to score in month. LWH & LNP agreed to schedule Pship Assurance Framework for July LNP Board (previously April)

Board Assurance Framework 2022-23

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.		
Related CQC Themes: Well Led			Link to Corporate risk/s: 2624		
Exec Lead: Claire Liddy		Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description
The trust strategy requires the growth of game changing research and innovation activities to enable an increase in R&D investment levels and generate commercial opportunity. The failure to deliver R&I strategies could result in an inability to achieve growth and new partnerships plans which will limit R&D investments and delay new discoveries. The delivery of the R&I activities may also expose the Trust to contractual and reputation risks due to the need to enter into legal agreements with academia, large corporate's, SMEs and investors. The delivery of the R&I activities will lead to industry data collaborations and AI with commercial contracts which will require robust data governance and ethics.

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

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation	08/11/2023	

Executive Leads Assessment
July 2022 - Claire Liddy July - no change
June 2022 - Claire Liddy No change to risk in month
May 2022 - Claire Liddy May review - static

Board Assurance Framework 2022-23

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led			Link to Corporate risk/s: 2265, 2235		
Exec Lead: Kate Warriner		Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

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

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

Gaps in Controls / Assurance
Cyber security investment for additional controls approved - dashboards and specialist resource in place Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs Issues securing experienced resources in some services Anticipated delays with major programme delivery

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
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	01/09/2022	Recruitment to key leadership roles and vacancies in key teams in progress
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development

Executive Leads Assessment
July 2022 - Kate Warriner BAF Risk reviewed. Current scores remain in place. Aldercare programme currently in exception, formal review underway. Review has confirmed that October 22 go live is not viable, work in progress to establish revised go live date and associated required resources. Resourcing challenges are improving with recruitment of some key vacancies in some services. Mobilisation plans for Digital and Data Futures is in development.
June 2022 - Kate Warriner BAF Risk reviewed. Current scores remain in place. Deep dive undertaken with regards to Aldercare programme. Delays with programme go live are anticipated, detailed review in progress, due for completion June 22 to inform next steps. Resourcing challenges are improving with recruitment of some key positions in some services, however mitigations are still in progress. Mobilisation of Digital and Data Futures and transition from previous programmes of work is in development.
May 2022 - Ian Gilbertson This risk has been reviewed and current controls remain in place. There are currently no changes to the level of risk.

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Kerry Byrne, Committee Chair

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 14th July 2022, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 16th June 2022.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

The Audit & Risk Committee (ARC) 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 shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

The July meeting covers only risk and governance related items.

- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register
- Analysis of the Trust Risk Register
- Emergency Planning Resilience and Response (EPRR) documents:
  - EPPR Policy
  - Escalation Plan
  - Heatwave Escalation Plan
  - Hazardous Materials (HazMat) Chemical, Biological, Radiological, Nuclear & Explosives (CBRNE) Incident Management Plan
  - Business Continuity Plan
  - Local Business Continuity Plan Template

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

None.

4. Positive highlights of note

We received an update from the Director of Corporate Affairs regarding the creation of a Corporate Services Collaborative which will oversee performance, risk and CIP delivery within the corporate service teams. Reporting into the RMF this should provide a forum for greater scrutiny of corporate service risks.

We received an update from the new Associate Director of Nursing & Governance, Jackie Rooney, on areas of focus for the next few months which include teams that have no, or few, reported risks, long-standing risks with a score of 12, introducing a standard format for articulating risks and scrutinising risk registers with teams to ensure they are up to date and scored consistently.

5. Issues for other committees

Prior to the meeting it was agreed that ARC will take responsibility for EPRR reporting, which is currently split between ARC and SQAC. The ARC Chair is the NED responsible for oversight of EPRR on behalf of the Board and will report any relevant information into SQAC.

6. Recommendations

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

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 16th June 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	Regional Assurance Director	(GB)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Mrs R Lea	Associate Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
Observing	Mr. J. Wilcox	Divisional Accountant	(JW)
Item 22/23/34	Ms. P. Fagan	Head of Technical Risk Assurance, MIAA	(PF)
Item 22/23/34	Ms. G. Owens	Snr. Technology Risk Assurance Manager, MIAA	(GO)
Item 22/23/37	Mr. I. Gilbertson	Assoc. Director of Digital Transformation	(IG)
Item 22/23/40	Mr. R. Jolley	Procurement and Contract Manager	(RJ)
Apologies:	Mr. K. Jones	Associate Finance Director	(KJ)

22/23/30 Introductions and Apologies

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

22/23/31 Declarations of Interest

There were none to declare.

22/23/32 Minutes from the Meeting held on the 21st April 2022
Resolved:
The minutes from the meeting that took place on the 21st of April were agreed as an accurate record of the meeting.

The Chair queried as to whether the outcome of the advisory work that was conducted by MIAA on the incident relating to the stolen iPads should be submitted to the Committee for completeness. It was agreed to share the report on the outcome of the review, during September's meeting and report on the recommendations via the follow-up process.

22/23/32.1 Action: KS

22/23/33 Matters Arising and Action Log

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)* – It was agreed to conduct a repeat of the Project Management audit in 2023 to enable scrutiny to be given to other projects in the review. **ACTION TO REMAIN OPEN**

21/22/15.2: *Final Internal Audit Plan for 2021/22 (conduct a piece of work over the next twelve months, in association with MIAA, to look at what the Internal Audit plan would look like if a different approach was taken by the Trust on key financial controls)* – This action has been superseded by a mandatory piece of work that has been commissioned by the National Director of Finance for all providers. MIAA is in the process of trying to clarify the scope, resources and timeline for this work which is to be commissioned by August 2022. An update on this matter will be shared with the Committee during September's meeting along with the outcome of discussions between MIAA and Ernst and Young to confirm as to whether this leaves a gap in terms of standard key financial controls.
ACTION TO REMAIN OPEN

Action 21/22/87.1: *Trust Risk Management Analysis (conduct a piece of work to confirm that the information being reported in terms of zero/low risks by a number of areas across the Trust is correct)* – An update on this action will be provided during July's meeting.
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)* - An update on this action will be provided during July's meeting.
ACTION TO REMAIN OPEN

Action 21/22/89.1 – *Update on Risk Management Process within the Division of Surgery (during the next Risk Management Forum discuss the possibility of implementing a set of best practice standards Trust wide in order to have a standard approach for risk management* – An update on this action will be provided during July's meeting.
ACTION TO REMAIN OPEN

Action 21/22/101.1 – *Trust's Nil Net Assets Review (compile guidance to support the management of the process for nil net assets)* – An update on this action will be provided during September's meeting. **ACTION TO REMAIN OPEN**

Action 21/22/07.1 – *Trust Risk Management Analysis (circulate a revised version of the Trust Risk Management Analysis Report which includes data up until the 21.3.22)* – Committee members didn't receive a revised version of the report, but an updated report will be submitted ahead of July's meeting. **ACTION CLOSED**

Action 21/22/36.1: *Include a statement in the Annual Report for each committee highlighting whether (relevant BAF) risks are being well managed, to enable the Audit and Risk Committee to provide assurance to the Board on the overall effectiveness of the Trust's risk management process)* – It was agreed to include a paragraph in next year's annual reports to identify the BAF risks that each Committee is responsible for along with narrative confirming the Committee's agreement in terms of the scoring of each risk, verification that risks are being managed effectively and actions are being addressed on a timely basis. **ACTION TO REMAIN OPEN**

Action 22/23/13.1: *Project Management Review (RL to liaise with the Development Team to see if the overdue recommendations can be implemented within the next three months with an update to be provided to the June meeting)* – A meeting will take place with the Development team w/c 20.6.22 and an update will be provided to the Committee via e-mail. **ACTION TO REMAIN OPEN**

Action 22/23/22.1: *Annual Governance Statement (acquire advice in order to confirm as to whether the incident relating to the stolen iPads needs to be included in the Annual Governance Statement. Circulate the outcome via e-mail)* – It was confirmed that the incident relating to a number of stolen iPads does not need to be incorporated in the Annual Governance Statement as it was found not to be systemic weakness.
ACTION CLOSED

Action 22/23/24.2: *Audit and Risk Committee Self-Assessment Exercise - Ongoing Actions (number 2) - discuss as to whether the annual Committee reports should set out the assurance they have received and their impact on the organisation's assurance framework and advise of any matters to be brought to the attending of the Audit and Risk Committee* – It was agreed to include commentary in future annual reports to advise on the outcome of the external reports received by the Trust. **ACTION TO REMAIN OPEN**

22/23/34 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 during the period from April 2022 to June 2022. The following points were highlighted:

- Two reports have been finalised in this period; Conflicts of Interest and IT Service Continuity and Resilience, of which, both received substantial assurance.
- There are two reviews currently in progress and three Q2 reviews in the planning stage.
- *Audit Plan Changes* - The Committee was advised that NHSE has requested that all organisations commission an internal audit by the 31.8.22 to produce a report for the Audit Committee covering the most recent HFMA publication 'Improving NSH financial sustainability: Are you getting the basics right?' highlighting areas of weakness in financial governance and prescribing remedial actions. It was confirmed that further information on the scope, timeline and funding will be provided during September's meeting.

Gemma Owens provided an overview of the outcome of the IT Service Continuity and Resilience review and advised that overall the review identified that controls were designed and operating effectively. It was pointed out that the Trust has invested in the area of IT service continuity and resilience over the last few years ensuring that resilience is in place for key systems through the procurement of cyber recovery solutions as well as the collaborative working with nearby specialist trusts; Clatterbridge Cancer Centre and Liverpool Health and Chest.

It was reported that there are areas for improvement in terms of ensuring agreements are formalised and documentation is in place to support processes. A note was also made in

relation to conducting routine planned failover testing to ensure that problems are addressed ahead of a live situation.

The Chair thanked Gemma and Paula for providing the Committee with greater detail on the outcome of the review and asked that they attend future meetings when there is a focus on the follow up of IT/specialised audits.

The Chair drew attention to the great progress that is being made against the 2022/23 Internal Audit Plan so early in the year. It was reported that a further two reviews are scheduled for July 2022 and two scoping meetings have been planned for the end of June. The Chair requested a copy of the Terms of Reference for the Partnership Governance review.

22/23/34.1 **Action: KS**

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Progress Report.

22/23/35 **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 from April 2022 to June 2022. The following points were highlighted:

- Of the eighteen recommendations that have fallen due in this reporting period, thirteen have been implemented and five have been partially implemented. It was pointed out that four of the five recommendations that have been partially implemented relate to Consultant Job Planning and one relates to Complaints and PALS. MIAA referred to the five partially implemented recommendations and advised that further time is required to ensure the recommendations are fully implemented and embedded and can be fully tested over the summer period.

The Chair queried as to whether the Committee should request an update on the progress of the outstanding actions relating to Consultant Job Planning in order to receive assurance. It was reported that the Acting Chief Medical Officer, Alfie Bass, is taking a real interest in job planning and it was felt that it would be beneficial to hear his views on this matter and receive an overview of the forthcoming plans for this area of work. It was agreed that **1.** MIAA will make contact with Alfie Bass to provide background information on the recommendations in the follow-up report for Consultant Job Planning, and further details on the work that has taken place to progress the recommendations. **2.** Invite Alfie Bass to September's meeting to receive an update on future ideas/plans to address job planning.

22/23/35.1 **Action: KS/GB**
22/23/35.2 **Action: ABASS**

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Follow-up Report, and approved the extensions requested for the five partially implemented recommendations.

22/23/36 External Audit Year End Report on the Trust's Accounts for 2021/22 including:

The Committee received the external Audit Results Report for year ended the 31.3.22. The following points were highlighted:

- It was reported that the audit process is still ongoing therefore the Trust opinion is yet to be completed. An update was provided on the outstanding items for review and it was pointed out that E&Y will continue to challenge the remaining evidence provided and the final disclosures in the Annual Report and Accounts. The Chair queried as to whether there is anything remaining that could affect the overall opinion of the accounts. The Committee was advised that E&Y are reporting minor amendments but are at a point where they are looking to propose a clean opinion as it is felt that none of the outstanding items will affect the opinion.
- *Value for Money (VFM)* – It was confirmed that the VFM risk assessment has been completed and there were no risks of significant weakness identified against the three reporting criteria that E&Y are required to consider under the NAO's 2020 Code. E&Y plan to issue the VFM commentary as part of issuing the Auditor's Annual Report ahead of the date set for the laying of the accounts before Parliament.
- *Audit Differences* – The Committee was informed that subject to the completion of outstanding areas there are no differences to report where management have not agreed to amend the financial statements. It was confirmed that E&Y have identified one control issue which is outlined in section 7 of the report.

Ian Quinlan drew attention to the audit differences highlighted in section 4 of the report which exceed the £300k threshold and pointed out that the majority of these figures are for large amounts but don't seem to warrant any supporting commentary. The Committee was advised that this would have been reported as an adjustment if there were any issues identified as a result of the differences.

Rachel Lea reported that the majority of the larger differences have been resolved and advised of the actions that are taking place to either close the outstanding balances down or agree them. Following discussion it was agreed to provide the Board with assurance on each of the identified balances via the compilation of a briefing note.

22/23/36.1 Action: JW

The Chair referred to section 7 of the report and queried the actions being taken to address the issue of incorrect journal entries. It was confirmed that the incorrect entries have not had an impact on the financial statements and the Trust is looking to implement additional controls in terms of the purchasing process to try and prevent this issue occurring again.

Letter of Representations

It was reported that the Letter of Representations will need to be signed following the conclusion of the audit. E&Y agreed to submit an updated report to the Chair of the Committee once the audit is complete so that the final Letter of Representations can be revised to include any amendments. The Chair asked that a summary page be included in the report to highlight the changes.

The Chair requested confirmation from the respective members of the Committee in terms of there being no reason as to why the Letter of Representations shouldn't be signed by herself on behalf of the Trust. It was confirmed that there is no reason as to why the document shouldn't be signed by the Chair of the Audit and Risk Committee.

Trust's Annual Report, 2021/22

The Committee received the Annual Report for 2021/22 which was prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Committee was provided with an overview of the report and attention was drawn to the summary of changes for the year with a number relating to remuneration and the expanded requirements around fair pay disclosures.

It was reported that the Quality Account has been removed permanently from the body of the Annual Report and will be submitted to the Centre separately going forward. Erica Saunders paid tribute to Jill Preece for leading on the Annual Report.

Trust's Annual Accounts, 2021/22

The Committee was provided with an overview of the contents of the 2021/22 Annual Accounts and the supplemental finance report. It was reported that the Trust's year end position for 2021/22 remains at a surplus of £137k against a breakeven plan. A number of categorisation changes have been made following discussions with external audit, but this has not affected the overall position.

A number of key highlights were shared with the Committee in terms of performance; it was reported that the Trust delivered its Capital Plan with a total spend of £30.2m. This included areas of hosted capital and a number of new capital investments received via national money. Alder Hey also hosted the National Paediatric Accelerator Programme on behalf of ten specialist trusts which brought an additional income of £20m. It was confirmed that an element of the income from the Accelerator Programme was invested to support digital and innovation projects.

The Trust's cash balance as at the 31.3.22 formed the outcome of the organisation's liquidity assessment in terms of fully supporting that a Going Concern basis should be adopted for preparing the financial accounts. Attention was drawn to the increase in the organisation's provisions which relates to the Trust's liability for the reinstatement of the park.

On behalf of the Committee, the Chair offered thanks to Ian Quinlan for attending the meeting, the teams who have produced the Trust's Annual Report and Accounts and E&Y for the work that has been conducted on the audit.

Resolved:
The Audit and Risk Committee approved the Annual Accounts for 2021/22, recognising that there will be a number of minor amendments prior to the laying of the accounts before Parliament.

22/23/37 Annual Assurance Report for 2021/22 and Forward Plan for 2022/23 – Cyber Security and DPST

The Committee received the 2021/22 Annual Assurance Report for Cyber Security and DPST and the Forward Plan for 2022/23. The following points were raised:

- *Data Protection Security Toolkit* - The criteria for 2021/22 has been expanded and consists of 142 areas of compliance. It was confirmed that the Trust is compliant with 141 areas but is currently below the required 95% criteria for all staff to be compliant with IG mandatory training (93.4%). There is to be a set of focussed actions throughout June with an aim to meet the 95% standard ahead of the submission date on the 30.6.22.
- *Cyber Security* – It was reported that the Trust is performing well against all criteria, with investments being made to support the six national priority areas as outlined in the report. The Cyber Security Plan for the coming year includes continued compliance to the priority principles and the further implementation and development of the toolsets brought in during the last 12 months.

The Chair noted the progress that has been made in terms of the increase in the mandatory training figures for DPST.

Resolved:
The Audit and Risk Committee received and noted the 2021/22 Annual Assurance Report for Cyber Security and DPST and the Forward Plan for 2022/23

22/23/38 Third Party Assurance form ELFS – Payroll Service

It was agreed to defer this item to September's meeting. The Chair asked that an overview be compiled to highlight the areas of the report that appertain to the Trust.

22/23/38.1 Action: KJ

22/23/39 Committee Annual Reports for 2020/21

The Committee received the 2021/22 Annual Reports for the Assurance Committees that report into the Trust Board. The following points were highlighted:

- It was reported that each Committee has had an opportunity to formally reflect on the business that has been transacted during the year and highlight future priorities for 2022/23. Each Chair has reviewed and commented on their respective report, and attention was drawn to the work that was conducted by MIAA in terms of reviewing the annual reports to provide additional assurance.
- The Chair referred to action 21/22/36.1 and 22/23/24.2 and suggested including a paragraph in next year's annual reports to identify the BAF risks that each Committee is responsible for along with narrative confirming the Committee's agreement in terms of the scoring of each risk, verification that risks are being managed effectively and actions are being addressed on a timely basis. In terms of external assurance, it was suggested including commentary in future annual reports to advise on the outcome of the external assurance reports received by the Trust.

Resolved:
The Audit and Risk Committee commended the Annual Reports of the Assurance Committees to the Trust Board for approval.

22/23/40 Company Representatives Policy

The Company Representatives Policy is aimed at controlling the activities of supplier representatives on the Trust site, and the offer/receipt of gifts and hospitality. The policy has been in place for ten years and has been extended for twelve months pending the Health Procurement Liverpool Alliance policy being written.

The Chair pointed out that the Audit and Risk Committee will be approving the policy and asked for the narrative in the Quality Impact Assessment to be amended to reflect this.

22/23/40.1 Action: RJ

Resolved:
The Audit and Risk Committee received and approved the Company Representative Policy.

22/23/41 Any Other Business

The Chair thanked Anita Marsland for her service to the Audit and Risk Committee and wished her well as her term of office as a NED comes to an end on the 30.6.22.

2**2/23/42 Meeting Review**

It was felt that enough time had been set aside to discuss all agenda items. The Chair advised that the Committee will recommend the 2022/23 Accounts to the Board for approval during the Trust Board meeting that is scheduled to take place on the 20.6.22.

Date and Time of the Next Meeting: Thursday 14th July 2022, 2:00pm-5:00pm, via Teams.

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 27th June 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Anita Marsland	Non-Executive Director	(AM)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Rachel Lea	Deputy Director of Finance	(RL)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Mark Carmichael	Associate Chief Operating Officer	
	Mark Flannagan	Director of Communications	(MF)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Natalie Palin	Associate Director of Transformation	
	Graeme Dixon	Head of Building services	

22/23/41 Apologies:

Nathan Askew	Chief Nursing Officer	(NA)
Jim O'Brien	Capital Project Manager	(JO'B)
Catherine Kilcoyne	Deputy Director of Business Development	(CK)
Clare Shelley	Associate Director Operational Finance	(CS)

22/23/42 Minutes from the meeting held on 23rd May 2022

The minutes were approved as a true and accurate record.

22/23/43 Matters Arising and Action log

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

22/23/44 Declarations of Interest

There were no declarations of interest.

22/23/45 Finance Report

Month 2 Financial Position

The Trust has achieved an in-month trading deficit of £0.5m in May which is £0.3m adverse to the planned deficit of £0.2m. RABD noted the main drivers for the year to date position is in relation to CIP.

An update was received in relation to Better Payment Practice Code noting this was slightly down this month due to a cleansing exercise, this will improve over the next couple of months.

Resolved:

RABD received and noted the M2 Finance report.

22/23/46 2022-23 Plan

RL highlighted:

1. The submission of an I&E plan for the financial year 22/23 that will deliver a surplus of £4.6m to meet a stretch control target set by ICS.

2. The I&E plan is based on key assumptions for income allocations, expenditure investments and CIP delivery with CIP being the key risk at this stage.
3. A revised 22/23 capital programme of £12.8m with a residual risk of £927k due to restrictions in CDEL allocations.

Resolved:
RABD noted the challenging position of 2022-23 Plan with further updates to be received.

22/23/47 **Capital and Cash Update**
KJ reported the capital plan has been approved by the ICS with CDEL confirmed at £8.9m, the plan has been submitted to NHSI on this basis and YTD progress is maintained in line with these assumptions.

Cash will remain focused on 2022/23 due to unclarity on future years.

The Chair queried a contingency plan in relation to rising costs. KJ said this has been included in the divisional plans.

Resolved:
RABD noted the current position in relation to Capital and Cash.

22/23/48 **CIP and 2023 risks**
CIP target for 22/23 is £14.3m of which £10m is with the divisions. EK went through the actions completed since the last meeting including changes to SDG meetings into Sprint Cohorts to monitor progress.

SA asked for details on the non-pay supplies i.e. clinical drugs and whether this was in relation to cost increases or volume related. RL said there is some pressure on drugs which will be activity related, a deep diver would need to be carried out to see if cost inflation is also affecting cost of drugs. It was agreed an update would be received at the July RABD.
Action: RL/EK/CS

Resolved:
RABD received and noted the CIP update.

22/23/49 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
RL highlighted:
Planning permission in relation to the temporary modular buildings has been submitted to Liverpool Council.

Sunflower House/Catkin is being delayed working with builders to get back on track. A number of claims are being worked through with the legal advisors.

The Neonatal project has now commenced with the new contractors. A revised cost plan has been received higher than original plans due to cost inflation, this is currently being worked though. RABD will continue to receive regular updates.

Resolved:
RABD received the Campus and Park paper.

22/23/50 **Benefit Realisation**
NP reported on a review of business cases on benefit realisation.

Resolved:
RABD received the Benefit Realisation update noting further updates will be received on a bi monthly basis.

22/23/51 Alder Care

Following the Alder Care programme turning red on the Board Assurance Framework a number of reviews have been put in place due to be completed by the end of this week. The recent gateway exercise as anticipated did not pass. A Meditech Executive follow on meeting is taking place this Friday with further discussions to be held next week with NHSI. Progress has been made in relation to the template build.

SA asked if other Trust's have been having similar issues. KW said whilst there are some in terms of paediatric there are also a number of general risks. KW added that conversations with the ICS and NHSI will also support other Trust's going forward.

KW said Christopher Grimes has been appointed as the Trust Wide Clinical Information Officer and is due to start in post this Friday.

Resolved:
RABD noted the continued challenges around Alder Care. RABD will receive further updates.

22/23/52 Digital and Information Technology Update

KW highlighted:

- Alder Hey went live with the Communications project: Outpatient letters and reminders are now sent via texts with a link to a digital letter. The system receives an acceptance report for all read letters any unread will also receive a written letter.
- Compliant position on Information Governance mandatory training was recorded on Friday this will be recorded in the Data Security Protection Toolkit and will be submitted to Audit Committee.
- The integrated service continues to evolve with Liverpool Heart and Chest and is constantly looking at areas that could be enhanced through partnership working. With that in mind, in May 2022, a proposal was approved by both Trust Executive Committees to consolidate the Information Governance service through iDigital.
- The new Digital strategy is nearing completion and will be circulated with RABD in due course.

Resolved:
RABD noted and received the Digital, Information Technology update.

22/23/53 Safe Waiting List Management: diagnostic reporting changes

MC highlighted:

- At the end of May 2022, the trust reported 58.9% compliance against the 99% standard a breakdown of services was received within the report.
- A DEXA Imaging machine has been deemed as unfit to use a replacement is due to be in place no later than August 2022. Warrington and Halton Trust are providing support with weekly sessions from July.
- Issues with the plant in the trust decontamination unit have been ongoing since April 2022. Building Services are working with Gastroscopy to have this replaced.

- As the new video telemetry purchased supports epilepsy and not sleep monitoring an application has been submitted to the Alder Hey Charity to see if they would be able to provide funding for the right model due to the significant cost.
  AB added the video kit would be used to monitor sleep at the patients home and asked for Executive support with this to bring patient wait times down.
  Action: Execs
- The Urology team are currently in the process of recruiting a Specialty Doctor which will provide additional clinician availability to undertake Urodynamics, once in post the use of video urodynamics can be explored for some patients going forward. The department are scoping the use of community hubs for Pediatric urodynamics.

JG asked for a trajectory piece to be included going forward so RABD can monitor when it was likely for the standard to be closer to the 99% target.
Action: MC

Resolved:
RABD received the Safe Waiting List position a further update to be received at the September RABD.

22/23/54 **Month 2 Corporate Report**
AB reported good triage times in ED as well as good access to cancer care.

Challenges include compliance in relation to clinical letters. Only around 60% of letters are being signed off within the 10 day requirement. AB asked for this to be a quality improvement going forward and to be monitored through RABD.
Action: AB

AB referred to patients attending ED and plans in place for those who would be more suitable to be seen by a GP at a doctors surgery.

Access times in relation to patients waiting for elective care was 282 patients waiting a year for treatment, national standard is 2 years. Whilst compliant with the national standard Alder Hey continues to aim at patients waiting under a year for treatment. Two areas where there are particularly high waiting times is spinal surgery and dentistry. A number of the patients have learning disabilities a plan is to be put in place to bring these patient appointments forward.

Resolved:
RABD received and noted the M2 Corporate report.

22/23/55 **Communications update (starred item – only questions/answers will be noted)**
Resolved:
RABD received and noted the communications paper.

22/23/56 **Green Plan**
Focus continues on energy, MF suggested a more detailed update on this is received at the August or September RABD.
Action: AP

Plans in place to save over £100k on waste. Applications on a number of bids have also been submitted. RL said one of the bids is in relation to increasing the green plan team.

Resolved:
RABD noted the current position against the Green plan.

22/23/57 Procurement update

Following the end of the staff consultation period on 31st March 2022, recruitment and selection processes have been undertaken for vacant posts within the new Health Procurement Liverpool structure.

TUPE transfer continues and is hoped to be completed by the end of August.

SA asked if the benefit realisation programme will be used against the Procurement project. EK advised it would through the CIP programme. RL added that a detailed piece would be presented to RABD on both Procurement HPL project and Digital Project with Broadgreen Liverpool University Hospital. JG asked for a deep dive to be presented at the September RABD.
Action: RJ

MF asked if the green plans are included RJ said all workstreams have a procurement lead and Green plan has been included.

Resolved:
RABD noted the Procurement progress report.

22/23/58 PFI Report

RABD received an update in relation to SFP. A meeting was taking place later today with key leads to move forward and resolve ongoing issues. A further update will be presented to RABD at the July meeting.

Resolved:
RABD received and noted the M2 PFI report.

22/23/59 Board Assurance Framework

ES referred to a number of updates during the meeting noting that they didn't reflect the risk registered on the BAF. It was noted this would be looked into prior to the next RABD.

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

22/23/60 Any Other Business

Anita Marsland
On Behalf of RABD the Chair thanked Anita for her support and wished her well going forward. Anita's position as Non-Executive Director ends this month.

22/23/61 Company Representatives Policy

Resolved:
RABD received the above policy for information, the policy had been approved by Audit Committee on 16th June 2022.

22/23/62 Review of Meeting

The Chair noted challenges moving forward including CIP and cost pressures.

Date and Time of Next Meeting: Monday 25th July 2022, 1330, via Teams.

BOARD OF DIRECTORS

Thursday, 28th July 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	20th July 2022 – Summary 22nd June – Approved Minutes
Report of:	Fiona Beveridge, Chair, Safety Quality Assurance Committee
Paper Prepared by:	Julie Creevy, CQAC Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 20th July 2022, along with the approved minutes from the 22nd June 2022 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

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

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

2. Agenda items received, discussed / approved at the meeting at the meeting held on 20th July 2022

- Overview of reporting process from Patient Safety Strategy Board was received which outlined how the Patient Safety Strategy Board would operate, and detailed assurance would be provided to SQAC.
  SQAC RATIFIED the Patient Safety Strategy Board Terms of Reference.
- Assurance ED Activity Monthly update received
- DIPC Exception report was received, SQAC received an update regarding vaccination demand and the impact on Alder Hey, in addition to receiving an update regarding the demand regarding childhood immunisation support, and the direction of travel.
- SQAC received Quarter 1 Mental Health Attendances update, good discussion was held, issues raised regarding pressures within the team, and whether the organisation could learn more by focusing on some of the known patients who present to ED.
- Safe Waiting List update was received, which highlighted good progress made to date.
- Transition Update was received, which highlighted good progress made to date.
- Sepsis Monitoring Plan update was received which highlighted good progress to date.
- CCG Review of Trusts Safeguarding Report was received, SQAC acknowledged that this was an excellent report, SQAC noted the commencement of a lengthy and detailed piece of work to improve the organisation position and also to ensure greater clarity and connectivity across the ICS.
- Interpreter, Translation and Accessible Information Policy was received and RATIFIED.

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

None

4. Positive highlights of note

5. Issues for other committees

None

6. Recommendations

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

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 22nd June 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Interim Chief Medical Officer	(Abba)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Kerry Byrne	Non-Executive Director	(KB)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Adrian Hughes	Deputy Chief Medical Officer	(AH)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jackie Rooney	Director of Quality & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Christopher Talbot	Safety Lead – Surgery Division	(CT)
	Dame Jo Williams	Trust Chair	(DJW)

In attendance:

22/23/53	Jennie Williams	Head of Quality Hub	(JW)
	Mo Azar	Chief Pharmacist	(MA)
(part meeting)	Harriett Corbett	Divisional Director, Research Division	(HC)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Josh Goldblatt	(Observing)	(JG)
22/23/53	Andrea Gill	Clinical Pharmacy Services Manager	(AG)
22/23/59	Kim Hewitson	Sepsis Lead Nurse	(KH)
	Natalie Palin	Associate Director of Transformation	(NP)
22/23/59	David Porter	Consultant Infection & Immunology Consultant/ Sepsis Lead	(DP)
	Jacqueline Lyons-Killey	Associate Chief Nurse, Research Division	(JLK)
	David Reilly	Associate Director of Digital Systems (IM&T)	(DR)

22/23/49	**Apologies:**		
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	John Grinnell	Deputy Chief Executive	(JG)
	Christine Hill	Pathology Manager, Safety Lead	(CH)
	Dani Jones	Director of Strategy	(DJ)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)
	Kate Warriner	Chief Digital & Information Officer	(KW)

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

22/23/50 Declarations of Interest

SQAC noted that there were no items to declare.

000217

22/23/51 Minutes of the previous meeting held on 18th May 2022 – Resolved:
Subject to an amendment being made to item 22/23/39 the Committee members were content to **APPROVE** the notes of the meeting held on 18th May 2022.

22/23/52 Matters Arising and Action Log
Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/53 Quality Priorities Monthly update and DMO Update
NP presented the Quality Priorities and DMO Update.
NP advised that following feedback from Audit Committee and the need to strengthen and improve assurance regarding safety projects a project progress plan is to utilise PMO standards to undertake in depth assurance ratings and track progress against intended plans. The programmes for this financial year on medication safety and deterioration are within the scope of the Patient Safety Board, therefore it is the intention that those programmes, with PIDS are ready for this financial year to be approved and progress to the Patient Safety Board for the July 2022 meeting. Following this, the team would be able to provide assurance into SQAC as progression is made regarding project delivery.
FB requested clarity regarding what SQAC would receive, and the frequency of reporting. NP confirmed that SQAC would receive the quality assurance regarding good programme management standards i.e., is the group meeting; is there progress against delivery plans; are there appropriate resources to enable delivery; and is progress being made in the correct way. This would provide SQAC with assurance that systems of control are sufficiently robust to deliver the intended outcomes. NP stated that given that these projects would be reporting to Patient Safety Board and that they are not new projects, but ones which have been delivered in the last financial year, it would be possible to provide SQAC with an update of the first ratings at the August 2022 meeting, following the Patient Safety Board July 2022 meeting. FB sought clarity whether monthly reporting is intended and appropriate. NP confirmed this was the intention. FB stated that SQAC would welcome a report in August 2022, however, discussion is required as to whether there would be a meeting in August 2022, as during the period of August 2021 SQAC reviewed report circulation only, offline discussion to take place agree.

KB welcomed DMO assurance updates in addition to the management updates.
NA stated that the Quality Priorities are transitioning into reporting through the Patient Safety Board. NA & Aba to determine what should be reporting into SQAC, and the frequency of reporting into SQAC, and envisaged that the frequency of reporting may change. SQAC welcomed a brief overview regarding reporting from Patient Safety Board at July 2022 SQAC meeting.

Resolved: SQAC received and **NOTED** the Quality Priorities & DMO update.
SQAC requested a brief overview regarding reporting/workplan at July SQAC meeting.
Offline discussion to take place regarding whether there will be a SQAC meeting in August, or review of papers.

Safe

22/23/54 DIPC Exception Report
SQAC received and **NOTED** the DIPC exception report.

Resolved: SQAC received and **NOTED** the DIPC exception report.

22/23/55 Assurance ED Activity Monthly Update

SQAC received and **NOTED** the ED Activity Monthly update.

Resolved: SQAC received and **NOTED** the ED Activity Monthly update.

22/23/56 Quality Assurance Rounds themes and risks

PB presented the Quality Assurance Rounds Themes and Risks report key issues as follows:-

- During 1st April 2022 – 31st May 2022, eight quality assurance rounds had taken place across the Trust, no quality assurance rounds had been cancelled or rescheduled during that reporting period.
- Main challenges noted related to gaps in service due to staffing issues due to vacancies and long term sickness/maternity leave, mandatory training, recruitment and workforce issues, staff resilience, staff sickness and burnout, resource issues, IT issues, meditech, medisec and EMIS, waiting list backlog, increased demand from primary care referrals and long term impact of the economy on staff – travel costs/car parking costs and childcare costs.
- Successes related to improved reporting of incident themes, services showing best practice, staff continuing to go above and beyond, good governance structures to MDTs, positive feedback from FFT Survey, teams having an holistic approach to care, development of roles to support retention and sustainability of services, development of clinical pathways, compliance with policies, guidelines and leaflet and support staff well-being through SALS.
- The current approved risk register clearly triangulates the 'people's risks' and shows that these risks are being effectively addressed with supportive mitigations.
- Quality Assurance Rounds process had demonstrated outstanding achievements to support patient and staff safety, clinical effectiveness, responsiveness, caring and well-led across all areas visited.
- SQAC **NOTED** that staff are to be commended in their ability to be open and honest when discussing the key challenges that they are facing, together with the positive support systems that enable them to provide safe, effective care and positive patient experience.
- SQAC **NOTED** the next steps detailed in the report.

DJW thanked PB for update, and highlighted the importance of ensuring that all involved in Quality Assurance Rounds receive appropriate feedback on any improvements made following the Quality Assurance Rounds. This was welcomed for staff involved, and also for Non-Executive Directors who participate and support Quality Assurance Rounds.

JR sought clarification regarding frequency of future Quality Assurance Round reports presented to SQAC. FB advised that SQAC would welcome Quarterly Quality Assurance Round update reports.
FB thanked PB for a comprehensive update and welcomed a future update at September 2022 meeting.

Resolved: SQAC received and **NOTED** the Quality Assurance Rounds themes and risks update and agreed to the level of assurance provided.
Resolved: SQAC to receive quarterly Quality Assurance Rounds themes and risks report.

22/23/57 Ockenden Report Action Plan

PB presented the Ockenden Report Action Plan

PB recommended that the Ockenden Action Plan is monitored on a quarterly basis at SQAC to ensure actions are on trajectory. PB advised that there is likely to be a number of actions that have rapid closure.

FB thanked PB for informative update and welcomed Ockenden Action Plan updates at October 2022 and January 2023 SQAC meetings. PB to report by exception on any items not on trajectory at August 2022 meeting.

DJW queried progress with regards to Liverpool Women's NHS Foundation Trust Action plan and requested assurance regarding the rigour and pace in terms of Liverpool Women's NHS Foundation Trust Action plan. NA advised that the partnership had been working collaboratively, with regards to the neonatal aspect, and had been transparent. NA would liaise with colleagues at Liverpool Women's Hospital Foundation Trust to request a copy of the Ockenden Action Plan prior to Trust Board. NA referred to element of caution with regards to the challenge for Liverpool Women's NHS Foundation Trust given that every recommendation would be applicable to Liverpool Women's NHS Foundation Trust therefore completion is likely to take some time.

Resolved: NA would contact colleagues at LWH to request Ockenden Action Plan, ahead of Trust Board, and should an offline discussion be required thereafter this would be diarised as appropriate. NA would ensure that Liverpool Women's NHS Foundation Trust receive Alder Hey Ockenden Action Plan to align wherever possible.

FB referred to instances if recommendations overlap and the opportunity to synchronise the actions plans. FB stated that it would be beneficial for NA to share Alder Hey's Action plan in the first instance with colleagues at Liverpool Women's NHS Foundation Trust to ensure actions are identical. NA agreed with this in terms of the neonatal section, and advised that with regards to maternity this would be a nuance as most of the recommendations in this regard are indirectly applicable to Alder Hey.

NA expressed his personal thanks to PB for outstanding work with regards to the production of the comprehensive Ockenden Action Plan. FB echoed NA's comments and expressed thanks on behalf of SQAC for comprehensive Action plan.

JR stated that she is mindful of the changing landscape with regards to ICS and ICB and referred to NHSE local maternity system and referred to LMS and system oversight. NA advised that the LMS is still functioning and are focussing on maternity and leaves Alder Hey as an outlier.

Resolved: SQAC received and **NOTED** the Ockenden Report Action Plan
Resolved: SQAC to receive Ockenden Action plan update at October 2022 and January 2023 meetings. PB to report by exception on any items not on trajectory at August 2022 meeting.
Resolved: NA to obtain copy of Liverpool Women's NHS Foundation Trust Ockenden Action plan ahead of Trust Board on 30th June 2022 and ensuring Liverpool Women's Have Alder Hey Ockenden Action Plan.

22/23/58 Safe Waiting List update

AB presented the Safe Waiting List Update, which provided a comprehensive overview on the action plan to implement lessons learned from RCA relating to incidents associated with follow up care in neurology key issues as follows:-

- AB reported that completion of a new patient pathway form had been completed which captures outcomes in an improved way, with a live report of any outcome form which is missing for a child and young person.

  Data quality - included external independent quantitative statistical assessment of waiting list, which provided really high confidence with 99.68% indicating that the work undertaken to rebuild waiting lists and validate them has been successful, with confidence provided from NHSE regarding this.
  Safe Waiting List Programme – four of the five workstreams had been completed, an amendment had been made to the Access Policy to reflect new national guidance to ensure that children on a planned waiting list and who have a postponement when treatment is due are not disadvantaged in their care.
- Other actions in progress relate to training and embedding those new processes and completing a significant piece of work to validate and review the follow up waiting list which has the largest volume of children and young people with a real commitment to progress this through the course of the year.

FB questioned whether there is a mechanism in place to measure traction. AB stated that he would need to give further thought on how this would be measured and stated that he envisaged that a team would need to introduce qualitative assessments with the clinical teams regarding clinicians' familiarity and confidence in these new processes, as a large amount is administrative and safety checks by the assurance team to ensure confidence to clinical teams regarding accurate waiting lists.

DJW expressed her thanks to AB for the approach taken in reaching a good position. DJW questioned how this good practice is being shared regionally, and whether Alder Hey could support children and young people across the Northwest. AB stated that Alder Hey co-chairs the Northwest Elective Recovery Children & Young People group. AB confirmed that he and colleagues are reviewing access times for children and young people across the entire region.
PB referred to the Action Plan and sought clarity whether the full action plan would be presented to SQAC to demonstrate those actions that had been completed and highlighting those actions outstanding, given it is due at CCG in July 2022. AB advised that the Action Plan could be shared at July 2022 meeting and that he would require some support from PB with regards to which actions had been omitted.
Aba referred to the ongoing work with Manchester and the wider region and stated that Alder Hey count waiting list differently to the way Manchester count and queried how common this was to count differently. AB stated that the volume and complexity of waiting list across the NHS is high and that there are discrepancies and variation on how waiting lists are managed. There is a national Elective Recovery Group which is strengthening this, which is why Alder Hey have applied their National Guidance to planned patients.

FB stated that this is outstanding work, and that Alder Hey are providing leadership across the Northwest, SQAC gained a higher level of confidence in the accuracy of the waiting list and waiting list management and congratulated all involved in reaching this current position. FB welcomed continued progress.

Resolved: AB to consider how traction would be reviewed and measured with regards to Data Quality.

Resolved: PB to liaise with Aba with regards to updating the Action plan, in order for the full action plan to be presented to July SQAC meeting.

FB thanked AB for comprehensive update.

22/23/59 Sepsis Update

DP presented the Sepsis Update and welcomed Kim Hewitson, new Sepsis Nurse. They provided an overview of key issues as follows:-

- DP provided overview of work that was ongoing following previous update to SQAC DP stated since previous reporting the main change had been that the previous Sepsis inpatient Nurse moved post, resulting in no sepsis nurse from January 2022 – May 2022, which significantly impacted the service.
- DP advised that he does not have the data for the later part of 2021. Given no sepsis nurse was in post this had resulted in reduced liaison with wards, no involvement with training, Sepsis Steering Group had been paused and reduced clinical governance oversight.
- ED data from May 2022 – 86% of patients received antibiotics within 1 hour, compared to 80% in the previous month. Trends are not consistent in month by month data.
- Focus over the next 6 month period include data cleansing to resume accurate data reporting and resuming regular Sepsis Steering Group meetings.

FB welcomed DP update and stated it is important to reflect that whilst the role had been vacant it had been a single point of failure, and that SQAC are delighted regarding KH appointment. FB welcomed wider reflections on managing situation differently in the future in such instances of resignation, absence or illness to ensure Sepsis work continues on trajectory.

KB referred to data cleansing and queried whether there was any support that could be provided from the IM&T team to support system alignment and processes.

DR would liaise with KH & DP regarding any IM&T support with regards to data issues and any support that could be provided by IM&T.

DJW welcomed KH to Alder Hey and thanked DP for update. DJW stated that this is an area of considerable concern and SQAC acknowledged the complexities. DJW highlighted the importance for NA & Aba to ensure succession planning and ensuring KH has appropriate levels of support going forward. NA stated in the context of other comments, Aba and NA would like to meet offline with colleagues regarding Sepsis.

FB welcomed SQAC receiving outcome of future deliberations regarding outcome of succession planning and ensuring resilience going forward.

FB thanked DP and KH for update.

SQAC received and **NOTED** the Sepsis update

Resolved: NA & Aba to undertake offline discussion with colleagues regarding Sepsis, SQAC to receive update at future meeting following deliberations regarding outcome of succession planning and resilience going forward.

22/23/60 Clinical Audit & Effectiveness Report

PB presented the Clinical Audit & Effectiveness Report, with substantial progress in 87% of audits. JR had commenced in post and planned to undertake a review of Clinical Audits.

KB stated that the Ockenden Action Plan referred to Audit Committee overseeing a review of clinical audit, and that this would be added to the Audit and Risk Committee workplan for September 2022. KB stated that she is keen to be involved in the process.

KB requested that themes be included in future reports, as they had not been included in the current update, together with detail of follow up. PB confirmed that this would be included within future reports. PB referred to the NICE compliance update and that colleague would note a change in the way this is reported, and that colleagues are thinking of a similar methodology for demonstrating progress regarding audits, which would be included in future reporting.

FB referred to the Patient Safety Board and queried whether Patient Safety Board would have a role, NA advised that NICE guidance and clinical audit would remain to be overseen at Clinical Quality Steering Group and that there may be a potential cross over if there is an issue or risk raised following an audit.

FB stated that following the review it would be helpful for a flow chart identifying key information in terms of reporting mechanisms.

JR expressed caution on future updates as not all National findings had been published due to delays relating to covid.

SQAC received and **NOTED** the Clinical Audit & Effectiveness Report

Resolved SQAC received and **NOTED** the Clinical Audit & Effectiveness Report

22/23/61 Mortality Report

SQAC received and **NOTED** the Mortality Report, which had previously been shared at Trust Board. SQAC **NOTED** that no substantial issues of concern are raised within the Mortality Report.

Resolved: SQAC received and **NOTED** the Mortality Report

Clinical Governance Effectiveness

22/23/62 CQSG Key Issues report

PB advised that the Clinical Quality Steering Group had met on 14th June 2022, meeting had been extremely positive, phenomenal work had continued to date to ensure 100% compliance as reported at Clinical Quality Steering Group, with regards to patient information leaflet compliance as at 31st May 2022.

- Teams and services are all committed to ensure that the current position is maintained.
- 10 policies had been ratified at 14th June 2022 Clinical Quality Steering Group meeting, position is almost reaching 100%,
- Significant ongoing work regarding complaints and PALS, and at time of reporting as at 31st May 2022 all of the complaints were in date, complaints continue to be appropriately tracked in line with the 25 day process.
- MIAA complaint action plan had been received at CQSG, majority of the actions had been completed - with the exception of one action expected to be completed during the summer of 2022.
- CQSG received and approved the Blood Transfusion Committee report, which detailed work required regarding blood warmers and equipment that must be purchased.

FB thanked PB for extremely positive report and expressed thanks to teams for improvements in information leaflet and guidance compliance, together with progress regarding complaints and PALS.
FB acknowledged that this was a busy month and highlighted the importance of robust systematic approach going forward to ensure that policies and guidelines are updated and refreshed/approved in a timely manner.

DJW echoed FB comments. DJW referred to patient information and diversity, easy read, ensuring different languages are included etc and referred to next steps. PB stated that the Trust has 'browsaloud' which ensure any information to be translated into any language very quickly.
FB enquired about digital versus non digital policy that is applied to patient information, as some patient and families have better access than others. PB stated that it relies on staff at source providing an information leaflet on discharge to families as part of discharge process. NA stated that a discussion is required in the future with regards to how the Trust moves to providing digital information first, and how this is embedded within the process. FB stated it is important for Comms and marketing to aid and lead.

KB acknowledged the significant improvement which had taken place to date.
DR advised on Digital improvements relating to the launch of Digital appointments letters which is being launched on 22nd June 2022, DR referred to leaflets and advised that a number of services have QR codes, so that the patient can scan and download information whilst in clinic. DR advised on the electronic consent platform that would email the consent letter and any associated information to patients and families.
DR stated that IM&T colleagues try to cater for use of digital solution in the first instance and using paper if needed.

Resolved: SQAC received and **NOTED** verbal CQSG Key issues update.

23/23/63 NICE Compliance summary position report

PB presented the NICE Compliance Summary position report for the reporting period 1st May – 31st May 2022 which clearly showed the improvement journey.

PB welcomed comments on the new style of report.
FB welcomed the clear progress made, and the improved format of the report which was well received.
KB referred to those items at assessment stage, and those items that are indicating no progress, and referred to KPI's. KB queried whether items should be split for those new items, and for the previous/backlog items. PB agreed that this would be reflected in future reports.

JR sought clarity with regards to NICE report frequency and queried whether SQAC would like to continue receiving monthly NICE reports. FB stated that discussion is required with regards to whether this should move to bimonthly or quarterly updates for SQAC. NA recommended that NICE reports should be shared monthly at Clinical Quality Steering Group meetings, with quarterly updates to be received at SQAC, - this is on the premise of continued improvements to be evident at Clinical Quality Steering Group. SQAC were supportive of this approach.

NA thanked the Division of Medicine for the new reporting format.

Resolved: SQAC received and **NOTED** the improvements within NICE Compliance summary position report.
SQAC **NOTED** that NICE Compliance report frequency would change to quarterly reporting to SQAC, with monthly reports to CQSG to ensure ongoing sustained improvements.

Resolved: SQAC to received Quarterly NICE updates.

22/23/64 Divisional Governance Monitoring Update – Clinical Governance External Review Action Plan

NA presented the Clinical Governance External Review Action Plan. Following an external

review of Clinical Governance which had commenced in February 2022, the review provided an objective view on areas for improvement across all functions, and a professional view of any considerations for sequencing and any such improvement required.

Following the review two key overarching themes emerged: - the relationship between corporate and division function, and the IT management reporting systems in use in the organisation. It is clear that the 'devolved governance' terminology had been unhelpful in fostering a close working relationship between the corporate functions and clinical divisional teams and the organisation will move away from using this terminology.

IT Management System – the review recommended that the Trust required either a complete rebuild of the current system (Ulysses), or the procurement of a new system. Procurement has commenced in partnership with LHCH. SQAC **NOTED** that the roll out of a new system will take 18 months and will require adequate subject matter expert resource as well as product specific project management support to make this a success. NA suggested that the Action plan would be monitored through Clinical Quality Steering Group and SQAC would receive 6 monthly progress reports.

SQAC **NOTED** that the action plan would form the basis of the service improvement plan on commencement of the AD for Risk & Quality Governance.

KB stated that she had not reviewed the Action plan, FB requested KB to share any comments or feedback with NA or ES offline as appropriate.

Resolved: SQAC content to receive 6 monthly Action plan progress update reports

Resolved: SQAC received and **NOTED** the high level Clinical Governance External Review Action Plan and **NOTED** the recommendations within the Action Plan.
SQAC welcomed 6 monthly update reports.
FB thanked NA & ES for comprehensive update and welcomed update at December 2022 Meeting.

Well, Led

22/23/65 Board Assurance Framework

ES presented the Board Assurance Framework, and referred to the 3 Risks - 1.1 -Inability to deliver safe and high quality services, 1.2 -Children and young people waiting beyond the national standards to access planned care and urgent care and 1.4 - Access to Children & Young People's Mental Health. ES stated that focus had been made on gaps in assurance and referred to Sepsis as an example. ES stated that there is a need to continue to ensure that there are substantive items against gaps in assurance every month to ensure all areas are being addressed. ES referred to the Access and Safety risk which picked up upon the mental health risks collectively, and ensuring tracking through the agenda.

Resolved: SQAC received and **NOTED** the Board Assurance Framework.

22/23/66 Divisional Report/Quality Metrics update

Community & Mental Health Division – NA provided key issues as follows:-

- Challenge within the division regarding the raised number of calls to the Crisis care team during May 2022 - (800), this was also seen in ED with 94 attendances of Children and young people experiencing a mental health crisis. Raised numbers both highlight the challenges that the population are facing, and also having an

impact on the staff groups in both Crisis care team, ED and then in the wider community mental health services.

- Despite challenges across the board with regard to increased referrals and staffing challenges waiting times in 2 key areas were improving, RTT compliance for community paediatrics from 47% (April) to 54% in May and Eating Disorder Service routine waiting times compliance increased to 57% alongside that Mandatory training compliance remained green and the elective recovery target was met.

Medicine Division – UD provided an update on key issues as follows:-

- Division continue to focus on Friends and Family Test and feedback regarding ED. Work is ongoing regarding responses, the Division have a dedicated nurse reviewing Friends and Family responses, and an improvement plan is in place, including increased volunteers working in ED.
- PALS responses is improving across the Division - 91% in May 2022.
- The Was Not Brought rate had decreased to 8%. In Departments where the Was Not Brought rate increases above 8% the Division undertake a deep dive to fully review.
- Improvement in May 2022 across the Board on ED despite more than additional 600 attendances, with consistent performance across ED.
- Increased consistent theatre utilisation from 78% to 83%.
- Division continue to fully scrutinise Mandatory training compliance – currently 92% Division undertake deep dive of compliance to fully review any gaps and ensuring any appropriate support is required to individuals and teams to ensure mandatory training compliance. Also focussing on APS/PLS training safeguarding breaking down any support, required.

Surgery Division – CC provided an update on key issues, as follows:-

- The Division of Surgery had no Never Events for 14 months.
- During August 2022 new starters would attend an afternoon of mini stat programme.
- Division had seen improved complaint response times and commended the Division and governance teams ensuring prompt responses.
- Theatre Utilisation is 96% during May 2022, with significant improvements regarding continued focus on theatre recovery and throughput.
- Challenges regarding waiting lists – during May 2021 the Surgery Division had under 8,000 patients waiting on the waiting list – currently the Division have around 13,640 on the waiting list, this creates additional challenges.

DJW thanked CT for update and referred to Paediatric Dentistry and requested whether focus is planned at Patient Safety Board, DJW queried how staff and patients would be supported with regards to numbers and throughput.

AB stated that there had been commitment from the Trust to attempt to provide increased capacity for paediatric dentistry, which is a small team. AB stated that Paediatric Dentistry challenges/position would be scrutinised through RABD. AB highlighted that for those patients with learning disabilities the pathway is complex, and that there is a need for C&M to give some thought on how these patients are distributed.

AB referred to challenges within Diagnostics and advised that RABD would review position regarding Diagnostics. AB referred to challenges with regards to sleep studies, MRI and stated that the position is improving and is currently on a reasonable trajectory, this would also be reviewed at RABD.

FB questioned whether other potential options should be considered to reach an appropriate solution. FB offered support in putting AB in contact with colleagues at Liverpool Dentistry School to consider/ascertain whether there are any dental students

who would be able to provide the Trust with any support. AB welcomed the opportunity for Dentistry School contacts to be shared with him, to enable a discussion with appropriate personnel from Alder Hey and Dentistry School in order to explore any potential for support.

Resolved: FB to share contacts with AB to aid offline discussion with Alder Hey and Dentistry School.

AB stated that he and ABA are also working with ICB colleagues to address this issue which is an issue across the region which requires a Cheshire & Mersey solution.
FB thanked the Divisional Leads for the Divisional Updates.

Research Division – JLK provided an update, key issues as follows:-
- Challenges within the Division relating to staff turnover currently at 24%, and that the Division had seen a downward trend over the last month.
- Division are due to launch two significant large trials - 1 relating to gene therapy trial with Alder Hey collaborating with Royal Liverpool Foundation Trust, Division are due to launch a Harmony Trial with regards to a vaccination against RSV, recruitment due to commence in September 2022-February 2023.

Committee **NOTED** the pressures across each of the Divisions.

FB welcomed Divisional updates and thanked colleagues for updates.

Resolved: SQAC received and **NOTED** the Divisional updates and **NOTED** the pressures across each of the Divisions.

Responsive

22/23/67 **Policy Approval**
SQAC received and **RATIFIED** the Patient Identification Policy – RM25
Resolved: Patient Identification Policy – RM25 – RATIFIED.

SQAC received and **RATIFIED** Complaints & Concerns Policy
Resolved: Complaints & Concerns Policy – RATIFIED

SQAC received and **RATIFED** External Agency Visits Inspections and Accreditations Policy

Resolved: External Agency Visits Inspections and Accreditations Policy – RATIFIED

22/23/68 **Any other business**
. None

22/23/69 **Review the key assurances and highlight to report to the Board**
Positive updates were received regarding: -
- Quality Priorities & DMO monthly update was received, SQAC **NOTED** how Quality Priorities would progress in the future with Patient Safety Board in situ. SQAC **NOTED** a different form of reporting to SQAC in the future as a result of the reset of those projects.
- DIPC Exception Report received
- Assurance ED Activity Monthly update received

- Quality Assurance Rounds themes and risks report received. SQAC were extremely pleased to see emerging themes in the format of the report. SQAC agreed to receive quarterly updates in the future
- Ockenden Report Action Plan received, SQAC **NOTED** that significant work had been undertaken, that there was real clarity within the Ockenden Action Plan, and that significant progress is already being made to implement the actions. SQAC were pleased to note that future updates would be provided at October 2022 and January 2023 SQAC meetings, and by exception in August 2022.
- Safe Waiting List update received, good discussion held, significant assurance provided regarding the quality of work undertaken to date, demonstrating system improvement and leadership that Alder Hey is able to take across a wider geography, SQAC **NOTED** significant progress made.
- Sepsis update received, further offline discussions to take place regarding data issues, and discussion required to ensure that the situation does not recur in the future, whereby the Trust has no Sepsis Nurse or adequate cover to provide resilience regarding assurance in this area.
- Clinical Audit & Effectiveness Report was well received. SQAC requested emerging themes are included in future reports
- Mortality Report received and **NOTED.** The report had previously been shared at Trust Board.
- CQSG Key issues received which highlighted full discussions and good levels of improvement on review of Patient Information leaflets, response times on Complaints and PALS, and review of Policies etc. All Divisions were thanked for their focused attention on these issues.
- NICE Compliance summary position report received which demonstrated good progress made. The new form of the report was acceptable to the Committee and thanks given to Medicine Division for developing the format.
- Divisional Governance Monitoring Update was received. The Committee noted the completion of an external review and the focus on Relationships and IT improvements within the future. Future orientation will be towards systematising reviews, with IT systems aligned to support – this will develop in an evolutionary way.
- Board Assurance Framework received and **NOTED**, including risk 1.4 regarding access to Mental Health Support and Services as a new, separate risk, with oversight by RABD and SQAC.
- Divisional updates received with good discussion held. SQAC **NOTED** the Deep dive into the areas where there was a high Was Not Brought rates for patients, and the focus on mandatory training in Medicine Division which is to be commended.
- Surgery Division were commended as they had reached 14 months with No Never Events.
- SQAC **NOTED** the ongoing challenges with regards to paediatric dentistry and diagnostic challenges, both issues would be reviewed at RABD
- Community & Mental Health challenges **NOTED** with regards to access to Mental Health provision, with some improvements **NOTED** to date, however concerns **NOTED** regarding ongoing challenges regarding access to services.
- SQAC **NOTED** the challenges within the Research Division with regards to vacancies issues and staff turnover. SQAC **NOTED** the launch of 2 significant upcoming trials which were planned, a Gene Therapy Trial and a Harmony Trial regarding RSV for which a large publicity campaign is planned to take place from July - September 2022.
- Patient Identification Policy – RM25 was received and RATIFIED
- Complaints and Concerns Policy was received and RATIFIED

- Management of External Agency Visits Inspections and Accreditations Policy was received and RATIFIED

Committee are extremely assured regarding progress of policy ratification

21/22/70 Date and Time of Next meeting

20th July 2022 at 9.30 via Microsoft Teams