Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 30th June, commencing at 12:30pm

via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (12:30pm-12:45pm)							
1.	**22/23/71**	**12:45 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/72**	**12:46 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/73**	**12:47 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Thursday 26th May 2022**	**D**	Read enclosure
4.	**22/23/74**	**12:50 (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.	**22/23/75**	**12:55 (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.	**22/23/76**	**13:05 (15 mins)**	**Operational Update and Performance.**	A Bateman	To receive an operational update on performance.	**D**	Read report
Strategic Update							
7.	**22/23/77**	**13:20 (10 mins)**	**ICS Development Update.**	D. Jones	To receive an update on the development of ICSs.	**N**	Presentation
8.	**22/23/78**	**13:30 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To provide an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**22/23/79**	**13:40 (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
10.	**22/23/80**	**13:45 (10 mins)**	**Nurse Workforce Annual Report 2021/22.**	N. Askew	To receive the Nurse Workforce Annual Report for 2021/22.	**R/A**	Read report
11.	**22/23/81**	**13:55 (10 mins)**	**Ockenden Review Trust wide action plan.**	N. Askew	To receive the Trust wide action plan that was compiled following the 2022 Ockenden Review.	**A**	Read report
12.	**22/23/82**	**14:05 (15 mins)**	**Corporate Report; including Divisional updates:** • **Medicine.** • **Community & Mental Health.** • **Surgery.**	U. Das L. Cooper B. Pettorini	To receive a report on the Trust's performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
Sustainability through External Partnerships							
13.	**22/23/83**	**14:20 (10 mins)**	**Growing Great Partnerships.**	D. Jones	For information.	**A**	Read report
The Best People Doing Their Best Work							
14.	**22/23/84**	**14:30 (5 mins)**	**EDI Steering Group – Terms of Reference**	M. Swindell	To approve the final version of the Terms of Reference for the EDI Steering Group.	**D**	Read enclosure
Strong Foundations (Board Assurance)							
15.	**22/23/85**	**14:35 (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.	**22/23/86**	**14:40 (15 mins)**	**Monthly Financial Update for M2, 2022/23.**	R. Lea	To provide an update on the current position for Month 2, 2022/23.	**A**	Presentation
17.	**22/23/87**	**14:55 (20 mins)**	**Board Assurance Committees; report by exception:**		To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			• **Audit and Risk Committee:** - **Approved minutes from the meeting held on the 21.4.22.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 27.6.22.** - **Approved minutes from the meeting held on the 23.5.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 22.6.22** - **Approved minutes from the meeting held on the 18.5.22.** • **People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 29.6.22.** - **Approved minutes from the meeting held on the 23.5.22.**	K. Byrne I Quinlan F. Beveridge F. Marston			minutes
Items for information							
18.	**22/23/88**	**15:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal

Alder Hey Children's NHS Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
19.	**22/23/89**	**15:19 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 28th July 2022, 9:00am-1:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in May 2022
388: Letter on Indemnity (early work for NICU/SPV) – SPV

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M2, 2021/22	R. Lea

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 26th May 2022 at 12:35pm**
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. 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)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Mr. M. Carmichael	Assoc. Chief Operating Officer	(MC)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. R. Lea	Acting Director of Operational Finance	(RL)
	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	Prof. J. Jankowski	Member of the public.	(JJ)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Dr. U. Das	Director of Medicine	(UD)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
Patient Story	Ms. H. Crosdale	Deputy to Head of Service/Lead Clinician	(HC)
	Ms. K. Cunliffe	Community Physio/OT manager	(KC)
	Ms. M. Gladstone	Honorary Consultant and Senior Lecturer in Neurodevelopmental Paediatrics	(MG)
	Ms. C. Mason	Children's Occupational Therapist	(HM)
	Ms. J. Weston	Specialist community Physiotherapist	(JW)
Item 22/23/44	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 22/23/46	Ms. K. Turner	FTSU Guardian	(KT)

Staff Story

The Chair welcomed the SPOT team (***S**peech and Language Therapist, **P**hysiotherapist and **O**ccupational **T**herapist*) who had been invited to May's Board to provide an over overview of the work that they do in terms of offering a pre-school therapy service in Sefton. A number of slides were shared with the Board to provide the following information:

- SPOT is a multi-disciplinary therapy team that covers pre-school children 0-3 years with two or more therapy assessment requirements. Working alongside these therapists is a Consultant Community Neurodevelopmental Paediatric team.
- The team provides a co-ordinated development assessment of the children referred, in an informal clinic setting which covers all areas of development in one appointment with joint goals and treatment planning. This is advantageous for families as there is only one visit required to see three therapists and a doctor.
- The team provided an overview of the purpose of the Complex Clinic that takes place on a monthly basis, SPOT interventions, the NICE guidelines that are addressed, and the success of SPOT.
- A number of extracts were also shared with the Board of the recent feedback that was received from parents using the service, following a service review.
- The next steps for the team;
    - It is imperative to keep the service running.
    - Invest in the same parallel service in other areas of Liverpool.
    - Investment in speech and language therapy specifically for the service *(NICE guidelines request early communication as paramount).*
    - Continue to use innovative practices *(bringing in better joint working with Liverpool Women's Hospital Neonatal Unit and new technology for early identification of children at high risk).*

The Chair thanked the team for sharing the presentation with the Board and pointed out that the way in which the SPOT team are working together and with families is an exemplar and congratulated the team on the positive feedback received from the review and the families using the service.

Louie Shepherd referred to the integration of services for the very youngest of the population and felt that the SPOT team model is a brilliant example for disadvantaged children and those with disabilities. Louise Shepherd pointed out that the Trust is leading on the Children and Young People's Transformation Programme and advised that the organisation would be interested in looking at an offer that could be made into Liverpool and the wider region to enable children to have access to a service like SPOT.

22/23/32 Welcome and Apologies

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

22/23/33 Declarations of Interest

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

22/23/34 Minutes of the previous meetings held on Thursday 28th April 2022
Resolved:
The minutes from the meeting held on the 28th April 2022 were agreed as an accurate record of the meeting.

22/23/35 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 21/22/272.1: Q3 Mortality Report (*New Medical Examiner Process - Liaise with the Children's Alliance to see if they can offer any support on the new ME process)* – The regional ME has made contact with LUFT to see if they are able to offer support to Alder Hey on the new ME process. It was confirmed that the ME at LUFT was very receptive to this request therefore the Trust is looking at how this can be done in collaboration. It was reported that there is no statutory requirement for paediatrics until 2023 which provides time in which to collaborate with LUFT and produce an ME service fit for Liverpool. **ACTION CLOSED**

Action 21/22/276.2: *BAME Inclusion Taskforce Update* (*NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review' - Discuss the possibility of Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and child health across the BAME communities)* – It was agreed that the EDI Steering Group would progress this action. **ACTION CLOSED**

22/23/36 Chair's and CEO's Update

The Chair provided an overview of the Charity's Board meeting that took place on the 18.5.22. Attention was drawn to the following highlights of the meeting; **1**. The garden exhibited by the Charity at the Chelsea Flower Show will return to the site of Alder Hey following the event. **2.** The Charity's Board acknowledged the changing landscape and confirmed its continued support for the Trust. **3.** The Charity's Board acknowledged the work that is being conducted with the Children's Hospital Alliance and it confirmed that the CEO of the Charity, Fiona Ashcroft, will meet with the CEOs of the ten hospitals that make up the alliance.

The Board received an update from Louise Shepherd on the following areas;

Children's Hospital Alliance (CHA) – The Board was advised that the Children's Hospital Alliance is starting to emerge as a force with the opportunities that have been developed over the last twelve months providing a shared sense of purpose and recognition that lessons can be learnt from each other. Alder Hey has made an impact in terms of the innovation technologies that it has been developing, with Virtual Ward capturing the imagination of everybody involved in the CHA. The Trust gave a presentation along with staff from Gt. Ormand Street Hospital (GOSH) to the National Lead for Transformation and Innovation at NHSE, Tim Ferris, to provide information on the platform. It was pointed out that there is an increasing momentum behind the Virtual Ward platform and engagement is continuing to promote it. This innovation has also initiated discussions about having a trusted research environment and creating research data for children at national level. Attention was also drawn to the increasing opportunities for working with GOSH.

Local Update - The Chair and CEO of Cheshire and Merseyside ICS are visiting Alder Hey on the 14.7.22. This will provide the Trust with an opportunity to share its plans in terms of becoming a genuine partner for children and young people (CYP) and supporting the development of strong networks. It was reported that work is taking place on the models of care that will enable Alder Hey to make an offer to CYP across the wider geography. Further details on the offer to the wider system will be submitted to the Trust Board in due course.

Liverpool Health Partners (LHP) – Discussions have been taking place to look at how LHP can move forward effectively and develop a real community of expertise and partnership to support the research effort across the City. The partners are taking responsibility for developing a programme of work collaboratively which will be agreed by the 30.6.22. As the model emerges a more formal report will be submitted to the Trust Board.

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

22/23/37 Liverpool Clinical Services Review - Terms of Reference.

The Board received the Terms of Reference (ToR) for the independent clinical review of acute hospitals in Liverpool. It was reported that the C&M ICS has been asked by NHSE/I to commission an independent review of the city's acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency and effectiveness.

Louise Shepherd provided background information on the original initiative that was instigated by the ICS which brought six of the acute trusts together to look at enhancing joint working to improve pathways for CYP and influence better work on research and innovation.

The ToR were approved by the ICS and the Strategic Oversight Board at the beginning of May and were discussed with partners across Liverpool during a meeting that took place w/c 9.5.22. The CEO of Clatterbridge Cancer Centre, Dr Liz Bishop, will represent specialist trusts when selecting a partner to undertake the review. It was confirmed that further updates will follow as the process progresses.

Resolved:
The Board noted the Terms of Reference for the Liverpool Independent Clinical Review

22/23/38 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:

- *Neonatal and Urgent Care Development* – It was confirmed that the Trust has received approval for the PFI variation from NHSE/I, and Phase 1 of the enabling work to create a temporary car park for the Emergency Department has been completed. The Trust is awaiting a new programme of work and price for the construction of the development from Morgan Sindall, which is due to be submitted w/c 30.5.22.
- *Catkin Building and Sunflower House Construction* – It was confirmed that both schemes will be complete by the 17.6.22. The Trust has extended this date internally to the 1.7.22 to mitigate any further construction delays. A six week commissioning programme will commence on the 1.7.22 to enable occupancy of both buildings.
- *Temporary buildings* – There's a plan in place for vacating the old Catkin building based on temporary portacabin accommodation for staff. A meeting is scheduled to take place with Liverpool City Council on the 26.5.22 to discuss planning permission to enable the Trust to progress this plan.
- *North East Plot Development* – The Trust has agreed to conduct a survey of staff on behalf of Step Places to gain views in terms of what amenities people would like to see included in the new development.
- *North West in Bloom Competition* – It was reported that Alder Hey has been entered into the North West in Bloom competition. A small group of Governors are progressing this area of work with the support of the Trust's Development Director and members of his team.

Resolved

The Board received and noted the Campus Development update provided as at the 26th of May 2022.

22/23/39 Operational Update; including Financial Update for Month 1, 2022/23.

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

- *Elective Recovery* – The Trust achieved the national recovery standard in April 2022 of 104% delivery of day-case and elective operations.
- *Outpatients* – Patients requiring a new outpatient appointment is more challenged, with performance at 91% of pre-Covid levels and follow up-care numbers are high at 110%. This analysis reinforces the need to precipitate the development of the Trust's approach to follow-up care, and, with the capacity released, increase the number of patients able to access a new outpatient consultation. Attention was drawn to the work that is taking place to help more specialties test outpatient initiated follow-ups so it's based on need rather than a generic ask for everybody to come back and also expediting the roll out of the Was Not Brought artificial predictor to help more families get to their appointments.
- *Waiting Times* – It was reported that overall waiting times have increased with a particular issue in paediatric dentistry. There is a specific plan in place to invest in the dental workforce in order to expand capacity and have more lists. The Trust has also continued to provide support to the Royal Manchester Children's Hospital (RMCH) during April. This support has helped RMCH clear all of its very long wait patients who have been waiting over two years for treatment.
- *Mental Health Services* – There has been a significant rise in referrals for the service and a plateau in access waiting times. It was reported that currently 30% of patients are being seen for their first appointment within six weeks, and two out of three patients commence treatment within eighteen weeks. It was pointed out that the sheer demand for those services is surpassing capacity, recruitment and expansion. The Board was advised that there is a focus on patients requiring urgent attention to ensure they are being seen on time/gaining access to other interventions whilst they wait.
- *Eating Disorder Servic*es - It was reported that access times for Eating Disorder Services has been challenged for the past twelve months. However, the Trust is projecting delivery of the routine four week waiting time standard from May 2022 following successful recruitment and a new assessment model for the service.
- *Neurodevelopmental Pathways* – Waiting times for the ASD and ADHD diagnostic pathways have remained static in April and referrals continue to be significantly above the predicted levels for 2022. The Board was advised that waiting times are not improving despite the work that is being conducted with the independent sector and recruiting more staff. Attention was drawn to the importance of reviewing how the Trust works with partners to address this issue.
- *Emergency Department* – In April 73% of patients were seen within the four hour standard. A programme of work is underway to help improve patient experience and a more radical set of changes are planned for Quarter 2.

Fiona Marston queried as to whether it would be beneficial to track what the organisation is learning from the people pulse in respect to sickness rates to see if there is any correlation with wellbeing parameters in terms of recovery and staff carrying out additional duties to meet targets. Adam Bateman felt that it would be

helpful to have qualitative departmental level data reported via a systematic process.

The Chair acknowledged the challenges of achieving recovery targets and felt that the more data the Trust has to understand the pressures of the workforce, extra support can be provided. On behalf of the Board, the Chair offered thanks to everyone in the Divisions for the work that is being conducted to achieve targets.

Finance Update (M1, 2022/23)

The Trust reported an in month deficit of £755k against a planned deficit of £275k, with an adverse variance of £0.5m. Cash in the bank is £90.1m and Capital spend YTD is £0.4m.

Attention was drawn to the key drivers for the M1 position;

- Unachieved CIP target in M1 of £0.4m which is a key risk.
- High spend in non-pay in month due to an increase in activity.
- The Trust is anticipating a £0.2m risk on ERF but this has not been validated as of yet.

2022/23 Plan

The Board was advised of the latest position for the 2022/23 Plan;

- The plan submission for Alder Hey is a £2.4m control total surplus.
- C&M submitted a £148m deficit which includes a £40m risk, therefore the real risk £188m.
- Plans have not been approved by NHSI/E due to there being a considerable gap across all systems.
- £1.5bn of additional funding was announced by NHSI/E w/c 16.5.22 which will filter c£70m for C&M to fund excess inflation included in the plans. There is an expectation that all systems will be able to achieve a balanced plan with this funding. It was reported that there will be consequences if any systems remain in deficit including a restriction on access to new capital.
- The next submission of plans (*provider and system*) is due on the 20.6.22. It was reported that C&M are reviewing the distribution of risk in the plans and are undertaking in depth reviews for those trusts that are in deficit.
- Attention was drawn to the key risks of the 2022/23 plan which relate to the Trust's Cost Improvement Programme and achieving the ERF weighted value of 104%, and the next steps/actions that are to be implemented to achieve targets.

John Grinnell felt that it is important for the Board to reflect on the financial challenge that the Trust is facing in terms of scale, pace and the new environment which is raising the risk profile significantly. It is imperative that the organisation manages the in-year risk whilst ensuring line of sight in order to move forward. The Board was advised that further discussions will take place at RABD to reflect upon the Trust's approach for addressing the financial issues, as outlined in the next steps/actions. An update will be provided in due course.

On behalf of the Board, the Chair acknowledged the scale of the financial challenges that the Trust faces and the work that is taking place to try and address them.

Resolved:
The Board noted the operational update which included a financial update for M1, 2022/23

22/23/40 Digital Strategy 2022/23.

The Board was provided with an overview of the direction for the refreshed 2022/23 Digital and Data Strategy. It was reported that there are a range of programmes in the 2022/23 Operational Plan that are linked to the four new key delivery themes highlighted in the Digital Strategy. Work is ongoing in terms of the resourcing of these programmes and investment plans. Attention was drawn to the top line benefits highlighted in the report.

Louise Shepherd pointed out that it is an ambitious programme and there will be some challenges in achieving all of the goals set out in the strategy. Thought will need to be given to resourcing the prioritised programmes, recruitment and providing support to the Chief Digital and Information Officer to progress this area of work. It was pointed out that some deadlines may not be met but it was reported that the Executive Team will take responsibility for addressing these challenges/issues. The Chair acknowledged that deadlines may need to be extended which is a risk, and that progress updates will be provided on a regular basis.

Resolved
The Board endorsed the direction of travel for the Digital and Data Futures strategy and approved the prioritised programmes for 2022/23.

22/23/41 Quality Strategy 2022/23; including Patient Safety Strategy Update.

A number of slides were shared with the Board that provided information on the following areas:

Brilliant Basics (*Reflection on 2021/22 and an outline of the future direction*);

- *Success to date*
  - Quality Hub.
  - Children and young people's involvement.
  - Frontline coaching and training.
  - Strategy into action.
- *Brilliant Basics approach*
  - Leading for improvement.
  - Learning for improvement.
  - Delivering improvement.
  - Enabling improvement.
- Key deliverables for the year.
- *The Trust's journey to outstanding*
  - Foundations.
  - Building capability.
  - Continuous improvement.

Quality Strategy

It was reported that the Quality Strategy is underpinned by three broad pieces of

work; experience, safety and effectiveness that will focus on:

- Increasing the voice of CYP and their families.
- Rolling out the Patient Safety Strategy.
- Measuring effectiveness via robust data.

Patient Safety Strategy

There are eighteen workstreams which have been prioritised within the strategy. The Main priorities for the next twelve months are to review the organisation's safety metrics to make sure they are fit for purpose, roll out an NPSA alerting process, improve the organisation's education and training offer around safety and make some of it mandatory, appoint a patient safety specialist, continue the work around deteriorating patients, sepsis, medication and parity of esteem. The Trust is in the process of identifying individuals to lead on the strategy and the progress of the workstreams will be overseen via the new Safety Board which will report into SQAC. A number of slides were shared with the Board that provided information on the following areas:

- Focus on Patient experience.
- Clinical effectiveness priorities;
- Inspection regime changes;
  - As a result of the CQC changes there will be a move towards targeted inspections of services based on data, assurance, compliance with standards and information from other sources.
- To become outstanding the organisation will be focussing on three key pieces of work;
  - Services to consistently demonstrate good housekeeping and safe practices.
  - Provide assurance and insight into services via data that demonstrates compliance with regulations and set targets nationally and locally.
  - Showcase outstanding work and the improvement journey to staff, CYP, families and external regulators.
- Examples of quality governance.
- Next steps to become inspection ready;
  - Divisional level assurance across the good housekeeping metrics.
  - Refresh and share the staff handbook.
  - Teams to think about the Trust's improvement journey and examples of outstanding care.

John Grinnell reflected upon the scale of the work in terms of the various components and queried as to how the organisation can keep the message simple when promoting the safety priorities Trust wide. It was confirmed that work will take place to look at capturing the message in the simplest of formats whilst strongly emphasising its importance.

Adam Bateman felt that further work needs to be done to enable the Trust to have a true account of its efficacy and consistently receive feedback from CYP on the impact that Alder Hey has on the quality of their lives. It was agreed that thought needs to be given in terms of how the organisation uses clinical outcomes and patient experience measures as a package to evaluate the care provided to patients. It was also reported that the Trust will be employing two young apprentices supported by a youth leader to help Alder Hey shape its process and policies for CYP involvement, prioritise processes, look at remuneration for CYP and their families and develop the rights of CYP.

Melissa Swindell advised of the forthcoming work that is going to take place to develop staff safety alongside patient safety.

The Chair thanked Nathan Askew and Alfie Bass for the fantastic work to address safety, quality and patient experience and felt assured that the Trust is focusing on the right issues.

Resolved:
The Board received the:

- Update on the Brilliant Basics Programme and the plan for 2022/23.
- 2022/23 Quality Strategy.
- Patient Safety Strategy update and approved the formation of the Patient Safety Board.

22/23/42 Brilliant Basics

Refer to agenda item 22/23/41.

22/23/43 Serious Incident Report

The Board received the Serious Incident, Learning and Improvement report for the period from the 1.4.22 to the 30.4.22 . The following key points were highlighted:

- There were ten incidents reported to StEIS which included one Never Event. There was also one level two Trust commissioned RCA.
- Five serious incident investigations were closed in March 2022; four StEIS reported investigations and one internal level two investigation.
- There Board was advised of the improvement in the overdue action plans. It was reported that the Division of Medicine has two action plans that remain past their expected date of completion which should be closed by the end of May 2022.
- Nathan Askew thanked all those involved for the work that was conducted to bring the respective StEIS reported investigations to a close.

Resolved:
The Board received and noted the contents of the Serious Incident report for period from the 1.4.22 to the 30.4.22.

22/23/44 Infection Prevention and Control (IPC) Update

The Board received an IPC update for May. A number of slides were shared which provided the following information:

- It was reported that there has been a decrease in confirmed Covid-19 cases in the UK, but attention was drawn to the reduction in testing which is resulting in a lack of real time data. The Board was advised that Covid remains a threat to the organisation.
- *Update on the Omicron variant and its sub-lineages* - BA.2 is the predominant sub-lineage in the UK but BA.4 and BA.5 are likely to have a growth advantage over BA.2, including within the UK. It was pointed out that the virus will continue to mutate therefore it is important to have systems in place that will keep the Trust safe.
- The Board received an update on the current position on the monkeypox cases confirmed in the UK. It was reported that monkeypox is a rare viral infection that does not spread easily between people. It is usually a mild self-

limiting illness that most people recover from within a few weeks. However, severe illness can occur in some individuals.

- An IPC improvement project that has been commissioned by Nathan Askew, Bea Larru and Marianne Hamer is in the process of being launched. The aim of the project is to improve safe care in the Trust by improving the organisation's IPC systems and processes, and ensure the Trust is prepared for future threats.
- The Board was advised of the mitigation strategies that have been developed specifically for Covid-19 prevention which are supported by high-quality scientific studies and the mitigation strategies that are standard in healthcare facilities; especially important for communicable diseases, and how they are being put into practice in the Trust.

The Chair pointed out that more people accessing the Alder Hey site aren't wearing masks and felt that it would be beneficial to have some communications on this matter to support the Trust's frontline staff. Mark Flannagan advised that there is a programme of work scheduled to refresh posters in the hospital and provide up to date information.

Resolved:
The Board noted the IPC update for April 2022.

22/23/45 Corporate Report; including Divisional Updates
Resolved:
The Board received and noted the Corporate Report for April 2022 which included an update from the Division of Medicine, Division of Surgery and Division of Community/Mental Health services, as detailed in the Corporate Report.

22/23/46 People Strategy Objectives for 2022/23

The Board received the People Plan priorities for 2022/23. A number of slides were shared which highlighted the four key priority projects that the Trust will be focusing on over the next twelve months. The following information was provided:

- *Attraction and Retention Project;*
  - To have a more inclusive and diverse workforce.
  - To address the shortages in specific staff groups/roles across the NHS which cause financial and service delivery pressures.
  - To deliver an enhanced recruitment experience for both managers and candidates.
- Organisational Health and Wellbeing;
  - To improve organisational health and wellbeing, and engagement.
- Workforce Planning;
  - The Trust's ambition is to have a robust workforce planning framework in place, to allow an alignment of the organisational needs with those of the workforce. However, it's recognised that to do this effectively there is a need to establish accurate workforce availability/ vacancy data.
- Great Space to Work;
  - Ensure that all workplace provision meets the expected standards.

Resolved:
The Board noted the People Strategy objectives for 2022/23

EDI Steering Group Update

The Board received the draft Terms of Reference (ToR) for the Equality Diversity and Inclusion Steering Group (EDISG) and was advised that the purpose of the steering group is to oversee the Trust's strategic ambitions and specific EDI goals, and to ensure that EDI is at the heart of the Trust's policies and practices as an employer, health care provider and procurer of services.

It was pointed out that the EDISG will maintain the lessons learnt from the BAME Taskforce, will adopt a principle around targeted universalism and address the issues that the Trust data identifies in order to create an organisation that is leading around equality, diversity and inclusion. The ToR have been circulated widely for consultation and the Trust is awaiting feedback/recommendations from Staff Side at the present time. Attention was drawn to inclusivity of the membership.

The inaugural meeting of the EDISG is to be scheduled for June 2022. Executive Directors were asked to register their interest with Melissa Swindell if they wish to be involved with the EDISG.

Dani Jones felt that it was important to look at connecting the EDISG agenda with the health inequalities and prevention work that is taking place as both areas have mutual drivers but with different audiences. It was agreed to discuss this outside of the meeting.

22/23/46.1 Action: DJ/GD

For noting:
It was agreed to approve the EDISG ToR in their draft form. An updated version will be submitted to the Trust Board for formalisation purposes once all amendments have been made, and a decision will be made as to whether the steering group should become a committee that reports directly to the Board.

22/23/46.2 Action: MS

FTSU Update

The Board received an update on the activities of the FTSU team in Q4 and an outline of the actions planned for the next six to twelve-month period. The report also includes data from the SALS service to provide a line of sight across both mechanisms in terms of themes and hotspots. The following points were highlighted:

- A summary was provided of the issues that were raised via the FTSU route during 2021/22.
- It was reported that there was a spike in cases during Q4 with 20 cases being submitted; six of the cases related to process and policy, eight to behaviours and relationships, five to staff safety and one relating to detriment. Of the 20 cases, six have been closed.
- *SALS Contacts* – SALS data has been included to demonstrate the parallel with the themes that both reporting routes are seeing. The Board was advised that the highest number of users using the FTSU route are from the nursing workforce followed by admin and clerical staff. Attention was also drawn to the number of cases that have been raised associated with behaviours and relationships. It was reported that the data provided by SALS indicates that a high number of staff are presenting with work related stress that could have elements of poor behaviours and breakdown in relationships. SALS staff have indicated that there is a common theme of conflict, which is also increasing amongst staff.
- *Staff Survey Results* – It was reported that question 21e has seen a slight decline in staff feeling safe to speak up therefore work is required to

understand why this is and what needs to be done to reverse it. Question 21f, is a new question and whilst the Trust is below the best it is above the national average. Understanding where the gap exists in terms of this question could be beneficial in encouraging staff to report and speak up.

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

Anita Marsland referred to the narrative in the report that indicates a common theme of conflict between staff in terms of relationships and felt that this needs to be monitored by the organisation. Attention was also drawn to the importance of staff completing the Speak Up, Follow Up E-Learning packages that are available. Nathan Askew pointed out that there was a real focus in the Ockenden Review on the effectiveness of raising concerns and felt that it would be timely for the Trust to consider the FTSU training becoming mandatory. Nathan Askew asked as to whether any reflections could be given to determine the sheer number of concerns that are being raised and whether there is a group of staff who are being overlooked. It was reported that further work is required to ensure that staff are reporting via the appropriate routes.

The Chair felt that additional thought needs to be given to ensure that staff are being signposted in the right direction and encouraged to use the appropriate route. Further discussions also need to take place to agree whether FTSU training should become mandatory for staff.

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

FTSU Review Tool for Boards

The Board received the half year update for the Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts. The review tool indicates that the Trust has high levels of exposure at Board level on this area of work. Attention was drawn to the importance of reinforcing awareness in terms of the appropriate reporting routes for staff raising concerns. Work is taking place to systematically align activity reports to provide the Board with better levels of assurance/visibility and identify the gaps to enable the Trust to address them.

The Board was advised that there has been a slight increase in staff invoking the formal route for whistleblowing under the Raising Concerns Policy. These instances provide a lot of learning which can be utilised to potentially prevent the deterioration of relationships in teams and between individual members of staff.

Resolved:
The Board noted the half yearly update on the FTSU review tool for Boards.

22/23/47 Board Assurance Framework

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

- A separate risk is to be incorporated in May's BAF relating to Mental Health and investment levels.
- BAF risk 4.2 (*Digital Strategic Development and Delivery*) - It is anticipated that the BAF will be impacted in May due to the challenges being experienced in terms of the Alder Care Programme.

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

22/23/48 Proposal for the Appointment of a Senior Independent Director.
Resolved:
The Board received the proposal for the appointment of a Senior Independent Director (SID) to replace Anita Marsland when her final term of office expires at the end of June; following discussion the Board approved the appointment of Kerry Byrne to the additional role as SID of the Trust. It was confirmed that a process of self-nomination for the role had been undertaken.

22/23/49 Board Assurance Committees

RABD – The approved minutes from the meeting held on the 25.4.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 23.5.22 there was a focus on Alder Care, Digital Futures and the financial challenges that the Trust is facing.

SQAC – The approved minutes from the meeting held on the 27.4.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 18.5.22 there was a focus on the Organ Donation Annual Report and a report relating to the outcome of a fireplace injury investigation.

PAWC – The approved minutes from the meeting held on the 25.4.22 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 23.5.22; People Plan, sickness absence, deep dive into the turnover off staff and the staff pulse check.

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

22/23/50 Any Other Business

There was none to discuss.

22/23/51 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 May's Board. Attention was drawn to the inspiring strategy session that took place on the morning of the 26th which will help towards shaping the Trust's future.

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

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for June 2022							
24.6.21	21/22/65.2	Approach to End of Life Care when there is a dispute	Provide a progress update on the Trust's process that supports end of life discussions and agreements.	Adrian Hughes	30.6.22	On track Jun-22	
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	On track Jun-22	
Actions for July 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	Jul-22	
28.4.22	22/23/15.1	IPC Update	*PCR Testing for Patients Ahead of Surgery* - Look towards progressing a model, if possible, based on local testing for patients and share this information via the network.	B. Larru	28.7.22	Jul-22	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
24.2.22	21/22/272.1	Q3 Mortality Report	*New Medical Examiner Process* - Liaise with the Children's Alliance to see if they can offer any support on the new ME process.	A. Bass	26.5.22	Closed	**31.3.22** - A meeting has been scheduled for the 28.4.22 between the Trust, Manchester Children's Hospital and the regional ME to discuss a way forward in terms of providing a service for a relatively small number of children. It was agreed to provide an update on the outcome of the meeting during May's Board meeting. **26.5.22** - The regional ME has made contact with LUFT to see if they are able to offer support to Alder Hey on the new ME process. It was confirmed that the ME at LUFT was very receptive to this request therefore the Trust is looking at how this can be done in collaboration. It was reported that there is no statutory requirement for paediatrics until 2023 which provides time in which to collaborate with LUFT and produce an ME service fit for Liverpool. **ACTION CLOSED**
24.2.22	21/22/276.2	BAME Inclusion Taskforce Update	*NHS Race and Health Observatory 'Ethnic Inequalities in Healthcare: A Rapid Evidence Review'.* - Discuss the possibility of Government funding for the Lab to Life Child Health Data Centre to look at health inequalities and child health across the BAME communities.	S. Arora/ C. Dove	28.4.22	Closed	**22.4.22** - An update will be provide on the 28.4.22. **28.4.22** - It was reported that tackling health and inequalities/data that the Trust generates is being addressed via the Accelerator Programme. The Innovation Committee received a presentation on the Lab to Life Child Health Data Centre which is focussing on a different area of work therefore it was suggested that a conversation take place with Claire Dove to provide an update and discuss the possibility of further funding to support the Accelerator Programme in respect to health inequalities. **26.5.22** - It was agreed that the EDI Steering Group would progress this action. **ACTION CLOSED**
28.4.22	22/23/13.1	Ockenden Review Update 2022	Submit the Trust wide action plan that has been compiled following the 2022 Ockenden Review, to the Board on the 30.6.22.	N.Askew	30.6.22	Closed	**24.6.22** - This item has been included on June's agenda. **ACTION CLOSED**
26.5.22	22/23/46.2	EDI Steering Group Update	Submit the final version of the Terms of Reference for the EDI Steeting Group for approval.	M. Swindell	30.6.22	Closed	**24.6.22** - This item has been included on June's agenda. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

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

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

1. Introduction

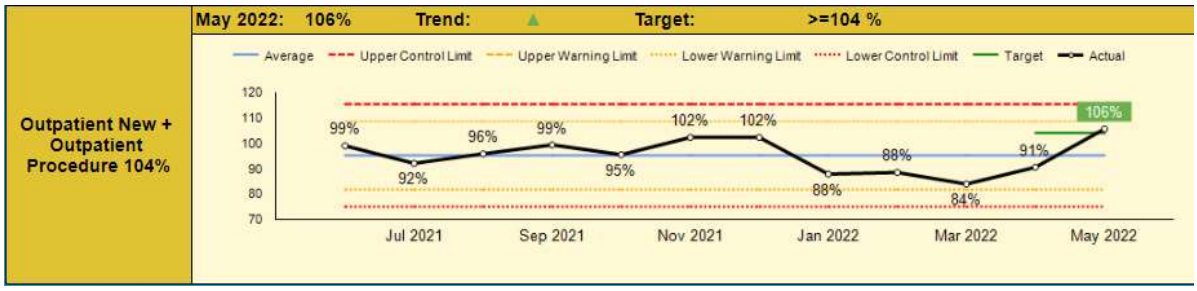
In May our teams delivered an excellent level of service recovery in elective and outpatient care. In mental health services we continue to see high waiting times, driven by significant increases in referrals. However, there has been a notable improvement in routine waiting times for eating disorder services. In emergency care we treated more patients in the Emergency Department than April and delivered a marginal improvement in the number of children and young people treated within 4 hrs.

2. Recovery of elective & outpatient services

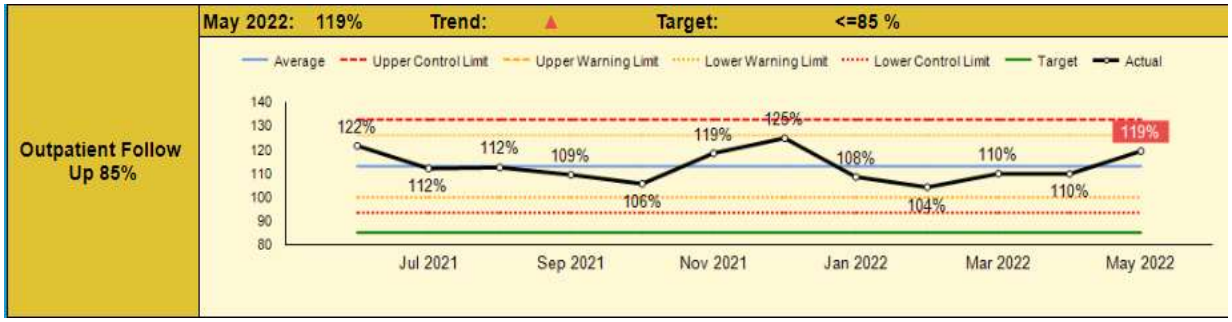
2.1 Elective recovery

We achieved 110% elective recovery in May, which is outstanding. As yet, there is no statistical evidence of special cause variation. On the 20 June 2020 we are expanding the theatre schedule from 139 theatre session to 141, in order to advance elective recovery further.

2.2 Outpatient recovery



We achieved the national target of 104% recovery, and this was the best level of outpatient recovery in the past 12 months. Our outpatient transformation project is working to sustain this level of recovery, with plans to review clinical templates to shift capacity into new outpatient appointments and to develop alternative arrangements for providing some follow-up care.



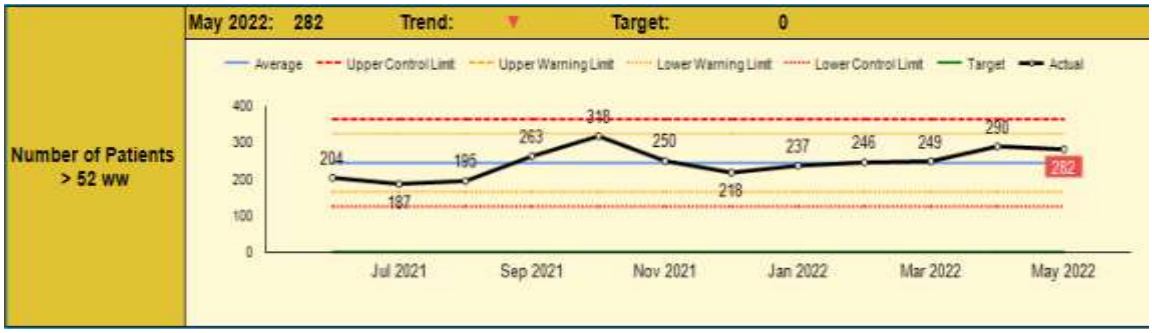
In May we delivered 119% follow-up recovery, which is significantly in excess of the 85% financial payment we will receive. We are seeking to balance a reduction in face-to-face follow-up activity, with a need to reduce overdue follow-ups. In order to do this, we are testing safe alternatives to managing follow-ups, such as patient initiated follow-ups.

2.3 Was Not Brought (WNB)

In order to support recovery, efficiency and reduce waiting times, we have 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 we had in 19-20.

Please see Appendix 1 for more information on our quality improvement work to reduce WNB rates through the Artificial Intelligence WNB predictor and targeted support.

2.4 Waiting times for patients on a referral to treatment (RTT) pathways



We are challenged in reducing it due to significant pressures and imbalance between demand and capacity in paediatric dentistry. Two thirds of the total number of long wait patients are awaiting dental treatment. Please see Appendix 2 for more information on the paediatric dentistry 'leader standard work' (Brilliant Basics) to reduce waiting times. Spinal Surgery has the second highest number of long wait patients: 37 inpatients and 2 outpatients. The Department has successfully recruited a new consultant and clinical fellow, and have been allocated an additional all-day theatre list.

We have no patients waiting over 104 weeks for treatment, achieving this standard ahead of the end of June 2022 national deadline. We are presently working to clear the backlog to a maximum wait of 78 weeks. Our progress in achieving this is depicted in the graph below:

2.5 Diagnostics

Diagnostic performance remains below the 99% target for DM01 reporting with particular challenges in MRI, gastroscopy, sleep studies, DEXA and urodynamics.

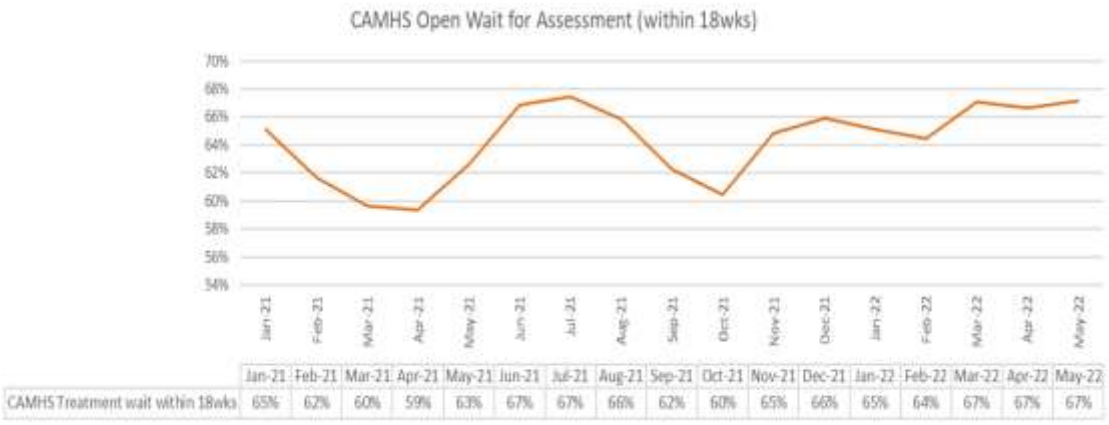
	Apr-22				May-22			
	<6Weeks	Breach	Total WL	Compliance	<6Weeks	Breach	Total WL	Compliance
Magnetic Resonance Imaging	109	40	149	73.2%	148	28	176	84.1%
Computed Tomography	27	4	31	87.1%	44	2	46	95.7%
Non-obstetric ultrasound	87	0	87	100.0%	122	0	122	100.0%
Barium Enema	0	0	0		0	0	0	
DEXA Scan	8	17	25	32.0%	2	20	22	9.1%
Audiology - Audiology Assessments	0	0	0		0	0	0	
Cardiology - echocardiography	0	0	0		0	0	0	
Cardiology - electrophysiology	0	0	0		0	0	0	
Neurophysiology	7	4	11	63.6%	12	3	15	80.0%
Respiratory physiology - sleep studies	21	143	164	12.8%	29	138	167	17.4%
Urodynamics - pressures & flows	11	46	57	19.3%	26	45	71	36.6%
Colonoscopy	1	0	1	100.0%	1	1	2	50.0%
Flexi sigmoidoscopy	0	0	0		0	0	0	
Cystoscopy	12	11	23	52.2%	9	12	21	42.9%
Gastroscopy	39	34	73	53.4%	34	49	83	41.0%
	322	**299**	**621**	51.9%	**427**	**298**	**725**	58.9%

In June, a diagnostic recovery plan was submitted to RABD. In the majority of modalities we have plans to deliver > 90% of patients receiving a diagnosis within six weeks by September 2023. The exceptions to this are sleep studies and urodynamics which have longer term plans that are predicated on recruitment and capital investment. They are working towards targets of compliance by April 2023. We are currently receiving mutual aid from Warrington in the DEXA service due to equipment unavailability.

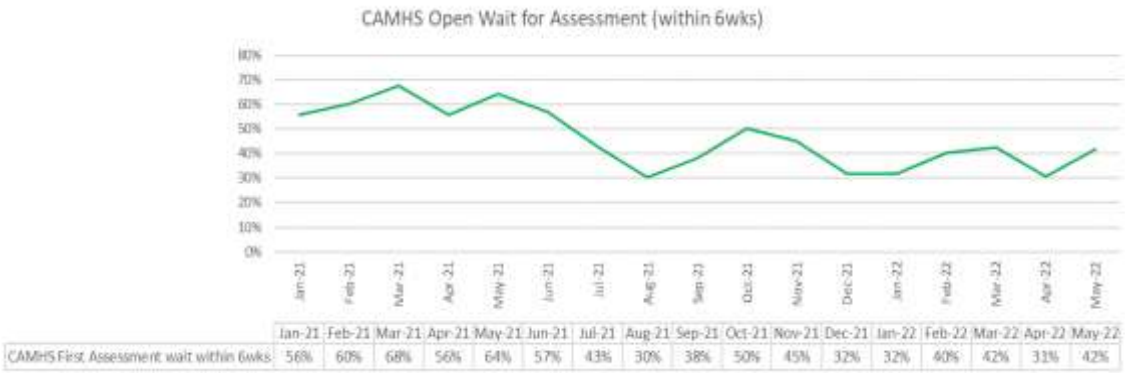
3. Waiting times for community and mental health services

3.1 Specialist CAMHS

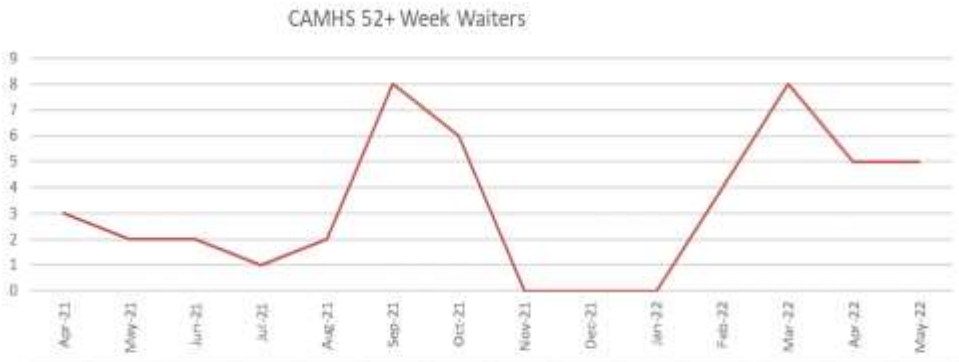
Our waiting times for CAMHS are shown graphically below:



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
CAMHS Treatment wait within 18wks	65%	62%	60%	59%	63%	67%	67%	66%	62%	60%	65%	66%	65%	64%	67%	67%	67%



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
CAMHS First Assessment wait within 6wks	56%	60%	68%	56%	64%	57%	43%	30%	38%	50%	45%	32%	32%	40%	42%	31%	42%



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
CAMHS 52+ wk Waiters	3	2	2	1	2	8	6	0	0	0	4	8	5	5

Access to locality based mental health services (Liverpool and Sefton) remains challenged due to a continued increase in referrals and the complexity of presentations; there has been a persistent increase in the number of children and young people requiring urgent assessment and treatment which has subsequently lengthened the routine appointment waiting time.

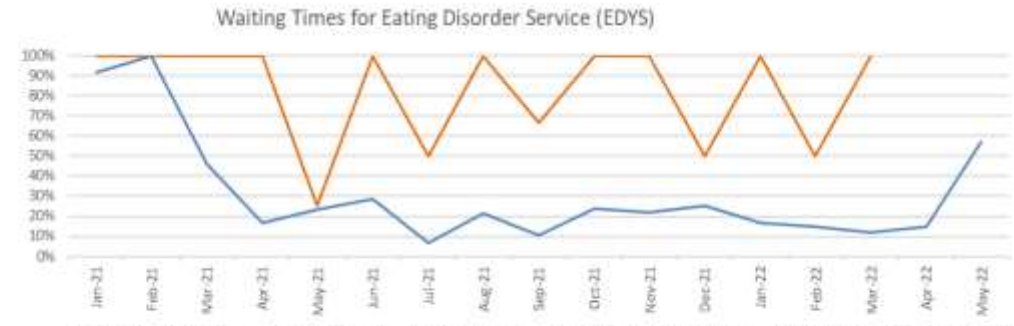
The following actions are being taken in response to this:

i. A business case has been developed and shared with commissioners requesting investment for 22/23 and discussions at CCG and ICS level are ongoing

ii. Recruitment to existing vacancies is continuing utilising schemes from the mental health workforce plan

iii. Available capacity is the service is being maximised, including implementation of WNB predictor tool with the aim of improving appointment attendance

3.2 Eating Disorder Service



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Urgent EDYS Pathway (95%)	100%	100%	100%	100%	25%	100%	50%	100%	67%	100%	100%	50%	100%	50%	100%		0%
Routine EDYS Pathway (95%)	92%	100%	46%	17%	24%	29%	7%	21%	11%	24%	22%	25%	17%	15%	12%	15%	57%

For 12 months we have not met the four-week waiting time standard for routine referrals, due to a significant increase in referrals following the pandemic. However, access times have improved significantly in May 2022 and routine assessment capacity is now available within 4 weeks. It is expected that the service will meet the 95% target from June 2022.

3.3 Waiting times for Neurodevelopmental Pathways

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
% ASD Pathway under 30 Weeks	65%	61%	56%	54%	52%	47%	43%	58%	51%	48%	47%	50%	50%	51%
% ADHD Pathway under 30 Weeks	88%	87%	86%	80%	78%	73%	75%	80%	78%	74%	78%	83%	80%	80%

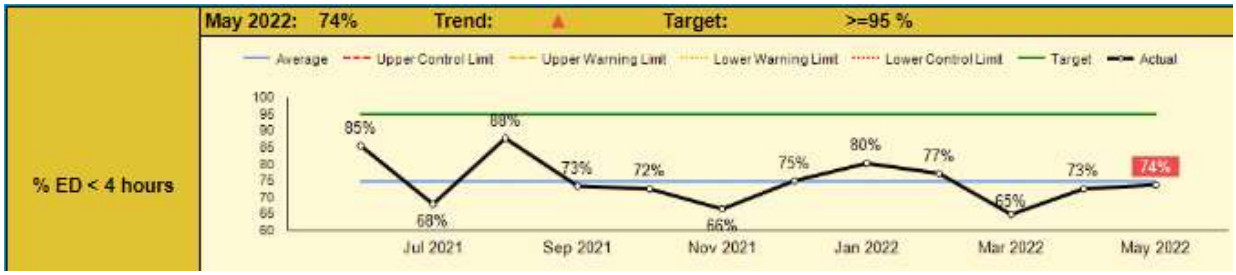
Waiting times for the ADHD and ASD diagnostic pathways have plateaued.

The following actions are being taken in response to this:

i. Recruitment to clinical posts from new CCG investment is underway
ii. A proposal is being shared with schools to provide an additional offer to support education services
iii. Operational improvements underway to reduce time waiting for MDT diagnosis discussion

4. Emergency and urgent care admissions and attendances

4.1 Emergency Department attendances to hospital & 4-hour standard



In May, we made a marginal improvement in the timelienss of treatment in the Emergency Department, despite seeing more than 600 additional patients relative to April. The Department and the Executive team are working closely together to improve patient experience and staff support. We have an 'ED at its best' programme which has enabled a numebr of staff to share their views and feelings on culture and performance. This engagement has led to the creation of a clear cultural goal to create an environment of 'psychological safety'. Practically this will involve changes to the environment in ED relating to 'the hub' where staff work on shift, and the process of the team huddles. Engagement will be ongoing working with the trust's transformation teams and Brilliant Basics coaching for department leaders.

The service provided by Go To Doc has seen an improvement in coverage across 7 days per week. We have made permanent two successful trials: firstly, basing the GP service in the Outpatient Deparmtent, and secondly booking next day appointments for GP suitable patients attending out of hours. Both tests of change have helped depressurised the ED waiting area and in turn supported a better experience of care for families.

Appendix 1: WNB case study – using artificial intelligence to target support for families who need help to attend outpatient appointments

Summary progress report: Advancing Outpatient Care Transformation project

We are utilising the Artificial Intelligence Was Not Brough Predictor to identify patients at risk of not attending appointments. The early-stage pilot evaluation results show that 48% of the 147 who received support to attend their appointment, did so. Of those patients who we could not contact, only 27% attended their appointment.

Appendix 2: Paediatric Dentistry support plan

BRILLIANT BASICS	24th June 2022	Person(s) responsible	Exec lead
	GOAL 1: PDEN 0 Outpatients waiting >52 weeks by 03/10/2022	Rachel Rowson / Chloe Lee	Adam Bateman
	GOAL 2: PDEN 0 Inpatients waiting >52 weeks by 03/10/2022	Rachel Rowson / Chloe Lee	Adam Bateman

Summary OP	Summary IP	Actions we 20/06/2022	Future Actions wc 27/06/2022
Position @ 20/05/22 ❑ If no action taken by 03/10/2022 there will be 308 patients >52 weeks **Gap** ❑ Medium number of slots per week = 31. Require an additional 16 slots per week for the next 19 weeks in order to clear. **Current 40+ week position** ❑ 91 patients >52 weeks; 39 booked. ❑ 99 patients between 45-51 weeks; 7 booked. ❑ 72 patients 40-44 weeks; 2 booked ❑ RTT compliance 45%	**Position @ 20/05/22** ❑ IP RTT at 33 weeks = 200 OP RTT at 33 weeks = 371 OP RTT conversion to IP at 57.6% = 214 Minimum slots required = 414 Capacity = 17.5 slots per week before AL Maximum capacity = 332.5 **Gap** Shortfall = 82 slots minimum Figures above does not allow for: ❑ P2 patients ❑ Elective planned with a due date; ❑ Case-mix challenge i.e. complex care requiring double slots ❑ Annual leave Potential for 80 WLI slots on weekend sessions between June & end Aug (confirmed 4 weeks before hand) **Current 40+ week position** ❑ 143 patients >52 weeks; 44 with a TCI ❑ 28 patients between 45-51 weeks; 6 with a TCI ❑ 23 patients between 40-44 weeks 5 with a TCI ❑ RTT compliance 16.62%	Look forward updated – circulated as separate document. ❑ Amendment to last week - Registrar agreed additional Monday; clinics organised up to end July. ❑ Dental nursing paper drafted. ❑ Dental nursing FT post closes 24/06/22. ❑ Weekly Friday AM theatre agreed from September. ❑ Honorary contract confirmed for specialist dentist; although not available until September (1 day per week). ❑ SM shadowed dental day-case list. ❑ Discussion with pre-op team to confirm correct process being following. Agree for monthly meeting between pre-op and dental. ❑ Appointed into vacant PCO role – awaiting start date.	❑ Final authorisation expected for Locum Specialty and Substantive Specialist Dentist posts – escalated. ❑ Specialty dentist agreed to additional Friday morning; action c/f as Nursing lead off sick with COVID. ❑ Weekly meeting set-up with ACCO/DD/Dental team from 30/06/22 **Challenges** ❑ Team not available for Super Saturday's outpatients. ❑ Sickness in dental nursing team ❑ Registrar transferring training to alternative location from August/ Loss 2 days per week. Recruitment was unsuccessful. ❑ Goal's will need to be revised as with current staff challenges these dates are not achievable. ❑ Filling 2 x all day lists on a Saturday is challenging as we have exhausted fit & well extractions only. Criteria has been expanded.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 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

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

June 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 6 in Quarter 2 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Salient Points

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Programme and Cost Pressure	Working closely with contractor to finalise and agree in preparation for presentation to Board, cost being presented WC 27th June 22.
Sunflower House / Catkin	Programme delay; HO 1st July 2022 Quality issues	Weekly route to HO meetings held, escalating within GT to provide reassurances. Architectural advisor and specialist experts engaged to review and provide solutions.
Temporary Modular Office	Planning approval	Working with LCC liaison and LPA to agree route.
Main Park Reinstatement	Vacation of Catkin, linked to Sunflower House / Catkin and modulars projects and their programmes.	PM brought in to over see the management of these works to coordinate and tie together. Additional support being brought in to manage projects.
Innovation Park 2	Programme delay; HO 16th September due to fire stopping issues.	Project meetings being held to mitigate works and fast track elements. Liaison with legal teams and Landlord to resolve.

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 underway; 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. 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. Continue working with Project Co to mitigate impact.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Completion date delayed until 1st July 2022. Planning of the occupational commissioning continues with representation of the users, clinical staff, FM and estates. Furniture and interiors discussions have concluded and so furniture ordering has commenced.	Further programme delays. Quality issues being experienced on site.	HO date advised by contractor slipped to 1st July 2022 as expected by Trust team. Risk this extends further. Architectural advisor engaged from BDP to review and set quality improvement plan.

Modular Office Buildings

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

Police Station

Current status	Risks/issues	Actions/next steps
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.

Alder Hey Children's NHS
NHS Foundation Trust

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 recovering. 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 have 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.

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. Aiming to complete and seed the majority of this Phase in March 22, with a planned early hand back in Summer 2023. LCC engaged and supporting AH in these works.	Delays to demolition of old Catkin delays completion of phase 3A	Vacation of old Catkin into various locations is planned to complete in spring ready for decommissioning and demolition. Phase 3A will commence in May ahead of demolition.

Alder Hey Children's NHS
NHS Foundation Trust

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 July 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 16th September 2022	Delays to works delays the move from Catkin.	Regular site meetings to monitor progress.

Alder Hey Children's NHS
NHS Foundation Trust

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 23rd June 2022.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

Paper Title:	Serious Incident, Learning and Improvement report 1 May -31 May 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Jackie Rooney Associate Director Nursing: Governance and Risk Jo Gwilliams 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

Alder Hey Children's NHS
NHS Foundation Trust

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), for the reporting timeframe 1st-31st May 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.

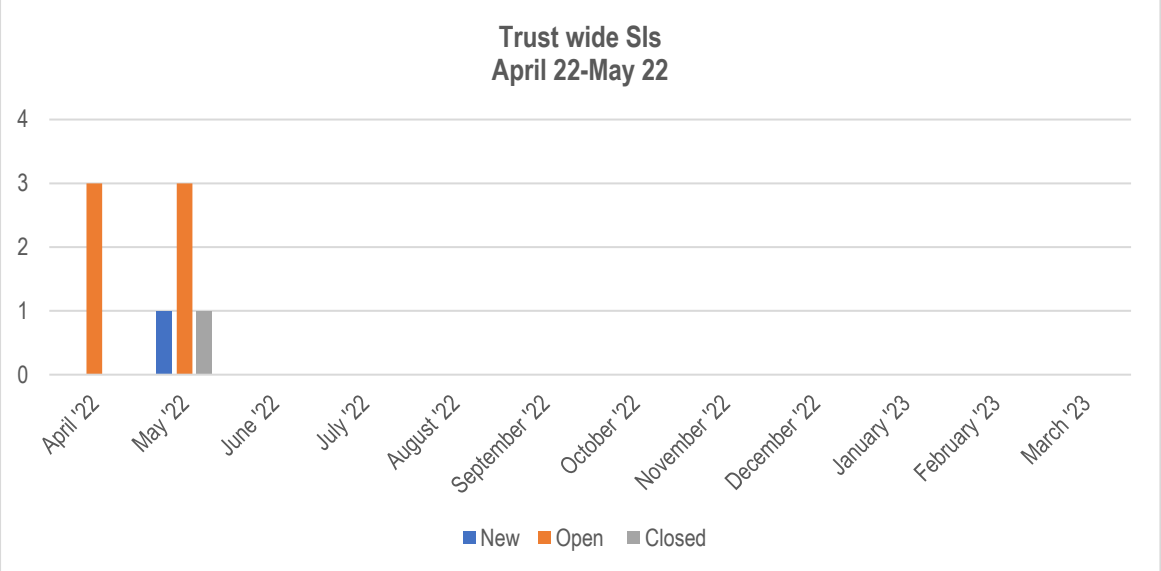
3. Local context

3.1 Never Events

The Trust declared **Zero** Never Events during the reporting time frame 1st -31st May 2022.

3.2. Serious Incidences

Graph 1 Trust wide StEIS reported SI status May 2022



3.2.1 Declared Serious Incidences

The Trust declared **1** StEIS reportable incident that met the SI criteria (unexpected child death) during the reporting timeframe (1st-31st May 2022); however following receipt of 72-hour review and confirmation that the sudden unexplained death in a child (SUDiC) protocol is being followed, Liverpool CCG have downgraded the incident from an SI and closed the case at the time of reporting.

In line with a learning culture ,following admission to PICU the child rapidly deteriorated and suffered a cardiac arrest. In line with protocol an internal 72 hour or rapid review of this case was undertaken but this review did not identify any learning for the Trust. The post-mortem has also concluded and unfortunately no cause of death was identified. This incident will now be reviewed as part of the SUDiC protocol and any further learning if identified will be shared with the Trust.

No further reportable SIs have been declared by the Trust during the reporting period1st-31st May 2022.

3.2.2 Open Serious Incidences

There are currently **3** SIs open during the reporting time frame 1st -31st May 2022 as outlined in table 1 below:

Table 1 Open SIs May 2022

StEIS reference	Date reported	Division	Incident	Summary
2022/2634	4/2/2022	Medicine	Treatment delay meeting SI criteria.	Refer to appendix 1for further detail
2021/24660	25/11/2021	Surgery	Near miss reported for potential for learning	
2021/24473	22/11/2021	Surgery	Treatment delay meeting SI criteria	

3.2.3 Serious incident reports

3.2.4 SI action plans

At the time of reporting **5** SI action plans are overdue their expected completion date.

5 SI action plans have been completed and submitted to commissioners for review.

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Date action plan due Progress to date
2019/23494	24/10/2019	25/10/2019	Medicine	outstanding laboratory test results identified	17	30/04/2020 All actions complete Action plan submitted to CCG pending closure

2018/21323	02/08/2018	31/08/2018	Surgery	Never Event – wrong tooth extraction	18	30/11/2020 All actions complete Action plan submitted to CCG pending closure
2019/21208	25/09/2019	26/09/2019	Surgery	Never Event – retained foreign object post-procedure	5	19/12/2020 4 actions outstanding
2020/608	08/01/2020	09/01/2020	Medicine	Misdiagnosis of tumour	6	30/06/2021 1 action outstanding
2020/18368	28/09/2020	29/09/2020	Surgery	Patient required treatment for avulsed teeth; teeth were replanted into incorrect sockets	4	30/06/2021 1 action outstanding relating to roll out of Meditech Expanse Action plan submitted to CCG pending closure
2020/19349	08/10/2020	12/10/2020	Medicine	Inappropriate clearance of C-Spine	0	30/06/2021 Action plan completed Submitted to CCG pending closure
2020/16210	24/08/2020	26/08/2020	Medicine	14 yr female, with a new diagnosis of acute promyelocyti c leukaemia (APML). Patient suffered intracranial bleed requiring immediate neurosurgical intervention Patient sadly died 2 days later.	14	30/06/2021 5 actions outstanding Pending evidence to support completion of actions
2020/12954	09/07/2020	10/07/2020	Corporate Services	Incorrect settings on port-a-count machine resulting in	11	20/12/2021 2 actions outstanding

				staff being incorrectly passed on an FFP3 mask		
2020/23808	10/12/2020	11/12/2020	Surgery	Category 3 Pressure Ulcer	10	28/02/2022 1 action outstanding relating to roll out of Meditech Expanse Action plan submitted to CCG pending closure
2021/1919	03/01/2021	15/01/2021	Medicine	Patient under care of Bangor, contacted Neurology Team at AHCH for telephone advice. Patient treated according to advice provided, patient suffered raised intracranial pressure requiring shunt	11	30/04/2022 6 actions outstanding Pending evidence to support completion of actions

3.3 Internal level 2 RCA Investigations

The Trust declared **Zero** internal level 2 RCA investigations during the reporting time frame 1st -31st May 2022.

4. 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.

No Duty of Candour responses were required/issued during the reporting timeframe.

5. 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.

Initial findings and immediate learning from the current open SIs are noted in appendix 1.

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.

Zero investigation reports have been completed and submitted to commissioners during the reporting timeframe 1st – 31st May 2022.

6. Next steps

- Review of open SIs with overdue actions plans to be undertaken by Divisions as a matter of urgency
- Further support to be 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, to ensure barriers to completion are addressed and learning is embedded across the organisation as required.
- Improved collaboration between corporate governance team and divisions to be established
- Themes and trends from SIs will be reported to Trust Board once outstanding RCAs have concluded.

Recommendation

The Trust Board is asked to:

- Note content of report
- Note actions to address open SI overdue action plan

Alder Hey Children's NHS
NHS Foundation Trust

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken (as identified via 72-hour review)
SI 2022/2634	10-year-old boy brought to the Emergency Department 15th July 2021 with neck pain and unable to move. Patient was taken out of the department before being seen. Pt left before seen proforma was completed and this was sent to GP. Presented again on 28th July 2021 at 15:51 with similar presentation but was discharged following investigations on antibiotics for a dental abscess. Patient sent to Whiston for an urgent CT head and neck by the GP on 28th January 2022 for ongoing torticollis. Pt recalled presenting to Alder Hey Neurosurgical team as an emergency following formal reporting when a C1/2 subluxation was identified.	Reason for initial investigations unclear – c-spine tenderness and torticollis not indicators of dental abscess in the absence of fever, dental pain, facial swelling Reason for initial diagnosis unclear (cervical lymphangitis) as no recorded fever or cervical lymphadenopathy on examination. In view of documented examination findings and history of trauma the patient should have received imaging of the cervical spine +/- neurosurgical consultation depending on the result.	Consideration for a question to be asked in triage regarding any trauma, rather than relying on parents. Use of the word "trauma" may not be appropriate. Manchester triage for neck does ask about trauma to neck – consider rewording this to ask for any trauma as child/parent may not realise related trauma. Walk in Centre (WIC) do not always send letters with parents, but nursing staff do not ask for this – to consider adding this in case letter has been forgotten by parent.
2021/24660	Traumatic death from penetrating neck injury -	Incident was initially identified as catastrophic, however following in-depth review, the conclusion is that	A comprehensive level 2 investigation to be undertaken with external expertise input

	reported as per protocol (as Near Miss).	this is a near miss incident with potential lessons to be learned, therefore reclassified as a near miss but StEIS reportable due to potential for learning.	
SI 2021/24473	Suboptimal management of a scalp haematoma that became infected and resulted in loss, need for a skin graft and will require scalp expansion to reconstruct later	On review the surgical team felt that incision and drainage should have occurred on first presentation of abscess. There were missed opportunities to intervene in care to alter the outcome for this patient.	Shared information with all teams likely to care for children with this type of injury.

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS

Thursday, 30th June 2022

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing
Subject/Title:	Nursing Workforce Report 2021/2022
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Hard Truths: The Journey to Putting Patients First: Department of Health, 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Quality Network for Community CAMHS Standards for Services: Royal College of Psychiatrists, 2020 • Safe staffing for nursing in adult inpatient wards in acute hospitals: National Institute for Clinical Excellence July 2014 • Safer Staffing: A Guide to Care Contact Time: NHS England 2014 • Single Oversight Framework: NHS Improvement September 2016 • Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals: Department of Health and Social Care, February 2016 • Standards of Proficiency for Registered Nurses: Nursing and Midwifery Council, May 2018 • Supporting Nurses, Midwives and Nursing Associates (England) in the event of a COVID-19 epidemic in the UK, March 2020 • Developing Workforce Standards: Supporting providers to deliver high quality care through safe and effective staffing: NHSI, 2018 • Stepping Forward to 2020/21: The mental health workforce plan for England: Health Education England, July 2017 • NMC Emergency Standards: NHSE January 2021

	• Advice on acute sector workforce models during COVID-19: NHSE, December 2020 • Joint statement on developing immediate critical care nursing capacity: NHSE, March 2020 • Deploying the healthcare science workforce to support the NHS clinical delivery plan for COVID-19: NHSE, May 2020 • Covid-19: Deploying our people safely: NHSE, April 2020 • Winter 2021 preparedness: Nursing and midwifery safer staffing: NHSE/I November 2021 • Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals: NHSE, September 2021 • Advice on acute sector workforce models during COVID-19: NHSE, December 2020 • Ockenden report - Final: Department of Health and Social Care, March 2022
Purpose of Paper:	This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing at times of increased pressure To inform the Trust Board of proposed workforce improvements in 2022/23
Action/Decision Required:	The Trust Board is asked to approve: • The content of the report and assurance that appropriate information is being provided to meet national and local requirements • The information on safe staffing and the impact on quality of care • Recommendations
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	

Executive summary

The aim of this paper is to provide assurance to the Trust Board of Directors 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.

Since the previous annual Nurse Staffing Board report for 2020/21, the senior nurse / AHP leadership team have continued to work on the recommendations that were agreed. This report contains an updated position with regard to the nursing workforce and makes further recommendations for continued improvement.

The recruitment action plan has continued in order to provide safe staffing levels. Alder Hey has demonstrated continued success in this highly competitive regional and national market, and the attrition rate of nurses offered employment at Alder Hey has remained very low at 8%.

In the last financial year of 2021/22, 101.5 WTE Band 5 Registered Nurses have been recruited through local, national and international campaigns. Although there was a reduction of new nurses recruited compared to 2020/21 (122 WTE recruited), this was due to the early commencement of the Extended Clinical Placement (ECP) students starting full time work in the Trust earlier than their initial qualification date; as such, this group contributed to an increased number of new recruits in 2020/21. However the aggregated figure across the two years (2020/21 and 2021/22) is consistent with previous successful recruitment campaigns with a mean recruitment figure of 110 WTE.

In addition, the Trust successfully recruited to key senior nursing leadership posts in 2021/22, namely the new role of Director of Allied Health Professionals, new role of Chief Nursing Information Officer (CNIO), new role of Associate Nurse for Advanced Practice, new role of Head of Nursing in Surgery, and the Outpatient Department Matron.

In year, nursing vacancy rates are below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As of March 31st 2022, the Trust had 22.68 WTE Band 5 vacancies (21.03 WTE in PICU; 1.65 WTE on Ward 3C). Staffing pressures are therefore largely due staff availability to work due to sickness absence and maternity leave, rather than vacancies.

There was an average of 31.6 WTE staff on maternity leave, with a peak in January 2022 of 36 WTE. Sickness absence rates were high with an average of 22.3 WTE staff on long term sickness with a peak of 32.7 WTE in December 2021, and an average of 23.9 WTE staff on short term sickness with a spike of 45.6 WTE in December 2021.

The Trust's mandated monthly submission of staffing levels to NHS website was 92% overall for 2021/22, however due to very high sickness levels during the winter, staffing levels between November 2021 and February 2022 were reported to be 81% to 88% which is below the nationally accepted level of 90%. The Trust utilised temporary staffing where possible to address staffing pressures. The staffing model was reviewed and revised for winter 2021 and Amber and Red models were devised in collaboration with senior nursing staff. Where the Red model was invoked, in line with the escalation process, this was immediately escalated to the Chief Nurse.

The average leaver rate per month in 2021/22 increased significantly to 7.2 WTE per month, however this is associated with a significant reduction in the previous year of an average 2.5 WTE per month due to the pandemic. The increased number of leavers is reflective of the national picture following the Covid-19 pandemic and an increased number of staff leaving the NHS. However the number of leavers jointly during the 2-year pandemic era of 2020/21 and 2021/22 averages of 4.9 WTE per month which is comparable and lower than the average leaver rate pre pandemic

A review against the RCN standards was repeated which has demonstrated sustained compliance with 15 of the 16 core standards. A key requirement in 2022/23 is to ensure all wards have a

supranumery clinical co-ordinator on every shift as the Trust is not compliant on Ward 3A, Ward 4B, and Ward 4C. The importance of a supranumery clinical co-ordinator was a significant finding and "must do" action in the Ockenden report of March 2022.

The senior nurse / AHP leadership team continued to implement the comprehensive Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025 and a Workforce group was set up Chaired by the Chief Nurse.

The strategy has a clear vision to:

- Be a national leading centre in the training, education, and recruitment of paediatric nursing and HCSW's.
- Diversify recruitment strategies to be more representative of the population we serve
- Ensure that staff have clear opportunities to develop, grow and progress in the organisation
- Develop to embrace new roles and transition to a sustainable model for the future.
- Have clear structure for advanced and specialist roles; services will be developed around the needs of children, young people, and their families, and will clearly align to the service needed to provide their care.

The report details proposed workforce improvements in 2022/23 which include addressing the gap of funded establishment for supranumery clinical co-ordinators (Ward 3A, Ward 4B and Ward 4C), addressing the requirement for increased Health Care Assistants (HCA) due to increased number of children and young people requiring HCA 1:1 care and supervision, addressing workforce and safe staffing recommendations from the Ockenden report (March 2022), and continued implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025

Contents

1. Introduction Page 7

2. National context and regulation Page 7

3. Summary of achievements Page 9

- 3.1: Recruitment Page 9
- 3.2: Safe staffing levels Page 10
- 3.3: Strong and effective leadership Page 10
- 3.4: Educational developments Page 11
- 3.5: Quality metrics Page 12

4. Hospital staffing model Page 12

- 4.1: Ward establishments Page 12
- 4.2: Safer staffing levels Page 12
- 4.3: Compliance with RCN guidelines Page 13
- 4.4: Recruitment and resilience Page 14
- 4.5: Workforce developments in 2020/2 Page 16
- 4.6: Proposed workforce developments in 2021/22 Page 16

5. Workforce challenges Page 17

- 5.1: Leavers Page 17
- 5.2: Age profile of nursing staff Page 18
- 5.3: Maternity leave Page 19
- 5.4: Sickness Page 20
- 5.5: Attrition rates of recruited staff Page 22
- 5.6: Increasing patient acuity Page 22
- 5.7: Temporary staffing: NHSP and agency Page 22
- 5.8: Winter pressures / increased staffing demand Page 23
- 5.9: Staffing risks and incidents reported Page 24
- 5.10: Ockenden report: Workforce planning and sustainability, and safe staffing Page 25

6. Recommendations Page 26

7. Conclusion Page 27

Appendix 1: Staffing availability report 2021/22 Page 28

Appendix 2: Compliance with RCN core standards and specific standards 2021/22 Page 29

- A2.1: RCN compliance by ward / department 2021/22 Page 29
- A2.2: Compliance with RCN core standards Page 30
- A2.3: Compliance with RCN specific standards Page 33

Appendix 3: Band 5 Starters Page 35

- A3.1: Band 5 nurses recruited 2016/17 to 2021/22 Page 35
- A3.2: New Band 5 staff commenced in post in 2021/22 by ward / department Page 36

Appendix 4: Band 5 leavers Page 37

- A4.1: Band 5 leavers 2016/17 to 2021/22 Page 37
- A4.2: Band 5 leavers in 2021/22 by ward / department Page 38

Appendix 5: Age profile of ward / departmental registered nursing staff in 2021/22 Page 39

Appendix 6: Band 5 maternity leave in 2021/22 by ward / department Page 40

Appendix 7: Band 5 long term sickness in 2021/22 by ward / department Page 41

Appendix 8: Band 5 short term sickness in 2021/22 by ward / department Page 42

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care delivered by the right staff, in the right place, with the right skills, and to ensure we have a resilient, resourced, well trained nursing workforce to deliver this.

This report aims to provide assurance that the Trust has safe nurse staffing levels across all in-patient and day case wards, and appropriate systems and processes in place to manage the demand for front line nurse staffing.

This report will outline the national guidance and regulatory requirements related to nurse staffing, a summary of achievements in 2021/22, compliance with workforce standards, and detail the workforce pressures and challenges experienced in year, particularly during winter 2021.

The report details proposed workforce improvements in 2022/23 which include addressing the gap of supranumery clinical co-ordinators (Ward 3A, Ward 4B and Ward 4C), addressing workforce and safe staffing recommendations from the Ockenden report (March 2022), and continued implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025.

2. National context and regulation

There are a number of tools available to determine safe staffing levels. The tools currently used at Alder Hey are Royal College of Nursing standards nurse to patient ratio, skill mix review, patient acuity and dependency assessment through the SCAMP Safer Nursing Care Tool, professional judgement, and triangulation with nurse sensitive indicators.

Specific guidance for safe staffing levels in neonatal and paediatric settings is set in the main by the Royal College of Nursing (2013). A review of the Trust's compliance against the 16 core standards for 2021/22 can be found in section 4.3 and Appendix 2, with the Trust fully compliant with 15 standards and partially compliant with 1 standard.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011). The Royal College of Psychiatrists set out CAMHS standards (RCP, 2020).

In November 2017, the National Quality Board (NQB) published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. The improvement resources are based on the NQB's expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time.

In September 2021, NHSE published staffing guidance regarding the anticipated surge in Respiratory Syncytial Virus (RSV) in winter 2021 in the paediatric population (Respiratory syncytial virus 2021 preparedness: Children's safer nurse staffing framework for inpatient care in acute hospitals). In addition, in November 2021 NHSE/I published the Winter 2021 preparedness: Nursing and midwifery safer staffing document to assess winter and surge readiness which was reported to the Trust Board in December 2021 as outlined in section 5.8. The Trust undertook specific reviews of staffing requirements in 2020/21 and 2021/22 in response to the potential unique staffing challenges resulting from the covid-19 pandemic and anticipated surge in RSV; annual establishment reviews were undertaken between June and October 2021; annual establishment

reviews for 2022 are planned for June 2022 across a 3-week window to facilitate prompt aggregated analysis and action.

In October 2018, NHSI published the Developing Workforce safeguards document to build on the NQB tools by helping Trusts manage common workforce problems, providing recommendations to support making informed, safe and sustainable workforce decisions. The document sets out that Trusts compliance with the triangulated approach to staffing will be assessed, combining evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time based on patients' needs, acuity, dependency and risks, and the requirement for ward to board monitoring. A specific workforce statement is provided in the annual governance statement which is monitored by NHSI. Implementing the recommendations and strong, effective governance, provides Trust Board assurance that workforce decisions promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards, NHSI compliance and the Board's statutory duties.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are required to submit monthly staffing data. The Trust is compliant with submitting data to the public through NHS website and on the Alder Hey website (Section 4.2 and Appendix 1)

In 2000, the Department of Health proposed that every hospital should have Matrons who are accountable for a group of wards and are easily identifiable to patients, in order to improve the delivery of patient care and patient experience, and to provide strong clinical leadership and authority at ward and departmental level. In 2021, the Matron and Head of Nursing structure was reviewed, and it was identified that due to the increase in patient acuity, and breadth of the role, the structure needed to be strengthened to provide increased clinical leadership and expertise in the Medical Division and Surgical Division and as such a new Head of Nursing roles were introduced in both Divisions; the Surgical Head of Nursing role has been recruited to.

The Nursing and Midwifery Council (NMC) implemented Nurse Revalidation from April 2016, which requires all registered nurses to revalidate every 3 years to maintain their professional registration. The purpose of revalidation is to improve public protection ensuring nurses remain fit to practise throughout their careers. To date, all registered nurses due to revalidate have done so successfully.

The RCN's Principles of Nursing Practice states that 'Nurses and nursing staff must have up to date knowledge and skills and use these with intelligence, insight and understanding in line with the needs of each individual in their care'. In May 2018, the Nursing and Midwifery Council (NMC) launched new standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. The Standards of Proficiency for Registered Nurses represents the skills, knowledge and attributes all nurses must demonstrate. Practice Educators play an essential role in the development of a workforce that is able to deliver high quality, effective and safe care. The clinical education team, expanded in 2018/19, has proved invaluable in supporting students, new registered nurses and existing staff with support and education throughout the year and specifically during the Covid-19 pandemic, providing induction to new staff, supporting the student nurses and providing PPE training (section 4.4).

As the consequences and impact of the Covid-19 pandemic became apparent, a multitude of associated new national guidance was set out by NHSE/I and professional bodies (referenced in background papers). In 2020, the Chief Nurse (CNO) for England recognised that the pandemic would require temporary changes to practice, requiring health and care professionals to be flexible, working in unfamiliar circumstances or surroundings or working in clinical areas outside of their usual practice for the benefit of patients, individuals and the population as a whole whilst practicing in line with the NMC code and using judgement in applying the principles to situations that you may face, and using professional judgement to assess risk and to make sure people receive safe care. The CNO acknowledged this included a rational approach to varying practice in an emergency as part of that professional response.

In response to the national crisis, a temporary model of nursing was devised by the Trust for the first wave of the pandemic in March / April 2020. The staffing guidelines devised at the time of the crisis (Green, Amber and Red staffing levels) were for that point in time and were stood down back to the usual Green staffing levels in line with national guidance in summer 2020. In preparation for the second wave and more sustained staffing challenges over the winter period in 2021, including the anticipated surge in RSV, the staffing model was reviewed and revised Amber and Red models were devised in collaboration with senior nursing staff. The Director of Nursing worked in collaboration locally with the Ward Managers, Matrons and Associate Chief Nurses; and at regional and national level with the Association of Chief Children's Nurses, the RCN and the C&M Director's of Nursing in order to ensure safe staffing levels were set to cope with winter and surge requirements. Between November 2021 to February 2022 staffing levels were reported to be between 81% to 88%, with decreased staffing levels across day and night shifts and across registered nurses and HCAs as outlined in section 4.2 and shown in Appendix 1. Where the Red model was invoked, this was immediately escalated to the Chief Nurse.

In March 2022, the Department of Health and Social Care published the Ockenden report; the outcome of an independent review of the maternity services provided by another Trust. NHSE/I have set out that in reviewing the report, Trust Boards must take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars. Two of the four key pillars directly related to the front line nursing workforce are:

1. Safe staffing levels
2. A well-trained workforce

The Trust has devised a comprehensive action plan to address the recommendations that directly and indirectly apply to Alder Hey as outlined in section 5.10. Of particular importance is that Alder Hey must urgently address deficits in the funded establishments through business planning to ensure that all wards have a funded supranumery clinical co-ordinator (Ward 3A, Ward 3C and Ward 4C).

3. Summary of achievements

The overall impact of the success of the recruitment, reduction in vacancies, response to the pandemic and other developments to support safe nurse staffing is as follows:

3.1: Recruitment

i. 101.5 WTE front line nursing staff recruited in 2021/22
ii. Vacancy rates less than 2%
iii. From the successful international recruitment campaign undertaken in 2019/20, a further 28 of the 105 nurses given a conditional offer have successfully commenced employment at Alder Hey in 2021/22 and all have passed the OSCE enabling them to register with the NMC
iv. Trust has 7 qualified Nurse Associates and 1 Trainee Nurse Associate across the Trust, and we are undertaking a workforce review to increase our future training opportunities related to this role
v. Successful appointment of 9 Registered Nurse Degree Apprentices (RNDA)
vi. Successful appointment of 8 internal Nurse Associate and Assistant Practitioners to the RNDA 2-year programme
vii. Appointment of a pastoral support educator to support nurses who have joined the Trust from oversees following a successful bid the previous year.
viii. A responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days and a comprehensive induction and preceptorship programme for new nursing staff. Ongoing recruitment work also continues via the virtual recruitment programme
ix. Recruitment strategy partnership working with Higher Education Institutes to attract potential student nurses from diverse backgrounds

x. Delivery of the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is a HCA vacancy
xi. Support from NHSE to start involvement in the refugee programme, with our first recruit started in Autumn 2021

3.2: Safe staffing levels

i. Staffing levels higher than 90% for 7 months of the year for open beds
ii. Daily Safer Staffing meeting operational and fully embedded; led by Associate Chief Nurse
iii. Winter / surge (including Covid-19) staffing plan and models reviewed and agreed
iv. Matron for Surgery and Matron for Medicine allocated responsibility to oversee safe staffing for their Division on a daily basis and ensure robust plans
v. Green, Amber and Red staffing model invoked at times of pressure in line with escalation process; this was particularly required November 2021 to February 2022

3.3: Strong and effective leadership

i. Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025 comprehensive 5-year workforce strategy devised with executive leadership and responsibility delivered by the Chief Nurse; a Workforce group set up to deliver the strategy and monitor actions to completions. The strategy has a clear vision to:
    a. Be a national leading centre in the training, education, and recruitment of paediatric nursing and HCSW's.
    b. Diversify recruitment strategies to be more representative of the population we serve
    c. Ensure that staff have clear opportunities to develop, grow and progress in the organisation
    d. Develop to embrace new roles and transition to a sustainable model for the future.
    e. Have clear structure for advanced and specialist roles; services will be developed around the needs of children, young people, and their families, and will clearly align to the service needed to provide their care.
ii. New post established for a Director of Allied Health Professionals (AHPs) role to provide professional leadership to AHPs; successful external recruitment and commenced in post October 2021
iii. New post established for an Associate Chief Nurse for Advanced Practice role to provide professional leadership, structure and governance for staff in advanced practice roles; successful internal recruitment and commenced in post January 2022
iv. New post established for a Chief Nursing Information Officer (CNIO) role to provide a clear and effective link and bridge with digital team, identifying and implementing digitally enabling improvements in nursing; successful internal recruitment and commenced in post in August 2021
v. Review of the senior nurse leadership structure in Surgical Division; new Head of Nursing for Surgery post established with successful external recruitment
vi. Internal recruitment to the Oncology Matron secondment in the Medical Division
vii. Internal recruitment to the Specialist Medicine Matron role in the Medical Division
viii. Review of the senior nurse leadership structure in Medical Division and Head of Nursing areas of responsibility; new Head of Nursing post established
ix. External recruitment to the Matron for Outpatients Department in the Community and Mental Health Division
x. Internal recruitment to Ward 3C, 4B and 4C Ward Manager posts
xi. Internal promotion to Band 6 Ward Sister / Charge Nurse positions
xii. Senior Nurse / AHP on Site role devised to provide an additional layer of professional support and leadership out of hours (Monday to Friday 1700-2100; Saturday, Sunday and Bank Holidays 0800-1200) with implementation planned for May 2022
xiii. External recruitment to the Play Manager post
xiv. Safer Staffing Huddle Chaired by a senior nurse

xv. Senior nurse oversight and involvement at all stages of the redeployment process due to the ongoing pandemic / winter pressures
xvi. Standard Operating Procedure devised and implemented to clearly outline the role and responsibility of the Nurse in Charge of the ward / clinical co-ordinator

3.4: Educational developments

i. Bespoke Staff Nurse preceptorship and rotation programme continues for all newly qualified nurses; facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
ii. Devised a Band 5 development framework, to offer guidance through initial first 2 years post recruitment to clearly evidence the learning available in conjunction with the new career pathway for nursing; implementation planned for May 2022.
iii. Devised major trauma competencies for the wards which are being implemented across the organisation
iv. Successful bid awarded from Health Education England for the Clinical Placement Expansion Programme to increase the number of Registered Nurses nationally; an additional 27 Student Nurses have been offered placement at Alder Hey with the funding awarded supporting their education
v. Developed practice-based learning packages to support increased number of learners and reviewed diversity of learning opportunities the organisation can offer
vi. Partnership working with the HEIs to involve student nurses in vaccination clinics; students effectively trained and supervised and experience positively evaluated as achieved professional and educational objectives in a new and innovative way. Hub and spoke placement to include time within the Vaccination Clinic set up for 2022
vii. Devised a transition support package for use by final year nursing impacted by reduced variety of placements / patients due to the covid pandemic; implementation planned for 2022
viii. Held a student nurse listening event; developments planned for 2022 including the establishment of a learner forum.
ix. Parity of esteem quality workstream implementing training to ensure staff are trained to care for children and young people to address all their physical and mental health needs holistically
x. Successful recruitment of 9 candidates to the Registered Nurse Degree Apprenticeship (RNDA 4). Funds awarded will support backfill arrangements for trainees and / or support externally appointed applicants
xi. Successful recruitment of 8 internal nurse associate / assistant practitioners into the Register Nurse Degree Apprenticeship (RNDA 2)
xii. Successful implementation of the Supportive Coaching In Practice (SCiP) model to support our learners onsite.
xiii. Supported 15 nursing staff to undertake the Professional Nurse Advocate (PNA) training with 8 now successfully completed
xiv. Established a PNA forum to ensure an organisational approach to implementation of the PNA role and effective partnership working with existing organisational staff support functions.
xv. Continued to support senior nurses and aspiring nurse leaders to undertake the MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
xvi. Director of Nursing successfully completed the Chief Nursing Officer Safer Staffing Fellowship programme
xvii. Practice Education Facilitators and Clinical Practice Educators continue to address organisational education requirements and provide a streamlined approach to a wide variety of staff development opportunities.

3.5: Quality metrics

i. Continued monitoring of the Tendable (Perfect Ward) quality audit tool across all wards during the pandemic
ii. Re introduction of the Ward Accreditation programme temporarily suspended during the height of the pandemic.
iii. Implementation of Quality Ward Rounds undertaken every 2 weeks by senior nursing / AHP team to increase visibility and undertaken improvement work in identified subject areas
iv. Patient Safety Meetings continued throughout the pandemic
v. Challenge boards introduced for each ward within Divisions and assurance regarding key performance indicators reported to CQSG, SQAC and executive performance reviews
vi. CNIO supporting digitally enabled quality improvements and solutions

4. Hospital nurse staffing model

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with the national requirements as outlined in section 2, patient acuity, professional judgement, and review of compliance with key quality metrics. 100% of ward establishments were undertaken and analysis fed back and escalated to the senior nurse / AHP team and Gold Command.

Significantly Ward 3A, Ward 3C and Ward 4C do not have a funded supranumery clinical co-ordinator. This is a fundamental core standard (RCN, 2013) and a key finding in the Ockenden report as outlined in section 5.10. It is recommended that the funded establishments for each of these areas is increased to support a supranumery clinical co-ordinator as detailed in the recommendations section 6.

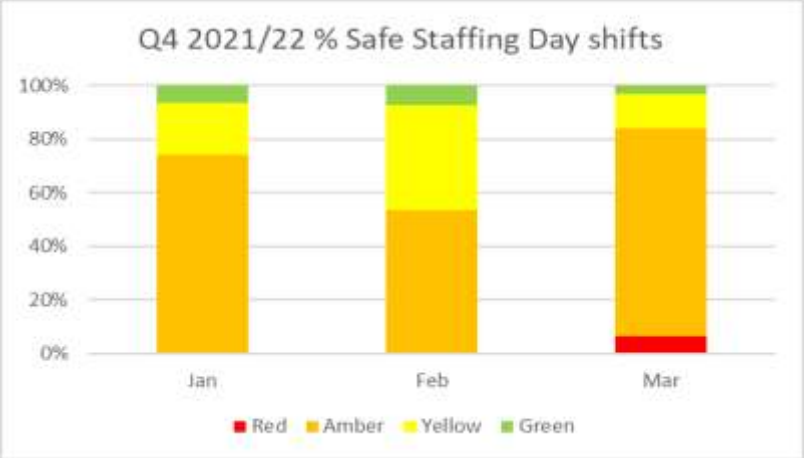
Staffing models and winter planning review undertaken with each Ward Manager, Matron and Associate Chief Nurse.

4.2: Safer staffing levels

Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level; the Trust is compliant with submitting data. The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2021/22 demonstrated that the average overall staffing level was 92% for the year. However between November 2021 to February 2022 staffing levels were reported to be between 81% to 88%, with decreased staffing levels across day and night shifts and across registered nurses and HCAs as shown in Appendix 1.

Safer Staffing meetings were held twice per day Chaired by a Divisional Associate Chief Nurse where plans were made for the day and night in line with the Standard Operating Procedure (Nurse Staffing Escalation Ward and Departmental Optimal and Minimum Staffing Levels: Green, Amber and Red staffing models Winter 2021). The overall staffing status (Green; Yellow; Amber; Red) was escalated to the Daily Operational meeting and to the Chief Nurse in line with the escalation process. Where the Red model was invoked, this was immediately escalated to the Chief Nurse.

A breakdown of the status of day and night shifts in Q4 is shown in the graphs below.



4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, a review against the RCN standards has been repeated in 2021/22 by the Director of Nursing as detailed in Appendix 2.

4.3.1: RCN Core Standards

The thermometer below demonstrates the journey of improvement against the RCN core standards since the first audit was undertaken in 2014.

July 2014	2	4	6	7	8	10	11	15	16	1	3	5	9	12	13	14
Feb 2017	2	4	6	7	8	9	10	11	12	13	15	16	1	3	5	14
Feb 2018	2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14
Mar 2019	2	3	4	5↑	6	7	8	9	10	11	12	13	15	16	1↑	14↑
Mar 2020	2	3	4	5	6	7	8	9	10	11	12↑	13↑	15	16	1	14↑
Mar 2021	2	3	4	5	6	7	8	9	10↑	11↑	12	13	15	16	14↑	1
Mar 2022	2	3	4	5	6	7	8	9	10	11	12	13	15	16	14↑	1

The recent review has demonstrated a static position with compliance against the 16 core standards. Core standard 1 (all clinical areas are required to have a supernumerary shift supervisor) has remained at Amber (partially compliant). Ward 3A, 3C and 4C do not have a funded establishment to support a supranumery shift co-ordinator; this is a significant gap and was raised to Gold Command in 2021. The finance department have been working in collaboration with the senior nurse / AHP team to identify the gap; Alder Hey must urgently address deficits in the funded establishments through business planning to ensure that all wards have a funded supranumery clinical co-ordinator.

The Trust has rated compliance with core standard 5 (25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave) since 2019. Although the Trust has an uplift of 23%, the remaining 2% uplift is considered to be supported through the funding of the additional 40 WTE Band 5 nurses above establishment, however this uplift is not consistently achieved as the Trust is not consistently 40 WTE above funded establishment. This standard will be reviewed in line with the Ockenden report as outlined in section 5.10.

A full analysis is detailed in Appendix 2.2

4.3.2: RCN specific standards

Analysis has taken place to review front line staffing against the relevant specific staffing guidance sections of the RCN guidelines not captured within the core principles.

The review demonstrated that the Trust remains fully compliant with 2 standards and partially compliant with 2 standards, with an improved position in standards 7 and 8. Majority of wards (12 out of 15 for standard 7; 6 out of 9 for standard 8) are fully compliant in the standards rated Amber and a staffing plan is in place to mitigate any gaps as detailed in Appendix 2.3.

Feb 2017	5	6	7	8
Feb 2018	5	6	7	8
Mar 2019	5	6	7↑	8↑
Mar 2020	5↑	6	7	8
Mar 2021	5	6	7↑	8↑
Mar 2022	5	6	7↑	8↑

4.4: Recruitment and Resilience

The senior nursing team have continued to undertake recruitment activities throughout 2021/22 and have recruited 101.5 WTE front line Band 5 registered nurses. In year, nursing vacancy rates are below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As of March 31st 2022 the Trust had 22.68 WTE Band 5 vacancies of which 21.03 WTE are in PICU and 1.65 WTE are on Ward 3C. Staffing pressures are therefore largely due staff availability to work, rather than vacancies, as detailed in section 5 workforce challenges.

A highly successful recruitment campaign was undertaken in November 2019, and the Trust welcomed a further 28 highly skilled and experienced nurses from India in November 2021 and December 2021, totalling 78 international nurses recruited since 2019. A comprehensive induction and OSCE programme was put in place however in response to the Covid-19 pandemic, the national guidance regarding overseas nurses changed to enable the staff to join a temporary register sooner with the NMC to then work at Band 5 rather than the intended six month Band 4

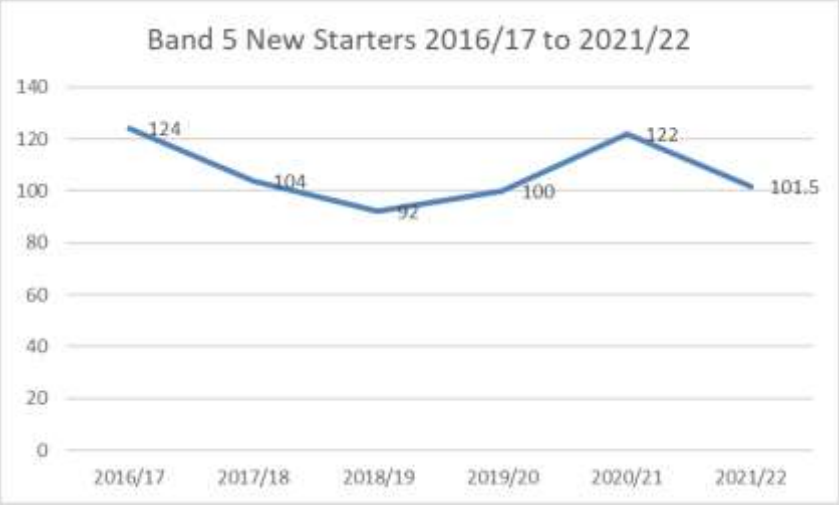
period. All of the nurses, including the 28 nurses who joined Alder Hey last year, have successfully passed their OSCE examination.

The Trust has 3 qualified Nurse Associates and 2 Trainee Nurse Associates across the Trust and are planning to recruit 8 per year across 2 intakes. However, many have undertaken the opportunity to undertake further academic training via the Registered Nurse Degree Apprenticeship 2-year programme (RNDA 2) to gain registered nurse status.

Table 1 shows the actual number of starters per month in 2021/22, and the graph below shows the actual numbers over the past 6 years. Although there was a reduction of new nurses compared to 2020/21, this was due to the early commencement of the Extended Clinical Placement (ECP) students starting full time work in the Trust earlier than their initial qualification date; these students would have normally commenced in post as Staff Nurses in May 2022. This was a national strategy put into place as a result of the pandemic whereby the Nursing and Midwifery Council (NMC) offered 3rd year students in the final six months of their training the option of the ECP placement as full time paid work. As such, this group contributed to an increased number of new recruits in 2020/21 (122 WTE), however the aggregated figure across the two years (2020/21 and 2021/22) is consistent with previous successful recruitment campaigns with a mean recruitment figure of 110 WTE. Comparator figures are shown in Appendix 3.1.

It is anticipated that recruitment figures will remain consistent and increase as the Trust has increased placement capacity for student nurses; introduced in 2021 with an additional 27 student nurses offered clinical placements at Alder Hey.

Table 1: Front line registered nurses recruited in WTE												
Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
5	2.23	1	0	2	15.15	36.76	12	22	1.76	0	3.61	**101.5**



The senior leadership team worked closely with HR and the Communications Team to ensure a robust recruitment drive; advertising on social media as well as traditional routes such as NHS Jobs, for both registered and non-registered nurses

The “One Stop Shop” recruitment day has been embedded over 3 years and has been evaluated positively by new starters. A talent spotting adjusted recruitment pathway is in development, to enable those student nurses who demonstrate consistent exceptional practice to be identified and

successfully recruited. This will enable local Ward / Departmental Managers to offer a recruitment opportunity for final year students to their area in recognition of exceptional practice

The senior nurse leadership team, together with HR and the BAME Task Force, recognise that our nursing staff are not representative of our local population. Only 6% of student nurses who have had placement at Alder Hey in the last 5 years are from black, Asian and minority ethnic backgrounds. The nursing workforce is also predominantly female. The senior nursing leadership team, HR and Communications team have been working in partnership with the local HEI's to take positive action to increase the diversity of future student nurses and working to align recruitment strategies. This is a continued priority for 2022/23

Appendix 3.2 provides analysis of all new Band 5 nurses in 2021/22 by ward.

4.5: Workforce developments in 2021/22

i. **PICU buddies:** In response to anticipated surge of RSV patients, and due to staffing challenges related to the pandemic, the learning from the training and redeployment process established and implemented during the first wave of the pandemic was built upon and staff who volunteered to work on PICU were released from their ward or department to undertake a PICU buddy role alongside a trained critical care nurse; this was positively evaluated

ii. **E-roste**r: The Trust implemented an e-roster system with Ward Managers working with the lead to build staffing profiles for all acute nursing areas; specific principles and guidelines being devised

xvii. **Enhanced nurse leadership:** Internal promotion and external recruitment to Ward Manager, Matron and Head of Nursing roles. Secondment opportunities to these roles also supported

iii. **Professional Nurse Advocate:** Nine nurses predominantly from the Education team successfully completed the PNA training and are starting to explore the organisational implementation of this role

iv. **Senior Nurse / AHP on Site (SNOS):** Additional layer of support implemented for the Trust out of hours (weekdays 1700-2100; weekends and Bank Holidays 0800-1200) following organisational change; the role supports the wards and departments with matters such as professional issues, safe staffing, quality improvement, and supporting families who wish to raise a concern

v. **Chief Nursing Officer Safer Staffing Fellowship programme:** The Director of Nursing successfully completed the programme (Cohort 5) which aims to have a trained Fellow in each Trust. The programme aims to embed a sustainable, consistent approach to safer staffing in the NHS to plan and implement evidence-based staffing programmes for a variety of clinical specialties ensuring safer staffing skills within NHS Trusts and supporting compliance with developing workforce safeguards. The Director of Nursing has been involved in reviewing national workforce tools as a result of the programme and will lead the implementation of SNCT.

4.6: Proposed workforce developments for 2021-2025

i. **Continue implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025 with focus on:**
    a. Compliance with Regulatory guidance and safe staffing
    b. Education, Training and routes of entry
        i. HCA's
        ii. Degree entry student nurses

iii. RNDA
iv. Associate Practitioners
v. Nurse Associates

c. Education and development pathways
d. Establishment reviews and moving to a sustainable model of care
e. Ensuring every ward has a supranumery clinical co-ordinator
f. Mental health and learning disabilities
g. Extended scope and advanced practice roles
h. Equality, Diversity and Inclusion
i. Clinical Academic Careers

ii. **Reduce use of temporary staffing**

iii. **Implement Children and Young People Safer Nursing Care Tool (SNCT):** This will replace the SCAMPS acuity and dependency tool. The SNCT is an evidence-based measurement tool which facilitates comprehensive establishment reviews as part of triangulated approach

iv. **Implement review of Band 2 and Band 3 HCA roles** to ensure clinical HCA roles are Band 3

5. Workforce challenges

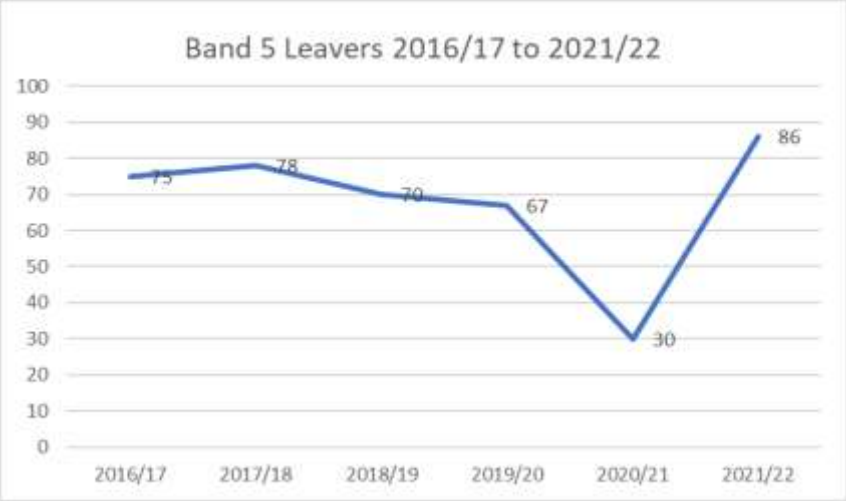
5.1: Leavers

The average leaver rate per month in 2021/22 increased significantly to 7.2 WTE per month, however this is associated with a significant reduction in the previous year of an average 2.5 WTE per month due to the pandemic. The increased number of leavers is reflective of the national picture following the Covid-19 pandemic and an increased number of staff leaving the NHS. However the number of leavers jointly during the 2-year pandemic era of 2020/21 and 2021/22 averages of 4.9 WTE per month which is comparable and lower than the average leaver rate of 5.5 to 6.5 WTE per month in the 4 years pre pandemic.

Table 2 shows the actual and average number of leavers per quarter in 2021/22, the graph below shows number of leavers for the past 6 years, and Appendix 3.1 gives a breakdown of actual and average number of leavers since 2016/17.

Table 2: Actual and average Band 5 leavers in WTE per Quarter

	Q1		Q2		Q3		Q4		Total	
Year	Actual	Mean per month	Actual	Mean per month	Actual	Mean per month	Actual	Mean per month	Total	Mean for year
2021/22	**19.4**	(6.5)	**23**	(7.7)	**18.6**	(6.2)	**25.2**	(8.4)	**86.3**	(7.2)



The number of leavers equates to a turnover of 16% compared to 4.8% in the previous year. The main reasons for leaving have been voluntary resignation and relocation, and work life balance along with retirement and retire and return, accounting for 76% of leavers. 11 staff left the organisation citing the reason for leaving as promotion suggesting that there was a lack of opportunity for progression within Alder Hey, primarily from Band 5 to Band 6. 10 front line nursing staff have retired.

As part of the nursing retention programme, based on national best evidence, Alder Hey developed a transfer window, allowing staff to move between departments as well as applying for promotion to Band 6 in any area of the Trust. This allows staff to easily transfer to learn new skills and explore areas of interest, not just in the acute environment, but also within team such as research education and community services. The transfer window was temporarily paused during the pandemic as staff were redeployed as part of the covid response to other areas such as PICU. However the process will be relaunched in July 2022 and renamed the internal transfer process. The process was previously successful, with 202 nurses transferring internally over the preceding 3 years; these staff have been effectively retained within the Trust rather than leaving to gain employment elsewhere.

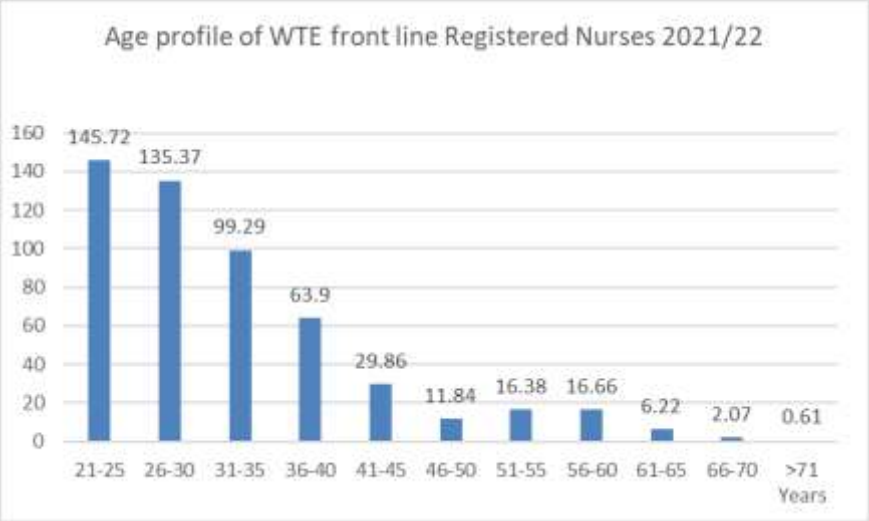
Appendix 3.2 provides analysis of Band 5 nurses who left in 2021/22 by ward.

5.2: Age profile of nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

Any registered nurse in the pre-1995 NHS pension scheme is eligible for full retirement at the age of 55 and actuarially reduced retirement from the age of 50. The nursing age profile in Table 3 and the graph below identifies 25.6 WTE front line nursing staff aged 55 and over who could retire with immediate effect. There are a further 11.8 WTE (aged 51-55) achieving retirement age in the next 5 years. Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years.

Table 3: Age profile of front line nursing staff in WTE											
Age range	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**	**>71**
WTE 2021/22	145.7	135.3	99.29	63.9	29.86	11.84	16.38	16.66	6.22	2.07	0.61



Effective succession planning is key, and there has been successful internal promotion to front line Band 6 and Band 7 nursing roles, including three Ward Manager roles (Ward 3B, Ward 3C and Ward 4C).

Analysis by ward is provided in Appendix 5

5.3: Maternity leave

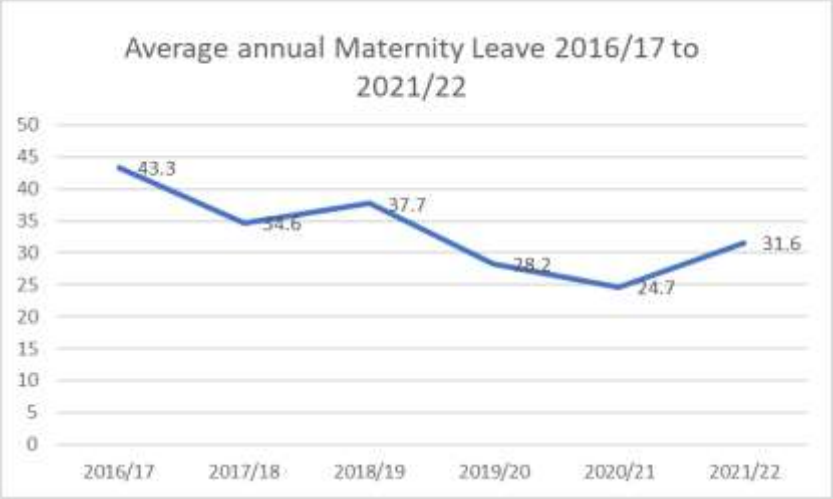
Maternity leave cover is not included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the funded "nursing pool" to 40 WTE in order to further improve resilience and optimise bed occupancy.

Table 4 shows the average maternity leave by quarter and the graph below demonstrates the average by year since 2016/17; there has been an increase compared to the previous 2 years. The frontline nursing workforce is predominantly female and the age profile demonstrates that a large number of our staff could be considered of childbearing age therefore this rate can increase as well as decrease. (The 'nursing pool' is also utilised to provide cover for long term sickness outlined in section 5.4.)

60% of maternity costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the region of £480,000 per annum. Appendix 6 provides analysis of all maternity leave in 2021/22 by ward.

Table 4: Average maternity leave in WTE

Year	Q1	Q2	Q3	Q4	Average in year
2016/17	42.6	41.6	44.3	45	43.3
2017/18	36.8	35	31	35.6	34.6
2018/19	36.4	36.6	39.6	38.4	37.7
2019/20	27	26.8	30	29	28.2
2020/21	28.7	23.3	23	24	24.7
2021/22	27.2	30.4	33.4	34.8	31.6

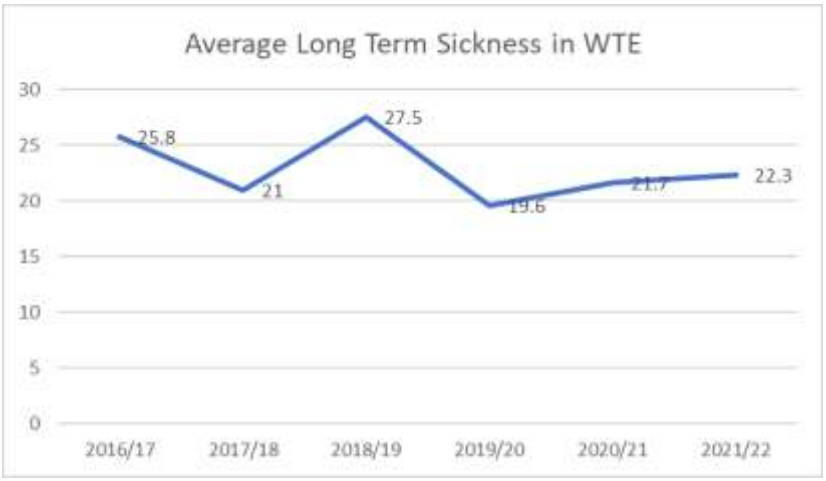


5.4: Sickness

Long term sickness (LTS) has remained high and comparable with the previous reported year. Ward Managers are supported by the HR team to ensure all staff on LTS are appropriately supported and managed.

Table 5 and the graph below demonstrate the trend in long term sickness. This supports the need for the nursing pool with 40 WTE above funded establishment due to staff availability to work

Table 5: Average LTS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	30.9	21	27	24.6	25.8
2017/18	15.7	14.7	24.4	29.4	21
2018/19	22.5	30.5	25	32	27.5
2019/20	22.2	17.2	18.5	20.5	19.6
2020/21	22.4	21.2	22.2	21	21.7
2021/22	22.3	24.0	22.4	20.7	22.3



Short term sickness increased to the highest reported level in 6 years due to the pandemic and other short term illness, with a peak in December 2021 of 45.6 WTE front line nurses off sick short

term. Sickness absence due to the Covid-19 pandemic was closely monitored by HR and Gold Command and reviewed daily at the Safer Staffing meetings and Daily Operational meetings. In addition some staff were required to isolate at times and a number of frontline nursing staff were required to shield. Shielding staff were supported to work from home as appropriate supporting services such as Track and Trace.

Ward Managers continued to work in collaboration with HR to support the physical and mental health and wellbeing of staff; it is well recognised both within the Trust and at regional and national level the impact that the pandemic has had on both the mental and physical wellbeing of staff, with staff reported to be exhausted and burnt out. The Staff Advice and Liaison Service (SALS) has been a vital support service for all staff, and Ward Managers signpost staff to SALS as well as referring to Occupational Health and the Alder Centre, in addition to staff accessing SALS support directly. A focus on encouraging staff to take a break, and supporting managers to enable breaks to be taken by staff, was undertaken including a Quality Ward Round talking to a wide range of staff groups to ascertain their views.

Table 6 and the graph below demonstrate the trend in short term sickness.

Table 6: Average STS in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average**
2016/17	20.8	12.5	14.2	10.8	14.5
2017/18	6.8	8	13	15.7	10.8
2018/19	14	15	18.9	21.7	17.4
2019/20	13.7	13	17.4	20.5	16.1
2020/21	11	24	22	17	18.5
2021/22	17.5	19.4	30.0	28.6	23.9

Staff health and wellbeing, particularly mental health, is a key priority for the senior nursing team and will continue throughout 2022/23 in close partnership working with HR and SALS

Analysis by ward is provided in Appendix 7 for long term sickness and Appendix 8 for short term sickness.

5.5: Attrition rates of recruited staff

In 2021/22 the Trust saw very low attrition rate of just 8% amongst new recruits taking up employment elsewhere. This has previously been 30-35% compared to a nationally reported figure of 50%. The reason attributed to such a low rate for 2 successive years is that the majority of new nurses from national recruitment are student nurses from the local HEI's who evaluated their experiences as ECP students during the pandemic so favourably that they all chose to come and work at Alder Hey as registered nurses. The learning therefore from the ECP students is being taken forward into practice to ensure that future student nurses upon qualification choose to work at Alder Hey; the learning is in particular respect to how the ECP students were allocated to care for patients under the supervision of a registered nurse. Furthermore the Trust has worked in partnership with the HEIs and involved student nurses in vaccination clinics; this again has been evaluated very positively by both the student nurse as they have achieved so many professional and educational objectives in a new and different way.

5.6: Increasing patient acuity

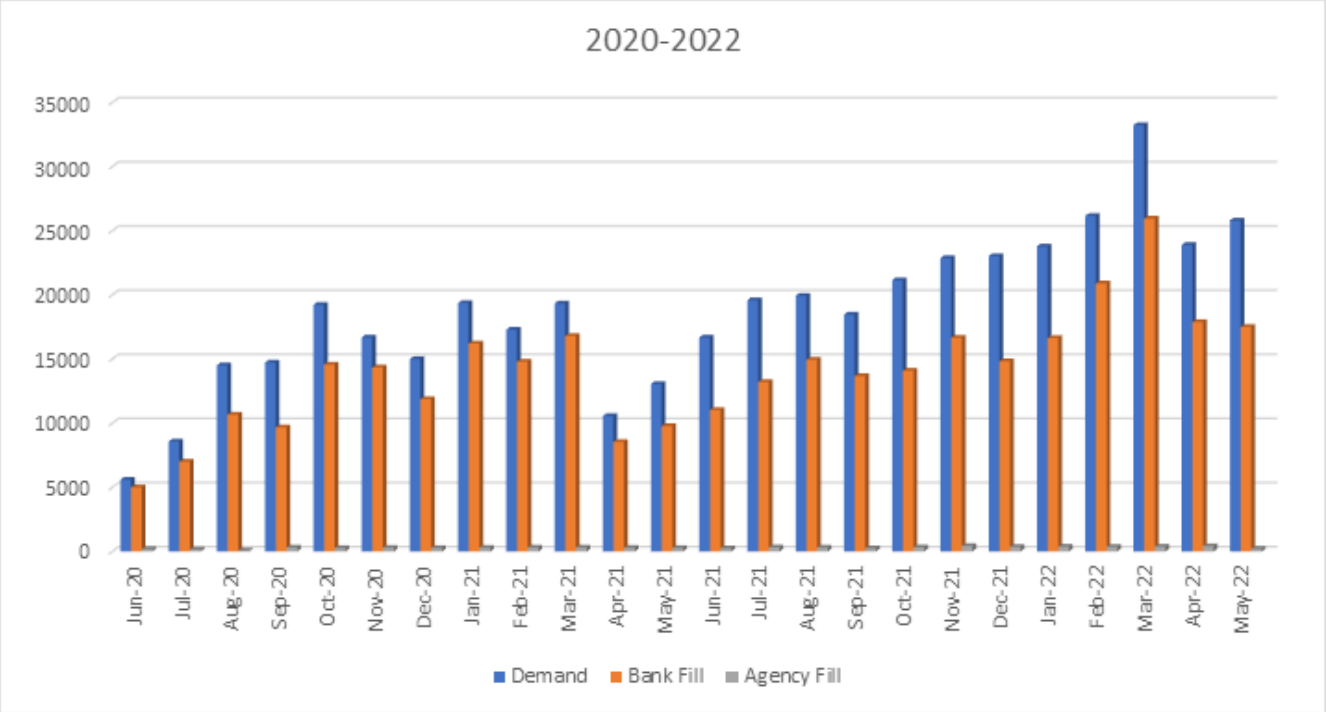
2021/22 saw an increased number of patients requiring 1:1 nurse to patient ratio of care over and above the inpatient ward usual rostered shift pattern and funded establishment (excluding PICU and HDU). The vast majority of 1:1s are on surgical wards (3A), and medical wards (3C, 4C and 4B). Wards 4B and 4C in particular saw an increase in patients requiring a HCA 1:1 due to an increase in neurology patients and an increased number of children and young people with complex and challenging behaviours. This has been a continuing trend throughout 2021/22 and has increased the HCA NHSP expenditure to provide a 1:1; this increase in acuity has been identified during establishment reviews with a recommendation that the Medical Division analyse the likelihood of this increase in patient numbers requiring a 1:1 continuing particularly on Ward 4B. Community Division have supported Ward 4C with additional temporary funding in recognition of the increase in children with challenging behaviour. The ward establishments have been profiled with an increase in HCAs to accommodate the increase and it is recommended that the HCA funded establishment is increased in these wards pending the outcome of the Medical Division analysis.

The SCAMP acuity and dependency measurement tool enables the nurse to categorise the patient against pre-determined levels and criteria which determines the level of care required. This is an evidence based tool. Professional judgement is also applied by Ward Managers indicating increasing patient acuity, together with information from Careflow, indicating where the sickest patients and highest numbers of sick and high acuity patients are being cared for outside of critical care.

The Children and Young People Safer Nursing Care Tool (CYP SNCT) will be implemented in 2022/23; the tool is similar to SCAMPS as it is evidence based however the tool is also linked to outcomes, which SCAMPS is not, therefore this will provide an enhanced measurement. A working group has been established to take forward the implementation during summer 2022.

5.7: Temporary staffing: NHSP and agency

The Chief Nurse has led a continued drive to reduce the use of bank and agency staff, however due to staffing pressures particularly linked to sickness during winter months, the requirement for NHSP has remained high in 2021/22 however there has been zero use of agency nurses as show in the graph below. Reduction of NHSP remains a priority for 2022/23 in line with the Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025.



In May 2021, the Chief Nurse led a review of NHSP payment rates, resulting in an agreed flat rate of pay competitive with other Trusts in the region, rather than pay to grade, in order to incentivise temporary staffing and increase the fill rate; this was undertaken following a comprehensive benchmarking exercise across the region to ensure parity and competitive.

In October 2021, a winter incentive was also applied to the flat rate to increase the fill rate during the winter months when staffing was under increased pressure. The winter incentive ended in March 2022 apart from allocation shifts to the "virtual ward" – meaning staff booked onto that shift can be allocated anywhere within the Trust. There will be a review of the winter incentive for winter 2022/23.

The Chief Nurse set out clear guidance for Ward Managers on the use of NHSP including that staff who have been off sick cannot work an NHSP shift for 2 weeks following their return to work from sickness; this is to support the health and wellbeing of all staff.

5.8: Winter pressures / increased staffing demand

A paper published by NHSE/I in November 2021 (Winter 2021 preparedness: Nursing and Midwifery Safer Staffing), set out actions that Trusts must focus on, to ensure effective decision making and escalation processes to support safer nursing for the winter period. This built on previous national guidance, the core fundamental principles of safe staffing, and Executive Nurse responsibilities. Trust Board received a report in December 2021 providing assurance that plans were in place to ensure safe nurse staffing over the winter period and that plans were connected to the wider system staffing planning, resourcing and mutual aid. The report included a completed Assurance Framework against the four domains below set out by NHSE/I and identified where any improvement in systems can be made to further enhance safety and assurance:

1. Staffing Escalation / Surge and Super Surge Plans
2. Operational Delivery
3. Daily Governance via EPRR route (when / if required)
4. Board oversight and assurance (BAU structures)

The Assurance Framework demonstrated the policies, procedures, plans and strategies in place to support safe staffing over the winter period, including a revised model of nursing (Green, Amber and

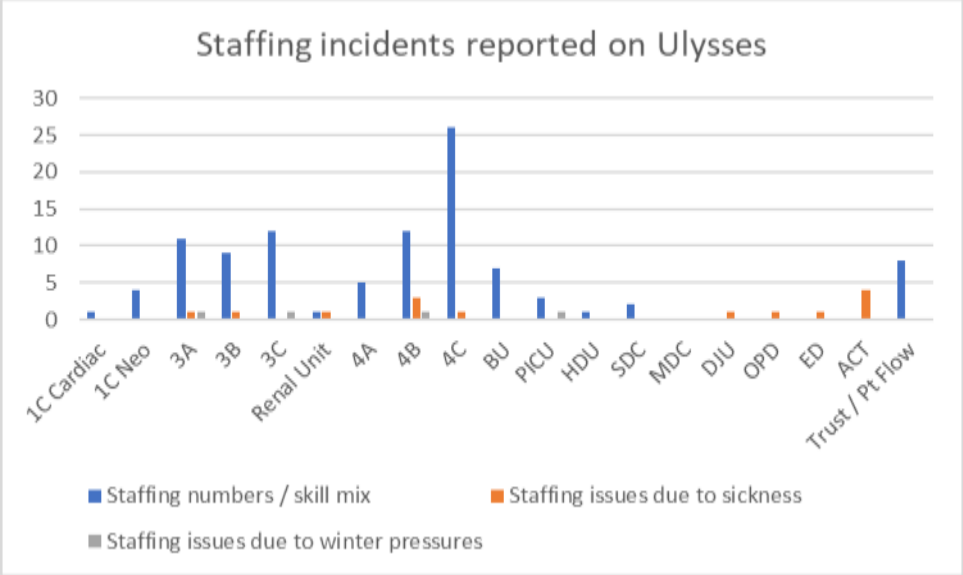
Red staffing levels), a clear nurse staffing escalation process, and a clear strategy to provide safe staffing in critical care particularly at times of increased pressure and / or surge in line with national guidance, particularly RSV preparedness, Of note, the Alder Hey model was reviewed, supported and approved by the Cheshire and Mersey Paediatric Network. The Assurance Framework demonstrated the collaborative multi-disciplinary approach to safe staffing including senior nurse leaders, Human Resources, senior managers and operational teams, Finance, and a wide variety of staff support services.

Actions identified in the assurance framework are incorporated in the Alder Hey Nursing and Health Care Support Worker Workforce Plan 2021-2025 and monitored at the Workforce meeting Chaired by the Chief Nurse.

5.9: Staffing risks and incidents reported

There were a total of 120 staffing related incidents and near misses reported in 2021/22. Where staffing related incidents were a theme within a week, this was reported to and discussed at the weekly Patient Safety Meeting. Staff are actively encouraged to report incidents, concerns and near misses via the Ulysses Incident reporting system and a high level of reporting is a positive indicator of a Trust with an open, transparent and learning culture.

The main reported themes relate to staffing issues due to staff shortages and concerns regarding skill mix as shown in the graph below.



The incidents were primarily reported by the Medical Division (73/120) accounting for 61% of all nurse staffing incidents reported. The main department reporting concerns was Ward 4C with 27 incidents and issues reported. There is a risk on the Risk Register for Ward 4C (risk reference 874: current risk score 6) with controls and ongoing actions identified. Controls include daily staffing monitoring in place, E-roster system implemented on Ward 4C, and a rolling recruitment programme. The establishment review led by the Director of Nursing has identified a gap in the funded establishment of registered nurses as the current establishment does not meet national fundamental standards (RCN, 2013) as there is not sufficient establishment for a supranumery clinical co-ordinator as well as maintaining recommended nurse to patient ratios.

In 2022/23 the senior nursing team will be undertaking specific work with teams in regards to skill mix as it is recognised that this concern is frequently raised without always recognising and valuing the contribution of all staff; referring to staff as “newly qualified” for protracted periods of time.

Examples of action taken to address and reduce staffing incidents are as follows:

- The Safer Staffing Huddle has been embedded to ensure a clear and agreed daily staffing plan each day; appropriate redeployment of staff from other areas following assessment and review
- Use of temporary staffing
- Weekly staffing overview meeting overseen by Associate Chief Nurse
- Weekly forward look of TCIs to plan staffing requirement
- Clinical Educator working alongside new nurses and student nurses
- Recruitment strategy
- Retention strategy in collaboration with HR
- Education strategy for nursing staff including induction, preceptorship, clinical supervision, CPD. Clinical Educator on ward
- Identification of gaps in funded establishment through annual reviews (Ward 3A, Ward 3C and Ward 4C)

There are currently 7 open risks on the Risk Register relating to staffing with risk scores in the main ranging from 6 to 9 and one risk scored at 16 relating to Ward 1C Neonatal Service. All have appropriate control measures and associated actions. 4 staffing risks were closed on the Risk Register in 2021/22.

5.10 Ockenden report: Workforce planning and sustainability, and safe staffing

In March 2022, the Department of Health and Social Care published the Ockenden report; the outcome of an independent review of the maternity services provided by another Trust.

NHSE/I have set out that in reviewing the report, Trust Boards must take action to mitigate any risks identified and develop robust plans against areas where services need to make changes, paying particular attention to the report's four key pillars.

Two of the four key pillars directly related to the front line nursing workforce are:

1. Safe staffing levels
2. A well-trained workforce

It was reported that the Labour ward had insufficient staffing and did not have supranumery shift co-ordinators, and daily staffing levels did not meet national guidance. Funded establishments did not meet national guidance and not all workforce training requirements were met.

The report includes recommendations and action regarding safe staffing, workforce planning and training that must be considered by Alder Hey:

- Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.

- Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and (maternity) leave.

- All trusts must implement a robust preceptorship programme for newly qualified (midwives) (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.

- All trusts to ensure newly appointed (labour) ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development

- When agreed staffing levels across (maternity) services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS.

- All trusts must ensure the (labour) ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.

- All trusts must ensure there are visible, supernumerary clinical skills facilitators to support (midwives) in clinical practice across all settings.

- Newly appointed Band 7/8 (midwives) must be allocated a named and experienced mentor to support their transition into leadership and management roles.

The Trust has devised a comprehensive action plan to address the recommendations that directly and indirectly apply to Alder Hey; it is recommended that the completion of the action plan is monitored on a quarterly basis at SQAC.

Of particular importance is that Alder Hey must urgently address deficits in the funded establishments through business planning to ensure that all wards have a funded supranumery clinical co-ordinator (Ward 3A, Ward 3C and Ward 4C).

Furthermore, the Trust must review the funded uplift as outlined in section 4.3.1. Recommendations and actions are referred to further in section 6 of this report.

6. Recommendations

A firm foundation has been built to support ongoing workforce management and further development. The senior nursing team will continue to implement the Trust Nursing and Health Care Support Worker Workforce Plan 2021-2025. In addition, the team will continue to respond to the national picture, including emerging risks, national and local developments and changes, and identify opportunities to transform and enable effective new ways of working. The team will take responsibility and accountability for completing actions allocated in the Trust Ockenden report action plan.

The Trust Board of Directors are asked to support the following recommendations for further development:

a) Support the implementation of actions identified in the Trust Ockenden action plan

b) Support the urgent addressing of deficits in the funded establishments through business planning, to ensure that all wards have a funded supranumery clinical co-ordinator (Ward 3A, Ward 3C and Ward 4C)

c) Support the review of the funded uplift

d) Support either the increase in funded establishment for HCA's on Ward 3C, Ward 4B and Ward 4C to provide 1:1 care for the increased number of patients, or the creation of a HCA "pool" to deploy HCA's to provide 1:1's where required pending the outcome of the Medical Division analysis of future demand and acuity. This will also reduce HCA NHSP temporary spend

e) The ward establishments have been profiled with an increase in HCAs to accommodate the increase and it is recommended that the HCA funded establishment is increased in these wards pending the outcome of the Medical Division analysis.

f) Implement planned developments, recruitment strategies, workforce reviews, and educational strategies in line with the Nursing and Health Care Support Worker Workforce Plan 2021-2025

g) Support the improvements and developments as detailed in section 4.6.

h) Continue to monitor and evaluate staffing levels and review safety and effectiveness

i) Continue to work in partnership with HEI's in the evaluation and further development of new nursing and support roles including through the apprenticeship route.

j) Continue to work with HEI's to promote nursing as a career choice with people from all backgrounds and ethnic groups.

k) Continue recruitment activities to ensure low levels of nursing vacancies.

7. Conclusion

Trust Board are asked to approve the content of this report and support the recommendations and proposed developments outlined in section 6 of this report.

Appendix 1: Staffing availability report 2021/22

Ward Safer Staffing 2021/22	Day registered	Day HCA	Night registered	Night HCA	Overall staffing
April	99%	92%	99%	96%	98%
May	101%	90%	100%	92%	99%
June	101%	84%	100%	86%	98%
July	91%	84%	90%	87%	90%
August	92%	90%	91%	99%	92%
September	93%	94%	94%	107%	95%
October	92%	94%	92%	86%	92%
November	88%	89%	86%	91%	88%
December	86%	81%	85%	80%	85%
January	83%	72%	81%	75%	81%
February	86%	77%	85%	73%	83%
March	98%	83%	98%	91%	97%

Appendix 2: Compliance with RCN core standards and specific standards 2021/22

A2.1: RCN compliance by ward / department 2021/22

Standard	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sec 5	Sec 6	Sec 7	Sec 8
1C Card																				
1C Neo																				
3A																				
3B																				
3C																				
4A																				
4B																				
4C																				
PICU																				
HDU																				
Burns																				
EDU																				
MDC																				
SDC/ SAL																				
Renal																				
Trust RAG rating	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=	=

Key

Green:	Compliant	**↑:**	Improved position compared to 2020/21
Amber:	Partial compliance	**↓:**	Deteriorating position compared to 2020/21
Red:	Non compliant	**=:**	Static position compared to 2020/21
Blue:	Trust agreed workforce requirement		
Grey:	Not applicable		

A2.2: Compliance with RCN core standards

Table 7 provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to improve compliance:

Table 7: Core standards to be applied in services providing health care for children and young people		
Standard		**Compliance**
1	The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff	**Partial**
	10 out of 15 areas have a supranumery clinical co-ordinator. Gaps exist on Wards 3A, 3C, and 4C. All Ward Managers are supernumery; all wards benefit from presence of a supernumery Matron; and all wards benefit from the support of a Clinical Educator. Several wards have implemented a Deputy Ward Manager role to support from within existing Band 6 funded establishment. All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward. Review of this standard is a key component within the establishment reviews; Alder Hey must urgently address deficits in the funded establishments through business planning to ensure that all wards have a funded supranumery clinical co-ordinator (Ward 3A, Ward 3C and Ward 4C).	
2	Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff	**Compliant**
	Fully compliant	
3	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need	**Compliant**
	100% compliance with the Trust resuscitation policy for areas identified to have APLS or PLS trained staff on each shift	
4	There will be a minimum of 70:30 per cent registered to unregistered staff	**Compliant**
	Fully compliant. Where a ward looks to have high HCA ratio (for example Ward 4B), this is a deliberate workforce configuration to provide HCA 1:1 patient care and the required number of registered nurses are in place in line with RCN specific standards	
5	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave	**Compliant - review**
	The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce. In addition, 6 WTE nurse Clinical Educator's in post. This standard will be reviewed in line with the Trust Ockenden report action plan	
6	There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas	**Compliant**
	Fully compliant	
7	Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles	**Compliant**
	Fully compliant	
8	Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's	**Compliant**

	oncology, children's neurosurgery	
	Fully compliant. Specialist wards have locally or regionally delivered programmes to support staff development and expertise in their field as identified in their local Training Needs Analysis	
9	Support roles should be used to ensure that registered nurses are used effectively. Support roles are defined in the standards as a minimum of the following:	**Compliant**
	Supernumery Ward Manager: Fully compliant	
	Ward receptionist / ward clerk / admin support for ward staff: Fully compliant	
	Play Specialist: Fully compliant apart from PICU however they can make a referral to the Play Specialists as required which will then be reviewed and actioned appropriately.	
	Housekeeper: Fully compliant. Burns Unit access PICU / HDU housekeeper	
10	Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks	**Compliant**
	Successful bid awarded from NHSE/I to support national strategy for zero Health Care Assistant (HCA) vacancies. Funding being used to deliver the HCA Care Certificate and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is a HCA vacancy. All new Health Care Assistants signed up to NHSP undertake Advanced Clinical Skills training. All HCA's on wards have assessment of competency in assigned skills.	
11	The number of students on a shift should not exceed that agreed with the university for individual clinical areas	**Compliant**
	Fully compliant	
12	Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels	**Compliant**
	SCAMPS tool in place; plan to implement Shelford SNCT tool and MHOST tool (Tier 4) in 2022/23	
13	Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.	**Compliant**
	Ward Managers / Senior Nurses attend daily Safer Staffing Huddle to inform of ward level patient acuity and requirement for additional staff; staffing plan is agreed, implemented and reported into the Bed Meeting. Tendable (Perfect Ward) audits, Infection Control audits and covid audits, and Ward Accreditation ratings reviewed at establishment reviews. Challenge boards monitored for each ward within Divisions and assurance regarding key performance indicators reported to CQSG, SQAC and executive performance reviews	
14	Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered children's nursing qualification	**Compliant**
	The Trust is fully compliant with this standard with a Band 8a nurse on duty 24/7. Review of the ACT team undertaken from March 2022; review of requirement for a Senior Nurse / AHP on Site (SNOS) commenced in February 2022	
15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences	**Compliant**

	for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day	
	Fully compliant. Nursing and Medical staff on call	
16	Children, young people and young adults must receive age appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs	**Compliant**
	Appropriately trained workforce and specially designed Children's Hospital	

A2.3: Compliance with RCN specific standards

Table 8 provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to mitigate and improve compliance:

Table 8: Staffing principles within "Defining staffing levels for children and young people's services"		
Section		**Compliance**
Section 5: Neonatal services	Bedside, deliverable hands-on care: Special care 1:4 nurse: infant High dependency care 1:2 nurse: infant Intensive care 1:1 nurse: infant	**Compliant**
	Fully compliant. Neonates requiring intensive care are nursed on PICU, surgical and cardiac neonates requiring high dependency care are nursed on Ward 1C. Neonates on other wards are nursed 1:3 in line with standards in Section 7 below. The Trust is part of a single neonatal service with LWH. Rotation of ANPs and nursing staff in place and a new Ward Manager, Matron and Head of Nursing has joined the team from LWH. Additional funding awarded to achieve BAPM standards	
Section 6: Designated children's intensive care and children's high dependency services	PICU 6.7-7.06 WTE per bed dependent upon maternity leave included in calculation Bedside, deliverable hands-on care: Level 1: HDU 1:2 nurse: child Level 2: PICU or HDU cubicle patient: 1:1 nurse: child Level 3: PICU: 1:1.5 nurse: patient Level 4: 2:1 PICU: nurse: patient (ECMO)	**Compliant**
	Current ratio now at 6.6 WTE per PICU bed. HDU compliant with 4.4 WTE per bed. Full nursing ECMO team established in PICU. All patients are nursed as per ratios set above unless not required for example a patient who is being transferred from PICU to a ward. HDU care provided on general HDU, Ward 4A and Ward 1C Cardiac all provide 1:2 care PICU cared for adult patients during both wave 1 and wave 2 of the covid-19 pandemic supported by staff redeployed from other areas of the Trust following a training programme	
Section 7: General children's wards	Bedside, deliverable hands-on care: Children < 2 years of age 1:3 registered nurse: child, day and night Children > 2 years of age 1:4 registered nurse: child, day and night	**Partial**
	12 out of 15 areas fully compliant: All wards compliant except Wards 3B, 4C and EDU on night duty however additional temporary staff are sourced where acuity is high and necessitates the need to increase the night nurse to patient ratio. Staffing levels and patient	

	acuity are monitored and appropriate action taken to ensure safe staffing at the daily Safer Staffing Huddle. This staffing plan continues to be monitored and evaluated and all wards have annual establishment review undertaken as per best practice guidelines.	
Section 8: Specialist children's wards	At least a third of patients on specialist wards (such as oncology, cardiac, neurosurgery) should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent. The relevant standards must be followed (1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child	**Partial**
	6 out of 9 areas fully complaint; there is a case to say that almost all of the in-patient wards at Alder Hey are specialist in nature. Wards with dedicated HDU beds (Ward 1C and Ward 4A) are established for 1:2 ratio for commissioned HDU beds, and in addition Ward 4A provides 1:2 ratio for orthopaedic patients requiring a higher intensity of care. Ward 3C, Ward 4B and Ward 4C regularly have high acuity patients requiring a HCA 1:1 and this is supported and facilitated through temporary staffing as required; action in 2022/23 to review continued high acuity and either increase HCA funded establishment or create a HCA "pool". Wards are not established for 1:3 ratio for remainder of patients. Achieving compliance with this standard would require significant additional financial investment. However staffing levels and patient acuity are monitored and appropriate action taken to ensure safe staffing at the daily Safer Staffing Huddle. Amber and Red models invoked in line with escalation process	

Appendix 3: Band 5 Starters

A3.1: Band 5 nurses recruited 2016/17 to 2021/22

Front line registered nurses recruited in WTE												
Q1 2016/17			Q2 2016/17			Q3 2016/17			Q4 2016/17			Total
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	25	5.8	6		65.6		2		5.45	12.22	2.8	124.87

Q1 2017/18			Q2 2017/18			Q3 2017/18			Q4 2017/18			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
2	22.35	2.61	2.51	1	49.67	10.15	3.92	0	5.96	3.46	1	104.63

Q1 2018/19			Q2 2018/19			Q3 2018/19			Q4 2018/19			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
4	26.21	3	1.22	0.76	4	48.53	2.22	0	1.31	0	1.39	92.64

Q1 2019/20			Q2 2019/20			Q3 2019/20			Q4 2019/20			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
0.92	16.9	5.41	1.61	1	2	34.75	1.5	0.43	6.5	3.51	26	100.53

Q1 2020/21			Q2 2020/21			Q3 2020/21			Q4 2020/21			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
20.52	0	0	0	0	19.72	52.26	3	0	11	10.92	4.52	121.94

Q1 2021/22			Q2 2021/22			Q3 2021/22			Q4 2021/22			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
5	2.23	1	0	2	15.15	36.76	12	22	1.76	0	3.61	101.5

A3.2: New Band 5 staff commenced in post in 2021/22 by ward / department

Starters WTE 2021/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac	1					1		1	3				
1C Neo		1.23							3				
3A	1					1	4.92	1					
3B							4						
3C						5.61		3	1			1.61	
4A						3	2		3	1			
4B	2					0.92	4	2					
4C		1				1.61	3	3					
BU							0.92		2				
PICU						2						2	
HDU							1						
SDC							1						
MDC	1						6			0.76			
DJU					1		8.92	2					
OPD					1								
ED			1				1		10				
Total	**5**	**2.23**	**1**	**0**	**2**	**15.15**	**36.76**	**12**	**22**	**1.76**	**0**	**3.61**	**101.51**
Quarter total	**Q1: 8.23**			**Q2: 17.15**			**Q3: 70.76**			**Q4: 5.37**			

Appendix 4: Band 5 leavers

A4.1: Band 5 leavers 2016/17 to 2021/22

Actual and average Band 5 leavers in WTE per Quarter										
	Q1		Q2		Q3		Q4		Total	
Year	Actual	Mean per month	Actual	Mean per month	Actual	Mean per month	Actual	Mean per month	Total	Mean for year
2016/17	**20.6**	(6.8)	**12.3**	(4.1)	**22.5**	(7.5)	**19.2**	(6.6)	**75.4**	(6.2)
2017/18	**20.5**	(6.8)	**14.5**	(4.8)	**24.7**	(8.2)	**18**	(6)	**78.4**	(6.5)
2018/19	**10.9**	(3.6)	**21**	(7)	**15**	(5)	**22.4**	(7.4)	**69.4**	(5.7)
2019/20	**15.7**	(5.2)	**13.9**	(4.6)	**15.6**	(5.2)	**21.9**	(7.3)	**67.2**	(5.6)
2020/21	**5**	(1.6)	**4**	(1.3)	**14.6**	(4.8)	**6.4**	(2.1)	**30**	(2.5)
2021/22	**19.4**	(6.5)	**23**	(7.7)	**18.6**	(6.2)	**25.2**	(8.4)	**86.3**	(7.2)

A4.2: Band 5 leavers in 2021/22 by ward / department

Leavers WTE 2021/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac					1.23		1		1.61	1			**4.84**
1C Neo													**0**
3A	0.39	0.61			1		0.46		0.35		1.69		**4.5**
3B								0.61		2			**2.61**
3C	0.61	0.61	2		2.15	1					0.8		**7.17**
4A		2.23		3	0.92	0.92	1	1.59		1.92			**11.58**
4B	1					1		1		0.92	0.61		**4.53**
4C			1		0.92		1.92	0.61	1	1	1.61	1	**9.06**
BU								0.61					**0.61**
PICU	0.92	3.69	1.53	1		2	0.61		1	3.53	1	1.27	**16.55**
HDU	0.92		1.92		2.92	1		1.69		2.92	0.61		**11.98**
SDC						1							**1**
MDC						1							**1**
DJU			2		1						1		**4**
OPD								1					**1**
ED						1		1.65	0.87	2		0.33	**5.85**
Total	**3.84**	**7.14**	**8.45**	**4**	**10.14**	**8.92**	**4.99**	**8.76**	**4.83**	**15.29**	**7.32**	**2.6**	**86.28**
Quarter total	**Q1: 19.43**			**Q2: 23.06**			**Q3: 18.58**			**Q4: 25.21**			**av WTE 7.19**

Appendix 5: Age profile of ward / departmental registered nursing staff in 2021/22

Age profile 21/22	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>71 Years
1C Cardiac	14.84	15.53	8.25	6.15	1.69		1	0.92	0.77		
1C Neo	5	1.61	2	0.69	0.61		1.92		1	0.61	0.61
3A	13.84	5.84	10.05	7.37	3.99	0.92	1.53	0.61			
3B	6	2.84	13.11	3.53	1.52	0.61		0.75	0.92		
3C	11.92	12.45	4.19	2.53	4.37		3.11	2.23	0.61	0.92	
4A	17.76	10.36	9.15	8.37	1	0.92	1.38				
4B	13.92	7.22	6.62	1.84	1.61	0.92	1	0.61			
4C	11	12.3	8.14	8.07	2.45			0.69	0.31		
BU	3.92	0.92	1.92	4.6	1			1			
PICU	20.92	29.24	14.91	5.73	4.61	3.92	3.32	4.3	0.43		
HDU	15.8	16.5	11.59	3.91	1.84	0.87				0.53	
SDC	1	1.76		4.03	1	3.68	1	0.81	1		
MDU		1	1.76	0.76			0.51	0.76			
DJU	2	1	1	1.6	1.6				0.43		
OPD		2	1	0.6	1.56		0.8	1.71	0.76		
ED / EDU	7.8	14.79	5.6	4.11	1		0.8	2.27			
Total	**145.72**	**135.37**	**99.29**	**63.9**	**29.86**	**11.84**	**16.38**	**16.66**	**6.22**	**2.07**	**0.61**

Appendix 6: Band 5 maternity leave in 2021/22 by ward / department

ML 2021/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	1.8	1.8	2.72	3.64	3.64	4.56	5.56	5.56	5.56	5.56	5.56	4.56	4.2
1C Neo	1	1	1	1	1	1	1	1	1	1	0	0	1
3A	3.38	3.38	2.38	3.3	3.3	2.61	1.69	1.69	1.69	2.61	3.53	3.53	2.7
3B	0.61	2	2	2	2	2	2	2.92	2	3.92	2.92	1.92	2.1
3C	0.8	1.11	2.03	2.03	1.23	1.23	1.23	1.23	1.23	3.23	4.92	4	2
4A	2.92	2.92	2.92	1.92	1.92	1.92	1.92	1	1	1	1	1	1.8
4B	3	3	2.92	2.92	2.92	2.92	3.61	4.32	3.61	2.32	2.32	2.32	3
4C	2.07	2.69	2.69	2.69	2.69	2.69	2.69	3.69	2.69	2.92	1	1	2.4
BU	0	0	0.92	0.92	0.92	0.92	0.92	0.92	0.92	0	0	0	0.5
PICU	1	1	2	2	5.92	5.92	5.92	6.84	5.92	8.61	9.22	9.83	5.3
HDU	3.92	3.92	2	2	2	2	2	1	2	0.92	0.92	0.92	2
SDC	0.76	0.76	0.76	0.76	0	0	0	0	0	0	0	0	0.25
MDC	0	0	1	1	1	1	1.76	1.76	1.76	1.76	1.76	0.76	1.1
DJU	1	1	1	1	0	0	0	0	0	0	0	0	0.3
OPD	0	0	0	0	0	0	0	0	0	0	0	0	0
ED / EDU	2.99	3.91	2.91	2.91	1.92	1.92	2.92	2.92	2.92	1.92	2.79	2.79	2.7
Total	**25.25**	**28.49**	**29.25**	**30.09**	**30.46**	**30.69**	**33.22**	**34.85**	**32.3**	**35.77**	**35.94**	**32.63**	
Q average	**Q1: 27.7**			**Q2: 30.4**			**Q3: 33.4**			**Q4: 34.8**			**21/22: av 31.6WTE**

Appendix 7: Band 5 long term sickness in 2021/22 by ward / department

LTS 21/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	2.38	0.94	0.88	1.16	1.04	0.26	0.26	0.27	2.07	0	0	0	0.8
1C Neo	0.53	0.81	1	1.34	2.34	2.77	2.4	2.48	1.98	1.22	0.5	0.38	1.5
3A	1.22	0.7	1.38	1.47	1.23	0.43	1.14	1.18	1.62	1.34	1.04	0.38	1.1
3B	1.03	3.06	2.08	1.47	1.67	1	1	1.03	3.38	1.87	1.05	0.52	1.6
3C	2.22	2.46	2.49	2.25	2	1.53	0	0	0.99	0.95	2	1.65	1.5
4A	2.04	2.75	1.73	2	2.6	0.85	0.85	0.87	3.92	2.24	0.99	0.85	1.8
4B	0.63	1.56	0.59	0.76	1.56	0.38	0.38	0.39	4.61	2.89	1.65	3.47	1.6
4C	2.17	1.59	0.85	3.15	1.85	2.92	3.97	4.1	3.09	2.8	2.37	0.18	2.4
BU	0	0.66	0.74	0.38	0.38	1.38	0.32	0.33	0.12	0.22	0	0	0.4
PICU	2.33	4.01	3.27	2.02	2.27	3	2.4	2.48	2.06	2.55	1.1	0.91	2.4
HDU	1.69	2.35	4.7	4.66	4.37	2.76	1.51	1.56	2.73	3.05	5.01	4.75	3.3
SDC	0.17	0	1	1	1.37	0.36	1	0	0.54	0.58	0.58	0.58	0.6
MDC	0	0	0	0	0	0	0	0	0	0.58	0.58	0.58	0.1
DJU	0.53	1	0.7	0	0.77	0.75	0	0	0	0	0	0	0.3
OPD	0	0	0	1	0.87	0	1.01	1.05	1.36	1.36	2.36	1.08	0.8
ED / EDU	2.88	2.76	0.92	1.89	2.2	2.48	1.23	1.28	4.28	1.96	1.05	2.98	2.2
Total	**19.82**	**24.65**	**22.33**	**24.55**	**26.52**	**20.87**	**17.47**	**17.02**	**32.75**	**23.61**	**20.28**	**18.31**	
Q average	**Q1: 22.3**			**Q2: 24**			**Q3: 22.4**			**Q4: 20.7**			**21/22: 22.3**

Appendix 8: Band 5 short term sickness in 2021/22 by ward / department

STS 21/22	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	0.3	1.04	1.63	1.77	1.75	2.18	1.33	1.37	3.26	3.96	1.31	2.19	1.8
1C Neo	0.13	0.27	0.5	0.77	0.93	0.2	0.35	0.37	1.08	0.58	1.02	0.42	0.5
3A	0	1.01	0.11	1.33	0.62	1.47	0.93	0.96	3.56	4.37	1.27	1.97	1.5
3B	1.22	0.5	2.14	0.51	1.82	1.57	2.6	2.69	2.81	3.9	1.86	1.96	2
3C	0.4	1.03	1.4	0.87	1.2	1.37	1.62	1.68	2.73	3.78	1.23	2.49	1.6
4A	1.3	1.99	1.92	3.3	1.55	1.94	1.85	1.91	2.96	2.42	1.51	1.57	2
4B	0.8	1.22	0.79	1.69	1.16	1.54	1.89	1.95	4.61	0.98	0.17	2.6	1.6
4C	1.04	0.22	2.56	0.81	1.2	1.89	1.2	1.24	2.92	2.46	1.72	1.69	1.6
BU	0.24	0.26	0	0.53	0.45	0.21	0.03	0.03	0.23	0.27	0.49	0.33	0.3
PICU	2.5	3.9	2.82	3.39	1.32	3.07	3.86	3.99	7.68	6.14	6.08	3.67	4
HDU	1.95	3.96	4.18	3.06	3	2.33	4.11	4.25	7.87	5.49	4.77	4.66	4.1
SDC	0.5	0.46	0.31	0	0	0.6	0.52	0.53	0.75	0	0	0	0.3
MDC	0.1	0.04	0.4	0.02	0	0.12	0.06	0.06	0.35	0.13	0.14	0.07	
DJU	0.04	0.03	0.7	0	0	0	0	0	0	0	0	0	0
OPD	0.1	0.25	1.05	0.39	1.03	1.2	0.56	0.58	0.37	0.65	0.08	0.36	0.5
ED / EDU	0.67	1.42	3.07	1.02	1.84	1.03	0.98	1.01	4.46	2.8	1.16	1.96	1.8
Total	**11.29**	**17.6**	**23.58**	**19.46**	**17.87**	**20.72**	**21.89**	**22.62**	**45.64**	**37.93**	**22.81**	**25.94**	
Q average	**Q1: 17.5**			**Q2: 19.4**			**Q3: 30**			**Q4: 28.9**			**21/22: 23.9**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

Paper Title:	**Ockenden Report Action Plan 2022**
Report of:	**Chief Nurse**
Paper Prepared by:	Pa ine ro n ire tor o rsin

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

Alder Hey Children's NHS Foundation Trust

Ockenden report Action Plan: May 2022

BRAG Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

Directly / Indirectly applicable key:	
Directly (D)	
Indirectly (I)	

Overarching action plan owner
Pauline Brown Director of Nursing
Overarching monitoring Committee
SQAC

Ockenden essential action	D / I	Ockenden "musts"	Alder Hey action and LNP action	AH or LNP	Workstream	Operational Lead	Exec Lead	Monitoring Committee	Progress and evidence	Target completion date	BRAG
1: WORKFORCE PLANNING AND SUSTAINABILITY											
Financing a safe (maternity) workforce: The recommendations from the Health and Social Care Committee Report: The safety of (maternity) services in England must be implemented	**2**	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	National safe staffing levels should be implemented across the entire trust	AH	Workforce	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	PAWC	Annual establishment reviews commenced: Ward 3A, 3C and 4C not compliant with RCN standards as not currently funded for a supranumery shift co-ordinator	31st August 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Ward 1C Neonatal Unit establishment review to be undertaken however LNP have reviewed and liaising with NHSE/I. BAPM standards applicable	31st August 2022	
	3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and (maternity) leave.	A review of the staffing uplift should be undertaken	AH	Workforce	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	PAWC	Uplift reviewed and in line with national guidance at 23% - NQB recommends 21-25% uplift Staffing metrics reported for past 3 years to Trust Board	In place May 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating	LNP Board	As above; this is within the calculations used for BAPM standards; 23% uplift in Ward 1C Neonatal Unit	In place May 2022	

							Officer LWH				
Training: We state that the Health and Social Care Select Committee view that a proportion of (maternity) budgets must be ring-fenced for training in every ((maternity)) unit should be implemented.	**5**	All trusts must implement a robust preceptorship programme for newly qualified (midwives) (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this.	A review of the preceptorship program for newly qualified nurses should be undertaken	AH	Workforce	Phil O'Connor Deputy Director of Nursing	Nathan Askew Chief Nurse	SQAC	All newly qualified nurses undertake an organisational induction and preceptorship. This includes 1 week face to face teaching and then 3 weeks supervisory working in their allocated area. They then utilise the organisational preceptorship framework to structure and guide their development for the next 6 months. Those commencing within our neonatal ward have a bespoke programme to ensure they are able to access the associated training provided by LWH however will still utilise the organisational preceptorship to guide their development.	In place at May 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above; preceptorship programme in place, all new nurses receive supernumerary period and also complete the NWNODN introduction to Neonatal Care Programme	In place at May 2022	
	7	All trusts to ensure newly appointed (labour) ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development	A review of the coordinator role should be undertaken an appropriate training and resources put into place	AH	Workforce	Phil O'Connor Deputy Director of Nursing	Nathan Askew Chief Nurse	SQAC	Standard Operating Procedure for Nurse in Charge implemented Trust wide in March 2022 Training needs to be identified, training needs analysis to be devised, and staff to be identified by the Ward Manager and through individual annual PDR	31st October 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Standard Operating Procedure for Nurse in Charge implemented Trust wide in March 2022 Training needs to be identified, training needs analysis to be devised, and staff to be identified by the Ward 1C Neonatal Unit Ward Manager and through individual annual PDR	31st October 2022	
2. SAFE STAFFING											
All trusts must maintain a clear escalation and mitigation policy where (maternity) staffing falls below the minimum staffing levels for all health professionals.	**11**	When agreed staffing levels across (maternity) services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and	There should be a review of the staff staffing escalation process to ensure that there is executive oversight	AH	Workforce	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	SQAC	Standard Operating Procedure for Nurse Staffing Escalation in place incorporating Ward and Departmental Optimal and Minimum Staffing Levels Daily Safer Staffing meetings Chaired by a senior nurse	In place May 2022	

		LMS.	of any deficiency						Escalation in line with the SOP		
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above and there is an escalation plan in place for the care of Neonates in AH, this need to be ratified at senior level.	31st August 2022	
	13	All trusts must ensure the (labour) ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	There should be a review of the coordinator role description	AH	Workforce	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	PAWC	Review Job Descriptions to ensure they clearly incorporate the requirement to undertake the role of Nurse in Charge / Shift Co-ordinator	31st October 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Review Job Descriptions to ensure they clearly incorporate the requirement to undertake the role of Nurse in Charge / Shift Co-ordinator	31st October 2022	
	17	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support (midwives) in clinical practice across all settings.	The trust should review the current model of clinical education	AH	Workforce	Phil O'Connor Deputy Director of Nursing	Nathan Askew Chief Nurse	PAWC	Practice Educators in place across all wards / departments; establishment reviews confirming WTE which DDoN will then review	31st October 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP has a supernumerary education team supporting the team in clinical practice	In place at May 2022	
	18	Newly appointed Band 7/8 (midwives) must be allocated a named and experienced mentor to support their transition into leadership and management roles.	The support for newly appointed ward managers should be reviewed	AH	Workforce	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	PAWC	To review	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating	LNP Board	All new band 7 nurses will have Matron /DHoN/HoN mentor	In place at May 2022	

							Officer AH Gary Price Chief Operating Officer LWH				
3: ESCALATION AND ACCOUNTABILITY											
Staff must be able to escalate concerns if necessary	**21**	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding (a woman's) care in case of disagreement between healthcare professionals.	A conflict of clinical opinion and associated escalation process should be developed	AH	TBC	TBC	Alfie Bass Chief Medical Officer	SQAC	Lead to be identified to devise process	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above; local Trust Policy will be followed	31st December 2022	
4: CLINICAL GOVERNANCE-LEADERSHIP											
Trust boards must have oversight of the quality and performance of their (maternity) services. In all (maternity) services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the (maternity) governance systems	29	All clinicians with responsibility for (maternity) governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities	A review should be undertaken to ensure those responsible for clinical governance activities have time in their job plan dedicated to this	AH	Patient Safety Board	TBC	Alfie Bass Chief Medical Officer	SQAC	To review	31st October 2020	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Consultants within the LNP have allocated PA for Risk and Governance	In place at May 2022	
	30	All trusts must ensure that those individuals leading (maternity) governance teams are trained in human factors, causal analysis and family engagement.	The trust should review the education and training for leads of clinical governance	AH	Patient Safety Board	Jackie Rooney Associate Director of Nursing & Governance	Nathan Askew Chief Nurse	SQAC	To review	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief	LNP Board	Members within the LNP are trained in Human Factors and work closely with maternity teams on the LWH site	In place at May 2022	

							Operating Officer LWH				
	31	All (maternity) services must ensure there are (midwifery and obstetric) co-leads for developing guidelines. The (midwife) co-lead must be of a senior level, (such as a consultant midwife), who can drive the guideline agenda and have links with audit and research.	Each division should have allocated MDT leads for the development of guidelines policies and patient information	AH	Divisional Integrated Governance Committees Patient Safety Board	Divisional Associate Chief Nurses Divisional Directors	Nathan Askew Chief Nurse Alfie Bass Chief Medical Officer	SQAC	Divisional Directors, ACNs and Governance leads advised of requirement and ensure appropriate specialists allocated to author and review guidelines Progress will be monitored through CQSG	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Guideline are developed using the MDT across both sites of the LNP	In place at May 2022	
	32	All (maternity) services must ensure they have (midwifery and obstetric) co-leads for audits.	The trust clinical audit process should be reviewed	AH	Divisional Integrated Governance Committees Patient Safety Board	Divisional Associate Chief Nurses Divisional Directors Jackie Rooney Associate Director of Nursing & Governance	Nathan Askew Chief Nurse	Audit Committee	Divisional Directors, ACNs and Governance leads advised of requirement and ensure appropriate specialists allocated to lead and co-lead audits Associate Director of Nursing and Governance to review the audit process Progress will be monitored through CQSG	31st October 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Specific consultant PA are allocated to audit within the LNP	In place at May 2022	
5: CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS											
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner.	33	All (maternity) governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are explained in lay terms.	The trust should ensure that complaints and investigations are responded to in easy to understand language	AHP	Divisional Integrated Governance Committees	Divisional Associate Chief Nurses Divisional Directors	Nathan Askew Chief Nurse	SQAC	All investigation reports and complaint response letters are quality checked by the Division with a final quality check by the Chief Nurse Trust SIRI policy and Trust Complaints and Concerns policy set out the need for clear easy to understand language	In place at May 2022	

				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	All investigation reports and complaint response letters are quality checked by the Division with a final quality check by the Chief Nurse Trust SIRI policy and Trust Complaints and Concerns policy set out the need for clear easy to understand language	In place at May 2022	
	35	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred.	Evidence that the change in clinical practice has occurred should be included in the action plan for clinical incidents	AHP	Divisional Integrated Governance Committees Patient Safety Board	Divisional Associate Chief Nurses Divisional Directors	Nathan Askew Chief Nurse	CQSG	Divisional Directors, ACNs and Governance leads advised of requirement All Divisions to review their audit programme to ensure aligned to the findings and changes made following a SIRI and ensure that there is a direct correlation from SIRI action plan to audit plan this is in place going forward Progress will be monitored through CQSG	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	This audit process was implemented in May 22 and will be reviewed	31st December 2022	
	36	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	The trust should develop a process to demonstrate changes from SI investigations have occurred within six months	AHP	Patient Safety Board	Jackie Rooney Associate Director of Nursing & Governance	Nathan Askew Chief Nurse	SQAC	Corporate and Divisional Governance leads to devise a process	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above; the LNP is committed to ensure that there is an auditable trail of actions taken within the specific timeframe requested.	31st December 2022	
	37	All trusts must ensure that complaints which meet SI threshold must be investigated as such	A process should be in place that identifies complaints that meet the SI threshold	AH	CQSG	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	SQAC	Trust Complaints and Concerns policy has strengthened the process to identify a SIRI arising from a complaint; policy due to be ratified at June CQSG and approved at June SQAC	30th June 2022	
				LNP	LNP Operational	Jen Deeney Head of Neonatal	Adam Bateman Chief	LNP Board	Trust Complaints and Concerns policy has strengthened the process to identify a SIRI arising from a complaint; policy due to be	30th June 2022	

					workstream	Nursing	Operating Officer AH Gary Price Chief Operating Officer LWH		ratified at June CQSG and approved at June SQAC		
	38	All (maternity) services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	The trust should involve children, young people and their families in a review of the complaints process	AH	Patient Experience Group	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	SQAC	Work underway with the CYP Forum to develop posters and pop ups; Quality Ward Round undertaken 27th May 2022 to garner the views of CYP and parents; developing a QR code for complaints as young people have told us this is how they would want to raise a concern	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP actively encourages the voice of users at board and they will also sit on the integrated governance meeting (Sept 22)	31st January 2023	
	39	Complaints themes and trends must be monitored by the (maternity) governance team	Complaints themes and trends should be reported on a regular basis to the trust board	AH	Patient Experience Group	Pauline Brown Director of Nursing	Nathan Askew Chief Nurse	SQAC	Complaints themes and trends are analysed and reported on a quarterly basis to Trust Board; reports shared at PEG, SQAC and Commissioners via CQRM	31st May 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Complaints themes and trends are analysed and reported on a quarterly basis to Trust Board; reports shared at PEG, SQAC and Commissioners via CQRM Complaints are also reported monthly to LNP Board	31st May 2022	
7: MULTIDISCIPLINARY TRAINING											
Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on (labour) ward without appropriate regular CTG training and emergency skills training Staff who work together must train together	44	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	The trust should ensure that the SBAR tool is used in practice and staff receive training on induction	AH	Education Governance Committee	Katherine Birch Director of Alder Hey Academy	Nathan Askew Chief Nurse	SQAC	All new nurses to the organisation receive a local orientation / induction where relevant tools, skills and knowledge including SBAR is provided to ensure they are equipped to fulfil the role. Need to review for medical staff, clinical support staff and AHPs	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating	LNP Board	As above; the education team are working to ensure all staff are competent in the use of SBAR tools	30th September 2022	

							Officer AH Gary Price Chief Operating Officer LWH				
	45	All trusts must mandate annual human factor training for all staff working in a (maternity) setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS	The development of patient safety training should include human factors training as well as principles in this action	AH	Patient Safety Board	Jackie Rooney Associate Director of Nursing & Governance	Nathan Askew Chief Nurse	SQAC	Patient Safety Board to review provision, proposal and implementation with subject matter experts	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Human factors training is used within our simulation training within the LNP. An MDT approach is taken across the LNP and family health division at LWH	In place at May 2022	
	46	There must be regular multidisciplinary skills drills and on-site training for the management of common (obstetric) emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Simulation training for clinical emergencies should be in place	AH	Education Governance Committee	Katherine Birch Director of Alder Hey Academy	Nathan Askew Chief Nurse	SQAC	Education Governance Committee to review provision, proposal and implementation with subject matter experts	31st December 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Education Governance Committee to review provision, proposal and implementation with subject matter experts Simulation training in place as part of Human Factors training	31st December 2022	
	47	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	The trust should review emotional and psychological support mechanisms within the organisation	AH	Health and Wellbeing	Jo Potier Associate Director of OD	Melissa Swindell Chief People Officer	PAWC	The Trust has an established staff advisory and liaison service (SALS) available to all staff The Trust also has a number of professional nurse advocates (PNA's) within the organisation who are all available to provide support to our staff The Trust has a Pastoral Support Nurse to support nurses recruited from overseas	In place at May 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating	LNP Board	As above and all staff within the LNP have access to OH, Counsellor, resilience hu and will soon be able to access LNP psychologist for work related incidents.	In place at May 2022	

							Officer LWH				
9: PRETERM BIRTH											
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. Trusts must implement NHS Saving Babies Lives Version 2 (2019)	57	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability	The trust will seek assurance from the LNP but neonatal teams are routinely involved in such discussions	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	All parents are spoken to by consultant or senior clinician within 24 hr (NNAP data) Where possible ante natal conversations are had with parents both by neonatologists, surgeons and specialist teams (for example cardiac)	In place at May 2022	
13. BEREAVEMENT CARE											
Trusts must ensure that (women) who have suffered (pregnancy) loss have appropriate bereavement care services.	77	Trusts must provide bereavement care services for women and families who suffer (pregnancy) loss. This must be available daily, not just Monday to Friday.	The current bereavement arrangements will be reviewed	AH	Medical Division Integrated Governance	Fiona Berry Alder Centre Manager	Urmi Das Medical Division Director	SQAC	To be reviewed and updated	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above Robust bereavement support in place in line with NWNODN Pathway. Close links also with all local hospices	30th September 2022	
	78	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours (of birth). They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	The number of staff who are trained in obtaining consent for post-mortem will be reviewed	AH	Medical Division Integrated Governance	Fiona Berry Alder Centre Manager	Urmi Das Medical Division Director	SQAC	To be reviewed and updated	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	All LNP consultants are trained	In place at May 2022	
	79	All trusts must develop a system to ensure that all families are offered follow-up appointments after (perinatal) loss or poor serious neonatal outcome.	The LNP will provide assurance that routine follow-up appointments are provided following neonatal	AH	Medical Division Integrated Governance	Fiona Berry Alder Centre Manager	Urmi Das Medical Division Director	SQAC	To be reviewed and updated	30th September 2022	
				LNP	LNP Operational	Jen Deeney Head of	Adam Bateman	LNP Board	All bereaved families are offered follow up	In place at	

			death		workstream	Neonatal Nursing	Chief Operating Officer AH Gary Price Chief Operating Officer LWH		appointment with a consultant.	May 2022	
	80	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a (perinatal) loss, with reference to guidance such as the National Bereavement Care Pathway.	Bereavement care will be reviewed in line with national best practice guidance	AH	Medical Division Integrated Governance	Fiona Berry Alder Centre Manager	Urmi Das Medical Division Director	SQAC	Policy in place C5 Bereavement Policy for the Care of a Child who has Died and his / her Family (policy review date Sept 2021). To review in line with national guidance	30th September 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As above Robust bereavement support in place in line with NWNODN Pathway.	30th September 2022	
14: NEONATAL CARE											
There must be clear pathways of care for provision of neonatal care. This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.	81	Neonatal and (maternity) care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Working with specialist commissioners and NWNODN to define the designation of the neonatal care at AHCH. There are clear pathways of care for babies currently within this service	31st December 2022	
	82	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local (maternity) Neonatal Systems (LMS/LMNS) quarterly.	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	Any activity outside the expected pathway is exception reported to the NWNODN	In place at May 2022	
	84	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating	LNP Board	Staff within the LNP can rotate throughout the service to ensure the maintain competence and gain experience. The LNP also offers the opportunity for staff within the C&M Network to rotate within the LNP	In place at May 2022	

		occasional basis to maintain clinical expertise and avoid working in isolation.					Officer LWH			
	85	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation.	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP actively takes place in NWNODN meetings and education	In place at May 2022
	86	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	As a tertiary service provider, there is always consultant or senior presence available. We are working through staffing model with commissioners with regards to AHCH site	31st December 2022
	87	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	ANNP within the LNP practice within tier 1 and 2 of the medical rotas and are suitably trained to deliver the care necessary during resuscitation.	In place at May 2022
	88	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications	The LNP will provide assurance with compliance with this recommendation	LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP are working with Specialist commissioners to ensure there are adequately trained medical teams across both sites of the LNP.	31st December 2022
15: SUPPORTING FAMILIES										
Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of	89	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and	The trust will ensure that psychological support is available	AH	Medical Division Board	Emma Twigg Clinical Psychologist Mark	Urmi Das Medical Division Director	SQAC	Psychologist is available to Ward 1C Neonatal Unit Dedicated support available in some ward departments (for example PICU, HDU,	31st December 2022

(maternity) service provision (Maternity) care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care		specialist psychological support as appropriate.	to the families on the neonatal unit			Carmichael Associate Chief Operating Officer Medical Division			Oncology, Cardiac) Review of psychological provision being undertaken Breastfeeding Nurse regularly visits Ward 1C Neonatal Unit and provides emotional support		
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP has just appointed a psychologist to attend the needs of families within our care. There is recognition that further development is needed in line with GIRFT	31st December 2022	
	90	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences.	The LNP will provide assurance with compliance with this recommendation	AH	Medical Division Board	Emma Twigg Clinical Psychologist Mark Carmichael Associate Chief Operating Officer Medical Division	Urmi Das Medical Division Director	SQAC	Psychologist is available to Ward 1C Neonatal Unit Breastfeeding Nurse regularly visits Ward 1C Neonatal Unit and provides emotional support Midwife clinic once per week for newly delivered mothers All staff are responsible for escalating and referring to appropriate services or support to assist families through adverse experiences	In place at May 2022	
				LNP	LNP Operational workstream	Jen Deeney Head of Neonatal Nursing	Adam Bateman Chief Operating Officer AH Gary Price Chief Operating Officer LWH	LNP Board	The LNP has just appointed a psychologist to attend the needs of families within our care. There is recognition that further development is needed in line with GIRFT	31st December 2022	
	91	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of (maternity) care.	The LNP will provide assurance with compliance with this recommendation	AH	Medical Division Board	Emma Twigg Clinical Psychologist Mark Carmichael Associate Chief Operating Officer Medical Division	Urmi Das Medical Division Director	SQAC	Psychologist is available to Ward 1C Neonatal Unit Dedicated support available in some ward departments (for example PICU, HDU, Oncology, Cardiac) Review of psychological provision being undertaken	31st December 2022	
				LNP	LNP Operational	Jen Deeney Head of	Adam Bateman	LNP Board	The LNP has just appointed a psychologist to attend the needs of families within our care.	31st December	

					workstream	Neonatal Nursing	Chief Operating Officer AH Gary Price Chief Operating Officer LWH		There is recognition that further development is needed in line with GIRFT	2022	

Alder Hey Children's NHS Foundation Trust

TRUST BOARD Report May 2022

Alder Hey Children's NHS
NHS Foundation Trust

Contents

EXECUTIVE SUMMARY 3

PART 1 - EXECUTIVE SCORECARD 7

RECOVERY 8

OUTSTANDING SAFETY 10

GREAT PLACE TO WORK 12

FINANCIAL SUSTAINABILITY 13

SAFE SYSTEMS 14

PART 2 - DASHBOARD OF METRICS 15

SAFE 16

CARING 17

EFFECTIVE 18

RESPONSIVE 19

WELL LED 20

R&D 21

PART 3 - DIVISIONAL PERFORMANCE 22

MEDICINE 23

SURGERY 28

COMMUNITY 32

RESEARCH 36

How Did We Do?

Executive Summary **Month: May** **Year: 2022**

Delivery of Outstanding Care

Safe

- Continued evidence of good reporting culture with highest number of incidents reported this year with most being near miss or no harm.
- There were 7 Medication errors resulting in harm, the highest number this year, mainly relating to administration and prescribing
- There have again been 0 grade 3 or 4 pressure ulcers reported.
- There are continued challenges with ED sepsis compliance and an absence of in-patient data which continues to be addressed by the division of medicine.
- Excellent in month performance re IPC with no HAIs reported

Highlight

- Highest clinical incident reporting levels of the year in May
- 0 clinical incidents resulting in moderate harm or above
- No grade 3 or 4 pressure ulcers reported
- No HAIs reported in May
- Improved sepsis response performance in ED in May

Challenges

- 7 medication errors that resulted in harm
- Sepsis response across the Trust continues to be a challenge

The Best People Doing their Best Work

Caring

- Some disparity in FFT scores in May with OPD, Mental health and in patients scoring well, but improvement still needed in ED, with Community's score being unusually low this month.
- Work is ongoing to ensure we meet the national timeframes re responses to formal complaints and PALS

Highlight

- Improved FFT scores in Mental Health reaching 100% in May

Challenges

- Overall compliance score re FFT in May compromised by poor ED performance
- ED FFT score remains a challenge and the Medical Division continue to work on addressing the issues.

Delivery of Outstanding Care

Effective

The Emergency Department dealt with a 14.8% 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 in our urgent 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.

The 10-day clinical letter sign-off standard is a new KPI within the corporate report which has been introduced to improve performance in this area. We will use the Brilliant Basics methodology in Divisions to improve the time taken for letter sign-off.

Highlight

- Clinical triage time of less than 15 minutes in ED

Challenges

- Emergency Department waiting times
- Clinic letters completed within 10 days
- On the day elective cancellations (primary reason is list overran)

Delivery of Outstanding Care

Responsive

At the end of May there were 282 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. There is a national goal to safely reduce follow-up activity and given the 85% funding cap we need to continue to support the adoption of new approaches to follow-up care. In this vein, just under 200 patients have, year-to-date, been added to patient-initiated follow-up appointments.

Our overall diagnostics position remains very challenged. Although, we have made an improvement this month with 58.9% waiting less than 6 weeks for a test. A business case has been submitted for investment in home monitoring equipment to increase capacity. The most challenged investigation is respiratory physiology (sleep studies), at 17%. MR waiting times has improved to 84%.

Highlight

- Access to cancer care
- High level of theatre utilisation
- High levels of elective recovery

Challenges

- Growth in waiting list size
- Number of 52 ww patients
- Diagnostic waiting times

The Best People Doing their Best Work

Well Led

Finance

For the month of May (Month 2), the Trust is reporting a deficit of £0.5m which is £0.3m away from the planned position. For the year to date, the Trust is reporting a deficit of £1.3m which is £0.7m away from the plan position. The main drivers for the YTD position is risk to Elective Recovery Funding threshold due to Outpatient Follow Up being high, CIP non-delivery offset with slippage in investments.
Cash in the bank at the end of May was £85.3m.
The overall capital expenditure for the year to date is £0.9m.
The external audit for 2021/22 is almost complete and is progressing well thus far.

Sickness

Attendance across the trust remains a key area of focus, with key activities taking place across all divisions and teams, bespoke to specific service and staff requirements. The HR team continue to support hotspot areas with a physical presence as required and relationships with TP Health as the Trusts Occupational Health provider, continue to develop to ensure that the Trusts voice is heard linked to individual absence management work. As at 9th June, 2022 absence was running at 6.57% (270 people) against a workforce headcount of 4108. COVID absence has now reduced to 0.75% which is a significant reduction from the beginning of the year. The Trust target is <4%.

Staff Turnover

Turnover is currently running at 12.33% against a trust target of 10%. Activity is underway to refresh the exit strategy approach in order to gain an increased response rate and depth of understanding from people who choose to leave the organisation. Increased reporting to divisions is also taking place.

Highlight

Challenges

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

Game Changing Research and Innovation

Research and Development

Month 1 Research Activity:

- 184 research studies currently open
- Studies in set up 18
- 2,075 patients recruited to research studies (Q1 22/23)
- 3 SAEs to sponsors in Q1 (22/23), all within 24 hour time frame.

Divisional Participation:

- 94 health care professionals from 28 specialities acted as Principal Investigators for 189 clinical research studies
- The Alder Hey Clinical Research Facility (CRF) was awarded a further £2M in funding from the National Institute for Health and Care Research (NIHR) for enabling vital delivery of early stage clinical research to continue until 2027

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 87.4%

Highlight

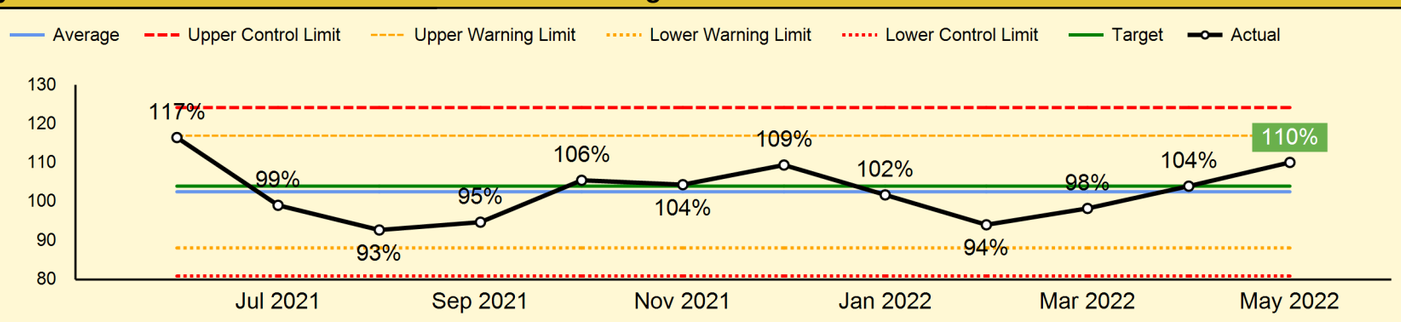
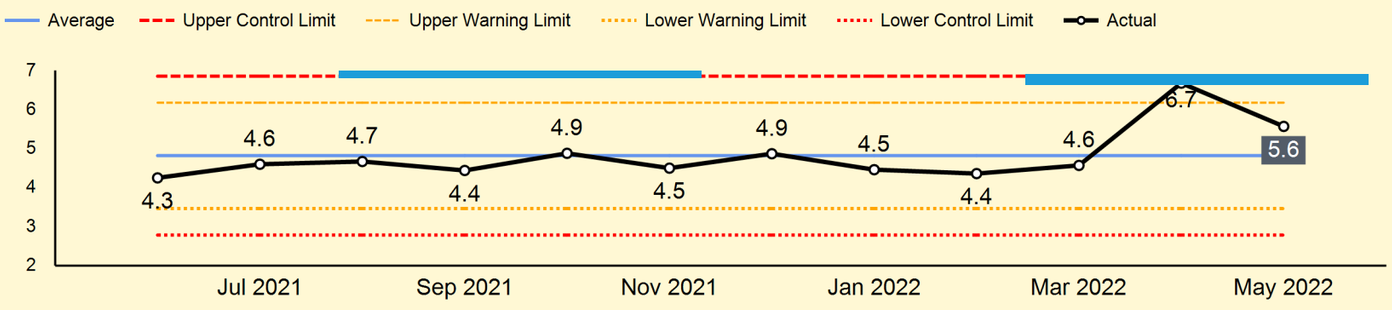
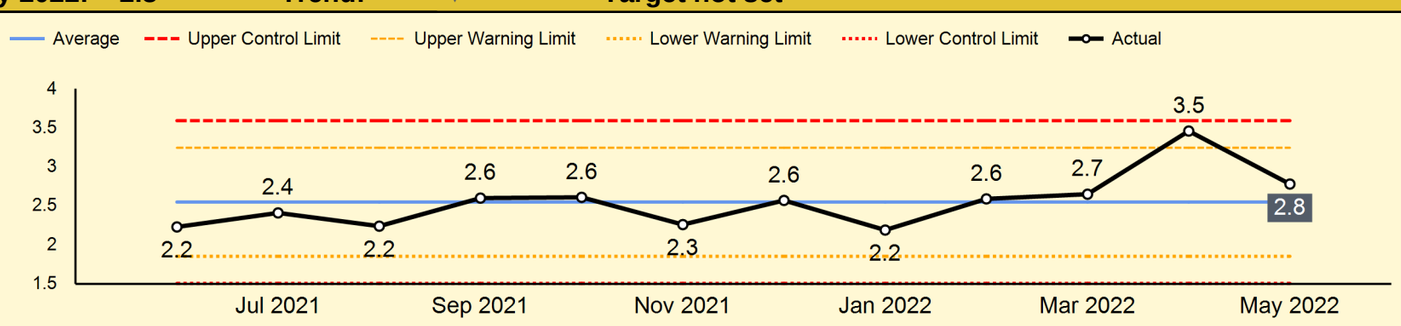
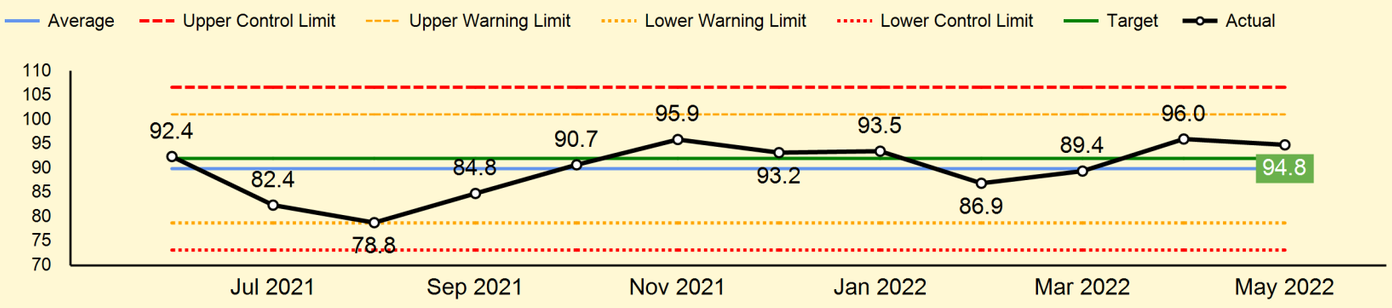
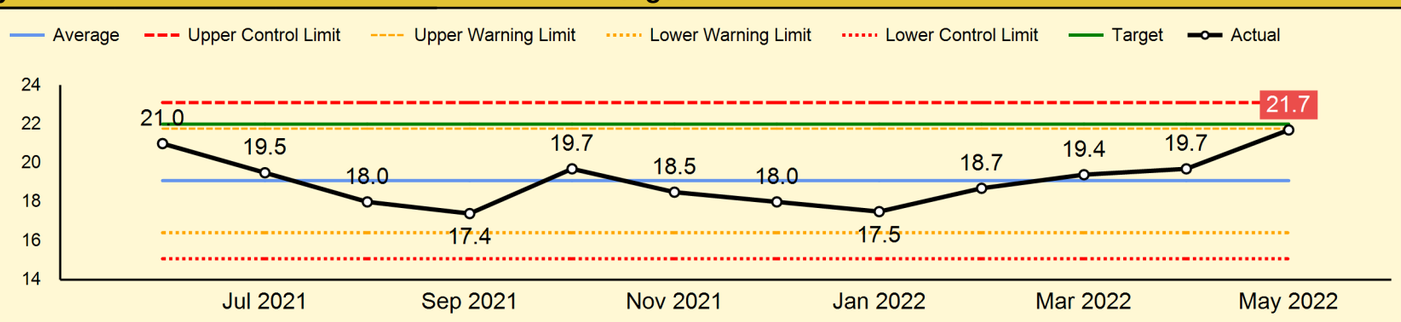
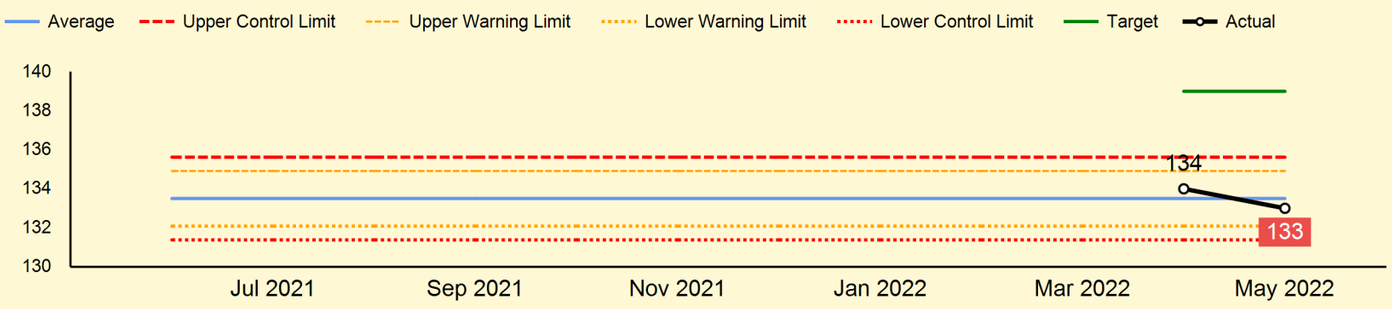
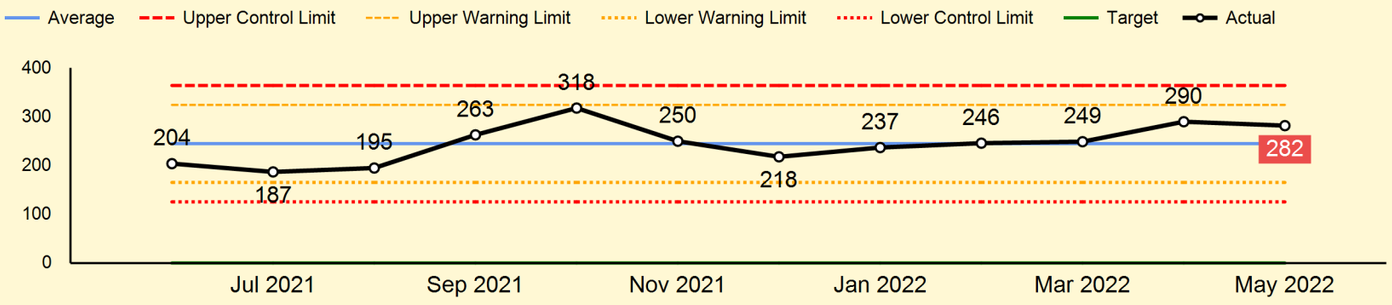
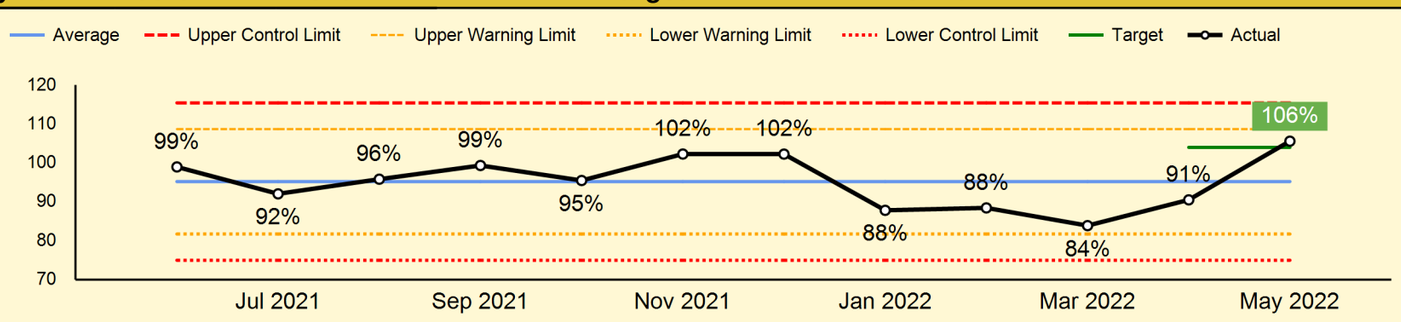
- Selected as site for several significant national and international studies.
- Highest recruiter for Stop RSV.
- Highest recruiter of patients to research studies amongst NHS organisations in the North-West in 21/22.
- Recruitment process 6/9 vacancies filled.

Challenges

- Funding from commercial studies is a forecast model only.
- Activity for invoicing slow (Post Pandemic and staffing).
- Staffing and capacity remains a concern (As per RR).
- Divisional Staff turn-over (Several Fixed Term Contracts about to end) can not action until funding workstream completed.

Alder Hey Children's NHS Foundation Trust

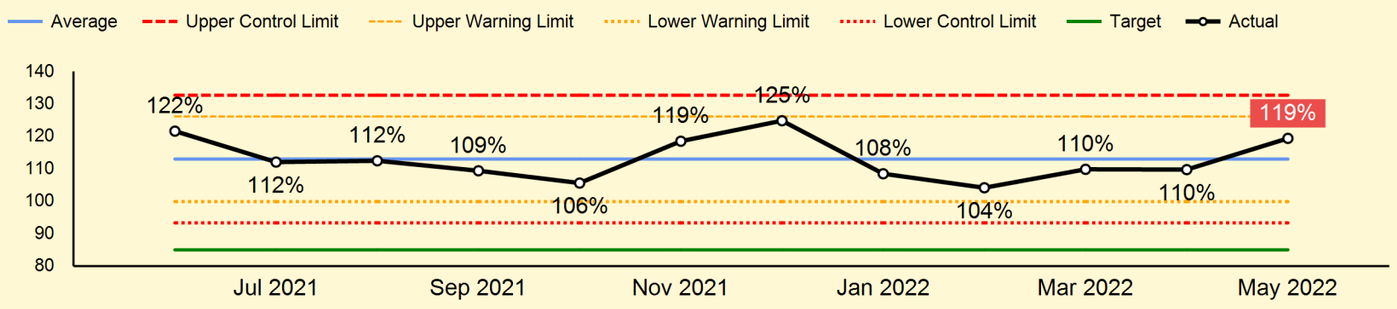
Part e ti e ore ar

Metric	Recovery		
104% Activity - Elective and Daycase	**May 2022: 110%** **Trend: ▲** **Target: >=104 %** 	**Comments:** Achieved 110% elective recovery in May. There is no statistical evidence as yet of special cause variation. In order to advance elective recovery the theatre schedule will expand to 141 theatre session from the 20 June 2022.
Average patients per Theatre Session (DC)	**May 2022: 5.6** **Trend: ▼** **Target not set** 	**Comments:** Cases per session continue to increase in comparison to 19/20 baseline. In month improvement for Paediatric Dentistry. Theatre utilisation for May was 94.6% across Surgery & Medicine
Average patients per Theatre Session (EL)	**May 2022: 2.8** **Trend: ▼** **Target not set** 	**Comments:** Average of 2.8 patients per session achieved in May. This exhibits natural variation in line with previous 12 months.
Average Patients per Working Day (DC Spells)	**May 2022: 94.8** **Trend: ▼** **Target: >=92** 	**Comments:** Average of 94.8 patients per working day achieved in May. This exhibits natural variation in line with previous 12 months.
Average patients per working day (Elective Spells)	**May 2022: 21.7** **Trend: ▲** **Target: >=22** 	**Comments:** Achieved an average of 21.7 which remains below the target of 22. This is the highest figure achieved in the last 12 months, but would still be considered natural variation.
Theatre Sessions per week	**May 2022: 133** **Trend: ▼** **Target: >=139** 	**Comments:** There are only 2 data points for this metric which isn't enough to analyse a trend. The value of May 2022 is below the target of 139.
Number of Patients > 52 ww	**May 2022: 282** **Trend: ▼** **Target: 0** 	**Comments:** 188 of the patients facing a long waiting time are awaiting paediatric dentistry care. Spinal surgery is the second specialty with the highest number of long wait patients: 37 inpatients and 2 outpatients.
Outpatient New + Outpatient Procedure 104%	**May 2022: 106%** **Trend: ▲** **Target: >=104 %** 	**Comments:** Achieved the target of > 104% in May and is the highest % achieved in the past 12 months. Despite this the value of 106% represents natural variation. During June, action will be taken to change clinic templates reducing follow ups and increasing New slots. It is expected this benefit will be seen from September onwards.

000109

Outpatient Follow Up 85%

May 2022: 119% **Trend:** ▲ **Target: <=85 %**



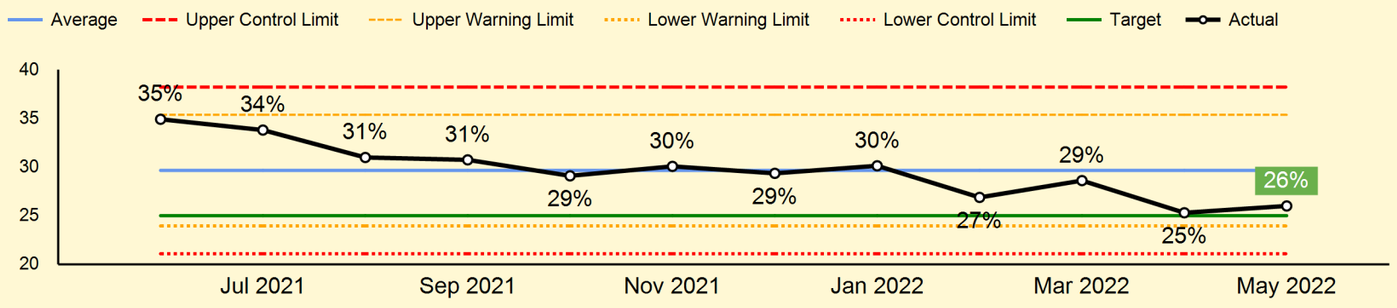
Comments:

May showed 119% OPFU, significantly in excess of 85% target. Balance to reduce FU volume, whilst also reducing overdue FUs and ensure safe clinical pathways.
Also noting that Community and CAMHS have received investment to increase OP activity and reduce waiting times.
Divisions confirmed no FU appointments booked on WLIs

si ni i ant o in e er ise is ein a n e as a n er o ons tations an assess ents are ein re or e as en a ore a ro riate o e o e treat ent or e a es re o erati e assess ents an t era inter entions are resent re or e as

Virtual Outpatient 25%

May 2022: 26% **Trend:** ▲ **Target: >=25 %**

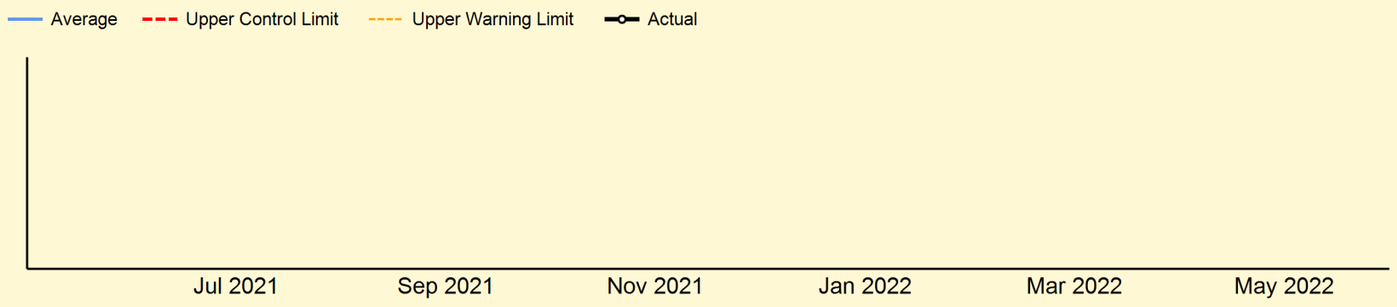


Comments:

Target of 25% virtual OP appointments achieved in May. Special cause variation has been observed as there are 7 or more points below the average over the past 12 months. It is expected, without further intervention, that the performance will dip below 25% target in future months.

No Harm whilst waiting > 52 weeks on waiting list

May 2022: **Trend:** **Target not set**

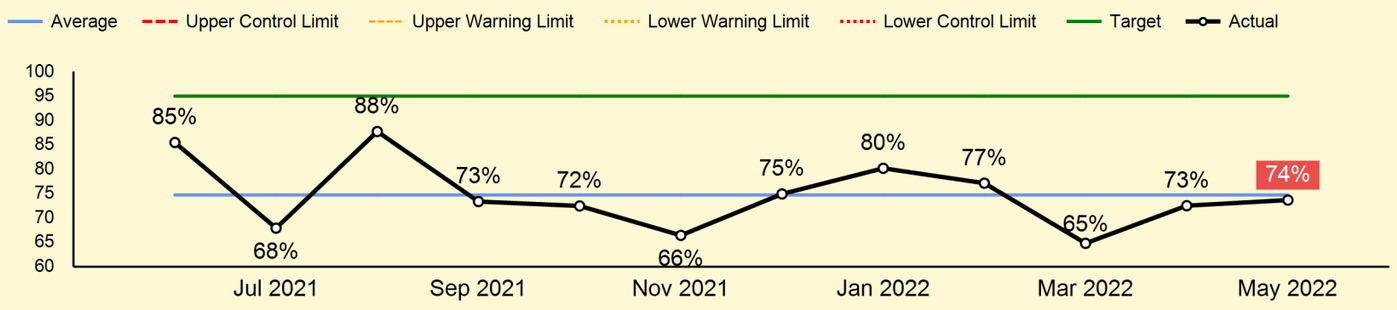


Comments:

Data collection for this metric is in development.

% ED < 4 hours

May 2022: 74% **Trend:** ▲ **Target: >=95 %**



Comments:

We saw a marginal improvement in our performance for May 2022. Our GP service coverage has been improving with more shifts filled, and we have piloted patients attending out of hours returning to booked appointments the next day. We are continuing to work on improvement with executive colleagues, and are recruiting to our vacant posts as poor skill mix in the department is one of the key contributors to lower performance

My Alder Hey 000110
Executive Scorecard

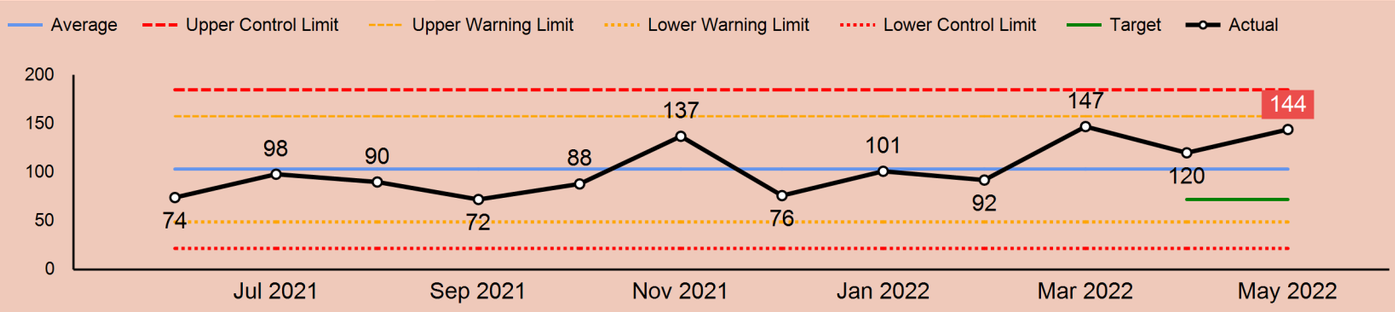
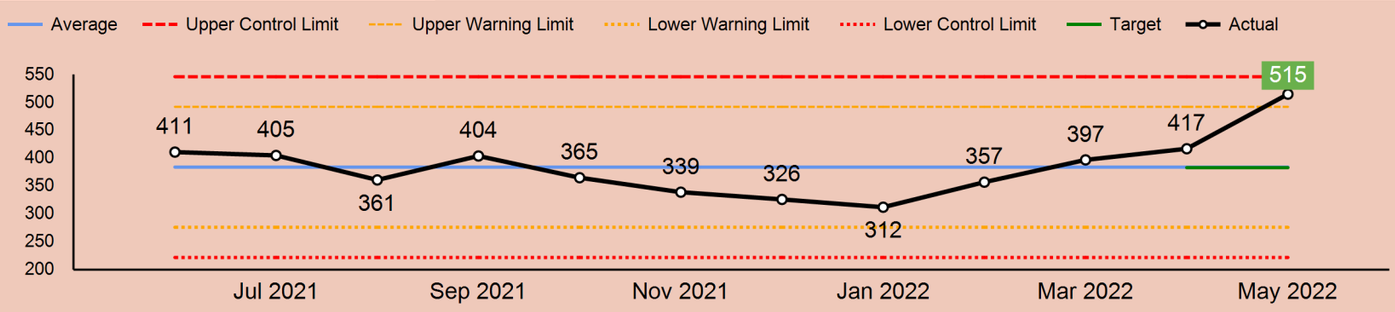
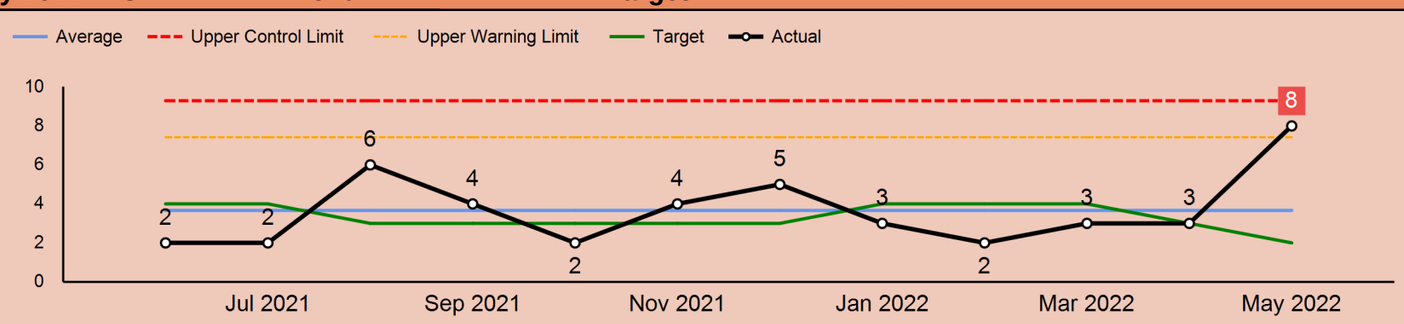
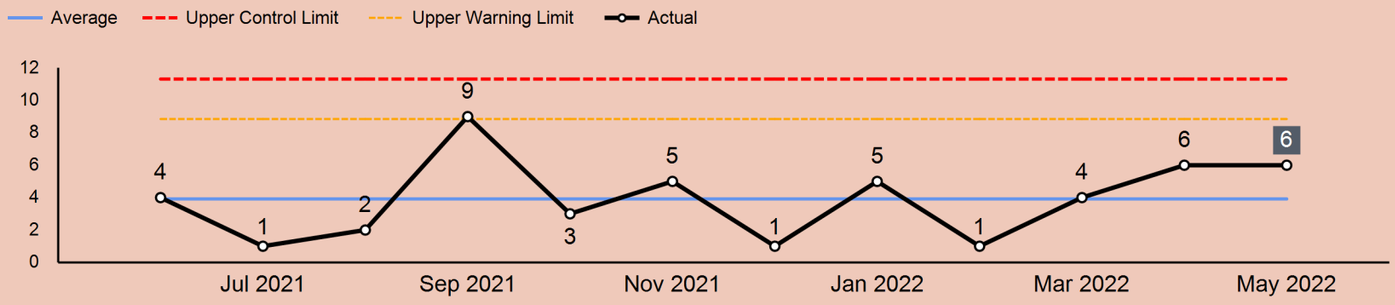
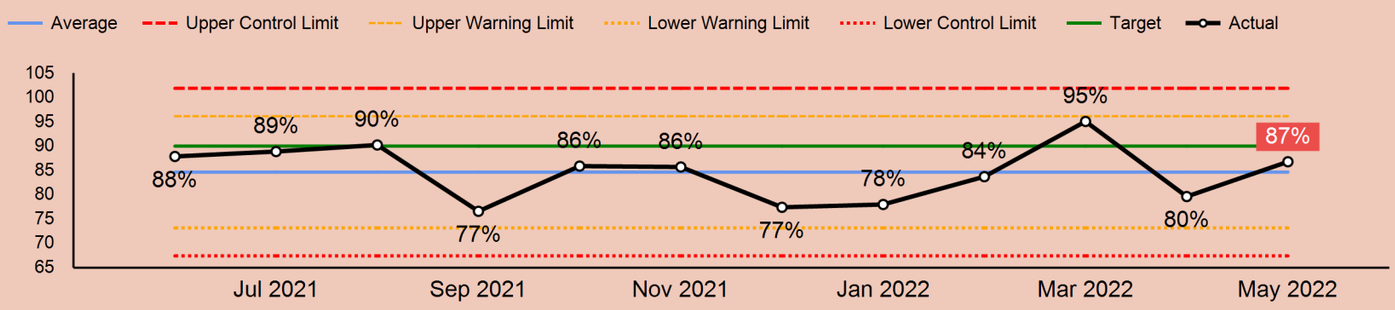
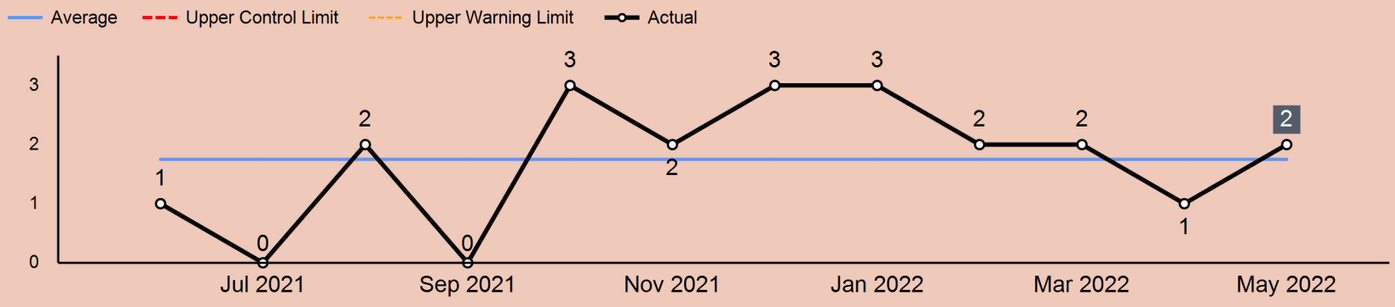
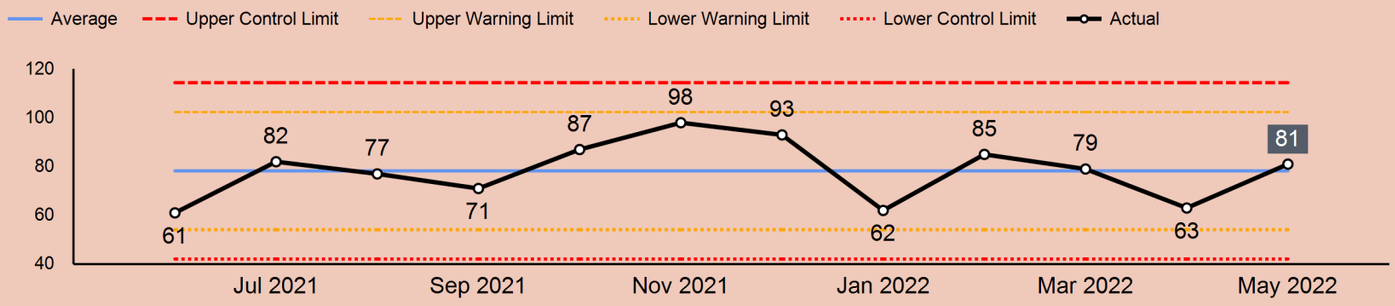
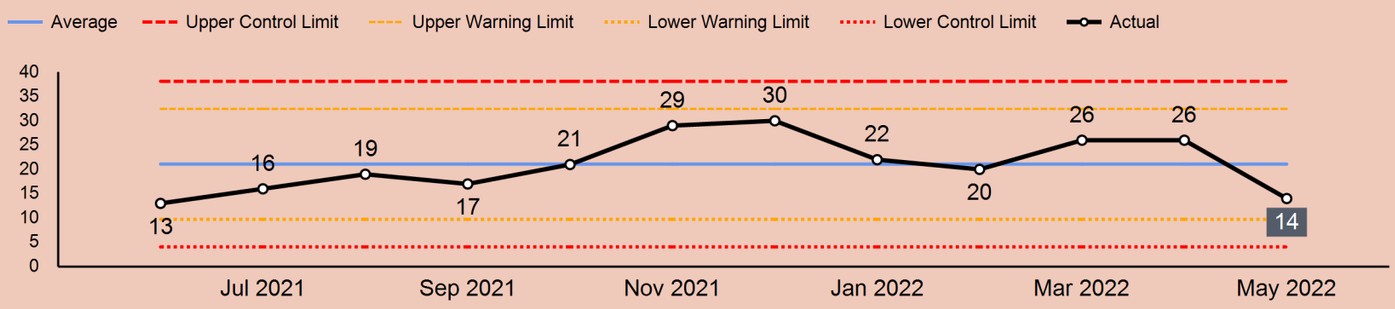
Dashboard refreshed 24 Jun 2022 16:30 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children's NHS Foundation Trust

Home > Detailed Scorecard

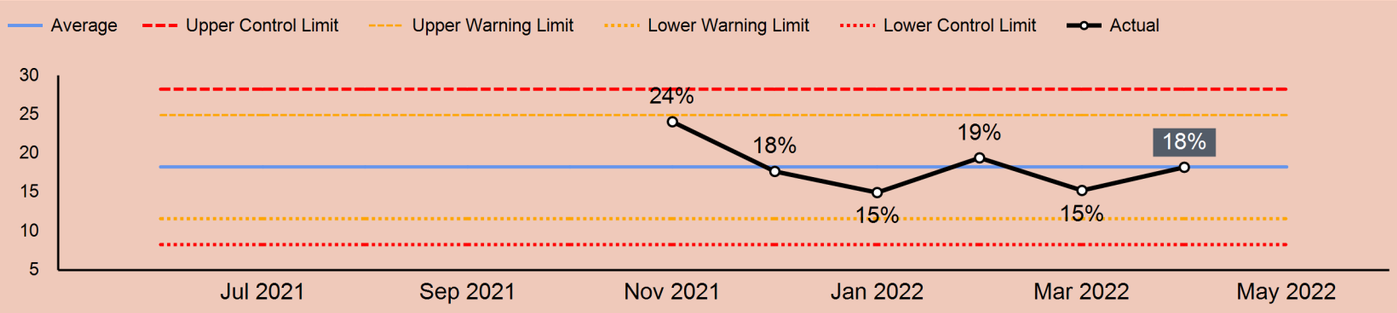
Please click on the word 'Home' to navigate back to the summary page

Metric	Outstanding Safety		
25% Reduction in Harms	**May 2022: 144** **Trend:** ▲ **Target: <=72**		**Comments:** Currently averaging 98 over a 12 month period with a target of 72 per month. This is the second month of the new target and May value, demonstrates natural variation which is in line with previous 12 months performance. Therefore no evidence of reduction in harms towards the target improvement to date.
Incidents rated "No Harm & Near Miss"	**May 2022: 515** **Trend:** ▲ **Target: >=383**		**Comments:** This metric should remain at previous year level or increase, to indicate open and transparent reporting culture. May figure of 513 is within the normal range,but above upper warning limit, however no special cause variation has been observed.
Medications with minor harm or above Incidents	**May 2022: 8** **Trend:** ▲ **Target: <=2**		**Comments:** There are small numbers of incidents each month with an average of 3 per month over the past 12 months. May 2022 (8) indicates an increase on this average and is above upper warning limit but no special cause variation is observed.
Pressure Ulcers G2-4	**May 2022: 6** **Trend:** ▬ **Target not set**		**Comments:** There are small numbers of pressure Ulcers G2-4 each month with an average of 3.5 per month over the past 12 months. May 2022 (6) is consistent with this average, all of which are Grade 2. There have been no Grade 3-4 in the last 3 months.
Sepsis < 60 mins (ED only)	**May 2022: 87%** **Trend:** ▲ **Target: >=90 %**		**Comments:** May 2022 (87%) has failed to hit the target this month and demonstrates natural variation in line with the previous 12 months performance. Currently average 85% over the past 12 months which is close to the 90% target. This means that some months will be above target (March 2022) and other months will be below target (April 2022). Improvement work needs to be undertaken to consistently achieve the target of 90%. Please note this data is ED only, and data do not include Inpatient Sepsis targets as this data is not available due to a Sepsis Nursing vacancy.
Cardiac Arrests	**May 2022: 2** **Trend:** ▲ **Target not set**		**Comments:** This is a brand new metric presented in the Executive Scorecard. There is no target associated with these data and the numbers are very low month on month.
Unplanned Admission to HDU/PICU	**May 2022: 81** **Trend:** ▲ **Target not set**		**Comments:** This is a brand new metric presented in the Executive Scorecard. Performance in May is within the normal range, and work with the clinical team is required to set target for reduction aligned to actions focused on Deteriorating Patients.
Step Downs out of CC out of hours (7pm-7am)	**May 2022: 14** **Trend:** ▼ **Target not set**		**Comments:** This is a brand new metric presented in the Executive scorecard. The data is from Meditech where a patient has been discharged from Critical Care to another ward or home. There is no target set for these step downs currently. The current average is 21 step downs over the past 12 months and May demonstrates natural variation in line with this average. Work is required with the clinical teams to use this data to develop better understanding of timeliness of step downs, and associated safety risks.

000111

% Consent before day of surgery

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

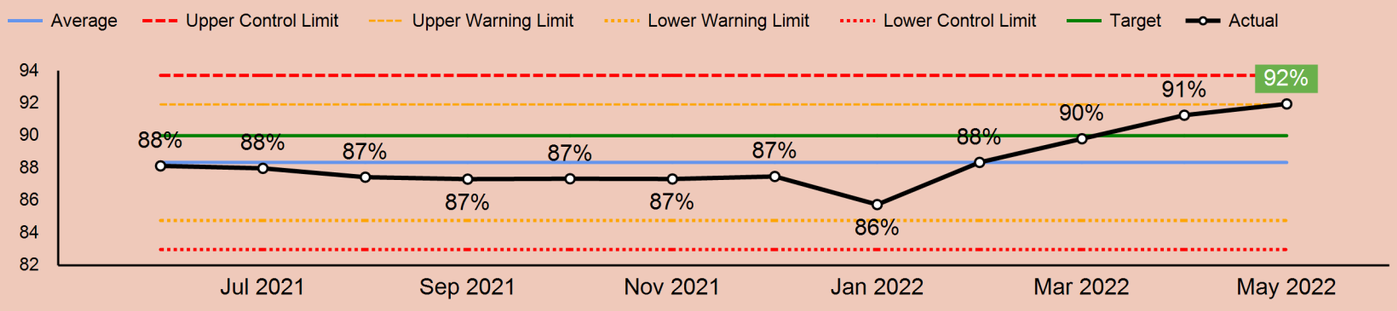


Comments:

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

% Mandatory Training Compliance

May 2022: 92% **Trend:** ▲ **Target:** **>=90 %**

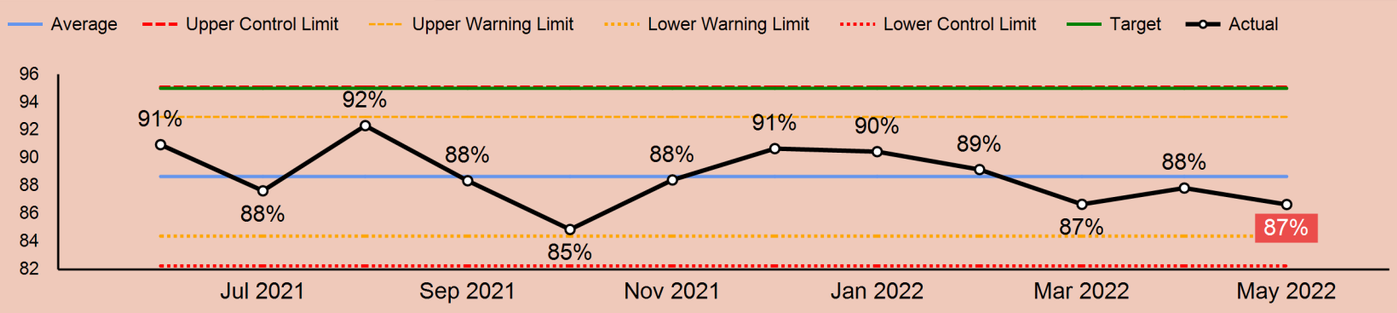


Comments:

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

FFT % Recommend Trust

May 2022: 87% **Trend:** ▼ **Target:** **>=95 %**

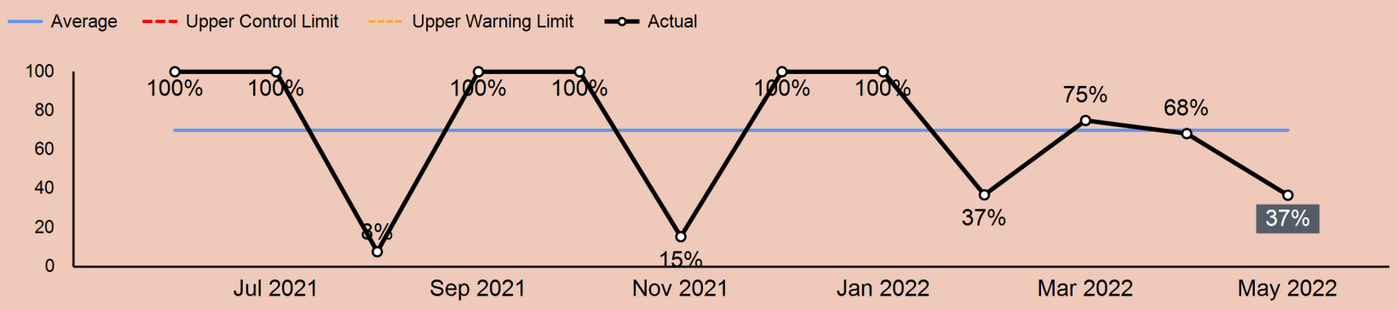


Comments:

Current average is 89% which is below the target of 95%. May 2022 (86%) demonstrates natural variation in line with the current average. The Target is in line with the current Upper Control limit which means significant improvement needs to be undertaken to consistently pass this target. Previous investigation has indicated that this metric has been affected by the current challenges seen in ED.

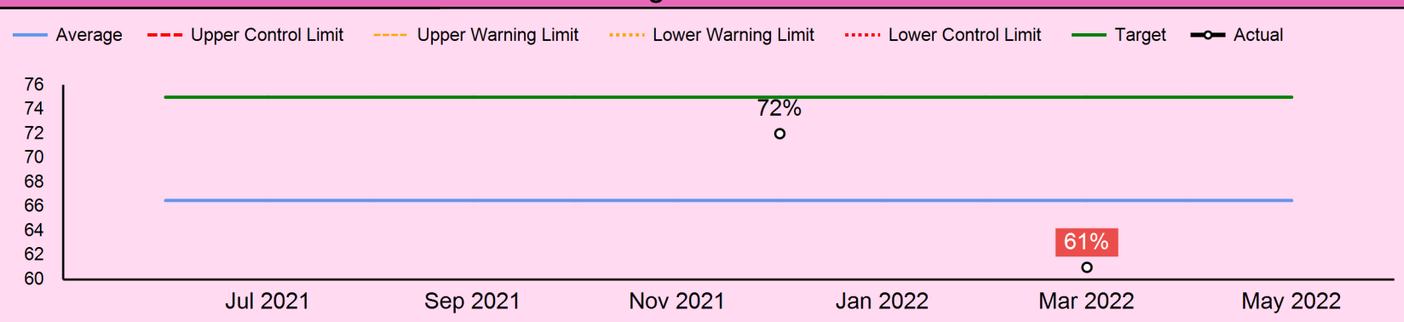
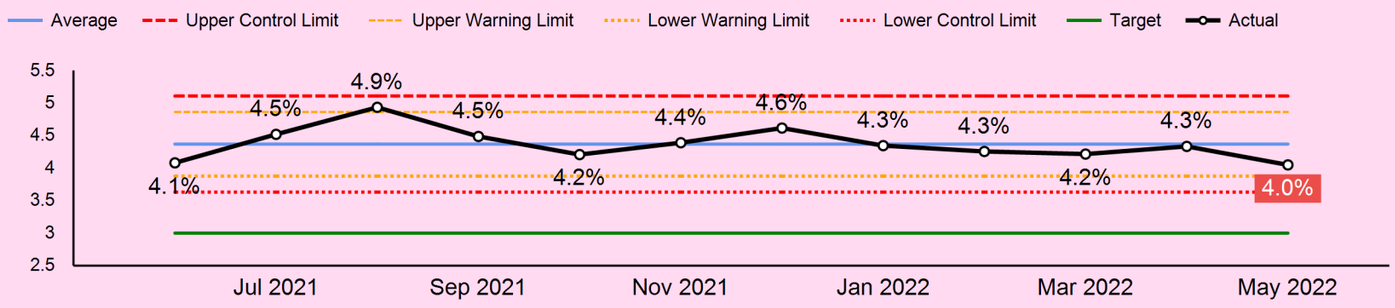
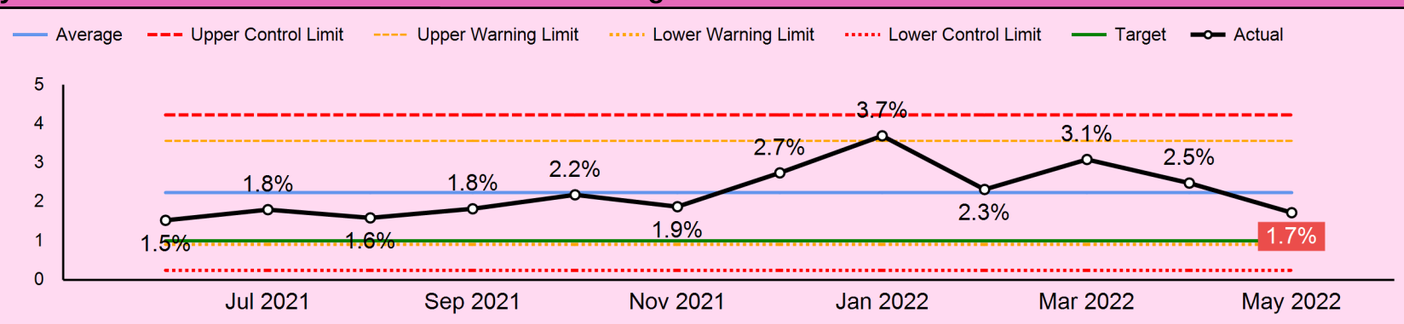
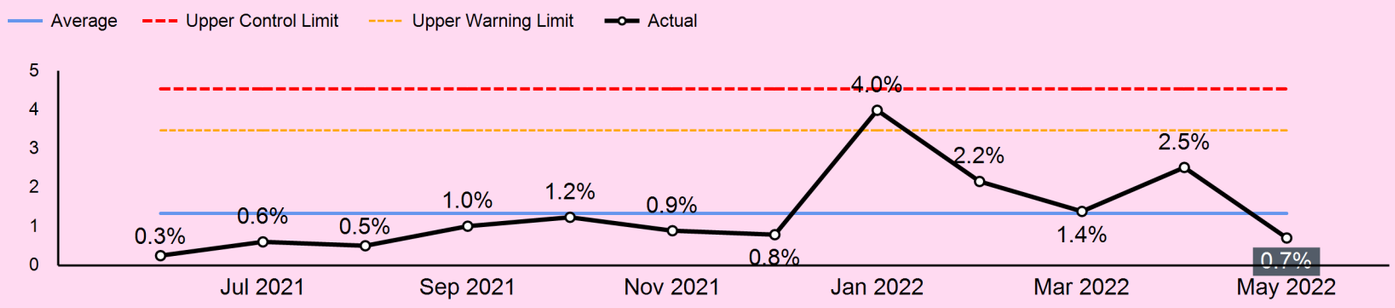
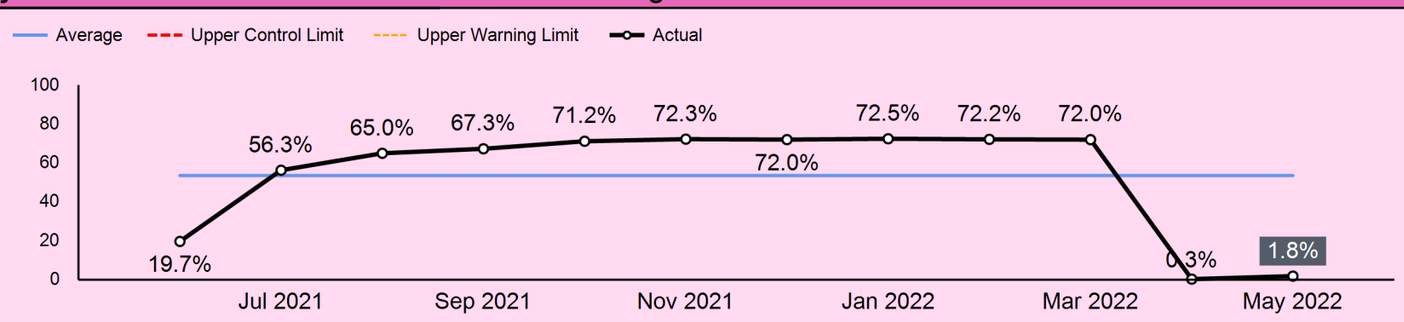
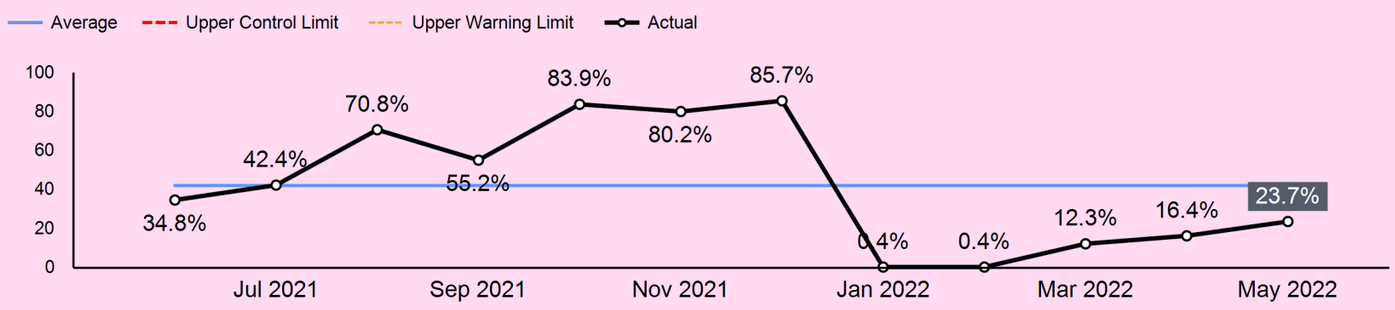
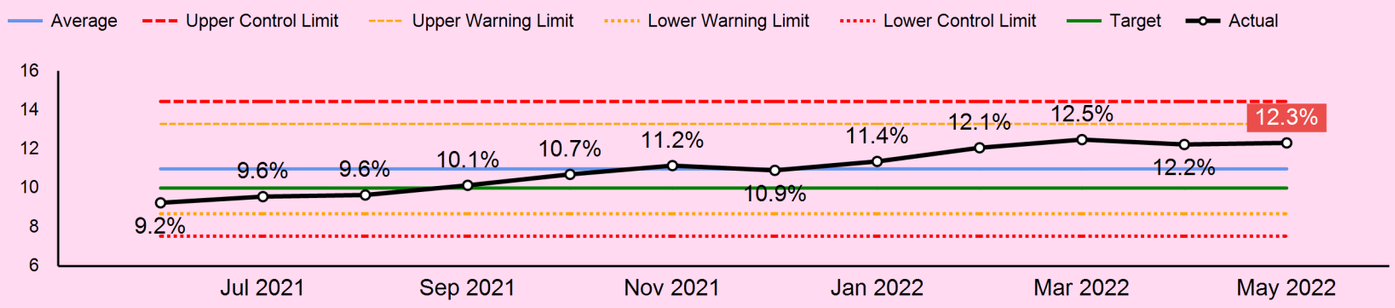
% Compliants response within 25 working days

May 2022: 37% **Trend:** ▼ **Target not set**



Comments:

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

Metric	Great Place to Work		
> 75% of staff recommend as a place to work	**Mar 2022: 61%** **Trend:** ▼ **Target: >=75 %** 	**Comments:** Only 2 data points, so difficult to analyse data given the frequency of the survey (quarterly). The underlying position will become clearer after subsequent pulse checks are completed. However, the latest data point of 61% is below the target of >75%.
Long Term Sickness	**May 2022: 4.0%** **Trend:** ▼ **Target: <=3 %** 	**Comments:** Current 12 month average is 4.4%. May 2022 (4.0%) demonstrates natural variation in relation to the 12 month average. The target figure of 3% is well below the lower control limit over the past 12 months so this will not be achieved in any individual month without significant improvement work and actions implemented to reduce LTS towards the target.
Short Term Sickness	**May 2022: 1.7%** **Trend:** ▼ **Target: <=1 %** 	**Comments:** Current 12 month average is 2.2%. May 2022 (1.9%) demonstrates natural variation in relation to the 12 month average. The target figure of 1% is at the lower control limit over the past 12 months so significant improvement work would need to be done to achieve this target in any individual month.
Absence COVID Related	**May 2022: 0.7%** **Trend:** ▼ **Target not set** 	**Comments:** Peak in January was above Upper Warning Limit, reflecting the Omicron surge. Figures in 2022 have not yet returned to the 2021 average.
% PDR Compliance YTD	**May 2022: 1.8%** **Trend:** ▲ **Target not set** 	**Comments:** PDR compliance in 2021/22 did not achieve the 90% target. In April, PDR Compliance has reset down to 0.3% due to the opening of the PDR window. We would expect to see increase over the coming months, with target for all senior posts to have PDR completed by end of July 2022.
% Medical Appraisals YTD	**May 2022: 23.7%** **Trend:** ▲ **Target not set** 	**Comments:** Window for Medical appraisals opened in January, and current performance shows steady rise. The new process is for each Consultant to get an appraisal in their birth month so these data will need to be adjusted to reflect this.
% Staff Turnover	**May 2022: 12.3%** **Trend:** ▲ **Target: <=10 %** 	**Comments:** Not only is the average above the 10% target but the past 7 months show values consistently over the average - therefore special cause variation has been observed. This indicates statistically over a sustained period of time that there is an increase in Staff leaving the organisation. This should be investigated to understand root causes and identify appropriate actions.

My Alder Hey 000113
Executive Scorecard

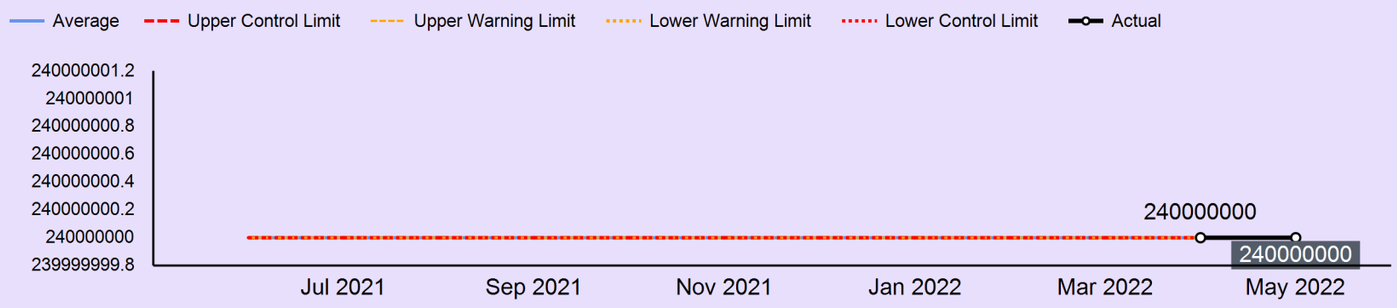
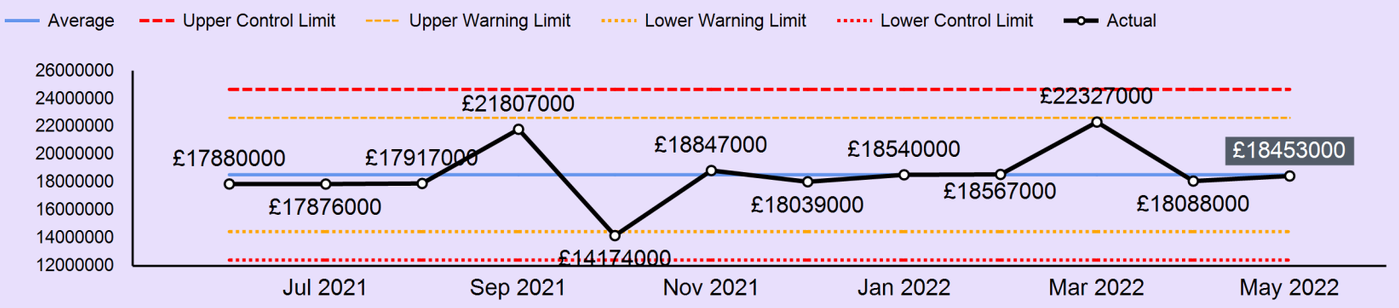
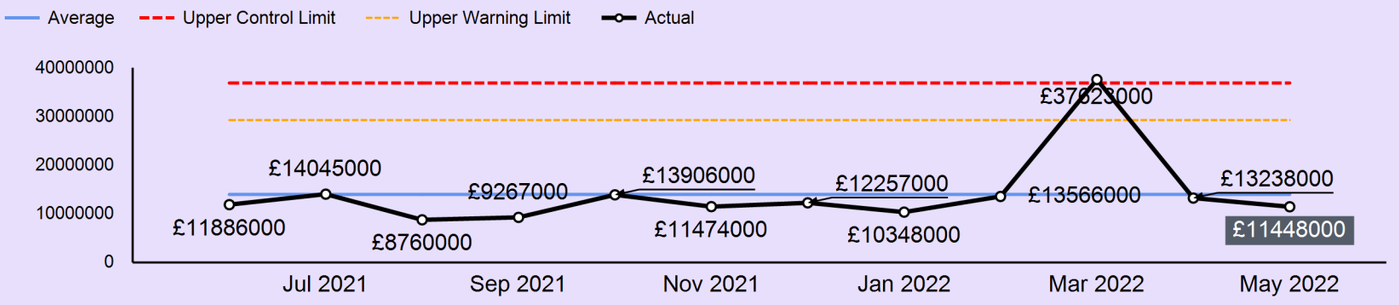
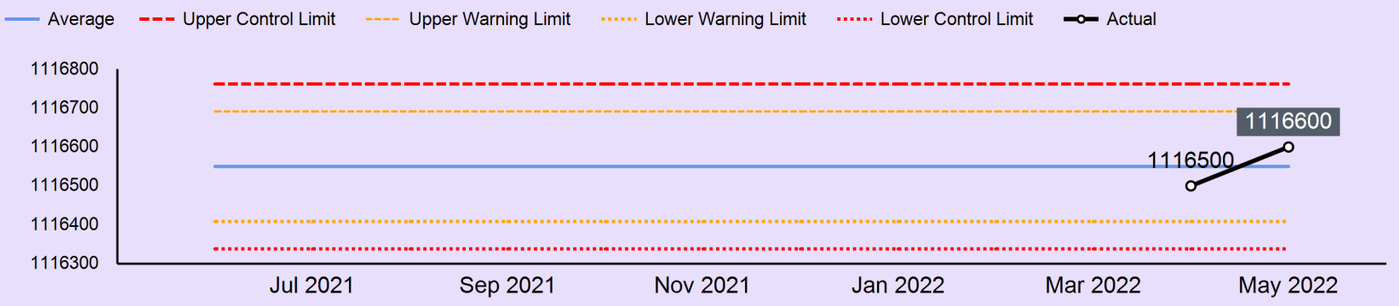
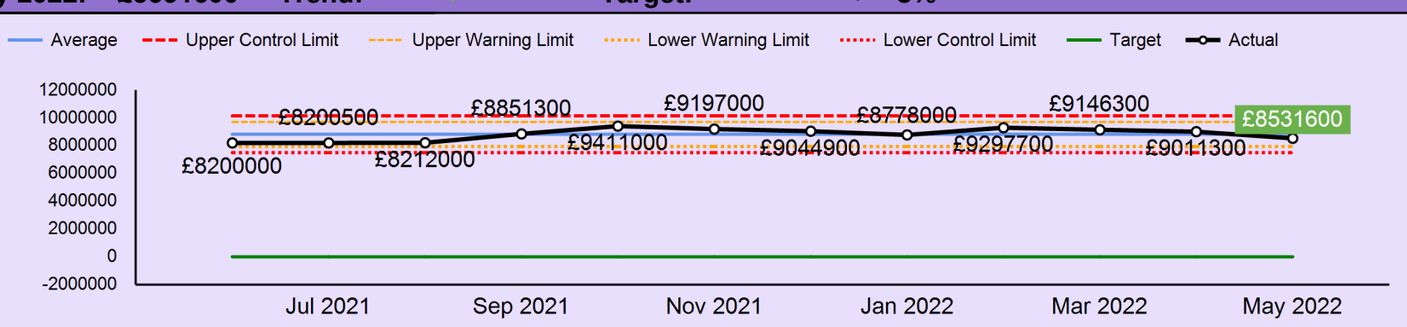
Dashboard refreshed 24 Jun 2022 16:30 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children's NHS Foundation Trust

Home > Detailed Scorecard

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

Metric	Financial Sustainability	
I&E Breakeven	**May 2022: 2.4m Trend: — Target not set** 	**Comments:** I & E Break Even Comment: Provider forecast reporting to NHSEI have been suspended until month 3 as financial plans progress. At this early stage in the financial year, the Trust will be forecasting to meet the submitted plan of a £2.4m surplus.
I&E vs Plan (YTD)	**May 2022: -80 Trend: ▲ Target: >=-5%**	**Comments:** is a is n er e e o ent For the month of May (Month 2), the Trust is reporting a deficit of £0.5m which is £0.3m away from the planned position. For the year to date, the Trust is reporting a deficit of £1.3m which is £0.7m away from the plan position. The main drivers for the YTD position is risk to Elective Recovery Funding threshold due to Outpatient Follow Up being high, CIP non-delivery offset with slippage in investments.
Expenditure Run Rate (Pay)	**May 2022: £18453000 Trend: ▲ Target not set** 	**Comments:** Pay £0.3m favourable to plan due to a small number of vacancies within the Trust.
Expenditure Run Rate (Non Pay)	**May 2022: £11448000 Trend: ▼ Target not set** 	**Comments:** No Comment provided
CIP Forecast	**May 2022: 11m Trend: ▲ Target not set** 	**Comments:** The Trust is forecasting to deliver £11m of the £17m savings target at this early stage of the year. Further work is ongoing to identify opportunities.
CIP Delivered (YTD)	**May 2022: -0.1m Trend: ▲ Target not set**	**Comments:** n er e e o ent e r st as oste P a ainst a tar et o in ont rt er or is on oin to ost rt er P o er t e o in ont s ere s e es a e een i enti ie an a ie e
Capital Plan (vs CDEL)	**May 2022: 53400 Trend: ▲ Target: >=-5%**	**Comments:** n er e e o ent
Cash	**May 2022: £8531600 Trend: ▼ Target: >=-5%** 	**Comments:** No Comment provided

My Alder Hey 0001114
Executive Scorecard

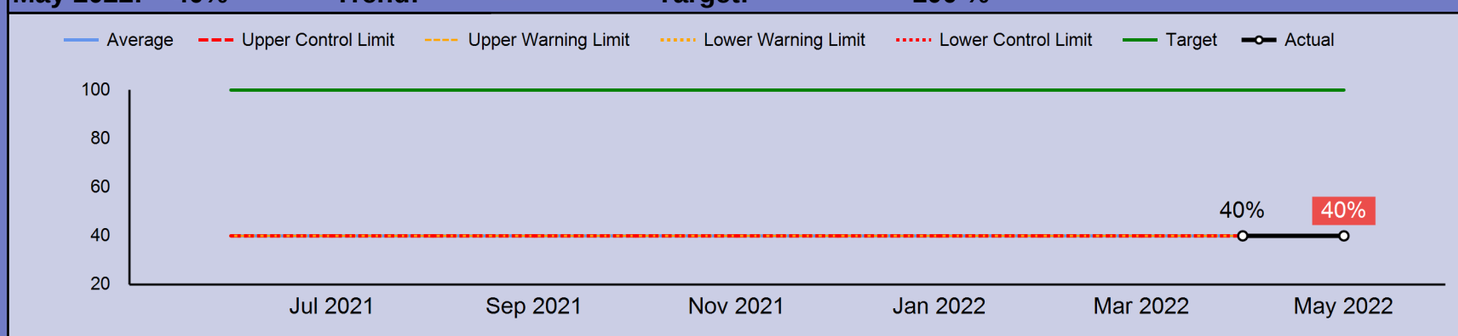
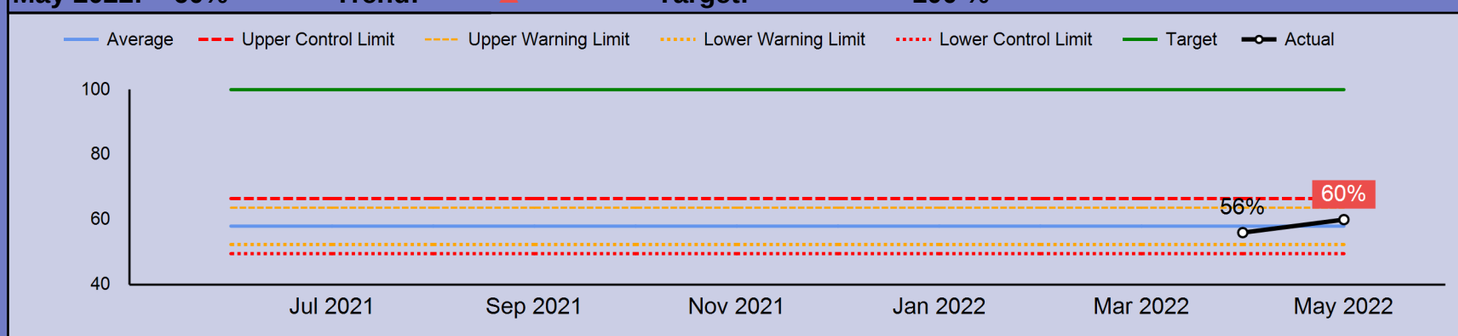
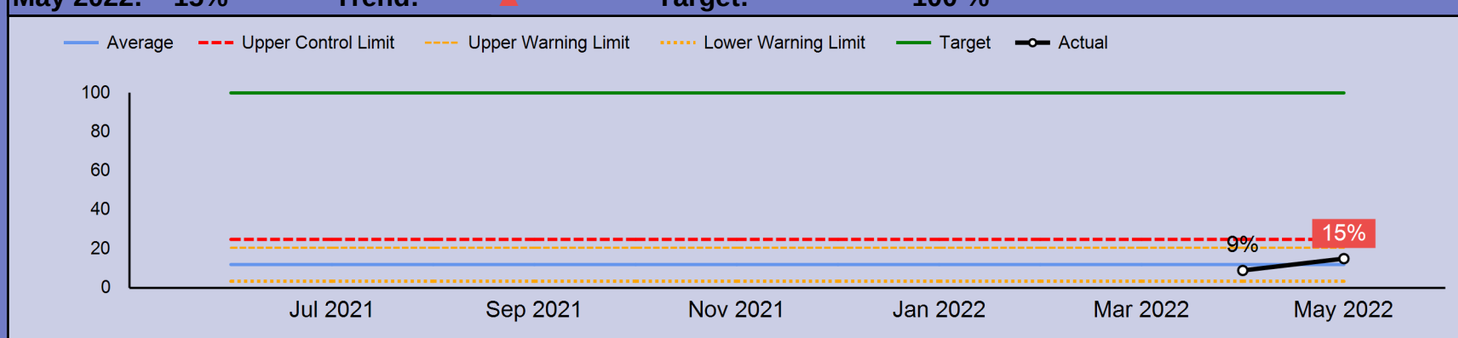
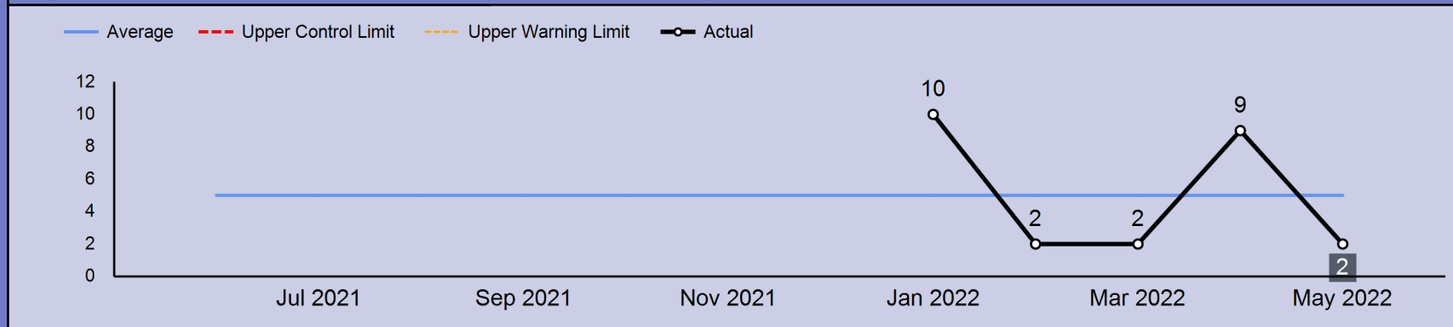
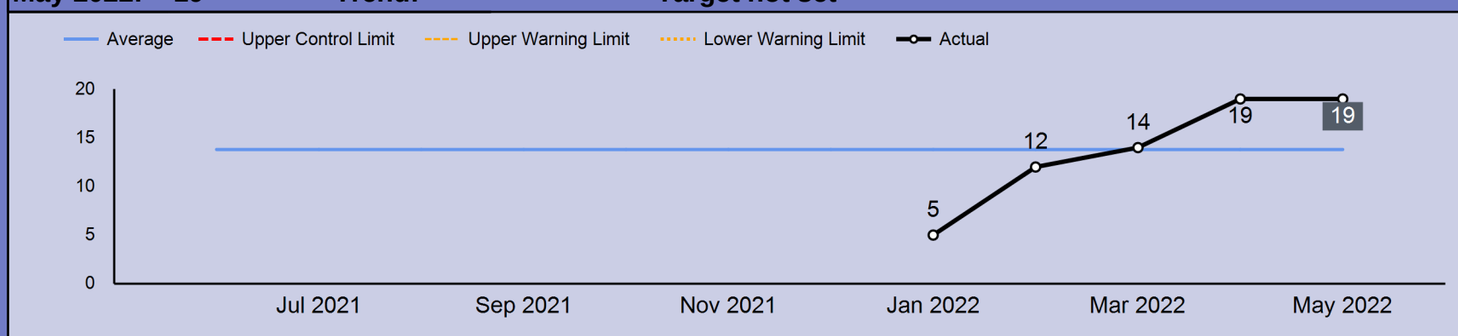
Dashboard refreshed 24 Jun 2022 16:30 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children's NHS Foundation Trust

Home > Detailed Scorecard

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

Metric	Safe Systems	
100% safety compliance	May 2022: 40% Trend: — Target: 100 % 	Comments: Within the programme, the clinical team have identified a number of key 'patient safety criteria' which must be met prior to go live to achieve a safe and successful implementation. There are currently 40% of the solutions signed off and approved. This is behind the predicted 73% for the end of May due to awaiting solutions from Meditech and complexity of sign off for these criteria. This has been 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. Delays in solutions from Meditech has been escalated to the Meditech leadership.
% system build completion	May 2022: 60% Trend: ▲ Target: 100 % 	Comments: Within the new system the majority of the modules need fully rebuilding and this section will aim to track and monitor build progress by Meditech and the System Development Team. Overall there is 60% of the system now built this is an increase of 4% from previous month.
% specialty sign off	May 2022: 15% Trend: ▲ Target: 100 % 	Comments: As part of the programme, each specialty will need to review and approve any of their bespoke specialty documentation. This is another area which has fell behind and a recovery plan is currently being established, which will include a schedule for engaging with the Divisions and completing the build work. This is currently at 15% an increase of 6% from April.
Number of staff involved in prototype testing	May 2022: 2 Trend: ▼ Target not set 	Comments: Its important we engage the users and involve them in the testing of the new system. Users have been invited to test the current prototypes to help get a feel for how the new system will function and ensure it meets their needs. A total of 25 staff have now been involved in prototype testing.
Number of staff trained in Alder Care	May 2022: 19 Trend: — Target not set 	Comments: Training and educating users on how to get the utilise and get the best out of the system is one of the key priorities in the programme. This will be delivered through multiple different methods to cater for the different needs of staff groups. The training numbers are currently low and will increase significantly in the 6 weeks leading up to go live.

Alder Hey Children's NHS Foundation Trust

Part as oar o etri s

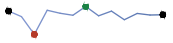
	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	99.1%	99.6%	99.6%	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%	99.6%	99.8%	99.6%	100.0%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	81	90	73	62	91	89	65	76	74	79	91	99	111		No Threshold	
Clinical Incidents resulting in No Harm	363	321	332	299	313	276	274	250	238	278	306	318	402		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	80	73	94	88	72	86	135	76	99	90	145	118	146		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	5	1	1	1	0	1	1	0	2	1	1	2	0		No Threshold	
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	1	1	0	0	1	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	2	6	4	2	4	5	3	2	3	3	8		<=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	0	1	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	94.4%	87.9%	88.9%	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%	83.7%	95.1%	79.6%	86.8%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	89.7%	91.7%	88.9%	86.4%	81.1%	87.0%	82.9%	75.9%							>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	1	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	1	0	2	0	0	1	3	1	0	0	1	1	0		No Threshold	

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	90.2%	91.0%	87.6%	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%	89.2%	86.7%	87.8%	86.7%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	76.2%	79.2%	59.8%	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%	69.5%	59.3%	60.3%	59.6%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	92.4%	95.9%	97.1%	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%	90.5%	94.4%	100.0%	92.4%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	95.1%	87.0%	88.8%	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%	93.9%	95.7%	96.5%	95.3%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	85.7%	95.0%	94.7%	95.8%	96.3%	90.6%	96.4%	100.0%	96.2%	95.5%	94.1%	96.4%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	94.4%	94.8%	95.5%	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%	94.1%	93.3%	93.9%	93.3%		>=95 % >=90 % <90 %	✔
Complaints	9	15	10	12	13	13	14	9	16	20	19	15	15		No Threshold	
PALS	119	149	122	88	148	136	141	106	100	135	136	101	147		No Threshold	

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%					No Threshold	✔
ED: 95% Treated within 4 Hours	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%		>=95 % N/A <95 %	✔
ED: Patients In Department >12 Hours	3	2	17	0	14	47	46	26	11	23	70	19	10		0 N/A >0	✔
ED: Median Time to Triage (Mins)	6	1	8	10	14	17	17	13	10	12	20	12	14		<=15 N/A >15	✔
ED: Median Time to Clinical Assessment (Mins)	140	117	158	76	100	108	129	87	83	102	125	106	104		<=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	7	13	13	12	32	23	56	23	22	16	23	22	23		<=12 N/A >12	✔
28 Day Breaches	3	0	3	8	5	11	12	25	7	3	9	10	13		0 N/A >0	✔
Clinic Letters Completed within 10 Days	25.9%	56.1%	60.4%	60.5%	64.7%	60.7%	67.9%	55.1%	70.3%	63.4%	66.4%	58.5%	62.6%		>=95 % N/A <95 %	✔

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	98.0%	94.3%	94.4%	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%	93.0%	95.3%	95.7%	97.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	99.0%	94.3%	94.4%	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%	96.7%	97.8%	99.3%	97.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	92.2%	96.4%	93.9%	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%	67.6%	66.1%	66.4%	66.9%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	98.5%	98.6%	97.0%	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%	97.1%	98.7%	97.1%	98.9%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	80.0%	79.3%	82.7%	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%	80.9%	87.3%	78.7%	78.6%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	91.7%	89.3%	91.9%	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%	91.9%	93.0%	95.3%	90.8%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	71.9%	74.8%	72.7%	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%	61.5%	61.3%	60.1%	61.8%		>=92 % >=90 % <90 %	✔
Waiting List Size	11,564	11,414	12,096	13,286	13,092	18,495	18,976	19,127	19,098	19,731	20,612	21,894	22,885		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	235	204	187	195	263	318	250	218	237	246	249	290	282		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%			100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	95.2%	98.5%	95.5%	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%	63.3%	56.9%	51.9%	5 .9%		>=99 % N/A <99 %	✔
PFI: PPM%	99.0%	99.0%	99.0%	99.0%	99.0%	97.0%	99.0%	99.0%	96.0%	92.0%	99.0%				>=98 % N/A <98 %	✔

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	592	391	-589	-51	835	-854	381	165	2,122	-726	-904	-606	-93		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	974	13	162	234	-339	-221	-159	406	964	403	-5,413	-445	-534		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	88,440	82,001	82,006	82,121	88,514	94,111	91,971	90,450	87,781	92,978	91,464	90,114	85,317		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	715	1,597	2,980	-1,713	2,766	-2,610	149	1,474	1,047	273	27,774	1,210	204		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-370	-545	553	71	-2,466	2,477	676	-16	6	9	-7,579	-121	426		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	247	-661	-4,122	1,591	534	-720	-443	-1,293	1,068	-1,008	-21,099	-1,694	-723		>=-5% >=-20% <-20%	✔
PDR	6.3%	19.7%	56.3%	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%	72.2%	72.0%	0.3%	1.8%		No Threshold	
Medical Appraisal	30.9%	34.8%	42.4%	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%	0.4%	12.3%	16.4%	23.7%		No Threshold	
Mandatory Training	87.2%	88.1%	88.0%	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%	88.4%	89.8%	91.3%	92.0%		>=90 % >=80 % <80 %	✔
Sickness	5.3%	5.6%	6.3%	6.5%	6.3%	6.4%	6.3%	7.4%	8.0%	6.6%	7.3%	6.8%	5.8%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	1.4%	1.5%	1.8%	1.6%	1.8%	2.2%	1.9%	2.7%	3.7%	2.3%	3.1%	2.5%	1.7%		<=1 % N/A >1 %	✔
Long Term Sickness	3.9%	4.1%	4.5%	4.9%	4.5%	4.2%	4.4%	4.6%	4.3%	4.3%	4.2%	4.3%	4.1%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	1,040	960	1,132	1,096	1,367	1,137	1,592	1,523	1,387	1,620	2,080	1,570	1,374		No Threshold	
Staff Turnover	9.6%	9.2%	9.6%	9.6%	10.1%	10.7%	11.2%	10.9%	11.4%	12.1%	12.5%	12.2%	12.3%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	98.8%	97.6%	89.6%	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%	84.0%	81.7%	83.7%	86.4%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	88.6%	100.0%	97.7%	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%	100.0%	100.0%	97.5%	97.0%		>=85 % N/A <85 %	✔

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	103	108	117	125	132	139	142	145	148	150	153	154	148		>=130	>=111	<111	✔
Number of Open Studies - Commercial	36	38	37	38	40	43	44	42	43	44	38	40	39		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	2	3	7	3	7	7	4	1	3	0	3	3	1		>=3	>=2	<2	
Number of New Studies Opened - Commercial	3	1	1	0	2	3	3	0	3	0	0	1	1		>=1	N/A	<1	✔
Number of patients recruited	1,039	896	439	1,060	983	931	1,038	816	978	937	1,157	917	944		>=100	>=86	<86	✔

Alder Hey Children's NHS Foundation Trust

Part i isiona Per or an e

Medicine Division

SAFE	7 CLABSIs reported in May 2022. All reviewed via RCA process and action plans in place for 3C and 3B. Increased PPE and hand hygiene audits. Re-circulated Care for Central Venous Line (CVL) Access poster amongst wards. Ensuring Infection Controls training is 100% for relevant staff. Reiterating in safety huddles.	**Highlight** • Ask for CVL champions on 3B and to spend time with IV and IPC Team. • Assured that Division has a set of robust action places in place to monitor improvement against all IPC indicators **Challenges**
CARING	Increase in 1-1 requirements being met across Medicine with impact on 4B regarding ventilation and complex needs. Friends and Family Test – work being carried out in AED to increase number of responses. Monthly reports have been developed and sent to ward/department managers for review and action plans to be developed.	**Highlight** • 91% of PALS have been responded to within the 5 working days in May • Dedicated Senior Nurse leading FFT improvement plan for AED • Increased volunteers presence in AED **Challenges** • Ensuring correct skill mix and staff resources are available for 1-1s and the financial implications of this. • Improving response numbers to FFT.
EFFECTIVE	ED metrics improved across the board in May despite more than 600 additional attendances compared to April. Performance was more consistent then seen in previous months. Theatre utilisation has improved but areas of underperforming noted, and sessional allocation changes planned in those areas.	**Highlight** • Theatre utilisation improved to 83% from 78% previous. • WNB rate remains low at 8.3% with focus on those teams in excess of 8% **Challenges** • Hospital appointment cancellations remained high due to short notice sickness. ACOO has requested <6 weeks cancellation be an area of focus as part of the Divisional recovery program
RESPONSIVE	DM01 recovery plan in place for all modalities. Awaiting outcome of business case for home sleep study kit as this will be the most impactful change to support long term improvement in performance. Gen Paeds waiting times improving with new locum in place. 2nd locum starting in August. Gastroenterology and neurology remain the biggest risk in terms of waiting times with pressures on inpatient and outpatient services respectively.	**Highlight** ▪ Cancer standards remain green. Good performance against FDS ongoing. **Challenges** ▪ Neurology capacity for specialist services in OPD mean the division continues to have patients being seen close to 52 weeks from referral. ▪ Gastro long waits for outpatients coupled with loss of decontamination unit have meant an increased wait for scope patients. ▪ DM01 performance low due to scope performance, DEXA and sleep studies and Gastroscopy due to business continuity issues in the decontamination unit.

WELL LED	Mandatory Training is under extensive scrutiny across the division. As an outcome the overall level of compliance is green, however focus remains a priority in key areas and across key themes. Finance - £996K YTD Deficit The division are showing an adverse position to plan (£996k YTD deficit) due to £468k unachieved CIP with pay and non-pay. There is also significant pressure within HCA Bank relating to 121's (£140k) and Junior doctors (£192k). There are also pressures emerging within non pay, specifically around clinical supplies, fixtures and fittings and security.	**Highlight** • Mandatory Training compliance now at 92.45%., with a stretch target of 95% agreed by the triumvirate. Specific focus on themes of Resus (ALS/APLS), Sepsis, IPC and Information Governance. • Action plans for Mandatory Training and learning from the Staff Survey have been presented to DMT. **Challenges** • Medic mandatory training compliance has been highlighted as a divisional risk to DMT (82.32%) as has Ancillary and Facilities (88.33%) • Sickness absence for the division is 7.34% (99 people), ED and wards being provided with bespoke support to decrease levels of sickness within these areas, including training. • Number of service reviews / organisational change initiatives are at proposal stage or are underway e.g., ED – ANP's, Radiology and Psychology. • CIP Target is £3.6m and plans worth £1.5m have been identified, leaving a gap of £2.1m unidentified CIP. • Junior doctor usage continues to be significant with an additional 26.34 WTE doctors paid above budget in May. • HCA Bank usage continues to be significant with an additional 12.46 WTE HCAs paid above budget in May.

Medicine 000125

SAFE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	32	36	29	28	33	39	24	49	32	39	36	43	45		No Threshold
Clinical Incidents resulting in No Harm	125	89	101	101	133	93	87	100	104	103	88	107	104		No Threshold
Clinical Incidents resulting in minor, non permanent harm	24	17	18	17	12	28	25	18	19	16	16	19	27		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	3	1	1	0	0	0	0	0	0	0	0	1	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	1	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	0	1	0	2	3	1	0	1	1	0	0	1	2		No Threshold
Medication Errors (Incidents)	42	26	14	20	35	24	20	30	28	18	20	31	29		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	3	2	0	2	1	6	7	4	1	4	2	0	4		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	88.2%	93.3%	96.2%	75.0%	85.7%	91.3%	83.3%	83.3%							>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	1	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	0	0	2	3	3	4	2	1	0	1	3	7	7		No Threshold
Hospital Acquired Organisms - MSSA	0	0	0	0	0	1	1	0	0	0	0	1	0		No Threshold
Cleanliness Scores	98.2%	98.6%	98.6%	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%	98.8%	99.4%	99.7%	99.4%		No Threshold

CARING

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Complaints	5	2	4	4	3	5	7	2	5	5	4	6	7		No Threshold
PALS	23	40	43	26	49	50	45	42	35	50	52	33	44		No Threshold

EFFECTIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Referrals Received (Total)	2,317	2,480	2,342	1,995	2,558	2,740	2,823	3,175	3,050	2,646	3,433	2,554	2,426		No Threshold
ED: 95% Treated within 4 Hours	81.1%	85.5%	67.9%	87.7%	73.4%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%		>=95 % N/A <95 %
ED: Patients In Department >12 Hours	3	2	17	0	14	47	46	26	11	23	70	19	10		0 N/A >0
ED: Median Time to Triage (Mins)	6	1	8	10	14	17	17	13	10	12	20	12	14		No Threshold
ED: Median Time to Clinical Assessment (Mins)	140	117	158	76	100	108	129	87	83	102	125	106	104		No Threshold
ED: Percentage Left without being seen	7.4%	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 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	0	0	0	0	1	0	1	4	0	1	1	0	1		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	0	0	0	0	1	0	0	3	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	9.5%	8.6%	9.8%	9.7%	8.4%	9.2%	9.6%	9.9%	9.1%	8.8%	9.5%	9.4%	8.4%		No Threshold
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised	76.9%	73.9%	74.2%	72.2%	78.5%	76.6%	76.7%	73.7%	70.8%	74.9%	79.3%	78.6%	83.3%		>=90 % >=80 % <80 %

Medicine 000126

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
On the day Elective Cancelled Operations for Non Clinical Reasons	0	1	0	3	2	3	5	0	4	0	5	9	0		No Threshold
28 Day Breaches	0	0	0	0	1	1	2	2	0	0	2	1	9		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	21	37	42	30	43	45	40	33	37	26	36	27		No Threshold
OP Appointments Cancelled by Hospital %	11.0%	11.6%	14.9%	14.6%	13.8%	15.2%	12.4%	12.3%	12.5%	13.3%	12.8%	15.0%	15.4%		<=5 % N/A >10 %
Was Not Brought Rate	8.2%	9.3%	10.0%	10.7%	9.2%	9.1%	8.8%	8.8%	8.6%	7.8%	8.0%	8.9%	8.5%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	9.1%	10.8%	10.3%	10.9%	8.6%	9.3%	8.6%	8.7%	10.4%	7.4%	9.0%	8.7%	8.2%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	8.0%	9.0%	9.9%	10.8%	9.4%	9.1%	8.9%	8.8%	8.3%	7.9%	7.8%	9.0%	8.6%		<=14 % <=16 % >16 %
Coding average comorbidities	5.17	5.58	5.47	5.58	5.50	5.68	5.57	5.49	5.51	5.41	5.54	5.73	5.69		No Threshold

RESPONSIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	98.3%	93.5%	87.9%	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%	92.1%	93.4%	92.2%	98.0%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	100.0%	89.1%	87.9%	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%	97.0%	95.9%	98.0%	96.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	91.5%	95.7%	86.2%	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%	58.4%	53.7%	51.0%	55.0%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	100.0%	97.8%	93.1%	87.2%	90.2%	100.0%	94.9%	96.2%	97.3%	95.0%	97.5%	95.1%	98.7%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	88.1%	71.7%	81.0%	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%	80.2%	89.3%	80.4%	79.2%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	89.8%	80.4%	87.9%	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%	92.1%	96.7%	95.1%	90.6%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	93.1%	92.5%	86.8%	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%	63.4%	62.8%	61.5%	62.0%		>=92 % >=90 % <90 %
Waiting List Size	2,819	3,122	3,338	3,507	3,565	5,605	5,842	5,943	5,955	6,136	6,411	6,922	7,266		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	3	6	11	7	13	23	10	15	5	2	2	5	8		0 N/A >0
Waiting Times - 40 weeks and above	12	15													No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	95.7%	100.0%	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks	95.1%	98.4%	95.6%	94.4%	97.1%	96.4%	88.7%	92.3%	88.5%	66.7%	59.6%	55.2%			>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%			100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	92.6%	91.1%	91.6%	91.9%	89.8%	89.8%	90.0%	88.2%	89.8%	90.4%	88.9%	89.9%	90.2%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	99.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	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	96.0%	100.0%	99.0%	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%	99.0%	99.0%	97.0%	96.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	96.0%	95.0%	92.0%	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%	82.0%	89.0%	83.0%	80.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	57.0%	52.9%	54.0%	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%	64.0%	67.0%	61.0%	62.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	100.0%	91.9%	89.4%	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%	72.5%	77.1%	73.2%			>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	100.0%	100.0%	93.5%	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%	93.5%	91.2%	87.1%			>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	100.0%	99.3%	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%	100.0%	100.0%	100.0%			>=99 % N/A <99 %

Medicine 000127

WELL LED

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	200	-1,036	-347	-58	253	-127	-199	87	144	-261	-344	-343	-633		No Threshold
Income In Month Variance (£'000s)	-26	-1	209	-490	201	-184	1,138	829	-308	135	273	1,294	638		No Threshold
Pay In Month Variance (£'000s)	60	-150	48	47	121	-35	15	70	-96	-218	-376	-151	-140		No Threshold
AvP: IP - Non-Elective	794	808	822	694	826	1,008	956	860	892	913	902	-32	-4		>=0 N/A <0
AvP: IP Elective vs Plan	170	162	132	134	112	125	125	95	120	136	165	-4	3		>=0 N/A <0
AvP: OP New	1,073.00	1,208.00	1,154.00	945.00	1,234.00	1,130.00	1,254.00	896.00	980.00	922.00	1,115.00	-413.34	-95.86		>=0 N/A <0
AvP: OP FollowUp	4,686.00	5,198.00	4,275.00	3,827.00	4,608.00	4,182.00	4,528.00	3,689.00	4,236.00	3,907.00	4,779.00	702.87	966.00		>=0 N/A <0
AvP: Daycase Activity vs Plan	1,187	1,371	1,240	1,139	1,276	1,276	1,377	1,166	1,203	1,231	1,471	144	269		>=0 N/A <0
AvP: Outpatient Activity vs Plan	6,823	7,494	6,395	5,764	6,851	6,381	6,955	5,618	6,133	5,800	7,067	-14	719		>=0 N/A <0
PDR	6.8%	18.5%	50.2%	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%	74.2%	74.0%	0.0%	1.6%		No Threshold
Medical Appraisal	28.6%	33.9%	42.0%	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%	0.0%	10.2%	13.5%	22.1%		No Threshold
Mandatory Training	87.6%	87.9%	87.2%	86.9%	87.0%	86.1%	86.6%	86.7%	85.9%	87.0%	88.9%	90.2%	91.5%		>=90 % >=80 % <80 %
Sickness	5.5%	5.3%	6.4%	7.1%	6.3%	6.5%	7.4%	9.3%	9.8%	8.0%	8.9%	8.5%	6.8%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.5%	1.5%	2.0%	1.9%	1.8%	2.3%	2.2%	3.6%	4.5%	2.9%	4.1%	3.2%	1.8%		<=1 % N/A >1 %
Long Term Sickness	4.0%	3.7%	4.4%	5.2%	4.5%	4.3%	5.2%	5.8%	5.3%	5.1%	4.8%	5.3%	5.0%		<=3 % N/A >3 %
Temporary Spend ('000s)	262	230	265	263	292	311	373	370	452	495	614	484	506		No Threshold
Staff Turnover	6.8%	7.3%	7.5%	8.3%	9.3%	9.5%	9.7%	9.8%	11.2%	12.1%	12.7%	12.5%	13.3%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	97.9%	96.0%	87.2%	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%	77.0%	81.3%	76.3%	78.2%		>=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 • Reduction in CLABSI (ICU) in month (1) • Continued increase in near miss/no harm reporting • Cleanliness scores continue to increase- 99.5% **Challenges** • Sepsis data is still not readily available • Medication errors increased (6)
CARING	Although the division saw a decrease in formal complaints we had a significant increase in PALS in May and key themes were around appointment delays and Outpatient waiting times. These lie mainly within our RTT pressure areas. 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** • Formal complaints reduced for 4th consecutive month (5) **Challenges** • PALS increased significantly in May relating to waiting times
EFFECTIVE	Total referrals increased significantly in month and the division will look to review which speciality areas this affects to ensure sufficient capacity plans are in place. Significant improvement in theatre utilisation in month with a continued focus on recovery, theatre performance and throughput of cases through lists. Further development of the theatre dashboard continues to move to 'touch time' which will offer further opportunity to increase productivity.	**Highlight** • Reduction in 28 day breaches (4) despite an increase in on the day elective cancellations • Continued improvement in number of less than 6 week clinic cancellations- result of improving approval process • WNB decreased, particularly for new patients **Challenges** • Increase in on the day elective cancellations- number relating to list overruns (specialty areas under review)
RESPONSIVE	Our waiting list size continues to grow within the Division (13,640). Although the RTT position improved in month the challenge remains 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 62.7% • Reduction in total patients waiting over 52 weeks (reduction of 18 in month) **Challenges** • DM01- Data not available in report but compliance remains a challenge within the division for Urodynamics due to Radiology workforce constraints.

WELL LED	Overall Sickness absence rates have improved in month for both long and short term sickness. Our mandatory training position is now 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. Temporary spend reduced for 2nd consecutive month. The division still remain focused on reducing this further via stricter financial controls and full budget reviews.	**Highlight** • Mandatory training remains over target at 90.9% • Sickness absence rates improved in month at 5.4% **Challenges** • 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

Surgery 000130

SAFE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	32	43	27	25	42	33	33	21	25	21	35	37	40		No Threshold
Clinical Incidents resulting in No Harm	165	164	120	113	107	103	118	117	78	114	133	110	140		No Threshold
Clinical Incidents resulting in minor, non permanent harm	28	38	31	49	39	43	81	40	40	43	42	46	67		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	2	0	0	1	0	1	1	0	2	1	1	1	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	1	1	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	2	1	2	3	1	1	3	4	1	2	2	1	6		No Threshold
Medication Errors (Incidents)	36	29	24	27	26	20	28	29	21	21	26	25	39		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	1	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	91.7%	88.9%	66.7%	100.0%	75.0%	82.6%	82.4%	75.0%							>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	1	0	2	0	0	0	2	1	0	0	1	0	0		No Threshold
Cleanliness Scores	98.4%	98.2%	98.7%	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%	98.7%	99.1%	98.5%	99.5%		No Threshold

CARING

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

EFFECTIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	2	0	1	2	0	0	0	1	1	1	0	0	0		No Threshold
% Readmissions to PICU within 48 hrs	2.6%	0.0%	1.4%	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%					No Threshold
Referrals Received (Total)	4,134	4,391	3,781	3,248	3,954	3,614	4,009	3,164	3,373	3,628	4,268	3,401	4,208		No Threshold
Theatre Utilisation - % of Session Utilised	83.0%	78.4%	79.5%	81.0%	83.8%	86.7%	79.4%	81.5%	77.2%	85.9%	88.7%	87.6%	96.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	7	12	13	9	30	20	51	23	18	16	18	13	23		No Threshold
28 Day Breaches	3	0	3	8	4	10	10	23	7	3	7	9	4		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	46	59	63	74	54	78	43	51	48	34	50	39	28		No Threshold
OP Appointments Cancelled by Hospital %	10.1%	11.2%	9.6%	11.3%	11.3%	10.5%	8.8%	10.5%	12.8%	12.4%	13.7%	14.4%	12.1%		<=5 % <=10 % >10 %
Was Not Brought Rate	7.3%	7.9%	9.5%	10.1%	8.6%	7.8%	8.3%	9.1%	9.3%	8.1%	7.9%	9.3%	8.8%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	9.8%	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 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	6.3%	7.3%	8.5%	9.4%	8.1%	7.3%	7.6%	8.6%	8.6%	7.6%	7.7%	8.5%	8.4%		<=14 % <=16 % >16 %
Coding average comorbidities	4.40	4.49	4.62	4.57	4.51	4.50	4.28	4.51	4.57	4.64	4.58	4.47	4.47		No Threshold
CCAD Cases	31	39	28	19	23	29	24	33	20	22	27	29	26		No Threshold

Surgery 000131

RESPONSIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	97.9%	94.7%	97.1%	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%	93.6%	96.4%	97.7%	97.6%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	98.6%	96.8%	97.1%	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%	96.5%	99.0%	100.0%	99.0%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	92.5%	96.8%	97.1%	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%	73.1%	73.8%	75.4%	75.2%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	97.9%	98.9%	98.6%	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%	98.2%	99.5%	98.3%	99.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	76.7%	83.0%	83.5%	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%	81.3%	86.2%	77.7%	78.1%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	92.5%	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 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	64.2%	67.9%	68.5%	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%	61.5%	61.9%	61.0%	62.7%		>=92 % >=90 % <90 %
Waiting List Size	7,980	7,484	7,787	8,632	8,319	11,360	11,505	11,621	11,567	11,949	12,413	13,085	13,640		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	232	197	174	186	249	294	239	202	231	244	246	282	265		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	93.8%	100.0%	100.0%	88.9%	80.0%	83.3%	66.7%	32.5%	35.4%	29.6%			>=99 % N/A <99 %

WELL LED

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	217	108	583	-5	-137	-349	-598	-657	-130	-232	-581	-603	-353		No Threshold
Income In Month Variance (£'000s)	49	209	223	28	-144	-43	68	59	-16	23	131	10	10		No Threshold
Pay In Month Variance (£'000s)	28	-116	541	-64	-158	-82	-452	-331	-85	-358	-196	-218	5		No Threshold
AvP: IP - Non-Elective	472	485	406	386	421	371	411	404	386	385	452	6	-15		>=0 N/A <0
AvP: IP Elective vs Plan	277	299	298	243	270	288	278	247	213	237	281	-45	-34		>=0 N/A <0
AvP: OP New	2,322.00	2,562.00	2,485.00	2,145.00	2,790.00	2,422.00	2,446.00	1,917.00	2,007.00	1,878.00	2,290.00	-1,025.15	-552.71		>=0 N/A <0
AvP: OP FollowUp	6,809.00	7,012.00	6,817.00	5,651.00	6,599.00	7,012.00	8,204.00	5,883.00	6,078.00	6,220.00	7,610.00	-447.98	-20.15		>=0 N/A <0
AvP: Daycase Activity vs Plan	665	795	711	622	710	732	837	696	672	611	720	-102	-98		>=0 N/A <0
AvP: Outpatient Activity vs Plan	10,554	11,199	10,961	9,230	10,991	10,964	12,473	9,162	9,278	9,411	11,194	-1,564	-613		>=0 N/A <0
PDR	9.0%	20.3%	47.2%	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%	61.3%	61.1%	0.3%	0.5%		No Threshold
Medical Appraisal	34.8%	37.8%	44.2%	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%	0.8%	14.4%	19.8%	26.7%		No Threshold
Mandatory Training	87.1%	87.8%	88.2%	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%	88.5%	89.4%	91.1%	90.9%		>=90 % >=80 % <80 %
Sickness	5.6%	5.8%	6.7%	6.2%	6.4%	6.0%	5.6%	7.1%	8.2%	5.9%	6.9%	6.3%	5.4%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.6%	1.6%	2.2%	1.6%	2.3%	2.5%	1.9%	3.2%	4.4%	2.6%	3.3%	2.7%	2.1%		<=1 % N/A >1 %
Long Term Sickness	4.1%	4.2%	4.5%	4.5%	4.1%	3.5%	3.8%	3.9%	3.8%	3.3%	3.5%	3.6%	3.3%		<=3 % N/A >3 %
Temporary Spend ('000s)	457	332	445	469	532	363	631	535	474	535	824	621	341		No Threshold
Staff Turnover	8.9%	8.9%	9.6%	10.2%	10.4%	11.1%	11.4%	11.3%	11.8%	12.2%	12.4%	12.1%	11.4%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	99.2%	98.4%	90.0%	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%	86.6%	80.5%	86.8%	90.4%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	Improvement changes from incidents: **Incident 57665 (**ADHD) Child absconded from clinic following attempt to undertake diagnostic test. **Improvement** – All Meditech notes to be reviewed before proceeding with tests such as QB testing, to understand if child is likely to have difficulties completing the assessment. **Incident 57385** (ASD) Parent confirmed ASD diagnosis for a child who was previously out of area and this was subsequently found to be incorrect. **Improvement** – All clinicians to ensure diagnosis is confirmed through GP or other professional documentation before adding to medical record.	**Highlight** • Zero clinical incidents resulting in moderate harm, severe harm or death • Zero grade 3 or 4 pressure ulcers • 245 incidents reported (206 clinical, 39 non-clinical) **Challenges** • Incident reported in phlebotomy relating to clinic room which is not wheelchair accessible and was therefore unable to be accessed by a parent. Alternative phlebotomy space is being identified to maintain current service capacity.
CARING	Improvement changes from complaints includes: **SO20241** (Developmental Paediatrics/Speech & Language Therapy) – Complaint related to communication concerns relating to referral and appointment. **Improvement** – Triage process in service to be reviewed and circulated to staff to ensure re-referral process is followed and recovery plan has been established for SALT.	**Highlight** • 28 Excellence Reports submitted in May • 22 Compliments submitted in May • 92% FFT Scores for Community • 100% FFT Scores for Mental Health • 93% FFT Scores for Outpatients **Challenges** • 3 formal complaints received in May. These complaints relate to waiting times in ASD; Speech and Language Therapy and Rainbow services. • 26 PALs recorded in May; this is a decrease compared to April (31 PALs).
EFFECTIVE	SEND re-inspection took place in Liverpool which was supported by Alder Hey SEND team and other clinical services.	**Highlight** • Division met the 104% elective recovery target for new outpatient appointments in May **Challenges** • Significant increase in calls to Crisis Care Service in May (800 calls), corresponding with an increase in mental health presentations to the Alder Hey Emergency Department (94 attendances).

RESPONSIVE	Non-recurrent investment approved by Transforming Care Fund to maintain Intensive Support Team for 2022/2023. This supports complex children and young people with a Learning Disability and/or Autism.	**Highlight** • Increase in RTT compliance for community paediatrics from 47% (April) to 54% in May. However. further improvements required to meet national target. • Eating Disorder Service routine waiting times compliance increased to 57% and assessments are now available within the 28-day target. **Challenges** • Continued increases in referrals to the ASD and ADHD diagnostic pathway which has challenged service recovery plans. Recruitment is underway following confirmation of investment and further discussion with commissioners is taking place. Ongoing wider system discussions regarding levels of referrals led by Director and ACCO.
WELL LED	Director Community & Mental Health and Divisional Clinical Information Officer presented digital mental health innovations at National Children's Mental Health Conference Divisional Patient Experience sub-group established, and first meeting held in May.	**Highlight** • Mandatory training remains above Trust target at 95.3%. Action plan in place to address individual staff with non-compliance. **Challenges** • PDR completion rates are lower than predicted at 1.6% however dates for senior staff have been prioritised before the end of July and compliance is expected to significantly increase.

Community 000134

SAFE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	12	7	11	4	8	4	2	4	13	14	10	12	18		No Threshold
Clinical Incidents resulting in No Harm	54	51	92	65	50	63	56	29	40	51	64	88	145		No Threshold
Clinical Incidents resulting in minor, non permanent harm	19	12	20	10	14	8	9	4	7	17	65	39	43		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	9	10	8	12	18	13	5	6	5	15	5	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	99.0%	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

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

EFFECTIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Referrals Received (Total)	1,284	1,326	1,061	729	1,021	1,116	1,234	1,063	1,145	1,152	1,406	894	1,315		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	5	9	21	22	17	25	41	17	12	8	13	2	0		No Threshold
OP Appointments Cancelled by Hospital %	10.2%	11.9%	13.6%	15.7%	12.2%	17.0%	9.6%	13.9%	13.7%	14.0%	17.0%	14.0%	10.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	17.7%	13.8%	19.0%	13.6%	15.7%	17.2%	16.4%	15.8%	16.2%	12.2%	10.6%	16.1%	10.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	13.6%	12.5%	16.0%	16.2%	13.8%	13.4%	14.0%	13.1%	12.2%	13.2%	11.8%	14.8%	14.4%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	22.5%	17.1%	19.8%	17.1%	19.9%	16.9%	16.7%	18.0%	18.5%	11.1%	12.7%	16.0%	10.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	17.0%	18.5%	22.0%	24.4%	24.0%	20.1%	19.0%	15.7%	15.6%	14.8%	14.5%	17.6%	12.1%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	15.8%	11.7%	23.4%	19.7%	12.6%	16.2%	21.1%	17.5%	18.3%	16.2%	13.4%	22.6%	13.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	13.3%	12.0%	15.8%	15.2%	10.9%	12.0%	13.8%	14.0%	12.4%	13.8%	12.3%	15.1%	16.7%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	114.3%	112.9%	100.0%	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%	128.6%	128.6%	128.6%	124.9%		No Threshold
CAMHS: Tier 4 DJU Bed Days	248	237	217	216	214	267	217	198	219	252	279	270	270		No Threshold
Coding average comorbidities		2.00		8.00			4.50	7.00	3.50			15.00	2.00		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU					1	1	1		4						No Threshold
CAMHS: Referrals Received	536	638	374	297	475	526	567	433	535	484	622	350	567		No Threshold
CAMHS: Referrals Accepted By The Service	254	316	173	141	233	302	306	219	275	233	317	171	275		No Threshold

Community 000135

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
CAMHS: % Referrals Accepted By The Service	47.4%	49.5%	46.3%	47.5%	49.1%	57.4%	54.0%	50.6%	51.4%	48.1%	51.0%	48.9%	48.5%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	74.0%	69.6%	57.1%	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%	54.1%	52.0%	49.7%	54.3%		>=92 % >=90 % <90 %
Waiting List Size	765	808	971	1,147	1,208	1,530	1,629	1,563	1,576	1,646	1,788	1,887	1,979		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	0	1	2	2	1	1	1	1	1	0	1	3	9		0 N/A >0
CAMHS: Crisis / Duty Call Activity	757	718	573	367	675	563	766	629	687	619	751	652	800		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	68.0%	70.1%	69.3%	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%	67.2%	70.6%	69.2%	69.6%		>=92 % >=90 % <88 %
ASD: Completed Pathways	151	137	103	234	56	66	95	68	86	71	47	42	45		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	27.2%	18.2%	11.7%	4.3%	10.7%	7.6%	15.8%	17.6%	14.0%	8.5%	2.1%	11.9%	15.6%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)			6.7%	21.4%	10.5%	23.8%	21.7%	25.0%	16.7%	15.0%	12.0%	15.0%	57.1%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)			50.0%	100.0%	66.7%	100.0%	100.0%	50.0%	100.0%	50.0%	100.0%		0.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	135	150	582	144	143	165	168	177	150	140	157	134	165		No Threshold
CCNS: Number of Contacts	821	835	959	809	736	931	959	951	740	823	904	800	928		No Threshold

WELL LED

	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	212	-11	287	250	540	16	60	185	346	-77	93	36	297		No Threshold
Income In Month Variance (£'000s)	88	50	154	75	118	-78	59	118	-112	-106	78	53	0		No Threshold
Pay In Month Variance (£'000s)	-49	-87	260	167	15	142	319	-9	248	228	-112	17	90		No Threshold
AvP: OP New	800.00	651.00	570.00	518.00	586.00	593.00	662.00	534.00	544.00	592.00	673.00	79.21	281.29		>=0 N/A <0
AvP: OP FollowUp	4,070.00	4,220.00	3,732.00	3,069.00	3,804.00	3,423.00	4,157.00	3,411.00	3,757.00	3,600.00	4,088.00	910.79	1,369.33		>=0 N/A <0
AvP: Outpatient Activity vs Plan	4,870	4,871	4,302	3,587	4,391	4,016	4,825	3,959	4,314	4,204	4,780	998	1,656		>=0 N/A <0
PDR	1.5%	21.5%	71.5%	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%	82.5%	82.6%	0.0%	1.6%		No Threshold
Medical Appraisal	24.0%	24.0%	36.0%	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%	0.0%	8.6%	10.8%	9.1%		No Threshold
Mandatory Training	91.0%	92.3%	92.1%	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%	92.4%	93.3%	94.4%	95.3%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	192	229	171	127	168	192	166	273	168	278	493	202	254		No Threshold
Safer Staffing (Shift Fill Rate)	99.1%		99.2%	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%	99.1%	99.4%	96.9%	96.9%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance • Thematic review of incidents completed quarterly with briefing circulated across the division under lessons learned. • Trust metrics checked for compliance at individual 121's under management review and actions recorded for assurance • PDR's dates planned for B7 and above, to complete by end of July • Nursing leads now part of Senior Nurse on Site rota supporting safe staffing levels across the trust. • CRD staff have contributed to red staffing model across the Trust • Reduction seen in Cleanliness audit	**Highlight** • Mandatory Training > 92% • GCP training >97% • SOP compliance 87.9% (Upward trajectory from last month) • ANTT compliance remains at 100% • CRD ICP compliant • 100% compliance report on recent CD audit **Challenges** • PDR Target has been slow to improve since window opened as new schedule for PDRs is embedded. • X1 incidents reported in month (1 covid sickness reporting) • Safe staffing across the Trust has required research nurses on 3 occasions in month under red model. This has required reporting to CRN under funding update. • Reduced score for May on cleanliness audit anticipated to be due to sickness of clinical lead.
CARING	• 0 complaints received • 0 PALS issues • Patient outcomes driver for decision on new study trials to open. • Patient feedback used to improve quality of patient care and experience • Quarterly staff survey's completed under people plan. • Health watch Liverpool and Sefton planned visits	**Highlight** • X 0 Complaints or PALS concerns • Collaborative working with local partners continues • Research participating in Trust PEG. • Research attended CYP forum (regular invite established) • PRES link and paper versions given to all families to capture feedback- awaiting response rate from CRN **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system. • Compliments to be added to Ulysses as standard practice.
EFFECTIVE	• Trust compliant with NIHR reset programme. • Clinicians encourage children and young people to make informed decisions about participating in studies. • New models of working being established, staff engagement sessions planned. • Survey for Matrons group to explore research awareness in clinical ward nursing teams completed. Results shared with CNO to compliment other workstreams	**Highlight** • CCP WHO Public health study initiated in response to hepatitis outbreak in children word wide. • Priority given to seasonal RSV studies to open earlier than planned to respond to trends in infection rates. • Accepted as site for Harmonie (Little Lungs) RSV vaccine trial. • Gene therapy trial planned. **Challenges** • CRD working with local system partners to improve research participation. • Funding for new model of working in ED following completion of pilot. • Awaiting delivery of Isolator for gene therapy trial

<table>
<tr>
<td>RESPONSIVE</td>
<td>

Brilliant Basics team supporting research department with specific improvement projects
Coordinated and partnership working with local providers to offer joint training programmes.
Targeted training planned for new managers in the department for risk reporting.
New desk plan for IITP staff to aid desk access

</td>
<td>
Highlight

Collaborative working with external partners continues
Plan has been made to have regular archiving events to clear closed studies and send to offsite storage.
Education Lead post agreed and out to advert.

Challenges

Storage for site files and equipment is insufficient for research department
Research team support for Trust vaccine programme ongoing
Desk space for research staff. Agile working introduced to offset limited space.

</td>
</tr>
<tr>
<td>WELL LED</td>
<td>

Impact of changes to working pattern undergoing data collection for audit and review
Internal staff survey results have been collated and shared
CRF grant for £2m award from NIHR now agreed. Objectives in new grant applied and ahead of schedule
New education post confirmed and in process of recruiting to post.
BC action plan to be completed for June deadline
6/9 vacant posts have now been recruited to which has concluded some actions on risk register. Work continues with remaining vacancies to manage current risk.
Staff turnover reduced slightly in month but still a concern. SMT working with HR business partner to identify data sources

</td>
<td>
Highlight

Flexible working (hybrid model) continues
Staff survey results above Trust Targets
People plan metrics were positive
Big conversation underway
Staff LiA’s events planned
Departmental sickness has improved and almost in line with Trust metric.

Challenges

New model for future working to be embedded considering human dimensions of change. This requires compassionate leadership, adequate time for staff consultation and engagement.
Some staff will experience changes to working patterns period of adjustment needed
Recruitment and retention being monitored carefully due to increase in leavers
F2F exit interviews established with leavers with key questions focussed on retention, will be explored as local theme in BC events
Partner trusts have higher banding for the non-clinical roles that we have in the division.

</td>
</tr>
</table>

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

Paper Title:	Growing Great Partnerships
Report of:	Dani Jones, Director of Strategy and Partnerships
Paper Prepared by:	Dani Jones, Director of Strategy and Partnerships

Purpose of Paper:	Decision **Assurance X** **Information X** Regulation
Background Papers and/or supporting information:	Link to BAF Risk 3.6 – risk of partnership failures due to robustness of partnership governance.
Action/Decision Required:	To note **X** 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 X** Game-changing **research and innovation** **Strong Foundations**
Resource Impact:	N/A

Growing Great Partnerships

1. Introduction

The purpose of this report is to provide the Board of Directors with
- An update and assurance of progress and risk management within the Trust's established health and care partnerships
- An update on the Trust's emergent health and care partnerships
- Recommendations on an approach to providing assurance to the Board that the Trust is fulfilling all key partnership roles robustly and that associated risks are adequately managed.

2. Trust Vision and Strategic Objective

Alder Hey has long recognised that to achieve our vision of '*a healthier future for children and young people*' we must work in partnership. No individual NHS organisation can address the full range of patient pathways for any given child or young person. Alongside this, experiences during the early years and in education are particularly important for immediate and longer-term health and outcomes in other social determinants of health such as education, employment, and income[1]. Greater system action on health inequalities and prevention of ill health can give children a better start in life, enabling them to become healthier young people and adults.

To enable this, partner relationships with NHS trusts and commissioners, Primary Care networks (PCNs), Local Authority public health, social care and education teams, as well as voluntary, community and faith sector groups are essential. Alder Hey recognised this through the strategic objective 'growing great partnerships', as outlined in our strategic plan 'Our Plan' (2019-2024).

3. Definition and Scope

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 thanks to the implementation of integrated care systems (ICSs) through the Health & Care Act (2022). **The scope of this paper pertains to partnerships between the Trust and health and care system partners.** Alder Hey also engages in a range of commercial legally binding partnerships, out of scope here, but which are overseen via Innovation Committee or Resources and Business Committee and documented via standard operating procedures (for example, innovation, education, research and international).

There is no single definition of 'partnership' in the NHS, and currently no formal framework for the breadth of health and care partnerships to follow. As such, Alder Hey has undertaken a range of activities to categorise and scope our health and care partnerships, and to learn from others on approaches – examples include:

- Analysis of partnership-related Board Assurance Framework (BAF) risk themes, scores, controls, and mitigations across a range of NHS Trusts, supported by Mersey Internal Audit Agency (MIAA) (September 2019, October 2021)
- An assessment of a range of different types of partnership governance documentation, both within the NHS (such as historical NHSE/I Memorandum of Understanding guidance) and across other sectors (such as Local Authority partnership governance arrangements) with support from MIAA (Q2/Q3 2019)
- Review by Trust Executives deriving priority partnerships for 21/22 and promoting the development of a Partnership Quality Assurance Round Framework (more below).

[1] "All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside", Institute of Health Equity, May 22, p46

These activities have enabled broad categorisation of the Trust's health and care partnerships into; **established partnerships** (those with formalised agreements and pooled/shared resources/funding, and therefore degrees of associated risk to be managed by the Trust) and **emergent partnerships** (not yet formalised and with no pooled/shared resources/funding and therefore currently low risk to the Trust).

4. Markers of good partnership governance

Despite the lack of a framework for partnership governance in the NHS, there are common markers of good governance for all partnerships, regardless of their nature and range – these include

- Roles and responsibilities clearly set out and agreed by all partner organisations
- Governance arrangements in place between the Trust and its partners
- The Trust has robust monitoring and reporting arrangements
- The Trust has an established and effective group / committee responsible for management and oversight of each partnership, and that this group / committee is effective in discharging its responsibilities
- Assurance is provided to the Board that the Trust is fulfilling its role robustly and that associated risks are adequately managed.

Not all partnerships are created equal; there is a need for proportionality when matching the appropriate agreements/governance to the scale of the partnership. There is routine engagement with the Director of Corporate Affairs and / or MIAA for advice in setting this proportionality.

5. Established Partnerships – Assurance / Update

Established partnerships have been defined as those which have shared resource / finances. They vary in type, scale, longevity, and some are strategic, others operational. Depending on their scale each has a partnership agreement or a formalised strategic Board commitment.

Four established partnerships/joint services were selected as priorities for assurance in March 21 by Trust Executives, due either to the scale of shared resource or complexities in delivery. Two new partnerships have been established since March 21. Alongside these, the North West Paediatric Partnership Board was established in 2019 to drive joint oversight of the North West Operational Delivery Networks (ODNs) and outline our overarching commitment to collaborative delivery of specific specialist and tertiary paediatric services for the North West where mutually agreed.

A summary of each of these partnerships, their named executive leads, purpose, partners, governance/reporting arrangements, 21/22 progress and any risks or issues for escalation to Trust Board can be found below.

Established partnership	Executive Lead	Purpose	Partners	Estab-lished	Governance/ Reporting Arrangements	Summary Progress 21/22	Risks / Issues for Escalation to Trust Board[2]
Liverpool Neonatal Partnership	Adam Bateman	Joint delivery of Level 3 neonatal service	Liverpool Women's FT	2020	Liverpool Neonatal Partnership (LNP) Governance structure LNP Board (monthly) provides assurance to Trust Boards at LWH & AHCH LNP Integrated Governance (monthly) – assurance to Surgical Critical Care Board (AHCH) and Family Health Board (LWH) Internal – Division of Surgery	-Executive boards agreed leadership team hosted at LWH. -Medical cover increased at both sites. -Governance structure agreed & embedded. -FiCare accreditation achieved at LWH & working towards at AHCH expected September 2022. -Safety champions implemented on both sites. -Providing multidisciplinary education across both sites. -LNP received 'women of the year' award 2022. -Building will commence at Alder Hey September 2022.	2617 – (16) Unable to proceed with staff recruitment due to failure to progress with commissioning. LNP working with teams on both sites to provide relevant information to progress discussion with commissioners. 2587 – (16) – 1C Neonatal staff redeployed to other areas based on number of babies and not acuity as a result of trust sickness being at a high level leading to initiation of Amber model of nursing.
Liverpool ACHD Partnership	Alf Bass	Joint delivery of Level 1 adult congenital	Liverpool Heart & Chest FT Liverpool University	2018 – revised MOU Sept 2020	External – Liverpool ACHD Partnership Board (quarterly)	-NW-wide delivery of seamless all-age CHD service in partnership -Development of governance	1 residual risk of 12 re: historical adult Manchester patient backlog – held on LHCH risk register &

*Risk score 12+, with mitigation & link to Risk Register

[2] 4

		heart disease service	Hospitals FT Liverpool Women's FT		Internal – Division of Surgery	-Close working with CHD ODN and Specialist Commissioners to shape the approach to a single patient list (PTL) for adults and children across N.West Identification of historical backlog issues (adult) and partnership working to resolve (ongoing).	routinely reviewed by partners at ACHD Board.
NorCESS - North West Epilepsy Surgery	Benedetta Pettorini	Joint delivery of Northern Epilepsy surgical service - aim to improve the uptake and access to epilepsy surgery in those children for whom surgical control or amelioration for their epilepsy is a possibility	Royal Manchester Children's (Manchester Foundation Trust)	2012	External – North West Paediatric Partnership Board (NWPPB - Alder Hey & Royal Manchester) Internal – Division of Surgery	-NorCESS is a long-standing specialist commissioned service by NHS England, receiving regular funding and serving CYP across the N.West - the multidisciplinary team (MDT) review children with epilepsy who meet the criteria for evaluation for surgical intervention, provide a comprehensive pre-surgical evaluation and co-ordinate epilepsy surgical procedures for children for whom it is identified as appropriate.	Ongoing risks re: persistent problems with specialist recruitment (e.g., neurology and neurophysiology). These are logged within the joint service and escalated via an agreed escalation plan to NWPPB.
"Beyond" - C&M Children & Young People's (CYP) Transformat	Dani Jones	Improving CYP outcomes across the C&M system	Cheshire & Merseyside ICS – all partners	April 2021	External - C&M ICS Programme Board, NHSE/I NW Region Internal – 6mthly Trust Board programme update	-At scale C&M-wide multi-agency programme of transformation established. -Local Authority & NHS led priority work streams in situ	12 – Strategic changes risk destabilising the system resulting in failure of multi-agency working

ion Programme						-Significant success in attracting national funding for key initiatives. -ICS-wide workstreams established for: - Healthy Weight/Obesity -Mental Health/Emotional Wellbeing -Respiratory -LD/Autism -Cross cutting work on: Family Hubs & Starting Well, CYP & Family Participation, SEND -Diabetes -Epilepsy	12 – Capacity in social care impacting on ability to identify resource for one project – mitigation via Programme Both risks are actively mitigated and managed via the Programme Board (minutes available).
North West Obesity Tier 3 service	Dani Jones *NB oversight transition to Medicine Division – now in delivery.	Joint delivery of level 3 obesity hub & spoke model	Royal Manchester Children's (Manchester Foundation Trust) Royal Preston Hospital	Nov 21	External - NHSE/I monitoring & C&M CYP Programme Board (quarterly) Internal - Division of Medicine	-Full implementation of new Tier 3 obesity service for North West -Recruitment complete, service running across 2 hubs (AH & RMCH) and spoke in Preston. -Led for Alder Hey by Dr Senthil Senniappan.	None for escalation.
Alder Hey & Public Health Liverpool	Dani Jones	Delivery of a shared work plan via joint practitioner resource	Liverpool City Council Public Health	May 21	Internal – Health Inequalities & Prevention Steering group → Safety & Quality Committee	-Joint Senior Public Health Practitioner in post (May 21) -Shared work plan including increased funding (pending) for community-based prevention. -HIP Steering Group established - coalescing the -Trust's widespread	None for escalation.

						Health Inequalities activity -Prevention Pledge commitments – in partnership with the ICS. -Priority project work includes: -Prevention in pathways: supporting long waiters with access to preventative support e.g., Mental health, food insecurity etc -Dental / Oral Health -Smoking Cessation (CYP, families and staff) -Healthy Weight & Obesity – community/VCSE local delivery	
North West Paediatric Partnership (NWPPB)	Dani Jones	Joint oversight of NW ODNs & commitment to collaborative delivery of specific specialist / tertiary paediatric services as mutually agreed.	Royal Manchester Children's (Manchester Foundation Trust)	2019	External – North West Paediatric Partnership Board NWPPB – Quarterly) Internal - RABD – ODN assurance paper (Quarterly)	-Joint development and oversight of NW ODNs -MOU's/partnership agreements described on a case-by-case basis at a service/network level, following the principles set out in the NWPPB MOU approved by Trust Board in 2019. -Scoping future NW service models e.g., cardiology -Aligned models for NW delivery across e.g., PIMS/Long Covid	None for escalation.

6. Innovating – Partnership Quality Assurance Rounds (PQAR)

Alder Hey has commenced work to devise an innovative new approach; partnership quality assurance rounds (PQAR). 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.

The PQAR enables a comprehensive self-assessment by the partnership against each of the CQC well led domains, offering an opportunity for the partnership to demonstrate successes and what they are proud of, as well as raising any key risks, issues with their proposed mitigation. The PQAR assurance pack is intended to be jointly presented at the relevant partnership board. The ambition is that key partnerships are encouraged to repeat this exercise annually, with involvement from non-Executives from each partner. Resulting PQAR packs will be shared with Trust Board for information and assurance.

Alder Hey and Liverpool Women's FT jointly agreed to pilot the approach with the Liverpool Neonatal Partnership (LNP), and the initial PQAR pack was presented to the LNP Board in June 22. The LNP team reflected very positively on the PQAR process; the act of bringing together the partners to reflect on successes and focus on the partnership overall shone a light on the significant progress made as a partnership team. It was felt to be a helpful tool in framing the work still to do, and in developing an evidence base for the partnership's assurance. Learning from the LNP's experience will be built into the PQAR process, and other key partnerships will be encouraged to undertake this.

7. Whole system 'Place' Partnerships & Provider Collaboratives (Emergent)

Alder Hey is a committed partner in a range of developing 'Place' partnerships and two provider collaboratives at Cheshire and Merseyside level. These system partnerships are currently in gestation, with no formally committed pooled resource/finance, aside from committed resource 'in kind' from each partner organisation to develop towards more formal partnership and delivery arrangements.

Delivery across all system partnerships has been heavily impacted by the Covid-19 pandemic (drawing system attention into day-to-day pandemic management and mutual aid) and the national architecture changes brought about by the Health and Social Care Act (2022) which has provoked a colossal shift in commissioning and collaboration arrangements across the system. As each emergent partnership formalises, governance will be designed in accordance with good governance markers outlined above, and Trust Board can expect to receive (in some cases have already) Memoranda of Understanding (MOUs) and/or other partnership governance agreements as these are developed with system partners.

Place Partnership	Purpose	Key Groups / Priorities	Executive Lead(s)
One Liverpool Programme	A whole-system plan; how partners will come together to deliver improved outcomes, collaborate to establish integrated services that will better meet people's needs and ensure the local health and care system is financially fit for the future.	- One Liverpool Partnership Board - One Liverpool Delivery Group - Complex Lives – including Family Safeguarding Model - Healthy Children & Families (to commence Q2 22/23)	Louise Shepherd, Dame Jo Williams Dani Jones Lisa Cooper Dani Jones
Sefton Partnership	Brings Sefton council and CCGs together with	- Sefton Partnership Board	Louise Shepherd/ Dani Jones

	organisations from across health and social care in the borough including NHS providers, Sefton CVS, voluntary, community and faith groups and Healthwatch Sefton, to deliver Sefton2gether strategy.	- CYP Partnership Board - Sefton Integrated Commissioning Group - Start Well Sefton	Lisa Cooper Dani Jones Dani Jones
Framework for Integrated Care (Liverpool & Sefton localities)	The vanguard to implement the framework for Integrated Care is a system wide approach to support CYP from vulnerable groups with complex needs/lives	The vision is to improve access and support in the community for vulnerable CYP with complex needs and their families/carers. Outcomes are: • Avoidance of admission to inpatient unit • Prevention of safeguarding escalation • Decrease in out of area placement • Decrease in missing from home episodes • Decrease in offending behaviours • Routine Outcome Measures for mental health – symptom trackers, SDQ, RCADS • Re-engagement in education/employment • Decrease in attendance at A&E in relation to mental health crisis • Stabilisation of placement • Development and use of trauma-informed approaches across the multi-agency system.	Lisa Cooper

One Liverpool Partnership - Trust Board received the One Liverpool strategy in 2019, the objectives of which are to work as a whole system to: take targeted action on health inequalities, drive empowerment and support for wellbeing, a radical upgrade in prevention and early intervention and build an integrated and sustainable health and care service.

- **Complex Lives** - is one of the five 'Segment Delivery Groups' of One Liverpool. The ambition includes making best use of existing resources for families, refining the governance structure surrounding delivery of services and reconfiguring the operational model, understanding the needs of complex families in relation to current services, identifying opportunities to join up services, make efficiencies and increase early intervention and prevention.

- **Family Safeguarding** model - Liverpool City Council is leading a system-wide programme with partners to develop a new model of family safeguarding, based around the 'Hertfordshire' model, and focused on increasing early help and decreasing the numbers of CYP taken into care/placement. Alder Hey are committed to supporting this work, which is connected into the One Liverpool governance via the Complex Lives programme group.

- **Healthy Children & Families** – is another of the five segment delivery groups of One Liverpool. The ambition is to increase the number of healthy children and families by reducing infant deaths, improving school readiness, reducing childhood obesity, reducing health inequalities, and improving mental health and wellbeing. The plan has been co-designed across CYP health care providers, commissioners (Public Health and NHS) and local authority social care and education teams and is scheduled to kick off in Q2 of 22/23. Alder Hey will provide the senior responsible owner (SRO) role for this segment in partnership with Liverpool City Council Public Health.

Framework for Integrated Care – The vanguard to implement the framework for Integrated Care is a system wide approach to support children and young people from vulnerable groups with complex needs/lives. The vision and outcomes for this work will be met through the following objectives which align with the 6 principles of the Framework:

- Embedding ACE and Trauma informed Approaches
- Adopting an asset-based approach with children and young people, families and communities and building positive relationships
- Working as part of an integrated community model
- Children and young people and family centred, embedding co-production across development, delivery, and evaluation
- Building and sustaining capacity in the workforce to support vulnerable children and young people and families
- Strengthening existing pathways and collaborative working.

Sefton Partnership - The 'Live Well Sefton' plan is emerging with one of the three ambitions being "Start Well". This will involve children and young people up to age 18, but also those up to age 25 years with additional needs. This ambition will focus on the 6 action areas outlined below.

1. Seamless coherent offer of support for all families
2. Welcoming family hubs in the community
3. Digitalised, virtual, telephone, face to face information around family needs.
4. Empowered start for life workforce
5. Improvement the Start for Life offer - improving data, evaluation, and outcomes
6. Leadership and accountability for early years.

Primary Care Networks (PCNs) - Primary Care networks were established in 2019, to bring together clusters of general practices alongside broader community services in neighbourhoods of 30-50,000 population; the aim being to work together on improving patient care across whole populations. As PCNs develop, the system emerges from the pandemic and as Alder Hey shapes a more population health-based 2030 vision and strategy, the Trust is reaching out afresh to PCNs to develop collaborative approaches to increasingly community-based support for children and young people closer to home.

C&M Provider Collaboratives - Through the Health and Social Care Act (2022), NHSE/I prescribed that all acute and mental health providers must be members of at least one provider collaborative. Alder Hey are committed partners in the two C&M Provider Collaboratives (described below).

Provider Collaborative	Purpose	Chair	Alder Hey Exec Lead
CMAST - Cheshire & Merseyside Acute and Specialist Trust Provider Collaborative	A collaborative of acute and specialist providers working together on making impact at scale in areas such as: clinical pathways, elective recovery, diagnostics, financial management and workforce.	Ann Marr	Louise Shepherd
LD/MH/C - LD, Mental Health &	A collaborative of LD, Mental Health and community providers working together to	Joe Rafferty	John Grinnell

Community Provider Collaborative	respond to system pressures (e.g., in discharges, flow, recovery, variation) and to develop a system response to defined population segments, delegated responsibilities and a proposed lead provider collaborative model.		

These are in development and building upon system collaborations developed throughout the Covid-19 pandemic. Monthly updates are provided to Trust Board through ICS updates; this will be sustained until such time as partnership agreements are approved and Trust Board agrees an appropriate route for governance and oversight for the move into delivery.

8. Link to Board Assurance Framework (BAF) and Risk Appetite

Establishment of this quarterly partnership assurance report, coupled with implementation of the partnership quality assurance round approach is linked to reducing the risk outlined in BAF 3.6 – risk of partnership failures due to robustness of partnership governance. This is currently rated 3 (likelihood) x 3 (consequence) = 9 (Amber). It is anticipated that once these measures have been effectively implemented, the risk level can reduce to the target risk rating 2 (likelihood) x 3 (consequence) = 6 (Yellow).

In February 22 the Trust Board set out the Trust's risk appetite statement. For 'system working and partnerships which will benefit our local populations' a 'high' risk score threshold and a 'seek' level of risk appetite were set, meaning the Trust is prepared to be innovative and choose options offering higher business rewards despite carrying greater inherent risks. As a result of this 'seek' level it is recommended that a continued focus through the BAF is sustained, even once target level is reached.

The approach to partnership governance assurance outlined in this paper was presented to the Trust's Risk Management Forum in June 22 and warmly welcomed. Work will continue to further shape and embed the framework, categorisation of partnerships and internal governance throughout 22/23.

9. Recommendations

Trust Board are recommended to

- Receive and note the content of this report
- Receive a quarterly update of this assurance report
- Note the Partnership Quality Assurance Round framework and receive assurance updates from partnerships as it is deployed.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

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

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

Equality, Diversity, and Inclusion Steering Group

Terms of Reference

1. Purpose

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

To ensure that the Trust is committed to:

- Meeting the General Equality Duty as outlined in the Equality Act 2010
- Providing EDI leadership, insight and input as it relates to staff, volunteers and children, young people and families who access services
- Development of a culture promoting EDI to eliminate discrimination
- Ensuring mutual respect and civility exists in the workplace and for children, young people, families, carers and staff to be inclusive of all
- Implementation of the Equality Delivery System (EDS2/3) and the action plan
- Implementation of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) and associated action plans
- Implementation of the Gender Pay Gap and the action plan
- Alignment of aims, objectives and interdependencies with the Trust Health Inequalities Steering Group

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

2. Role

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

3. Duties

To create, implement and monitor progress of a strategy to promote EDI across the Trust for children, young people who access services and staff including a focus on:

3.1 Delivery of the Trusts performance

- To review the Trusts performance in EDI using the EDS2/3, GPG, WDES and WRES, the staff survey and listening initiatives.
- Ensuring there are clear reporting and accountability processes in place throughout Trust departments, divisions on EDI matters such as Task and Finish groups.

- To assess risks associated with ED&I and advise the Trust Board.
- To influence external parties such as suppliers and procurement to improve performance around EDI.
- To report the Trust's progress to the Trust Board via the People and Wellbeing Committee

3.2 Inclusive recruitment and progression practices and increased representation

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

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

3.4 Leadership and culture of inclusion and belonging

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

- To showcase evidence of activities in which the organisation champions EDI

3.4 Addressing differentials in experience

- To be responsible for focusing on matters of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation, providing a key strategic focus on matters of race, LGBTQI+ and disability and long-term health conditions based on evidence of need within the Trust.

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

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

- To promote equality of opportunity for all staff and children, young people and families who access services and to ensure all sections of the community have ease of access to the Trust, with care and information that supports their need.

- To champion the Making Every Contact Count approach to behaviour change.

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

4. Membership

4.1 The EDISG shall consist of:

Non-Executive Director (Chair)
Chief People Officer (Co-Chair)
Deputy Chief People Officer
Chief Nurse
Associate Director of OD
Director of Marketing and Communications
Deputy Chief Medical Officer
Medical Services Director
Head of EDI
Staff Network representative (s)
Medical Workforce representative
Staff Side representative
Head of Patient Experience
Youth Forum representative
Divisional Representatives
Innovation and Equalities Programme Manager
Health and Safety representative
Alder Hey Charity representative
Freedom to Speak Up Guardian
Charity representative
Spiritual Care Manager
Pastoral Support Educator/Professional Nurse Advocate

Other individuals may attend meetings as required.

4.2 The EDISG will be deemed quorate provided 4 members are in attendance to include a minimum of:

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

5. Conduct

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

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

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

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

6. Frequency of meetings

6.1. Meetings shall be bi- monthly.

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

7. Minutes and reporting

7.1 The minutes of all meetings of the EDISG shall be formally recorded.

7.2 The Chair of the EDISG will produce a written report to People and Wellbeing Committee after each meeting.

7.3 The EDISG will report progress with the People and Wellbeing Committee at least annually.

8. Review

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

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

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

Board Assurance Framework 2022/23

1. Purpose

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

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

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

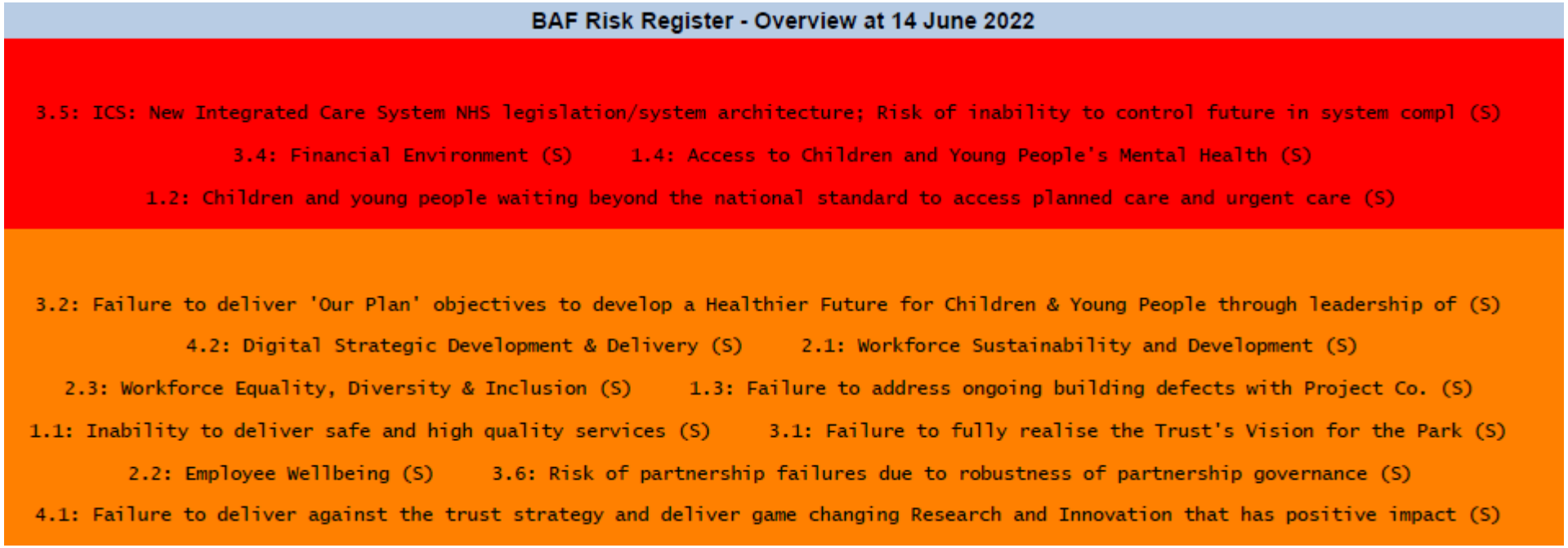
2. Review of the BAF

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

BAF Risk		Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Failure to address building deficits with Project Co.	Resources and Business Development Committee
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 14th June 2022

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



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

Report generated by Ulysses

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

4. Summary of BAF – at 14th June 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	-
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	**IMPROVED**	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 May 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. Assurance evidence updated and control added.

- ***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, Assurance evidence added.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month, additional control added.

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

- ***Failure to address building deficits with Project Co. (DP)***
  Risk reviewed and no change made to risk score.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  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.

- ***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 will be monitored through the patient safety board from July. No additional gaps in control have been identified.

- ***Financial Environment (JG).***
  Risk reviewed and added control gap on CIP programme and deliverability of the 22/23 targets.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Risk reviewed following Campus Review Session.

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

- ***Workforce Sustainability and Development (MS).***
  Actions updated and risk reviewed.

- ***Employee Wellbeing (MS).***
  Risk reviewed and actions updated. All actions on track except for action relating to Learning Review to be escalated. No change to risk rating

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

- ***Access to Children and Young People's Mental Health (LC)***
  New risk

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000160

BAF Risk

1.1

Inability to deliver
safe and high-quality services

(3x3=9)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

(2229) Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity. * (linked to 2.1)
(2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors
(2233) Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies
(2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval caused by UNHM and Alder Hey are served by two different transport services (KIDS & NWTS) meaning neither will transport non-time critical patients between trusts. Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours.
(2463) Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs * (Linked to 1.2)
(2501) Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments. *(Linked to 2.1)
(2516) Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.* (Linked to 2.1)
(2517) “Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes”, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.* (linked to 1.2 & 2.1)
(2327) Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence
(2332) : Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients (Linked to 1.1)
(2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.2 & 2.1)
(2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.2 & 2.1)
(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 2.1)
(2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.2 & 2.1)
(2578) Insufficient funding to provide Porter's service (Linked to 2.1)
(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.2)
(2570) Inadequate provision of inherited cardiac conditions (ICC) service for Children within the North West.
(2589) Inability to safely staff Catkin and Community Clinics (Linked to 2.1)
(2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal
(2410) Risk of long waits in ED department (Linked to 1.2)
(2326) Delayed diagnosis and treatment for children and young people (Linked to 1.2)
(2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced. (Linked to 1.2 & 201)
(2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 2.1)
(2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 2.1)

000161

BAF Risk	Strategic Aim	Related Corporate Risk(s)
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (3x5=15)	Delivery of **outstanding care**	(2233) Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies (linked to 1.1) (2501) Risk of inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 10 pandemic leading to a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments (linked to 1.1) (2463) Risk that Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals during 2020 (linked to 1.1) (2517) Risk of Children & Young People coming to harm whilst waiting for urgent treatment episodes, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS (linked to 1.1 & 2.1) (2383) Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation (Linked to 1.1 and 2.1) (2528) Recently the waiting time for first appointment and follow up appointments has increased significantly for the General Paediatric service, with their RTT compliance decreasing significantly (Linked to 1.1 and 2.1) (2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 2.1) (2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.1) (2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal. (Linked to 1.1 & 2.1) (2410) Risk of long waits in ED department (Linked to 1.1) (2326) Delayed diagnosis and treatment for children and young people (Linked to 2.1) (2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced. . (Linked to 1.1 & 2.1) (1902) Reduced availability of ED Consultants on shift to oversee the safety of the service, including the department's response to Major Trauma cases . (Linked to 1.1 & 2.1)

000162

BAF Risk

Strategic Aim

Related Corporate Risk(s)

1.3

Failure to address ongoing building defects with Project Co.

(4x3=12)

(1388) Risk of pipe burst due to corrosion

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.

000163

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) (2246) The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered (Linked to 1.1 & 1.2) (2578) Insufficient funding to provide Porter's service (Linked to 1.1) (2589) Inability to safely staff Catkin and Community Clinics (Linked to 1.1) (2597) There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal (Linked to 1.1 & 1.2) (2535) The Network has no direct nursing input. the network SLT is reduced by one third. the lead nurse is a full time post, therefore the work the network is capable of producing will be reduced (Linked to 1.1 & 1.2) (1902) Reduced availability of ED Consultants on shift to oversee the safety of the service, including the department's response to Major Trauma cases (Linked to 1.1 & 1.2) (2020) Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management. (Linked to 1.2) (2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 1.2) (2624) Reduction in the governance of research studies due to staffing levels within the Research Governance team (Linked to 4.1)

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

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

000166

BAF Risk	Strategic Aim	Related Corporate Risk(s)
4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP (3x3=9)	Game-changing **research and innovation**	(2624) Reduction in the governance of research studies due to staffing levels within the Research Governance team (Linked to 2.1)
4.2 Digital Strategic Development and Delivery (4x3=12)		None

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2383, 2332, 2441, 2461, 2265, 2427, 2326, 2514, 2384, 2233, 2340, 2516, 2312, 2229, 2332, 2383, 2536, 2570, 2246, 2578, 2497, 2100, 2501, 2589, 2597, 2326, 2535, 1902, 2415, 2410, 2020, 2528, 2230, 2617		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. SQAC will receive on going monthly updates on this program of work and improvements will be monitored through this process.	01/09/2022	Refer to SQAC reports for most up to date progress
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	01/09/2022	Refer to corporate report to SQAC and associated conversations
2. The Trust will deliver the Parity of esteem work program addressing this issue	01/09/2022	Please note most recent report to SQAC. Due to increased COVID response the working group was paused.

Executive Leads Assessment

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

Board Assurance Framework 2022-23

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

Board Assurance Framework 2022-23

NHS Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2233, 2383, 2246, 2497, 2578, 2463, 2501, 2501, 2597, 2326, 2535, 1902, 2410, 2528, 2517		
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	31/05/2022	

Executive Leads Assessment

0 - No Reviewer Entered
In October we have seen a positive increase in the level of service recovery: elective care was 103% and outpatient services 94% (provisional data) relative to 2019. The increase was driven in part by an increase in weekend sessions.. Nonetheless, there are risks to in-week throughput and recovery: firstly, PICU surge requiring volunteers to move from elective care to critical care. Secondly, high bed occupancy caused by a 20% rise in attendances to ED. As contained in our previous 52 week performance there has been an increase in the number of long wait patients from the Safe Waiting List Management programme. Our recovery plan in quarter 3 is focused on in-week productivity through the new theatre scheduling policy, additional sessions and recruitment through the accelerator investment.

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

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

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

February 2022 - Adam Bateman

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

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 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: 2497, 2517		
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.
Implementation of WNB predictor tool to improve appointment attendance	30/06/2022	Use of WNB predictor tool commenced for choice appointments with 4 Week Wait keyworker.
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 access and visibility of data relating to mental health. This includes: □ Ensuring activity data is accurate □ Improvements in EPR audit at practitioner level □ Visibility of national submitted MHSDS data □ A3 to be completed describing all actions relating to data	30/06/2022	Meeting held with locality leads on 13th May 2022 to discuss key actions relating to data
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	30/06/2022	Initial time one ROMS uploaded to app
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

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2340, 2312, 2516, 2497, 2383, 2536, 2246, 2578, 2497, 2100, 2501, 2589, 2597, 2535, 1902, 2020, 2528, 2624, 2617, 2517		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	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

Executive Leads Assessment

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.
April 2022 - Sharon Owen Sickness absence has continued has remained relatively static but higher than anticipated with absence rates circa 8%, creating pressures points across the Trust. Therefore this risk is not in a position to be reduced, however significant support and measures are in place to support staff and managers. Approx 2% of this is attributable to covid related absences.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2021 Staff Survey Report - main report, divisional reports and team level reports
Reward and Recognition Group relaunched after being on hold during the peak of the pandemic	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
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	Email sent to Melissa Swindell and Sharon Owen on 11th May re outcome of review and marked urgent. No response to date. A further email to be sent today 7th June requesting a response and outcome of the review
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	17/07/2022	See above
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.	17/07/2022	Business case complete and awaiting feedback from Finance before being presented at SRG
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	19/07/2022	Programme being developed by Sarah Robertson, Clinical Psychologist. Progress to be reported at the next HWB Steering group on 12th July

Executive Leads Assessment
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.
March 2022 - Melissa Swindell risk reviewed, actions on track

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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

June 2022 - Melissa Swindell
risk reviewed and actions updated

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation.
The impact of Covid-19 is both on physical progress on site and from an inability to engage with community stakeholders however the team continue to pursue works liaising with the appointed contractor.	The Trust is in contact with the City Council to discharge pre-commencement conditions so that once demolition is completed the Phase 1 park reinstatement works can commence in late summer.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
The Trust has appointed Capacity Lab for an 18 month period, they are responsible for working with the local community, planning activities in the park, supporting the local community to form an Enterprise/Community Interest Company. Whilst completing this work they will be engaging with Liverpool City council and local councillors. The work has already begun and feedback from the community is positive	Minutes of meetings SLA
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
We are working with a designer and a QS to review the Remediation Strategy which has now been submitted to LCC. This should lead to a reduction in estimated costs, if approved. In addition we are looking at alternative suppliers that meet the LCC specification.	Planning submission and the estimated costs. Estimated costs provided by Landscape Contractor and QS.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Establish an Eaton Road Frontage Review to Prepare Delivery Plan	30/06/2022	Meeting planned

Executive Leads Assessment

June 2022 - David Powell
Following Campus Review Session

May 2022 - David Powell
Risk reviewed prior to May Board

April 2022 - David Powell
Prior to April Board

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

	Board. ICS CEO in attendance. Programme progress accepted. 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

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

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)

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall position for 22/23 and beyond
2. Restriction on capital spend due to system CDEL limit and inability to deliver on 5 year programme
3. Long Term Plan shows £3-5m shortfall against breakeven
4. Long Term tariff arrangements for complex children shows underfunding c£3m for Alder Hey.
5. Devolved specialised commissioning and uncertainty impact to specialist trusts.
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.
22/23 CIP programme requires radical transformation focus	31/03/2023	

Executive Leads Assessment

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.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Membership of C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda	Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan
Specialist Trust Alliance membership of C&M ICS (HCP) Board - to ensure Specialist Trusts have a voice to influence	
C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors 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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	
Escalation process for risks and issues pertaining to ODNs and Joint Services	
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement)
Identification of 'pilot' partner to co-design the Framework	Pilot of Partnership Quality Assurance Round approach agreed with LWH MD - to be piloted via Liverpool Neonatal Partnership and presented to LNP Board in April 22
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - drafted to begin 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	01/07/2022	LNP Board agenda item re: completed partnership assurance framework moved to June 22
MIAA Audit scheduled for Q2 2022	31/10/2022	Draft TOR for audit currently under agreement

Executive Leads Assessment

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)

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation	Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.		
Related CQC Themes: Well Led		Link to Corporate risk/s: 2624		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation	08/11/2023	
2. Board approval of a joint R&I strategy with encompasses the new 2030 innovation Strategy and promotes a growth plan and brings inward investment.	31/05/2022	

Executive Leads Assessment

June 2022 - Claire Liddy
No change to risk in month

May 2022 - Claire Liddy
May review - static

April 2022 - Claire Liddy
April review - no change

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2265, 2235		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x1	Trend: 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	01/07/2022	New iDigital model supported through AH and LHCH Executives. Recruitment to senior management team partially complete. Recruitment with analytics and transformation teams in progress.
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development

Executive Leads Assessment

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.

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

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 21st April 2022**

Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance	Mr. G Baines	Assistant Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Ken Jones	Associate Finance Director	(KJ)
	Mrs R Lea	Deputy Director of Finance	(RL)
	Ms V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs K. McKeown	Committee Administrator	(KMC)
	M. 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)
	Ms C. Umbers	Assoc. Director of Nursing and Governance	(CU)
Observing:	Mr. J. Wilcox	Divisional Accountant	(JW)
Item 22/23/09	Ms K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/19	Mr. S. Riley	Acting Clinical Audit and Quality Improvement Manager	(SR)
Item 22/23/20	Ms K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/21	Ms N. Palin	Assoc. Director of Transformation	(NP)
Item 22/23/22	Mrs L. Shepherd	Chief Executive Officer	(LS)
Apologies:	Mr. A. Bass	Interim Chief Medical Officer	(ABASS)
	Ms L. Cooper	Director of Community Services	(LC)

22/23/01 Introductions and Apologies

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

22/23/02 Declarations of Interest

There were none to declare.

22/23/03 Minutes from the Meeting held on the 20th January 2022

Resolved:

The minutes from the meeting that took place on the 20th of January were approved pending the following amendment; page 5, first paragraph, should read:

The Chair advised that 'Medication Errors' is one of SQAC's three Quality Priorities (projects) for which a formal update is provided to SQAC at each meeting. Reduction in all medication errors is the key focus of this project. It was reported that a 10x medication summit was held in 2021/22 which resulted in a wide ranging improvement plan for this particular error type. As SQAC oversees this project on a monthly basis, it was felt that the Audit and Risk Committee does not need to do anything additional at this stage. If the Committee continues to question whether sufficient progress is being made the Committee will ask the project team to submit a report to the Audit and Risk Committee.

21/22/101 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 discuss this matter with the respective team with the view to conducting the audit towards the end of the financial year. An update will be provided during June's meeting. **ACTION TO REMAIN OPEN**

Action 20/21/57.1: *Non-Clinical Claims/Clinical Claims (Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* – Erica Saunders and Ken Jones are going to meet in the new financial year to review the data relating to this area of work and agree a mechanism. An update will be provided to the Committee in November 2022. **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)* – It was agreed to schedule a meeting to discuss this matter prior to the next Committee meeting. **ACTION TO REMAIN OPEN.**

21/22/65.1: *Update on the Risk Management Process within the Division of Medicine (Exec Team to review the job description/remuneration for the Governance Lead role in order to support the retention of staff in this role)* – It was agreed that the new Associate Director of Nursing and Governance will conduct a piece of benchmarking work by the end of November 2022 so that the Trust can determine whether the job description for the Governance Lead role is in line with other trusts and remunerated appropriately. **ACTION TO REMAIN OPEN**

Action 21/22/77.1: *Integrated Governance Committee Policies (review the suite of policies that used to be submitted to the IGC and share it with the Audit and Risk Committee to enable the Committee to streamline this area of work)* – A review has taken place and a suite of policies has been incorporated into a spreadsheet. Work is taking place to include the due dates for each policy. **ACTION TO REMAIN OPEN**

Action 21/22/87.1: *Trust Risk Register Analysis (conduct a piece of work to confirm whether the information being reported in terms of zero/low number of risks by a number of areas across the Trust is correct)* – It was agreed to conduct an exercise on this area of work via the RMF. An update will be provided in June. **ACTION TO REMAIN OPEN**

Action 21/22/87.2: *Trust Risk Register Analysis (look at a governance structure for the risks of services that sit under the remit of an Executive Lead, rather than a Division)* - A meeting has taken place with a number of Corporate Service leads and it has been agreed that a collaborative approach should be taken in terms of Corporate Services coming together to peer review risks. A proposal is to be submitted to the Exec Team and Divisional colleagues in May to describe how standards can be improved in terms of Corporate risk reviews and Corporate performance reviews. It was agreed to transfer this action to the Executive Team's action log and provide the Audit and Risk Committee with an update in June. **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)* – It was agreed to have a dedicated agenda item at the next RMF on best practice and lessons learned in order to address this action. It was agreed to transfer this action to the Executive Team's action log and provide the Audit and Risk Committee with an update in June. **ACTION TO REMAIN OPEN**

Action 21/22/101.1: *Trust's Nil Net Assets (compile guidance to support the management of the process for nil net assets)* - A new Head of Medical Devices is in post and work is taking place to compile a procedure document as part of this work. **ACTION TO REMAIN OPEN**

Action 21/22/108.1: *Update on the Matter Relating to Stolen iPads (submit a formal report to the Committee once the commissioned work (MIAA advisory review/HR investigation) has concluded and a final update has been received from Merseyside Police)* - This item has been included on the agenda. **ACTION CLOSED**

Action 21/22/110.1: *Review and approve Draft Internal Audit Plan for 2022/23 (Request third party assurance from ELFS in relation to the payroll service that they provide on behalf of the Trust)* – The Trust is due to receive this information during the next week. It was agreed to include this item on June's agenda and close the action. **ACTION CLOSED**

Action 21/22/110.2: *Review and approve Draft Internal Audit Plan for 2022/23 (meeting to take place with the Chief People Officer, Melissa Swindell, to discuss the detail of the Workforce Planning audit review for 2022/23)* - A meeting was held with Chief People Officer to discuss the detail of the Workforce Planning review, which is included in the 2022/23 Internal Audit Plan. **ACTION CLOSED**

Action 21/22/110.3: *Review and approve Draft Internal Audit Plan for 2022/23 (meeting to take place with the interim Chief Medical Officer, Alfie Bass, to discuss the detail of the Morbidity and Mortality audit review for 2022/23* - A meeting was held with the Chief Medical Officer in March 2022 to discuss the detail of the Morbidity and Mortality review, which is included in the 2022/23 Internal Audit Plan. **ACTION CLOSED**

Action 21/22/111.1: *Internal Audit Progress Report (review the link on page 5 of the progress report 'CQC inspections through the Audit Committee lens' as it doesn't work when the document is converted to a PDF* - The CQC Inspections through the Audit Committee Lens document was sent in Word format to the Audit and Risk Committee Chair in February 2022. **ACTION CLOSED**

Action 21/22/112.1: *Internal Audit Follow Up Report (PFI Compliance Follow Up Report 2016/17 - Discussion to take place to look at the scope of the recommendations in the original follow up report, agree new actions that will be useful and provide assurance, whilst recognising that time has moved on. A date for implementation will also be agreed)* - A meeting took place on the 30th March 2022 to discuss the recommendations from the PFI Compliance Report. **ACTION CLOSED**

Action 21/22/113.2: *Local Counter Fraud Progress Report (confirm as to whether there have been any changes made to the Accounts Payable system as a result of the five duplicate payments that have been identified.* – It was reported that there were five transactions that were corrected prior to being identified on the NFI database. The transactions were highlighted by the system as a result of having the same value. The Committee was advised that the suppliers had very similar names and the incorrect supplier had been paid. This was addressed forthwith, and the money was recovered. It was confirmed that the incorrect suppliers have been removed from the system to ensure that the same error doesn't occur again. A further review has been conducted and NFI has confirmed that they will remove the five entries from their database. **ACTION CLOSED**

22/23/05 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF year-end report as at the 31.3.22. The following points were highlighted:

- Attention was drawn to the month-on-month overview of risk scores during 2021/22 and the analysis of the risk ratings for the year. It was pointed out that risk 1.2 is the remit of both SQAC and RABD.
- A new risk has been incorporated on the BAF which relates to the failure to address the building deficits with Project Co (BAF risk 1.3). The main consideration for this is to acknowledge that risk 1.3 is a strategic risk and to ensure transparency in terms of public accountability.
- Thanks were offered to MIAA for the independent work that was conducted on the BAF which resulted in an opinion that provided the Trust with assurance.

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 31.3.22.

22/23/06 Risk Management Forum (RMF) Update; including Corporate Risk Register

The Committee received an overview of the RMF meeting that took place on the 29.3.22. The following points were highlighted:

- A deep dive took place into long standing high moderate risks, during March's meeting. The Chair of the RMF commended the work that the Divisions conducted in order to complete this piece of work. The Divisions have been asked to provide further clarity at the next RMF on a number of points that were raised following the deep dive session.
- During the Forum key discussions took place around the Corporate Risk Register and the Trust Risk Register report. The risk owners present at the RMF were able to articulate why specific risks remained at the score they had been ranked at and

provide assurance that the risks are being managed effectively with appropriate actions in place to mitigate them.

It was pointed out that the Trust Risk Register report has enabled a number of deep dives to take place in 2021/22, with the most recent one relating to 24 long standing high moderate risks on the risk register and 35 long standing risks with no action plans. The Committee was advised that it was evident that many of these risks could be closed and managed as business as usual and likewise for the risks without action plans A discussion which included lots of challenge took place during the RMF about managing risk registers at local level and whether operational/corporate risks are being looked at via the appropriate lens.

The Chair asked as to whether there is more awareness amongst colleagues following the deep dives, in terms of converting actions into controls and closing risks down when required. It was felt that Ulysses training/refresher courses are required to support staff. It was also confirmed that this topic has been discussed at the Safety and Quality Assurance Committee (SQAC).

Resolved:
The Audit and Risk Committee noted the update from the RMF meeting that took place on the 29.3.22, and the contents of the Corporate Risk Register.

22/23/07 Trust Risk Register Analysis Report

The Audit and Risk Committee received the Trust Risk Register Report for the period from the 1.1.22 to the 28.2.22. The Chair asked as to whether there was a report available that included data up until the end of March 2022. Cathy Umbers agreed to circulate a revised report that will include information up to the 21.3.22.

22/23/07.1 Action: CU

Resolved:
The Audit and Risk Committee received and noted the Trust Risk Register Report.

22/23/08 Annual Report on Risk Management, 2021/22
Resolved:
The Audit and Risk Committee received and noted the content of the Risk Management Annual Report for 2021/22. The Chair thanked the RMF and its attendees for engaging in the risk management process.

22/23/09 Formal Update on the Outcome of the incident relating to Stolen iPads from the Trust.

The Committee was advised that the Police and court proceedings relating to the iPads that were stolen from the Trust have concluded. It was reported that the independent review conducted by MIAA has been completed and identified a number of areas in the IT stock management process that could be improved. The internal HR investigation has also come to a close with the outcome being that there was no case to answer, but some learning will be embedded as part of the stock management process. It was confirmed that the immediate actions reported on during January's meeting have been completed. The Committee was informed of the outcome of the Liverpool Crown Court verdict.

Resolved:
The Audit and Risk committee noted the contents of the report and the formal outcome of the investigation by Merseyside Police.

22/23/10 Head of Internal Audit Opinion, 2021/22

The Committee received the Head of Internal Audit Opinion for 2021/22 which reflected an overall substantial assurance opinion for the period from the 1.4.21 to the 31.3.22. This provides assurance that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

It was reported that there is one audit that is due to be completed which is expected to receive a substantial opinion. The Chair thanked Management and MIAA for their work throughout the year.

The Assistant Director of MIAA, Gary Baines, felt that the Trust received a positive opinion in what was a very challenging year. Thanks were offered to the Audit and Risk Committee and Management for the co-operation that MIAA received during the year.

Resolved:
The Audit and Risk Committee received and noted the contents of the Head of Audit Opinion for 2021/22.

22/23/11 Internal Audit Plan for 2022/23.

The Audit and Risk Committee received the full version of the Internal Audit Plan for 2022/23. It was reported that there have been minimal changes since the Plan was submitted to the Committee in January 2022, and it was confirmed that the first audit has been scheduled and will commence in the next two weeks.

The Chair queried the three days that have been set aside in the plan for the Health Procurement Liverpool audit. It was reported that the Trust is now part of a procurement collaboration that is being led by the Walton Centre. The Audit Committee at the Walton Centre has asked partners to contribute three days to the review with each organisation receiving the output from the report.

The Chair requested, if possible, that the final version of the Internal Audit Plan for 2023/24 be submitted to the Committee in January 2023 in order to spread the Committee's workload and enable audits to be started promptly in the new financial year.

22/23/11.1 Action: KS

Resolved:
The Audit and Risk Committee received and approve the Internal Audit Plan for 2022/23.

22/23/12 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 February to March 2022. The following points were highlighted:

- It was reported that four audits have been completed which received substantial assurance with the exception of Recruitment Process which received moderate assurance. A robust action plan has since been agreed for this area based on the issues that came out of the review.
- The Committee was advised that confirmation has been received that the IT Service Continuity and Resilience review has been finalised and received substantial assurance. The Head of Internal Audit Opinion report will be updated to reflect this.
- The Chair pointed out that the Recruitment Process audit identified that there were some fundamental issues around retaining evidence of qualifications and required interview process documentation. The Committee was advised that the recruitment process has since been transferred to the TRAC system which is more robust and enforces these. disciplines. Kath Stott reported that Management steered MIAA to look at these issues and felt that the implementation of TRAC will address the issues identified in the audit.

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Progress Report.

22/23/13 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 February to March 2022. The following points were highlighted:

- It has been agreed to revise the format of future reports so that the Committee receives a much smaller/focussed report that provides an update only on recommendations that were due since the last report.
- The Chair referred to the request for a six month extension for the recommendations relating to the Project Management review and felt that the timescale for completion was not acceptable. The Committee was advised of the period of change that the Development Team has gone through and it was confirmed that a new structure is in the process of being implemented. Following discussion, Rachel Lea agreed to liaise with the Development Team to see if the recommendations can be completed within the next three months and provide an update during June's meeting. John Grinnell suggested that a discussion take place with Natalie Palin to look at whether an integrated approach can be taken in terms of the policy that needs developing and benefits realisation. Kath Stott agreed to review the recommendations in the report to ensure that they are applicable to the respective teams; Development Team/Project Management Team.

22/23/13.1 Action: RL

Resolved:
The Audit and Risk Committee received and noted the contents of the Internal Audit Follow-up Report.

22/23/14 Internal Audit Charter
Resolved:

The Audit and Risk Committee noted the Internal Audit Charter for 2022/23.

22/23/15 Counter Fraud Annual Report, 2021/22.

The Committee received the Anti-Fraud Services Annual Report for 2021/22. It was reported that the Counter Fraud Functional Standard Return summary may change following completion of the updated Fraud, Bribery and Corruption Risk Assessment, which is due to be completed by 31.5.22. It was confirmed that an update will be provided during September's meeting.

The Chair drew attention to two components that have changed from an amber rating to a green rating; Declarations of Interest and Fraud Awareness Training. Thanks were offered to both Jill Preece and Karen McKeown for the work that has taken place to achieve above 80% compliance for Declarations of Interest.

It was pointed out that component 1b has been self-assessed as amber. This requirement also covers the role of the Counter Fraud Champion. The Chair queried as to whether there have been any challenges in progressing the Fraud Champion role. It was reported that there had been difficulties in accessing the training initially, but this has since been addressed. Work will commence over the next twelve months in terms of working collaboratively with other trusts who have Fraud Champions and understanding what can be done internally in respect to best practice, ideas and changes. It was agreed to provide an update on this area of work during September's Meeting.

22/23/15.1 Action: KJ

Resolved:
The Audit and Risk Committee noted the Anti-Fraud Services Annual Report for 2021/22.

22/23/16 Counter Fraud Work Plan, 2022/23

The Committee received the Anti-Fraud Work Plan for 2022/23. It was reported that the Anti-Fraud team will be conducting an employment agency check review in 2022/23 as part of the programme of work with the support of Home Office who have offered to provide advice and guidance. This approach is being taken following a case that the Counter Fraud Service assisted with in relation to an agency worker who provided false documentation and, a result of this, gained NHS employment. The Committee discussed this matter and agreed that any internal learnings from this pro-active exercise would be beneficial to the Trust.

The Chair requested, if possible, that the final version of the Anti-Fraud Work Plan for 2023/24 be submitted to the Committee in January 2023 in order to spread the Committee's workload.

22/23/16.1 Action: VM

Resolved:
The Audit and Risk Committee approved the Anti-Fraud Work Plan for 2022/23.

22/.23/17 Statement on Going Concern

The Committee was provided with the key reasons as to why it should support and recommend to the Trust Board that the 2021/22 annual accounts and associated financial

statements should be prepared on a going concern basis.

Background information was provided on the going concern assumption and key considerations when preparing financial statements. It was reported that the Trust has completed a scenario analysis to assess operational liquidity for the next eighteen months to September 2023 and consider what level of cash the Trust could close with by the end of H2 2023/24. The outcome of this analysis demonstrates that in all three scenarios, the level of cash available at the end of the next financial year is likely to remain significant therefore, all examples fully support the Directors' assessment that a going concern basis should be adopted.

The Chair asked Ernst and Young as to whether, from their point of view, the Trust has conducted the appropriate assessment or whether there are any other scenarios that thought should be given to. Hassan Rohimun advised that the assessment conducted by the Trust was appropriate and felt that the paper provides reasonable assurance in terms of the organisation's liquidity position. The other area that is considered in relation to going concern is continuity of services, of which, the Trust has no issues in meeting this requirement.

Resolved:
The Audit and Risk Committee recommended the Trust's Statement on Going Concern to the Trust Board for approval.

22/23/18 External Audit Draft Planning Report and Fees

The Committee received the draft External Audit Planning Report for year ended 31.3.22. A brief overview of sections 1, 2, 3, 5, 8 and 9 was provided with attention drawn to the following points:

- Section 1;
  - The report outlines the change in risk/focus and specifically draws out inappropriate capitalisation expenditure as an area of focus.
  - *IFRS 16 Implementation readiness assessment* – As part of the audit for the 2021/22 financial year, E&Y will perform a readiness assessment to assess how prepared the Trust is for IFRS 16 implementation in the financial year beginning 1.4.22.
  - *Disclosures in Remuneration Report* – E&Y will review the Trust's Remuneration Report disclosure for any senior officers leaving the scheme during 2021/22.
  - *Materiality* - Performance materiality has been set at £3,309k, which represents 50% of materiality. This will revert to 75% for areas relating to accounts receivable. E&Y advised that the report will be updated to provide clarity.
  - *Audit Fees* - Attention was drawn to the significant increase in fees from the prior year; £70,000 (2020/21) to £105,000 (2021/22). It was reported that audit fees have yet to be finalised, but discussions are taking place with Management to address this matter.

The Committee agreed with the content of the report, and felt that the risk profile is appropriate in the areas outlined and that a pragmatic approach has been taken in terms of materiality. Following discussion on the audit fees it was agreed that a meeting should

take place outside of the meeting to progress this matter. It was confirmed that the audit will commence on the 4.5.22.

22/23/18.1 Action: HR/KB/JG

Resolved:
The Audit and Risk Committee approved the External Audit Planning Report with fees to be agreed outside of the meeting.

22/23/19 Clinical Audit Annual Report, 2021/22

The Committee received a summary of clinical audit activity within the Trust as at the end of Q4 2021/22, and an overview of the audit program for 2022/2023 which will be completed over the next 12-month period. The following key points were highlighted:

- There were 244 clinical audits registered in the Trust during 2021/22; 60 (25%) have been registered and completed, 176 (72%) audits are on-going of which 52 (30%) have exceeded their estimated completion date. 1 audit has not yet commenced but an amended start date has been confirmed and 7 (3%) audits were cancelled. It was reported that the Division of Surgery had the highest uptake of audit registrations; 45% of the total.
- The Committee was advised of the introduction of the BRAG monitoring process to provide SQAC with monthly assurance on the progress of audits.
- *Trust Audit Plan* – It was confirmed that the Trust submitted its 2020/21 audits and Quality Account work by June 2021. For the 2021/22 financial year data collection was ongoing in Q4 therefore audits with outstanding data collection are expected to be completed by May 2022. The Committee was asked to note the Trust's audit plan for 2022/23 (*Appendix 2*).
- Attention was drawn to the work that is taking place to support the Divisions develop audit action plans. It was reported that the Brilliant Basics approach has been adopted to monitor the Divisional action plans and develop a system for tracking the actions.
- The Clinical Audit service was audited by MIAA who made four recommendations. It was confirmed that these recommendations have been completed.

The Chair felt that it would be more informative for the Committee if the data collection audits which are mandated centrally could be separated from the audits identified by the Trust going forward and asked that the Divisional Audit Plans be submitted to the Committee once they have been completed.

22/23/19.1 Action: SR

Erica Saunders commended the Clinical Audit Team for the progress that has been made to shape this area of work in terms of its place in the overall control environment and pointed out that future audits that may arise as a result of CQC inspections.

Resolved:
The Audit and Risk Committee received and noted the Clinical Audit Annual Report for 2021/22 and the Audit Programme for 2022/2023.

22/23/20 Annual Assurance Report for 2021/22 and Forward Plan for 2022/23 – Data Quality

The Committee received an update on the current position and future developments with regards to data quality in Alder Hey during 2021/22. Attention was drawn to the following points:

- It was reported that MIAA have conducted an internal audit on the Trust's data quality controls and measures which received substantial assurance.
- Alder Hey is currently in the middle of a significant upgrade to its EPR system (Meditech). Due to the significant changes between the current and future version of Meditech, the programme is undertaking a detailed and managed data migration exercise. The management and monitoring of data quality is significant to this process, with assurance being provided to the Alder Care Programme Board.
- Work is also taking place on the Data Strategy refresh and the recommendations from the MIAA audit in terms of the work programme for next year.

Resolved:
The Audit and Risk Committee received and noted the contents of the Data Quality Annual Assurance Report for 2021/22 and the Forward Plan for 2022/23.

22/23/21 Annual Assurance Report for 2021/22 and Forward Plan for 2022/23 – Programme Assurance

The Committee received an update on the current assurance and governance arrangements of Alder Hey's Transformational Change Programme and the achievements to date for 2021/22. An overview of the following areas was also provided:

- Lessons learnt,
- Governance/assurance arrangements for 2022/23;
  - It was pointed out that a large number of programmes are yet to be sustained in terms of their benefits and are only able to move into sustain, review and closure once the benefits have been achieved and sustained for three months. It was confirmed that the majority of these programmes will continue within the portfolio for the 2023 Operational Plan. The programme outcomes and PIDs have also been refined and further developed therefore it is felt that ongoing assurance can be provided to the Assurance Committees on progress, delivery against milestones and key intended benefits.
- Next steps;
  - There has been a recent change in the governance arrangements for the Programme with Improvement Board meetings being replaced by Strategic Executive meetings to avoid duplication and ensure that all improvements are discussed in an operational context. This will enhance visibility and ensure that there is a clear line of sight around Assurance Committee structures.
  - Improvements to the realisation of benefits are also planned with the alignment of both Business Intelligence and financial leads to each project as well as the introduction of the Brilliant Basic (BB) approach.

The Chair raised two questions; 1. What needs to be done to improve on project delivery/delivery times? 2. In time, will the team be able to provide assurance ratings for benefits realisation?

In response to question 1, it was pointed out that the Trust is starting to prioritise the overall programme, and as a result of using the BB approach there is now clarity on prioritisation and alignment between Divisional/Trust priorities. It is also the role of the Transformation Director to identify any gaps between aspirations, achievability, resources and capabilities in terms of delivering the programme. As the process for reporting into the Assurance Committees commences there will also be a focus on this type of question.

In response to question 2, it was reported that there is better clarity in the 2022/23 financial year around intended benefits, and it was pointed out that the team will be connected to the innovation/finance work that is taking place around benefits realisation. As a result of the changes that have been made to the Programme Management Framework and the programme for 2022/23 there will be further clarity and visibility around the Exec score cards in terms of improvement in activities and delivery against key milestones. Rachel Lea advised the Committee that the quantification of benefits realisation is one of the top areas of focus for RABD.

Resolved:
The Audit and Risk Committee received and noted the Programme Assurance Annual Report for 2021/22 and the Forward Plan for 2022/23.

22/23/22 Annual Governance Statement

The Chief Executive, Louise Shepherd, presented the draft Annual Governance Statement (AGS) for 2021/22 to the Committee. It was pointed out that the Trust has built upon the governance lite approach that was established the previous year, in a really effective way. The organisation's risk management and governance process has also continued to improve which is clear throughout the whole Statement. Attention was drawn to the sustained ownership of risks by the Divisions which has been key in terms of managing the organisation's risks.

Louise Shepherd referred to the two areas of work that have transformed the way in which the Trust does things/provided a strong foundation to address recovery effectively going forward; 1. The organisation's response to the Section 31 Notice. 2. The work that took place in 2021 on Safe Waiting List Management.

Louise Shepherd paid tribute to all those involved who have helped the organisation maintain its focus on risk thus achieving a substantial assurance opinion from MIAA. The AGS was commended to the Committee by Louise Shepherd.

The Chair felt that the AGS reflects the work that has taken place during the year and praised the Trust's outstanding achievements in what was a very a challenging year. The Chair queried as to whether the Trust needs to reference the stolen iPads in the AGS from a significant controls issue perspective. The Committee was advised that this wasn't included in the AGS due to it being an exception and there being no single cause of factor that caused the breakdown. Kath Stott agreed to take advice on this matter and provide the Committee with an update via e-mail.

22/23/22.1 Action: KS

Resolved:

The Audit and Risk Committee approved the Annual Governance Statement for 2020/21 pending clarification on the query raised about referencing the stolen iPads in the AGS.

22/23/23 Audit and Risk Committee Terms of Reference
Resolved:
The Audit and Risk Committee received and approved the Committee's Terms of Reference.

22/23/24 Report on the Audit and Risk Committee Self-Assessment Exercise

The Committee received the report on the outcome of the Audit and Risk Committee Effectiveness Review for 2021/22. It was reported that the outcome of the self-assessment was positive and there were no fundamental issues identified.

The Chair drew attention to the four areas highlighted for discussion in the report, the new recommendations and the outstanding actions. The following points were raised:

- *Recommendation 4: Front cover sheets for the Audit and Risk Committee* - It was reported that the Trust is in the process of issuing a new set of templates Trust wide as part of the Leader Standard work that is taking place in association with KPMG. The Chair confirmed that recommendation 4 will be amended in order to reference the Leader Standard work.

22/23/24.1 Action: KB

- *Ongoing actions (2) - The Annual Report of the Assurance Committees should set out the assurances they have received and their impact (either positive or not) on the organisation's assurance framework and any matters to be brought to the attention of Audit and Risk Committee* – It was agreed to discuss this item during June's meeting when this year's Annual Reports are received.

22/23/24.2 Action: KB

- *Discussion areas (3) - Are there any other key services that are provided by third parties/shared services for which the Committee should consider receiving assurance? E.g. iDigital / Data Protection / Freedom of Information* – It was felt that it would be good practice to receive assurance on Freedom of Information (FoI), compliance and themes. As a result of the risk and complexity of these areas of work, it was agreed that the Committee will receive an annual report on Data Protection and Freedom of Information.

22/23/24.3 Action: ES

Resolved:
The Audit and Risk Committee received and approved the recommendations and noted the ongoing actions from the prior self-assessment.

22/23/25 Audit and Risk Committee Annual Report, 2021/22
Resolved:
The Audit and Risk Committee approved the Committee's 2021/22 Annual Report.

22/23/26 Gifts and Hospitality Register, 2021/22
Resolved:
The Audit and Risk Committee received the Gifts and Hospitality Register for 2021/22.

Alder Hey Children's NHS Foundation Trust

22/23/27 Waiver Activity Report

The Committee received the Waiver Activity Report for the period relating to the 1.4.21 to the 31.3.22.

It was reported that there were 77 Waivers approved during the relevant period. Although waiver activity by spend has reduced in 2021/22 the average of just over 6 waivers per month is higher when compared to the average of less than one waiver per month in 2019/20. Given that the levels of waivers are still higher than expected, the Trust has established a workflow which provides further check and challenge on the waivers.

Hassan Rohimun suggested including in the report waivers that haven't been approved. Rachel Lea agreed to capture this information going forward.

22/23/27.1 Action: RL

Attention was drawn to the waiver relating to Horticon which was over a £1m. The Committee was advised that the Trust has been working with this partner on the reinstatement of the park (*Phase 2 and 3*). It was confirmed that this waiver is a one off item and isn't expected to occur again.

Resolved:
The Audit and Risk Committee received and noted the Waiver Activity Report for 2021/22.

22/23/28 Any Other Business

There was none to discuss.

22/23/29 Meeting Review

The Chair advised that reflection will take place on the governance lite approach for the Committee to see if it is being achieved.

Date and Time of the Next Meeting: Thursday 16th June 2022, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 23rd May 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Claire Liddy	Managing Director of Innovation	(CL)
	Rachel Lea	Deputy Director of Finance	(RL)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Sue Brown	Associate Development Director (Campus)	(SB)
	Mark Carmichael	Associate Chief Operating Officer	
	Mark Flannagan	Director of Communications	(MF)
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Catherine Kilcoyne	Deputy Director of Business Development	(CK)
	Emily Kirkpatrick	Associate Director Commercial Finance	(EK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 26,36 30	Alex Pitman	Green Project Director	
	Natalie Palin	Associate Director of Transformation	

22/23/20 Apologies:

Nathan Askew	Chief Nursing Officer	(NA)
Anita Marsland	Non-Executive Director	(AM)
Graeme Dixon	Head of Building services	

22/23/21 Minutes from the meeting held on 25th April 2022
The minutes were approved as a true and accurate record.

22/23/22 Matters Arising and Action log
The Chair noted all actions for this month are included as an agenda item.

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

22/23/24 Finance Report
Month 1 Financial Position
An in-month trading deficit position of £0.8m in April which is £0.5m adverse to the planned deficit of £0.3m. A large proportion of the adverse position to plan is due to non-delivery of CIP in the first month of the year which was circa £0.4m against a target of £1m. The Chair asked for details on why the target was not met in month one and if it would be an ongoing challenge to meet the monthly target. RL advised that the CIP is the largest challenge in the financial plan. There are a number of schemes to be developed that will reduce the challenge.

CS went through the income and non-pay position. Details of the divisions adverse position mainly due to underachieving of CIP was shared with RABD.

The Chair asked for progress to continue to be made against the trade receivables.

Resolved:
RABD received and noted the M1 Finance report.

22/23/25 **2022-23 Plan**

AH submitted the final plan details with a £2.4m surplus. C&M submitted £148m deficit. Nationally NHSI/E have not approved plans due to the large deficit.

NHSI/E have announced £1.5 billion is to be received by the NHS, C&M will receive around £70m this is to be used for inflation costs. If excepted C&M will be required to submit a balanced plan on 20th June 2022. Trust's unable to submit a balanced plan will not be able to access any capital funding as well as increased reporting requirements.

C&M are meeting regularly to mitigate the outstanding deficit, RABD will continue to be updated as plans are developed.

Key risks for Alder Hey are: CIP, activity and run rate. JG asked that further detail was provided at the next RABD on approach to how plans will be met.
Action: RL/CS

Resolved:
RABD noted the challenging position of 2022-23 Plan with further updates to be received.

22/23/26 **Energy Prices and Inflation**

AP went through Alder Hey's current process for its energy noting the current contract is due to expire October 2022. Seven recommendations were presented to RABD including: renew contract with broker and proceed with negotiating contracts over the next 2 months, develop a proposal of how we could buy across the region by Oct '23 and provide RABD with a further update at the July RABD.
Action: AP

The Chair asked if it would be possible to agree a Broker on a fixed fee. AP advised the contract is based on energy usage.

CL asked what plans there are if any to innovatively reduce energy costs. AP noted the build was designed innovatively and the first step was to ensure the build was running to its full potential. CL asked if it would be possible for an external source to review Alder Hey's position and offer suggestions.

SA asked if there was any potential for a faster turnaround to review energy across the region before October 2023. RL advised that as Alder Hey's contract isn't due for renewal until October 2022 this would be the earliest date to review.

Resolved: RABD received and APPROVED the recommendations as set out in the paper with a further update to be received at the July RABD.

22/23/27 **Cash and Capital Update**
Resolved:
As plans on cash were to be approved it was agreed this item would be deferred until the June RABD.

22/23/28 **CIP**
Resolved:

The total CIP target for 22/23 is around £17m, CS gave a breakdown of this target and plans in place for this to be met.

22/23/29 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
SB highlighted:
Park – phase 1 is now completed with phase 2 in progress, phase 3 will commence in the autumn.
Modular buildings are in progress with the Catkin build to be demolished in the autumn.
The Dept are due to commission a manager to co-ordinates moves, this is due to three members of the team approaching retirement.
The communications plan was shared with RABD.
Resolved:
RABD received the Campus and Park paper.

22/23/30 **Benefit Realisation**
NP provide an update on the systems of control which support the achievement of CIP and wider benefits relating to targeted project work in 2022/23. The paper details, workstreams within the Operational Plan 2022/23; and how benefits will be monitored and reviewed.

Resolved:
RABD received the Benefit Realisation update noting further updates will be received on a monthly basis.

22/23/31 **Alder Care**
KW noted the programme had been in place for 18 months and a fortnightly programme Board is in place. The aim for the go live date is October 2022.

A review of the programme was carried out last year and priorities are being managed with good progress on clinical risks. Alder Care was rated as a red risk last month. There are 3 gateways that will require approval before Alder Care can move forward. To prepare for the first gateway a deep dive was carried out.

The Chair asked if Meditech would be able to provide further resources to Alder Hey. KW said the next Executive meeting with Meditech will be taking place in June and this will be discussed.

Resolved:
RABD noted good progress had been made on Alder Care however there were a number of challenges moving forward. RABD will receive further updates.

22/23/32 **Operational Delivery Network**
DJ provided highlights from the bi-annual report to RABD. AH hosts two North West Paediatric ODNs as well as joint host of other networks with Manchester Children's NHS FT.

Resolved
RABD received and noted the ODN paper, a further update will be received at the November RABD.

22/23/33 **Digital Strategy 2022 – 2025**
KW noted the current strategy ends this year and highlighted the following changes:

- Emphasis on data
- Four Key themes
- A number of proposed programmes for delivery

The Chair congratulated Kate and the team particularly on the significant benefits.

Resolved:
RABD supported the recommendation for the Digital Strategy to be presented at Trust Board on 2nd June 2022.

22/23/34 **Month 1 Corporate Report (starred item – only questions/answers will be noted)**
AB referred to the high waiting times in relation to dentistry services noting additional theatre sessions were to be arranged.

The Chair asked for the word aspiration to be removed in relation to the aspiration that no child will be in ED longer than 12 hours. AB agreed to feed this back to the data team.
Resolved:
RABD received and noted the M1 Corporate report.

22/23/35 **Communications update (starred item – only questions/answers will be noted)**
Resolved:
RABD received and noted the communications paper.

22/23/36 **Green Plan**
Resolved:
AP went through Alder Hey's carbon footprint and the key challenges to be addressed in the first phase.

22/23/37 **PFI Report**
Resolved:
RABD received and noted the M1 PFI report.

22/23/38 **Board Assurance Framework**
RL asked if it would be possible to split the financial risk into the current financial year and upcoming risks. ES and RL would take this forward outside of the meeting.

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

22/23/39 **Any Other Business**
Intellectual Property Policy
CL presented the Intellectual Property Policy (IPP) for approval highlighting:

- IPP has been developed by the Innovation Team with input from external lawyers specialising in IP.
- Has been reviewed by Innovation Committee
- Encourage staff to participate in research/education/innovation as part of the revenue sharing section within the policy.

  An example of revenue sharing had been included in the policy RL said it would be useful to add further examples on shares paid to inventors to ensure it is clear this is a discretionary gift.

RABD discussed contracts being clear for both permanent and contracted staff that IP belongs to Alder Hey. CL noted once IPP is approved a number of processes will be carried out to ensure the policy is live.

SA asked if a clause could be included to note IPP cannot be used retrospectively.

MF asked for support with the Sponsorship Policy. A number of attendees agreed to meet outside of RABD and provide an update at the June meeting.
Action: RL/CL/MF/ES/DJ/Richard Jolley

Resolved:
RABD APPROVED the Intellectual Property subject to the comments above.

22/23/40 Review of Meeting
The Chair noted challenges moving forward including CIP.

Date and Time of Next Meeting: Monday 27th June 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 30th June 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	22nd June 2022 – Summary 18th May – 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 22nd June 2022, along with the approved minutes from the 18th May 2022 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

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

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

2. Agenda items received, discussed / approved at the meeting at the meeting held on 22nd June 2022

- 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 notes the completion of an external review and the focus on Relationships and IT improvements within the future plans. 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
- FB stated that the committee felt extremely assured regarding progress of policy ratification

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.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 18th May 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)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	John Grinnell	Deputy Chief Executive	(JG)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Christine Hill	Pathology Manager, Safety Lead	(CH)
	Adrian Hughes	Deputy Chief Medical Officer	(AH)
	Dani Jones	Director of Strategy	(DJ)
	Beatrice Larru	Consultant, Infectious Diseases	(BL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Phil O'Connor	Deputy Director of Nursing	(POC)

In attendance:

22/23/27	Jennie Williams	Head of Quality Hub	(JW)
22/23/30	Will Weston	Medical Services Director	(WW)
22/23/31	Rd. Carla Thomas	Organ Donation Lead	(CT)
	Mo Azar	Chief Pharmacist	(MA)
	Caroline Cowperthwaite	Acting Associate Chief Nurse, Surgery Division	(CC)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Andrew Hanson	General Manager, Division of Medicine	(AH)
	Jill Preece	Governance Manager	(JP)
	Natalie Palin	Associate Director of Transformation	(NP)
	David Reilly	Associate Director of Digital Systems (IM&T)	(DR)
	Catherine Wardell	Associate Chief Nurse, Medicine Division	(CW)

22/23/23 Apologies:

Urmi Das	Divisional Director – Medicine Division	(UD)
Christopher Talbot	Safety Lead – Surgery Division	(CT)
Dame Jo Williams	Trust Chair	(DJW)

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

22/23/24 Declarations of Interest
SQAC noted that there were no items to declare.

22/23/25 Minutes of the previous meeting held on 27th April 2022 – Resolved:
Committee members were content to **APPROVE** the notes of the meeting held on 27th April 2022.

22/23/26 **Matters Arising and Action Log**
000211
Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/27 **Quality Priorities Monthly update**

JW presented the Quality Priorities Monthly update, which included highlight summary progress reports, and a deep dive on Deteriorating Patients. JW confirmed that all 3 projects within the safety project had been fully reviewed with the senior clinical lead, for the current financial year. Moving forward there would be a senior clinical lead presenting assurance reports, and any key escalation and risks, with the Quality Hub taking on a facilitatory & project managed role.

Deteriorating patients – CC provided an update on Deteriorating Patients - project is currently being re-defined, taking into consideration, changes in operational leadership, Trust Patient Safety Strategy and National PEWS requirements which would be incorporated. Terms of Reference had been reviewed, accelerated progress is anticipated, with a plan to appoint a Clinical Lead.

NA advised that each of the Senior Nurses would be leading on a specific safety priority going forward.

KB questioned the impact the three areas of challenge would have on the project. NA advised that the most significant impact was related to the reorganisation of the ACT team, and that the ACT team play a vital role in escalation pathway. NA stated that recruitment is underway and having these colleagues in post is vital.

FB, on behalf of DJW referred to quality priorities and medication errors and sought clarity on when the team envisaged a resolution to the submitted Business Case. JW stated that the team continue to escalate to colleagues in Finance, with feedback still awaited. MA confirmed that he had escalated the request for feedback to Finance Colleagues, and had also escalated to COO within Medicine Division, team await resolution and any update regarding progress.

JG advised that a report is being shared at Executive Team meeting on 19th May 2022 to review how safety investments are prioritised.

Resolved:
JG stated that the business case is positioned in the report very heavily as being a significant part of progress, whereas there are a whole suite of issues that are not accelerating as anticipated.

NA stated that given the financial challenges faced this year there is a need to review what the options would be if there was no investment made. The pharmacy team are requested to revisit the need to prioritise within their current resource. NA referred to the newly drafted goals and stated that the direct link from this role into the aims for this year.

Resolved: colleagues to consider what is achievable with either no resource, or less resource, and reprofiling within pharmacy, and to review whether it fully supports the ambition in the goals for this year.

Resolved: FB requested SQAC receive an update at June 2022 meeting.

Resolved: Quality Priorities Progress report to include update on feedback from IRG

000212 at June SQAC meeting.
FB thanked JW and colleagues for Quality Priorities update.

Resolved: SQAC received and **NOTED** the Quality Priorities update.

Safe

22/23/28 DIPC Exception Report

SQAC received and **NOTED** the DIPC exception report.

Resolved: SQAC received and **NOTED** the DIPC exception report.

22/23/29 Assurance ED Activity Monthly Update

SQAC received and **NOTED** the ED Activity Monthly update.

Resolved: SQAC received and **NOTED** the ED Activity Monthly update.

22/23/30 Level 2 Comprehensive Root Cause Analysis – Investigation into the Major Trauma Care Pathway following a Catastrophic Injury involving a Fireplace

WW presented the Level 2 Comprehensive Root Cause Analysis – Investigation into Major Trauma Care Pathway following a Catastrophic Injury involving a Fireplace. SQAC received a detailed overview of the case, findings and associated learning and action plan.

FB expressed thanks to all staff involved in this very sad and difficult case, FB stated that she was surprised that there were so many learning points identified, and welcomed reflection on how these issues are being addressed and monitored.

AH advised that as Chair of the RCA panel, the review committee spent 5 hours reviewing and deliberating with 2 external experts. The issues raised have been shared with the relevant clinical teams, the overall plan is being monitored by the major trauma group.

ABa thanked both WW & AH for comprehensive review, ABa stated that he is not surprised by the panel review findings. Aba referred to staff training and advised that the training is outside of the 'in house' training, which is likely to take some time to complete, given that the training courses are not run frequently, and have a very limited number of delegates on each course.

Aba referred to documentation and advised that the Trust had obtained a new App, which ensures real time acquisition of data, and the ability to record clinical information as the patient passes through the department.
FB sought clarity from committee members with regards to whether SQAC requested any further update in the future. SQAC were content that this forms part of usual governance process.
FB thanked WW & AH for comprehensive update.

Resolved: SQAC received and **NOTED** the Level 2 Comprehensive Root Cause Analysis – Investigation into the Major Trauma Care Pathway following a Catastrophic Injury involving a Fireplace

22/23/31 Organ Donation Annual Report

CT presented the Organ Donation Report for 2021-2022

Organ Donation Performance:-

- 58 Audited deaths at Alder Hey

- Neurological Death testing rate = 44%
- Donors after brain death (DBD) Referral rate = 88%
- DCD Referral rate = 43.3% (relates to patients who are eligible to donate organs following cardiac death)
- SNOD Approach = 20% - (how often the approach to families for consent or authorisation for organ donations takes place by a specialist nurse in organ donation, as opposed to one of the clinicians. CT advised that NHSBT have good evidence to demonstrate that when potential organ donors are approached by SNOD, as opposed to clinicians, that the authorisation rate is higher.
- 1 Organ donor, which resulted in 6 transplants, - 2 kidneys to adult recipients, heart, liver, double lungs, stomach, bowel and pancreas, which were all paediatric recipients.
- 3 missed potential organ donors, as the appropriate process was not followed

Recommendations:-

- Re-establish Alder Hey Organ Donation Committee and appoint Chair (Aba) has agreed to initially chair until permanent Chair appointed
- Ensure national policies, guidelines and best practice is implemented and followed consistently within the Trust
- Ensure staff are adequately trained
- Champion organ donation at Alder Hey
- Promote organ donation week in September 2022

FB thanked CT for taking on the Audit Donation Lead role, and for the Organ Donation Annual Report.

KB requested whether additional detail could be included within the next Organ Donation Annual Report to include total numbers regarding eligible organ donations, how many parents are asked about organ donation, and how many organ donation requests were refused, together with the total number of organ donations received.

NA advised on the importance of improving the role of SNOD to drive improvements in consent from families.

CT advised that these numbers would be included within the next Organ Donation Annual Report. CT advised that she aims to Benchmark across other Paediatric Hospitals, and that this information would also be included within the next Organ Donation Annual Report.

MA queried whether there was a breakdown of information regarding ethnicity. CT confirmed that there is less organ donation/less recipients with BAME background. CT advised that she intended to review this information further over the next 12 months.

FB referred to early discussions with CT and Communications Team, in order to fully promote Organ Donation Awareness week in September 2022.

FB thanked CT for Organ Donation Annual Report and welcomed review of Organ Donation Annual Report in May 2023.

Resolved: SQAC received and **NOTED** the Organ Donation Annual Report and welcomed the SQAC Organ Donation Annual Report at its May 2023 meeting.

22/23/32 Sepsis Update

CW provided assurance that in the absence of the sepsis nurse each division was reviewing the sepsis data daily. It is acknowledged that more work is required and that a formal report, rather than a verbal update is required to be presented to SQAC.

NA advised that he had undertaken an offline discussion with CW, and that significant work is taking place at patient and ward level, with good oversight. NA advised that there is a gap with regards to the information being transferred into the Corporate report which would be addressed to be included within June's report

22/23/33 Quarter 4 Transition update to also include update report on Transition Plan on a page

LC presented the Compliance with NICE Guidelines 43: Transition from Children to adults' services for young people using health or social care services

Self-assessment Compliance with NG43 as follows:

- Community & Mental Health – 100% service assessments completed. Divisional mean compliance against standards – 90.7%.
- Surgery Division – 86% service assessment completed, Divisional mean compliance against standards to be confirmed.
- Medicine – 100% service assessment completed, Divisional mean compliance against standards to 79.4%.
  Divisions will monitor achievement of standards via divisional governance meetings.
- A NG43 NICE transition service-assessment had been undertaken against the transition standards for the complex cohorts of young people, and compliance against these is 100%.
- Cohort 1 (age 19-24 years old) – in 2020, there were 52 patients on the Transition Exception Register, 100% of these young people had transition plans, health information passports and route into urgent care plans. There are now currently 6 young people remaining from Cohort 1. Of the 6 young people 4 live within the local areas and all young people have had a community professionals MDT with adult service provider. Plans are in place to transition these young people by September 2022.
- Cohort 2 (16-18 years old) - There are 23 young people in this cohort and 100% of these young people have transition plans, health information passports and route into urgent care plans. Transition planning has commenced with this cohort of young people.
- Cohort 3 (14 -15 years old) There are 24 young people identified as meeting the criteria for this complex cohort from a report of 300 complex young people. Transition planning has commenced with this cohort of young people.
- Data regarding young people over age 16 years accessing services is shared with services and divisions on a monthly basis to support the local transition arrangements for young people.

LC sought clarity on frequency for Transition reporting to SQAC given the significant improvements made.

FB stated that the cohorting of data was particularly helpful and provided assurance that early discussions and appropriate management of patients due to be transitioned are taking place.

AB sought clarity on whether there would be a trust project to review transition centrally, or whether each division would provide information.

000215 KB referred to non-complex patients, and referred to the high number of patients and queried whether there is further improvements to be made in this area, in order to create additional space on waiting lists, and queried whether a similar project would be beneficial to review the non-complex patients.

NA proposed that it would be helpful to standardise a service level reporting process to give an overview of the non-complex young people, this would be addressed offline outside of the meeting.

Aba referred to some conditions which the Trust are still required to treat after the patient reaches 16 years old – i.e., scoliosis surgery as such patients that have no adult service provider to safely provide care to children/young people, resulting in these patients requiring care at Alder Hey after they reach 16 years old.

SQAC **NOTED** the progress made with regards to complex patients.
FB advised on the importance of raising awareness across the organisation regarding the importance of early discussions to enable transition, and the need to measure progress.

NA advised that metrics would be defined and included within future Transition reports.

Resolved: Offline discussion to take place with NA & Associate Chief Nurses with regards to designing appropriate metrics within the corporate report, to enable an appropriate Divisional Led Transition report to be presented to SQAC.

22/23/34 Quarter 4 ED MH Attendance Quarterly Report

SQAC received and **NOTED** the Quarter 4 ED MH Attendance Quarterly Report.

Resolved SQAC received and **NOTED** the Quarter 4 ED MH Attendance Quarterly Report.

22/23/35 Aggregate Analysis Report

PB presented the Aggregate Analysis Report, key issues as follows:-

- Key themes related to admission, discharge, treatment/access, alleged medical/nursing care failure, top causes for incidents related to medication, access, admission, transfer and discharge which had remained the same for 2020/21 and 2021/22.
- Significant increase in the number of incidents reported relating to staff health and wellbeing, with ongoing work taking place across the organisation to support staff health and wellbeing.
- There had been a reduction in Medication Errors and Documentation incidents within Surgery and Community Divisions.

KB requested that annual reports are cross referenced against the risk register to provide assurance that key risks highlighted are reflected on the register.
PB stated that this could be reviewed as appropriate going forward.

Resolved: Review information/sense check regarding any emerging themes on the Risk Register.

KB referred to the SPC charts and requested clarity within future committee packs to contain a brief description of the symbols, to assist interpretation of the SPC charts. KB referred to how the upper/lower tolerance are set and constructed and welcomed further explanation on how these are constructed.

NA echoed KB comments and advised that keys should be included on the future agenda.

NA advised that the improved representation of data would allow SQAC to focus on those themes that are outside of normal variation, whilst acknowledging the need to continue to improve those themes that occur most frequently.

FB stated that the committee are open to the focus on the key issues, and that SQAC should also not just accept the themes but should also seek to reduce where possible.

Resolved: NA advised that colleagues would review level of detail, and provide update within next report.

Resolved: SQAC received and **NOTED** the Aggregate Analysis Report.

FB thanked PB or Aggregate Analysis Report.

Clinical Governance Effectiveness

22/23/36 CQSG Key Issues report

NA advised that the last CQSG meeting had been extremely positive, the Brilliant Basics approach had been adopted, resulting in a productive, decision and action orientated meeting, with significant progress made.

- Discussion took place regarding changing reporting of NICE compliance, and Governance teams within the Divisions showing strong leadership and ownership.
- CQSG welcomed the change in how the data for patient experience was being presented, which has resulted in an improved robust discussion, CQSG noted the improvements across many areas, (with the exception of ED), with regards to improvements for patient's experience, CQSG acknowledged and congratulated staff for improvement.

NA acknowledged the significant work undertaken by CQSG across a range of issues such as medical equipment and training, with a significant commitment to maintain and improve during pandemic.

23/23/37 Quality Account

SQAC received and endorsed the Quality Account. SQAC acknowledged the breadth of achievements contained within the Quality Account.
Resolved: SQAC received, **NOTED** and Endorsed the Quality Account.

22/23/38 NICE Compliance Summary position report

SQAC **NOTED** the NICE Compliance Summary position report and **NOTED** that that focus would be given to improve the reporting style, to fully demonstrate the work that is occurring across the organisation.

Resolved: SQAC received and **NOTED** the NICE Compliance Summary position and welcomed the new reporting style.

22/23/39 Clinical Audit Plan

PB presented the Clinical Audit Plan, key issues as follows:-

- 244 registered Audits in year, significant progress made

- 60 audits complete, with 176 ongoing
- 52 audits are making excellence progress
- 1 Audit is due to commence
- 7 audits had subsequently been cancelled
- CQSG have oversight of Clinical Audit Plan which is scrutinised/approved at CQSG
- Compliant with National Audit Programme
- All confidential enquiries that had been registered are complete
- Divisions continue to monitor audit/action and report to CQSG
- PB advised that the audits have to be aligned to Strategic priorities. in order to ensure real alignment.
- MIAA had undertaken an Audit performance review, which demonstrated substantial assurance, 4 recommendations had been made, with all 4 recommendations completed. PB commended the excellent Clinical Audit report which had been produced by S Riley.

FB acknowledged the progress made with the report content.
KB referred to Audit plans, and queried how they address complaints and PALS issues, and sought clarity on whether there were any areas of concern that should feature within the annual audit plan to provide a sense check, KB stated she would welcome a Divisional Audit plan report to be presented to SQAC.

NA expressed concern regarding the Divisional lack of progress with regards to the residual audits, and the need for ongoing commitment to address those audits that are significantly overdue.

In relation to the clinical audit annual planning process Erica advised that the process used by MIAA to prepare the internal audit plan might be applied to the clinical audit process and result in broader input and audit coverage. It was suggested that ES, KB and SR discuss offline.

Resolved: Offline discussion to be held with ES/KB & SR
Resolved: SQAC to receive Clinical Audit/Governance update at July 2022 meeting.

Resolved: SQAC received and **NOTED** the Clinical Audit Plan, and would receive a Clinical Audit/Governance update at July 2022 meeting.

Resolved: SQAC acknowledged the positive MIAA findings following MIAA Audit Performance Review, FB thanked all involved for ongoing improvements, with next steps to further improve governance.

22/23/40 Summary Progress Report – Optimising Clinical Governance and Effectiveness

NA advised that the External Review had been received during week commencing 9th May 2022. NA & ES would discuss offline regarding how the recommendations would be progressed.
FB sought clarity on timeline for SQAC to receive an update. NA advised that some aspects of the work required may take a relatively long time, FB agreed that SQAC would receive a quarterly update at August 2022 meeting.

Resolved: SQAC **NOTED** the Summary Progress Report – Optimising clinical Governance & Effectiveness.
SQAC to receive Quarterly update at August 2022 meeting.

Well led

22/23/41 Board Assurance Framework

SQAC **NOTED** that offline discussion had taken place with AB & LC with regards to separating the Mental Health risk. Following discussion both AB and LC recommended that the Mental Health Risk be a separate risk.
ES advised that this recommendation had been fully reviewed, and agreed that separating the Mental Health Risk is the correct approach. ES confirmed that risk would be aligned to SQAC, to enable SQAC to scrutinise and oversee.
LC confirmed that the necessary documentation would be included to ensure an update on this risk would be provided within the BAF update at June 2022 SQAC meeting.

FB requested whether a draft could be shared with her in advance of the next SQAC Meeting, - report would be shared with FB in advance of next SQAC.
FB requested that appropriate discussion regarding BAF takes place at June 2022 SQAC meeting. ES welcomed this, and advised that this warranted a deep dive across the 3 SQAC risks.

Resolved: SQAC received and **NOTED** the BAF update, and **NOTED** that the Mental Health Risk would be a separate risk. SQAC to undertake discussion at June 2022 meeting, with regards to deep dive across the 3 SQAC risks.
FB to receive draft BAF report in advance of next SQAC meeting.
FB thanked AB & ES for BAF update.

22/23/42 Divisional Report/Quality Metrics update

Community & Mental Health Division – LC provided key issues as follows:-

- FFT scores remain over 90%
- Community 100%
- Slight increase in PALS, regarding waiting times for assessment for ASD/ADHD appointments.
- Division continue to receive an increase in referrals for Neurodevelopmental services/ASD & ADHD. Division had been involved in further discussions with regards to ASD and ADHD referrals across both Liverpool and Sefton as part of the system planning work, and as part of the Liverpool SEND inspection which had taken place during week commencing 2nd May 2022.
- Complaints continue to remain static, with complaint themes regarding access and waiting times for both mental health, ASD & ADHD services.
- BAF risk would be updated and included onto the Risk Register

Medicine Division – AH provided an update on key issues as follows:-

- Division continue to experience challenges with regards to waiting lists, RTT performance had stagnated below 60%. Those challenging specialities have long term plans in place to recover position, action plans are reviewed and tracked at access to care meetings.
- Mandatory training compliance had increased to over 90%
- Key focus is targeted regarding Safeguarding Training and life support training to improve compliance.
- Staff turnover rate within the division is 12%, prior to January 2022, staff turnover equated to 9%, colleagues within the division are working closely with HR colleagues to establish factors why staff are leaving the Division, in order to retain staff within the division.

Surgery Division – CC provided an update on key issues, as follows:-

- Mandatory training is almost at 90%

000219

- Main focus for Division is to ensure clear process is in place regarding Transition Action plans, with ultimate review/sign off at Divisional Governance Meeting.
- Division had their first IPC Group for Division. Division had also established Safeguarding Group who will have its inaugural meeting in July 2022.
- Division are procuring Trust wide fridge monitoring equipment, which would provide proficient monitoring.
- FFT response rate is 94%
- Division are 100% compliant in terms of Complaints responses, with no second stage complaint requests.
- PALS -100% response rate during May 2022, with regards to responding to families within 5 working days.

FB welcomed the positive update regarding improved complaint's compliance in terms of responses, which highlighted good engagement across the division.

KB referred to the metrics, and the known date of discharge, and sought clarity on understanding what had changed, given that the trust had been outside of target for 6 month period.
KB also queried the implication on safer staffing shift fill rate metric.

CW advised that this was previously noted at Divisional Governance meeting and that there would be a plan in place, CW had already provided feedback to Heads of Nursing, matrons and clinicians, with ongoing work taking place to address., CW stated that the Committee would see an improved position at the next Divisional update to SQAC in June 2022 meeting.

NA referred to Staff Safe fill rate and stated that the metric is as reported is not particularly useful. The Trust is in the process of transitioning to reporting care hours per patient per day which can be nationally benchmarked. This requires BI support which so far has not been undertaken. The report will be in the board pack from next month. NA highlighted the importance of required BI support, given the significant delays. due to the lack of BI support.

CC stated that colleagues within Division of Surgery meet 3 times per day to review safe staffing, and to ensure each shift is safe and escalate as appropriate.

FB welcomed improved report which would reflect current position and provide assurance going forward.

FB thanked the Divisional Leads for the Divisional Updates.

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

22/23/43 Quarter 4 PALS & Complaints Quarterly Report

SQAC received and **NOTED** the Quarter 4 PALS & Complaints Quarterly Report.

Resolved: SQAC received and **NOTED** the Quarter 4 PALS & Complaints Quarterly

000220 report.

22/23/44 Quarter 4 Patient & Family Feedback quarterly report

SQAC received and **NOTED** the Quarter 4 Patient & Family Feedback quarterly report, key issues as follows:-

- Main reasons for PALS and formal complaints related to treatment and procedure, appointments, staff attitudes and communication.
- PB referred to performance and the ongoing journey of improvement
- Significant assurance is provided through CQSG
- Continued progress across Divisions to address PALS and complaints, with low threshold of escalation to Associate Chief Nurses.
- Overall compliance with PALS across the year, - team had not yet seen that increase at present, however PB is confident that the increase would be evident within the next quarterly report.
- Significant findings within Ockenden review regarding response to complaints, in terms of training, with little, or no training to support staff in local resolution of complaints.
- Significant work had taken place with Children & Young People Forum regarding The right to complain, and how the Trust responds to such complaints with focus provided at Quality Round on 27th May 2022.
- SQAC **NOTED** wholesome compliments received, and the impact on actions for families.

NA expressed his thanks to PB for clear report, NA advised that the team are moving to continuous monitoring, rather than a 'snapshot' this would enable clarity on the improvement journey and would demonstrate changes.

Resolved: SQAC received and **NOTED** progress/improvement regarding complaint 'turnaround' responses and **NOTED** the recommendations.

FB thanked PB and colleagues for Quarter 4 Patient & Family Feedback quarterly report

22/23/45 Patient Information Leaflet Policy – M13

SQAC received and **RATIFIED** the Patient Information Leaflet Policy - M13.
Resolved: Patient Information Leaflet Policy – M13 RATIFIED.

SQAC received and **RATIFIED** RM47 – Duty of Candour Policy.
Resolved: RM47 – Duty of Candour Policy – RATIFIED

22/23/46 Any other business

. None

22/23/47 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Quality Priorities Monthly update was received, which highlighted good progress made by teams, with strong engagement of teams. **NOTED** that these priorities are in the process of being refreshed for 2022-23
- Assurance ED Activity Monthly Update received
- Level 2 Comprehensive Root Cause Analysis – Investigation into the Major Trauma Care Pathway following a Catastrophic injury involving a fireplace. Good discussion held detailing actions that had been put in place to address any recommended actions/learning, with ongoing work progressing.

000221

- Organ Donation Annual Report was received, SQAC **NOTED** the new ongoing work planned.
- Transition Update was received, SQAC had a detailed discussion regarding current Transition position. SQAC agreed that NA would work with Associate Chief Nurses to define, design and develop metrics in order to track progress, to be included within future Transition Reports, to present Divisional Led Transition reports to SQAC. SQAC acknowledged the requirement to escalate Transition within the wider system regarding factors preventing transition taking place might be necessary on occasion.
- Aggregated Analysis Report received, SQAC **NOTED** the ongoing work regarding format of the Aggregated Analysis Report, and the clarity that this provides to SQAC.
- SQAC received and **NOTED** the Quarter 4 Patient & Family Feedback Quarterly report.
- SQAC received the Clinical Audit Annual Plan, and **NOTED** the significant progress made throughout the year.
- Quality Account was endorsed and **NOTED**
- Patient Information Leaflet Policy – M13 was received and RATIFIED
- RM47 – Duty of Candour Policy – was received and RATIFIED
- Divisional updates regarding highlights and challenges were **NOTED**

21/22/48 Date and Time of Next meeting

22nd June 2022 at 9.30 via Microsoft Teams

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 23rd May 2022
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Fiona Beveridge	Non-Executive Director
	Melissa Swindell	Chief People Officer
	Adam Bateman	Chief Operating Officer
	Erica Saunders	Director of Corporate Affairs
	Mark Flannagan	Director of Communications & Marketing
	Alfie Bass	Interim Chief Medical Officer
	Rachel Greer	ACOO – Community & Mental Health
	Chloe Lee	ACOO – Surgery
In attendance:	Lisa Cooper	Director of Community & Mental Health Services
	Pauline Brown	Director of Nursing
	Jo Potier	Associate Director of Organisational Development
	Adrian Hughes	Deputy Medical Director
	Clare Shelley	Associate Director of Operational Finance
	Carolyn Cowperthwaite	Associate Chief Nurse – Surgery
	Cath Wardell	Associate Chief Nurse – Medicine
	Kat Allsopp	Head of HR
	Ayo Barley	Head of Equality, Diversity & Inclusion
	Amanda Kinsella	Head of Health & Safety
	Darren Shaw	Learning & Development Manager
	Gill Foden	HR Business Partner – Surgery
	Kerry Turner	FTSU Champion
	Amanda Graham	Executive Assistant (Minutes)
Apologies:	Ian Quinlan	Non-Executive Director
	John Grinnell	Director of Finance
	Nathan Askew	Chief Nurse
	John Chester	Director of Research & Innovation
	Urmi Das	Director, Division of Medicine
	Katherine Birch	Director – Alder Hey Academy
	Claire Liddy	Managing Director, Innovation
	Phil O'Connor	Deputy Director of Nursing
	Sharon Owen	Deputy Chief People Officer
	Jacqui Pointon	Associate Chief Nurse – Community
	Mark Carmichael	Associate COO – Medicine
	Jason Taylor	Acting Associate COO – Research

22/23/019 Declarations of Interest

Fiona Marston – Liverpool School of Tropical Medicine

22/23/020 Minutes of the previous meeting held on 25th April 2022

Resolved : The minutes of the last meeting were approved as an accurate record, noting the email appended confirming approval of the Committee's Annual Report, Terms of Reference and Workplan.

22/23/021 Matters Arising and Action Log

No matters arising. The action log was updated accordingly.

Trust People Plan 2019-2024

22/23/022 Strategy Development

MS gave an overview of People Strategy development, sharing slides for discussion that give the shape of the People Plan going forward, which have previously been taken to Executive Committee. Colleagues were asked for their reflections; whether there is anything missing; is there enough ambition; is the balance between internal & external focus right; and are the strategic priorities the right ones. MS noted that things have changed since the original People Plan was issued in 2019, with a different social landscape, an increase in collaborative working and increased workforce vulnerability.

The National People Plan has identified four key areas of focus which MS proposed will form the basis of our Plan, aligning to the national strategic picture:

- Looking after our people
- Belonging in the NHS
- Growing the future
- New ways of working

MS outlined the key deliverables to be considered in shaping the Plan, including how the People Promises could be delivered.

FM noted that the word "inclusivity" doesn't seem to feature; MS noted that it is used as a concept within the NHS People Plan and would be happy for it to be included here. MF added that it feels like there is a real engagement in getting the language right; AB commented that there is currently a lot of debate around language and acronyms that have little effective meaning in relation to what the desire is to achieve e.g., anti-racism as against EDI.

FB commented that this is a great document, noting the following specific challenges: firstly, around challenges in being able to recruit the right people in digital and research, needing to train people maybe in partnership with other bodies, partnership could be stronger as for some of the challenges partnership might be absolutely what is required. Alder Hey's location is in an area with a very low skill-base and we can work with other bodies to address the upskilling need; secondly, around safety & wellbeing and being very thoughtful of the balance between the hospital being safe and the staff being safe. Being a safety-first culture could conflict with staff wellbeing and safety must be threaded through in terms of focus and training, psychological safety developing into patient safety. JP responded that she will be working on developing

the new patient safety strategy looking at the interface between staff and patient safety in all its forms.

FB asked if, when this report goes to the CYP Panel they will scrutinise it and be content with what it is saying about CYP – does it need to be more explicit that everyone at the Trust needs to have CYP at the heart of their work. Also, what is different about Alder Hey and other NHS workforces, is it that CYP are at the heart of everything we do and does that translate into anything for the workforce, any requirement or expectation that needs to be expressed to avoid it being taken for granted. MS noted that this is an interesting challenge and previously the strategy has not been taken to the Forum for their input, but it would be interesting to hear their feedback.

FM noted that there is representation from the CYP Forum on the EDI steering group, and while not suggesting someone at every meeting, should there be discussion about them being involved in what we do at PAWC. MF commented that there is work ongoing with external agencies on the Trust's Strategy for 2020-30 which should also involve the CYP Forum and perhaps there is an opportunity for a consultation / open workshop process to involve both staff and the CYP Forum. FM suggested discussion of involvement of the CYP Forum be taken offline and to bring back to the Committee for future discussion.

AK noted that staff safety should extend to also include site safety & safe premises.

CC noted the unique way Alder Hey looks after families and carers is by instead of saying they visit us, turning it around to say we are visitors in their episode, to really work at making sure they are cared for and look after at every step of that journey. Is there a way of championing that and including something in induction to consider every member of the family in all of their episodes.

ES commented that sight must not be lost of the importance of the Trust's values at the core of all we do and some revisiting & work around them might support some of the other work.

MS thanked the Committee for their input, noting that the next iteration would be brought back later in the year for further discussion.

ACTION: 22/23/022.1 – MS / FM to discuss CYP Forum involvement & bring back any proposal (MS / FM)

ACTION: 22/23/022.2 – MS to bring back next iteration of Strategy for discussion in September (MS / FM)

2022-23 Operational Plan Objectives – People

MS gave a brief overview of the Operational Plan Objectives for 2022/23, noting the following key areas of focus:

- Attraction & Retention
- Organisational Health & Wellbeing
- Workforce Planning
- Great Place to Work

Alongside those is also further development of the EDI Steering Group and its priorities for 2022/23.

Resolved: PAWC received and noted the update of the People Plan

Looking After Our People

22/23/023 Focus on Sickness Absence

GF gave an overview of sickness absence, noting a slight decrease in overall absence rates but a slight increase in long term sickness absence, with ongoing support being given to help absent staff back into work. Chest & Respiratory issues was the highest of the reasons for absence over the last 12 months, with Anxiety fourth after Gastro and Cold / Flu, with direct or indirect impact of Covid on these ratings. Information was also shared on staff support initiatives such as financial wellbeing, preventative access to OH and line manager sickness support training.

MF asked for clarification on whether the headcount absent figures shown were annual totals; GF confirmed that they are annual and offered more detail if required. FM asked for clarification to avoid misinterpretation.

GF noted that when viewed against benchmarking data from around the NW area, Alder Hey are upper mid-range but by no means top as of 31st December 2021. MS commented that for many years the NW region has had higher than average sickness figures than the rest of the NHS. MF noted that not every Trust will have facilities staff as Alder Hey do, which will impact on head count and absence data; MS advised that this particular national data set does not take account of the differences in workforce across different types of hospital.

AK asked for information on particular hotspot areas to be shared offline, so any H&S issues can be linked.

ES commented on the demographic profile of the organisation, noting that there is increasing evidence showing that menopause is a hidden issue within sickness causes which will be a significant and growing issue for the Trust.

KT commented that staff support should include Freedom To Speak Up as a support tool that needs to be more widely spoken about. KT also added that it has been good to be involved in development of the absence training for line managers. CW added that it is important that B6s and senior ward staff are included in this training, to ensure those doing the RTWs and having those conversations with staff are exposed to it.

Resolved: PAWC received and noted the focus report on sickness absence.

Turnover Report

GF gave an overview of the Turnover report for Q4 2021/22, noting that there have been some revisions to the layout and information provided. Figures for Q4 show an upward trend and an increase year on year finishing at 14.17% against 10% for 2020/21. A deep dive has been undertaken into the reasons for staff leaving, which range from lack of opportunity to relocation. There are also a high number of staff who leave within the first twelve months of joining the Trust, showing at 24% for 2021, which needs to be addressed as part of the attraction and retention project. However, there

is positive feedback from leavers which should also be taken on board for areas such as work-life balance.

DS asked whether there is any data to compare Alder Hey's position with other Trusts; GF replied that as yet there is no comparative data but when that is available it can be brought to the group. JP noted that from a staff survey perspective the Trust is in line with others regionally for percentage numbers of staff considering leaving; also, what can be done for those who are considering leaving, to ask what would make it better if they were to stay.

MS noted that there are very low response rates to exit interviews which will impact data; Also, further detailed analysis is being done on the data by Strasys and initially this has revealed that one in four people are moving either in or out of the Trust at any one time, and that the average length of stay for leavers is 3.8 years. FM asked what can be done to improve the exit interview process; MS responded that this is being reviewed. FM suggested maybe an offer of independent discussion could be made, rather than an exit interview with a line manager who may be a contributory cause of leaving.

FB commented that while a level of staff churn is good, it would also improve the data if there could be disaggregation of staff being promoted, those being awarded an extension to FTC etc. Also, an understanding of future aspirations from appraisals could be fed into the Academy to do more to help with those aspirations such as training to enable internal developmental moves. DS commented that conversations have been had around career development discussions being a bigger part of appraisal going forward within the potentially systemised process which would provide data for analysis and use by the Academy and HR teams.

CS noted that when exit forms have been completed, it is not clear who to send them to, and added that by the time this form is completed it is too late – conversations should be held within PDRs and 1:1s, along with wellbeing conversations, all of which hopefully help make any leaving experience more positive. Also, are trends picked up & highlighted where turnover is high; finally, there have been two years of remaining static within the Finance team during Covid and only now are staff beginning to move again, creating a higher-than-average level of churn. GF noted that disaggregated information is received on a quarterly basis but there does seem to be a need for more conversations with divisions and pulling the information together.

PB noted that within Nursing there is "transfer window" which allows staff seeking different experiences to move about within the hospital to different areas, retaining them within the Trust. MS commented that this could be looked at as part of the attraction & retention work planned for this year.

ABarley noted that tackling any issues around inclusivity and culture will hopefully have an impact on the retention rate particularly for underrepresented groups in the organisation.

The following comments were placed in the Chat:
CW noted the importance of F2F meetings for exit interviews, with line manager present.
KT asked that FTSU be included in the Exit Interview process.
AB noted that it would be good to accumulate and assess the themes we get from the different channels of staff feedback in one place, of which exit interviews are one channel.

JLK asked whether when internal opportunities arise, should we be doing a scoping on knowledge and skills assessments of internal staff in regards aligning to such positions.

Resolved: PAWC received and noted the turnover report.

Communications Update

MF gave an overview of progress with the new intranet, which is well underway, with close collaboration ongoing with different staff groups and engagement in terms of champions and representatives to help build it. The refresh of the Celebration & Recognition pack has been completed and progress is now at the stage of agreeing budget & staff resource. Finally, the Comms team are putting together a plan for summer events, which will be brought to the next meeting. KT asked that there is staff involvement in the celebration & recognition work, which MF confirmed there would be.

Feedback was requested on the Internet Discovery report provided in the meeting pack, preferably by end June.

Resolved: PAWC received and noted the Communications Update

Staff Survey – Temperature Check

JP gave a brief overview of the quarterly temperature check which is now a nationally mandated survey and is called the People Pulse. The Trust have no control over the questions and in fact they flex every quarter, so they are looking at slightly different things, except for some key points which are highlighted in the report.
There is a steady rate of people reporting reasonably high levels of anxiety, which should probably not be at all surprising given recent times. But interestingly, when all the feedback is reviewed the word “coping” comes out most often, along with “demotivated”, which links to a lot of the discussion about retention and a kind of loss of purpose, also concerningly engagement is dropping again and burnout and turnover rates are growing.

JP then briefly went through the Staff Survey Action Plan and asked for comments from the Committee on the themes and actions detailed in the document. FB commented that it is concerning that violence is not being reported and there needs to be more understanding about why they are not reporting, but also thought given to how we can respond quickly to this. KT added that there is a gap here between what is being reported and what is coming through FTSU, maybe an opportunity to link the behavioural framework and Trust values and to refocus attention, as shown by the zero-tolerance work undertaken within Nursing. AK added that in relation to the comments about breakout spaces within the paper, new furniture and refreshed spaces are being rolled out across the Trust. ABarley noted that there is a process being developed for training staff to become active bystanders when any bullying or harassment takes place, with a training provider being selected for this. Also, there is an opportunity to glean knowledge from other Trusts nationally around understanding the barriers to reporting bullying and harassment and understand where any gaps occur.

Resolved: PAWC received and noted the update on the Staff Survey & Temperature Check.

Belonging in the NHS

22/23/024 EDI Steering Group - Draft Terms of Reference

MS gave a brief overview of the Terms of Reference for the EDI Steering Group and asked for any comments to be made to her and ABarley.

Resolved: PAWC received and noted the Draft ToR for the EDI Steering Group.

Governance

22/23/025 Corporate Report Metrics – April 2022

The Committee received the Corporate Report and a paper from each of the Divisions, with detailed discussion will take place at the next meeting as Divisional representation was very limited due to operational meetings.

Resolved: PAWC received and noted the report on Divisional metrics.

22/23/026 Board Assurance Framework – April 2022

ES noted that the risks continue to be regularly reviewed and updated, with the identified gap in assurance within the EDI risk expected to show an impact in coming months as that profile begins to shift.

Resolved: PAWC received and noted the latest position of the Board Assurance Framework

22/23/027 Policies

Ms advised that both policies have been through the relevant processes and have been brought for approval and ratification.

Resolved: PAWC received and ratified the On Call Manager Policy

Resolved: PAWC received and ratified the Recruitment and Selection Policy

22/23/028 Board of Directors Summary

- Annual Report, Terms of Reference & Workplan were all approved by offline confirmation
- Draft People Plan 2022/27 – to return for more detailed discussion late summer prior to going to Trust Board in September
- 2022/23 Operational Plan & its projects:
- Attraction & Retention
  - Organisational Health & Wellbeing
  - Workforce Planning
  - Great Space to Work

- Suggestion to involve the Children & Young People's Forum and external partners in People Plan development – to be discussed offline
- Sickness absence deep dive including menopause and stress / anxiety
- Menopause Support Group now meeting regularly
- Staff turnover report including extracting themes, developing a targeted plan and inclusiveness
- Absence management training for managers now in place
- Programme of developing new Intranet is underway with feedback requested
- Working Group for 'Celebration & Recognition' to be set up
- Staff Survey & People Pulse Q1 results
- Brief EDI Steering Group Update
- Corporate Report Metrics/Workforce KPIs – April 2022
- Board Assurance Framework/Key Workforce Risks – April 2022
- Minutes of Sub Committee/Working Groups reporting to the Committee
    - JCNC – 25.03.2022
    - Education Governance Committee – 10.02.2022
- It was noted that NW England has historically had higher than average sickness absence rates
- It was noted that there is a gap in control of staff turnover (BAF 1.2 Workforce sustainability)

Resolved: PAWC agreed the Board of Directors Summary

22/23/029 CCG Workforce Development Report 2021/22

MS gave a brief overview of the CCG workforce development report, which is a regular annual report submitted to the CCG. The data comes from other reports that are already being published, so it is to keep the committee sighted on this being submitted in line with the CCG's requirements.

Resolved: PAWC received and noted the CCG Workforce Development Report

Sub Committee/ Working Groups reporting to Committee

22/23/030 The Committee received the approved minutes for the following for information, noted as read.

- Joint Consultation Negotiation Committee – 29.03.2022
- Education Governance Committee – 10.02.2022

Resolved: PAWC noted the content of the minutes.

22/23/031 Any other business

There were no items raised under Any Other Business

22/23/032 Review of Meeting

FM thanked all present for their contributions to the discussions, noting that there has been recognition of any gaps that exist, challenges faced and that actions to address them are in progress.

Date and Time of Next meeting - 29th June 2022, 10am