Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 8th June 2023, commencing at 9:00am

Meeting Room 2 and 3, Liverpool Innovation Park

AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
BOARD PHOTOGRAPH (8:45am-9:00am)							
PATIENT STORY (9:00am-9:15am)							
1.	**23/24/36**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/37**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/38**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **4th May 2023.**	**D**	Read enclosure
4.	**23/24/39**	**9:19 (1 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.	**23/24/40**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update and External Partnerships							
6.	**23/24/41**	**9:30 (20 mins)**	**Vision 2030 Strategy Update:**	L. Shepherd/ J. Grinnell	To receive an update on the work that is taking place on the Vision 2030 Strategy.	**A**	Read report
7.	**23/24/42**	**9:50 (10 mins)**	**Developing a CYP Strategy for Cheshire and Merseyside.**	L. Shepherd	For information and discussion.	**N**	Presentation
8.	**23/24/43**	**10:00 (10 mins)**	**Draft Terms of Reference:** • **Liverpool Trusts Joint Committee (LTJC).**	Chair/ L. Shepherd	For information and discussion.	**N**	Read enclosure
Sustainability through External Partnerships							

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**23/24/44**	**10:10 (15 mins)**	**Liverpool Neonatal Partnership.**	LNP Team	To receive an update.	**N**	Read report
Operational Issues							
10.	**23/24/45**	**10:25 (50 mins)**	• **Integrated Performance Report for M1; including Flash Report.** • **Finance Report for M1, 2023/24**	Exec Leads/ Divisional Leads J. Grinnell	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M1 position.	**A** **A**	Read report Presentation
11.	**23/24/46**	**11:15 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
12.	**23/24/47**	**11:25 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 22.5.23.** - **Approved minutes from the meeting held on the 24.4.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 24.4.23.	**A**	Read enclosure
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
13.	**23/24/48**	**11:30 (10 mins)**	**Mental Health Act Annual Report for 2022/23.**	L. Cooper	To receive assurance the Trust has robust arrangements in place to deliver the appropriate requirements of the Mental Health Act (1983 & 2007).	**A**	Read report
14.	**23/24/49**	**11:40 (10 mins)**	**Brilliant Basics Update.**	N. Askew	To receive an update on the current position.	**A**	Read report
15.	**23/24/50**	**11:50 (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
16.	**23/24/51**	**11:55 (10 mins)**	**Nurse Staffing Report – 2022/23.**	N. Askew	To receive the nurse staffing report for 2022/23.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
17.	**23/24/52**	**12:05 (5 mins)**	**PALS and Complaints Report, Q4.**	N. Askew	To receive the PALS and Complaints report for Q4.	**A**	Read report
18.	**23/24/53**	**12:10 (5 mins)**	**Mortality Report, Q4.**	A. Bass	To receive the mortality report for Q4.	**A**	Read report
19.	**23/24/54**	**12:15 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 17.5.23** - **Approved minutes from the meeting held on the 19.4.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 19.4.23.	**A**	Read enclosure
Lunch (12:20pm-12:40pm)							
The Best People Doing Their Best Work							
20.	**23/24/55**	**12:40 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Update.**	M. Swindell/ G. Dallas	To receive an update.	**A**	Read report
21.	**23/24/56**	**12:50 (5 mins)**	**People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 24.5.23** - **Approved minutes from the meeting held on the 29.3.23**	F. Marston	To escalate any key risks, receive updates and note the approved minutes from the 29.3.23.	**A**	Read enclosure
Strong Foundations (Board Assurance)							
22.	**23/24/57**	**12:55 (10 mins)**	**Transformation Programme Update.**	N. Palin	To receive an update on the current position.	**A**	Read report

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
23.	**23/24/58**	**13:05 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for information							
24.	**23/24/59**	**13:10 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
25.	**23/24/60**	**13:14 (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: Tuesday 27th June 2023, 10:00am – 11:30am, Lecture Theatre 2, Institute in the Park							

REGISTER OF TRUST SEAL
The Trust seal was used:
395 – Engrossment of the office site contract
396 – Engrossment of the Deed of Variation for the 2019 sale contract.
397 – Engrossment of the contract for Plot 1.
398 – Engrossment of the Transfer to Deed for Plot 1 (TP10).
399 – Engrossment of the covenant for Plot 1.
400 – Engrossment of the creche site contract.
401 – Engrossment of the Deed of Variation to the existing nursery lease.
402 – Lease (Alder Hey/John Moore University) – Weightmans.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M1, 2023/24	R. Lea

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 4th May 2023 at 9:00am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
`	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 23/24/06	Mrs. J. Rooney	Patient Safety Team	(JRO)
Item 23/24/06	Mr. C. Talbot	Patient Safety Team	(CT)
Item 23/24/06	Mr. W. Weston	Patient Safety Team	(WW)
Item 23/24/19	Ms. K. Turner	Freedom To Speak Up Guardian	(KT)
Apologies	Ms. B. Pettorini	Director of Surgery	(BP)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)

Patient Story

The Chair welcomed Beth and her mum Sam who had been invited to attend May's Trust Board to share Beth's experience of transitioning to adult care. Nicola Stringer, Volunteer Co-ordinator, accompanied Sam and Beth to support them. It was reported that Beth first came to Alder Hey when she was hours old and has just transitioned to adult care.

Sam provided an overview of her experience when she reached 22 weeks gestation and was informed that her unborn child had spina bifida. When Beth was born the family were transferred to Alder Hey where their journey with the Trust commenced. Sam informed the Board that upon her arrival at Alder Hey she was shown around and made to feel at home and as time went on developed a network of support from other parents in the same situation. Sam advised of her delight when she found out that the new Neonatal Unit is being built on the site of the Trust as she felt that this will be a real positive for new mums and their babies. Sam explained that during their time at Alder Hey Beth had had 22 operations but never had a bad experience throughout any of the procedures and the staff were amazing in their care of Beth.

Attention was drawn to Beth's transition from paediatric care to adult care which it was reported has been very disappointing, especially after having had 18 wonderful years of care and support at Alder Hey. Sam advised that she is trying to raise awareness of the issues that patients are experiencing when transitioning into adult services to see if something can be done to make it easier for other families who will be going through this process in the near future.

Beth informed the Board of her academic achievements and advised of her plans to commence university in September to do a BA degree in business. Sam thanked Alder Hey for being a huge part of Beth's life and helping her over the last 18 years. Sam pointed out that she won't hear a bad word said against Alder Hey and offered her support to the Trust if required.

The Chair thanked Sam and Beth for sharing their remarkable story and drew attention to the importance of time being set aside to reflect on the transition of Alder Hey's patients to adult services.

The Chair asked Beth if there is anything that the Trust could have done better. Beth reported that the bins in the disabled toilets require a person to tap them with their foot to open them. Beth advised that this is an issue for her due to having a medical problem with her foot. The Chief Operating Officer, Adam Bateman made a note of this matter.

23/24/01 Welcome and Apologies

The chair welcomed everyone to the meeting, in particular Non-Executive Director Fiona Marston on her return to the Board after a break of six-months, and made a note of the apologies that were received.

23/24/02 Declarations of Interest

There were none to declare.

23/24/03 Minutes of the previous meeting held on Thursday 30th March 2023
Resolved:
The minutes from the meeting held on the 30th March were agreed as an accurate record of the meeting. .

23/24/04 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 22/23/179.1: *Freedom to Speak Up (FTSU) Update (Deputy FTSUG Position - Review the current time provided to the FTSUG and consider as to whether this time could be increased. Compile a plan for moving forward)* – It was confirmed that the FTSUG's working hours have increased and the Trust is about to embark on a deputy FTSUG process. **ACTION CLOSED**

Action 22/23/287.1: *Mortality Report, Q3 Mortality (Liaise with Julie Grice to discuss the possibility of adjusting data from prior years to show a more like for like comparison*

in table and graphs in the report) – It was agreed to provide an update on this action in June. **ACTION TO REMAIN OPEN**

23/24/05 Chair's and CEO's Update

Cheshire and Merseyside (C&M) – The Chair advised of the Chairs and CEOs meeting that took place on the 28.4.23 with the Integrated Care Board (ICB). The Chair drew attention to the national financial crisis that is being experienced by the NHS and pointed out that the C&M system is one of the least well performing ICBs. It was reported that NHS England (NHSE) has asked local and national systems to develop a three year strategy by September 2023. It was pointed out that Alder Hey will help to develop the C&M strategy and contribute to the recovery plan. NHSE has advised that they expect greater transparency across systems and acknowledged that the NHS needs to transform in order to address the current issues. The message being shared is that ICBs/organisations need to manage their finances, reduce costs and work more collaboratively whilst NHSE look towards system transformation. During 2023/24 the focus will remain on GP access, recovery, waiting times, resources and recruitment.

The Chair acknowledged that it is going to be very difficult for Alder Hey to progress its strategy but informed the Board that the Trust will continue with its strategic approach, manage its resources, conduct preventative work and work with colleagues in the community to continue with its focus on CYP. It was pointed out that the Board needs to have a collective view of the system it's working in and continue with its strategic plans in a thoughtful way.

John Grinnell provided an outline of the reports/presentations to be shared during the meeting, and paid tribute to all those involved in the response to the industrial action that has taken place over the last month. It was pointed out that the previous weekend was very difficult due to the uncertainty surrounding the strike action but it was felt that the Trust responded well in the way it was led.

The Chair recognised the amount of time that has been spent on addressing the Trust's finances/Financial Plan for 2023/24 which has been all consuming and thanked John Grinnell, Rachel Lea and the Finance team for their hard work.

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

23/24/06 Patient Safety Strategy

The Board received a presentation which provided an overview of the Patient Safety Strategy and introduced the Patient Safety Incident Response Framework (PSIRF) which the organisation is required to transfer to in September as it is mandated nationally. A number of slides were shared which delivered the following information:

- The evolution of a safety culture that allows people to think about safety;
  - Safety 1 – unmindful, reactive.
  - Safety 2 – systematic, proactive, generative.
- Change relationship with error/failure;
  - Error + blame = more error.
  - Error + systems approach = learning and improved safety.
- The Trust's Patient Safety Strategy;

  - The team have interviewed and spoken to many patients, families and staff who have provided feedback.
  - The foundations of the strategy is based on culture and systems and the three key aims focus on involvement, insight and improvement. Using an approach that consists of Brilliant Basics, the Strong Foundations Programme and Freedom to Speak Up will help the Trust achieve the goals of the strategy.
- PSIRF is a framework for learning and improvement. There are 5 phases to prepare to PSIRF transition;
  - Orientation.
  - Diagnostic and discovery.
  - Governance and quality monitoring.
  - Patient Safety Incident Response planning.
  - Draft policy and plan.
- What does PSIRF mean for Alder Hey?
  - There will be a move to Patient Safety Incident Investigations (PSII) from Root Cause Analysis (RCA), and Patient Safety Responses (PSR).
- Organisational Responsibility;
  - The Board must be sighted on the work that is taking place on the Patient Safety Strategy and PSIRF.
  - The team will need to present the Patient Safety Incident Response Plan (PSIRP) before September 2023.
  - Executive Director support is required in order to fulfil certain responsibilities in the plan.
- Next steps;
  - Board to feedback patient safety concerns to inform the PSIRP by May 2023.
  - Development of a revised policy, governance and reporting processes by July 2023.
  - Approval of driver safety metrics by July 2023;
    - Reduction of harms per 1000 bed days from baseline.
    - 5% annual improvement on patient safety culture metrics .
  - Board and ICS to sign off the PSIRP by September 2023.
- How can you help?
  - Engagement, understanding and buy in.
  - Safety culture
  - PSIRP
  - Learning:
  - Visibility/Linking in
  - Business Cases for Training Programme, Investigation Team, Patient Safety Partners.

A discussion took place about the challenges being experienced from a PSIRF/ Patient Safety Strategy perspective in terms of implementing the new system, funding, assistance from the ICS, and the need for additional team members to support the progress of the strategy.

Jackie Rooney responded to a number of questions that were raised about **1**. Whether patient safety can be linked with the 2030 Strategy in order to understand if there are any pockets of inequalities when looking via an inequality lens. **2.** Whether there is an opportunity to think about non-patient safety incidents, for example, IT. **3.** How the team will capture patient experience to identify any changes as a result of the

programme/shift in culture. **4**. The support will be available as part of the new approach for staff involved in an incident.

John Kelly drew attention to the importance of being able to measure the cost of failure in order to reduce the cost of insurance policies and offered to support the team with the compilation of business cases.

23/24/06.1 Action: JRO

Melissa Swindell advised that the Board has approved the People Plan and felt that it would be beneficial to link in with the Patient Safety team around this area of work.

23/24/06.2 Action: JRO

Alfie Bass acknowledged that part of the process is about understanding the Trust's safety profile and highlighted the importance of communicating with staff about the underlying principle of this. It was felt that it will be necessary to focus on this over the next couple of months and also look at the next steps and what needs to be done to facilitate them. It was reported that there is a communications plan in place and blogs/ safety communications commenced last year. In terms of the next steps there will be a huge shift in culture and language. Level 1 safety training will need to be completed by Executives and Non-Executive Directors, but it was pointed out that additional support is required to enable the team to deliver the Patient Safety Strategy and PSIRF in the next four months.

The Chair felt that the changes that have been made in the last twelve months are remarkable and confirmed the Board's full support for the Patient Safety Strategy and PSIRF. The Chair explained that the key challenge for the Board will be understanding how members can help support the roll out of these two areas of work and highlighted the importance of the Divisions giving some thought about how they can support the Patient Safety team. The Chair and the Chief Nurse; Nathan Askew offered thanks to the team for their leadership, passion and hard work.

Resolved:
The Board received the presentation on the Patient Safety Strategy/PSIRF and confirmed their full support for these areas of work.

23/24/07 Vision 2030 Strategy Update

The Board was provided with an update on the continued development of the Trust's Vision 2030 Strategy and progress against the mobilisation milestones. The report provided detail on the following areas;

- Mobilisation Plan for the 2030 Strategy;
  - Strategic Initiatives (Initiation).
  - Confirmation of Executive Leadership portfolios and required capacity and capability.
  - Implementation of the Vision 2030 Strategy governance structures.
  - The establishment of 'CYPF Areas of Need'
  - Delivery of the Financial Strategy - Work is taking place on the delivery of the Financial Strategy and it was originally scheduled to be completed in Q2 but it was reported that there is a risk to delivery against this timeframe. Progress on the economic case has been challenging given the ongoing pressures with the national planning round therefore it will be necessary to

reassess the timeframe and the work that is required with the Resources and Business Development Committee (RABD). It was confirmed that the Board will be updated on this matter during June's meeting.
- Vision 2030 narrative and Communication Plan – A broadcast for staff took place on the 3.5.23 and the Trust is continuing to engage with staff about the strategy and acquire feedback.
- Development of the organisation's Strategic Outcomes (Strategic Executive dashboard).
- Development of Strategic Initiatives (Programme Governance) – A lot of work has taken place on governance with modifications to the Trust's governance standards currently underway.

It was confirmed that progress has continued to be maintained despite the disruption that the on-going industrial action has caused. Dates have been extended in terms of people engagement, but the overall completion date is not currently compromised. The Board was advised that the inaugural Strategy Board meeting will take place on the 6.7.23.

John Kelly felt that the RAG status for the delivery of the Financial Strategy should be ranked as red given the overall environment. John Grinnell agreed that consideration will be given to this matter in terms of accelerating it. The Board was advised of the commitment to provide a regular strategy update on a monthly basis.

Resolved:
The Board noted the Vision 2030 Strategy update.

23/24/08 Growing Great Partnerships

The Board was provided with a quarterly update and assurance on the progress of risk management within the Trust's established health and care partnerships. It was reported that the Trust continues to make progress in its partnership ambitions and is working tirelessly to ensure CYP are captured in system priorities at all levels. The update, as detailed in the report, focussed on;

- *National*;
  - *C*hildren's Hospital Alliance.
- *North West (Regional;*
  - CYP Specialist Services and Integrated Care Systems (ICSs).
  - North West Paediatric Operational Delivery Networks (ODNs) – CHD ODN
- Cheshire and Merseyside;
  - The Hewitt Review and implications for CYP.
  - C&M ICS update:
    - Shaping the system for CYP.
    - 'Beyond' – ICS CYP Programme update.
    - Provider Collaborative Updates – Acute & Specialist (CMAST) and LD/Mental Health and Community (LDMHC)
- Place Partnerships;
  - Liverpool Place.
  - Sefton Place.
- Partnership Governance;
  - Partnership Quality Assurance Round (PQAR) programme.

The Director of Strategy and Partnerships, Dani Jones advised that a presentation will be submitted to the Board in July to frame the interconnections of the partnerships.

The Chair drew attention to the complex picture and the hard work that is taking place to use every opportunity to advocate CYP. Thanks were offered to Dani Jones for driving partnerships forward and providing an update.

Resolved:
The Board noted the quarterly update on Growing Great Partnerships.

23/24/09 Operational Issues

The Board received an update on the progress that has been made against the eight 2023/24 operational priorities, as detailed in the slide; **1.** Strategic initiatives. **2.** Delivery of the Patient Safety Strategy. **3.** Increase people availability and wellbeing. **4.** Advance the clinical research portfolio and innovation pipeline. **5.** Handover Springfield Park to the community. **6.** Improve access to care and reduce waiting times. **7.** Financial sustainability. **8.** Safely deploy the Alder Care Programme.

The Chair felt that the information in the update was beneficial in terms of keeping the Board focussed on operational priorities and asked that this be a regular item on the agenda.

23/24/09.1 Action: AB

Integrated Performance Report, M11

The Board received the Integrated Performance Report (IPR) for Month 12. An update was provided on the following areas of the IPR:

- Outstanding Safety - *Safe;*
  - It was advised that there has been a continued positive reporting culture and sustained improvement in sepsis compliance in inpatient areas.
  - There is a continued reduction in unplanned admissions to critical care, and a downward trend in pressure ulcers.
  - It was reported that ED sepsis compliance requires continued support in order to achieve its target.
  - *Nursing Workforce:* There have been no red rated shifts for four months, and the latest cohort of international nurses are in the process of receiving training.

- Outstanding Safety - *Caring;*
  - Good performance continues with PALS responsiveness despite an increase in contacts.
  - Inpatient FFT scores are above target.
  - There has been a decline in ED in the Friends and Family Test (FFT) therefore a focus will take place on improving experiences in ED as well as the timely resolution of complaints.

- Well Led – *Risk Management*
  - Focus is required to ensure risks are reviewed in date.

- Well Led – Safe Digital System – *Digital*

- The new Risk and Incident Management system is due to go live and training has commenced. Additional modules will be included on the system during the next month.
- The final design has been selected for the Trust's new website.
- *Alder Care Deployment* - The programme continues to progress well and is on track to go live early in September 2023. Work is taking place on the staff support offer, and the 'simulation hub' on the Mezzanine was launched on the 21.3.23 which provides a location for users to engage with the programme and the Alder Care system. Engagement is increasing and training will commence in July.

Community and Mental Health Division

There was nothing to raise in addition to what was in the IPR.

Division of Medicine

- Consultant job planning is a priority and has to be uploaded onto the system by the 31.3.23. It was confirmed that contact will be made with each service that isn't compliant.
- *ED Performance* - An exception report is to be submitted if performance is below 76%.
- The Division has recruited a locum Neurology Consultant. It was confirmed that the post will eventually become a substantive role.

Division of Surgery

There was nothing to raise in addition to what was in the IPR.

Corporate

There was nothing to raise in addition to what was in the IPR.

The Chair drew attention to staff turnover which is a big challenge for the Trust and highlighted the importance of understanding the root cause of the matter in order to address this problem. Fiona Marston asked as to whether the Trust has an understanding as to why people are leaving the organisation. It was reported that this area of work is reviewed on a regular basis but a more granular long-term piece of work is required to look at development, training, external factors, etc.

Resolved:
The Board received and noted the content of the IPR for Month 12.

Proposal for changes to the IPR, 2023/24.

The Board was advised that as part of the annual planning and development of the new Vision 2030 Strategy the IPR requires a refresh to reflect the objectives and priorities for the 2023/24 financial year. Attention was drawn to the following changes:

- Introduction of a Flash Report.
- Updates to section titles, including 3 new areas.

- Updates to current suite of metrics, including additional clarity on source of targets, internal and external requirements.
- Removal of Metric Summary Tables.
- Updates to Divisional summary sections, with additional detail in Performance Review meetings.

It was reported that due to the realignment of Trust Board dates into the following month, it has been agreed to introduce a new 'Flash Report'. The aim of the flash report is to highlight a small number of metrics which the Board needs to receive promptly without waiting for the next IPR.

John Kelly felt that further metrics are required as there is a gap and pointed out that some cumulative metrics won't work in graph form, for example, Cost Improvement Programmes (CIPs).

Shalni Arora queried the absence of metrics for research and innovation. It was confirmed that these metrics will be included in June's report.

The Chair felt that good progress is being made but recognised the challenges.

Resolved:
The Board approved the proposed changes to the IPR.

Initial Flash Report.
Resolved:
The Board received and noted the Flash Report for April 2023.

Finance Report for M12, 2022/23

A number of slides were shared with the Board to provide the following information:

Year End Position;

- There was an overall surplus of £5.5m at the year-end compared to a control total of £4.6m.
- The Trust achieved the national target and supported the overall system position that came in on plan.
- £17m CIP was met in full in year but a recurrent £5.4m gap remains which will be rolled over to 2023/24.
- The Trust achieved its full Capital spend of £16.9m for the year.
- The 'Better Payment' practice code was achieved in March with 95% of invoices being paid.
- The Trust's cash balance at the year-end is £83m.

2023/24 Financial Plan

- The Trust's 2023/24 plan is a to achieve £12.3m surplus. The key areas to note are;
  - 5% CIP target of £17.6m
  - Elective activity targets of 104% and 108%.
  - Reset of income from both commissioners with payment by results (PBR) for elective activity.
  - There are some big changes, for example, public dividends, etc.

- 2023/24 key risks that will need to be managed collectively; income, inflation, system positioning and CIP.

The Chair drew attention to the elective targets that have been locked in by the commissioners and asked for the Chief Medical Officer's view on the Trust achieving a target of 108%. It was reported that one of the challenges in achieving elective activity targets is pay rates. Going forward, the Trust will be looking at the following areas to help increase productivity; level of pay that has been agreed for additional work, underused theatre lists, investments to grow the team, productivity and out of hours activity. In terms of speciality areas a testing of value will take place to see if additional cases can be addressed. The Board was advised that backfill will still be required in addition to the business case being approved.

John Grinnell advised that a lot of his concerns relate to access, performance, turnover and finances in terms of the complex issues that the Trust is experiencing at the present time and felt that the Exec Team should challenge itself to find solutions for these areas whilst ensuring the right oversight at Assurance Committee/Board level. It was agreed to share the Exec Team's initial thoughts on this matter during June's Trust Board.

23/24/09.2 Action: JG

Points were raised by members of the Board about the significance of having appropriate communications for staff regarding the recovery programme, the importance of being able to control the organisation's finances, the challenge in terms of the Trust's aspirations for treating CYP above its mandate, and productivity opportunities versus patient experience.

A conversation took place about the National Long-Term Plan and the importance of ensuring CYP remain on the agenda in order to receive the required funding. It was queried as to whether there is a risk that CYP won't receive resources. It was confirmed that this could be the case if CYP aren't included in the plan which is why the Trust is raising the profile of CYP locally, regionally and nationally. Garth Dallas asked as to whether the Trust is able to raise concerns about the potential for CYP missing out on funding. An example was provided where the Trust conducted a great deal of work to create a surgical space for dental care in a Hub and subsequently care for CYP was denied. Following discussion, the Chair agreed to raise this matter with the ICB.

23/24/09.3 Action: DJW

The Chair brought the agenda item to a close and pointed out that Alder Hey's leadership role is about being an influencer in a complex and challenging system whilst ensuring respective messages are shared across the system.

Resolved:
The Board noted the finance report for M12, 2022/23.

Digital, Data and Information Technology Update.
Resolved:
The Board received an update on Digital, Data and Information Technology and noted the progress to date.

23/24/10 Industrial Action Update

It was reported that the last period of strike action went smoothly and safely but it did have an impact on CYP access and staff. The Board was advised that the Trust reduced its footprint by combining as many wards as possible. There was 24 hour nurse cover on site with a number of ICU nurses offering to cover the Emergency Department (ED).

The Chief Nurse, Nathan Askew thanked medical colleagues in HDU, ED and general paediatrics for their support during this period of strike action thus ensuring nobody came to any harm on the day. Attention was drawn to the support that was also received from the ICB's Communication Team during the strike action period. It was agreed to send a note of thanks to the team on behalf of the Trust.

23/24/10.1 Action: MF

An update on the outcome of the latest pay deal offers was shared with the Board and it was confirmed that the Trust is awaiting formal correspondence from NHSE regarding this matter.

The Chair thanked all those involved in ensuring the Trust remained safe during strike action.

Resolved:
The Board noted the update on the most recent industrial action.

23/24/11 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:

- It was confirmed that the land transaction has been completed and the Trust is working on the agreed plan for the new nursery. A meeting is in the process of being organised with the community to provide an update.
- *Neonatal and Urgent Care Development* – It was reported that there has been a delay and cost implications to service diversion works. Work is taking place to look at reducing the programme, cost implications and the feasibility of overlapping service diversions and the main construction.
- *Sunflower House* – There are water compliance issues that are delaying occupation. It was confirmed that the Trust is awaiting test results, and a move plan/command centre protocols have been developed.
- *Elective Surgical Unit* – The Board was advised that the full scope of work exceeds the budget therefore the Trust is in the process of reviewing both to agree a way forward.
- *Main Park Reinstatement* - An issue has been identified in the old building relating to asbestos that could delay the programme. There is an action plan in place to help mitigate any programme risks. The Chair asked that in the event there are any consequences as a result of this issue that communications be shared with the community forthwith.

23/23/11.1 Action: MF

Resolved
The Board received and noted the Campus Development update provided on the 4.5.23.

23/24/12 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 27.3.23 were submitted to the Board for information and assurance purposes. During May's meeting the Committee identified its five top key risks; CIP, strategy, Alder Care, financials for the Vision 2030 Strategy and financials for the CIP programme. There was also a focus on the 2023/24 Plan and the changes for the Trust.

It was reported that there is to be a slight change to the way the Committee operates with quarterly business reviews taking place. This will enable the Divisions to attend the meeting on a face to face basis to discuss their revenue plans.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 27.3.23.

23/24/13 Serious Incident (SI) Report

The Board was provided with oversight of incidents that are considered as serious following the guidance from the NHS England Serious Incident Framework (March 2015), and associated learning for the reporting timeframe from the 1.3.23 to the 31.3.23. The following points were highlighted:

- There were zero Never Events and zero SIs reported during this period.
- The action plans relating to StEIS reference 2022/19971 and 2022/23391 remain open and are within their expected date of completion.
- It was reported that the Trust will be developing a report in 2023 that will transition between the SI report and PSIRF.

Resolved:
The Board received the Serious Incident report for the period from the 1.3.23 to the 31.3.23.

23/24/14 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 22.3.23 were submitted to the Board for information and assurance purposes. During March's meeting the Committee received the Trust wide Clinical Audit Annual Programme for 2023/24 and discussed the possibility of forthcoming Quality Assurance Rounds (QAR) taking place on a face to face basis. An update was also provided on the progress of the appointment of a Medical Examiner.

Attention was drawn to the QAR programme that has been developed for partnerships and the importance of ensuring that this is knitted in with the usual QARs that take place in order to have a standard reporting process.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 22.3.23.

23/24/15 Research and Innovation (R&I) Committee

The approved minutes from the Innovation Committee meeting held on the 6.2.23 were submitted to the Board for information and assurance purposes. The inaugural meeting of the R&I Committee took place on the 18.4.23 and the Committee received a presentation on research and innovation and how it will fit into the 2030 Strategy. A monetary review of innovation took place and an update on the development of the Alder Care Programme and Little Hearts project was provided. During July's meeting a discussion will take place on the development of a robust Financial Strategy and a Communications Plan that will align with it. The Board was advised that the Clinical Research Division are in the process of appointing a Clinical Director of Research

Resolved:
The Board noted the update and the approved minutes from the Innovation Committee meeting held on the 6.2.23.

23/24/16 People Plan Highlight Report

The Board received a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during March/April 2023. Included in the report was an update on people metrics and details of the pay 'offer in principle' made by the Government on the 16.3.23 to trade unions representing staff on NHS Agenda for Change (AfC) Terms and Conditions.

It was reported that the Workforce Race Equality Standard Action Plan (WRES), the Workforce Disability Equality Standard Action Plan (WDES) and the Gender Pay Gap report were approved by the People and Wellbeing Committee on the 29.3.23.

Resolved:
The Board noted the contents of the People Plan Highlight Report.

23/24/17 Equality, Diversity and Inclusion (EDI) Update

The Board was provided with an update on the Trust's equality, diversity and inclusion activity. The following points were highlighted:

- During February and March a number of engagement sessions took place; Spiritual Care team met with CYP and families, film night to mark LGBTQIA+ history week, communication campaign to support International Women's Day, and Ramadan celebrations.
- It was reported that the staff networks are working towards developing plans to support organisational objectives, and a deep dive is to take place on staff retention from a risk perspective.
- Attention was drawn to a letter that was circulated by NHSE relating to a recent judgement published by an employment tribunal that found that a senior black nurse employed by NHSE had been treated unfavourably because of her race and because she was willing to speak up. It was confirmed that the Equality, Diversity and Inclusion Steering Group (EDISG) is going to conduct a deep dive using this case as an example to learn lessons.
- The Board was advised that EDISG is starting to take shape and that staff networks have expanded; Staff Menopause Group and the Veterans Network. LGBTQ+ is active as is the REACH Network which is being supported by Angie Ditchfield. Funds have been identified for training

purposes via the BAME charity fund and a request has been made for an additional NED to sit on the EDISG.

John Grinnell queried as to whether the EDISG is heading towards achieving the three areas that the Trust committed to. The Chair of the EDISG, Garth Dallas confirmed that work is taking place to fully embed the networks and promote EDI across the Trust to ensure visibility. The Chairs of the networks will also receive training so that they are aware of how EDI links in with the Vision 2030 Strategy.

Fiona Beveridge felt that collecting data is key in terms of having a standard across the organisation aligned to the ways that the Trust might want to cut the data in the future. It was reported that this is embedded into the People Plan in terms of drilling down into data to find out where the hidden nuances are.

Resolved
The Board noted the EDI update.

23/24/18 Equality Act
Resolved:
The Board noted the contents of the WRES Action Plan, the WDES Action Plan and the Gender Pay Gap report.

23/24/19 Freedom To Speak Up Update (FTSU)

The Board received a summary of the activities of the FTSU team (Sept 2022 to March 2023) and an outline of the communication actions planned for the coming year. The following points were highlighted:

- It was confirmed that Kerry Turner will devote all of her working hours to the FTSU Guardian role.
- The Board was informed that work is taking place to draw out data to gain a true reflection of the number of concerns raised and align them regularly to determine total numbers across FTSU/SALS. It was confirmed that this piece of work is in progress.
- *FTSU Profile* – The FTSU Guardian has been working with the Divisions to promote the FTSU profile to encourage staff to become champions, and to recruit to the networks.
- *Speak Up, Listen Up, Follow Up E-Learning* - Attention was drawn to the issue around the uptake of Speak Up, Listen Up, Follow Up training and it was felt that due consideration should be given as to whether the e-learning modules should be mandated for all staff, so that assurance can be obtained regarding staff members understanding of the speak up process and managers ability to support staff through this process.
- *FTSU Champions* – It has been agreed that the Trust's current FTSU champions are to become Safety Champions. Three of the champions are scheduled to undertake training on the 3.6.23 and the remaining four will attend the next round of training.
- A new FTSU Communication Plan has been developed to ensure that all staff are aware of the FTSU service and how it can support them to raise concerns safely.
- A FTSU strategy statement had been prepared to support the implementation of the People aspects of the Vision 2030 strategy.

The Board was asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed, and to consider whether the Speaking Up e-learning modules should become part of mandatory training for all staff.

A discussion took place on the FTSU e-learning module becoming mandatory for staff. Following feedback from Board members it was agreed that this should be the case. Erica Saunders advised of the importance of ensuring training captures the essence of what FTSU means.

Resolved:
The Board noted the update on FTSU, approved the strategy statement and agreed that the Speaking Up e-learning modules should become mandatory for staff.

Freedom To Speak Up (FTSU) Review Tool for Boards

The Board received the close down report for the current review tool which provided an update from September 2022 to April 2023. It was reported that NHSE has published new/updated FTSU guidance and a review tool template to reflect the new FTSU policy that the Trust has adopted.

Resolved:
The Board received and noted the contents of the Freedom to Speak Up (FTSU) Self-Review Tool for NHS Trusts and Foundation Trust boards close down report.

23/24/20 Recognition of the Trust as a Going Concern

It was recommended to the Trust Board that the 2022/23 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2022/23 financial statements on this basis.

The Board was advised that the Trust has completed a scenario analysis to assess operational liquidity for the next eighteen months to September 2024, and to consider what level of cash the Trust could close with for H2 2024/25 expressed as a percentage of current levels. It was confirmed that the Trust's Directors have a reasonable expectation that Alder Hey will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements.

The Chair of the Audit and Risk Committee (ARC), Kerry Byrne affirmed that following submission of this report to ARC on the 20.4.23 the External Auditors supported the recommendation that the 2022/23 annual accounts and associated financial statements should be prepared on a going concern basis.

Resolved:
The Trust Board agreed to support the recommendation that the 2022/23 annual accounts and associated financial statements should be prepared on a going concern basis and to formally minute that they consider it appropriate for the Trust to prepare its 2022/23 financial statements on a going concern basis.

Alder Hey Children's NHS Foundation Trust

23/24/21 Board Assurance Framework Report (BAF)

The Board was provided with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 14 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- The Board was advised that a piece of work will need to be conducted on the risks that fall out of the 2030 Strategy therefore time will need to be set aside for this.

23/24/21.1 Action: ES

- It was reported that the Research and Innovation (R&I) Committee spent time during April's meeting discussing R&I risks which it was confirmed will be included in the BAF going forward. It was pointed out that there may be some risks that will sit under the Futures umbrella.

Garth Dallas drew attention to BAF risk 2.3 *(Workforce Equality, Diversity and Inclusion)* and indicated that this risk doesn't link in to any items on the Corporate Risk Register (CRR). Melissa Swindell advised that the Trust doesn't have any lower level risks on the CRR for EDI but it was agreed that a meeting will take place to discuss EDI risks from a CRR/BAF perspective.

23/24/21.1 Action: MS

Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the end of March 2023.

23/24/22 Audit and Risk Committee

The approved minutes from the meeting held on the 12.1.23 were submitted to the Board for information and assurance purposes. During April's meeting the Committee received the Head of Internal Audit Opinion for 2022/23. It was confirmed that the overall opinion for the 2022/23 period provides 'Substantial 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. The Committee received two assurance reports on key risk areas; EPRR and Project Assurance and was provided with an update on the Acorn Partnership. It was reported that the Deputy Director of Finance, Rachel Lea requested an audit to be conducted on Junior Doctors – Non-Consultant Spend which highlighted a high risk weakness and complexities in budgeting for substantive and locum junior doctor posts. It was reported that a discussion will take place with the Chair of SQAC to discuss the themes of this audit.

23/23/22.1 Action: KB

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 12.1.23.

23/24/23 Directors' Register of Interest
Resolved:
The Board noted the Directors' Register of Interest.

Alder Hey Children's NHS Foundation Trust

23/24/24 Any Other Business

The was none to discuss.

23/24/25 Review of the Meeting

The Chair felt that the Board had a number of open discussions that set the tone for the year ahead. It was pointed out that there are some critical areas for the Executive Team to reflect upon and feedback to the Board. The Chair thanked everyone for their constructive contributions throughout the duration of the meeting.

Date and Time of Next Meeting: Thursday the 8th June at 9:00am, Meeting Room 2/3, LIP.

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 2023							
27.10.22	22/23/182.2	Board Assurance Framework Report	Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way.	E. Saunders	15.12.22	Jun-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **29.3.23** - This action is linked to new risk system and is unchanged pending the go live of Inphase in April. **27.4.23** - The new risk system is due to go live on the 10.5.23 therefore an update will be provided in June. **ACTION TO REMAIN OPEN**
4.5.23	23/24/09.2	Operational Issues	Exec Team to challenge itself to find solutions for access, performance, turnover and finances in terms of the complex issues that the Trust is experiencing, whilst ensuring there is the right oversight at Assurance Committee/Board level. Initial thoughts to be shared on this matter during June's Trust Board.	J. Grinnell	8.6.23	On track Jun-23	
4.5.23	23/24/21.2	Board Assurance Framework Report	Meeting to take place between Melissa Swindell, Garth Dallas and Angie Ditchfield to discuss EDI risks from a CRR/BAF perspective.	M. Swindell	8.6.23	On track Jun-23	
Actions for July 2023							
24.11.22	22/23/198.1	Integrated Performance Report - Divisional Performance Update	*Division of Medicine* - Invite the Histopathology Team to April's meeting to provide an update on the work that is being undertaken by the team (post mortems and placenta work for North Wales/support for Birmingham Children's hospital, etc.)	M. Carmichael/ K. McKeown	27.4.23	July-23	29.3.23 - The Histopathology Team are to be invited to July's meeting. **ACTION TO REMAIN OPEN**
30.3.23	22/23/310.1	Vision 2030 Strategy Update	*ICS Update* - For clarity purposes, provide an overview of the various bodies detailed in the ICS updates to see 1. How they interlink. 2.The impact that have they on CYP. 3. How they determine the Trust's influence.	D. Jones	30.3.23	On track July-23	
4.5.23	23/24/09.3	Operational Issues	The Trust conducted a great deal of work to create a surgical space for dental care in a Hub and subsequently care for CYP was denied. The Chair agreed to raise this matter with the ICB.	Dame Jo Williams	6.7.23	On track July-23	
4.5.23	23/24/21.1	Board Assurance Framework Report	A piece of work is to take place on the risks that fall out of the 2030 Strategy.	E. Saunders	6.7.23	On track July-23	
Actions for September 2023							
27.10.22	22/23/176.1	Research and Innovation Committee Terms of Reference	*Alignment to RABD ToR* - RABD ToR to be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.	R. Lea	26.1.23	Sept-23	**19.1.23** - This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **ACTION TO REMAIN OPEN**
Actions for October 2023							
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	
Status							

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
27.10.22	22/23/179.1	Freedom to Speak Up (FTSU) Update	*Deputy FTSUG Position* - Review the current time provided to the FTSUG and consider as to whether this time could be increased. Compile a plan for moving forward.	K. Turner/ E. Saunders/ K. Byrne	15.12.22	Closed	**29.3.23** - An update will be provided in May when the FTSU report is submitted to the Board. **4.5.23 -** – It was confirmed that the FTSUG's working hours have increased and the Trust is about to embark on a deputy FTSUG process. **ACTION CLOSED**
24.11.22	22/23/208.1	Board Assurance Committees	Arrange for a patient story to be shared with the Board in May based on the Sensory Project that was discussed at SQAC.	K. McKeown	25.5.23	Closed	**29.3.23** - It has been arranged for this story to be shared in June. **ACTION CLOSED**
23.2.23	22/23/287	Mortality Report, Q3	Liaise with Julie Grice to discuss the possibility of adjusting data from prior years to show a more like for like comparison in table and graphs in the report.	A. Bass	30.3.23	Closed	**4.5.23** - It was agreed to provide an update on this action in June. **7.6.23** - It was not felt that this was necessary as the funnel plots and statistical analysis confirm the Trust's death rates which are consistent with those expected and benchmarked with the organisation's comparators. Within the data there is a graph which breaks down the deaths by cause which will provide the appropriate information. **ACTION CLOSED**
4.5.23	23/24/06.1	Patient Safety Strategy/PSIRF	Liaise with John Kelly re his offer to support with business cases.	J. Rooney	8.6.23	Closed	**7.6.23 -** A meeting took place with John Kelly on the 25.5.23. **ACTION CLOSED**
4.5.23	23/24/06.2	Patient Safety Strategy/PSIRF	Arrange for a meeting to take place with Melissa Swindell to discuss the People Plan in association with the Patient Safety Strategy *(to have one message*	J. Rooney	8.6.23	Closed	**7.6.23** - A meeting took place with an HR representative on the 2.5.23. A full action plan is in place. **ACTION CLOSED**
4.5.23	23/24/09.1	Operational Issues	Submit the slide on the progress that has been made against the eight 2023/24 operational priorities, at each Board meeting.	A. Bateman	8.6.23	Closed	**7.6.23** - It has been agreed to submit a slide on the progress against the eight 2023/24 operational priorities, at each Board meeting. **ACTION CLOSED**
4.5.23	23/24/10.3	Industrial Action Update	Send a note to the ICB Comms team to thank them for their support during the last period of industrial action.	M. Flannagan	8.6.23	Closed	**3.6.23** - This action has been addressed. **ACTION CLOSED**
4.5.23	23/24/11.1	Alder Hey in the Park Campus Development Update	Arrange for comms to be shared with the community if there is a delay to the reinstatement of the park due to the asbestos issues in the old Catkin building.	M. Flannagan	8.6.23	Closed	**3.6.23** - This action has been addressed. **ACTION CLOSED**

4.5.23	23/24/22.1	Audit and Risk Committee	Meeting to take place with Fiona Beveridge to discuss the themes of the Junior Doctors Non-Consultant Spend audit.	K. Byrne	8.6.23	Closed	**3.6.23** - This meeting has taken place. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Strategy 2030 – Mobilisation**
Report of:	Dani Jones, Director of Strategy and Partnerships John Grinnell, Deputy CEO/ DOF
Paper Prepared by:	Dani Jones, Director of Strategy and Partnerships John Grinnell, Deputy CEO/ CFO Natalie Palin, Associate Director of Transformation Rachel Lea, Deputy Director of Finance Erica Saunders, Director of Corporate Affairs Melissa Swindell, Chief People Officer Mark Flannagan, Director of Marketing and Communications

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	March 2023, Strategy Board Paper April 2023, Strategy 2030 Board Paper Board Strategy workshops across 22/23
Action/Decision Required:	To note ■ To approve ☐
Link to: **Trust's Strategic Direction & Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	

1. Introduction

The aim of this paper is to provide Trust Board assurance and oversight on progress against our 2030 Strategy mobilisation plan (*Board paper, March 23: Strategy 2030).* Our mobilisation plan details the key milestones that will support a rapid implementation (table 1). The overall position for the mobilisation plan is **on track** and progress has been sustained across all milestones.

The mobilisation requirements across Qtr.1 & 2 are significant and requires a continued commitment and prioritisation. The oversight of our mobilisation plan is reported into Strategic Executives on a weekly basis. This allows for transparency and shared accountability. The delivery of this plan spans across our Executive team.

The key messages that we are highlighting through this report are: -

a) Proposed alignment of the Executive Leadership to supporting achievement of our 2030 vision and outcomes,

b) Strategic Initiative Mobilisation is on track,

c) Updated position on the integrated governance management arrangements,

d) Confirmation of the financial principles and approach which underpin the early mobilisation of our strategic initiatives,

e) Our approach to the establishment and remit of CYPF areas of need has progressed and targeted stakeholder engagement is planned.

f) Engagement with our people has continued and is on track. The thematic analysis of the results will be completed following the completion of the full engagement plan. The feedback to date is positive from our people, they support the vision, whilst recognizing there will be challenges that we will need to collective address to achieve.

2. Background and current state

The Trust Board has approved the Strategy 2030 (March 23), with next steps of continuing to evolve our governance arrangements, pivot our change programme and review our leadership approach. This paper provides an update on the progress against the mobilisation plan, as detailed in table 1: -

Table 1: Mobilisation Plan 2030 Strategy

Mobilisation	By when	B/R/A/G Status*
1. Confirmation of Executive Leadership portfolios and required capacity and capability	Qtr. 1	Complete
2. Implementation of our Strategy 2030 Governance Structures	Qtr. 1	Complete
3. Strategic Initiatives - Initiation	Qtr. 1-2	On track
4. Establishment of 'CYPF Areas of Need'	Qtr. 1-2	On track
5. Delivery of our Financial Strategy	Qtr. 2	On track
6. Our 2030 – Narrative and Communication Plan	Qtr. 1	On track
7. Development of our Strategic Outcomes – Strategy Exec dashboard	Qtr. 2	
8. Development of Programme Governance	Qtr. 1	On track

**Rag status: Blue complete, Green on track, Amber at risk, Red off Track, Blank not started*

3. Executive Portfolios

	The proposal to align our Executive Directors more explicitly to our 2030 visions. The intention is to implement by start July 2023.	Qtr. 1

The Strategy 2030 Board paper (March 23) outlined a specific action of updating the trust board in respect to changes to Executive Leadership portfolios to support achievement of the 2030 strategic direction. Vision 2030 is radical. The Trust leadership will need to pivot to deliver the Vision to improve outcomes for CYPF significantly.

A separate discussion with Trust Board members will take place to understand the proposed changes further.

4. Implementation of our Strategy 2030 Governance Structures

	The Trust board approved the development of a new Strategy Board (March 23). We now have a detailed proposal for our new 2030 governance arrangements aligned to 2030, for discussion with board members.	Qtr. 1

The Trust Board (March 23) approved the development of the Strategy Board, the first meeting is scheduled for July 23. The inaugural Strategy Board will provide members with an opportunity to review the TOR and the draft work plan, in addition to oversight of the overall strategy development and delivery.

The current governance and integrated management arrangements have been reviewed in the context of 2030. This review has been designed to ensure that the underpinning wiring provides appropriate oversight, empowerment of our divisions

A separate discussion with Trust Board members will take place to understand the proposed changes further.

Next steps: Discussion on the new integrated governance proposals with board members.

5. Mobilisation of our Strategic Initiatives

	37% of Initiation requirements completion for Qtr.1 strategic initiatives. A robust plan is in place to support completion against deadline.	Qtr. 1-2

Background: Our 2030 strategy will be delivered through our strategic goals driven, via ten Strategic Initiatives – our 2030 Strategy Programme. Each of our Strategic Initiatives is led by an Executive lead, who act as the programmes Senior Responsible Officer - SRO (detailed in section 3). Our intention is that all Strategic Initiatives will be mobilised between Qtr. 1 & 2 (23/24) and the development has been phased over this period.

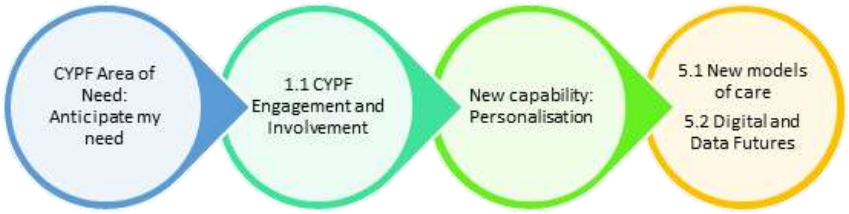
Strategic Initiative Development: Our 2030 Strategy programme has provided a unique opportunity for us to design our approach to achieve delivery excellence and develop new capabilities in our people. With an aim, that the deployment of strategy also forms part of our people development opportunities aligned to the '*2.1 Thriving*

and 2.3 Professional Development' strategic initiatives. Success will also be measured through the effectiveness of how we provide opportunities to inspire and involve our people, so through them we achieve our vision.

The initiation of any programme is crucially important as its effectiveness ensures strategic alignment and the achievement of the desired outcomes; whilst minimising potential challenges. Our development approach is led by the Trust's Delivery Management Office. The underpinning methodologies include programme and change management and our Brilliant Basic principles. This initiation stage is underpinned through the delivery of three facilitated Mobilisation workshops.

The Mobilisation Workshops provide dedicated time for cross functional collaboration focused on programme development. Effective collaboration and removing silos working is a key enabler to our delivery success. At its core our 2030 Strategy is reliant on interconnected delivery, firstly addressing '*CYPF areas of Need'* and secondly 'interdependencies for delivery of tangible capabilities' through other Strategic Initiatives' (illustrated example below Diagram 1). Our governance and assurance framework as detailed in section 4 is designed to reinforce a collaborative culture.

Diagram 1: Interconnected, worked example 1.1 CYPF Engagement and Experience



Status: There are four Strategic Initiatives scheduled for completion in Qtr.1. To date 37% of the initiation stages have been completed for these programmes. A robust plan to complete the final stages during June 23, is in place and Executive Leads have prioritised completion (with scheduled workshops and SRO meetings).

Table 2 provides the Board with an oversight of progress to date in the development of our Qtr.1 Strategic Initiatives and the overall position, is detailed in appendix 1, alongside an overview of the development framework.

Table 2: Phase 1, Strategic Initiatives

Strategic Objective (SRO)	Strategic Initiatives	Initiation Status	Workshops	By when
Unrivalled Experience *(Chief Nursing Officer & Experience Officer)*	1.1. CYP&F Engagement & Experience *	80%	3 complete	23 June
Supporting our people *(Chief People Officer)*	2.1 Thriving at Alder Hey*	20%	1 complete **2 Scheduled** *(07 & 13 June)*	23 June
Collaborating for CYPF *(Chief Strategy & Partnerships Officer)*	4.1 Building Communities*	10%	16/05/23	23 June
Smartest ways of working *(Chief Digital and Transformation Officer)*	5.2 Digital and Data	40%	2 workshop complete	23 June

Key messages to bring to the Trust Board's attention: -

- 37% of the Initiation stages have been competed for Qtr. 1 programmes.
- Barriers to mobilising 'Supporting Our People, 2.1 Thriving at Alder Hey' have now been addressed, since last reporting to Board (April 23).
- The 2030 Strategy Programme interdependencies map is continuing to be advanced, alongside the Strategic Initiative developments. The finalisation will be dependent on the completion of the individual programmes.
- At the first Strategy Board, members can expect to receive a high-level profiling of our Qtr. 1 Strategic Initiatives and the key capabilities moves we will be delivering in Qtr. 2 & 3, aligned to our 'Phased Plan' (Strategic Staircase) and learn about some of the longer term moves which will drive the strategic change.

Next steps: To continue the development of strategic initiatives in line with the detailed plan.

6. Development of our Strategic Outcomes

	Our design approach for the new Strategic Outcomes is in development and will be shared at Strategy Board (July 23)	Qtr. 1-2

Our ability to understand if we are achieving the overarching outcomes is reliant on the development of a suite of Performance Measures and standard approach *(linked to the plan on a page, Appendix 2).* Our 2030 Strategy is a radical shift on many levels, not least in how we measure outcomes and performance. Our current Trust measurement focus is aligned to traditional NHS Performance Indicators; and it's not aligned to our 2030 outcomes.

Our aim is to create a suite of '*Strategic Scorecard and Programme Measures'* that enable us to understand if our strategy is working as intended; whilst also providing oversight and assurance on our performance. The development of strategic outcomes is within the scope of our Strategic Initiative '**2.3 Insight Led Decisions'**. The Deputy CEO/CFO and Chief Digital and Transformation Officer are joint SROs for the 'Insight Led Decisions' strategic initiatives.

Our explicit areas of early focus will include: -

- **Development of new organisational capabilities** in our people to create the foundations for longer term sustainability.
- **Strategy 2030 Programme,** high level progress against strategic staircase, milestones, risks, and benefits.
- **Defining our measures, ownership, and goals** across the 2030 Strategy, aligning to our areas of need.
- **Conceptual development,** to define through research and stakeholder engagement the methodologies, including how we will collect.
- **Baselining** our new 'outcome measures' to set targets for longer-term improvements.

Whilst the outcome methodology is developed, appropriate proxy indicators identify by the SRO and aligned to the IPR (as refreshed for 2023), will be used.

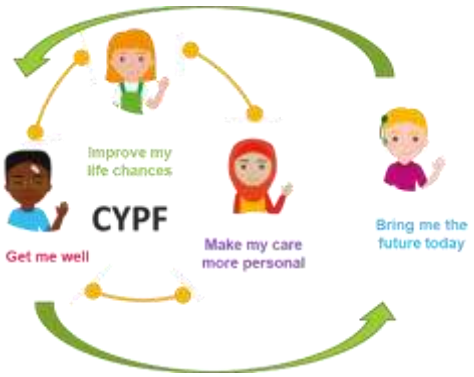
Next steps: To develop our 'Strategic Outcome approach' further with our Executive Team and wider stakeholders. The Trust Board can expect a 'proposal on our approach and timescales for developments at the Strategy Board (July 23).

7. Establishment of 'CYPF Areas of Need'

	The development of 'Our Blueprint' for our CYPF areas of need, is on track and wider consultation with key stakeholders, is supporting the finalisation of the approach.	Qtr. 1-2

The development of our 2030 strategy using a population health-based approach; is undoubtedly the biggest shift in our strategy from traditional NHS models. The effective mobilisation of the 'CYPF Areas of Need' will be essential for ensuring that we truly 'organise ourselves' around CYPF requirements and deliver the level of change that children and families have told us they want to see by 2030.

Our CYPF Areas of Need as the core focus of our 2030 Strategy, will be overseen by an SRO – Chief Medical Officer. The individual areas will each have an appointed Clinical Lead, who will champion the area of need and its priority outcomes to drive change across the Alder Hey and wider system.



- Get me well,
- Improve my life chances,
- Make my care more personal,
- Enabled by 'Bring me the Future Today'

Our **CYPF Area of Need** will each be seeking to enhance experience and ensure priority requirements are addressed whilst improving longer term outcomes. Alongside a wider championing piece across the CYP system, they will seek assurance that the tangible solutions delivered via our Strategic Initiatives are delivering the change required.

Status: To date a draft proposal for establishing 'CYPF Areas of Need' was discussed and developed further with the Executive team on 25.05.23. This was a productive discussion as it enabled a further refinement of the vision and our key success criteria of revolutionizing care. The draft proposal has been developed further and 'targeted stakeholder engagement' will enable testing and further enhancements.

Next steps: A second workshop discussion is scheduled for the 15.06.23 with the Executive Team, to consider the refined proposal and the 'Needs Mapping and Matrix'. The CYPF Areas of Need establishment plan will be shared as part of the agenda for the Strategy Board (July 23), thereafter establishment will commence.

8. Delivery of our Financial Strategy

	Progress continues against the delivery of the financial strategy with a phased approach proposed.	Qtr. 1-2

The delivery of our financial strategy is scheduled for completion in Qtr. 2, and this is progressing, however at the last Board, we did highlight a risk to the delivery of this due to ongoing external pressures which limited capacity to conclude the work required.

In response to this risk and reflecting on the approach required to delivering a full economic case, we are proposing to split this into two phases; Phase 1 –Strategic Initiatives, Phase 2 – Business Models around the 4 areas of need.

Phase 1: - Strategic Initiatives

The mobilisation of the strategic initiatives is underway with financial leads assigned, to undertake a financial assessment and quantify the benefits for each area. Within this, there will be some immediate opportunities that will deliver benefit in Year 1 (23/24) and will therefore deliver a financial benefit that can then contribute to the £6.5m transformation target included within our 23/24 financial plan.

Through the Executive Team, we have conducted a review of the areas requiring initial pump prime investment to enable the mobilisation of the Strategic initiatives. The output of this review is an agreed priority investment into `Workforce` and a repurpose of spend in `Green` which both demonstrate an ROI and can deliver cash releasing savings in year that will contribute to the £6.5m transformation CIP target in our annual plan. We are also in active discussion regarding a commercial partnership for Futures that would push at pace some early Year 1 quick wins and this will be shared in more detail at the July strategy board.

Further work is required on the remaining strategic initiatives which are seeking investment to understand opportunities for external support or repurpose of existing resource to ensure the remaining allocation of pump prime is used to maximum benefit. This will be concluded throughout June and reported back next month.

The full financial assessment of these `cross cutting` Strategic Initiatives will be concluded as Phase 1 and will be reported to the July board, showing the financial impact and tracking this against the Year 1 £6.5m CIP target.

Phase 2: Business Models

In order to model the impact of the 2030 strategy, we need to design and create a new business model for each of the 4 areas of need; Get me Well, Personalise my Care, Bring me the Future Today and Improve my Life Chances. This will need to be an iterative process that evolves as we progress through each need area and are

able to quantify the impact. This will carry on beyond Q2 but will be integral to the development of the strategy and will require clinical engagement to achieve the outcomes required.

9. 2030 Narrative and communication Plan

	Engagement and socialisation targeted completion is May 23. Ongoing monitoring of engagement representation highlights a good spread across Alder Hey Teams.	Qtr. 1

As detailed in our 2030 Strategy Board report, we have undertaken a high level of engagement with CYPF and targeted engagement with our people and partners.

Our focus in Qtr. 1 has been to raise awareness of Vision 2030 generally within the Trust and to provide our people with various, different opportunities to engage, at various, different levels, dependent upon their own choice, from watching a video to providing individual feedback. A range of materials have been produced and activity undertaken to support this. This includes guides to conducting conversations about Vision 2030 in teams, and Executive Director-led activity in the hospital atrium to get some 'fast feedback'.

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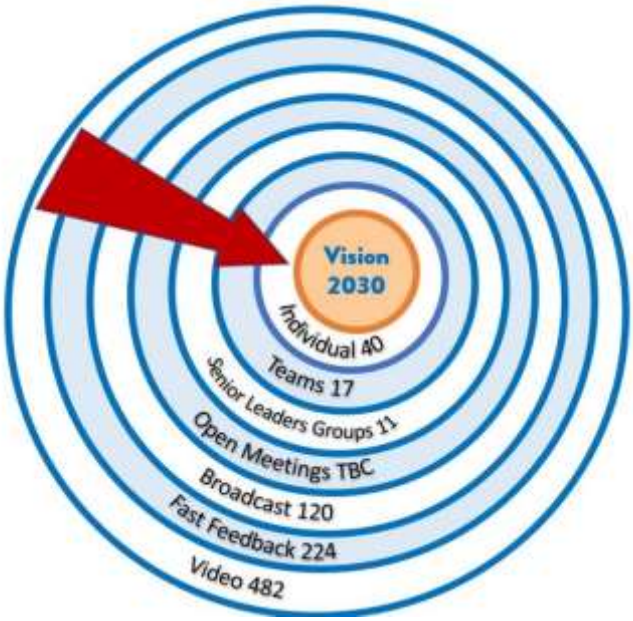
Diagram 1: Feedback numbers 25.05.23



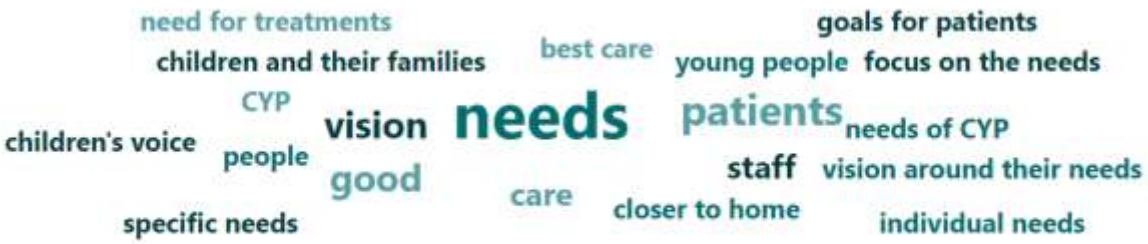
Note that the above engagement data does not include those teams and sections of staff that have been engaged outside of the opportunities outlined above, including

the ‘onboarding’ phase targeted to Divisional Boards and discreet teams (e.g., the Innovation team, HR & OD, and the Marketing and Communications team).

The feedback that we have received to date indicate high levels of support for the Vision. Following the completion of the engagement at the end of May 2023 a detailed report will be produced with thematic recommendations for inclusion in our strategy.

The word cloud below details the some of the high-level feedback around what our people, most like about what they have heard about our 2030 Vision. Which indicates a high-level of support, recognition that the current approaches are not always designed around and need, and they feel the vision creates hope ‘*it will help our people to have more good days’*. There is recognition that there will be collective opportunities and challenges that we will need to address, including funding, systems and more ‘head space for our people’.

Diagram 2: Word cloud – What are people liked about our vision



The Director of Communications is the SRO for the completion of the engagement plan (with weekly reporting into Strategic Execs). Monitoring of progress forms part of the weekly status update to Execs.

10. Conclusion

This paper provides an overview of progress against the high-level mobilisation milestones. The overall position against the mobilisation plan is **on track**, however there are six milestones requiring completion in Qtr.1 & 2. The continued commitment and prioritisation of 2030 mobilisation is required.

- Changes to Executive Leadership portfolios to support achievement of the 2030 strategic direction, have been detailed. This clarity of scope and leadership will inevitability assist the achievement of the ambitious deadlines, particularly regarding our strategic initiatives and CYPF Areas of Need.

- The paper provides a status update on the proposal to redesign our integrated governance structures to support the achievement of 2030. The new structure is also designed to empower and support our divisions, whilst maintaining accountability and oversight; with further discussion with board members.

- Progress has been continued in the development of Qtr. 1 Strategic Initiatives and work will continue during June 23. The Strategy Board will receive a high-level profiling of our Qtr. 1 Strategic Initiatives and the key capabilities moves we will be delivering in Qtr. 2 & 3, aligned to our 'Phased Plan' (Strategic Staircase) and learn about some of the longer term moves which will drive the strategic change.

- Engagement has continued with our people and key stakeholders, we have used a range of channels to socialise and seek feedback (ranging from stands across sites, townhall events, team conversations and senior leaders' briefings). The feedback that we have received to date, has indicated that teams and individuals have welcomed an opportunity to have a discussion around and support the vision. They have however highlighted some of the challenges, and the achievability of such a radical approach. The final engagement report will provide a thematic analysis of all the feedback.

11. Recommendations & proposed next steps

The recommendations following this paper are to note the progress that has been made to date in the mobilisation of our 2030 Strategy recognising the importance of establishing effective ways of working, transparency, and accountability to support our long-term ambitions.

We are seeking approval to move to the new integrated governance model.

Next steps

1. To finalise the agenda for our first Strategy Board (July 23)

2. To implement the proposal to realign Executive Director leadership to our 2030 Vision.

3. Discussion with board member on proposal for new integrated governance arrangements with an overall aim to test from July 23.

4. To continue the development of strategic initiatives in line with the detailed plan.

5. To continue to develop our approach in supporting the mobilisation of 'CYPF areas of Need'.

6. To develop our ‘Strategic Outcome approach’ further with our Executive Team and wider stakeholders.

7. To continue the development of our financial strategy and economic case and complete Phase 1.

8. To complete the analysis of the engagement results and provide a final report with a thematic analysis and recommendations to inform the final strategy.

9. To continue to develop our programme management approach to ensure effective alignment with our areas of need and overall strategic direction.

Appendix 1: 2030 Mobilising our Strategic Initiatives

Appendix 2: 2030 Plan on a Page

Alder Hey Children's NHS Foundation Trust

Appendix 1: Development of Strategic Initiatives

Strategic Initiatives (SRO – For Strategic Goal)	Status	3 Workshops	Due Date	Draft PID SRO	Engageme Strategic ex
1.1. CYPF Engagement & Experience *Chief Nurse and Experience Officer*	80%	3 complete	22 June	25/04/23	18/05/23
2.1 Thriving at Alder Hey *Chief People Officer*	20%	Workshop 1 - complete, Workshop 2 - 07/06/23 Workshop 3 - 13/06/23	22 June	02/06/23	22/06/23
2.2 Professional Development Hub	0%	TBC	21 Sept	29/06/23	13/07/23
2.3 Future Workforce	0%	TBC	21 Sept	24/08/23	14/09/23
3.1 Futures *COO / MD Futures*	0%	*Workshop 1* - 30/06/23	21 Sept	24/08/23	14/09/23
4.1 Building Communities *Chief Strategy and Partnership Officer*	10%	*Workshop 1* 06/06/23 Workshop 2 -14/06/23	22 June	08/06/23	15/06/23
4.2 Children and Young People's system	0%	Workshop 1 - 14/06/23	21 Sept	05/09/23	14/09/23
5.1 New Care Models *Chief Digital and Transformation Officer*	0%	*Workshop 1* - 07/07/23	21Sept	22/06/23	06/07/23

Strategic Initiatives (SRO – For Strategic Goal)	**Status**	**3 Workshops**	**Due Date**	**Draft PID SRO**	**Engageme** **Strategic ex**
5.2 Digital and Data	40%	*Workshop 2* – 19/05/23	22 June	08/06/23	15/06/23
5.3 Insight-led Decisions	20%	*Workshop 2* 09/06/23	21 Sept	06/07/23	20/07/23

Appendix 2: Plan on a Page

Vision	Objectives	Delivered Through (Exec Lead)		Outcomes	Measures
Healthier, happier, fairer futures where every child & young person achieves their full potential	Delivering the best possible outcomes and experience for CYP&F	**1.Outstanding care and experience**	1.2 CYP & Families Engagement and Experience	• Happier children, young people and families • Rated as Outstanding • Designing our care around the needs of CYPF	• Family QALY [H] • CYPF Experience • System Service Experience Management Quotient (SEMQ [H] • Staff Thriving Index [H] • Social Value [H • (Happy) Community Index [M] • Variation in Health and Care Outcomes [L] • Clinical Service Capacity [H] • Resource Optimisation [L] • Ecosystem Contribution [H] • Innovation Adoption Rate [M] • Productivity / Economic Gain [H]
	Supporting our colleagues to have fulfilling careers in a community that thrives	**2. Supporting Our People**	2.1 Thriving @ Alder Hey 2.2 Professional development hub 2.3 Future Workforce	• **Our People are thriving:-** a. have a sense of belonging and are actively engaged b. have the time, space and opportunity to improve the quality of care and meet the needs of CYPF • We invest in our people and their teams to ensure they can have amazing careers • New skills and capabilities across a dynamic and flexible workforce • Right sized workforce renowned for new ways of working • A borderless CYP workforce across communities	
	Pioneering to find novel solutions and treatments	**3. Pioneers Breakthroughs**	3.1 Futures	• State-of-the-art "Hospital Without Walls" • Northern Institute for Child Health & Well-Being • International Post-Graduate School • National Forum on Health Inequalities • Integrated paediatric data network	
	Working with partners to improve life chances of CYP	**4. Collaborating for Children and Young people**	4.1 Building communities 4.2 CYP system	• The heart of a CYP health and care system renowned, regionally and nationally • A convener of the system with frictionless, sustainable and shared CYP resources • We will be a valued anchor institution that attracts inward investment and creates opportunities across our communities	
	Ensure delivery of the very best health and care outcomes for CYPF locally, regionally, nationally and internationally	**5. Smartest Ways of Working**	5.1 New Care Models 5.2 Digital and Data 5.3 Insight led decisions	• Accessible models of care implemented around the needs of CYPF • World class resilient specialist services • Digital Centre of Excellence driving productivity, speed, scale and quality • Collaborating across communities to ensure CYPF only need to tell their story once • Insight Unit recognised as a global centre of excellence for CYPF intelligence	
CYPF Needs (Get me well, Make my care more personal, Improve my life chances, Bring me the Future Today)					

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Liverpool Trusts Joint Committee - Terms of Reference**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	**Liverpool University Hospitals NHS Foundation Trust**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☐ Regulation ☐
Summary / supporting information:	The Board is asked to approve the draft terms of reference for the proposed Liverpool Trusts Joint Committee which will be charged with oversight of the implementation of the Liverpool Clinical Services Review
Action/Decision Required:	To note ☐ To approve ☒
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

Liverpool Trusts Joint Committee

Terms of Reference

Version	DRAFT 1.4
Implementation Date	[ ]
Review Date	[ ]
Approved By	Trust boards
Approval Date	[ ]

REVISIONS		
Date	**Reason for Change**	**Author**
2 May 2023	Version 1.0 – first draft	HD
2 May 2023	Version 1.1 – second draft	HD
3 May 2023	Version 1.2 – third draft (to align with Sub-Committee TORs)	HD
3 May 2023	Version 1.3 – fourth draft	HD
30 May 2023	Version 1.4 – fifth draft	DS

1	Name	**Liverpool Trusts Joint Committee (LTJC)**
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); "**Chair**" means the chair of the LTJC; "**C&M MH&CC**" means the Cheshire and Merseyside Mental Health and Community Collaborative; "**CMAST**" means the Cheshire and Merseyside Acute and Specialist Trusts Collaborative; "**Delegation**" means the terms of any delegation to the LTJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 2 and "Delegated" shall be construed accordingly; "**ICB**" means the NHS Cheshire and Merseyside Integrated Care Board, including

		any individual, organisation or committee to which its powers or responsibilities are delegated; "**LCSR**" means the Liverpool Clinical Services Review "**LCSR Recommendations**" means the six recommendations from the Liverpool Clinical Services Review which come within the scope of the LTJC, as set out in paragraph 4; "**LTJC**" means the Liverpool Trusts Joint Committee; "**LTJC Sub-Committees**" means the three sub-committees of the LTJC, being • LUHFT and TWCFT (Aintree site) • CCC and LUHFT (Royal Liverpool site) • LHCH and LUHFT (Broadgreen site) "**Member**" refers to a member of the LTJC listed in paragraph 7; "**Purpose**" the purpose of the LTJC as set out in paragraph 3; "**Trusts**" are Alder Hey Children's NHS Foundation Trust (**AHFT**); Liverpool Heart and Chest NHS Foundation Trust (**LHCH**); Liverpool University Hospital NHS Foundation Trust (**LUHFT**); Liverpool Women's NHS Foundation Trust (**LWFT**); Mersey Care NHS Foundation Trust (**MCFT**); The Clatterbridge Cancer Centre NHS Foundation Trust (**CCC)**; and The Walton Centre NHS Foundation Trust (**TWCFT**); and "**Work Plan**" means the rolling plan of work to be carried out by the LTJC over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference. All references to legislation are to that legislation as updated from time to time.
3	Purpose	The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. A diagram setting out the various governance groups and organisations involved in overseeing and implementing the recommendations from the LCSR is set out at Appendix 1. Through delivering its Work Plan (via the LTJC Sub-Committees), the LTJC will be responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six LCSR Recommendations within the scope of LTJC.

		The six LCSR Recommendations within the scope of the LTJC are as follows: • R3 - Improving outcomes and access to emergency care using existing co-adjacencies • R5 - Providing timely access to high-quality elective care through existing estates/assets • R7 - Combining expertise in clinical support services to provide consistent services (Liverpool) • R9 - Attracting and retaining talent in Health and Social Care within Liverpool City Region • R11 - Integrating digital systems to improve care delivery • R12 - Making best use of resources to secure financial sustainability for all organisations in Liverpool. Should the LTJC identify further opportunities to improve clinical services in Liverpool through collaboration, these additional workstreams will be agreed to and overseen by the LTJC as part of the Work Plan. The following principles will inform the work of the LTJC in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that clinicians are at the forefront of the development of the envisaged approach, with appropriate clinical leadership from each organisation, on each site, to oversee the work and facilitate involvement from the clinical community • Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Places, CMAST, NHS Commissioning: Specialist Services, and the MHLDC Collaborative • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the LTJC to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation.

		• Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders • Ensure no detriment to patients within a wider geography to Liverpool.
4	Scope	The LTJC shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The LTJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the LTJC's Purpose. The LTJC shall hold to account the LTJC Sub-Committees which shall be responsible for delivering elements of the Work Plan and associated priorities through delegations from the LTJC and reporting back to the LTJC, as set out in their respective terms of reference.
5	Status and legal basis	The LTJC is established by the Trusts as a joint committee pursuant to sections 65Z5 and 65Z6 of the 2006 Act in respect of those functions within its scope which are formally delegated by the Trusts to the LTJC in accordance with paragraph 6 below. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the 2006 Act. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Trusts must have regard to the guidance published by NHS England in March 2023 (and any subsequent/replacement guidance) about the exercise of these powers.
6	Decision-Making	• Decision-making by each Trust Chief Executive Member of the LTJC The Chief Executive of each Trust sits on the LTJC. Where a Chief Executive has delegated authority from their Trust to take decisions, they are able to take decisions on behalf of their Trust while sitting on the LTJC. Other members of the LTJC cannot require a Chief Executive to exercise their delegated authority in a particular way. The Trusts will work towards having consistency in the levels of delegated authority held by each of the Chief Executives when sitting on the LTJC. Where the Chief Executive does not have delegated authority from their Trust to

		take a decision which the Trusts wish to take in the LTJC (outside of the formal delegations to the LTJC) then that decision will need to be referred back to the relevant Trust board for determination unless it has been delegated to the LTJC as outlined below. • Decision-making by the LTJC as a joint committee The Trusts may formally delegate decision-making to the LTJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Trusts have been delegated, the LTJC acts as a joint committee of the relevant Trusts. The LTJC shall make decisions by consensus of all Members, with the Chair and Chief Executive Members from each Trust seeking to make consensus decisions on behalf of their own Trust. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration.
7	Accountability	The LTJC is accountable to each Trust board.
8	Reporting arrangements	The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust's Council of Governors and that feedback from their Trust is fed through to the LTJC. The LTJC shall submit a summary of the minutes from the LTJC Chair to each Trust board meeting in public. The LTJC shall ensure that the work of the LTJC Sub-Committees is reflected in its own minutes. The LTJC shall provide regular reports on its work to the ICB. The LTJC shall provide an annual report to the Trusts and the ICB.
9	Membership	The Members of the LTJC are: • Chair of AHFT • Chief Executive of AHFT • Chair of LHCH • Chief Executive of LHCH • Chair of LWFT • Chief Executive of LWFT • Chair of LUHFT • Chief Executive of LUHFT • Chair of MCFT • Chief Executive of MCFT • Chair of CCC • Chief Executive of CCC

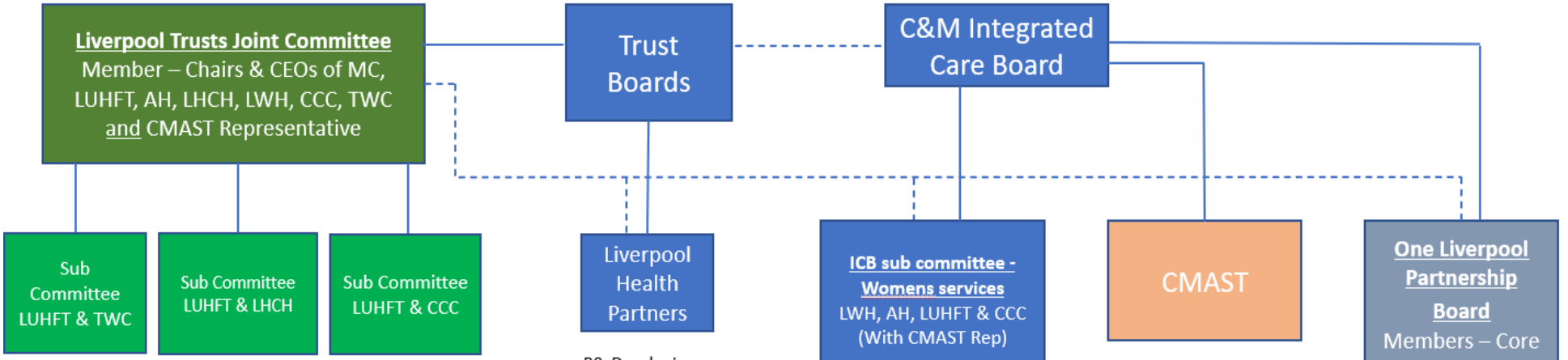
		• Chair of TWCFT • Chief Executive of TWCFT Decisions are taken by the Members as set out in paragraph 6 above.
10	Attendees	The Chair of the LTJC may invite such attendees to LTJC meetings to provide information or be involved in discussion as the Chair considers appropriate. The following shall be invited to attend every meeting of the LTJC: • Representative from CMAST A representative from C&M MH&CC may also where appropriate to the agenda be invited to attend meetings of the LTJC. The Trusts agree to make any of their officers who are involved in delivery of the Work Plan available to attend the LTJC as requested.
11	Deputies	With the permission of the Chair, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary. The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.
12	Chair	The first Chair of LTJC (the "**Chair**") shall be the Chair of LUHFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. Meetings of the LTJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the LTJC shall be final. The Deputy Chair of LTJC shall be agreed by a majority of the Members. If the Chair is not in attendance then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, one Member from each Trust, or their authorised deputy, must be in attendance for the LTJC to be quorate. If any Member of the LTJC has been disqualified from participating on an item

		in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The LTJC will meet at least monthly in private. Additional meetings may take place as required by giving not less than 14 calendar days' notice in writing to all Members. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	Support to the LTJC	The Lead Officer for the LTJC is the Director of Corporate Affairs of LUHFT and is responsible for managing LTJC agendas and all governance arrangements

		for the Work Plan. The LTJC will be provided support by LUHFT. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer; • Sending out agendas and supporting papers to Members at least five working days before the meeting. • Liaising with attendees invited to LTJC meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any LTJC meeting. • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval. • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions. • Publicising LTJC meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The LTJC is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of a Trust. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the LTJC. The LTJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The LTJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary provided it ensures that full funding is available to meet the associated costs.

		The LTJC is authorised to create sub-committees or working groups as are necessary to achieve its Purpose. The LTJC is accountable for the work of any such group. The LTJC may delegate decision-making to the LTJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.
18	Conduct of the LTJC	Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity. Members of the LTJC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The LTJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the LTJC to the Trusts and the ICB Board.
19	Amendments	These Terms of Reference may only be amended by resolution of each of the Trust boards. Any amendments shall only take effect upon all Trust boards agreeing the change to the Terms of Reference or on such date as all Trust boards agree, whichever is the later.
20	Review date	These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be required to be approved by all Trust boards.

APPENDIX 1 – LIVERPOOL CLINICAL SERVICES REVIEW GOVERNANCE ORGANOGRAM



R3. Improving outcomes and access to emergency care using existing co-adjacencies
R5. Providing timely access to high-quality elective care through existing estates/assets
R7. Combining expertise in clinical support services to provide consistent services (Liverpool – LCL)
R9. Attracting and retaining talent in Health and Social Care within Liverpool City Region (*needs to link to CMAST workforce priorities)
R11. Integrating digital systems to improve care delivery (*needs to link to ICB digital strategy)
R12. Making best use of resources to secure financial sustainability for all organisations in Liverpool

R8. Developing world-leading services in Liverpool through innovation, research and clinical trials

R6. Solving clinical sustainability challenges affecting women's health in Liverpool

R7. Combining expertise in clinical support services to provide consistent services (C&M Radiology Network)
R10. Achieving economies of scale in corporate services

R1. Improving Physical & Mental Health through PCNs and Neighbourhoods
R2. Socially inclusive training and employment for Liv City Region
R4. Levelling up performance on Cancer and Cadiovascular disease to address health inequalities

Organisations
C&M – Cheshire & Merseyside
MC – Merseycare NHS Foundation Trust
LUHFT – Liverpool University Hospitals NHS Foundation Trust
AH – Alder Hey NHS Foundation Trust
LCC – Liverpool City Council
TWC – The Walton Centre NHS Foundation Trust
LHCH– Liverpool Heart & Chest NHS Foundation Trust
CC – Clatterbridge Cancer Centre NHS Foundation Trust
LWH – Liverpool Womens Hospital NHS Foundation Trust

Lines of Accountability/Reporting
Accountable to ——
Reporting to - - - - -

APPENDIX 2 – TEMPLATE DELEGATION

[To be inserted]

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Liverpool Neonatal Partnership - 6 Month Overview**
Report of:	**Liverpool Neonatal Partnership**
Paper Prepared by:	Jen Deeney/Alison Bedford Russell/ Jo Minford

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☒ Regulation ☐
Summary / supporting information:	This is a summary overview of the risks, issues and achievements of the Liverpool Neonatal Partnership over the previous 6 months.
Action/Decision Required:	To note ☒ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☒ Sustainability through **external partnerships** ☒ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

1. Introduction – summary of key risks and issues

There have been several key risks and issues within the Liverpool Neonatal Partnership (LNP) over the last months. Some of these have been worked through and are now in an implementation phase, while others require ongoing collaboration with teams on both sites to achieve an outcome, that works for all teams. Some will need the realisation of the build to allow implementation. The issues and risks are:

1. Further development of the staffing models – funding agreed, model being implemented
2. Delivery of the new NICU – working with partners to ensure timely build
3. Delivery of support services to support the LNP – working with partners to define pathways
4. Clarity of data of babies that meet the neonatal definition within AH – working with partners to develop clarity and a robust system of reporting.
5. Developing clinical care model on 1C Neo – this is a constantly evolving model, improving care on 1C Neo.
6. Management of the risk register to ensure it reflects the challenges seen within the LNP.

Some highlights within the last 6 months should also be noted.

1. The achievement of Green FiCare accreditation across the LNP.
2. Visit from the Birmingham team with regards to their build of a neonatal surgical intensive care unit.
3. Runner up for Team of the year at the Neonatal Nurse of the Year Awards.
4. Recruitment of AHPs with monies received from Ockendon.

2. Background and current state

1. **Staffing:** Commissioners have agreed the to release funding for the next phase of staffing, this will include.
    - Consultant posts, 3.5 wte
    - ANNPs
    - Matron
    - Band 7 and 6 nurses
    - AHP recruitment

    The recruitment to these posts will begin in summer 2023 and phased over the next 6-12 months to ensure there are robust plans for training and development. This recruitment is also likely to improve the current clinical model on 1C Neo.

    4 Trainee ANNPs have commenced training in January and will qualify in January 2025. Funding has also been secured for 4 further trainee ANNP's to commence in January 2024.

Of 25 wte band 5 post advertised in autumn 2022, 23 wte are in post. All have undertaken the Foundation in Neonatal Nursing, and some will commence the Qualified in Speciality (QiS) course in September 2023.

60% of the registered nursing staff on 1C Neo are now QiS but ensuring that we maintain the trajectory of QiS for opening in April 2025, relies on ensuring that attrition remains low, staff feel supported and developed. Delays in the opening does challenge this.

Recruitment of AHPs has been successful. There is now 1 wte psychology, 1 wte physiotherapy, plus 0.6 wte already present at LWH. Currently out to advert are 0.8 wte Occupational Therapist, and 1 wte SALT. These posts have been funded by Ockendon.

The biggest challenges around recruitment have been the delays in getting the post through the system. Ockendon monies were awarded in October, but posts are now just been recruited to.

2. **Build:** All enabling works complete. Additional cost and time pressures are being experienced due to underground service diversion works. A paper articulating the issue was presented at RABD on the 22nd of May 2023. RABD tasked the construction team with a deep dive of the issues to bring back w/c 5th June 2023.If approved on the 5th of June 2023 by RABD will be presented to Trust Board on the 8th of June 2023 for final approval. Contract sign targeted for the 30th of June 2023. Construction Team hope to commence on site 3rd July 2023, with handover currently targeted for April 2025.

3. **Support services:** The Team have been working with Pharmacy, ID, Radiology, pathology, and IT to ensure that the development of the LNP reflects the impact on these services.
    - **Pharmacy** – ANNP now prescribing using agreed monographs, working with the pharmacy teams across site to ensure where possible guidelines are aligned or reflective of neonatal practice.
    - **Radiology** Leadership team have met with radiologists, Radiology service manager and Divisional manager for diagnostic medicine. Agreed that need gap analysis re: radiology requirements for NICU when increase from 9 to 22 cots and what is currently available. Business managers will obtain data and formulate Business Case. Agreed that will need enhanced resource. Already recognised is that radiology service should be 24/7 at AH. Mitigations and planning for the future are in place. Mobile XR machine is now located in 1C neo.
    - **Micro-ID.** LNP team and microbiology representatives from AH and LUFT (who currently provide all LWH neonatal microbiology support through an SLA with LWH), have met with AH ID and respective business managers. Actions: LWH-LUFT SLA to be unbundled to explore neonatal component. Obtain data regarding number of neonatal microbiology samples currently processed at LUFT. Estimate service requirements when number of NICU babies at AH increases from 9 to 22. Micro and ID stakeholders will collaborate to explore mutually beneficial new ways of working, and joint

microbiology recruitment opportunities within an ICP. Group will develop short/ medium/ long term plans.
- **IT** - Working with team across site to ensure there is sight on new Digicare system and this will interact with systems across the LNP.
- **Innovation** – The team continue to work with NeoLook and Phillips to develop the monitoring system within the new NICU. There are challenges around some of the technology and the approvals needed nationally for the comprehensive model, however, there is a solution in place and the team are confident this will be in place for 2025. The rotation innovation leads of the Neolook project also poses challenges with consistency and pace.

4. **Data:** Collection of neonatal activity data within Alder Hey has been a challenge, because not all babies follow a recognised neonatal pathway whereby data is collected by North West Neonatal ODN (NWNODN), eg referrals from West Midlands may go to PICU, then LWH – source/ address not always looked at. Babies referred from Burnley to LWH FMU in a pathway not aligned with Neonatal ODN pathways. Out of region IUTs through maternity. Referrals from Wales and IOM. Multiple recording systems are in use depending on referral source, and coding does not enable abstraction of data in the required format.
   The LNP team are working with the AH data team to find a way to systematically record data that will truly reflect the number of neonates receiving care within Alder Hey and their referral sources. This data is critical for capacity and activity planning and to understand patient flows for the LNP, NWNODN and for neighbouring regions.

5. **Clinical Care Model:** The clinical care model on 1C Neo has further developed over the last 6 months, with consultants now present 7 days a week. 8am-8pm, Monday to Friday and 8am-5pm, Saturday and Sunday. There will be further increase in weekend cover with the appointment of consultants later this year.

   The recruitment of the Matron and senior nursing team will allow for more senior out-of-hours nursing cover. This will also allow for the development of the senior nurses' skills around neurosurgery, cardiac etc.

   Due to the lack of experience of the ANNP team it is unlikely we will be able to increase this cover over the next 12 months, however, it will continue to be reviewed periodically.

   The biggest challenge of the clinical care model currently on 1C Neo is the out of hours care and that of the deteriorating patient. The LNP are working with the Trust teams to help develop a model that will not only support 1C Neo but the wider hospital teams.

6. **Risk Register:** Risk 2597 which is around levels of staffing has been reduced from 16 to 12. This reflects that work completed around recruitment and training, and the implementation of the escalation pathways for 1C neo about the movement of staff.

Risks 2042 and 2044 have been merged and are more reflective of the risks raised by the team. This risk remains at a 10.

3. Conclusion

This paper hopes to provide information to the board that there is ongoing development of the LNP, which is inclusive of the services that will work alongside the team to deliver world class neonatal care. Also, that the leadership team have sight of the next steps required and the individuals they need to engage to ensure that the project is kept on track and ready for opening in April 2023.

4. Recommendations & proposed next steps

- Recruitment of all funded positions
- Work with HR team to ensure efficient recruitment process
- Keep attrition low
- Sign of contract and commence construction
- Further development of work streams with support services
- Development off data recording that will allow for accurate and timely data
- Continue to develop model of care on 1C NEO
- Continue manage and review risks.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th June 2023

Paper Title:	**Integrated Performance Report (April 2023)**
Report of:	**Executive Leads/Divisional Leads**
Paper Prepared by:	Deputy Head of Information

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Summary / supporting information:	
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Implications:	

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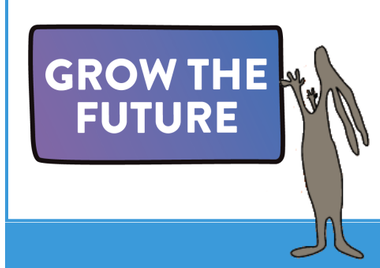
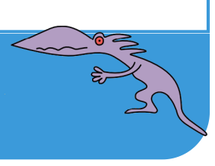
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: May 2023

Contents





Icon Definitions

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

A statistical process control (**SPC**) chart shows data over time. Process limits show how much variability there is in the data to the chart and patterns are highlighted to show where a change is statistically significant. If there is a target, this variability can be used to provide assurance on whether the target is likely to be met in future.

XmR chart

The most common SPC chart type is the XmR chart. Each data point is shown as a grey dot on a grey line. From this data, the mean is calculated and added between the dots as a solid line, and process limits are added as grey dashed lines. If there is a target, it is shown as a red dashed line.

Process limits

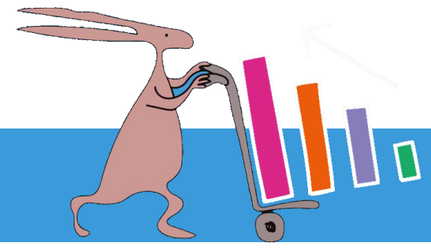
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

Data naturally varies but if this variation is statistically significant, this is called special cause variation and the grey dots are instead shown as blue or orange, depending on whether a higher value is better or worse – blue is used for improving performance, orange for concerning performance. If not significant, the dots stay grey and this is called common cause variation.

The four rules used to trigger special cause variation on the chart, as advised by the Making Data Count team at NHS England, are:

- a point beyond the process limits
- a run of points all above or all below the mean
- a run of points all increasing or all decreasing
- two out of three points close to a process limit as an early warning indicator



IPR Summary

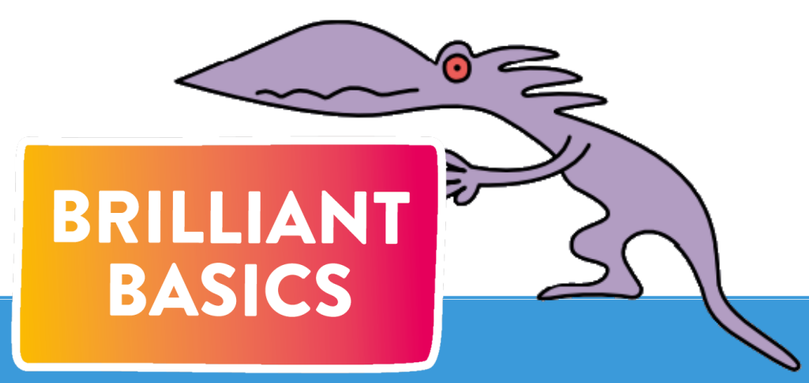
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Faster Diagnosis for Cancer demonstrates performance is consistently achieving target with an improving trend	Level 1 patient safety training and ED Sepsis are inconsistently achieving target with an improving trend	Medical Appraisals, Diagnostics, Recovery for Outpatient New & Procedures and AlderCare metrics, are not achieving targets but demonstrating improvement
	Common Cause	Cancer and Overall Financial position metrics are consistently achieving targets	Level of Harm, IP Sepsis, Recovery and ED performance, WNB metrics are inconsistently achieving target and are yet to evidence statistical improvement	Theatre Utilisation, >65 Wk waits (RTT & ASD/ADHD) and Clinic Letters completed are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern			Staff Turnover, CAMHS >52 week waits and Oral Health wait metrics are not achieving targets with a declining trend

From an overall perspective the headline analysis summary based on the assurance icons is as follows:

- 15.4% of our metrics are consistently achieving target
- 51.9% of our metrics are inconsistently achieving target
- We are not achieving the target for 32.7% of our metrics but experiencing improvement in 7 of these metrics.

Further narrative, specific to individual highlights, areas of concern and forward look are included within each section of the Integrated Performance Report.



Unrivalled Experience - Safety

SRO : Nathan Askew, Chief Nursing Officer and AHP/HCP Lead

Highlights:

Continued improvement in ED sepsis and continued reduction in pressure ulcers following the work underway relating to medical devices. 90% of staff have now completed level 1 patient safety training.

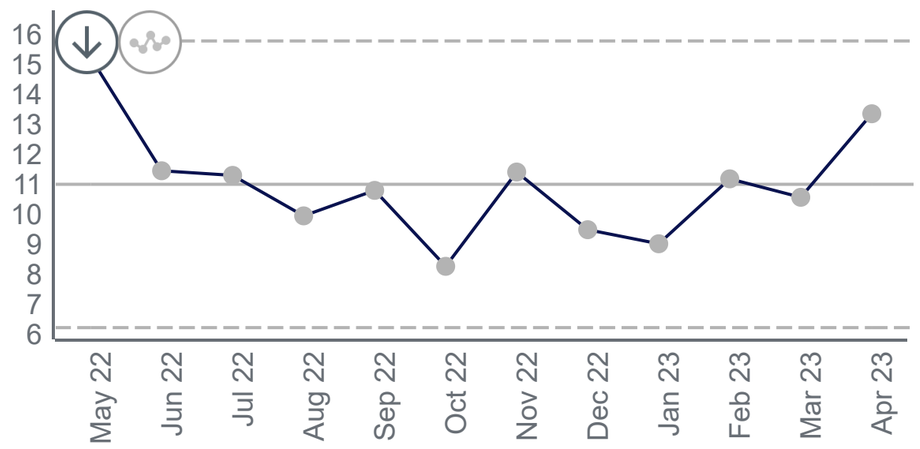
Areas of Concern:

Decline in performance related to sepsis for inpatients and a slight increase in the number of unplanned transfers to critical care.

Forward Look (with actions)

Continued focus on sepsis compliance and targeted approach to achieve 100% of staff trained in level 1 patient safety training.

Incidents of harm per 1,000 bed days (rated Minor harm and above)



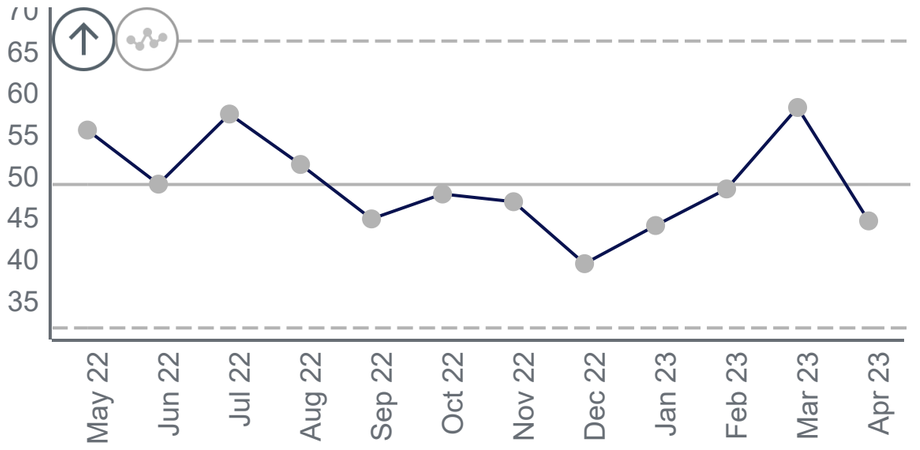
Technical Analysis:

Update to the metric, now showing incidents per 1000 bed days. Common cause variation has been observed with a 12 month average of 11 incidents per 1000 bed days.

Actions:

New incident management reporting system implemented – InPhase. All staff encouraged to continue to report incidents and near misses and contact the governance team for any help or support needed in using the new system

Number of Incidents rated No Harm and Near Miss per 1,000 bed days



Technical Analysis:

Update to the metric, now showing incidents per 1000 bed days, common cause variation has been observed with a 12 month average of 49 incidents per 1000 bed days.

Actions:

Incidents nominated by the Divisions for review at the weekly Patient Safety Meeting. The new InPhase system reports on both the level of actual harm and the level of psychological harm. Both levels will be reviewed at PSM

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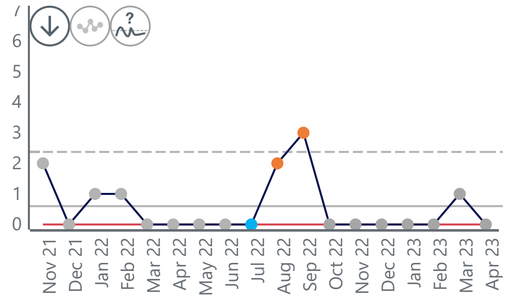
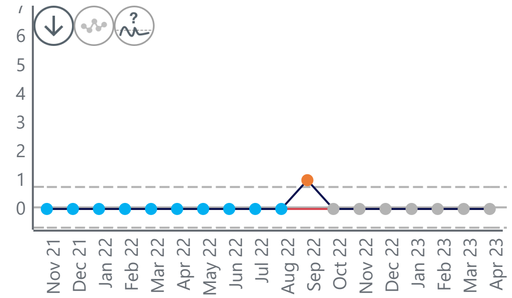
Unrivalled Experience - Safety - Watch Metrics

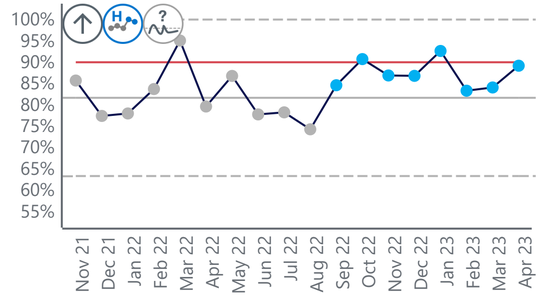
Number of Serious Incidents (Steis reported)



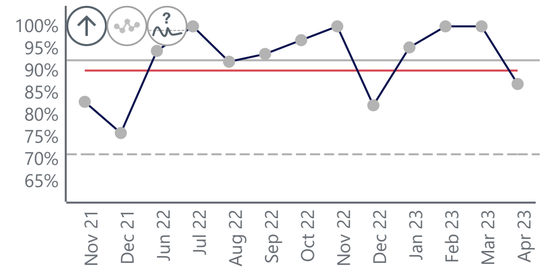
Number of Never Events



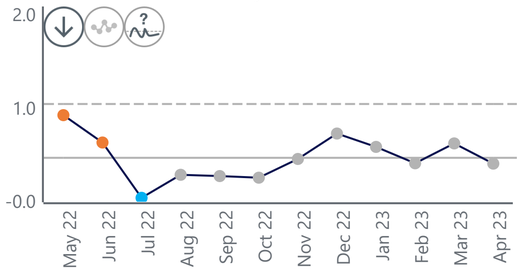
Sepsis % Patients receiving antibiotic within 60 mins for ED



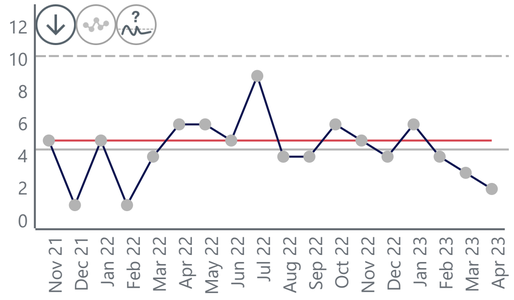
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



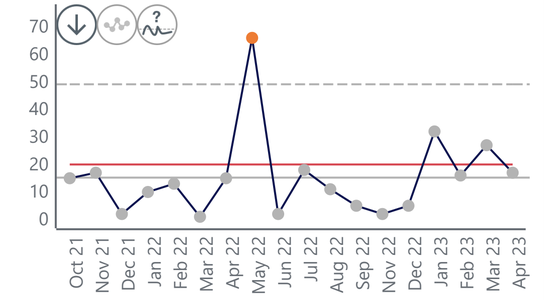
Medication Errors rated Minor harm and above per 1,000 bed days



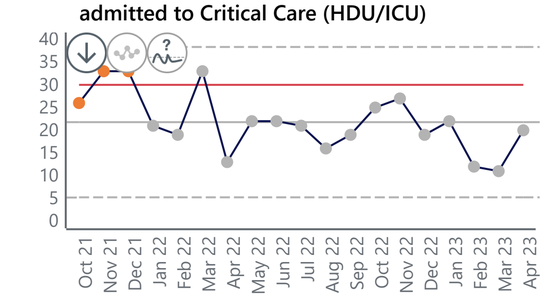
Pressure Ulcers G2-4



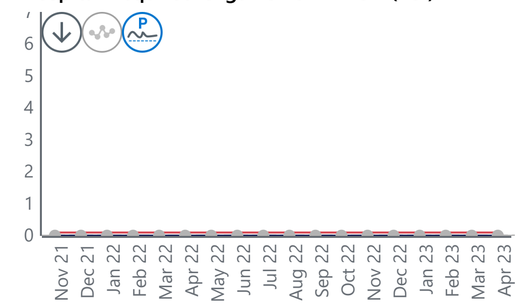
Use of physical restrictive intervention



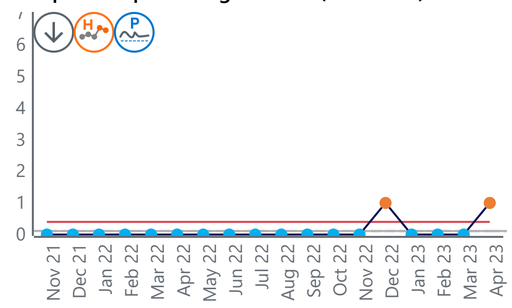
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



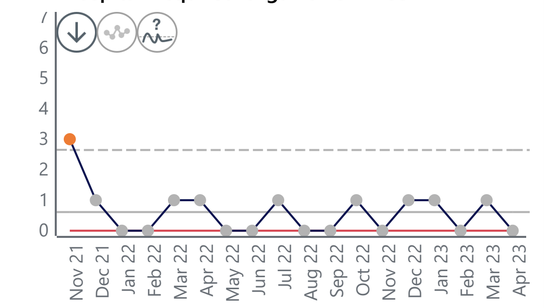
Hospital Acquired Organisms - MRSA (BSI)



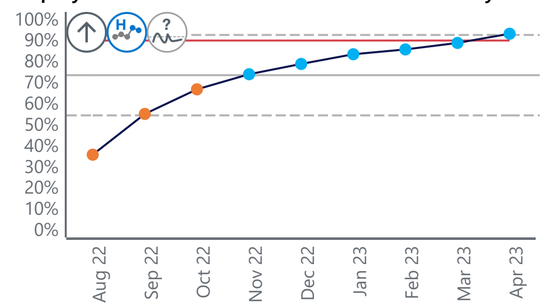
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



Unrivalled Experience - Caring

SRO : Nathan Askew, Chief Nursing Officer and AHP/HCP Lead

Highlights:

Continued sustained improvement in timely responses to PALS and formal complaints.

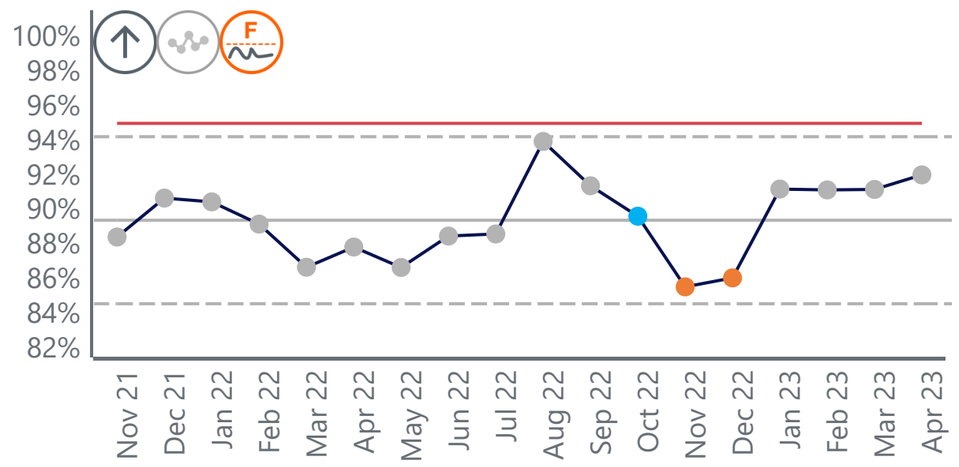
Areas of Concern:

Friends and Family Test feedback below 90% satisfaction.

Forward Look (with actions)

PALS office to be redesigned to make clear to our families the support services available, focus on immediate resolution, and one stop shop approach.

F&F Test - % Recommend the Trust



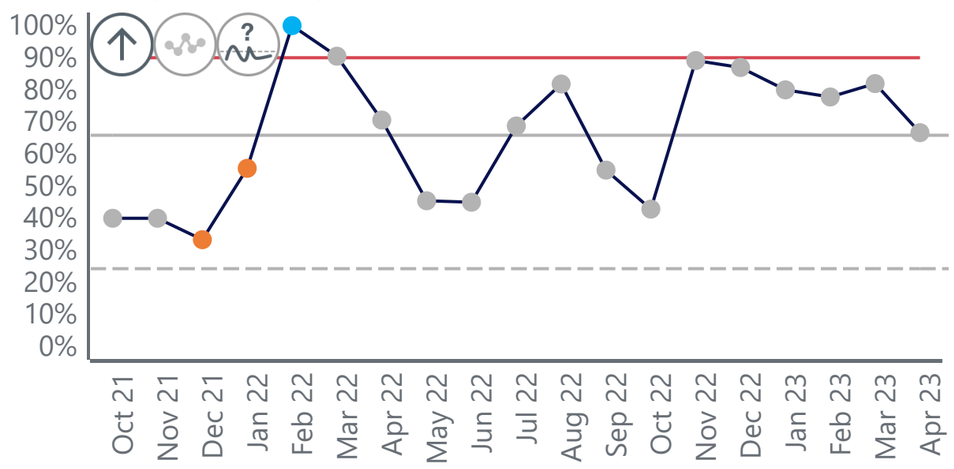
Technical Analysis:

Consistently not achieving the 95% target, but has had 4 months in a row above the average which, if continues would demonstrate special cause variation.

Actions:

Divisions to scrutinise feedback and identify and address any themes.

% Complaints Responded to within 25 working days



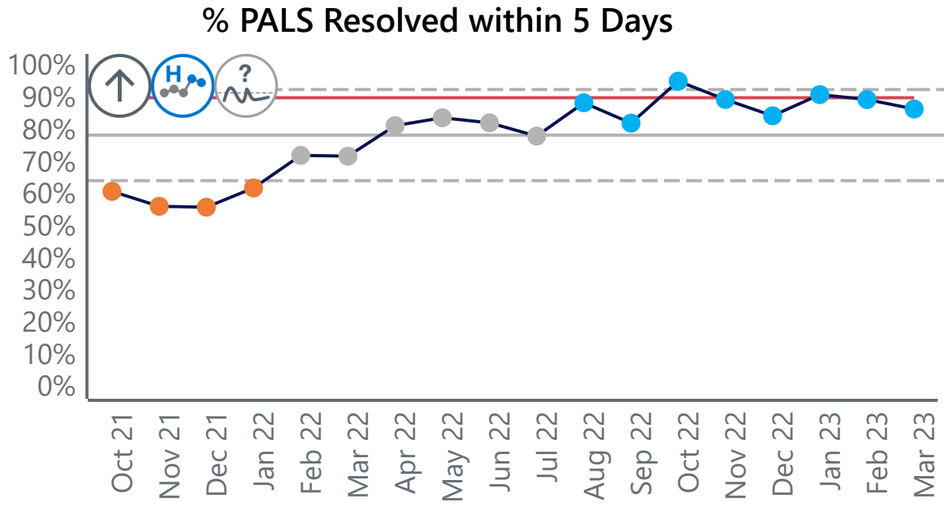
Technical Analysis:

Inconsistently achieving the 90% target with an average of 67% which shows significant fluctuation from month to month.

Actions:

Continued focus on responding to families promptly; where a family would like to meet outside of 25 days ensure a written response is provided awithin 25 days

% PALS Resolved within 5 Days



Technical Analysis:

Inconsistently achieving the 90% target but has demonstrated special cause variation of an improving trend in the previous 8 months.

Actions:

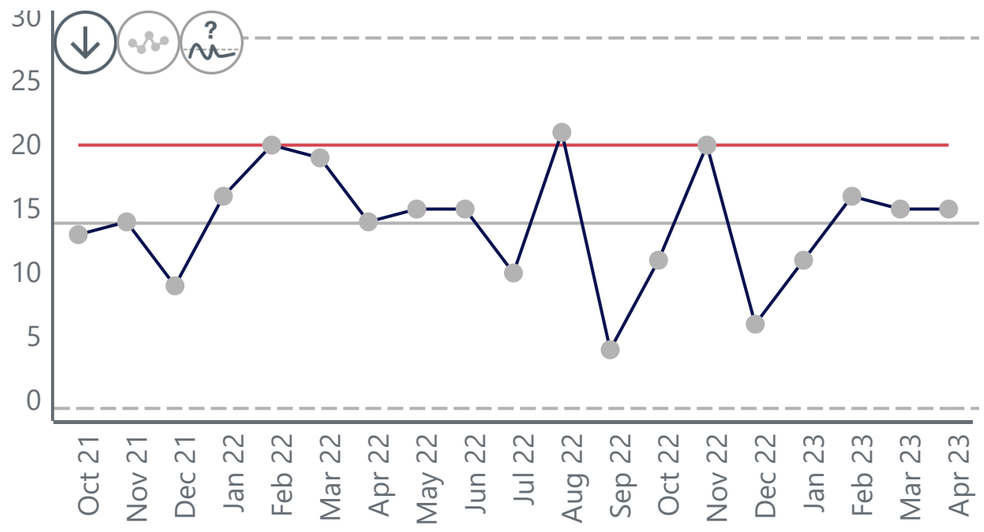
PALS Officers to support any corporate PALS received to ensure they are responded to within 5 days

Integrated Performance Report | May 2023

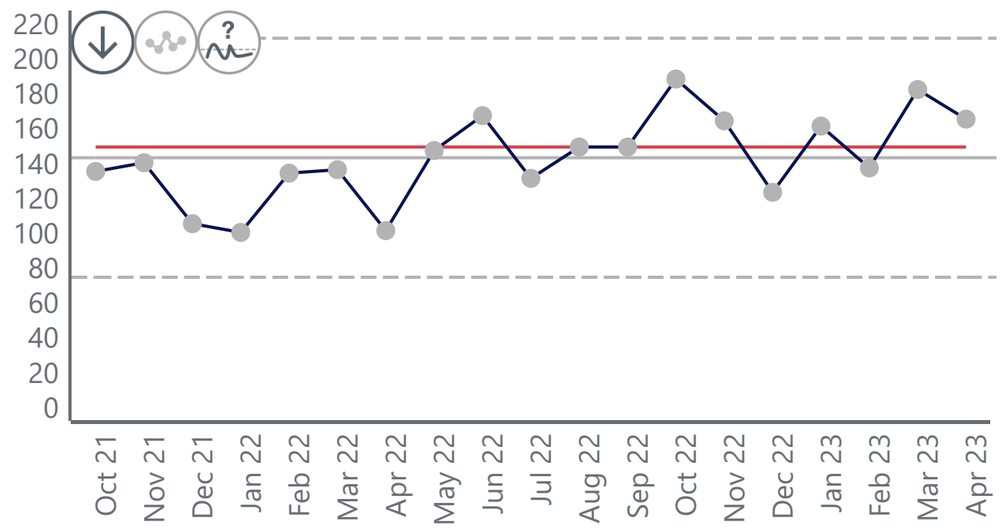
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

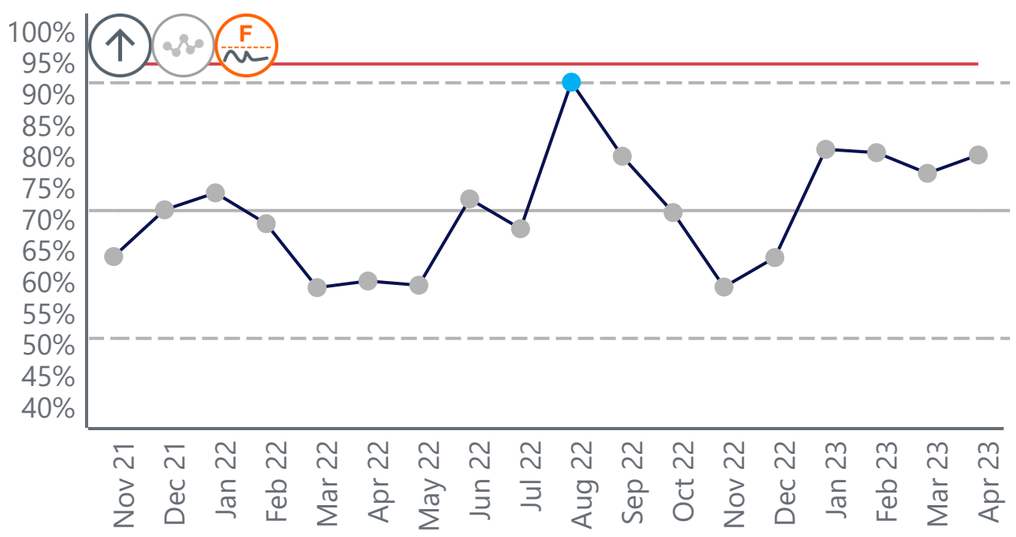
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Smartest Ways of Working - Accessible Services: Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

Marked improvement in performance against the 4-hour standard, 6% with 84%. From September 2022 to February 23 we are the sixth best performing Type 1 Emergency in England. 133% growth in virtual ward care days, relative to April 2022.
Cancelled operations significantly lower than target.

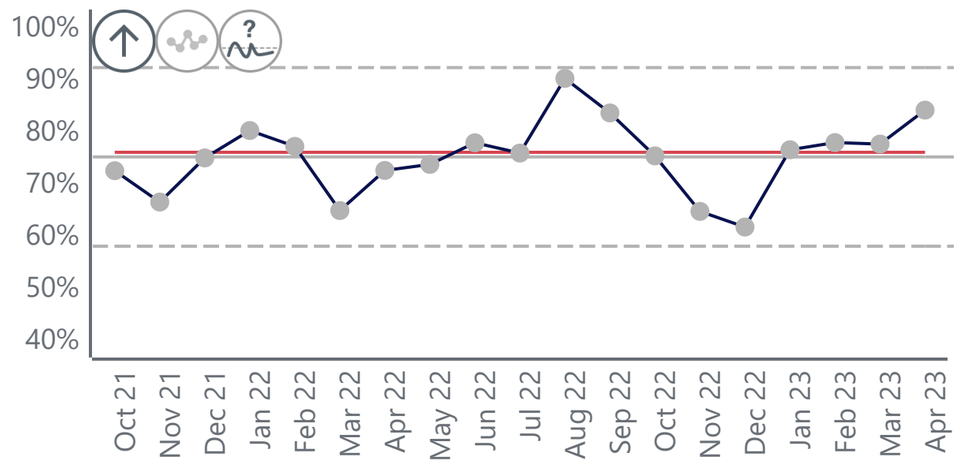
Areas of Concern:

In ED, the mean time to first clinician review 72 minutes in months against the national standard of 60 minutes and delays are concentrated in the evening and overnight. No statistical improvement in touch time theatre utilisation, clinic letters and levels of WNB.

Forward Look (with actions)

• Increase utilisation of new UTC • Increase evening & out-of-hours cover. Testing PAU in summer and new virtual urgent care model. Identify solution for management of test results following clinic to reduce delay in signing of letters. Provide support to individual colleagues with clinic letters still outstanding after 30 days. Weekly Productivity Group - new theatre scheduling approach from 1st May.

ED: % treated within 4 Hours



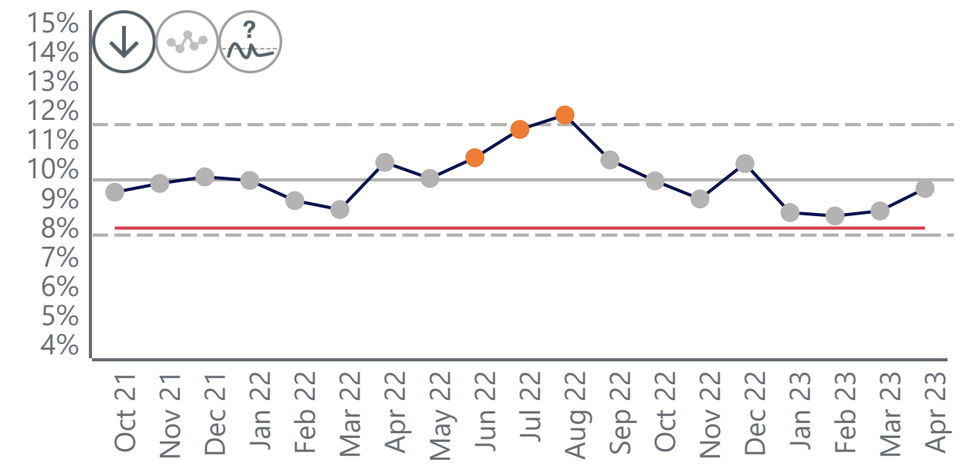
Technical Analysis:

Inconsistently achieve the new national target of 76%, common cause variation has been observed but the Trust has achieved the target for the past 4 months.

Actions:

Urgent Care System Improvement group launched with renewed focus on internal assessment processes and pilot PAU due early summer, expansion of the virtual urgent care offer, building in the success of the Symptom checker and continuing to bed in the effectiveness of Paediatric Urgent Treatment Centre.

% Was Not Brought Rate (All OP: New and FU)



Technical Analysis:

New driver metric which demonstrates common cause variation. Previous 4 months have been below the average which if continued would demonstrate special cause variation

Actions:

Disruption to appointment scheduling due to industrial action. Focus tests of change in community ophthalmology clinics to reduce WNB. Reviewing audit of WNB reducing solutions utilised in the Children's Hospital Alliance, and we will examine the adoption of high-impact interventions

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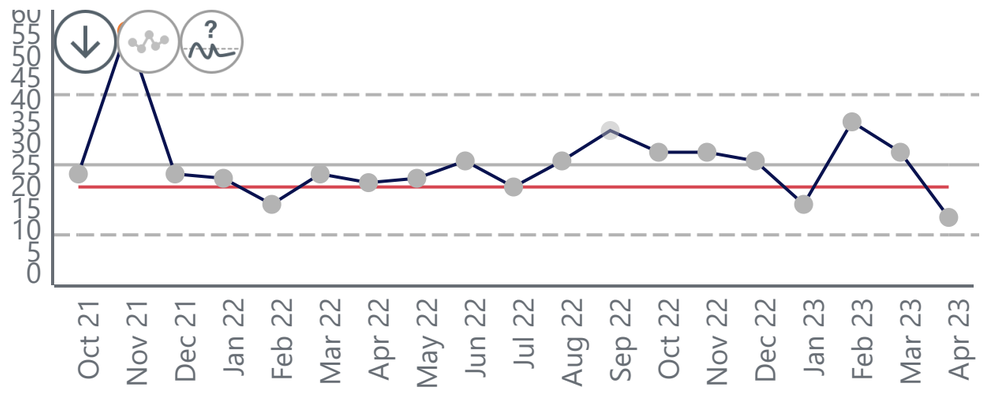
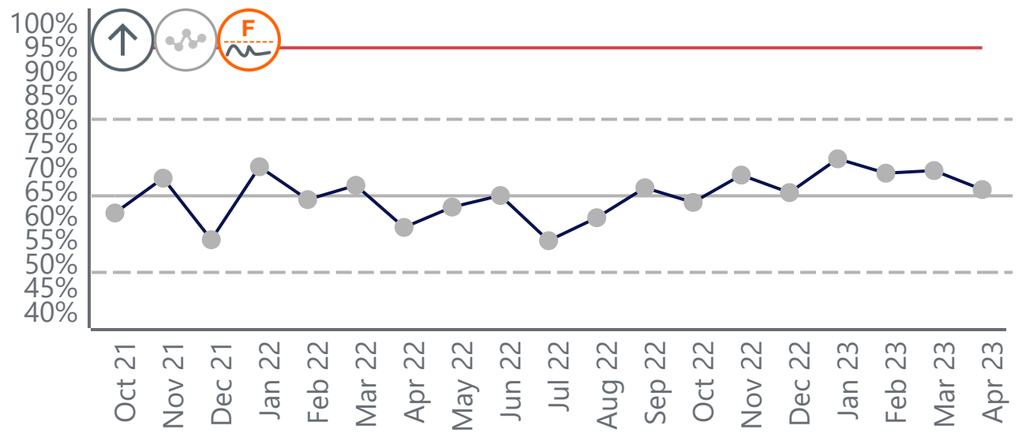
Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services - Effective - Watch Metrics

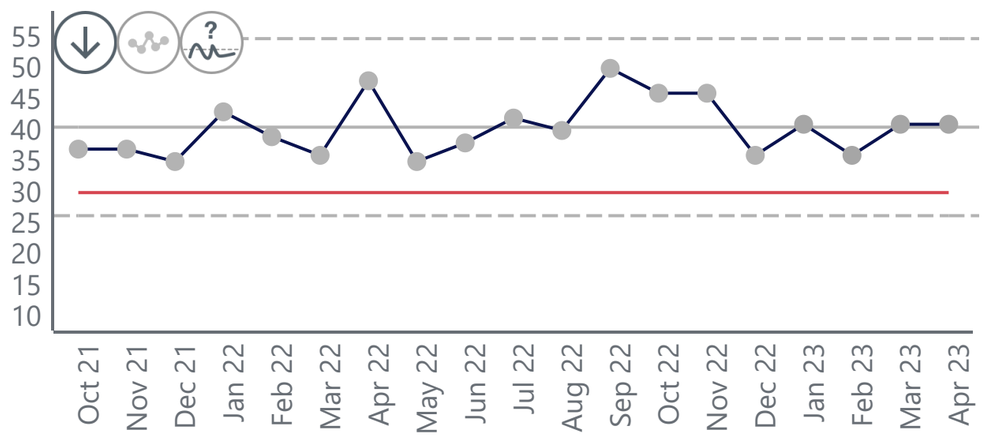
Number of Cancelled Operations (on day of admission for a non-clinical reason)



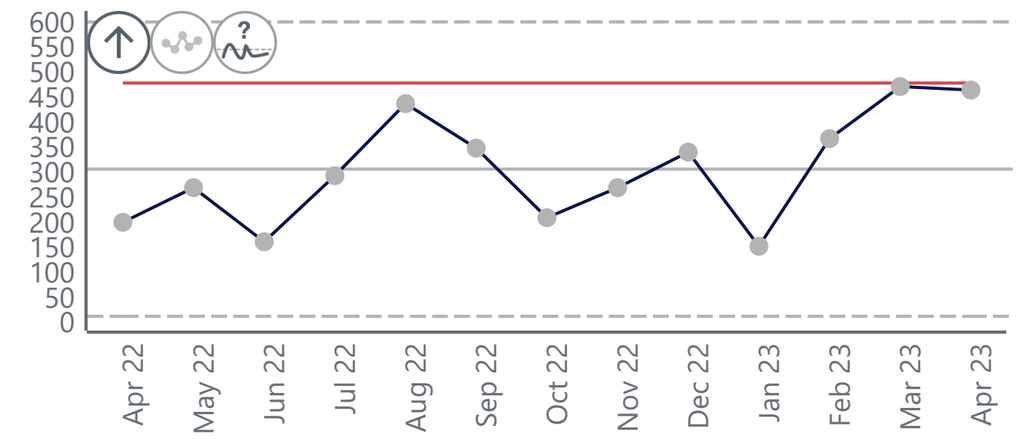
% of Clinical Letters completed within 10 Days



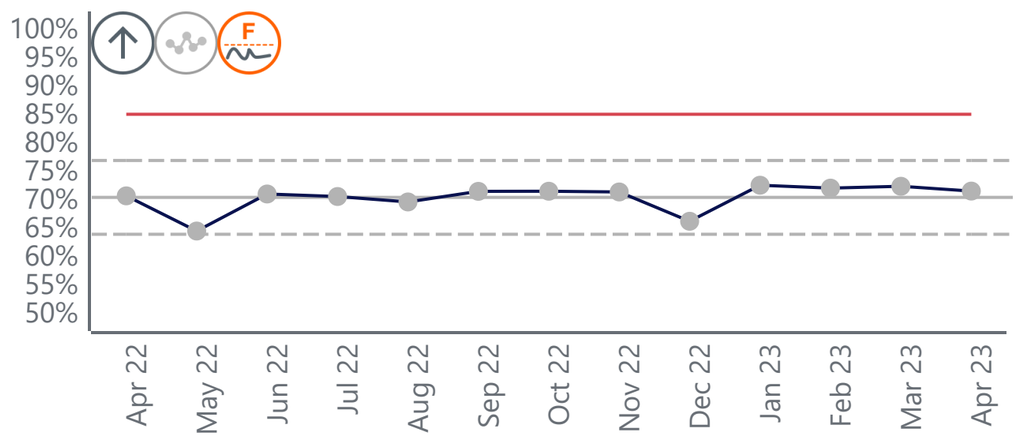
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Improvement sustained in access to diagnostics tests within 6 weeks. The success of the Home Sleep service launch means those children eligible are now waiting an average of 4 weeks. • Access to cancer care in line with all national standards • Outpatient recovery at 120% overall • Reduction in the number of patients waiting over 68 weeks for treatment

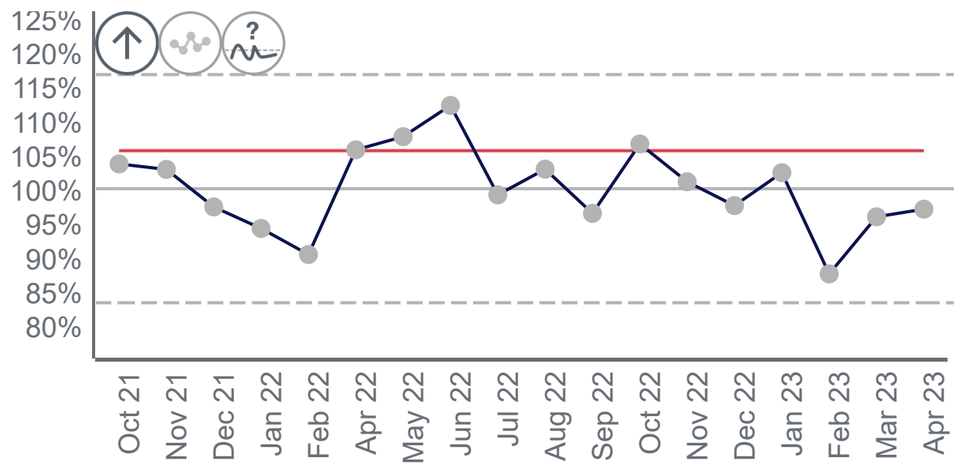
Areas of Concern:

• Elective and Day case recovery at 97% of 19/20 activity levels, impacted by junior doctor industrial action with a loss of 64 electives • Growing waiting list size and a rise in the number of C&YP waiting over 52 weeks, particularly within ENT & Dental

Forward Look (with actions)

• 6 week diagnostics: we are carefully managing the scheduling of appointments and capacity levels to ensure no C&YP waits longer than 13 weeks by the end of May and 6 weeks by the end of June. See drive metrics for detailed actions on waiting times and recovery levels.

% Recovery for DC & Elec Activity Volume



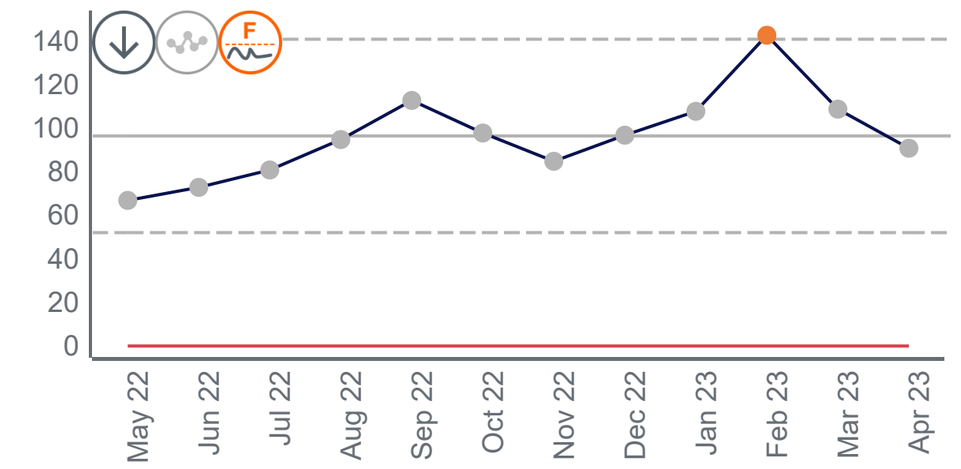
Technical Analysis:

Apr 23 performance of 97% by volume is below the target although marginally improved performance from Mar 23 (96%). Apr 23 was impacted by strike action but elective casemix supported financially. Monthly variation continues to demonstrate common cause variation.

Actions:

Additional 24 theatre sessions allocated in the theatre schedule in May. Business case for ENT & Dentistry to increase capacity, decision by Executive Directors - May 2023. Surgery has established a weekly Productivity Group launched with focus on 3 key specialties. This includes work on a enhanced theatre scheduling approach from 1st May

Number of RTT Patients waiting >65 weeks



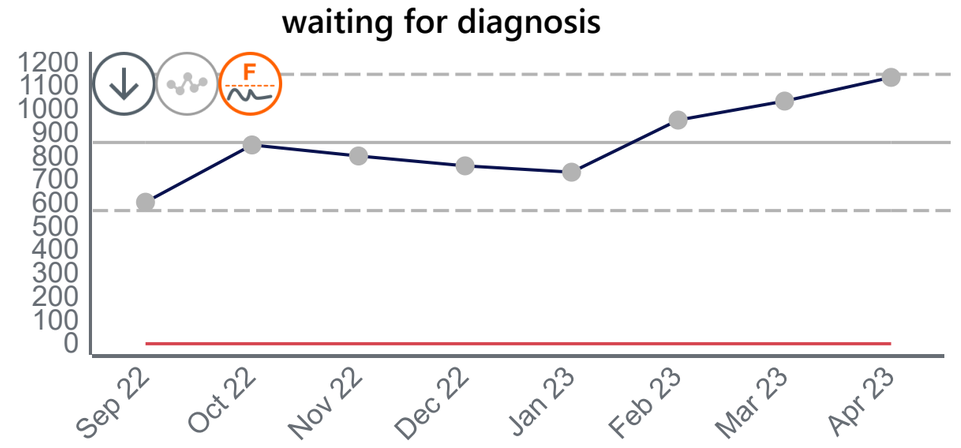
Technical Analysis:

Number of patients waiting > 65 weeks has reduced in April to 91 patients from 109 in March. Dentistry (n = 60) and ENT (n=20) have 80 patients >65 weeks, 88% of the Trust total.

Actions:

Reduction in number of patients waiting >65 wks. ENT & Dentistry have action plans in place, including additional capacity (internal & insourcing; pending approval) & planned workforce investments. Full pathway review planned in ENT to include new triage process & new outpatient clinic models. Both overbooking clinics in line with WNB rate

Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



Technical Analysis:

New Metric which shows on average 850 patients are waiting for an ASD or ADHD diagnosis per month, April shows 1135 patients which is close to the outer control limits.

Actions:

Recruitment to vacancies remains ongoing in both services; in the ADHD service 5 new nurses have commenced in post with a further 3 due to start in June. Alternative career pathways are being developed for psychology posts. Discussions are ongoing with commissioners regarding investment requirements for the service.

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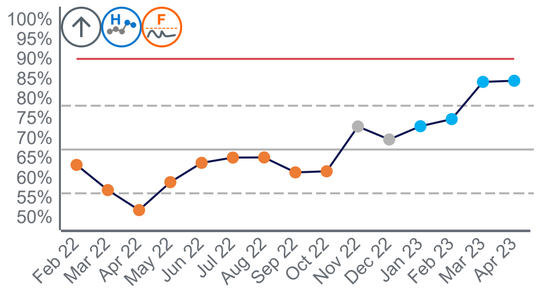
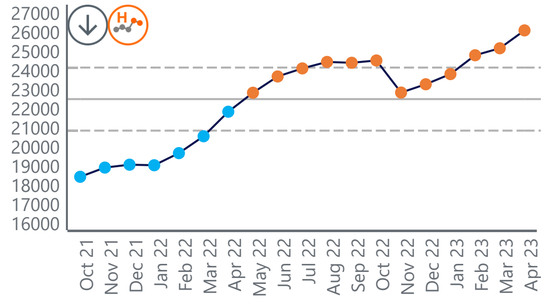
Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services: Responsive - Watch Metrics

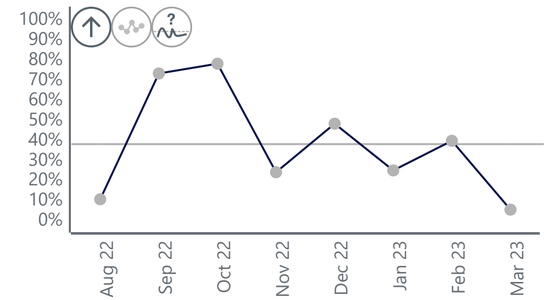
Diagnostics: % Completed Within 6 Weeks of referral



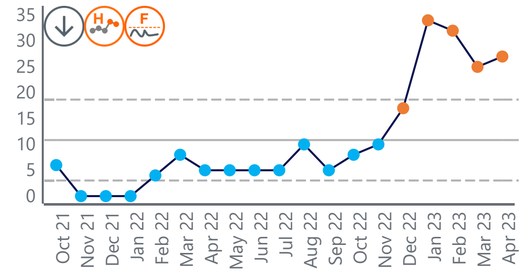
Waiting List Size



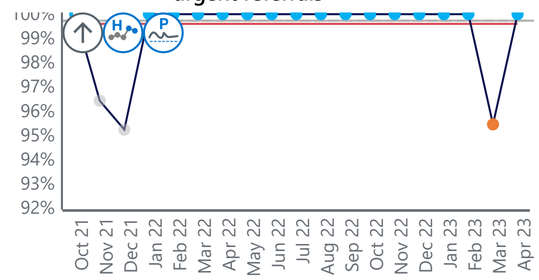
IHA: % complete within 20 days of referral to Alder Hey



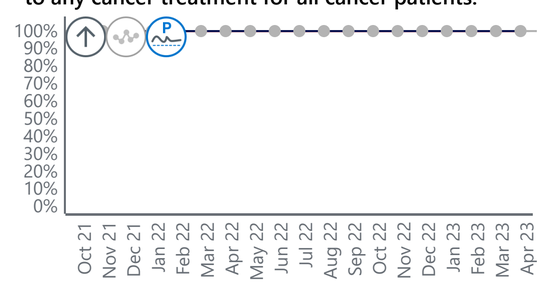
CAMHS: Number of children & young people waiting >52weeks



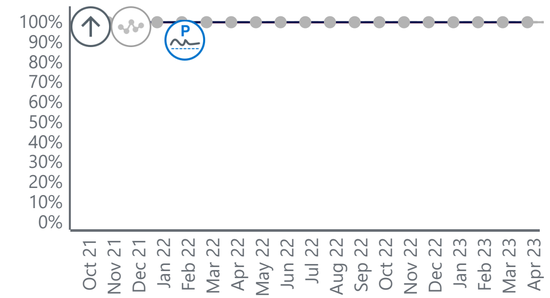
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



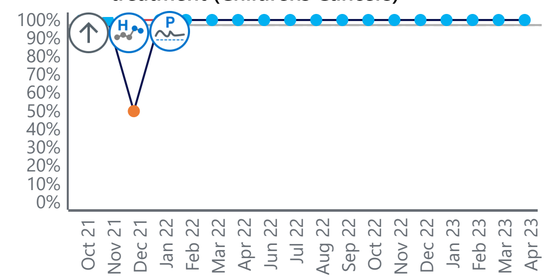
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



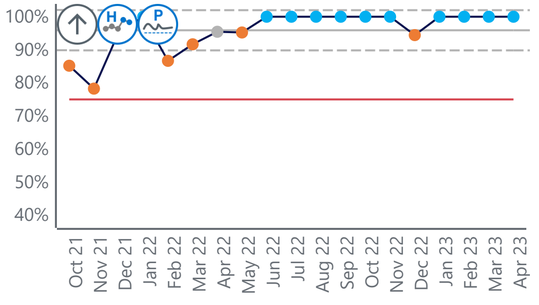
All Cancers: 31 day wait until subsequent treatments



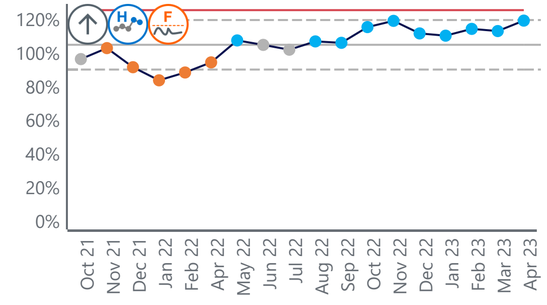
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)

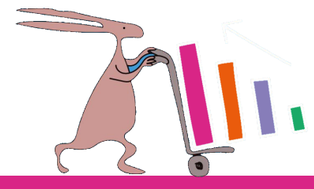


Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume





Collaborating for CYP - Reducing Health Inequalities: Responsive

SRO : Dani Jones, Director of Strategy and Partnerships

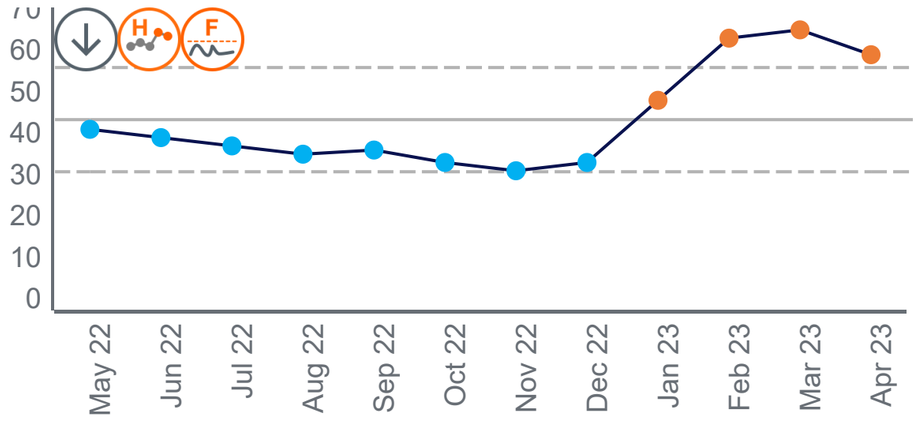
Highlights:

Number of children <10 years old waiting >52 weeks for tooth extraction decreased in April as a result of additional capacity in house & via NHS insourcing.

Areas of Concern:

Forward Look (with actions)

Oral Health: Number of children <10 years old waiting >52wks for tooth extraction



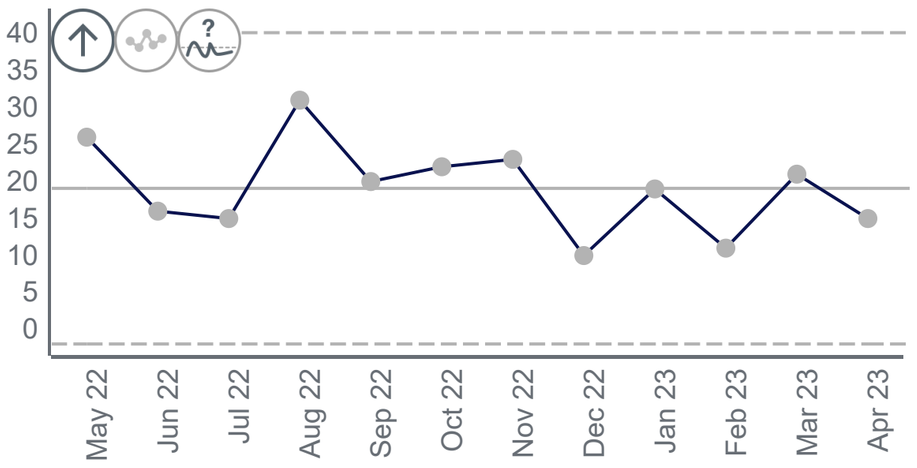
Technical Analysis:

Steady decline in children waiting >52 weeks up until Jan23 where we have since seen a sudden increase. Currently 59 children as at 1st May 23.

Actions:

Continue with additional planned capacity if approved via investment panel, which will see a continued downwards trajectory to ensure we achieve 0>65 weeks March 2024. Continue to work within C & M to collaboratively reduce waiting times and review where is most appropriate for C&YP to receive their Dental treatment.

CAMHS: Number of CYP of BAME background referred

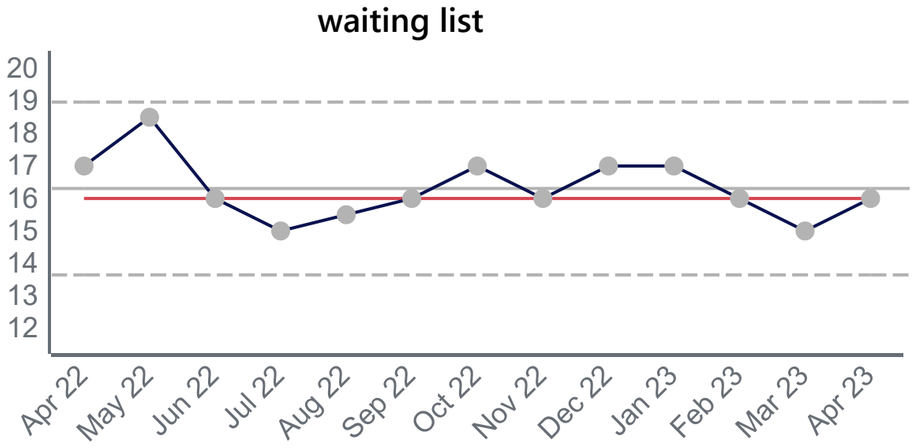


Technical Analysis:

New Metric which shows on average 19 referrals of BAME background are accepted per month, April shows 15 patients.

Actions:

Difference in Median Waiting time for patients with LD on the waiting list



Technical Analysis:

New Metric which shows median wait of our Learning and Disability patients from our RTT Inpatient and Outpatient open pathways was 16 weeks as end of April. This is in line with the previous 12 month baseline target of 16 week median wait for non-LD patients.

Actions:

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Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Trust wide compliance on PDR's is at 90%. Total sickness absence in April is 5.28% which is below the 5.5% target. A reduction from March at 5.91%. This comprises STS at 1.78% and LTS at 3.5%. This month is the first time the sickness absence rate has fallen below the target for the last 2 years (since May 2021)

Areas of Concern:

Staff Turnover remains 15% in April and has been stable since December with no further increases. However this remains a significant concern and this level of staff turnover is creating substantial risk for the Trust. This is being closely monitored by the Trust People and Wellbeing Committee. Retention initiatives underway which will be captured in the Trust long term plans on attraction and retention

Forward Look (with actions)

Increased focus on turnover and retention initiatives which will be captured in the Trust long term plan on attraction and retention. People and Wellbeing Committee will continue to receive detailed analysis and oversight of this

Colleague Satisfaction – Thriving Index - In Development

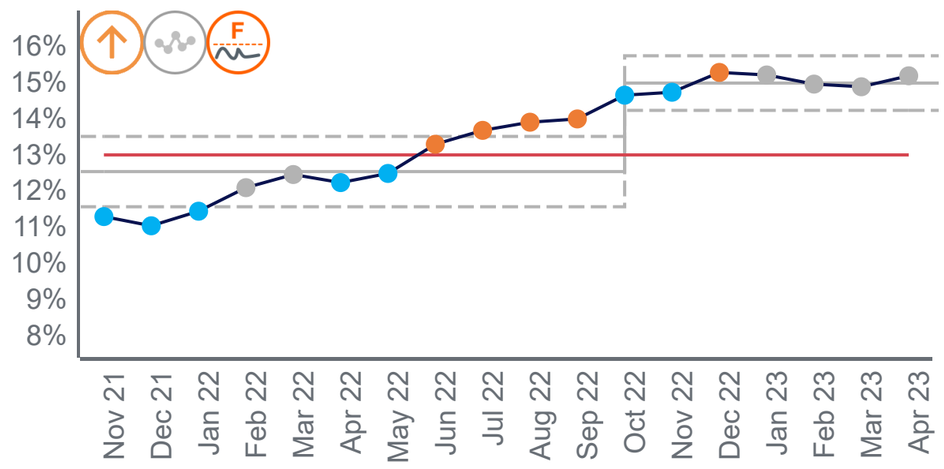
Technical Analysis:

Metric is in development

Actions:

In development

Staff Turnover



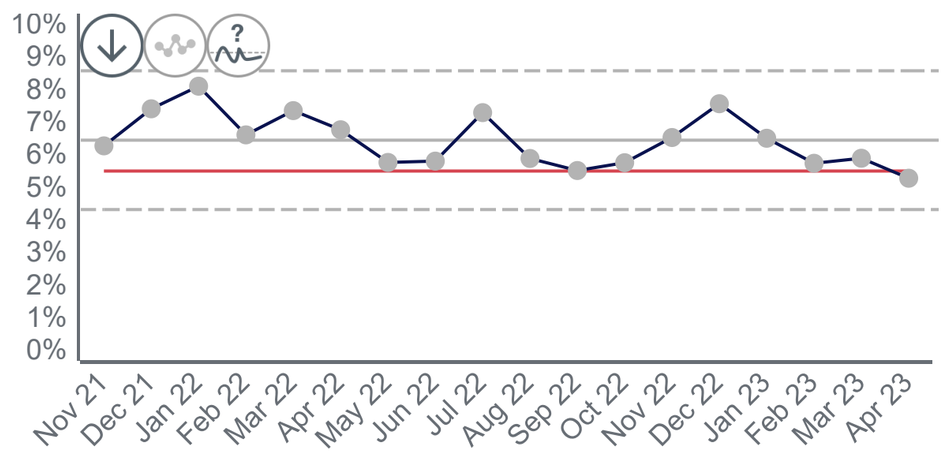
Technical Analysis:

Staff Turnover remains 15% in April and has been stable since December with no further increases. However this remains a significant concern and this level of staff turnover is creating substantial risk for the Trust.

Actions:

Increased focus on turnover and retention initiatives which will be captured in the Trust long term plan on attraction and retention. People and Wellbeing Committee will continue to receive detailed analysis and oversight of this

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in April is 5.28% which is below the 5.5% target. A reduction from March at 5.91%. This comprises STS at 1.78% and LTS at 3.5%. Still demonstrating common cause variation, first time below the target for the last 2 years (since May 2021).

Actions:

Regular monitoring and review through People and Wellbeing committee. Designated HR support to each area with Occupational Health and SALS support.

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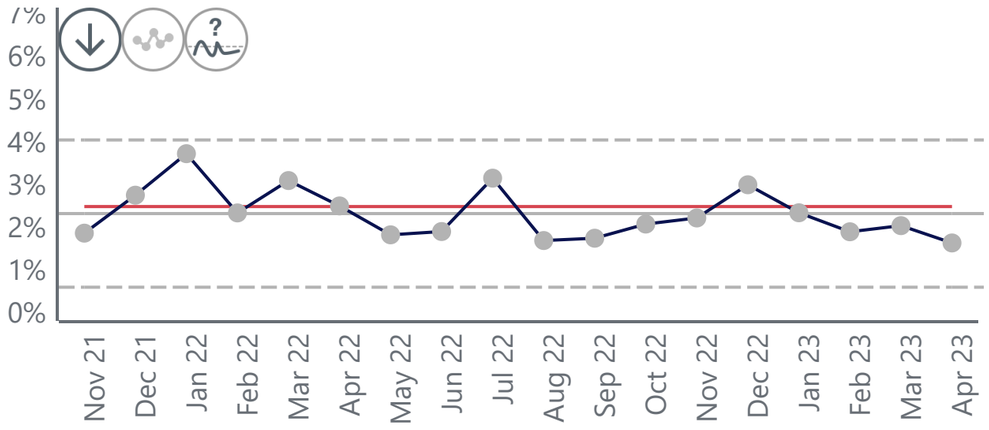
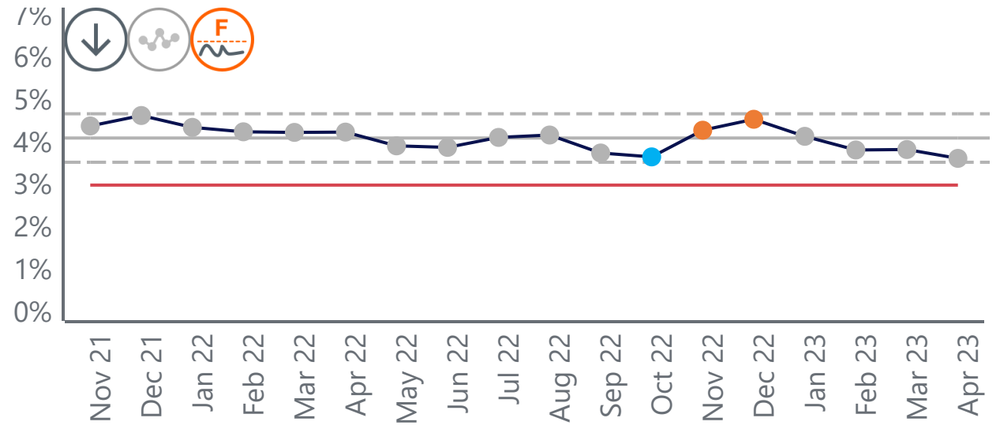
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

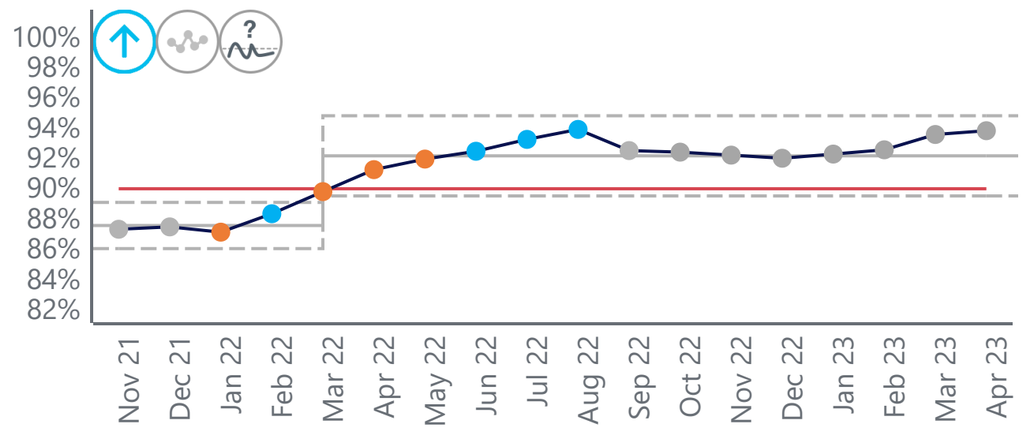
Short Term Sickness



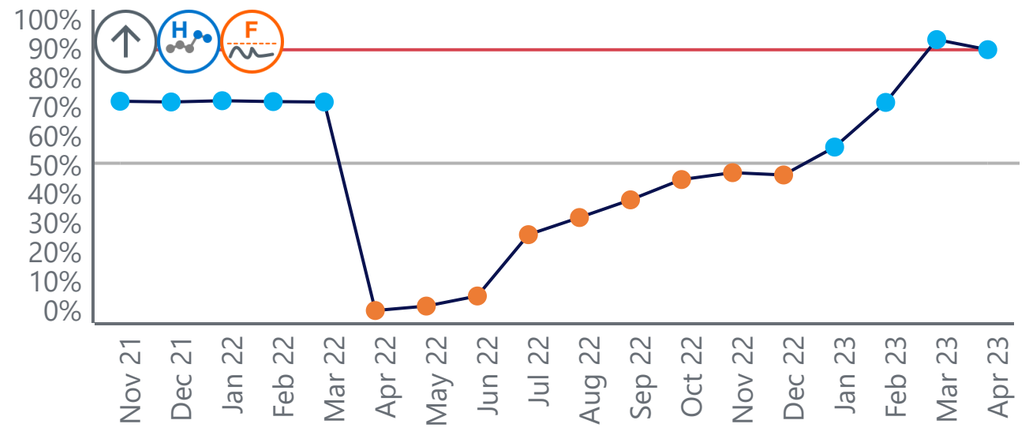
Long Term Sickness



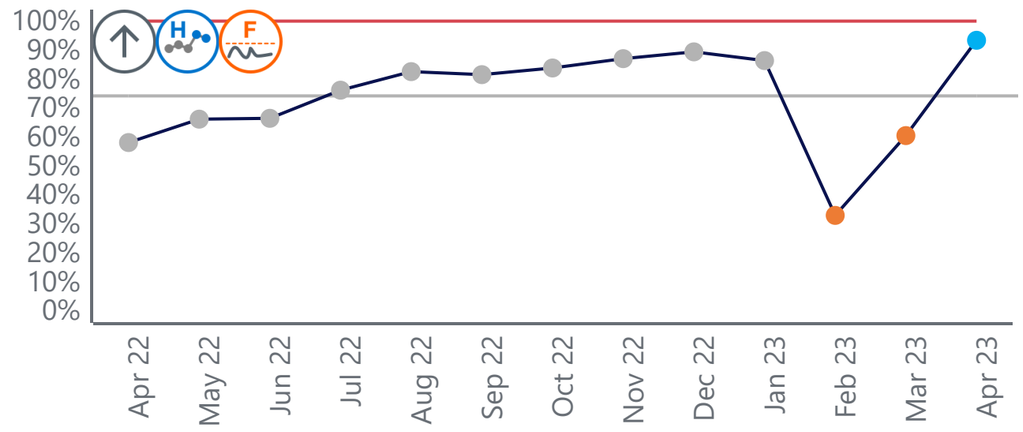
Mandatory Training



% PDRs completed since April



Medical Appraisal



Staff movement / Churn rate - In Development

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

Not required to report externally this month. For internal reporting purposes for April, the Trust is reporting a deficit of £0.5m which is inline with planned position for this month. The financial plan submitted to NHSEI on 4th May requires Alder Hey to achieve a surplus of £12.3m during 23/24. This also requires delivery of a recurrent £17.7m CIP Target. Cash balance for April remained high at £83.2m.

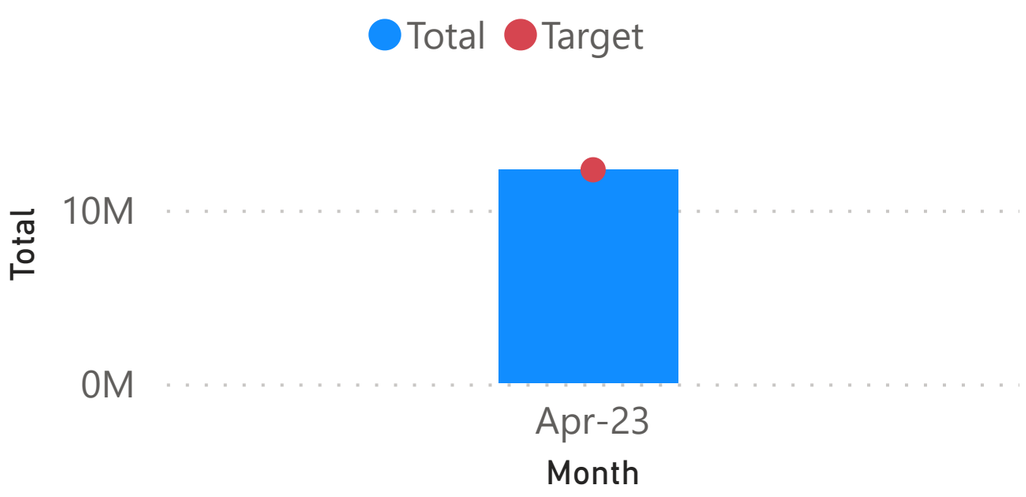
Areas of Concern:

Delivery of the £12.3m surplus is heavily reliant upon achieving the CIP target of £17.7m therefore identification of transformational schemes is urgent along with cost control measures to mitigate pressures should they arise. The Trust will also be required to meet activity targets in order to achieve the required levels of income to support delivery of the plan.

Forward Look (with actions)

Continued cost control to ensure achievement of the financial plan by end of the year. Urgent focus required on recurrent efficiency. Divisional finance panel meetings will be scheduled for areas not reporting to plan and will be subject to a quarterly business review at RABD.

Revenue Position (Year End Forecast)



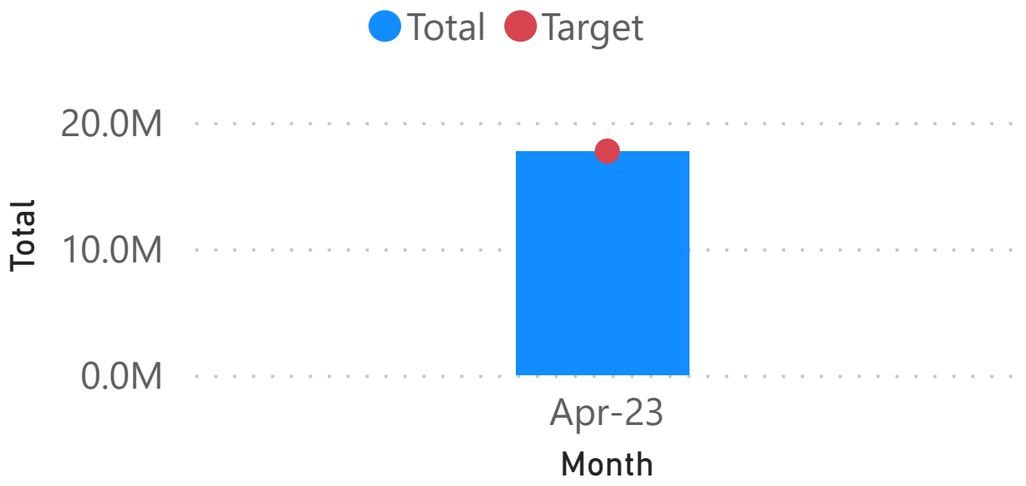
Technical Analysis:

Financial Plan submitted at £12.3m surplus position. Given the early stage of the year, the forecast is in line with this plan.

Actions:

Concerted effort to manage budgets within limits including identification of transformational recurrent CIP schemes in order to deliver the required control total.

CIP Position (Recurrent Full Year Effect)



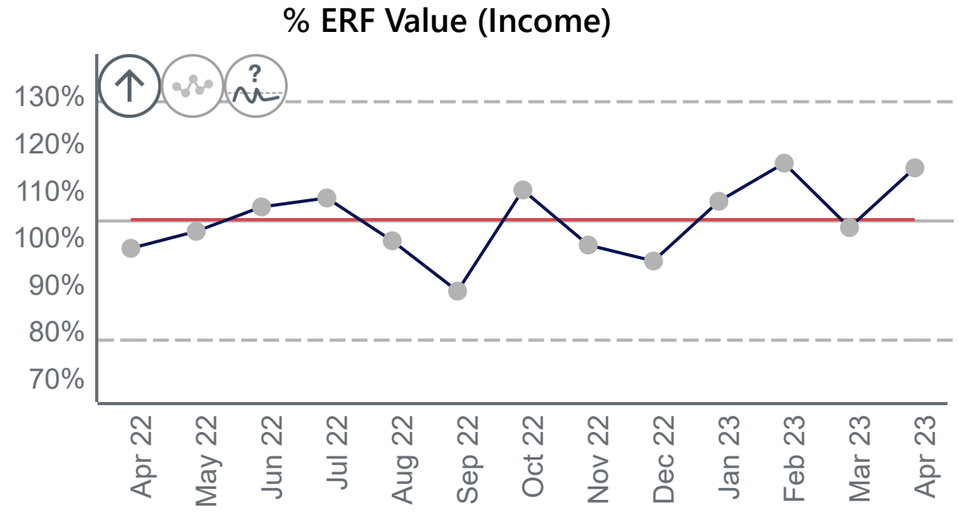
Technical Analysis:

CIP delivery in month has not been reported formally during April but forecast identified for the year thus far is £5.6m across the Trust which only represents 31% of the overall target which means 69% is yet to be identified.

Actions:

Scrutiny and challenge through financial reviews and SDG, across all areas to identify CIP opportunities. CIP deep dives will be reported at the RABD quarterly Business reviews with divisions

% ERF Value (Income)



Technical Analysis:

115% vs a target of 112.3% this is an estimate based on first-cut data at 3 working days prior to month-end. Main factors are A&E, OP attendances and community OP attendances. There is risk that the A&E and community OP attendance performance could be challenged by commissioners.

Actions:

Next step is to compare the first-cut data to flex data, to understand how accurate the 115% estimate is.

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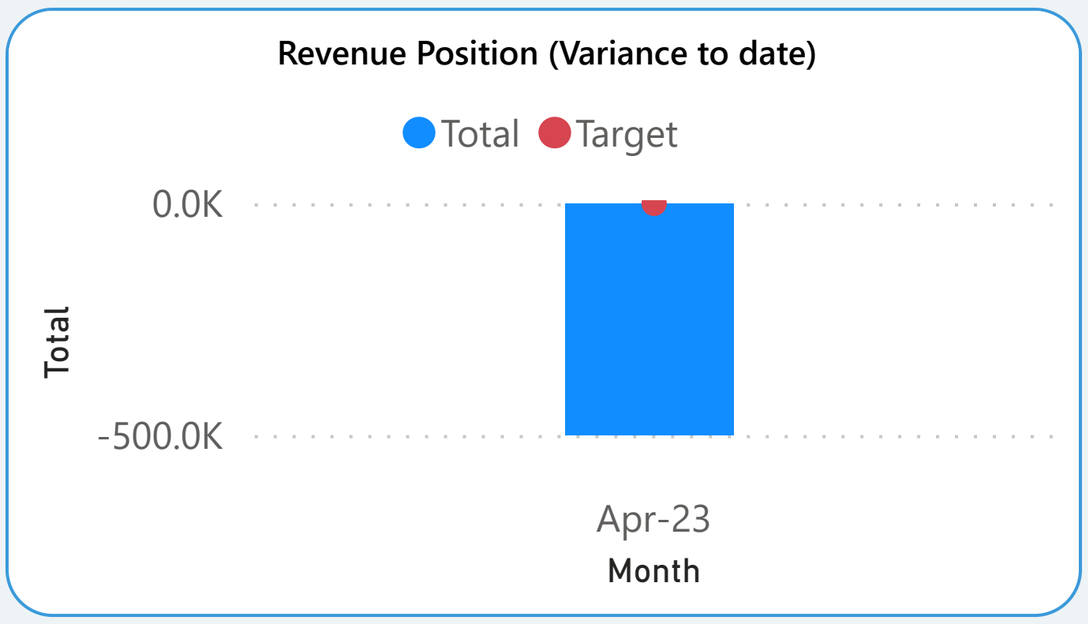
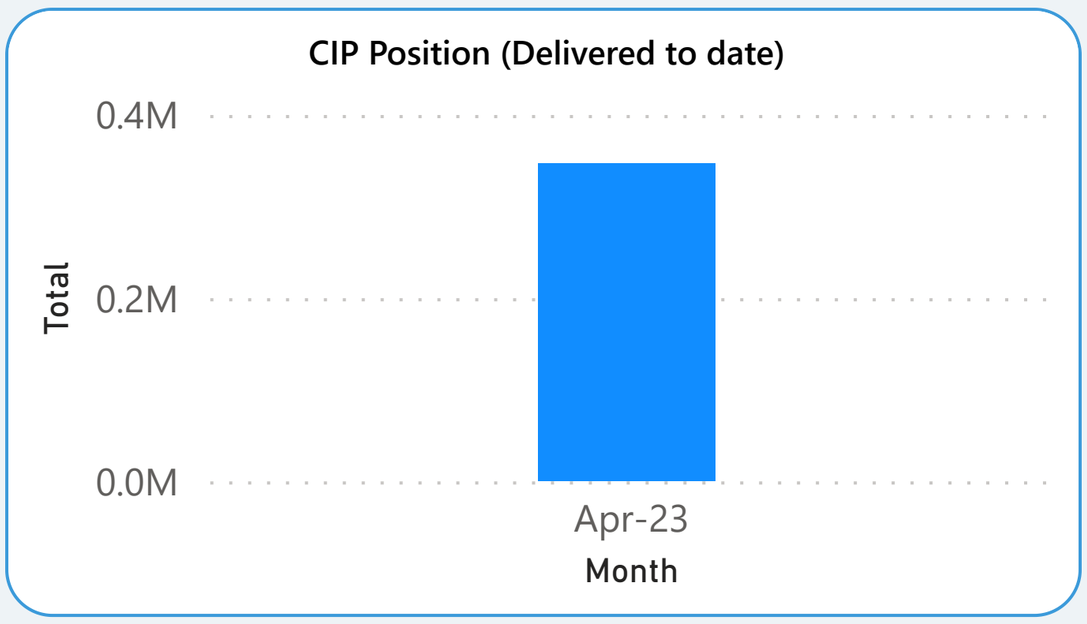
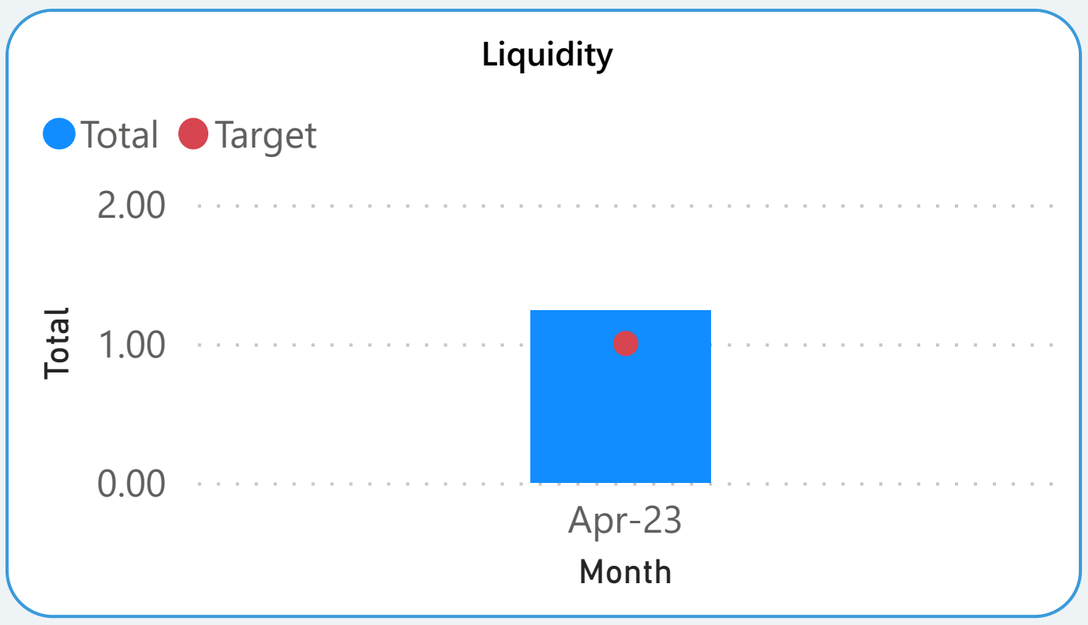
Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led - Watch Metrics







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

New risk management system implemented with Risk module going live 9th May 23. All staff encouraged to continue to report risk via new system and contact governance team for any support and guidance.

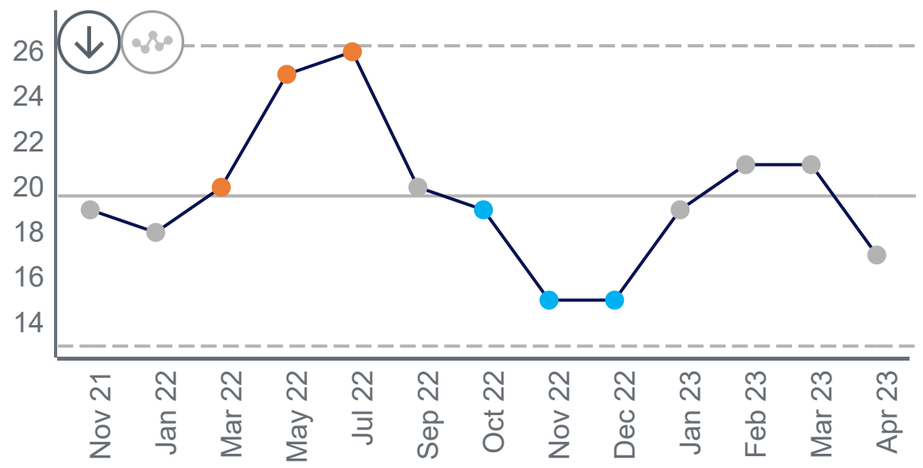
Areas of Concern:

Due to competing priorities, a number of monthly risk review meetings have been postponed by services in month. Still a small number of risks with no agreed action plans which have been escalated to relevant Divisional Directors/teams for review and action.

Forward Look (with actions)

Ongoing review of all risks via the monthly risk overview meetings. Renewed focus on update of corporate risks with oversight at Corporate Service Collaborative. Priority to review all risks that are either under scored or with no target date.

Number of High Risks (scored 15 and above)



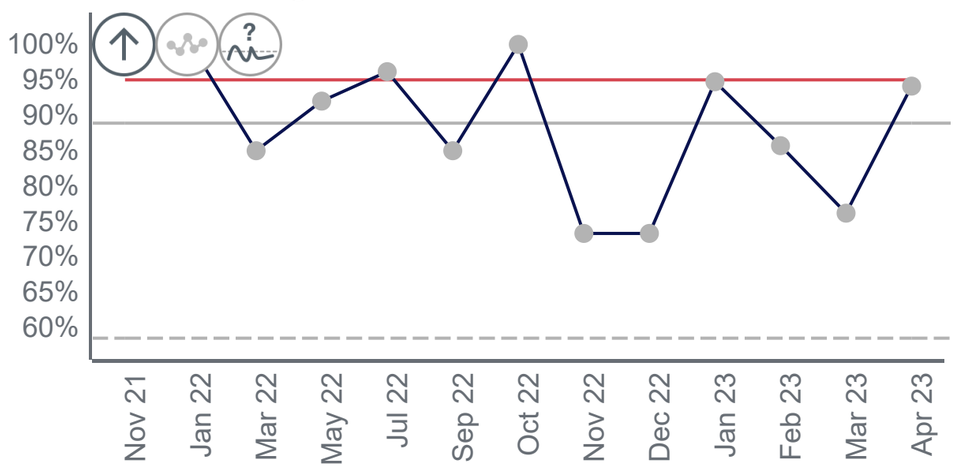
Technical Analysis:

There are 17 High Risks on the risk register at the end of April. Overall, this remains stable and is within the normal range.

Actions:

Continue to meet with Divisional and Corporate Services leads as part of the monthly risk review process to review progress of mitigation against existing risks. Continued focus on high risks at Risk Management forum individually or via service led deep dive.

% of High Risks within review date



Technical Analysis:

Compliance of reviewing High risks within date is variable, with 1/17 risks overdue at the end of April. Action is required to ensure consistent compliance with the 95% target.

Actions:

1/17 high risk overdue risk review which has been escalated to risk lead

Smartest Ways of Working - AlderC@re - Well Led

SRO : Kate Warriner, Chief Digital and Information Officer

Highlights:

• Cycle 5 of AlderCare patient journeys complete • Gateway 2 work off plan continues • Training Booking App launched for AlderCare • GoLive dates confirmed for AlderCare Sep23 • Change freeze approved • GoLive of new Risk and Incident Management System, InPhase • Launch of Electronic Medical Consent Forms • HSJ Shortlisting for Safety (Electronic Anaesthetic Record) and Urgent Care (Online Symptom Checker).

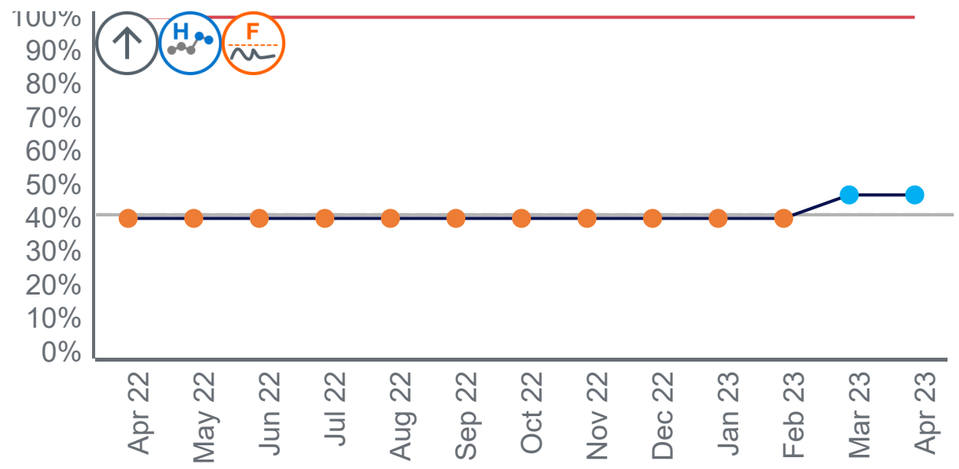
Areas of Concern:

• Completion of AlderCare build to time and quality still contains risks and is being monitored closely • AlderCare reporting workstream recovery plan in place and daily monitoring continues • AlderHey Anywhere testing and issue resolution ongoing but good progress made.

Forward Look (with actions)

• Gateway 2 work off plan for outstanding items. • Gateway 3 scheduled for May 2023. • Finalise Go-Live Date. • Website scheduled for a 'soft launch' end of June • AlderHey Anywhere deployment • Launch of Trauma App in ED • Complete Inphase deployment.

Alder Care - Divisional Critical Criteria



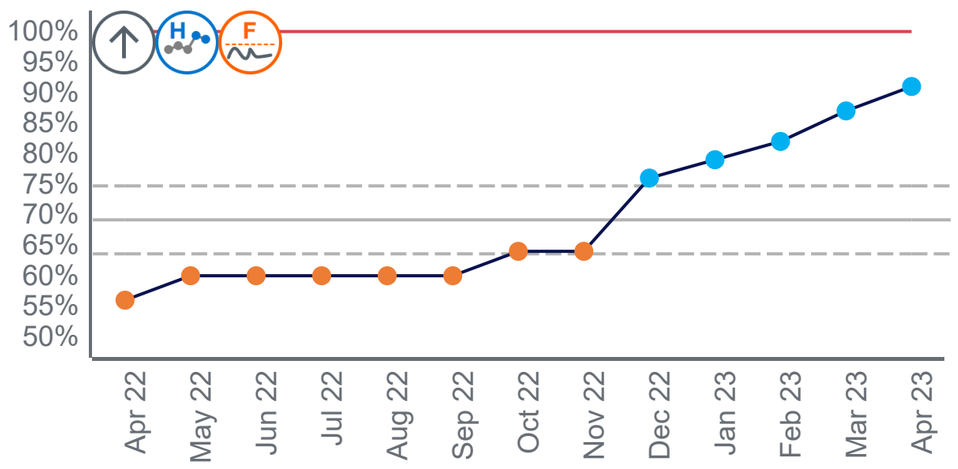
Technical Analysis:

7/15 critical criteria complete. Remainder awaiting system build, resolution of P1 issues or key decisions. Performance metric is for "sign off" so percentage only increases once each item is fully signed off by CXIO team.

Actions:

Ongoing development for remaining items. Review WHO checklist approach with Surgery, and resolve display feedback for clinical documentation

Alder Care - % System Build Completion



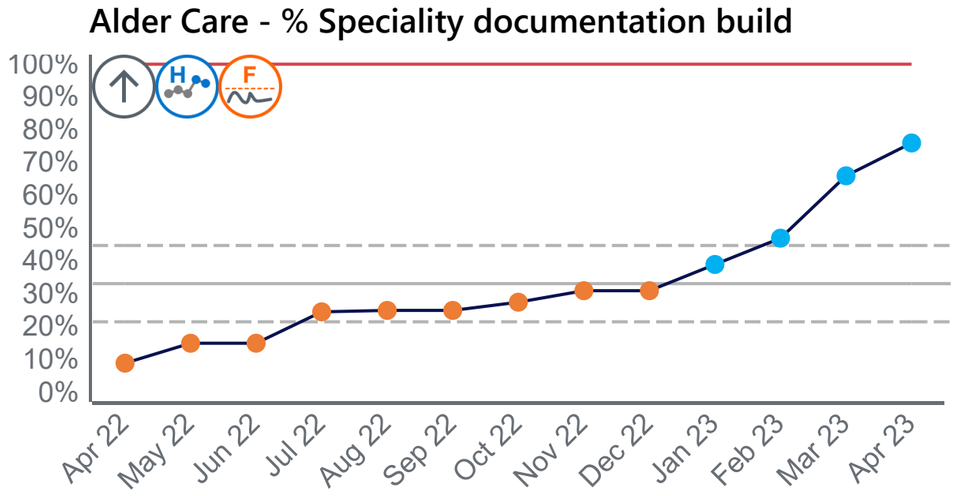
Technical Analysis:

This metric monitors build across all workstreams. Build completion continues to increase in line with individual trajectories. Majority of core build due to complete by end of May, with theatres June and EPMA in July.

Actions:

Continue build. Monitor progress on EPMA build (86%). Undertake Meditech readiness assessment.

Alder Care - % Speciality documentation build

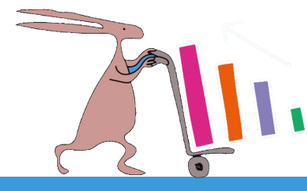


Technical Analysis:

39 of 58 specialty documents have now been completed, with others partially built. Programme Team working with Divisions.

Actions:

Continue build (76%) and sign off process (28%). Work with divisions to sign off Specialty Packages build.



Collaborating for CYP - Green Plan: Well Led

SRO : Mark Flanagan, Director of Marketing and Communications

Highlights:

This is the first time we have reported as part of the IPR. This month's highlights include development of improvement plans for future investment e.g. solar, panels and LED roll out.

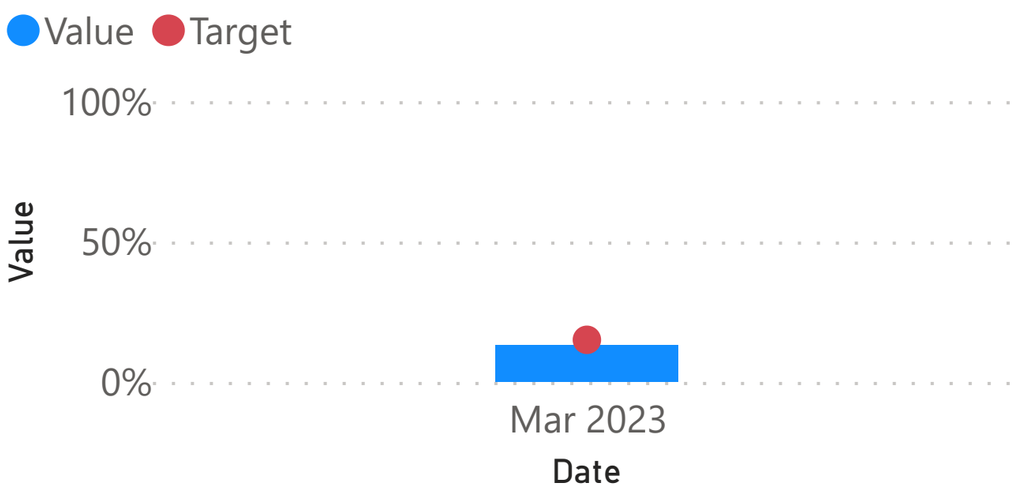
Areas of Concern:

Reliability of core equipment including combined heat and power plant (CHP) and our ground source heat pump (GSHP) impacting results. Highly visible issue of external lights being on all the time outside A&E.

Forward Look (with actions)

Clean Air Day on 15th June will bring together people from across C&M. National event with NHSE and Active Travel England being finalised. Solar panel project will be brought to June RABD.

Green Plan: Reduce Carbon Footprint



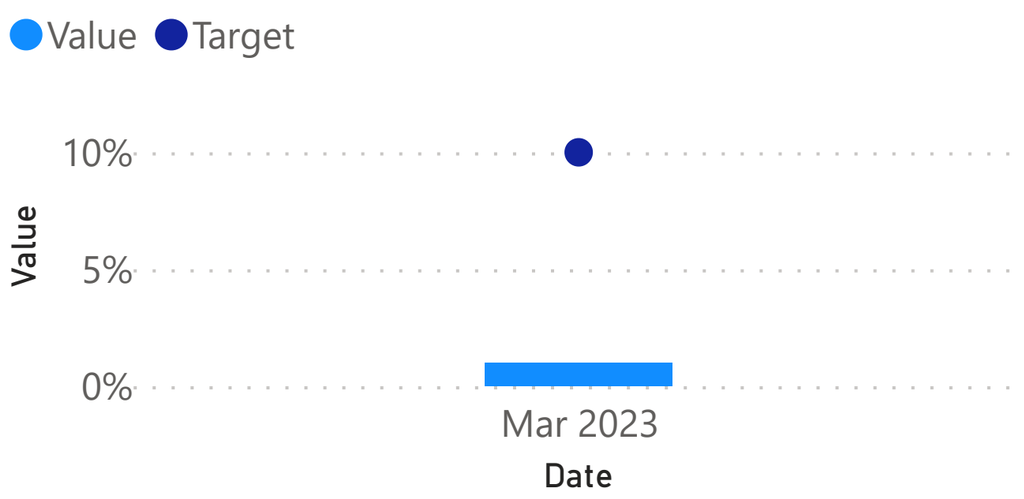
Technical Analysis:

Unusually cold March (13% more heating required than last year) impacted year end results

Actions:

Deliver operational fixes and improvement projects

Green Plan: Reduce Energy Usage



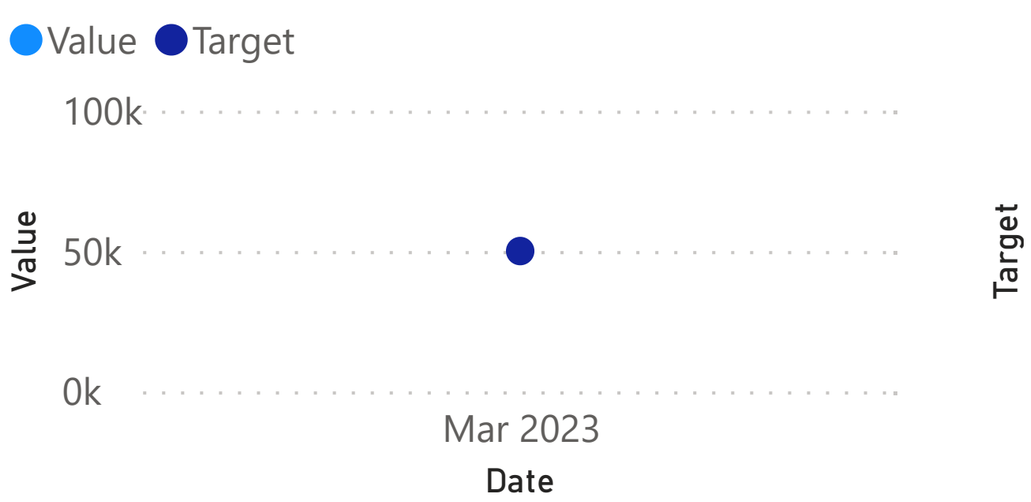
Technical Analysis:

Total energy use impacted by issues with combined heat and power plant (CHP)

Actions:

SPV developing plan with MITIE

Green Plan: Reduce Waste



Technical Analysis:

Savings start when new compactor and balers in place

Actions:

Continue capital project

Pioneering Breakthroughs - Research and Innovation: Well Led

SRO : John Chester, Director of Research and Innovation

Highlights:

Refer to CRD update on page 31

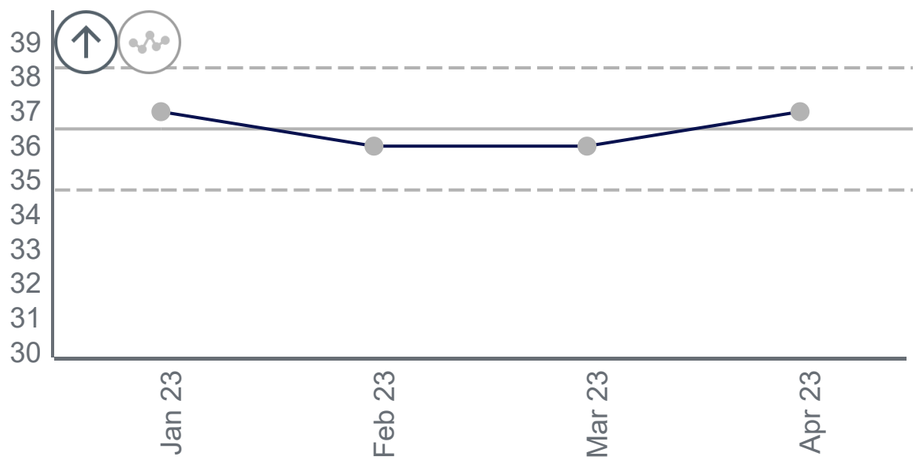
Areas of Concern:

Refer to CRD update on page 31

Forward Look (with actions)

Refer to CRD update on page 31

Number of Chief Investigator led studies

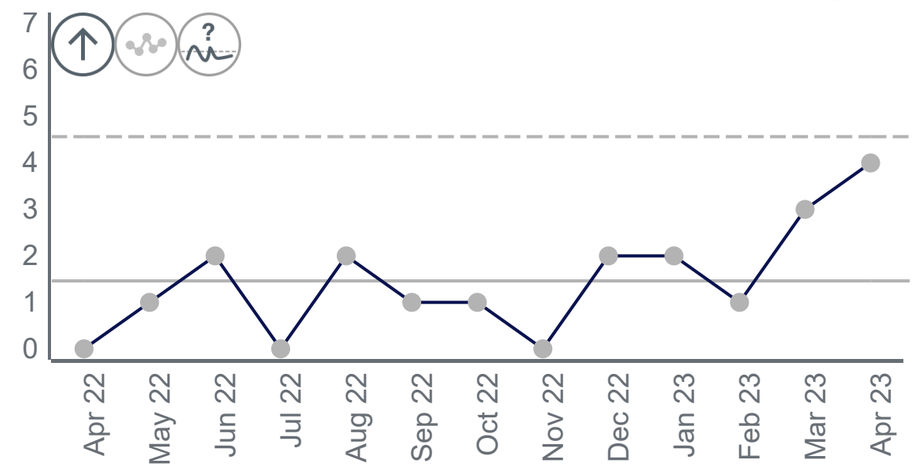


Technical Analysis:

Actions:

- Prioritising approval of studies led by Alder Hey based Chief Investigator
- Investment in early career researchers to grow own capacity for the future
- Growth of number of Chief Investigators to be a key enabler of new research strategy

Number of innovation solutions deployed with real-world impact



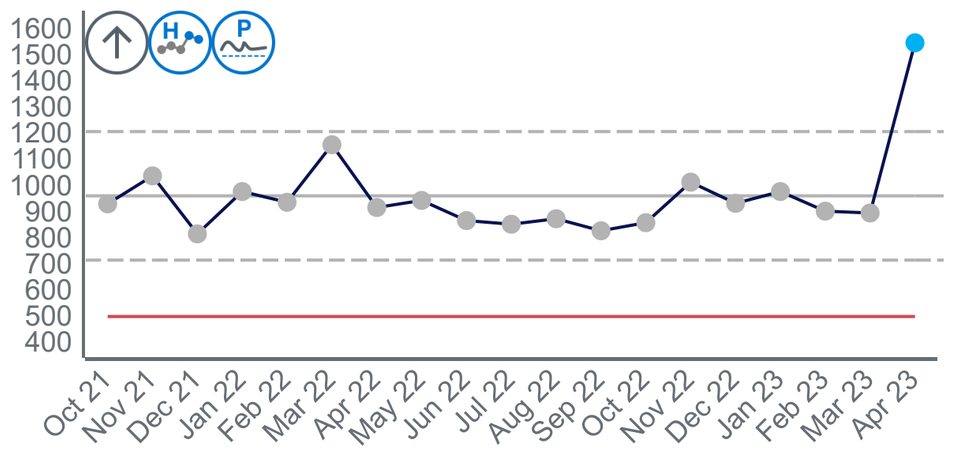
Technical Analysis:

This metric monitors the number of projects deployed across Launch Pad, Data Science & Automation Solutions.

Actions:

- Prioritising Innovation pipeline of work; continue engagement with Trust to identify new opportunities
- Benefits & Costs - Workshop across teams to develop scope of ROI and action plan for capture & reporting financial impact to Trust

Number of Patients Recruited into Research Studies



Technical Analysis:

Actions:

- Shift in strategy towards higher intensity, lower recruiting studies
- Regular monitoring of timeliness of recording study recruitment data
- Renewed focus on performance management of studies recruitment performance

Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• Continued reduction in sickness absence rates (short & long term) across Division.
• Continued high levels of outpatient activity (above 2019 baseline and 2023 plan).
• Urgent referrals for eating disorders are seen within 7 days
• High levels of mandatory training across Division (96%)
• Reduction in waiting times for community Speech and Language therapy in line with agreed improvement plan
• Reduction in the number of patients waiting >65 weeks. ENT and Dentistry have action plans in place which include additional capacity (internal & insourcing- pending approval) & planned workforce investments. Full pathway review planned in ENT to include new triage process & new outpatient clinic models. Both are overbooking clinics in line with WNB rate.

Areas of Concern

• Completion of Initial Health Assessments for children new into care within the statutory 20-day timescale remains a significant concern for the Division. An improvement plan is under development with Place Designated Nurses and includes actions to support maximising capacity as well as focus on system wide improvements to ensure timely notification of requests.
• Number of children waiting over 65 weeks to conclude their ASD / ADHD diagnosis remains a challenge due to a continued increase in demand above commissioned capacity. Recruitment to vacancies remains ongoing in both services; in the ADHD service 5 new nurses have commenced in post with a further 3 due to start in June. Discussions are ongoing with commissioners regarding investment requirements for the service.
• Children & young people waiting over 52 weeks within Community Mental Health Services continue to present a challenge (wait is for specific treatment not initial appointment) and is expected to reduce as new staff come into post during May & June. Aim is Zero 52 week waits by July.

Forward Look (with actions)

• High WNB rate across some areas of the Division; specifically, Community Mental Health Services and ADHD Service. In addition to implementation of WNB predictor tool, teams are considering the use of PIFU for some pathways to support improvements in attendance at appointments.
• IHA improvement plan to be shared with Designated professionals for Place by 31 May 2023.
• Capacity plan with investment requirements for Community Mental Health Services for 20233/24 currently in development and will be shared with Place by 31 May 2023.
• Lack of decision regarding ASD and ADHD investment decision has been escalated to Place Directors and Executive Team.

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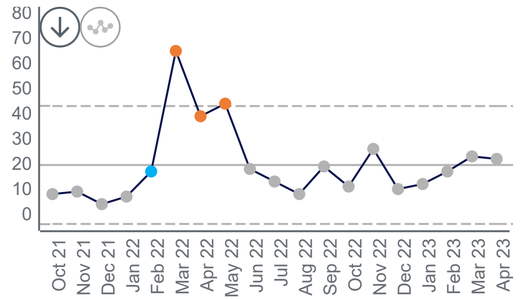
Integrated Performance Report | May 2023

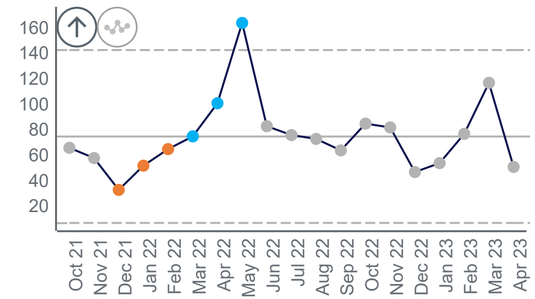
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

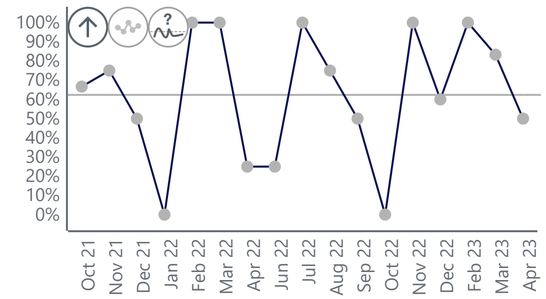
Number of Incidents rated Minor Harm and above



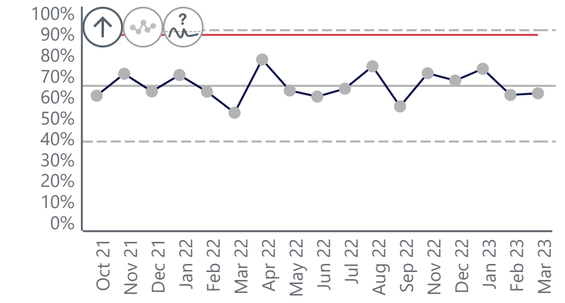
Number of Incidents rated No Harm and Near Miss



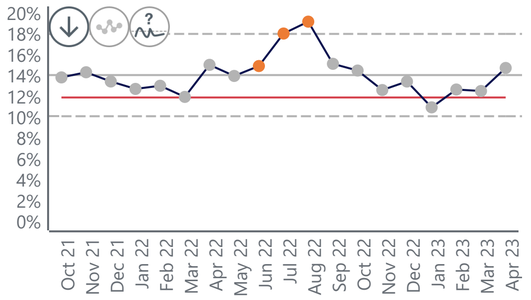
% Complaints Responded to within 25 working days



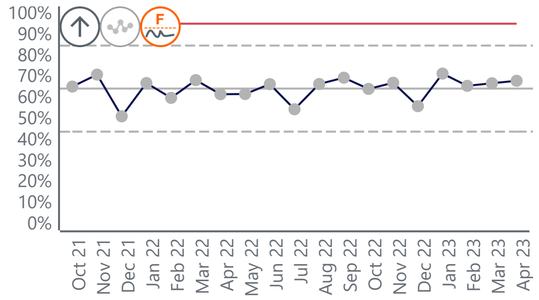
% PALS Resolved within 5 Days



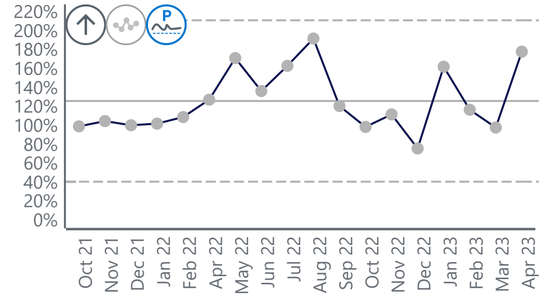
% Was Not Brought Rate (All OP: New and FU)



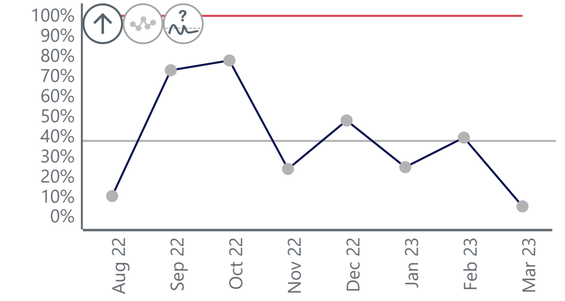
% of Clinical Letters completed within 10 Days



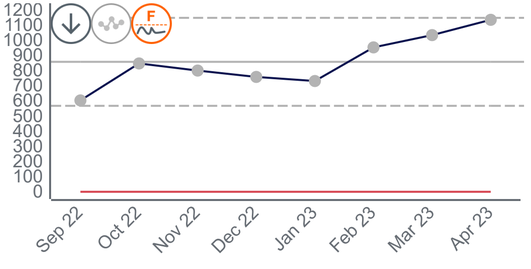
% Recovery for OP New & OPPROC Activity Volume



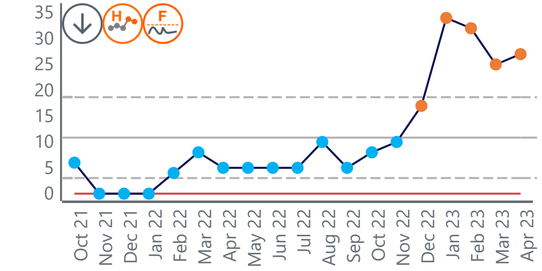
IHA: % complete within 20 days of referral to Alder Hey



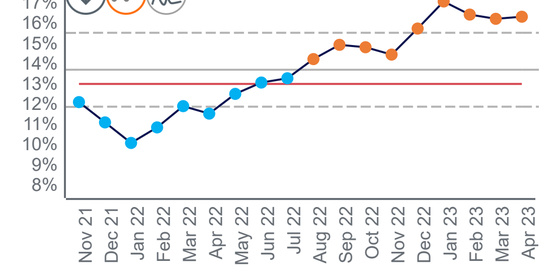
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



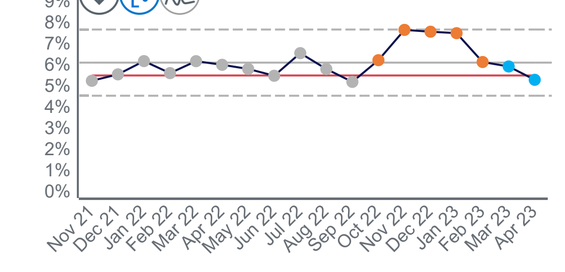
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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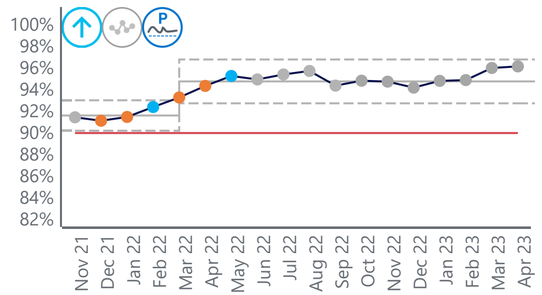
Integrated Performance Report | May 2023

Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

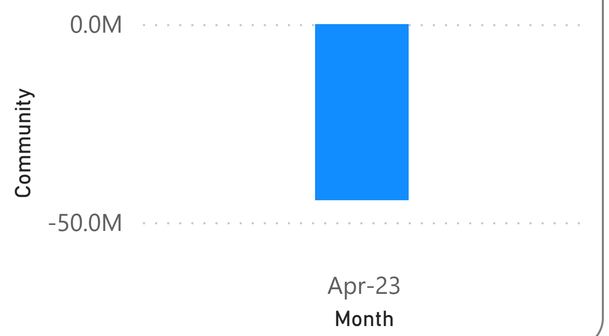
Mandatory Training



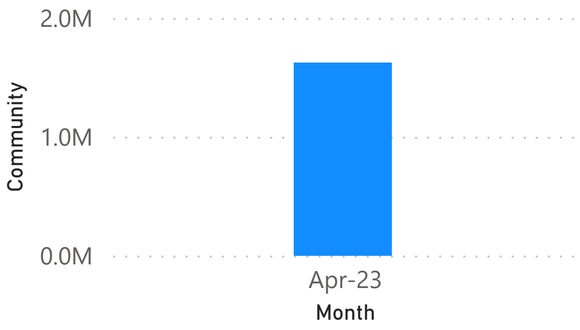
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

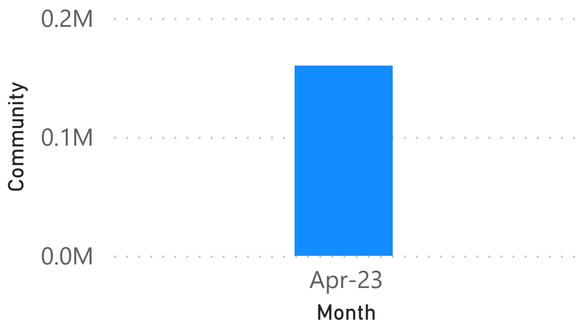
Revenue Position (Year End Forecast)



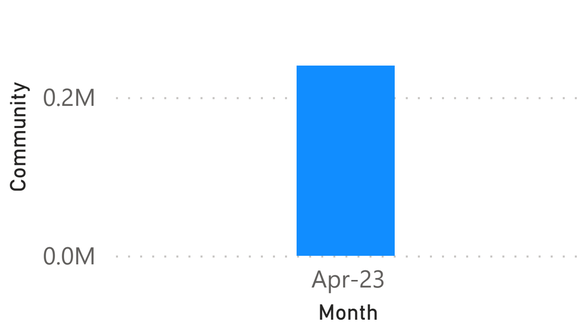
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• The Trust continue to maintain Children's Cancer Standards over and above national standards.
• In month, an overall improvement in sickness absence rates, with rates at 5%; a number of hotspots remain across the Division, managers, supported by HR continue to focus.
• In month 6% improvement in the 4-hour access standard in ED, achieving 84%.
• In month, 2% improvement in access to diagnostics, achieving 86%; sleep and gastroscopy recovery plans in place.

Areas of Concern

• Reduced compliance for Sepsis across the wards (88%) and ED (89.5%) although incremental improvement in ED overall.
• No improvement in 52 weeks waits in month; the impact of Industrial action in month resulting in mutliple cancellations to ensure safe medical rotas 24/7. Teams remain focused on 18-weeks recovery this year.
• Deterioration in Complaints turnaround caused by one extension and one complaint where the resolution meeting could not be arranged with all parties within 25 days.
• For the first time since April 2022 elective and daycase recovery below 19/20 levels, impacted again by Industrial Action.
• 10-day turnaround for clinical letters deteriorated in month by 8%; those clinicians with backlogs over 30 days being addressed by the Clinical Directors; further work required to support the management of results, a reason being cited for some delays in signing

Forward Look (with actions)

• Continue to focus on diagnostics recovery; further review requested of Inpatient Sleep capacity to ensure the 6 week target is met by July.
• Move ahead with Urgent Care System Programme and finalise ED Improvement workstreams, including the PAU pilot, expansion of Virtual Urgent Care offer and steeping up utilisation of the PUTC.
• Explore digital solution for results management to improve clinical letters turnaround times.
• Continue to focus on recovery with ambition of achieving 18 weeks in most specialities this year.
• Continue to focus on absence hot spots.
• Continue engagement activity across the Division.

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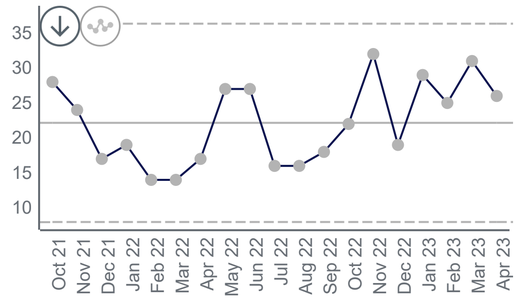
Integrated Performance Report | May 2023

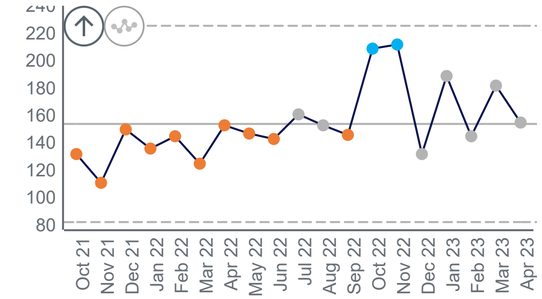
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

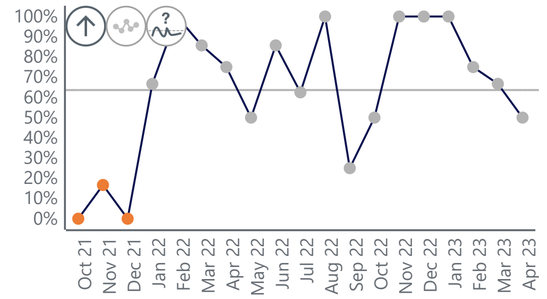
Number of Incidents rated Minor Harm and above



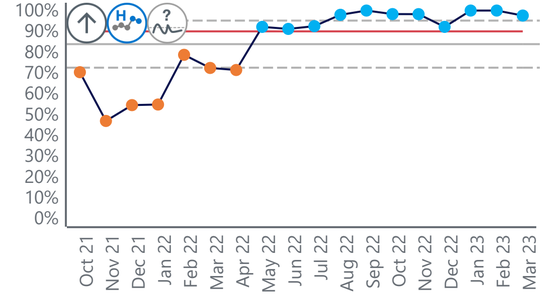
Number of Incidents rated No Harm and Near Miss



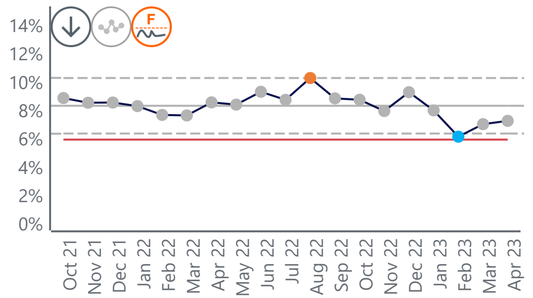
% Complaints Responded to within 25 working days



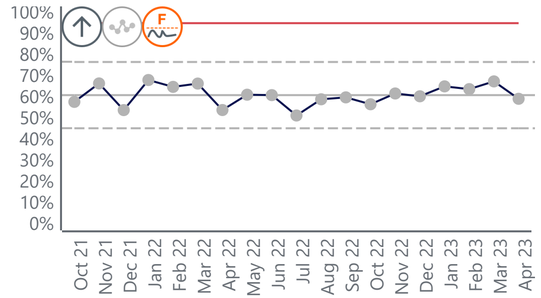
% PALS Resolved within 5 Days



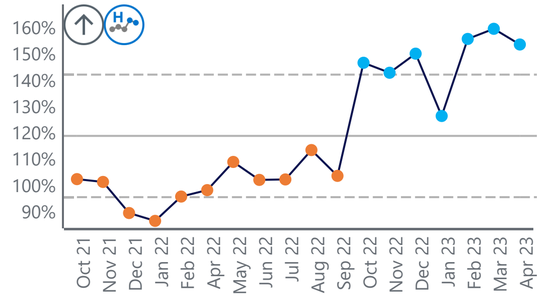
% Was Not Brought Rate (All OP: New and FU)



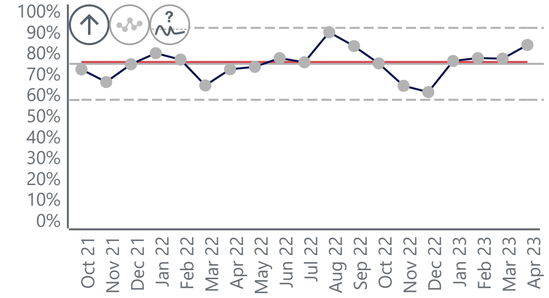
% of Clinical Letters completed within 10 Days



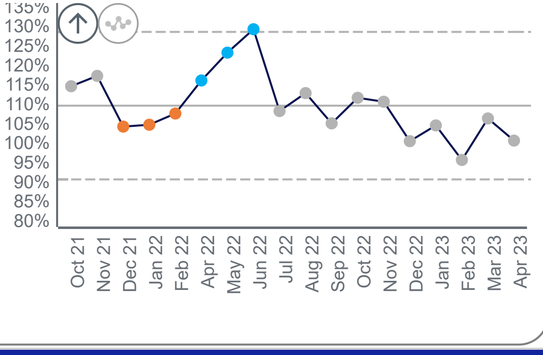
% Recovery for OP New & OPPROC Activity Volume



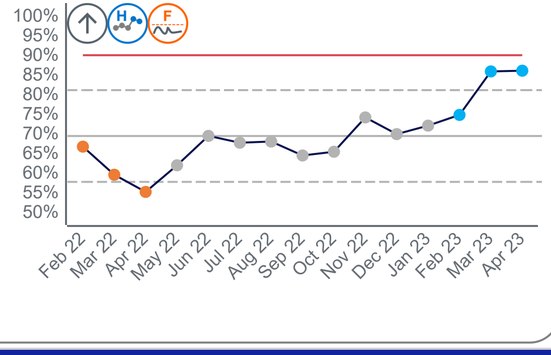
ED: % treated within 4 Hours



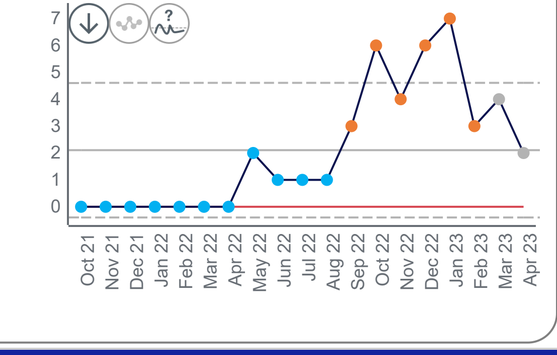
% Recovery for DC & Elec Activity Volume



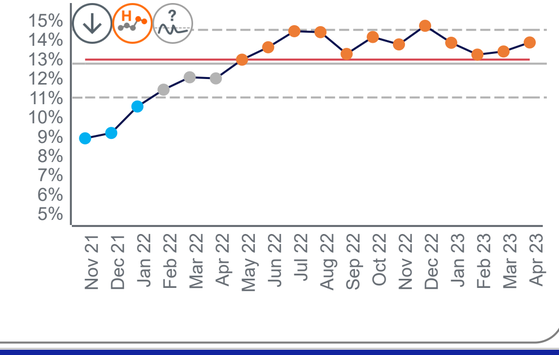
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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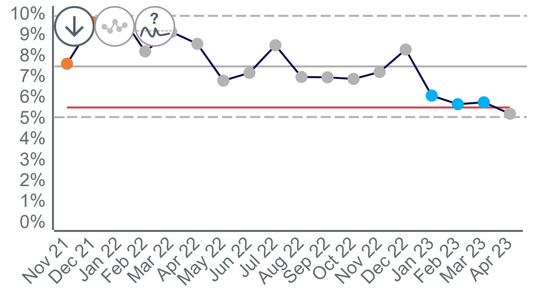
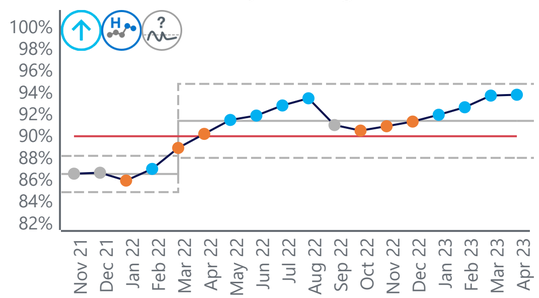
Divisional Performance Summary - Medicine

Sickness Absence (Total)



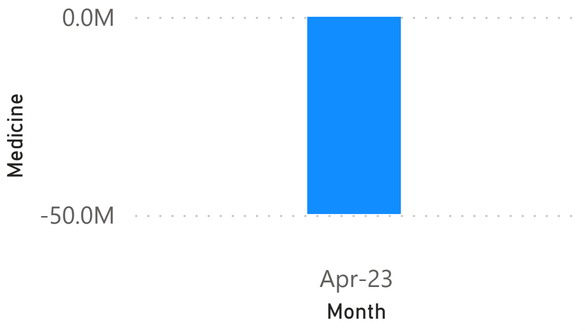
Mandatory Training



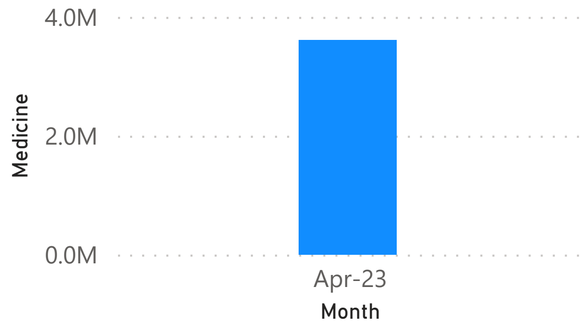
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

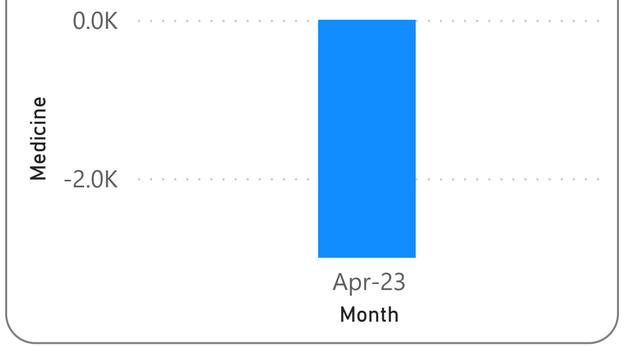
Revenue Position (Year End Forecast)



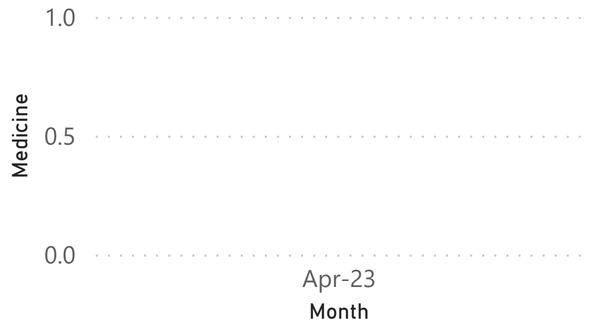
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• Maintained 100% compliance with both PALS and formal complaints responses.
• OPNEW/PROC recovery significantly improved in M1 despite some impact from Industrial Action causing cancellations.
• Sickness absence decreased in M1 and was just above trust target at 5.1% with a particular improvement in LTS which was below trust target at 2.6%.

Areas of Concern

• WNB rate not yet achieved new lowered target
• 67% Clinical letters signed within 10 days remains below target, although number unsigned over 2 weeks significantly improved
• % recovery ELEC/DC was just under 100% (volume) for M1 however significantly impacted by Industrial Action (64 electives). Income position however was over plan due to case mix benefit.
• Growing waiting list size and a rise in the number of C&YP waiting over 52 weeks, particularly within ENT & Dental - full trajectories presented via business case to increase workforce & capacity via both internal and insourcing models.
• DM01 compliance reduced in month relating to Urodynamics. Loss of capacity due to IA and waiting list is now in single figures so impact shows as a significant decrease.

Forward Look (with actions)

• WNB planned improvement work in outlying specialties. Community Ophthalmology has a specific action plan due to high WNB rate. Interventions to date have reduced rates significantly however still further work to bring in line with target.
• ACOO continues to write formally to those with outstanding clinical letters, alongside piece of work to implement a digital solution to support tracking of results. Compliance is reported into Divisional Governance meeting and led by speciality governance leads.
• Additional 24 theatre sessions allocated in May to mitigate IA impact in April.
• Theatre Improvement Group established to focus specifically on productivity within key challenged specialties for Access. Comprises of targeted workstreams around implementing GIRFT recommendations, touch time utilisation & enhanced scheduling (supported by regional improvement team).
• Additional capacity planned in June for Urodynamics to bring back to target in Q2.

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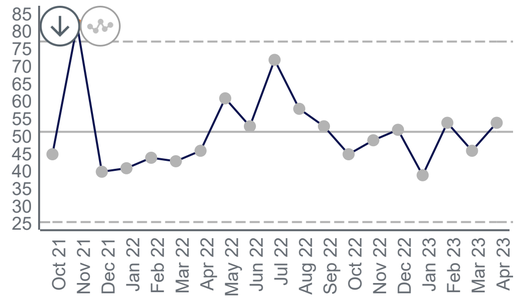
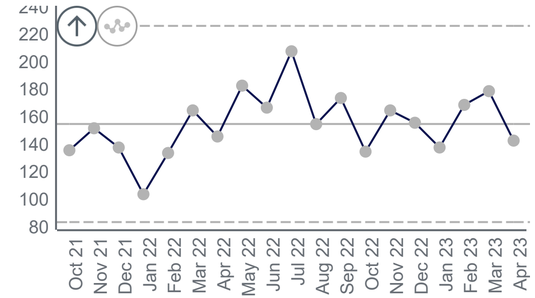
Divisional Performance Summary - Surgery

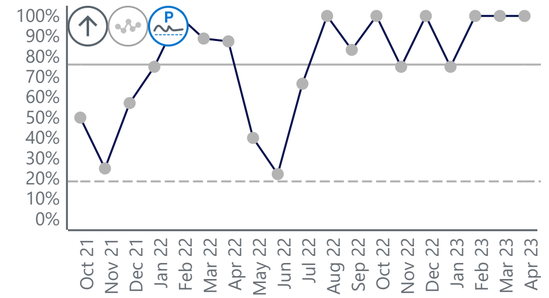
Number of Incidents rated Minor Harm and above



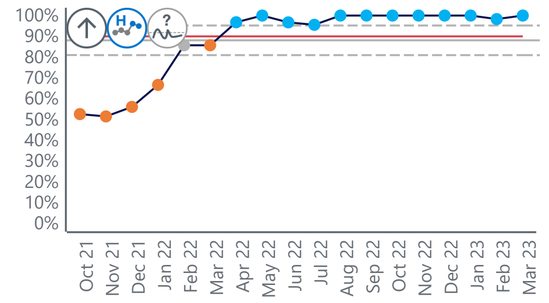
Number of Incidents rated No Harm and Near Miss



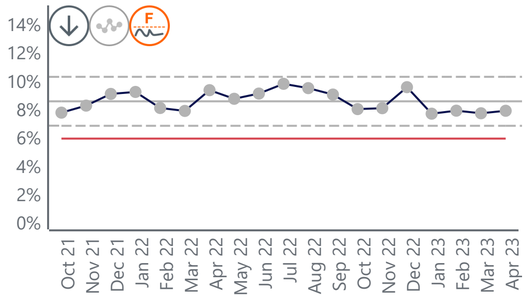
% Complaints Responded to within 25 working days



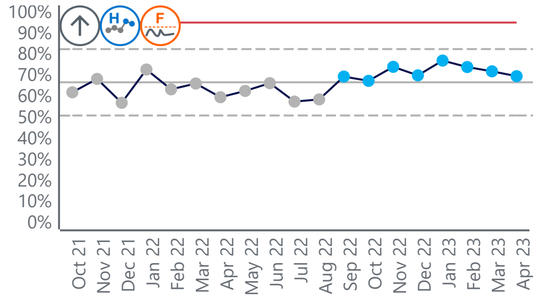
% PALS Resolved within 5 Days



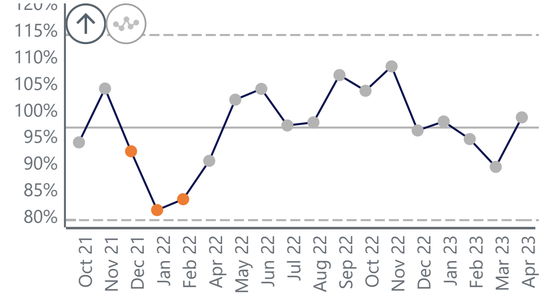
% Was Not Brought Rate (All OP: New and FU)



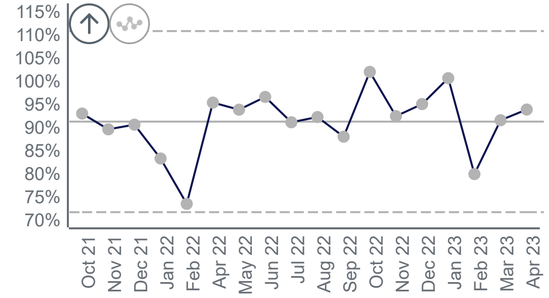
% of Clinical Letters completed within 10 Days



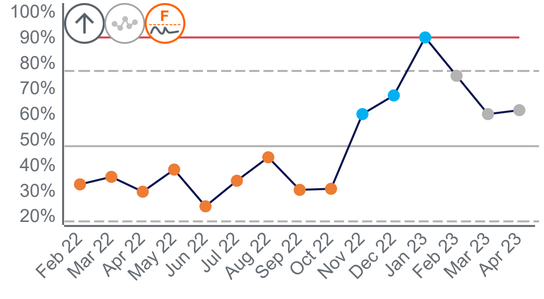
% Recovery for OP New & OPPROC Activity Volume



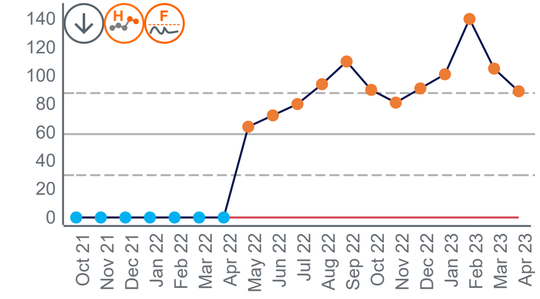
% Recovery for DC & Elec Activity Volume



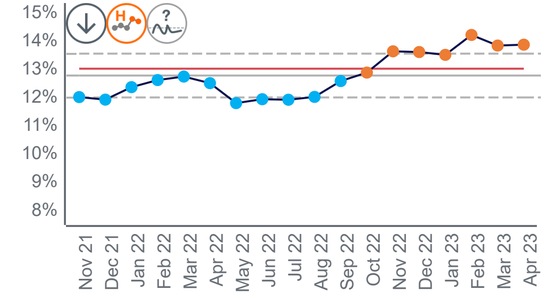
Diagnostics: % Completed Within 6 Weeks of referral



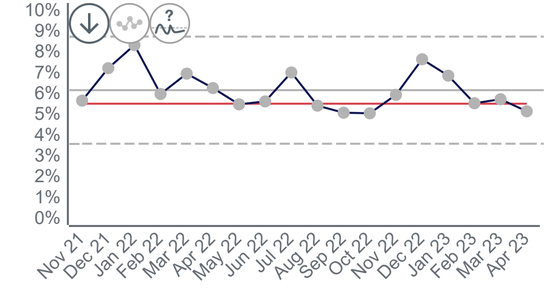
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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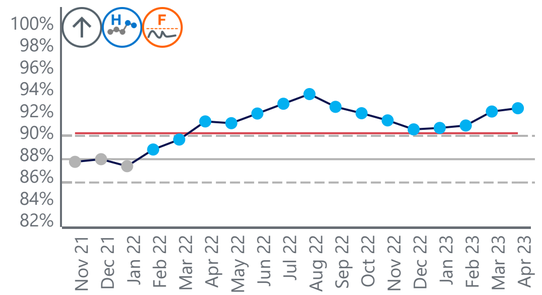
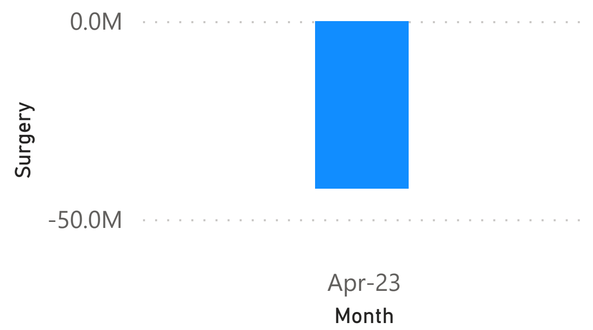
Mandatory Training



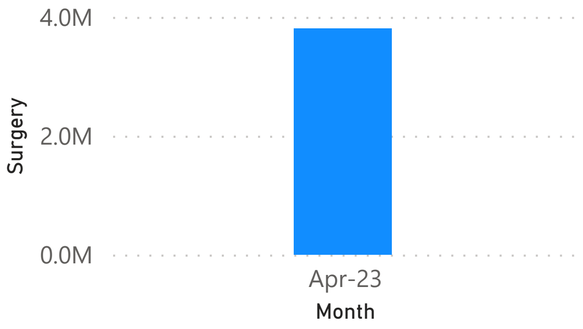
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

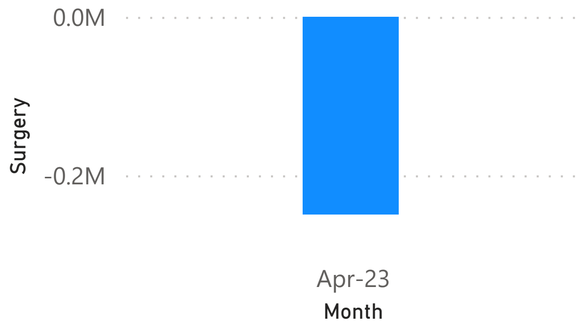
Revenue Position (Year End Forecast)



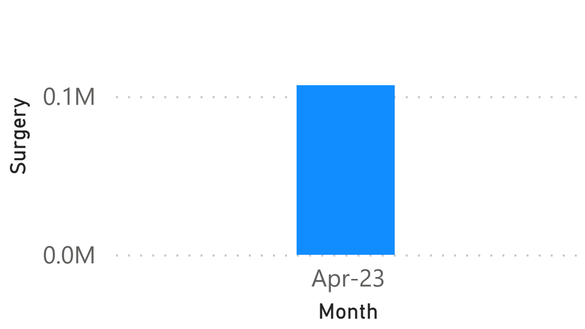
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO : John Chester, Director of Research and Innovation

Highlights

• Research Seed Corn Fund Launched • Commercial Incentive Fund Introduced • £246K grant secured from NIHR • First UK patient recruited to a lupus nephritis study at NIHR Alder Hey CRF • First Gene Therapy treatment provided to patient via Pfizer study • Streamlined research pathway introduced • Divisional Leadership team appointed/in place • PMRU team selected for Advanced Research Teaching Programmes • Big Conversation conducted and Action Plan underway • Research Celebration delivered.

Areas of Concern

Staff turnover although high remains static. National reduction in commercial research activity.

Forward Look (with actions)

Healthy pipeline of opportunity in hosted studies, grants and projects. New governance structures emerging including finance & performance, divisional assurance and continued partnership working with innovation.

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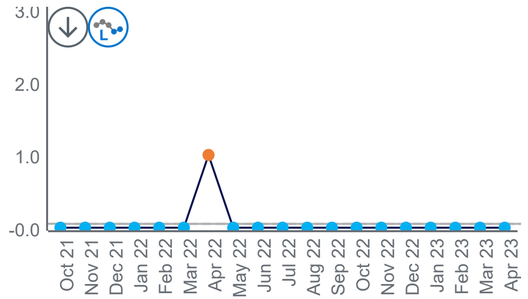
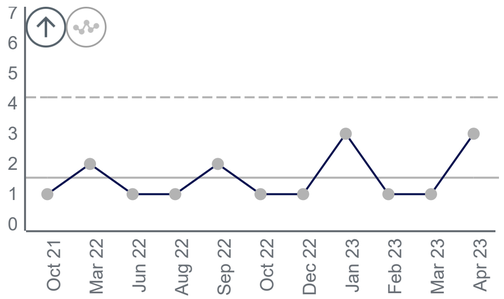
Divisional Performance Summary - Clinical Research

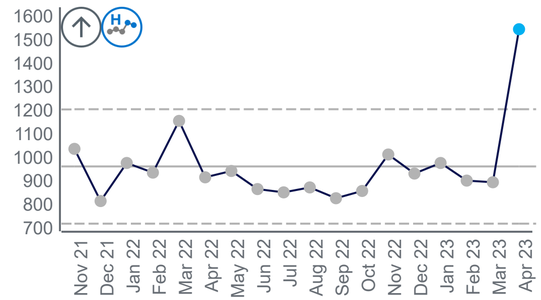
Number of Incidents rated Minor Harm and above



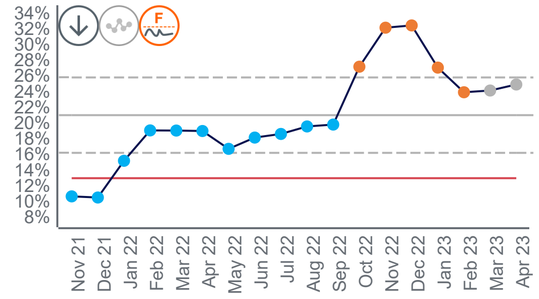
Number of Incidents rated No Harm and Near Miss



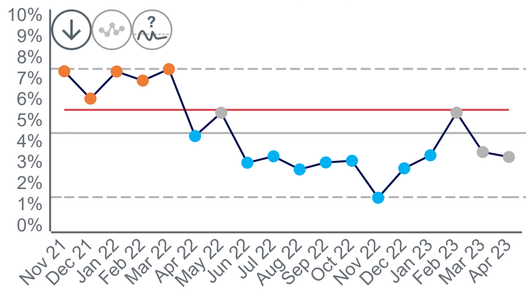
Number of Patients Recruited into Research Studies



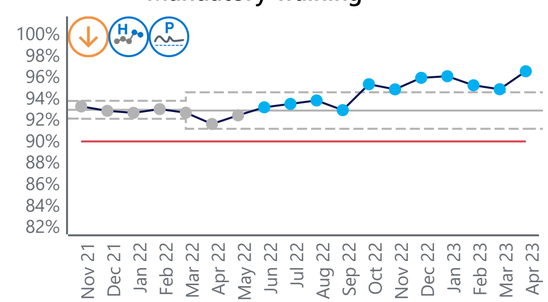
Staff Turnover



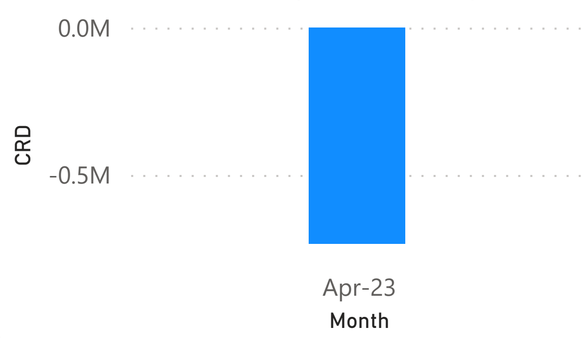
Sickness Absence (Total)



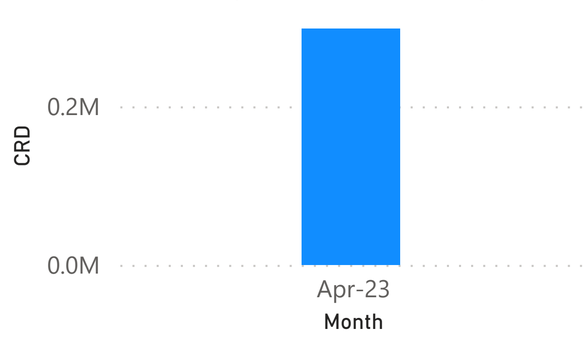
Mandatory Training



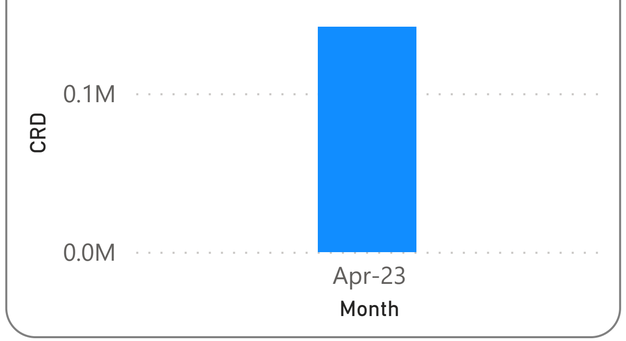
Revenue Position (Year End Forecast)



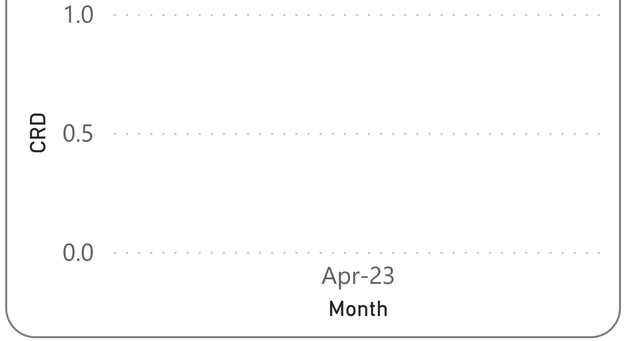
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Collaborative (CSC) continues to meet monthly with good attendance and engagement. Highlights from the meeting held on 22nd May 2023: • Mandatory training for Corporate Services remains above the 90% target at 94% • Sickness absence saw a slight decrease in April to 7.43% • The PDR rate for Band 7+ currently stands at 95% (against a target of 90% by end of July 2023) • The PDR rate for all AfC currently stands at 92% (against a target of 90% by end of March 2023) • Staff Surveys shared with departments and Big Conversations underway • Corporate CIP target for 2023/24 noted as £1.8m, of which £1m has been implemented.

Areas of Concern

• Staff turnover rates remain an area of focus, currently sitting at 15.89% (rolling 12m) against a target of 10% • Return to work completion is currently sitting at 79% against a target of 100%.

Forward Look (with actions)

• Ensuring all risks are reviewed within timescale • Deep dive into one service area at each CSC to better understand workforce data and hotspot areas such as turnover, mandatory training, sickness etc. • work is ongoing to increase compliance against return-to-work compliance.

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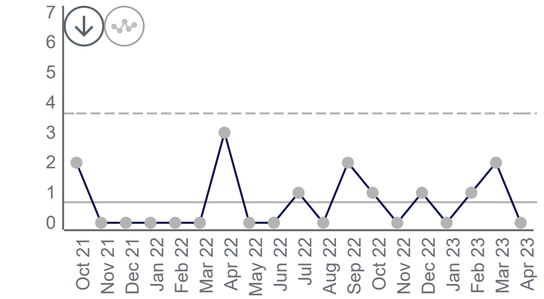
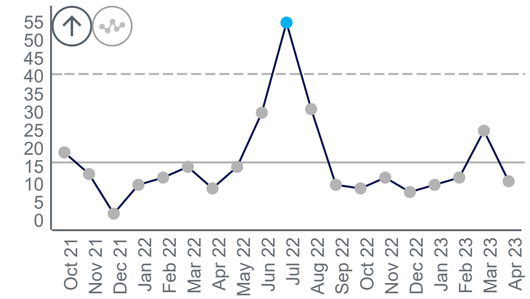
Divisional Performance Summary - Corporate

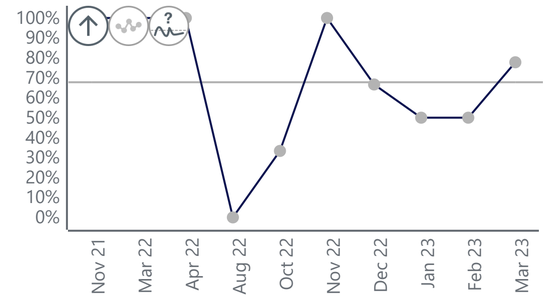
Number of Incidents rated Minor Harm and above



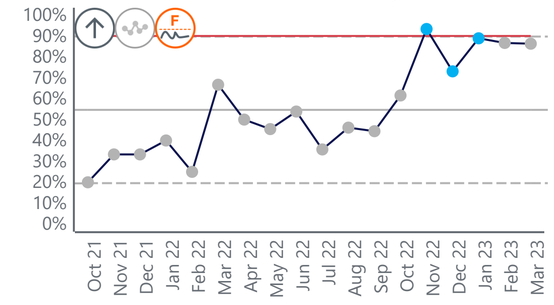
Number of Incidents rated No Harm and Near Miss



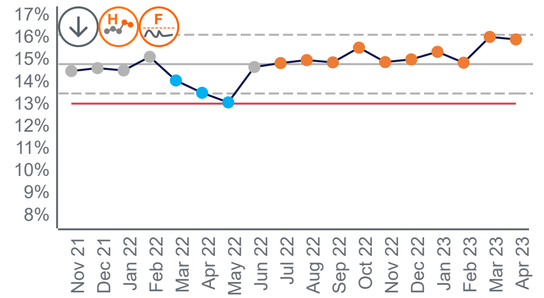
% Complaints Responded to within 25 working days



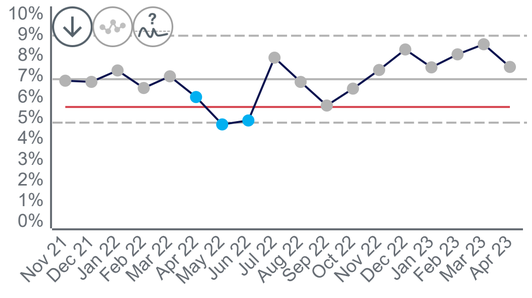
% PALS Resolved within 5 Days



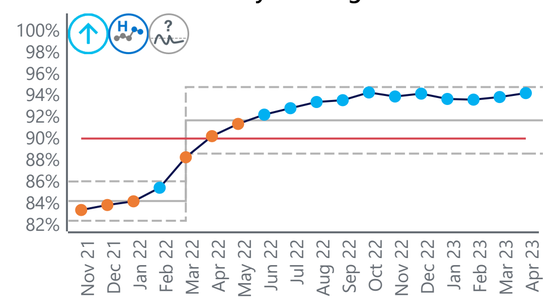
Staff Turnover



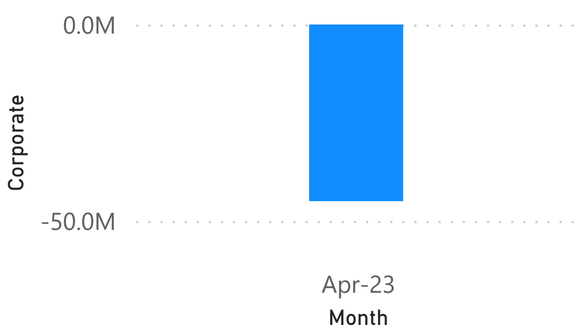
Sickness Absence (Total)



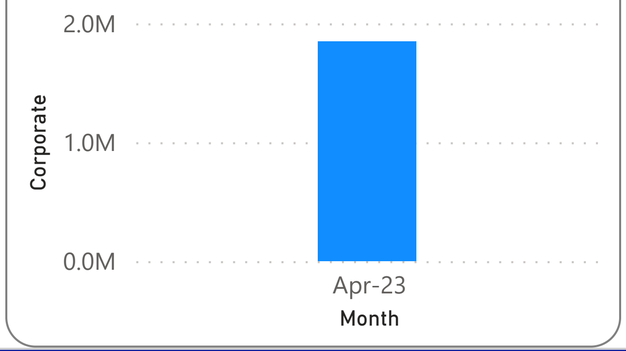
Mandatory Training



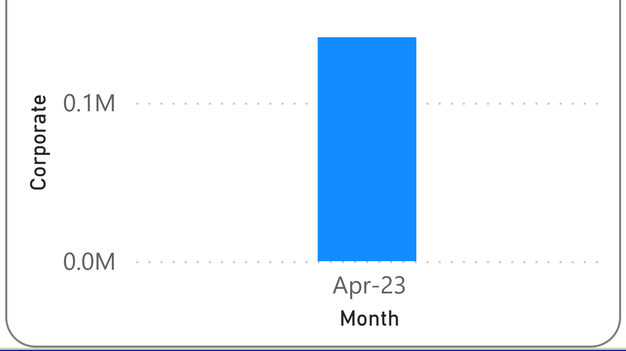
Revenue Position (Year End Forecast)



CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)

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Safe Staffing & Patient Quality Indicator Report
January 2023

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy		Turnover (Leavers)		Sickness		Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at Midnight	CHPPD Rate		RN - %	HCA - %	RN - %	HCA - %	RN - %	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	93%	-	98%	-	1928	**105**	18.36	13.45	5.08%	47.00%	0.00%	0.00%	2.85%	0.00%	4	4	0	0	5	100%	0	0
HDU	71%	106%	73%	96%	7916	**273**	29.00	29.01	5.17%	13.14%	1.36%	0.00%	10.50%	0.00%	5	5	0	0	1	100%	1	0
ICU	67%	86%	67%	13%	13706	**454**	30.19	29.01	7.21%	-130.26%	3.23%	0.00%	8.43%	49.19%	12	12	0	0	2	100%	0	0
Ward 1cC	89%	90%	89%	91%	7221	**576**	12.54	12.54	-3.20%	-21.01%	3.24%	0.00%	6.95%	10.46%	5	5	0	0	9	100%	0	0
Ward 1cN	65%	100%	65%	-	3149	**226**	13.93	13.93	6.90%	17.70%	0.00%	0.00%	9.90%	0.00%	2	2	3	3	2	100%	0	0
Ward 3A	88%	93%	95%	128%	8065	**834**	9.67	10.19	-4.57%	20.59%	0.00%	0.00%	7.80%	5.92%	5	5	0	0	32	96.9%	2	0
Ward 3B	83%	91%	92%	-	4652	**346**	13.45	13.39	-9.91%	-65.59%	0.00%	0.00%	7.23%	0.82%	0	0	3	3	4	100%	0	0
Ward 3C	94%	89%	86%	183%	8450	**840**	10.06	9.77	-1.52%	28.87%	1.75%	0.00%	8.14%	0.00%	2	2	0	0	14	92.9%	3	0
Ward 4A	77%	70%	81%	71%	7762	**725**	10.71	10.19	0.15%	8.11%	1.17%	0.00%	11.29%	0.99%	4	4	0	0	26	96.2%	2	0
Ward 4B	64%	83%	56%	89%	7714	**600**	12.86	11.48	9.49%	-4.08%	0.00%	2.90%	14.24%	12.27%	12	12	0	0	8	87.5%	0	0
Ward 4C	89%	113%	89%	94%	7318	**834**	8.77	10.98	-5.28%	18.05%	0.00%	0.00%	7.57%	14.40%	19	19	0	0	22	86.4%	0	0

The purpose of the safe staffing and patient quality indicator report is to provide a summary of overall Nursing & HCA staffing fill rates and Care Hours per Patient Day (CHPPD). Overall key concerns are areas where the staffing fill rate has fallen below 80% and to understand the impact this may have on patient outcomes and experience.

Medicine

Sickness has reduced across the medical wards in January, however ward 4B remains high at 14% with no themes. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention.

Ward 3B commenced an improvement workstream in September to focus and support staff wellbeing and retention. Newly recruited ward manager specifically focused on staffing and reducing sickness levels. Staffing above 80% and sickness significantly reduced in January.

4C has the highest level of medication incidents. However good reporting culture with most incidents near misses or no harm.

Surgery

Ward 1C Neo registered staffing levels were below 80% for January. This can be explained with sickness levels being unusually high and some vacancies. Staffing is overseen by Liverpool Women's Partnership Programme.

Ward 4A had 5WTE off on long term sick for a prolonged period. Ward 3A & 4A still have a high requirement for 1:1s which has required NHSP cover.

Critical Care

Following a successful recruitment day, several new nurses commenced in critical care in October but will be supernumerary for 4 months (till January 2023) and not included in numbers. From February all supernumerary nurses were included in the staffing numbers and staffing levels increased.

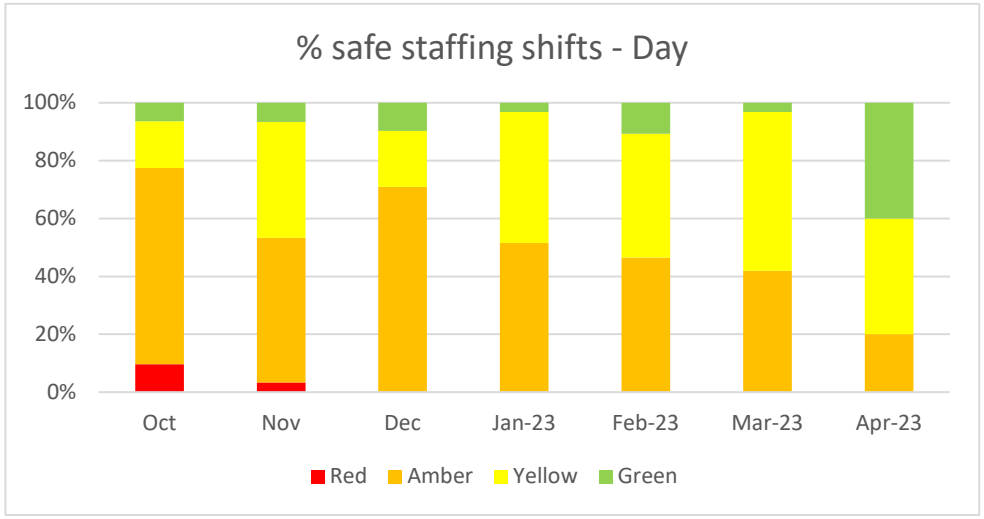
Summary

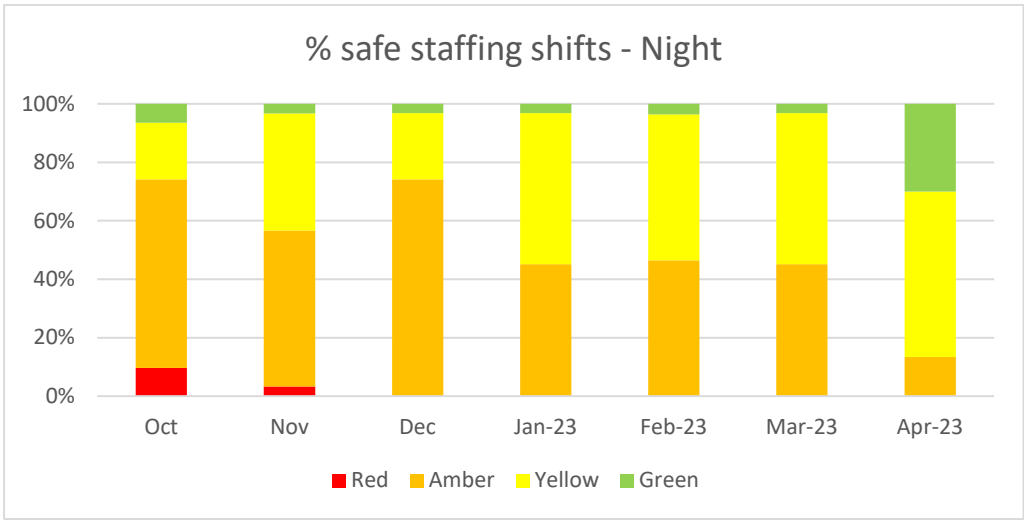
CHPPD benchmarks equally on most wards with the exception of Ward 4C. 4C was particularly busy during this period and were at full capacity with high acuity patients. Burns CHPPD remains higher than the national benchmark. This is explained by Alder Hey incorporating a day case clinic nurse with the unit and numbers.

During this period reported, staff moves on NHSP were not recorded on eRoster.

Summary of April staffing

Staffing rag has seen an increase in green days and nights. 0 red days have been recordered since November indicating an improvement in staffing levels.





Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 6 June 2023

Strategic Goals	2023-24 Operational Priorities	Progress in May 2023	Areas of challenge
Unrivalled Experience	**1. Deliver our Patient Safety Strategy**	• PSIRF presented to Trust Board • PSIRP out for consultation • On track with workstreams • Safety Board now assurance and improvement function	• Standardised assurance reports • Business case for PSI team
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Strategy Workshops to develop PIDs scheduled • Resource requirements discussed and partially supported	• Recruitment timeline will impact upon delivery of plan and potential cost savings • Full resource plan still in discussion phase
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• Recruited the first UK patient to an international lupus nephritis study • £128K secured from Roche to start the CAMEO study (investigating the acceptability of placebo minitablets) • £0.5 m grant secured from Innovate UK for 'living greens' nutrition study • Research Celebration Days • Fully appointed to the Clinical Research Division Leadership Team	• National decline in commercial research activity • Finalising 23-24 R&I Financial Plan • Development of the research strategy
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Old Catkin building is being demolished to clear the way for the Park • Pathway connection into Springfield Park established	• Lighting for MUGA outstanding from LCC • Foundations under Catkin more extensive than anticipated • Clearance of the site to allow park contractor to progress
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Sustained improvement in Emergency Department (ED) performance: 85% seen in 4 hrs in May. • Alder Hey ED ranked 6th (of 124) for Type 1 performance in a recent national assessment • Further improvement in access to diagnostics: 90% of tests undertaken within 6 weeks in May.	• Impact of junior doctor industrial action • Growing number of patients waiting >52 weeks in ENT. Progress made with the recovery plan, including agreement for additional patients in clinic, investment in in-sourcing capacity and three session theatre days.

		• Elective recovery 105% in May 2023	• Significant waiting times in neuro-developmental pathways (>65wks). Division planning a pathway stock-take and investment case is with commissioners.
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month deficit of £0.5m in May (M2) and £1.0m deficit YTD. This is in line with the plan • Financial awareness and training programme in progress and planned for launch in June • Redesign of Service Line Reporting system	• External requirements from NHSIE regarding the ICB system position. Increased scrutiny and spend restrictions for Trusts reporting adverse to plan positions. • 38% of recurrent CIP identified. Focus on transformational schemes to identify further savings.
Smartest ways of Working	**7. Safely deploy Alder C@re**	• 94% of new EPR built. • 57% of critical criteria signed off • Date agreed for go-live: 8- 11 September 2023 • 623 staff have booked in for training	• E-prescribing module: build on track (67%), awaiting final dates from Meditech on Priority 1 solutions from Meditech in June and July. • Specialty packages: 53% signed off. Target completion is end of June. • Reports: 54 reports completed against target of 80. Working with Meditech to resolve technical issues and exploring additional resources.

Integrated Performance Report | May 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -May 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for May
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**1**
		Number of Serious Incidents (Steis reported)	0	**1**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**x1 MSSA**
		FFT - % Recommending Trust	> 95%	**91.6%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	**14.5%**
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**On Track**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	**84.7%**
		Number of RTT Patients waiting >65weeks	0	**99**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,325**
		Elective Recovery (Vol)	> 100%	**105.7%**
		Diagnostic Performance	> 90%	**90.0%**
	Financial sustainability	Revenue position – Year End forecast	12.3m	**12.3m**
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	**On Track with risks**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June

Report of	Development Director
Paper prepared by	Interim Deputy Development Director Jayne Halloran
Subject/Title	Development Directorate Projects Update
Background papers	Nil
Purpose of Paper	The purpose of this report is to provide a Campus and Park progress update.
Action/Decision required	The Board is asked to confirm acceptance of the update and advise if reassurance has been provided.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	N/A

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development Report on the Programme for Delivery

June 2023

1. Introduction

The Development Programme is at a critical stage in June with a combination of actions to:

- Complete the campus development and the associated reinstatement of Springfield Park;
- Launch a range of new projects, principally the new Neonatal and PAU unit.

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Blue light route Delay and Cost Implications to Service Diversion Works	Road ready to be delivered once service diversions commence. Review of options undertaken to mitigate programme and cost pressures arising from the service diversion works issues. Further programme workshop planned. Focus of workshop is to look at alternatives to moving all services from under building with consequent 18week delay to programme and increase in cost. The result of the workshop will be incorporated into a paper for review at RABD.
Sunflower House	Fire Compliance; Sprinklers Water Safety Issues	Cause & Effect review of fire alarm completed. Engagement of industry specialists in progress. Pipework replacement completed in Sunflower House, and in progress within Catkin. Water test results continue to be monitored.
Elective Surgical Day Case	Confirmation of available space to accommodate Schedule of Accommodation (SOA). Full scope of works exceeds available budget.	Budget and scope review, led by Divisional senior leadership team supported by Development Team. Progress report to be presented June 2023.
Eating Disorder Day Case Unit	Current SoA cannot be accommodated within footprint of the building.	Agreement of phasing, final designs and budget.

	Full scope of works exceeds available budget.	Option appraisal to be undertaken by Development Team and Division; outputs/recommendations to be reported June 2023.
Main Park Reinstatement	Work Package Risks Affecting Phase 3 Reinstate Park.	Revised milestone dates to be assessed with Trust advisors and Beech. Mitigation plan to be developed.

3. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2022-2024 (financial years).

Table 1.	**22/23**				**23/24**			
Scheme	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Neonatal and Urgent Care Blue Light Route (BLR) & Service Diversions								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (Dec 2024)								
Sunflower House / Catkin Construction								
Sunflower House Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Police Station)								
Police Station Design								
Police Station Construction								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 2/3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Fracture / Dermatology								
Eating Disorder Day Case Unit (EDYS)								
Elective Surgical Day Case								

4. Project Updates

Neonatal and Urgent Care Development

Current Status	Risks/Issues	Actions/Next Steps
Delay and Cost Implications to Service Diversion Works.	Increased costs, delay to unit opening.	Further programme workshop planned.
Equipment transfer audit undertaken to assess new items required, and those deemed fit for transfer for the Urgent Care Centre.	Confirmation of charitable funding.	Requirements confirmed and costed. Draft charitable bid being developed by Division and Development Team.

Sunflower House Construction & Occupation

Current Status	Risks/Issues	Actions/Next Steps
Finalising contract position.	GT contract claim.	GT to propose their full and final account and programme.
Re-programming of staff attack system undertaken 16.05.23 to alert staff at Ground Floor as well as First Floor.	Operational readiness/staff safety.	Staff awareness briefing/SOP.
Temporary car park in operation following closure of the under croft.	Fire compliance; sprinklers.	Cause & Effect review of fire alarm completed. Engagement of industry specialists in progress.
Move 3 final occupation 17.05.23.	GT Snagging & Defects.	After Care 'huddle' established for the duration of the 12-month defect period.

Sunflower House Construction & Occupation (Continued)

Current Status	Risks/Issues	Actions/Next Steps
Re-programming of lighting as per NDTi recommendations completed 19.05.23.	Minor disruption within the unit.	Work alongside clinical team to coordinate.

Modular Office Buildings

Current Status	Risks/Issues	Actions/Next Steps
2 Storey Modular building (2SM) deemed not to be required. Staff currently occupying the former police station have been moved to vacant space in the 3 Storey Modular building.		
The Development Team has submitted a proposal to Executive Directors for the management of office accommodation across the site. This compromises three main phases, and will follow a process of consultation with Divisional and service leads. Proposals will be presented for consideration and approval.	Issue of clinical teams sharing space with other teams.	Assessment of recurring revenue costs.
Refurbishment of the former police station – progress has been slower than anticipated: • legal and lease issues remain outstanding, however, resolution expected imminently; • costs have been received from the main contractor, and subject to final clarifications, are within budget; • tender report issued with a view to final sign off; • contractors to commence early activities June/July subject to approvals, legals, receipt of letter of intent; • completion programme not yet agreed.	Incoming services and future proofing capabilities. Timescale for completion, potentially up to 24 weeks.	Workshop to develop options. Discussions on-going.

Park Reinstatement

Current Status	Risks/Issues	Actions/Next Steps
MUGA construction works complete.	LV power connection to Alder Road awaited to allow completion of light installation.	LCC to complete LV installation.
A meeting took place 23 May 2023 involving: Friends of Springfield Park (FOSP), Alder Hey and Liverpool City Council. The purpose of the meeting was to air all outstanding issues, update on progress and agree a way forward on working together. The main areas of discussion included: the present situation, the future of the park, key issues including lighting and to agree the date of a follow up meeting.	Resolution with LCC of details of lighting and drainage.	Follow-up sessions to track actions and improve communications.
Refinement of landscape works adjacent to East Prescott Road to ensure fit with FOSP areas	Any change will require planning amendment.	Share proposals for the soft landscape proposals with FOSP and the Council.
Demolition of the former Catkin building is now complete; however, this was delayed and is showing an impact of 4 weeks on programme.	Potential delay to smaller projects planned.	Revised milestone dates to be assessed with Trust advisors and Beech. Mitigation plan to be developed.

Mini Master Plan for Eaton Road Frontage

Current Status	Risks/Issues	Actions/Next Steps
Revised proposals presented at the 27.04.23 Executive Design Review were well received.	Budget to be identified for phases 2 &3.	Finance to confirm funding options.

Fracture and Dermatology Outpatients

Current Status	Risks/Issues	Actions/Next Steps
RIBA stage 2 information completed, and presented at 27.04.23 Executive Design Review. Initial phasing proposal developed. Staff consultation underway. Overall project programme and cost plan updated. Initial meeting held with Trust and the Special Purpose Vehicle (SPV). Plans, costings and programme shared to inform the tender package submission for appointment of a construction contractor.	Trust governance/sign off. Trust's ability to manage activity, and to provide safe access/egress routes for staff, patients & emergency procedures during works. Any costs to be identified. Timely appointment of a construction contractor.	Formal sign off. Initial assessment undertaken by the Division 26.05.23. Regular meetings. Close monitoring of critical risks.

Elective Surgical Day Case

Current Status	Risks/Issues	Actions/Next Steps
RIBA Stage 1 report developed: • Feasibility study to assess potential layout options and phasing. • Expansion space required to enable SOA to be identified. • Early assessment of affordability and budget pressures.	Layouts not yet agreed. Consideration of operational requirements e.g. site & welfare compound, capacity to manage the service during works, etc. Confirmation of available (expansion) space to accommodate SoA. Full scope of works exceeds available budget.	Budget and scope review, led by Divisional senior leadership team. Agree governance structure and escalation route. Progress report to be presented June 2023.

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. Community Liaison Officer appointed.	Loss of reputation, locally and regionally. Lack of engagement internally and externally.	Maintain links with community and support their development work. Community sessions active engagement programme using newly appointed community liaison team.

Eating Disorder Day Case Unit (EDYS)

Current Status	Risks/Issues	Actions/Next Steps
RIBA Stage 1 update: • High-level cost plan produced and reviewed with the senior leadership team. • Master site plan options identified for possible mitigation. • Leases and land ownership discussions progressing.	Current SoA cannot be accommodated within footprint of the building. Building condition unknown.	Agreement of phasing, final designs and budget. Option appraisal to be undertaken by Development Team and Division; outputs/recommendations to be reported June 2023. Condition surveys commenced w/c 22 May 2023, following Dewi Jones Unit move to Sunflower House.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 24th April 2023 at 13:30, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Deputy Director of Finance	(RL)
In attendance:			
	Audrey Chindiya	Business Accountant, Medicine	
	Ian Gilbertson	Assistant Chief and Information Officer	
	Emma Hughes	Acting Manging Director for Innovation	
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Graeme Montgomery	Business Accountant, Surgery	
	Andy McColl	Associate Chief Operational Officer, Performance	
	Jill Preece	Governance Manager **For items 05 and 09**	
	David Powell	Development Director	
	Clare Shelley	Associate Director Operational Finance	
	Mark Flannagan	Director of Communications	(MF)
	Gary Wadeson	Business Accountant	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda Item: 13	Jason Bradley	AlderC@re Strategic Advisor	
15	Graeme Dixon	PFI Manager	
18	Alex Pitman	Green Plan Programme Lead	

23/24/01 Apologies:

Erica Saunders	Director of Corporate Affairs	(ES)
Melissa Swindell	Director of HR & OD	(MS)
Jim O'Brien	Associate Development Director	
Kate Warriner	Chief Digital and Information Officer	(KW)

23/24/02 Minutes from the meeting held March 2023
The above minutes were approved as a true and accurate record.

23/24/03 Matters Arising and Action log
All actions had been included on the agenda.

23/24/04 Declarations of Interest
There were no declarations of interest.

23/24/05 Committee Effectiveness
JP went though the report noting conduct of this remit was achieved firstly through the Committee being appropriately constituted and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

Areas to focus on 2023/24 include role of Investment Committee monitoring performance through regular updates and agreed five areas of risk to be monitored.

Resolved:
RABD received and noted the Committee Effectiveness report 2022/23.

23/24/06 **Finance Report**

Month 12 Financial Position

M12: CS presented the draft M12 position and noted this may be subject to change following final review and any audit changes. Alder Hey achieved an in-month trading surplus of £2.0m in March which is £1.1m ahead of the planned financial position. For the year end position (M1-12) AH is reporting a surplus of £7.5m which is £2.8m ahead of plan and £0.3m improvement against the forecasted out turn position reported to Cheshire & Mersey ICB and NHSEI at month 11. CS highlighted key adjustments to income, pay any non-pay.

As reported last month, the Trust has now delivered the in-year CIP challenge of £17.3m with the full amount now transacted. However not all of the in-year CIP was identified recurrently therefore the recurrent gap of £5.4m remains and is factored into annual planning for 23/24.

JK thanked the team for the report noting the clear changes on variances.

Resolved:

RABD received and noted the M12 Finance report.

22/23/07 **Month 12 Integrated Performance Report**

AB presented the IPR and highlighted:

- No clinical incident outcome was reported during the Junior Doctor strikes held in April 2023.
- Rising number of patients waiting over 52 weeks, caused by the cumulative effect of industrial action and a capacity deficit in ENT.
- Improving access to diagnostic tests, within 84% now completed within 6 weeks.
- Surgery and Medicine are working through the back log of clinical letters.

Resolved:

M12 IPR report was received.

22/23/08 **23/24 Financial Planning**

RL gave an overview of the current position noting Cheshire and Merseyside had submitted plans as requested at the end of March 2023. AH submitted a £2m surplus. As none of the system plans were accepted a second round of planning submissions has been requested by 2nd May 2023.

All Trusts are being asked to improve on plans. AH is reviewing its position in line with the system ask to support the overall position for 23/24 and it is likely the surplus will be increased further to support on a non recurrent basis which could result in a £10m surplus for 2023/24.

RL noted a number of options and agreed to keep members updated.

Resolved:

RABD received the current position noting a second increase submission had been requested on 2nd May 2023.

23/24/09 **To agree Top Risks for 23/24**

The top five key areas for RABD focus 23/24:

- Immediate financial performance – outturn, capital and cash
- The Cost Improvement plan in the context of the National financial constraints
- Benefits realisation, governance and prioritisation of change programme to 2030
- Alderc@re implementation

- The campus & Park developments

Going forward it was agreed quarterly meetings would be held face to face with deep dives on divisional performance.

Resolved:
RABD APPROVED 5 top areas of risk for 23/24 and face to face quarterly meetings going forward.

23/24/10 CIP

The Trust has now met the in year target of £17.3m in full however has reported a shortfall of £5.4m against the recurrent target.

Focus continues on schemes as part of 23/24 annual planning, A further update will be presented next month.

Resolved:
RABD received and noted CIP 22/23 had been met with 23/24 annual planning in place.

23/24/11 5 Year Cash Flow Forecast

EK presented the above paper noting a downside and upside cash flow forecast had been modelled, the assumptions in both of these scenarios will evolve and be updated throughout the year and reported back to committee.

Resolved:
RABD received a 5 year cash flow forecast noting the base case model shows the cash balance is likely to move from £83.5m in March 2023 to £46.1m by March 2028, with the balance decreasing to £20m in the downside model, and £76.6m in the upside model.

22/23/12 Campus update

DP highlighted key risks within the campus update paper

Neonatal Project: An update was received on the delay to building work start day and potential cost increases.
Sunflower House: Test results are awaited in relation to water compliance, move in date has been delayed.

Resolved:
RABD received the monthly update in relation to the Campus.

22/23/13 Aldercare

IG and JG presented the report to the committee and highlighted:

- Go live date has been confirmed for Sunday 10th September 2023.
- Continue build of the system and preparation for formal testing
- The simulation hub on the Mezzanine was launched on the 21st of March.
- Begin the detailed cutover planning in conjunction with service managers and MEDITECH including training plans
- Action the work off plan for Gateway 2 scheduled for the end of March 2023 and prepare for Gateway 3 at the end of May.

Resolved:
RABD received the monthly update on Aldercare.

22/23/14 Digital Strategy update

IG gave a summary noting progress with digital developments and delivery at Alder Hey remain good and on track against plans. There are several challenges however all have mitigation plans in place. Performance of operational key performance indicators are good

22/23/15 PFI – Building report

GD highlighted:

- General performance from Mitie was good in March achieving 99% PPM compliance.
- Energy consumption for the month of March was 14% over the monthly contractual target and 6% over the annual.
- Following on from last year's Merseyside Fire and Rescue visit, March saw the first of a series of best practice visits to allow familiarisation and a view of a high compliance estate.

Resolved:

RABD received the monthly update on PFI.

22/23/16 Board Assurance Framework

Resolved:

RABD received an update on BAF risks noting a review for 2023/24.

22/23/17 Green Plan

AP noted Alder Hey carbon emission 2022/23 was 9,567 CO2e tonnes. Scope 1&2 carbon has reduced by 17% year on year driven by reduced energy usage, lower nitrous gas usage and repairs to our chiller systems. We report electricity at "grid average" and this improves as we add more renewables to the grid.

Resolved:

RABD noted Carbon emission 2022/23.

22/23/18 Energy Procurement

AP presented the above paper asking for approval to purchase 50% of winter energy now at a fixed price, reducing the risk of changes later in the forecast.

Resolved:

RABD APPROVED the request to purchase 50% of winter energy.

22/23/19 Terms of Reference

Resolved:

RABD APPROVED Terms of Reference.

22/23/20 Business Cycle

Resolved:

RABD agreed quarterly meetings would be held face to face with deep dives on divisional performance.

22/23/21 Any Other Business

No further business was reported.

22/23/22 Review of Meeting

The Chair noted going forward divisional performance would be presented.

Date and Time of Next Meeting: Monday 22nd May 2023, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	Use of the Mental Health Act (1983 & 2007)
Report of:	Lisa Cooper Director Community & Mental Health Service
Paper Prepared by:	Dr Andrew Kevern Consultant Child & Adolescent Psychiatrist Mental Health Act Lead

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:	None identified

1. Report Purpose

The purpose of this paper is to provide assurance to Trust Board regarding activity in relation to use of the Mental Health Act (1983 & 2007) (MHA) for the reporting period 01 April 2022 – 31 March 2023.

2. Introduction

There are several different legal frameworks under which Alder Hey treats children and young people aged 0-18 years, which have been determined by Statute and Case Law.

Most children with physical disorders are treated under their own consent if they are Gillick Competent, that is if they have enough intelligence and understanding of the decision to be made; or under Parental Consent if the decision is within the Scope of Parental Responsibility and if parents are believed to be acting in the best interests of the child.

The Scope of Parental Responsibility has some limitations clarified by the Mental Health Act Code of Practice and some limitations clarified by Case Law. Otherwise, there must be a decision made over whether the consent is ‘a decision that a parent should reasonably be expected to make’ in relation to medical care of their child.

In practice children and young people are detained under the Mental Health Act if they have a mental disorder and require hospital treatment and:

1. Require deprivation of their liberty significantly beyond age-appropriate levels of parental supervision such as the use of a seclusion room or restraint to prevent absconsion

2. Require deprivation of their liberty and the local authority has acquired ‘parental responsibility’, as the local authority cannot consent to a deprivation of liberty

3. Refuse admission and/or treatment and are Gillick competent or aged 16+

4. Require repeated intrusive treatments such as restraint for intramuscular injections if they are extremely agitated and putting themselves and others at risk and after all alternative interventions have failed or such as requiring restraint for nasogastric feeding if they have an eating disorder

Children and young people are detained for a period of assessment and treatment (Section 2: up to 28 days) or for a period of treatment (Section 3: up to 6 months). Children and young people can challenge any of these decisions by appealing to a Mental Health Tribunal or to the Independent Associate Hospital Managers. Children and young people have access to the support of an Independent Advocate who will assist them to appeal.

Children and young people may be brought to the Emergency Department by Police under Section 136 of the Mental Health Act. The Emergency Department is a designated place of safety for those children and young people who appear, to a police officer, to be suffering from a mental disorder and to be in immediate need of care or control. Once in the Emergency Department these children and young people will receive a mental health assessment which may result in detention under Section 2 or 3 of the Mental Health Act.

Children and young people may be detained to Alder Hey or from Alder Hey to another hospital on the recommendations of two doctors and an Approved Mental Health Practitioner (AMHP). If children and young people are being sectioned to another hospital, then the detention starts on arrival at that hospital, and they are recorded in the destination hospital's figures and not the Trust's.

Children and young people may be discharged from hospital on a Community Treatment Order (CTO) These are children and young people who have been detained on a Section 3 and the Section is put aside to allow discharge with some conditions. If those conditions are not complied with the section can be reinstated (recall)

The Mental Health Act (1983 & 2007) authorises the Trust to deprive children and young people of their liberty to assess and treat a mental disorder. The Mental Capacity Act (2005) authorises the Trust to deprive adults (>18) of their liberty to manage a physical disorder. A Family Court or Court of Protection deprivation of liberty order authorises the Trust to deprive children and young people (<18) of their liberty to manage a physical disorder or to keep them safe. All qualifying children and young people have access to Independent Mental Health Advocacy (IMHA) in line with the Act. The provider, "Real Advocacy" is a specialist Tier 4 Mental Health Advocacy Service that works in close liaison with the Tier 4 and Paediatric Wards when children and young people are detained under the Mental Health Act.

To support both the increase in young people detained under the Mental Health Act and ensure that the legal and statutory administrative processes related to the use of the Mental Health Act are followed correctly, a service level agreement with Merseycare NHS Foundation Trust is in place. This service level agreement supports the complex administration of the Mental Health Act, facilitates the review of appropriate Trust policies, and promotes effective staff training in relation to the Mental Health Act.

3. Detentions under the Mental Health Act

For the reporting period 01 April 2022 – 31 March 2023, the Trust had **17** children and young people detained under a section of the Mental Health Act. This is an increase compared to 2021/2022 when **12** children and young people were detained under a section of the Mental Health Act. This increase is due to an increase of children and young people with an eating disorder requiring detention to a paediatric ward for refeeding as part of their overall treatment plan.

Table 1 shows the breakdown of children and young people detained under the Mental Health Act for the reporting period compared with previous years. The sections of the Mental Health Act used are shown in **Appendix One**.

Table 1: Annual detentions under Mental Health Act

Location	2020/2021	2021/2022	2022/2023
Tier 4 In patient Unit	2	2	2
Paediatric Ward	3	3	7
CTO	0	2	1 (Tier 4)
CTO recall	0	0	1
Section 136	2	5	6
Total	**7**	**12**	**17**

4. Deprivation of Liberty Order Safeguards

In relation to those aged 18 years or over, the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in April 2009, as part of the implementation of the Mental Capacity Act 2005, to ensure better legal and administrative protection for all those who may, for whatever reason, lack Capacity to consent to the care they are receiving, including where they live and how they are cared for on a day to day basis.

Prior to the Mental Capacity Act, there was a lack of clarity about how the liberty and human rights of those lacking capacity to consent to their care arrangements, including where these restricted their movement and choices, should be protected. The bulk of people whom the Act was intended to help had serious disabilities including those arising from dementia, learning disabilities and serious mental health problems.

The DoLS regime only applies to hospitals (NHS or private) and care homes (registered with CQC). In any other type of placement, deprivation of liberty can only be authorised by an order from the Court of Protection. If there is no authorisation in place, then a deprivation of liberty is unlawful.

Three factors determine deprivation of liberty under Article 5 of the European Convention on Human Rights:

1. The objective element: i.e. that the person is confined to a particular restricted place for a non-negligible period of time
2. The subjective element, i.e. that the person does not consent (or cannot, because they do not have the capacity to do so) to that confinement
3. State imputability: i.e. that the deprivation of liberty can be said to be one for which the State is responsible.

The statutory framework of the Deprivation of Liberty Safeguards (DoLS) does not apply to those under 18 years of age. For under-18s, a legal framework must be placed around the arrangement to ensure that the deprivation of liberty is lawful.

A deprivation of liberty will be lawful if warranted under statute, for example, under

- Section 25 of the Children Act 1989 (placement in secure accommodation)
- Mental Health Act 1983

- Youth remand provisions of the Legal Aid, Sentencing and Punishment of Offenders Act 2012
- Custodial sentencing provisions of the Power of Criminal Courts (Sentencing) Act 2000

Where the deprivation of liberty is not authorised by statute, then the appropriate consent must be obtained, either from the Court of Protection or from the High Court exercising its inherent jurisdiction:

- Children/Young People Under the Age of 16 - the Mental Capacity Act 2005 does not apply to those under 16 years; therefore, application must be made for authorisation under the inherent jurisdiction of the High Court.
- Children/Young People Aged 16 and 17 - the Mental Capacity Act 2005 applies. An application must be made to the Court of Protection.

Table 2 below shows the number of Deprivation of Liberty Order Safeguards applications made for the reporting period compared to previous years.

Table 2: Applications for Deprivation of Liberty Order Safeguards

Applications	2020/2021	2021/2022	2022/2023
Urgent DoLS applications	11	11	4
Standard DoLS applications	3	2	11
Court of Protection	0	1	0
Total	**14**	**14**	**15**

5. Mental Health Act Training

Currently Mental Health Act training is required for the following areas on an annual basis: Specialist Mental Health Services, Ward 4C and Emergency Department. Training compliance for these identified areas within the Trust is shown in **Table 3** for the reporting period.

Table 3: Mental Health Act Training Compliance

Service/Ward	Mental Health Act Training Compliance
Specialist Mental Health Services	94%
Ward 4C	93%
Emergency Department	92%

In addition, to annual Mental Health Act training, Merseycare provide training regarding Mental Health Act paperwork and administration to appropriate staff across the Trust as part of the service level agreement.

6. Independent Mental Health Advocacy Service

An Independent Mental Health Advocate (IMHA) is a specialist advocate. The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act. This gave legal rights to IMHAs which are not available to other advocates. These rights mean that IMHAs may:

- Meet qualifying children and young people in private
- Consult with professionals concerned with the child or young person's care and treatment
- See any records relating to the child or young person's detention, treatment, or after-care, for the purpose of providing help to the child or young person and where the child or young person consents
- Request access to records where the child or young person lacks capacity to consent, if accessing the records is necessary to carry out the functions as an IMHA.

IMHA services are independent, confidential, and free of charge to the child or young person and whilst they do not have to accept help from an IMHA they can change their mind at any time, as such this service should be promoted to children and young people detained under the Mental Health Act. Alder Hey commissions "Real Advocacy" to provide advocacy support to children and young people detained under the Mental Health Act within the Tier 4 Childrens Inpatient Unit and acute paediatric wards.

For the reporting period there were **5** children and young people referred for advocacy support from the Trust's Tier 4 Childrens Inpatient Unit and **10** children and young people referred from Ward 4C.

Issues discussed with children and young people who required advocacy support included:

- MHA Rights
- Support to appeal detention
- Representation of views to care team
- Liaison with CSC in relation to placement
- Representation in Ward round meeting
- Request for medical records
- Request for information about discharge requirements
- Time off the Tier 4 Children Inpatient Unit
- S117 Aftercare rights
- CETR process
- Observation levels
- School visits
- Medication
- Support within CPA meeting

In addition, the Advocacy Service liaised closely between the clinical teams on Ward 4C, Eating Disorders Team and the Mental Health Act office (Merseycare) to ensure that young people detained to the acute paediatric ward have timely access to an IMHA and that in the event of an appeal this is processed swiftly. The Advocacy

Service has also provided training to Ward 4C staff on the role of advocacy and will continue to provide this on a quarterly basis.

There were no safeguarding incidents requiring involvement from the Advocacy Service during the reporting period and no formal complaints or concerns raised from the children and young people referred to the service. There were no complaints or compliments raised regarding the Advocacy provider during the reporting period.

7. Next Steps

The Trust Board are asked to note the contents of this report and be assured that the Trust has in place robust arrangements to deliver the appropriate requirements of the Mental Health Act (1983 & 2007) and is responsive to the needs of children and young people for whom this applies.

Appendix One: Definitions of sections of the Mental Health Act

Section of Mental Health Act	Definition
Section 2	The criteria for detention under Section 2 of the Mental Health Act 1983 (2007), is if a person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment and possibly medical treatment for a limited period of 28 days. The assessment will be completed by 2 doctors and an Approved Mental Health Practitioner (AMHP). This section can only be extended if an application is made to the county court on specified grounds for an acting nearest relative to be appointed (s.29(4)) or if the patient has been AWOL and returned to the hospital before the section expires. Otherwise, a further assessment will take place for a Section 3 if treatment is still required and is not available in the community.
Section 3	The criteria for detention under Section 3 of the MHA is if a person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital. Alternative means of treatment must have been considered prior to the decision of detaining in hospital. The section is valid for up to 6 months and can be renewed by the Responsible Clinician (RC) for a further 6 months. After this, it can be renewed for a period of up to 12 months at a time however the RC has the power to discharge at any time.
Section 136	Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety and for detention there to allow for a MHA assessment. Alder Hey Emergency Department is a designated place of safety for children.
Community Treatment Order (CTO)	The purpose of a CTO is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery. The principles, in treating patients using the least restrictive option and maximising their independence; and purpose and effectiveness should always be considered when considering CTOs.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Brilliant Basics Update**
Report of:	**Nathan Askew, Chief Nurse, Brilliant Basics SRO**
Paper Prepared by:	Jennie Williams, Head of Quality Hub

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Summary / supporting information:	This report provides assurance on the progress of the Brilliant Basics Delivery Plan 2023/2024.
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

1. Introduction

The aim of this paper is to provide Trust Board assurance and oversight of the Brilliant Basics (BB) Delivery Plan 2023/2024. The plan details the key milestones that will support the development of a culture of continuous improvement.

80% of milestones are on track, 20% (n=3) are undergoing further A3 thinking – problem solving to ensure the plan will address the problem. Mitigating actions are in place and detailed in the paper.

There are **no risks or issues** to identify to Board. Programme governance assurance is **rated green** in all areas.

The oversight is managed through the Brilliant Basics Friday Forum that meets monthly and reports into Strategic Executives bimonthly. This allows for discussion, alignment and shared accountability.

The key message highlighted in this report is: -

- Progress is in line with approved Brilliant Basics Delivery Plan

2. Background and current state

Trust Board approved the BB Delivery Plan (March 23). Table 1 outlines the objectives, key outcomes, and measures for each of the workstreams.

Table 1: Plan on a page

VISION	OBJECTIVES	DELIVERED THROUGH		KEY OUTCOMES	MEASURES
Small Changes, Big Improvements, Healthier Futures.	To develop Brilliant Basics routines and leadership behaviours that are role modelled by the Board and cascaded throughout all levels of the organisation.	Leading	Leader Standard Work Leadership Behaviours	• A shift from command and control to humility and coaching style • Creating time for improvement • Direct reports who know how to 'do the work' and how to improve	**DRIVER** Percentage of staff who feel they can make improvements in their work. • Leadership behaviours maturity • Leader standard work; process confirmation and impact statements • 16 teams coached • Evaluation of delivery of learning • Maturity assessments of frontline teams who have been coached • Impact and outcome of CYP&F Involvement • 12 case studies that evidence impact • Ward to Board reporting using BB progress summary • Maturity of Divisional routines
	An integrated learning and development programme to build capacity and capability for Brilliant Basics tools, routines and behaviours across the organisation.	Learning	Online learning Coaching	• Agile delivery options for all Brilliant Basics Learning • Teams that are empowered to make improvements	
	Deliver the strategic objectives at every level in the trust utilising the Brilliant Basics routines and behaviours.	Delivering	CYP&F Involvement Ward to board BB routines	• CYP&F involvement in strategic objectives • CYP&F Rights Based Approach in practice • BB routines with standard work clearly supporting performance and improvement	

This paper provides an update on progress to date; high level information on milestone progress can be found in Table 2 below. Further detail on each workstream, including actions completed and planned next steps can be found in Appendix 1.

Current state

Table 2 below provides high-level current state on progress of programme milestones.

Milestones that are rated amber have mitigating actions in place which can be found in the text below the table. The most recent Programme Management Assurance has rated the delivery as green and effective mitigations and controls are in place for the milestones rated as amber.

Table 2: Current Milestone progress

Workstream	Milestone	Progress Rating*
Leading	Executive Leader Standard Work (LSW) Review	
	Board Development Plan	1
	Leadership Maturity	
	Divisional LSW	
Learning	Online learning resource	
	BB approach to support strategy deployment	
	Leadership for Improvement offer	
	Teams coached through BB (16)	
	SharePoint site development	2
	Health Inequalities embedded in learning	
Delivering	BB in the DNA of the organisation	
	CYP&F Involvement in Strategy and BB waves	
	Rights of the Child Approach; implementation in clinical areas	3
	Alignment of priorities through BB cascade	
	Divisional Routines to manage performance and improvement	
	BB approach utilised in PSIRF	

*Key: Green = on track. Amber = further development underway

Mitigating actions for the three milestones rated amber are:

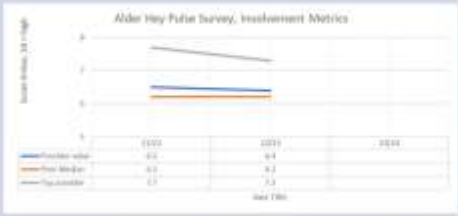
1. BB principles and approach will be embedded into the governance structures which will support the delivery of the 2030 Vision as well into our Strategic Initiatives.

2. Action plan being developed. Site content and functionality changes planned.

3. A3 thinking review with Youth Engagement Lead to ensure key actions address the problem/opportunities identified and that measures for improvement are established from the outset in order to establish impact.

Table 3 below details progress against driver and watch metrics.

Table 3: Progress of Driver and Watch metrics.

We are data driven to inform change and demonstrate improvement					Analysis and Insight: what does the data tell us?
Driver	**Current**				**Insight**
NHS Staff Survey Involvement Question: The degree to which staff feel that they are involved in making improvements within their organisation **Target** Brilliant Basics will **contribute** to increasing the numerical value of this survey result.					**What the data tell us:** Over the preceding 2 years, when this metric was available, Alder Hey has maintained a result that is mid-high quartile 3 compared to national providers and a provider value that is higher than peers. When compared to the provider that scores top for this metric, in the most current data Alder Hey are 0.9 of a point lower but over the preceding 2 years have maintained a more consistent provider value. This data will be updated in line with national reporting frequency; end of quarter in the pulse survey and annually in the NHS staff survey. *Data source: Model Hospital. Comparator: Staff survey benchmarking group. Category: Involvement (Q 3D,E,F) Analysis: 0=low, 10=high.
Watch	**Target**	**YTD (current)**	**Measured how**	**On / Off Track**	**Insight**
Impact and outcome of CYP&F involvement	Strategic and local level	Both in motion	Case studies		Link to video describing progress to date here
Leadership maturity	TBC	TBC	Maturity assessment		A review is underway as part of the planned Executive Leader Standard Work assessment. This will be completed by end of Q1 in line with original milestones.
16 teams coached	16	4	Local database		4 team completed wave 5 recently. Over 10 teams in pipeline. This measure will include a combination of previous teams and new teams as part of sustainability work the QH team are undertaking.
Evaluation of delivery of learning	5 out of 5	4.9 out of 5	Learning evaluation		All learning provided by the QH team continues to evaluate consistently highly.
12 case studies that evidence impact over 12 months	12	2	Case studies		Two case studies – pre-op team and SEND team – evidence positive impact BB is making to staff and CYP&F.
Maturity of Divisional routines	TBC	TBC	Divisional Maturity Assessment		BB plan in Q1; to understand current routines for divisional improvement priorities. A baseline of maturity and any initial progress will be available from Q2 onwards.

3. Conclusion

This paper provides assurance on consistent progress to date against BB Delivery Plan milestones and mitigating actions where milestones have been identified as requiring further management control.

4. Recommendations & proposed next steps

Recommendations are:

- Note progress in line with the approved BB Delivery Plan
- BB team to continue with mitigating actions of amber milestones
- BB team to continue with delivery
- Trust Board to continue to receive quarterly updates for information and assurance

ENDS

Appendix One – Workstream Updates

Summary Progress Report (Page 3): Leading for Improvement

Presented by: John Grinnell — Alder Hey Children's NHS Foundation Trust

Workstream Objective

To develop Brilliant Basics routines and leadership behaviours that are role modelled by the Board and cascaded throughout all levels of the organisation.

Actions completed

A3 thinking: Data collection on current state of Executive Leader Standard Work complete

Shadowing divisional routines for progression and management of divisional improvement priorities (clinical divisions)

Actions planned

Smart Action	Owner	Due date
Executive Leader Standard Work (LSW) review outcome presented to BBFF (Brilliant Basics Friday Forum)	Jennie Williams	26/05/23
Executive LSW next steps paper for discussion at Strategic Execs meeting	Jennie Williams	June 23
Establish new governance approaches, aligned to BB principles.	Exec	
Leadership requirements A3 thinking complete and presented to BBFF	Jennie Williams	June 23
Assessment of LSW requirements and discussion with Divisional Leadership Teams	Jennie Williams	July 23

Escalation

None in this reporting period

Summary Progress Report (Page 4): Learning for Improvement

Presented by: Melissa Swindell — Alder Hey Children's NHS Foundation Trust

Workstream Objective

An integrated learning and development programme to build capacity and capability for Brilliant Basics tools, routines and behaviours across the organisation.

Actions completed

A3 thinking: Maturity and sustainability of BB in practice. Progressing with testing change ideas.

4 new teams completed wave 5 BB and celebrated all of their achievements.

Actions planned

Smart Action	Owner	Due date
Sustainability review completed and change ideas evaluated	Lesley Dooley (QH)	July 23
Leadership offer for Strong Foundations designed	Lesley Dooley (QH)	July 23
Plan for BB approach to support strategy delivery at frontline complete	JW/NP	June 23
Recruitment to wave 6 to align Divisional improvement priorities with BB tools and routines	JW/LD	August

Escalation

None in this reporting period

Summary Progress Report (page 5): Delivering Improvement

Presented by: Adam Bateman — Alder Hey Children's NHS Foundation Trust

Workstream Objective

Deliver the strategic objectives at every level in the trust utilising the Brilliant Basics tools, routines and behaviours.

Actions completed

Categorised and prioritised change ideas for BB to become part of the DNA of Alder Hey.

Children, Young People and Families continued involvement in 2030 strategy development

Actions planned

Smart Action	Owner	Due date
Paper to PAWC on BB approach being embedded in routine processes	JW	July 23
A3 thinking to develop align CYP Rights based approach	Jess Robinson	July 23
Alignment of frontline teams use of BB to directly support divisional priorities	JW	September 23
Assessment of Divisional routines to drive improvement priorities completed	JW/LD	July 23

Escalation

None in this reporting period

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 30th April 2023
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Summary / 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:	To note ☑ To approve ☑
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None identified

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidents that are considered as serious incidents following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st – 30th April 2023.

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 Trust's weekly patient safety meeting and where appropriate a root cause analysis (RCA level 2) investigation is instigated.

Outcomes and oversight of SIs are currently considered at Divisional Assurance Boards, and Safety and Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. Moving forward oversight and learning from SIs will also be considered at the Trusts Patient Safety Group . The Trust Board receives a monthly summary report.

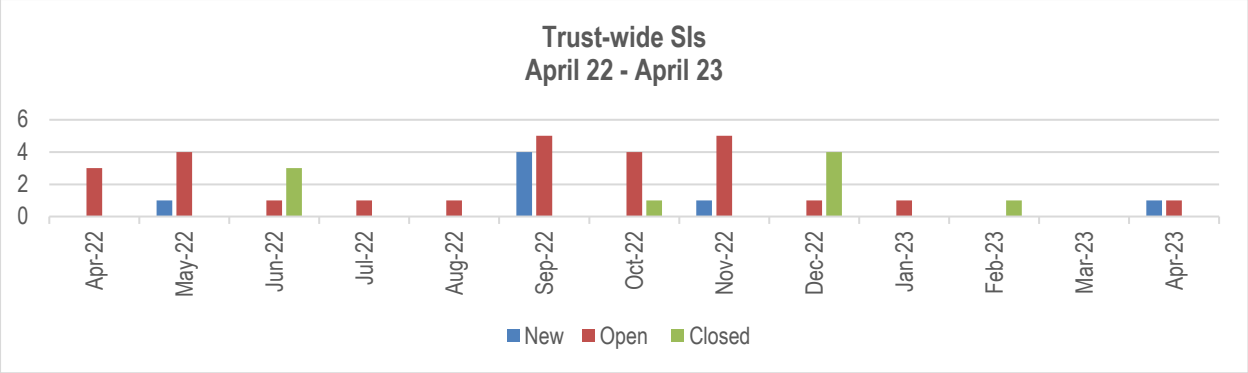
3. Local context

3.1 Never Events

The Trust declared **0** Never Events during the reporting period (1st – 30th April 2023).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status April 2023



3.2.1 Declared Serious Incidents

The Trust declared 1 StEIS incident during the reporting period (1st – 30th April 2023) see table 1 for detail

3.2.2 Open Serious Incidents

1 SI was open during the reporting period as outlined in table 1.
0 SI investigations were completed in this reporting period (1st – 30th April 2023).

Table 1 Open SIs April 2023

StEIS reference	Date reported	Division	Incident	Summary
2023/7350	10/03/2023 (reported to StEIS (06/04/2023)	Medicine	Patient triaged to Urgent Treatment centre (UTC) GP stream with watering left eye. Seen by Go to Doc, discussed with ED Senior Doctor and discharged home with oral antibiotics. Returned 6 hours later with swollen eye and signs of orbital cellulitis. Required emergency theatre overnight for drainage of collection.	Refer to appendix 1

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 30th April 2023), there were **2** SI action plans, of which:

- **1** SI action plan is within their expected date of completion.
- **1** SI action plan was completed and closed.

Full details of the SI action plan position can be found at appendix 2.

3.3 Internal level 2 RCA Investigations

The Trust declared **zero** internal level 2 RCA investigations during the reporting period (1st – 30th April 2023).

3.4 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.

3 initial Duty of Candour responses were required and completed within expected deadlines during the reporting period (1st – 30th April 2023).

4. Learning from serious incidents

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

SI action plan completion is monitored internally via divisional processes and patient safety group to ensure barriers to completion are addressed and learning is embedded across the organisation as required. Immediate lessons learnt from all SIs are outlined in appendix 1.

1 SI action plan was completed during the reporting period (1st – 30th April 2023). Immediate lessons learnt from all SIs are outlined where applicable in this report.

The main theme identified from the completed SI action plans were:

- Failure to follow systems & process
- Human error

Further detail of actions to address findings is outlined in in appendix 3.

Recommendations

The Trust Board is asked to note the contents and level of assurance provided in this report.

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/ 7350	Clinical discretion resulted in a decision to treat patient with oral antibiotics for periorbital cellulitis rather than orbital cellulitis.	Clinical documentation noting consideration for diagnosis of orbital cellulitis being made but the relevant treatment plan (when following the ED guidelines) was not undertaken, due to clinical discretion to treat as mild periorbital cellulitis.	ED orbital cellulitis guideline has been reviewed by the ED team and felt that the word “fever” should not be included in the flow chart column. Ensured all pathways in ED handbook are readily available on all computers in the UTC and staff are aware of how to access. ED Sepsis Nurse/ID Consultant/Sepsis Lead to review both attendances by patient to ED to ensure sepsis status was correct. **April 2023:** RCA panel to be arranged with expert input from external ophthalmologist as subject matter expert .

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Extension date agreed by commissioners	Number of extensions
2022/19971	14/09/2022	16/09/2022	Surgery	Never Event – retained foreign object post procedure.	6 Completed	31/01/2023	31/05/2023		3
2022/23391	10/08/2022	02/11/2022	Research	Never Event – wrong side biopsy.	30 1 action outstanding (Undertake audit)	30/09/2023			0

Appendix 3

Learning from SIs		
StEIS reference	**Theme**	**Learning and Actions**
2022/19971 Never Event – retained foreign object post procedure.	Failure to follow systems & process	Final instrument checks not completed due to human error. Report shared with team
2022/ 23391 Never Event – wrong side biopsy.	Failure to follow systems & process	Undertake a documentation audit of muscle biopsies to assure that the recommendations and learning from this RCA have been implemented. The audit should include: a) Theatre lists to assure side and site of all muscle biopsies now routinely included b) Ambulatory orders to assure side and site of all muscle biopsies now routinely included c) Consent forms to assure side and site of all muscle biopsies routinely included d) Consent forms to understand the frequency, prevalence and circumstances of consent form stating *"site to be determined"* e) Site Marking Verification Forms correlate with consent form f) Surgical Safety Checklist correlate with consent form

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing and Deputy Director of Nursing
Subject/Title:	Nursing Workforce Report 2022/2023
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 • 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 • 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 • 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

	• 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 Board of Directors of proposed workforce improvements in 2023/24
Action/Decision Required:	The Board of Directors are asked to approve the following: 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 report for 2021/22, 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 for the first time the attrition rate of nurses offered employment at Alder Hey was zero in 2022/23 meaning that all of the nurses we offered a post to took up employment in the Trust; this is extremely positive and significantly lower than the national average.

In the last financial year of 2022/23, 153.2 WTE Band 5 Registered Nurses have been recruited through local, national and international campaigns; 82.2 WTE through national recruitment and 71 WTE through international recruitment. This is the highest number of front line nursing staff recruited since reporting in this format commenced in 2016

In addition, the Trust successfully recruited to key senior nursing leadership posts in 2022/23, including the new role of Deputy Director of Allied Health Professionals, and Heads of Nursing in the Emergency Department and Community.

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 2023, the Trust had 13.56 WTE Band 5 vacancies which are mainly aligned with PICU and Ward 4C. 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 34.6 WTE staff on maternity leave. Sickness absence rates remain high with an average of 20.1 WTE staff on long term sickness, and an average of 22.4 WTE staff on short term sickness with a spike of 33 WTE in December 2022.

The Trust's mandated monthly submission of staffing levels to NHS website was 80% overall for 2022/23 which is below the nationally accepted level of 90%; in 2022/23 the Trust fully implemented an electronic submission of the data through the e-roster compared to a previous manual process. The staffing number does not include international recruits who work at Band 4 until receipt of their NMC PIN number therefore staffing levels often overall higher than reflected in the percentage position. The Trust benchmarked positively with comparator organisations for Care Hours per Patient Day (CHPPD) with the exception of Ward 4C. The Trust utilised temporary staffing where possible to address staffing pressures. 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 2022/23 decreased to a pre pandemic average rate of 6.2 WTE per month. The Trust is focusing on retaining the nursing workforce and a Nurse retention lead has been appointed for 12 months.

A review against the RCN standards was repeated which has demonstrated improved compliance with all core standards now rated as compliant. This is due to the approval of a business case to fund a supranumery clinical co-ordinator on Ward 3C and Ward 4C. The Division of Surgery are adjusting establishments where some areas may be over established to fund a supranumery co-ordinator on Ward 3A.

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 2023/24 and continued implementation of the Nursing and Health Care Support Worker Workforce Plan 2021-2025

Contents

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 2022/23, compliance with workforce standards, and detail the workforce pressures and challenges experienced in year.

The report details proposed workforce improvements in 2023/24 which include 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 by the Royal College of Nursing (2013). A review of the Trust's compliance against the 16 core standards for 2022/23 can be found in section 4.3 and Appendix 3, with the Trust now fully compliant with all 16 standards.

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 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.

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)

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.

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.

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.

3. Summary of achievements

The overall impact of the success of the nursing workforce strategy, including a reduction in vacancies, development opportunities and other initiatives to support safe nurse staffing is as follows:

3.1: Recruitment

i. 153.2 WTE Band 5 nursing staff recruited in 2022/23: 82.2 WTE national recruits; 71 international recruits. An additional 12.92 WTE Band 5 nurses recruited to the Liverpool Neonatal Partnership single service to undertake post registration neonatal training
ii. Zero attrition rate of nurses being offered a post at Alder Hey to commencement in post
iii. Vacancy rate less than 2%.
iv. A responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days, plus, a comprehensive induction and preceptorship programme for new nursing staff.
v. A return to our 'one stop' recruitment event in 2022, with all candidates being interviewed on the same day and if successful their recruitment team and admin appointment confirmed at the same time.
vi. Recruitment strategy partnership working with Higher Education Institutes to attract potential student nurses from diverse backgrounds and wider work to engage with the student workforce to provide a clear offer to encourage their choice for Alder Hey to be their preferred work option.
vii. Continued expansion of our international recruitment programme with an additional 71 nurses recruited and supported by our Pastoral Support Educator and wider PEF team.
viii. Trust received a national Pastoral Support Quality Award from HEE for the outstanding support and processes in place to support international recruits; only three Trusts in England achieved this prestigious accolade
ix. Support from NHSE to continue involvement in the refugee programme, with our first recruit started in Autumn 2021 continuing to progress towards competence and registration.
x. Further successful bid awarded by NHSE/I to continue to support the funding of our international nursing workforce strategy.
xi. Continued work on our Health Care Support Worker (HCSW) programme to achieve the NHSE zero vacancy target. Further funding being used to deliver the HCSW Care Certificate for our substantive staff and working in partnership with NHSP to deliver the Care Support Worker Development Programme across areas where there is HCA vacancy.
xii. The successful ongoing support of 9 Registered Nurse Degree Apprentices (RNDA).
xiii. The successful ongoing support of 8 internal Nurse Associate and Assistant Practitioners to the RNDA 2-year programme.
xiv. Further investment in the PEF workforce team to support the delivery of our workforce and education programmes.

3.2: Safe staffing levels

i. Successful business case submitted to address the gap in funded establishments for Ward 3C and Ward 4C to enable a funded supranumery clinical co-ordinator
ii. The daily 'Safer Staffing' meeting continues to be fully operational and fully embedded. It has been led by the Divisional Associate Chief Nurses or, more recently the Heads of Nursing with other senior nursing support and information feeds into both the Bed Meeting and the Daily Safety Meeting. The meeting is now well embedded
iii. Matrons for Surgery and Medicine allocated responsibility to oversee safe staffing for their divisions on a daily basis and ensure robust plans are in place.
iv. The 'Red, Amber and Green' staffing model was utilised at times of pressure in line with escalation process; this was particularly required during the industrial action episodes and during seasonal pressures.

v. Positive comparison against benchmarking data comparing Care Hours per Patient Day (CHPPD) with comparator wards / departments nationally
vi. Monthly safer Staffing report now produced and monitored through SQAC

3.3: Strong and effective leadership

i. Comprehensive 5-year workforce strategy devised with a clear vision to: Continue to be a national leading centre in the training, education, and of paediatric nurses and HCSW's. Continued to work through the implementation plan, reporting progress into workforce subgroup and senior leadership team.
ii. Continued to diversify our recruitment strategies to be more representative of the population we serve.
iii. Development and recruitment to a new role of Nursing Retention Lead to support a reduction in leaver rates through development of nurse retention programmes.
iv. Opportunities for staff to develop, grow and progress in the organisation
v. Continued to develop our workforce teams and implement our strategy, to embrace new roles and transition to a sustainable model for the future.
vi. Developed a clear structure for advanced and specialist roles; services will continue to be developed around the needs of children, young people and their families, and will clearly align to the service needed to provide their care and to Vision 2030.
vii. Continued review of the Matron and Heads of Nursing structure, with additional leadership roles implemented this year.
viii. Successful recruitment to the Community and AED Heads of Nursing roles.
ix. Successful recruitment to the new Deputy Director of AHP role.
x. Internal and external recruitment to Senior Nurse/Ward Managers positions.
xi. Internal promotion to Band 6 Ward Sister/Charge Nurse positions.
xii. Safer Staffing Huddle chaired by a senior nurse.
xiii. Involvement in the regional Band 6 'Task and Finish Group' to develop a robust and consistent Band 6 development programme.
xiv. Implementation of the ward-based coordinator development programme.
xv. Establishment of the competency development programme.
xvi. Implementation of the Band 5 development programme
xvii. Continued roll out of the Band 2-3 organisational change process for our HCSW.

3.4: Educational developments

i. Review of our Nursing preceptorship framework to align with new national guidance and ensure post pandemic requirements are being met.
ii. Rotation pathway 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.
iii. Embedded the Band 5 development framework, which offers clear guidance through the initial first 2 years post recruitment identifying the range of learning available and expected.
iv. Successful completion of phase one of the new career pathway for nursing with the delivery of a professional development day in September 2022. Phase 2 is in progress with the generation of resources and information sharing options, for the members of the nursing workforce to access; implementation planned for January 2024.
v. Implementation of the major trauma competencies across the organisation.
vi. Successful bid awarded from Health Education England via the RePAIR process to enable the production of resources to support ongoing recruitment and retention projects.

vii. Practice-based learning packages have been developed to support an increased number of learners and reviewed the diversity of learning opportunities the organisation can offer.
viii. Ongoing partnership working with our HEI partners to ensure full utilisation of existing placement capacity and the opening of new placement opportunities linked to research and management.
ix. Devised a full student engagement programme with annual engagement days for all nursing students focusing on key skill development and enhanced knowledge building.
x. Implementation of a quarterly learner forum which provides a learning hour and listening hour for multi-professional learners within the organisation.
xi. Ongoing support of our 9 students on the Registered Nurse Degree Apprenticeship (RNDA 4) who are progressing well.
xii. Ongoing support of our 8 internal Nurse Associate/Assistant Practitioners on the Register Nurse Degree Apprenticeship (RNDA 2) due to complete in January 2024.
xiii. Full implementation of the Supportive Coaching in Practice (SCiP) model to support our learners onsite. Now sharing this development via national events and regional groups.
xiv. Supported 24 nursing staff to undertake the Professional Nurse Advocate (PNA) training with 10 now successfully completed.
xv. Ongoing support of PNA forum and the overall PNA organisational strategy to ensure full utilisation of this role to support the nursing workforce.
xvi. Fully embedded the Practice Education Recognition Certificate (PERC) adjusted recruitment pathway. This enables those student nurses who demonstrate consistent exceptional practice to be identified and successfully recruited. Ward / Departmental Managers are able to offer a recruitment opportunity for final year students to their area in recognition of exceptional practice.
xvii. 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.
xviii. 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 different aspects of practice using the Tendable Audit Tool across all the wards.
ii. The Ward Accreditation programme has been re-established and is being further developed to include other departments. All areas have successfully currently achieved either Gold or Silver awards
iii. Collaborative working with the Research Team, IT, and ward teams to continue work on the Vitals study.
iv. E-roster system continues to be rolled out and monitored across wards, with KPI's reviewed updated and performance monitored.
v. Local challenge boards continue to monitor staffing at Divisional level providing information for recruitment events. They also provide assurance around key performance indicators reporting into Trust wide committees.
vi. Patient Safety Meetings continue to provide assurance around our safety culture.
vii. Acuity review with associated SOP developed.

viii. Process of Quality Ward Rounds embedded with a range of quality topics reviewed. Associated action plans are monitored via Divisional Governance committees. The quality rounds are undertaken by the senior nursing team and provide visibility to the ward teams and drive improvement work across all areas.
ix. CNIO supporting digitally enabled quality improvements and solutions.
x. Monthly Safer Staffing report provides an update on quality metrics

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 across a 4 week window in June 2022 and analysis fed back and escalated to the senior nurse / AHP team and the Executive team.

Ward 3A, Ward 3C and Ward 4C were not compliant as having 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. As a result of the establishment review a business case was undertaken by the Deputy Director of Nursing to address the funding gap for Ward 3C and Ward 4C; this was subsequently approved and the funded establishment increased. Across the Division of Surgery funded establishment over the required amount was identified and it was recommended that this additional funding be transferred to Ward 3A to fund a supranumery co-ordinator.

Staffing models and winter planning review undertaken with each Ward Manager, Matron, Head of Nursing and Associate Chief Nurse. The establishment review was also extended to include the Divisional Human Resources Business Partner and the Financial Business Partner; there presence and input into the review was extremely beneficial and they provided a breakdown of all financial and HR metrics related to that ward / department. This improved methodology will continue in 2023 establishment reviews scheduled for a 3 week period in June.

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 Trust produces a monthly Safe Staffing and Patient Quality Indicator Report to provide a summary of overall Nursing and HCA staffing fill rates and Care Hours per Patient Day (CHPPD). This data relates directly to the number of patients on an inpatient ward and informs the Trust of how staff are deployed and how productively. Data can be compared and benchmarked with CHPPD figures from comparative wards enabling investigation to understand any significant variation and to make sure the right staff are being used in the right way in the right numbers. CHPPD includes total staff time spent on direct patient care including clinical time such as preparing medicines, documentation and safeguarding.

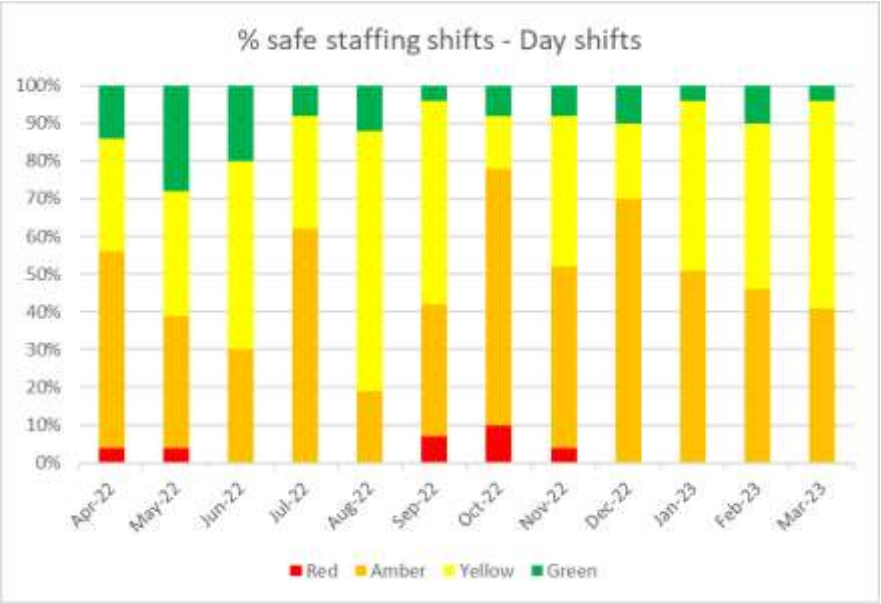
The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2022/23 demonstrated that the average overall staffing level was

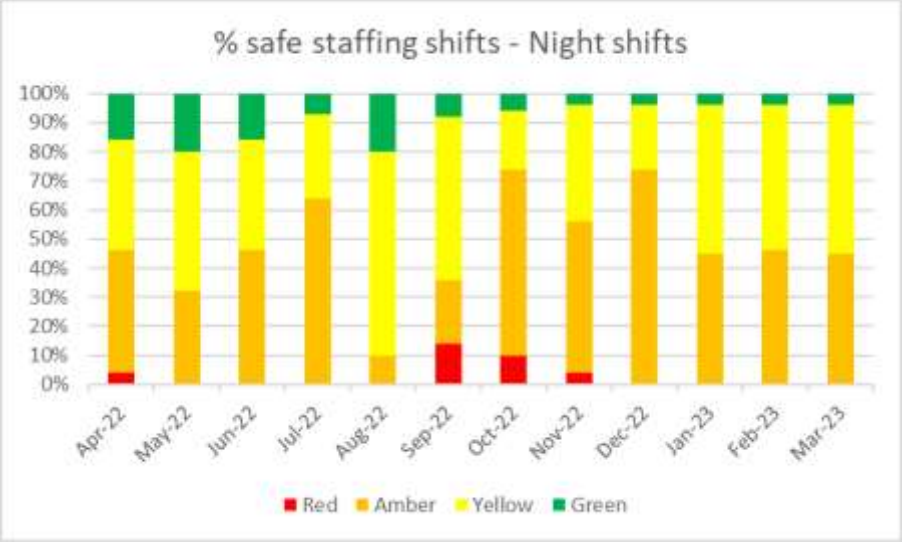
80% for the year as shown in Appendix 1. This is a change in year to that previously reported when the Trust maintained a position over 90% however this is understood to be in part due to electronic system calculation following implementation of the health roster as opposed to manual submission by local managers. For assurance, the percentage figure does not include the international nurses who have been working on the wards; whilst they await their NMC PIN number they are a Band 4 and therefore not included in this figure. Therefore in real terms the local staffing figures by ward are higher than shown in percentage terms.

Appendix 2 shows the CHPPD benchmarking data by ward for 2022/23. An analysis of the CHPPD benchmarking demonstrates that the Trust provides a similar or slightly higher than average care by patient hours. The benchmarking data used for HDU is the same comparator as for PICU therefore it is appropriate that this figure is lower. The Burns Unit compares higher than the national benchmark however that is because the Trust has included the day case clinic activity with the unit and numbers; this will be amended in 2023/24 to capture inpatient activity only in line with the guidance. The only area that does not meet the national benchmark is Ward 4C which has failed to meet this benchmark between August 2022 and January 2023 (externally published data available up to January 2023 at time of reporting); this position will be monitored and reviewed as part of the annual establishment review. It is expected that the increase in the funded establishment will have a positive impact on CHPPD. There is not a set CHPPD standard for each ward as staffing requirement and care requirement is based on acuity and dependency.

Safer Staffing meetings were held twice per day Chaired by a Divisional Associate Chief Nurse or Head of Nursing 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 year is shown in the graphs below which shows there has been no escalation to Red status since November 2022. The data also demonstrates the effective management across the 24 hour period with staffing comparative on day and night shifts in line with activity.





4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, a review against the RCN standards has been repeated in 2022/23 by the Director of Nursing as detailed in Appendix 3.

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
Mar 2023	1↑	2	3	4	5	6	7	8	9	10	11	12	13	14↑	15	16

The recent review has demonstrated an improved position with compliance against the 16 core standards as the Trust is now compliant with core standard 1 (all clinical areas are required to have a supernumerary shift supervisor) following a successful business case to increase the funded establishments on Wards 3C and 4C and adjusted establishments within the Division of Surgery to address the gap on ward 3A. This is a significant improvement and demonstrates the commitment to ensuring safe staffing from ward to Board.

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 3.2

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 has increased compliance following additional funded establishment in Ward 3C and Ward 4C and is now compliant with standards 7. 6 out of 9 wards are fully compliant with standard 8; a staffing plan is in place to mitigate any gaps as detailed in Appendix 3.3.

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↑
Mar 2023	5	6	7↑	8

4.4: Recruitment and Resilience

The senior nursing team have continued to undertake recruitment activities throughout 2022/23 and have recruited 153.02 WTE front line Band 5 registered nurses: 82.2 WTE national recruits and 71 WTE international recruits. This is the highest number of Band 5 nurses recruited since reporting. This is due in the main to a high number of international nurses joining the Trust and a zero attrition rate across all nurses who were offered a post at Alder Hey. This is highly significant and testament to the work of the workforce and recruitment team who keep in touch with candidates on a regular basis ahead of their start date but also demonstrates the positive placement experiences that newly qualified nurses joining from the local HEI's have experienced at Alder Hey demonstrating that they want to come and work at Alder Hey.

In year, nursing vacancy rates are below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As at year end (March 31st 2023) the Trust had 13.56 WTE Band 5 vacancies mainly across Ward 4C and PICU. Staffing pressures are therefore largely due to staff availability to work, rather than vacancies, as detailed in section 5 workforce challenges.

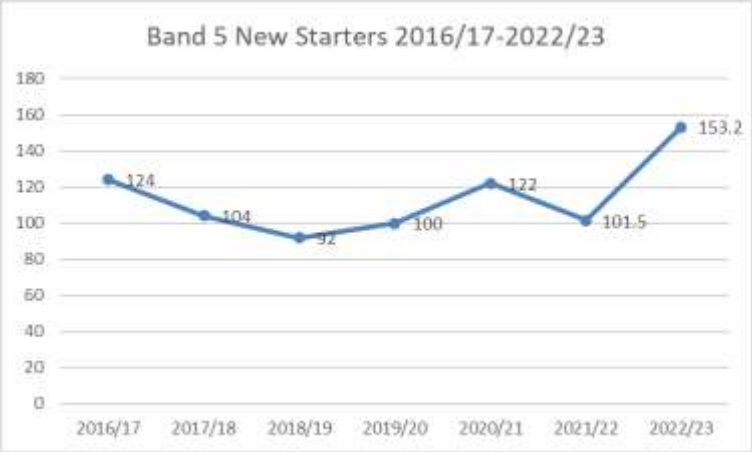
We continued with our highly successful international nurse recruitment campaign and the Trust welcomed a further 71 highly skilled and experienced nurses from India between May 2022 and March 2023, totalling 149 international nurses recruited since 2019. A comprehensive induction and OSCE programme is in place and our support of these nurses has been nationally recognised with the Trust being awarded the Pastoral Support Quality Award by HEE for the outstanding support and processes in place to support international recruits; only three Trusts in England achieved this prestigious accolade

The Trust currently has 4 qualified Nurse Associates (NA's) and 2 Trainee Nurse Associates, with further workforce plans being considered. However, many NA's have undertaken the opportunity to complete 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 2022/23, and the graph below shows the actual numbers over the past 6 years. This reflects a mean recruitment figure of 110 WTE. Comparator figures are shown in Appendix 4.1.

It is anticipated that recruitment figures will remain consistent and further 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 in 22/23. In addition there is a plan for a further 34 international recruits in 2024.

Table 1: Front line registered nurses recruited in WTE												
Q1 2022/23			Q2 2022/23			Q3 2022/23			Q4 2022/23			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	31.6			2		47	1	19		30.6	22	153.2



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. We offer recruitment sessions as part of our partnership with local HEI's and also offer a recruitment preparation session for any prospective candidates.

The "One Stop Shop" recruitment day has been embedded over 5 years and has been evaluated positively by new starters. This day ensures a robust recruitment process is completed, but also enables successful candidates are notified on the day and commence the onboarding process. The Practice Education Recognition Certificate (PERC) adjusted recruitment pathway is now in place. This enables 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 the 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 2023/24

Appendix 4.2 provides analysis of all new Band 5 nurses in 2022/23 by ward.

4.5: Workforce developments in 2022/23

i. **CSWD programme:** Further development of our Care Support Worker Direct Programme has seen our Band 3 HCA vacancy rate reduce to near 0%. This programme allows a local workforce with limited health care experience access to clinical paediatric ward-based placements. They also attain the national care certificate and move into a substantive or bank post. It provides our new starters with a pipeline to further development via the apprenticeship route or on to Nurse Associate or Registered Nurse programmes.

ii. **Band 5 Development programme**: This year we have revamped our offer to our new starters. A dynamic preceptorship programme helps the newly qualified nurse transition from pre to post registrant and starts their development pathway through competency assessment and practical and experiential learning.

i. **Enhanced nurse leadership:** Internal promotion and external recruitment to Ward Manager, Matron and Head of Nursing roles has occurred this year. We have also seen recruitment into leadership roles in specialty areas to drive improvement and assurance.

iii. **Professional Nurse Advocate:** Our programme continues to develop, and the group has established itself across many areas of the Trust. The work of the PNA forum continues to embed the role across the Trust. The PNA organisational strategy provides a basis to ensure full utilisation of this role to support the nursing workforce across the organisation.

iv. **Response Team:** This team has established itself in 2022/23 with a plan towards full staffing by April 2023. This group will provide senior clinical support to the ward and departmental teams on a 24/7 7 day a week basis. The team also has site management responsibility out of hours and works alongside our bed management and medical teams. The implementation of this team has meant we have improved in RCN core standard 14 in regard to having a Band 8a on site 24/7.

v. **International recruitment**: Our international nursing programme has continued to develop in 22/23.

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 supernumerary 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. **Focus on improving retention** led by the new lead nurse for retention. Role will provide strategic oversight for the implementation of a number of key projects to support the organisation nurse retention plans.

iii. **Reduce use of temporary staffing:** Continue to review ways of reducing use of temporary staffing, including workforce reviews and reduction of agency spend.

iv. **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 a triangulated approach.

v. **Improvements for the HCA workforce:** Ensure that the Band 2 to Band 3 HCA organisational change continues to be implemented, with further roll out across our temporary staffing workforce. Ensure clear career pathways and development opportunities are available.

vi. **Continued focus on education through:**

a. Continued partnership working with local HEI's to ensure learner experience is positive within the organisation.
b. Redevelopment of the Standards of Student Supervision and Assessment (SSSA) training, to link with new preceptor training and a coaching conversation session.
c. Review of preceptorship framework to ensure compliance with new national guidance and also to ensure the post pandemic requirements of the nursing workforce are being met.
d. Engagement with local schools and colleges to support career choices and workplace experiences.

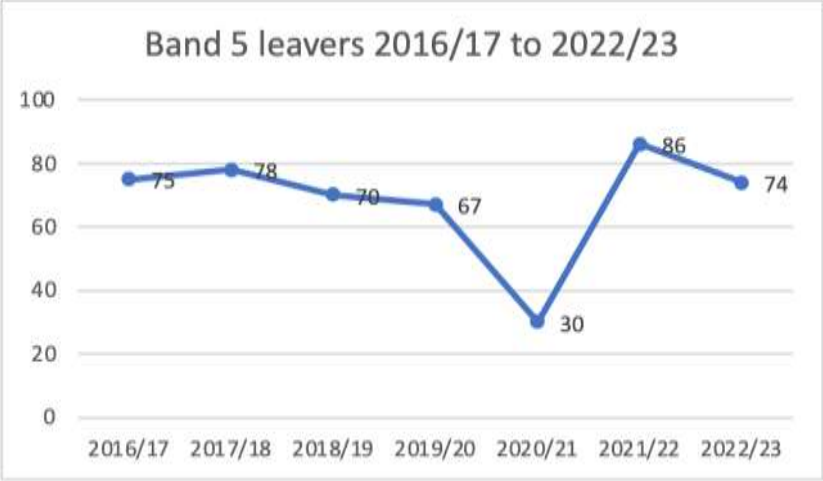
5. Workforce challenges

5.1: Leavers

74 WTE front line Band 5 staff left in 2022/23. The average leaver rate per month reduced from the previous highest rate of 7.2 WTE per month in 2021/22 to 6.2 WTE per month in 2022/23 which is reflective of the average leaver rate pre pandemic. This return to pre pandemic averages is reflective of the national picture and an increased number of staff leaving the NHS.

Table 2 shows the actual and average number of leavers per quarter in 2022/23, the graph below shows number of leavers for the past 6 years, and Appendix 5.1 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	**19.2**	(6.4)	**12.8**	(4.3)	**24.8**	(8.3)	**17.3**	(5.8)	**74.05**	(6.2)



The main reasons for leaving have been voluntary resignation for work life balance relocation (30.4 WTE; 40%) and voluntary resignation for relocation (23.2 WTE; 30%). 11 staff (13%) 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. Leaver rates from our international recruits is very low with virtually all our nurses continuing to work at Alder Hey. Despite the Trust having revamped the preceptorship and Band 5 development programmes, we continue to see significant numbers of nurse registrants leave the organisation within the first eighteen months of their commencement.

Our position with retention is not uncommon and NHSE have acknowledged this in setting up both regional and national retention programmes, with programme leads identified. We are part of the Cheshire and Merseyside retention workstream and are working with the group to develop initiatives to improve retention rates.

One of these initiatives was to appoint a local nurse retention lead and we recently appointed a Nurse Retention Lead for 12 months. The retention lead will be responsible for leading the nurse retention programme at Alder Hey. We will look to identify a clear offer and be able to articulate this to all our new nurse starters. We will also embed the internal transfer process which has been developed by Alder hey to facilitate 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. Further focussed initiatives and target driven objectives will look to significantly reduce nurse leaver rates in 2023/24. The retention lead will also link up with the regional and national teams and the wider Trust retention team to help deliver elements of the Trust People plan.

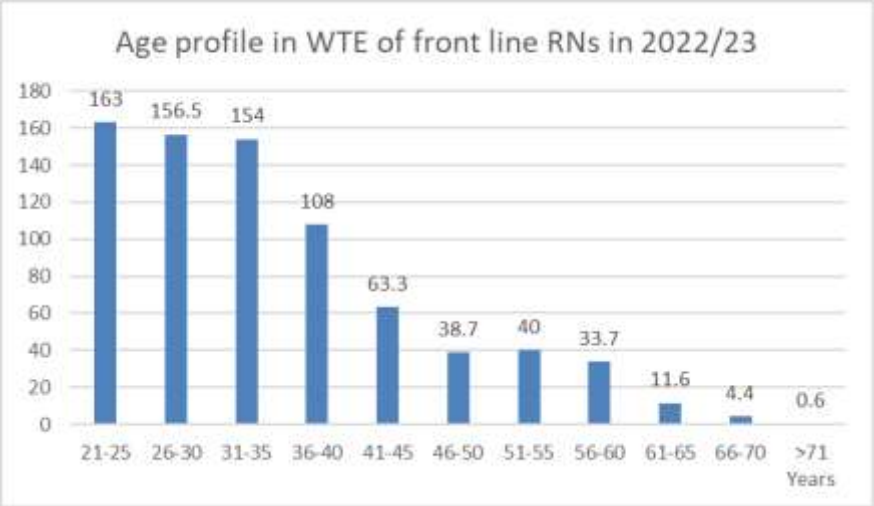
Appendix 5.2 provides analysis of Band 5 nurses who left in 2022/23 by ward.

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 50.3 WTE (6.5%) front line nursing staff aged 55 and over who could retire with immediate effect. There are a further 40 WTE (aged 51-55) (5%) 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. However there has been a significant shift to the left with 473.5 WTE (61%) of front line nursing staff being between 21-35 years of age.

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 2022/23	163	156.5	154	108	63.3	38.7	40	33.7	11.6	4.4	0.6



Effective succession planning is key, and there has been successful internal promotion to front line Band 6 to Band 8B nursing roles

Analysis by ward is provided in Appendix 6

5.3: Maternity leave

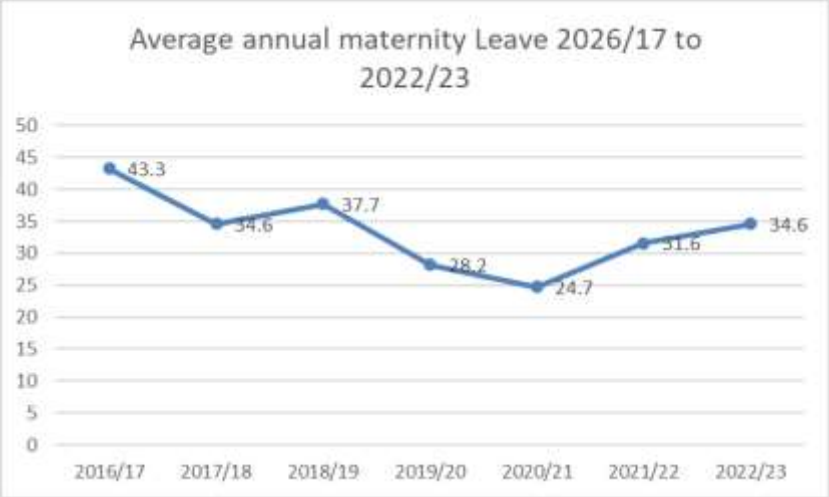
Maternity leave cover is not included within the calculated ward establishments for any of the wards. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Trust Board supported an increase to the funded "nursing pool" to 40 WTE in order to further improve resilience and optimise 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 7 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
2022/23	34.2	37.2	35	32.3	34.6



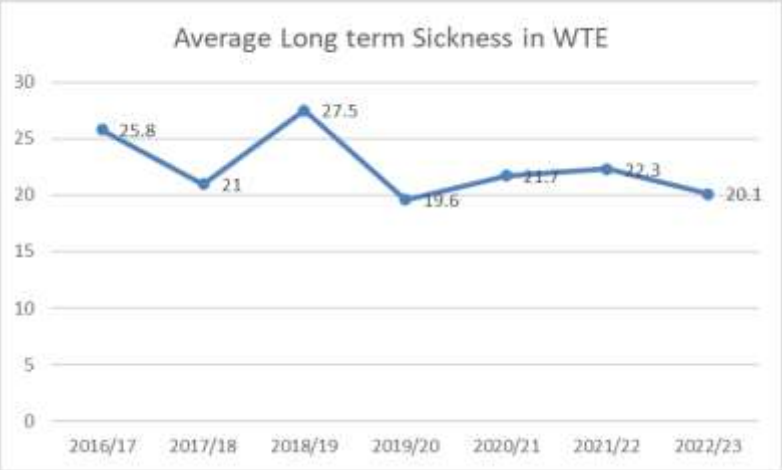
5.4: Sickness

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

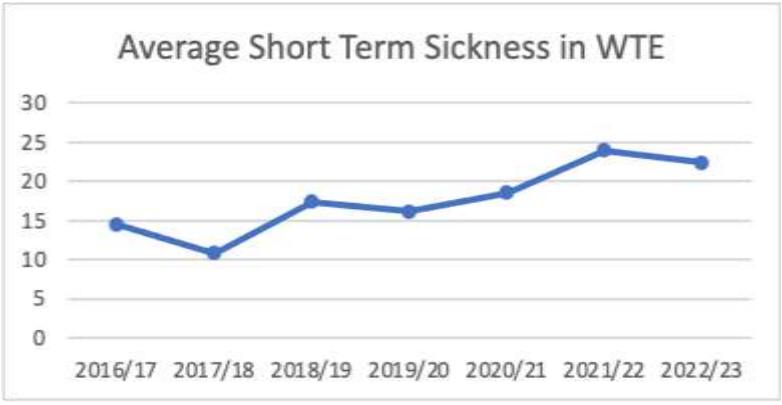
2020/21	22.4	21.2	22.2	21	21.7
2021/22	22.3	24.0	22.4	20.7	22.3
2022/23	18.5	21	23.4	17.6	20.1



Short term sickness remained high but static. Ward Managers continued to work in collaboration with HR to support the physical and mental health and wellbeing of staff. Staff are signposted to SALS and referred to Occupational Health in addition to staff accessing SALS support directly.

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
2022/23	21.1	23.1	25.8	19.9	22.4



Staff health and wellbeing, particularly mental health, is a key priority for the senior nursing team and will continue throughout 2023/24 in close partnership working with HR and SALS

Analysis by ward is provided in Appendix 8 for long term sickness and Appendix 9 for short term sickness.

5.5 Industrial action

2022/23 saw unprecedented industrial action following a ballot of Royal College of Nursing (RCN) members in October 2022 where Alder Hey RCN members voted in favour of industrial action.

Alder Hey were called out to lawfully strike on 15th December 2022 and 20th December 2022; the RCN supported the derogations for safe staffing levels as requested by the Chief Nurse.

Further lawful strike action involving Alder Hey members was taken on 6th to 7th February 2023 with the majority of derogations requested supported. Strike action planned for 1st to 3rd March 2023 was cancelled; this was to be the first strike action with no supported derogations. Further lawful strike action was taken in 2023/24 on 30th April to 1st May and no derogations were in place. A national process of escalation for significant patient safety concerns and a process to allow for members to be called back to work was set up.

The Trust supported all staff in their personal decision as to whether to take lawful industrial action, respecting the decisions that colleagues made.

Staff were supported throughout by weekly updated FAQs, drop in Q&A sessions with the Chief Nurse, access to SALs, Professional Nurse Advocates and their Line Manager. The Chief Nurse sent out regular communications which fostered our honest and open culture. Nursing staff who wanted to take industrial action but were required to work as part of approved derogations were supported to attend the picket line where possible for some of their shift

Weekly strategic executive meetings were held regarding any action plus weekly ‘Gold’ meetings with operational leads to plan and undertake specific actions. Strike days were managed through control and command structures and a dedicated staffing hub was set up each strike day to monitor staffing and manage on the day challenges

Through appropriate actions put in place by the Gold team to mitigate the risks, all inpatients were cared for safely and no incidents were reported associated to decreased staffing levels.

5.6: Increasing patient acuity

2022/23 saw a sustained 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 increased number of children and young people with complex and challenging behaviours. This has been a continuing trend post pandemic and has increased the HCA NHSP expenditure to provide a 1:1. A Standard Operating Procedure has been developed and implemented to provide guidance and consistent practice application in identifying a patient who requires a 1:1.

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 2023/24; 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 and a presentation for another children's hospital has been delivered at Alder Hey in order that we can learn from their experiences. The Director of Nursing and the Associate Chief Nurse for the Medical Division are part of a national working group reviewing the CYP SNCT criteria.

5.7: Temporary staffing: NHSP and agency

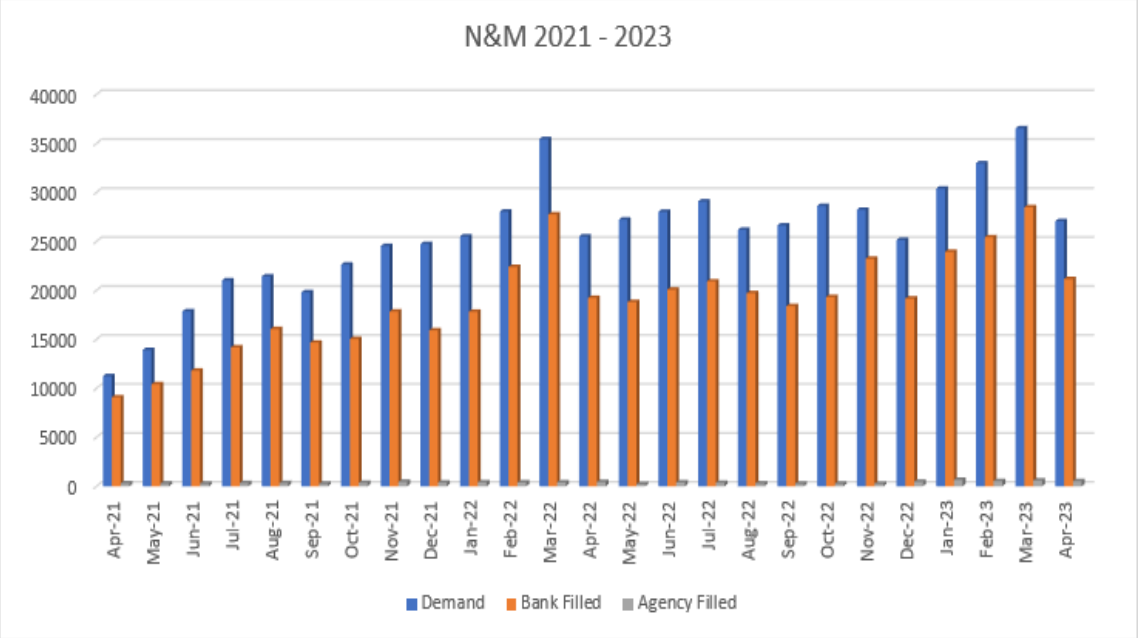
The Chief Nurse has led a continued drive to reduce the use of bank and agency staff, however due to staffing pressures particularly linked to sickness during winter months, the requirement for NHSP has remained high in 2021/22.

Demand for Nursing bank staff increased by 29% in 22/23 compared to 21/22. Bank filled hours met demand and increased by 33%, with an overall fill rate of 74.6% for full year 22/23. Agency increased by 13% (527 hrs), however is still minimal at 1.4% for the year with justified rationale (recovery plan and niche mental health teams) and agency migration/reduction plans are in place for areas with agency usage.

Winter incentive was in place from November 22- March 23, supporting bank fill rates to remain consistent each month through winter pressures. Rates concluded 1st April 2023, remaining only for the allocation pool.

Care support worker (CSW) development programme has supported CSW fill to an average of 81.2% across the year, increasing by 3% year on year and leading to substantive roles for a proportion of bank staff where vacancy was present.

The graph below reflects comparator bank, agency, demand, and fill rate data from the last 2 years.



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.

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 have previously received assurance that plans are 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)

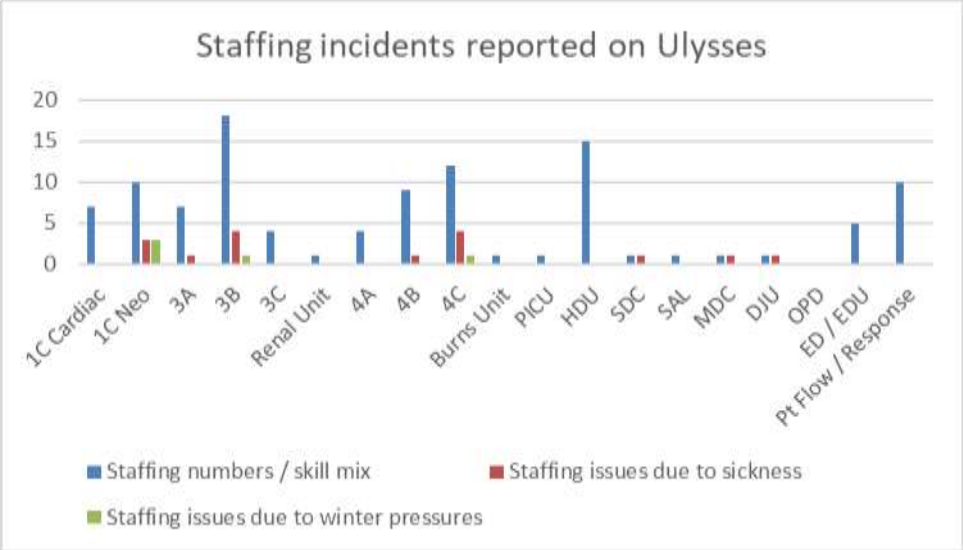
The Assurance Framework demonstrated the policies, procedures, plans and strategies in place to support safe staffing over the winter period, including a revised model of nursing (Green, Amber and Red staffing levels), a clear nurse staffing escalation process, and a clear strategy to provide safe staffing 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 Deputy Director of Nursing.

5.9: Staffing risks and incidents reported

There were a total of 145 staffing related incidents and near misses reported in 2022/23 (120 previous year). 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.



Ward 3B reported the highest number of incidents; the ward and the Division of Medicine are undertaking targeted work relating to workforce improvements.

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
- Successful business case to address gaps in funded establishment on Ward 3C and Ward 4C

The monthly Safer Staffing report provides an update on all clinical incidents that have occurred that month to consider whether staffing has been a contributory factor to the cause of the incident.

There are currently 6 open risks on the Risk Register relating to staffing with risk scores ranging from 9 to 12. All have appropriate control measures and associated actions. 9 staffing risks were closed on the Risk Register in 2022/23. An overview of the risks is shown in Appendix 10.

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:

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; all actions relating to safe staffing levels and a well trained workforce have been completed.

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 Trust Board of Directors were asked to support the following recommendations for further development which CQRM are asked to note:

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

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

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

d) 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.

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

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

7. Conclusion

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

Appendix 1: Staffing availability report 2022/23

Ward Safer Staffing 2022/23	Day registered	Day HCA	Night registered	Night HCA	Overall staffing
April	86%	75%	85%	72%	80%
May	84%	81%	91%	77%	83%
June	80%	81%	79%	79%	80%
July	79%	75%	77%	82%	78%
August	83%	71%	83%	79%	79%
September	71%	73%	70%	71%	71%
October	71%	78%	70%	74%	73%
November	79%	89%	75%	96%	85%
December	75%	79%	73%	85%	78%
January	78%	86%	77%	97%	85%
February	77%	93%	72%	107%	87%
March	77%	88%	74%	96%	84%

Appendix 2: Care Hours per Patient Day (CHPPD) report June 2022- January 2023

CHPPD	Jun-22		Jul-22		Aug-22		Sep-22		Oct-22		Nov-22		Dec-22		Jan-23	
	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark	AH	Benchmark
1CN	16.9	16.85	12.92	12.92	14.83	14.83	15.96	15.96	12.68	12.68	12.37	40.1	12.46	12.46	13.93	13.93
1CC	14.5	13.79	12.84	13.4	15.22	15.22	13.92	13.92	13.53	13.53	12.93	13.3	8.22	11.02	12.54	12.54
3A	10.2	10.18	10.11	10.49	10.66	11	9.78	10.19	9.23	9.46	9.41	5.69	9.98	10.49	9.67	10.19
3B	14.5	9.96	12.23	9.61	13.01	13.01	10.59	10.59	10.45	10.45	10.7	7.48	12.55	12.55	13.45	13.39
3C	8.83	8.83	8.44	8.44	9.72	8.6	8.35	7.93	7.61	7.69	8.72	8.05	9.7	9.33	10.06	9.77
4A	11	10.49	10.88	10.49	11.35	11	10.73	10.19	9.69	9.46	10.2	5.69	10.99	10.49	10.71	10.19
4B	13.1	11.38	12.85	11.33	13.94	10.3	13.18	9.35	11.13	8.59	11.67	9.42	14.43	11.7	12.86	11.48
4C	8.11	8.11	8.13	8.13	9.6	11.3	9.21	11.51	7.7	11.46	7.48	11.45	7.98	11.2	8.77	10.98
BU	19.3	13.12	18.12	12.15	23.01	7.91	19.98	14.73	15.9	12.04	20.25	12.57	38.33	21.26	18.36	13.45
PICU	37.4	30.35	36.41	30.09	38.24	31.06	33.82	29.87	36.64	27.3	29.83	28.25	30.46	28.49	29	29.01
HDU	22.5	30.35	22.64	30.09	25.82	31.06	23.43	29.87	27.12	27.3	26.67	28.25	23.45	28.49	30.19	29

(November 1CN benchmark highlighted as figure an outlier with previous benchmark data)

Appendix 3: Compliance with RCN core standards and specific standards 2022/23

A3.1: RCN compliance by ward / department 2022/23

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 2021/22
Amber:	Partial compliance	**↓:**	Deteriorating position compared to 2021/22
Red:	Non compliant	**=:**	Static position compared to 2021/22
Blue:	Trust agreed workforce		
Grey:	Not applicable		

A3.2: Compliance with RCN core standards 2022/23

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	**Compliant↑**
	12 out of 15 areas have a supranumery clinical co-ordinator. A business case was successfully submitted in 2022 which supported the increased funding required to enable a supranumery co-ordinator on Ward 3C and Ward 4C. The Surgical Division are enacting on a recommendation from the 2022 establishment reviews to transfer funding where possible from other areas to fund a supranumery co-ordinator on Ward 3A. The remaining 2 areas are EDU and the Renal Unit. EDU is supported by the Team Leader in ED and the Renal Unit is supported by an Advanced Nurse Practitioner and Clinical Nurse Specialist. Both are small units and do not specifically require a supranumery co-ordinator. This is a significant improvement in year and with a plan in place to address the shortfall on Ward 3A it is considered that the Trust is compliant with this standard	
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**
	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, Clinical Educator's in post.	
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 oncology, children's neurosurgery	**Compliant**

	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 2023/24	
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. Senior Nurse / AHP on Site (SNOS) commenced in February 2022. Response Team recruited and implemented which comprises of senior skilled nurses providing support to the hospital. The implementation has been a phased approach to allow for further recruitment and a consistent approach. The team consists of 6wte Band 8a Senior Clinical Site Practitioners and 5.6 wte Band 7 Clinical Site practitioners	

15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences 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	**Compliant**
	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	

A3.3: Compliance with RCN specific standards 2022/23

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. Full establishment review taken place as part of commissioning the service and establishment increased in line with 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	
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	**Compliant↑**
	Fully compliant following increase in establishment for ward 3C and Ward 4C	

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 4: Band 5 Starters

A4.1: Band 5 nurses recruited 2016/17 to 2022/23

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

Q1 2022/23			Q2 2022/23			Q3 2022/23			Q4 2022/23			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	31.6			2		47	1	19		30.6	22	153.2

A4.2: New Band 5 staff commenced in post in 2021/22 by ward / department

Starters WTE 2022/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac		1					1				1	1	**4**
1C Neo		4.6					4						**8.6**
3A		3					3				4	2	**12**
3B		2					3		4		1.6	2	**12.6**
3C		2					4		2			4	**12**
4A		5					1				3	2	**11**
4B		1					4		4		3	3	**15**
4C		1					3		1		6	4	**15**
BU												1	**1**
PICU		8					9		8		4		**29**
HDU							8				4	3	**15**
SDC		1											**1**
MDC													**0**
DJU					1			1					**2**
OPD					1								**1**
ED		3					7				4		**14**
Total	**0**	**31.6**	**0**	**0**	**2**	**0**	**47**	**1**	**19**	**0**	**30.6**	**22**	**153.2**
Q total	**Q1: 31.6 WTE**			**Q2: 2 WTE**			**Q3: 67 WTE**			**Q4: 52.6 WTE**			

Appendix 5: Band 5 leavers

A5.1: Band 5 leavers 2016/17 to 2022/23

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)
2022/23	**19.2**	(6.4)	**12.8**	(4.3)	**24.8**	(8.3)	**17.3**	(5.8)	**74.05**	(6.2)

A5.2: Band 5 leavers in 2022/23 by ward / department

Leavers WTE 2022/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac		0.61					0.61		0.92	1.92			**4.06**
1C Neo		0.61					1.77						**2.38**
3A	1	1.92		0.92			1	0.61					**5.45**
3B	0.6	1	1				0.92	1					**4.52**
3C			0.92							1		0.61	**2.53**
4A			0.61				1	2		0.77	1		**5.38**
4B					1	0.92	0.92		1				**3.84**
4C	1.92				1		1	0.92	1			2.46	**8.3**
BU					0.92								**0.92**
PICU			1.77	1	1	1.92	1.77	1.92	1	4.45			**14.83**
HDU	1.77	2.45		0.61	0.92		1.77	1	1	0.92		0.61	**11.05**
SDC													**0**
MDC													**0**
DJU											0.76		**0.76**
OPD		1									0.76		**1.76**
ED		2		1.8		0.8	0.67	1			1	1	**8.27**
Total	**5.29**	**9.59**	**4.3**	**4.33**	**4.84**	**3.64**	**11.43**	**8.45**	**4.92**	**9.06**	**3.52**	**4.68**	**74.05**
Q total	**Q1: 19.18 WTE**			**Q2: 12.81 WTE**			**Q3: 24.8 WTE**			**Q4: 17.26 WTE**			**6.2 WTE average**

Appendix 6: Age profile of ward / departmental registered nursing staff by WTE in 2022/23

Age profile 22/23	21-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65	66-70	>71 Years
1C Cardiac	13.92	14.53	10.91	7.29	5.91	0.92	1.44	1.92		0.61	
1C Neo	10.84	3.00	9.25	1.00	5.32		1.61	2.53	1.00	1.61	0.61
3A	12.84	7.92	9.91	10.52	4.07	0.92	5.53	1.61			
3B	6.00	6.76	11.80	4.48	3.08	2.61	1.38	1.75	0.92		
3C	13.92	10.84	7.00	6.17	6.07	2.84	3.60	4.65		0.61	
4A	18.60	13.05	12.37	10.08	2.34	2.34	4.82	2.15			
4B	10.92	9.76	10.28	1.84	3.53	1.00	2.61		0.61		
4C	16.00	10.37	10.79	11.60	2.45	2.00		0.69	0.31		
BU	1.92	3.00	3.84	3.24	2.76	0.80		1.00			
PICU	26.53	32.29	32.89	19.59	12.04	6.53	10.68	6.13	4.83		
HDU	16.60	22.51	13.43	9.90	0.61	5.63				1.15	
SDC	1.00		1.76	3.27	1.00	3.76	4.00	1.80	1.00		
MDU		1.00	1.00	2.32	1.00		0.51	0.76			
DJU	2.93	2.00	1.00	3.51	1.00			1.00	0.43		
OPD		1.00	1.00	1.60	2.56	1.76	2.80	4.15	0.76		
ED / EDU	11.00	18.44	16.87	11.50	9.59	7.60	1.00	3.57	1.79	0.40	
Total	**163.03**	**156.48**	**154.10**	**107.90**	**63.34**	**38.71**	**39.99**	**33.71**	**11.65**	**4.39**	**0.61**

Appendix 7: Band 5 maternity leave in 2022/23 by ward / department

ML 2022/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	3.76	3.76	3.84	2.92	2.92	2	1	1	1	1	1	2.92	2.2
1C Neo	0	0	0	0	0	0	0.8	0.8	0.8	0.8	0.8	0.8	0.4
3A	2.61	3.53	3.53	5.45	5.45	5.45	3.76	3.76	5.68	6.68	4.84	4.84	4.6
3B	1.92	1.92	3.44	4.36	4.36	5.28	5.28	4.36	4.36	3.36	3.36	2.44	3.7
3C	4	4	4	4	4	4	3	2	1	1	1	1	2.7
4A	1	1	1	2	2	1	2	2	2	1	3.69	3.69	1.9
4B	2.32	3.24	2.32	1.63	0.92	0.92	0.92	1.84	2.84	2.53	2.53	3.53	2.1
4C	1.92	1.92	1.92	3.61	3.61	4.61	3.61	4.61	3.69	3.69	4.61	4.61	3.5
BU	0	0	0	0	0	0	0	0	0	0	1	1	0.2
PICU	8.83	6.83	7.83	6.83	6.83	5.91	6.53	5.76	6.15	5.53	4.61	3.61	6.2
HDU	1.84	2.45	2.45	2.45	3.07	3.07	4.07	4.07	4.07	3.15	2.31	2.31	2.9
SDC	0	0	0	0	0	0	0	0	0	0	0	0	0
MDC	0.76	0.76	0.76	0.76	0.08	0.76	0	0	0	0	0	0	0.3
DJU	0	0	0	0	0	0	0	0	0	0	1	1	0.2
OPD	0	0	0	0	0	0	0	0	0	0.6	0.6	0.6	0.2
ED / EDU	3.79	4.79	4.79	3.79	3.79	3.79	4.79	3.8	3.8	2	1	1	3.4
Total	**32.75**	**34.2**	**35.88**	**37.80**	**37.03**	**36.79**	**35.76**	**34**	**35.39**	**31.34**	**32.35**	**33.35**	
Q average	**Q1: 34.2 WTE**			**Q2: 37.2 WTE**			**Q3: 35 WTE**			**Q4: 32.3 WTE**			**34.6 WTE average**

Appendix 8: Band 5 long term sickness in 2022/23 by ward / department

LTS 22/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	0	0	0	1.22	1.09	0	0.45	0.38	0	0.13	0	0	0.3
1C Neo	1.05	0.95	0.38	1.05	1	1	1.85	1.2	1.79	0.06	0	0	0.9
3A	1.6	1.87	0.71	0.29	0.52	0.53	1.3	1.8	1.33	1.17	0	0.61	1
3B	1.49	3.64	2.28	0.85	0.85	1.71	0.79	1.22	0.51	0.38	0.84	0.99	1.3
3C	1.85	2.19	1.08	2	1.38	3.8	2.62	3.08	3.15	2.1	0.21	0	1.9
4A	0.08	0.76	1.39	0.89	1.38	1.51	2.46	2.48	4.54	2.99	1.96	2.71	1.9
4B	5.58	1.77	2.59	2.75	2.27	2.43	2.36	3.34	3.17	2.83	3.75	0.97	2.8
4C	1.38	1.64	1.68	1.85	1.37	1.1	1.08	2.19	2.35	2.34	1.94	2	1.7
BU	0	0	0	0.61	0.94	0	1	0.23	0	0	0	0	0.2
PICU	2.16	2.67	2.22	2.1	1.24	4.63	2.97	3.62	3.28	3.37	1.84	2.7	2.7
HDU	3.29	2.07	0.88	3.92	2.6	3.35	1.52	2.2	2.38	2.42	1.22	0.92	2.2
SDC	0.58	0.58	0.12	2.13	2.42	1	1.39	0.48	0	1.73	0.56	0	0.9
MDC	0.06	0	0	0	0	0	0	0	0	0	0.19	0.58	0
DJU	0	0	0	0	0	0	0	0	0	0	0	0	0
OPD	1	1	0.4	0	1	1.03	1.64	1.23	1.3	1.97	1.57	3.45	1.3
ED / EDU	1.75	0.03	0.78	0.81	1.12	1.25	0.29	0.64	0.64	0.64	0.64	1.02	0.8
Total	**21.87**	**19.17**	**14.51**	**20.47**	**19.18**	**23.34**	**21.72**	**24.09**	**24.44**	**22.13**	**14.72**	**15.95**	
Q average	**Q1: 18.5 WTE**			**Q2: 21 WTE**			**Q3: 23.4 WTE**			**Q4: 17.6 WTE**			**20.1 WTE average**

Appendix 9: Band 5 short term sickness in 2022/23 by ward / department

STS 22/23	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Average
1C cardiac	1.17	1.58	1.35	2.41	1.55	3.49	3	0.49	5.22	3.14	2.33	2.25	2.3
1C Neo	0.13	0.26	0.75	1.36	0.23	0.42	0.38	1.08	2.23	2.04	0.75	0.79	0.9
3A	3	1.26	1.7	1.91	1.21	1.93	1.35	2.07	2.49	0.78	1.22	1.84	1.7
3B	0.78	0.89	1.49	1.43	2.26	1.53	2.59	0.59	1.8	2.06	0.75	0.74	1.4
3C	2.46	0.83	1.85	1.6	1.27	0.72	2.38	0.79	1.79	1.65	0.41	1.78	1.5
4A	2.73	2.45	1.57	3.54	2.1	2.61	2.11	2.6	2.25	2.01	1.81	1.91	2.3
4B	1.88	1.95	1.75	1.74	1.36	1.4	2.73	1.5	1.49	1.62	1.39	2.5	1.8
4C	1.37	1.02	2	1.73	1.54	2.75	3.54	2.04	4.24	1.04	1.47	0.92	2
BU	0.2	0.11	0.43	0.55	0.26	0.83	0.35	0.29	0.29	0	0.17	0.47	0.3
PICU	4.91	3.18	3.51	3.18	3.69	2.6	0.87	2.01	3.89	0	3.18	2.96	2.8
HDU	1.21	2.82	4.49	2.35	2.28	2.32	2.62	2.76	2.63	1.91	1.49	1.86	2.4
SDC	0	0	0	1.38	0.19	0.55	0.03	0.48	1.47	0.11	1.43	0.42	0.5
MDC	0.02	0.04	0.13	0	0.39	0	0.06	0.06	0.32	0.24	0.25	0.04	0.1
DJU	0	0	0	0.06	0.23	0.07	0.32	0.43	0.42	0	0.21	0.13	0.2
OPD	0.3	0.08	0.23	0.36	0.19	0.15	0.94	0.85	0.22	0.41	1.2	0.03	0.4
ED / EDU	2.34	1.83	1.25	2.31	1.37	2.06	1.09	2.03	2.29	2.72	1.07	1.93	1.8
Total	**22.5**	**18.3**	**22.5**	**25.91**	**20.12**	**23.43**	**24.36**	**20.07**	**33.04**	**19.73**	**19.13**	**20.57**	
Q average	**Q1: 21.1 WTE**			**Q2: 23.1 WTE**			**Q3: 25.8 WTE**			**Q4: 19.9 WTE**			**22.4 WTE average**

Appendix 10: Risk Register staffing risks: Open and closed in 2022/23

Open risks			
Ref	**Division**	**Dept**	**Title**
2050	Surgery	3A	Patient safety and delivery of care on ward 3A associated with funded establishment.
2020	Medicine	4B	Reduced availability and resources on Ward 4B to deliver staff training in invasive and non-invasive ventilation and sleep study management resulting in the cancellation or delay in admissions to Ward 4B and potential harm to patients and delay in treatment
2614	Medicine	Palliative	If the Paediatric Oncology Outreach Nurses don't have an adequate number of nurses then the families we support will not receive the best quality care
2589	Community & MH	OPD	Inability to safely staff Catkin and Community Clinics
2501	Community & MH	OPD	Inability to safely staff waiting list initiative (WLI) clinics in OPD
2737	Community & MH	DJU	Risk of not meeting required safe staffing numbers on the Unit for all shifts

Closed risks				
Ref	**Division**	**Dept**	**Title**	**Risk Score**
2444	Medicine	3B	Current nurse staffing levels and skill mix do not reflect the increased acuity of care and activity due to sickness/absence, Mat leave and vacancy. The risk is that patients on Ward 3B will experience delays in care. Potential for failure to recognise a patients care needs or treat patients safely. Potential for increased sickness absence and staff retention issues resulting in reduction in bed numbers. Potential for poor patient experience resulting in increased PALS/Complaints	9
2351	Medicine	3C	Staff may not be able to maintain mandatory training compliance.	6
2630	Medicine	3C	Clinical coordinator unable to be out of the clinical numbers to maintain a safe environment for patients, staff and visitors.	8
874	Medicine	4C	Patient safety may be compromised on occasions due to skill mix of Nurses, numbers of nursing staff, visibility of nursing staff, fluctuating levels of acuity and dependency	6
2631	Medicine	ED	Difficulty in maintaining Emergency department skilled workforce in Nursing to provide safe effective care.	3
2550	Surgery	Burns	Delay in patient care and delivery of medication. No break cover for staff.	9
2067	Medicine	Diabetes	Risk of not meeting the National Best Practice Tarrif (BPT) due to fragile nursing workforce resulting in Trust BPT payment being removed and possible significant harm to patients	12
1931	Community & MH	OPD	Risk of disruption and delays to the provision of Outpatient services as a result of set working patterns.	4
2665	Research Division	Research	Unable to fully deliver oncology research portfolio to a good standard. Delivery of quality standards under contemporaneous data recording. Regular requests from clinical division for research nurses to support clinical care under safer staffing model.	3

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Quarter 4 / Year End 2022/23 Complaints, PALS and Compliments report**
Executive Lead:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q4 and full year 2022/23, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and recommendations for proposed developments in 2022/23 based on Trust learning and learning from national reports (Ockenden, 2022)
Summary and/or supporting information:	41 formal complaints received in Q4; 5 subsequently withdrawn therefore 36 in total. 164 complaints received in full year; 10 subsequently withdrawn therefore 154 complaints in total which is consistent with the previous year The top reason for formal complaints received in Q4 and in year continues to be treatment and procedures, appointment, and communication Compliance with the 3 working day acknowledgement for formal complaints is 95% in Q4 with an average of 96% compliance in year. Compliance with the internal Trust target of 25 working day response time is 78% and 74% in year; this is a significant and sustained improvement and testament to the focus and hard work of services and Divisions to respond to families in a timely manner in line with the new policy and processes. 2 second stage complaints were received in Q4 and 13 in total in year; this equates to 8% (13 out of 158) of first stage responses that result in second stage complaints No new referrals to the Parliamentary & Health Service Ombudsman during this period and no ongoing investigations There were 507 informal PALS concerned raised in Q4 which is consistent with the rest of the year. However there has been a significant increase in the number of informal concerns in year (1904) compared to 2021/22 (1539). The increase is understood to be partly associated with recovery following the pandemic and increased waiting times to time to see and treat patients

	Compliance with the 5-day target to resolve informal concerns was 85% in Q4 and an average of 82% in year. This is a significant and sustained improvement and testament to the focus and hard work of services and Divisions to respond to families in a timely manner in line with the new policy and process 514 compliments are recorded centrally in the Ulysses in year which is a marked increase in capturing this important feedback
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.
Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution and not having staff appropriately trained to locally resolve issues in their ward / department / service
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Delivery of outstanding care** **The best people doing their best work** Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	Trust Board are asked to note the content of this report and support recommendations in section 5

1. Introduction

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

This report aims to provide assurance that the Trust is responding to patient complaints in line with its procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO).

This report provides an overview of formal complaints and informal PALS concerns received and completed between January to March 2022 (Q4) and also provides an overarching year-end report for 2022/23. The aim of the report is to provide assurance that the Trust is responding to the concerns raised by children, young people and their families in line with Trust procedures, Department of Health legislation and standards expected by the PHSO; identifying and analysing themes more widely that the Trust needs to address to make service improvements; and to highlight action taken.

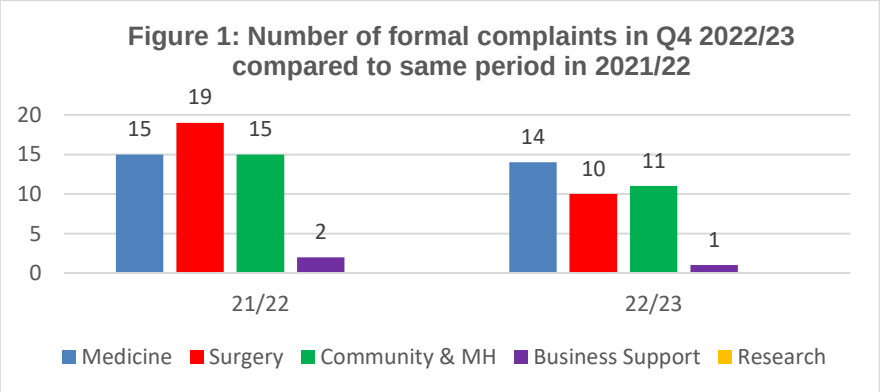
2. Formal Complaints

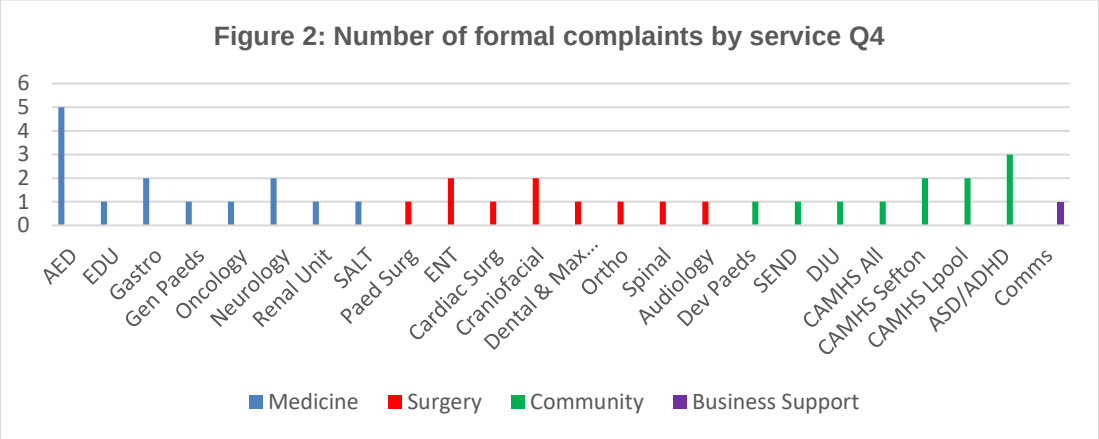
2.1 Number of formal complaints

2.1.1 Number of formal complaints received Q4 2022/23

41 formal complaints were received in Q4 of which 5 were subsequently withdrawn (3 in Surgery; 1 in Community & Mental Health; 1 in Business Support) resulting in a total of 36 which is the same as Q3. This is a decrease in comparison to the same reporting period last year (51 in Q4 2021/22).

A comparison of Q4 with the same period last year 2019/20 is shown in Figure 1 (does not include withdrawn complaints); Figure 2 shows the breakdown of complaints received by service in Q4.

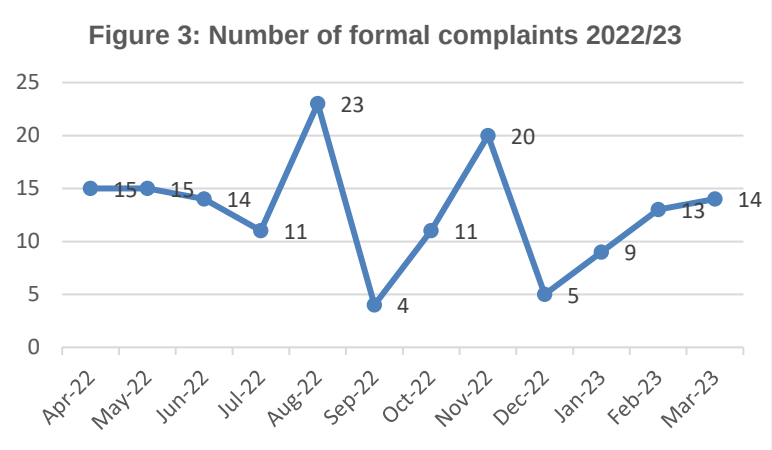


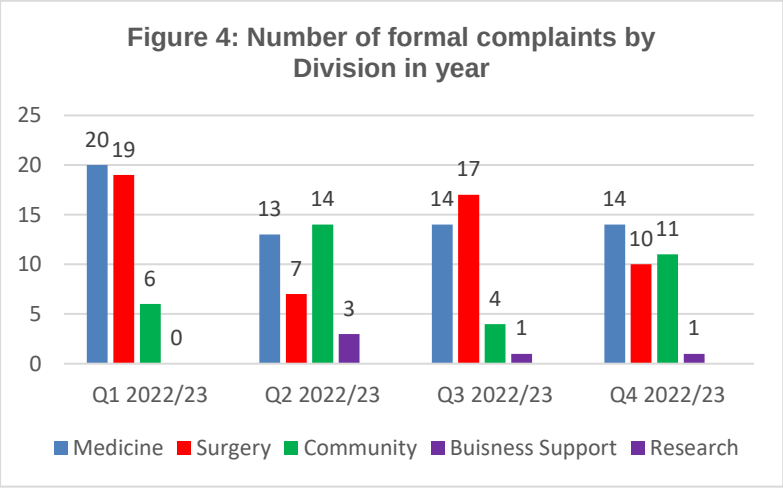


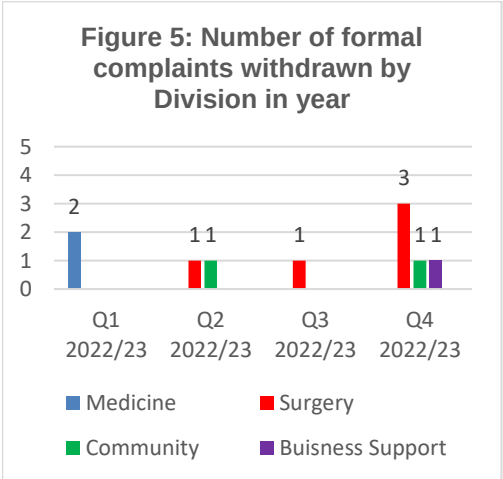
2.1.2 Number of formal complaints received in year 2022/23

There have been 164 formal complaints received in 2022/23 however 10 have subsequently been withdrawn resulting in an adjusted total number of 154 formal complaints as shown in Table 1 and Figure 3 (not inclusive of complaints withdrawn). Figure 4 shows the number of complaints (not inclusive of complaints withdrawn) by Quarter by Division for the full year with Figure 5 demonstrating the number of complaints withdrawn.

Table 1: Number of complaints 2022/23			
Quarter	**Received**	**Withdrawn**	**Actual**
1	46	2	44
2	40	2	38
3	37	1	36
4	41	5	36
	164	**10**	**154**

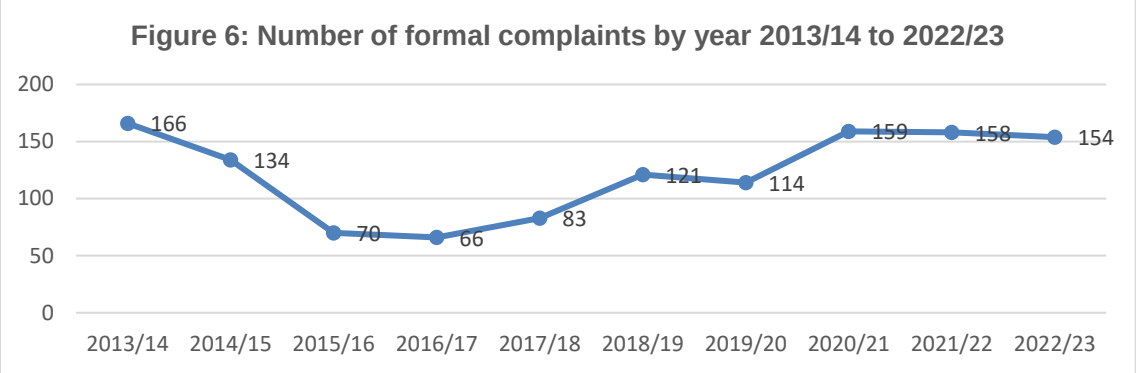


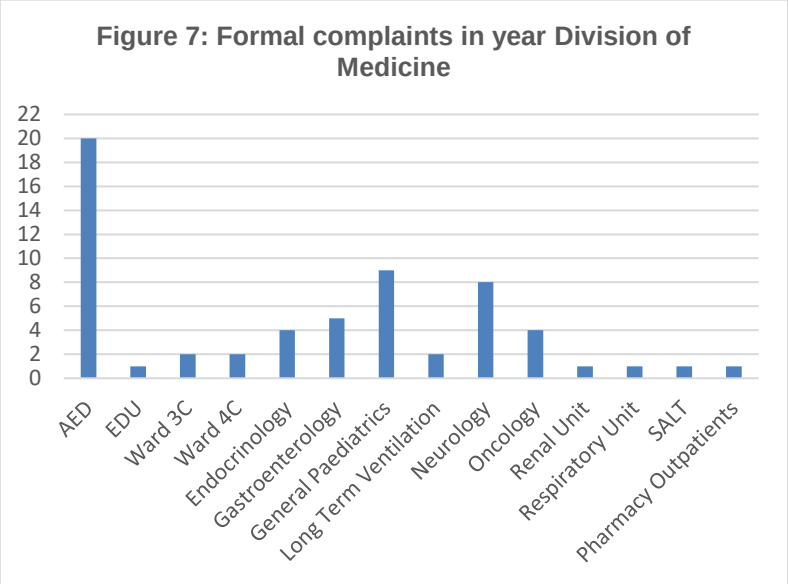


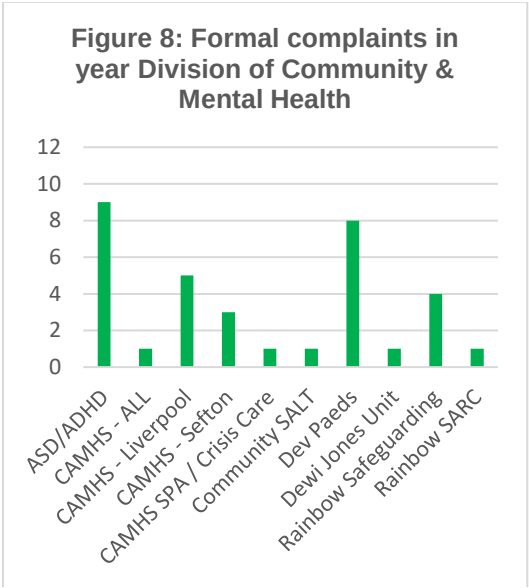


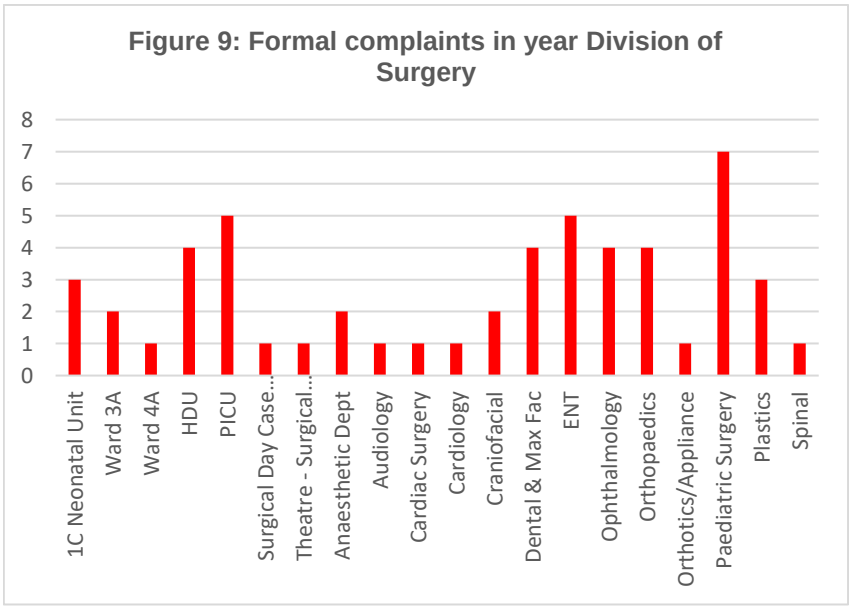
The number of formal complaints has fluctuated significantly in recent years, as shown in Figure 6, however has remained static in the last 3 years. The period of low formal

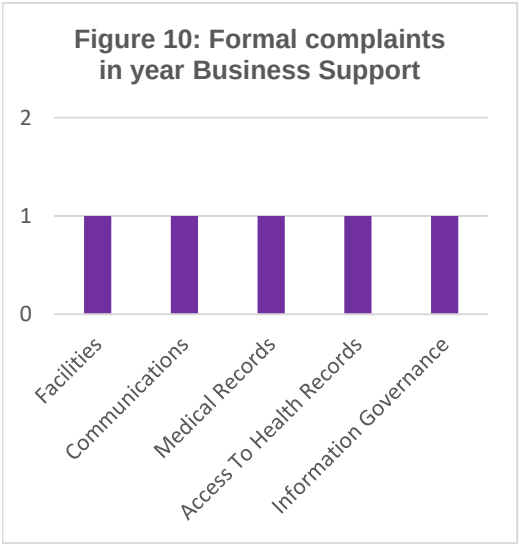
complaints between 1015-2018 may be attributed to the opening of the new hospital. Figures 7, 8, 9 and 10 show the complaints by service for each Division during 2022/23.







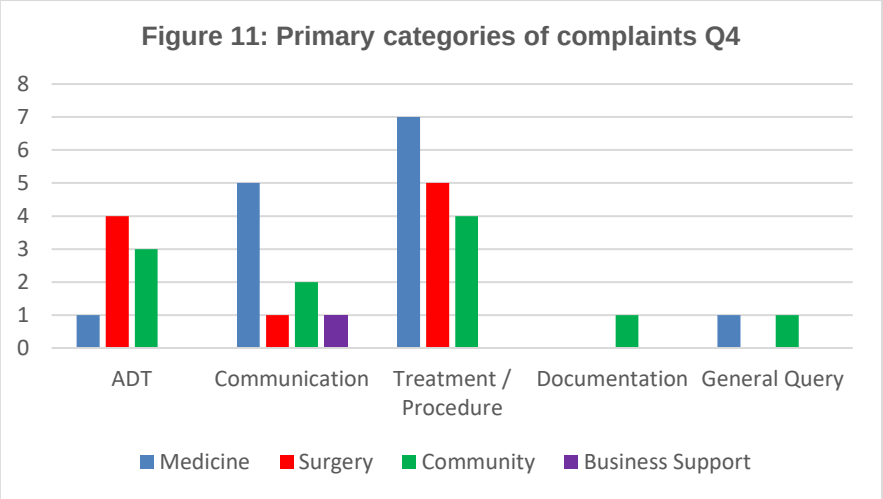


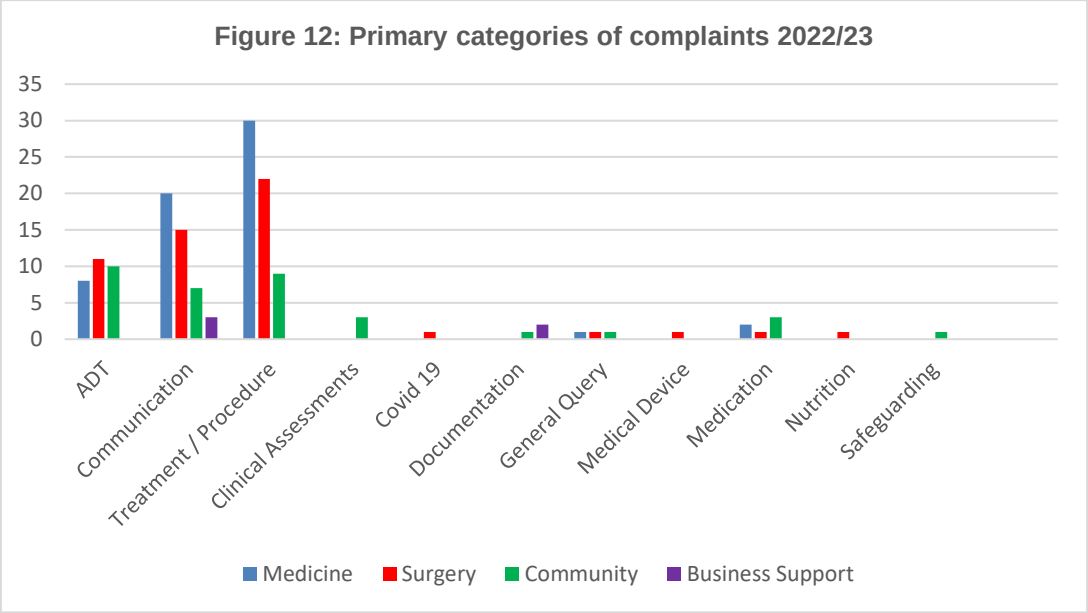


2.2 Complaints received by category Q4 2022/23 and full year 2022/23

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

Figures 11 and 12 demonstrate that the main theme in this quarter and across the full year continues to be in relation to treatment and procedure with a total of 16 complaints (44%) in Q4, and 61 (40%) in year (73 in 2021/22).





NB re primary categories: 'ADT' = Admission / Discharge / Transfer; 'Communication' = Consent / Communication / Confidentiality; 'Documentation' = Documentation (Records, Identification, IT System)

Sub-category identification provides further detail regarding the primary issues raised by families. Figures 13 and 14 demonstrate that the main theme within the treatment and procedure category is in relation to alleged failure in medical care with 10 complaints (28% of all complaints) in Q4 and 41 complaints (26% of all complaints) in year. In March 2023 a deep dive into complaints categorised as treatment and Procedure was undertaken. The

other main themes relate to communication, access / admission / discharge / transfer, and staff attitude.

Figure 13: Sub categories of complaints Q4

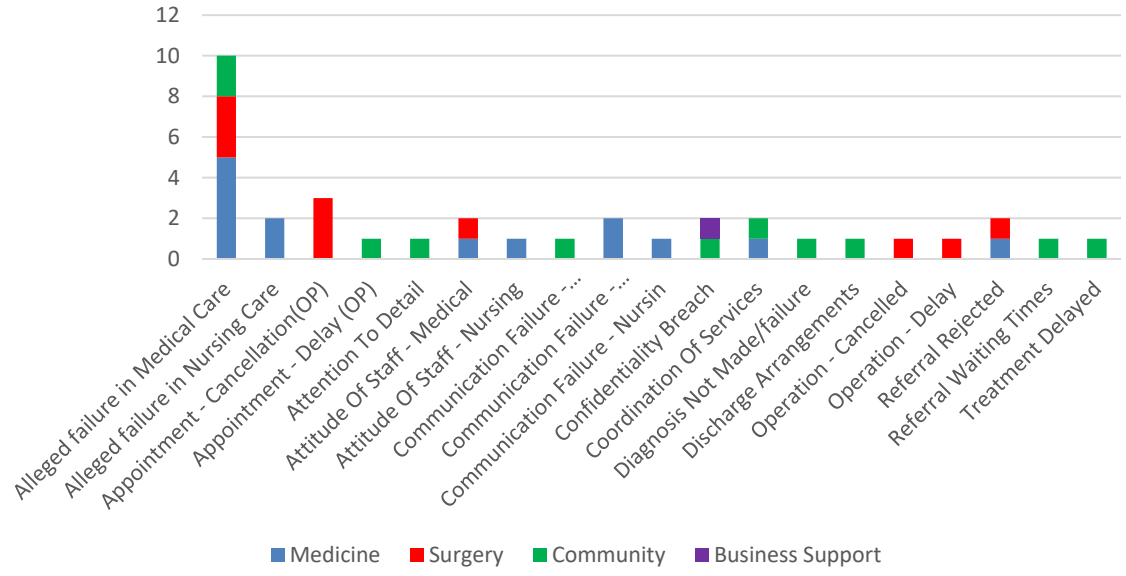
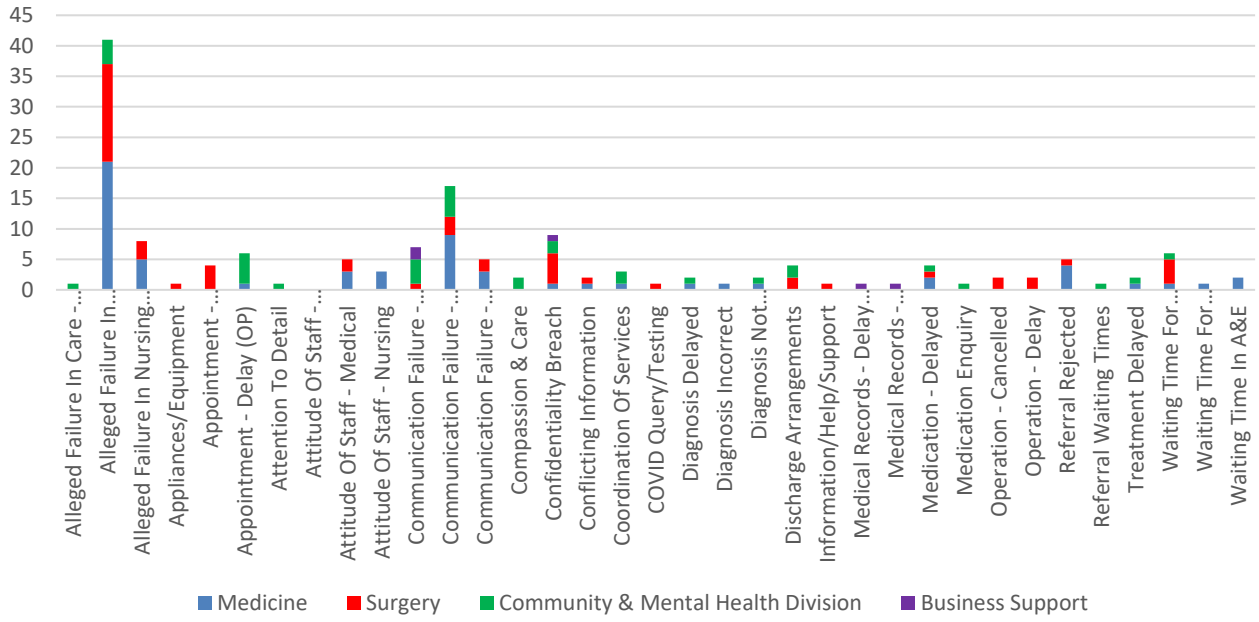


Figure 14: Sub categories of complaints 2022/23



2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however acknowledge that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust continues to aspire to responding to complaints in line with RM6 Complaints and Concerns policy.

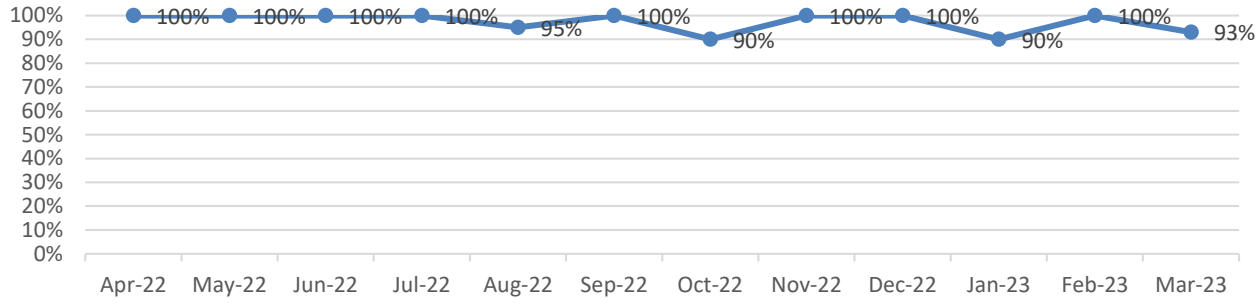
2.3.2 Compliance with 3-day acknowledgement 2022/23

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

In Q4, 95% (39 of 41) of the formal complaints received were acknowledged within 3 working days, with 37 (90%) being acknowledged on the same day. The two complaints not acknowledged within 3-days was due to administrative oversight.

158 of 164 (96%) complaints received in 2022/23 were acknowledged within 3 working days, demonstrating overall high compliance and sustained performance with this standard. Figure 15 shows the percentage compliance by month for 2022/23.

Figure 15: Percentage complaince with 3 day acknowledgement 2022/23



2.3.3 Complaints responded to and closed in Q4 and in year 2022/23

32 complaints were responded to and closed in Q4 of which 24 were received during Q4 and 8 were received in Q3. (5 complaints received in Q4 and subsequently withdrawn not included in the 32 responses).

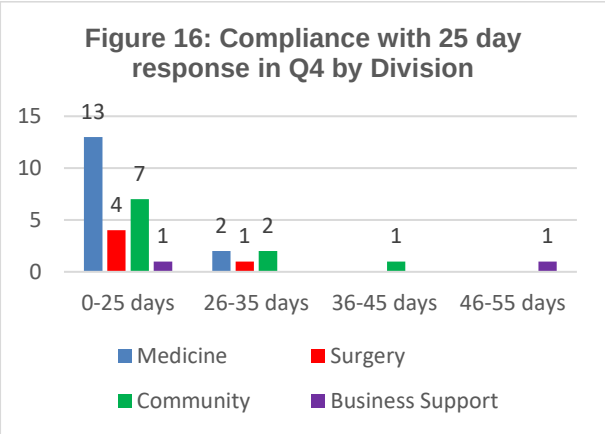
In year, 158 complaints were responded to: 63 by the Division of Medicine; 52 by the Division of Surgery; 37 by the Division of Community & Mental health; and 6 by Business Support

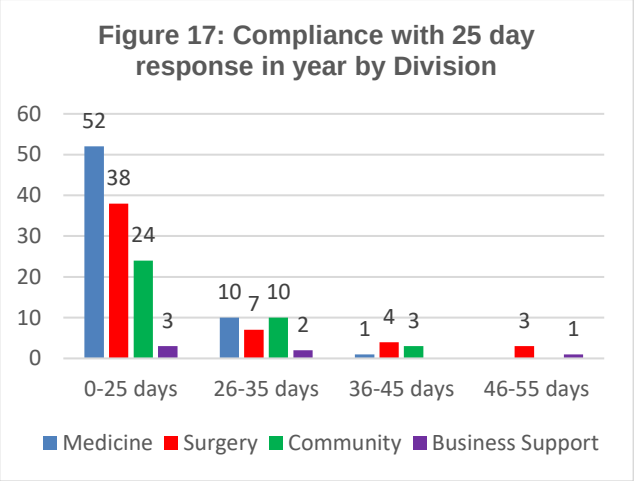
2.3.4 Compliance with 25-day response

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

In Q4, 25 of 32 complaints (78%) were responded to within 25 working days as demonstrated in Figure 16. Of the 7 complaints not responded to within 25 working days, 2 were responded to within 26 days and 3 were responded to within 27 days which demonstrates a significantly improved performance. Of the 12 complaints which remained open from 2022/23 and under investigation, all were within the 25 working days as at 1st April 2023.

In 2022/23, 117 of 158 complaints (74%) were responded to within 25 working days as demonstrated in Figure 17. The longest time to respond to a complaint was 49 days.

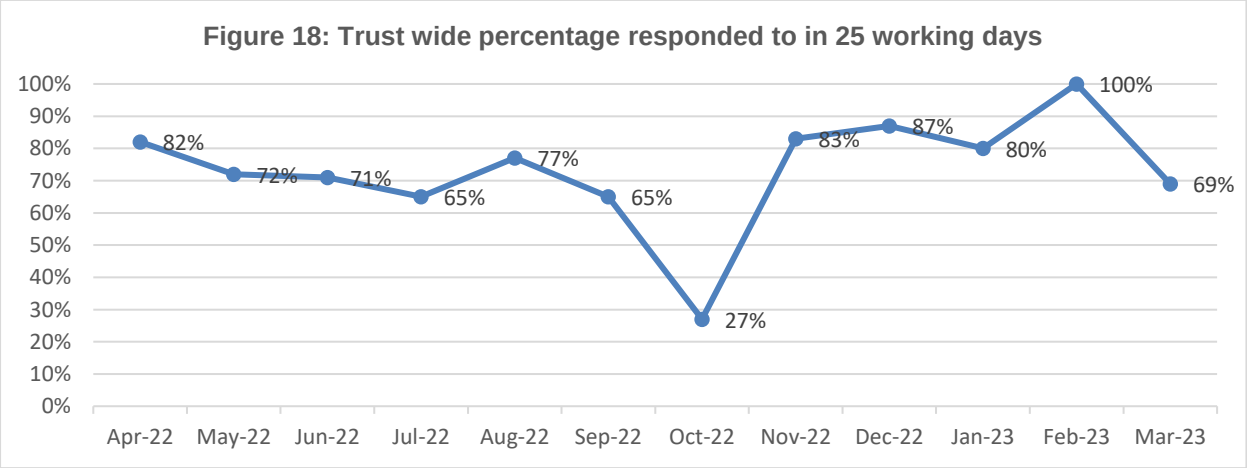




Percentage compliance is affected by the number of complaints where numbers are small, however compliance by Division in year is:

- Medicine: 82% (52 of 63)
- Surgery: 73% (38 of 52)
- Community & Mental Health: 65% (24 of 37)
- Business Support: 50% (3 of 6)

Figure 18 shows the Trust wide monthly percentage performance with this standard, and Figure 19 shows the number of complaints received in month (does not include complaints withdrawn), the total number closed in month and the number responded to within 25-days. Further analysis of performance with this standard by Division is provided in Figures 20-23.



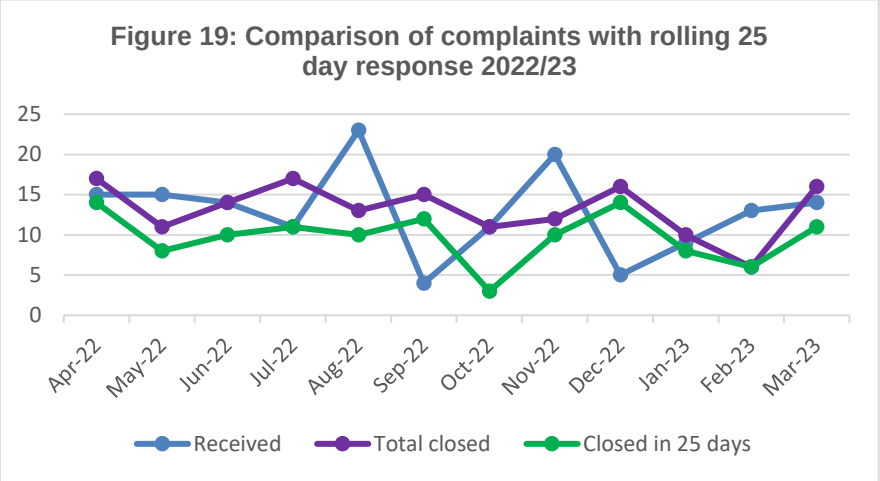


Figure 19: Comparison of complaints with rolling 25 day response 2022/23
25
20
15
10
5
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Received
Total closed
Closed in 25 days

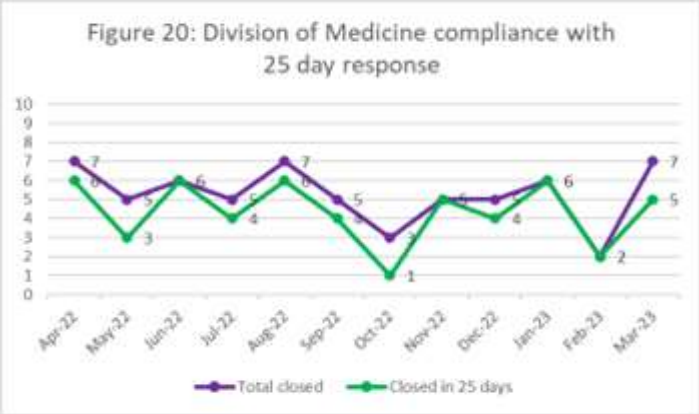


Figure 20: Division of Medicine compliance with 25 day response
Total closed
Closed in 25 days

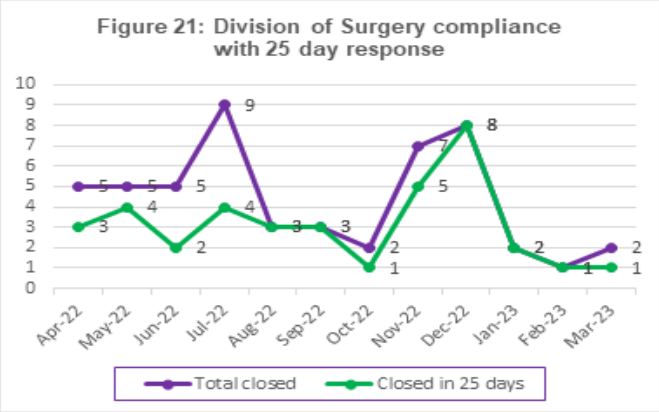


Figure 21: Division of Surgery compliance with 25 day response
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Total closed
Closed in 25 days


Figure 22: Division of Community & Mental Health compliance with 25 day response
Total closed
Closed in 25 days


Figure 23: Business Support compliance with 25 day response
Total closed
Closed in 25 days

Delays in completion of responses have on occasion been a result of complex complaints. Delays have also been caused where corporate quality check of the complaint has identified that further work is required by the associated Division to ensure that the complaint response fully answers the concerns raised, demonstrates compassion, apologises, and identifies what action will be taken as a result of the learning from the complaint

Whilst it is recognised that improvement work related to responding to families in a timely manner is a continued priority, there has been significant and sustained improvement in this performance indicator with an average of 74% of complaints responded to in 25 working days compared to an average of 55% in 2021/22. This is testament to the hard work of all the professionals involved.

2.3.5 Number of open and closed formal complaints by month

Table 2 shows there were 164 formal complaints opened in 2022/23 of which 10 were subsequently withdrawn resulting in 158 new complaints in year. The number of open complaints is inclusive of second stage complaints. 158 complaints have been closed in year. Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 2: Formal Complaints received 2022/23													**Cumulative to date**
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received (includes withdrawn)	15	15	16	12	24	4	11	21	5	11	15	15	**164**
Withdrawn and closed	0	0	2	1	1	0	0	1	0	2	2	1	**10**
New complaints (adjusted from withdrawn)	15	15	14	11	23	4	11	20	5	9	13	14	**154**
Open (first stage)	3	2	19	10	7	11	14	21	8	8	7	12	
Investigated, responded to and closed	17	11	14	17	13	15	11	12	16	10	6	16	**158**
Re-opened (Second stage)	1	1	2	0	2	2	3	0	0	2	0	0	**13**

2.3.5 National complaint reporting: KO41a return

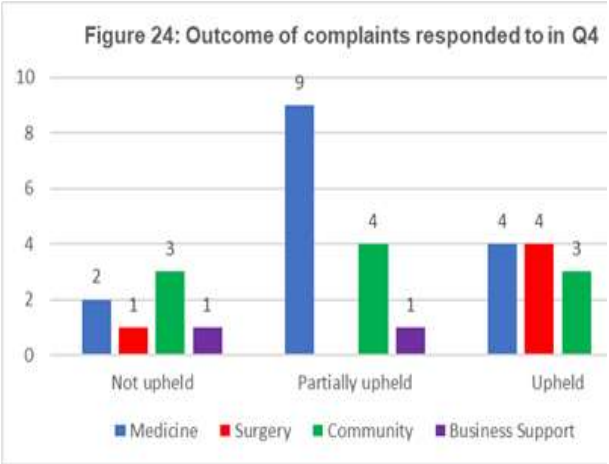
The Trust has previously been mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

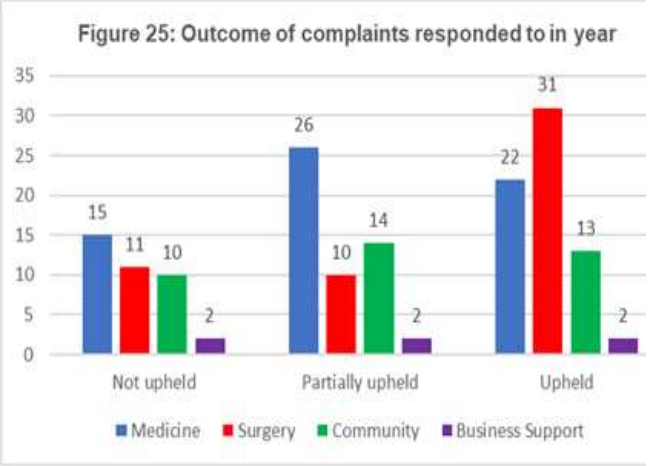
In November 2022, NHS Digital advised the move to a single, annual collection and publication. Submission of data for 2022/23 will be between April and May 2023; submission dates are yet to be confirmed.

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q4 7 (22%) of complaints were not upheld; 14 (44%) were partially upheld, and 11 (34%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 24 shows the outcome of complaints by Division for Q4 and Figure 25 for 2022/23 which is consistent with the Q4 position: 38 (24%) not upheld; 52 (33%) partially upheld, and (68) 43% fully upheld. These percentages are consistent with 2021/22 (23% not upheld; 35% partially upheld, and 41% fully upheld).





2.4.2 Second stage complaints

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

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

In year, 13 families informed us that they were not satisfied with the outcome of their initial complaint response: 4 received in Q1; 4 received in Q2; 3 5 received in Q3; 2 received in Q4. Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. All 13 cases were investigated and responded to as second stage complaints and all have been closed and resolved to the satisfaction of the complainants.

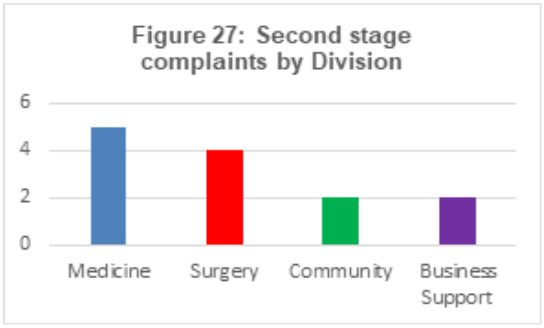
Of the 13 second stage complaints received, 1 relates to Q4 2021/22 and 12 relate to complaints responded to in 2022/23. Therefore at the time of reporting, 13 second stage complaints received relating to 158 initial responses (8%) The number of second stage complaints received in response to complaints responded to in 2021/22 can now be updated as a further 1 received in 2022/23: therefore 24 out of 162 (15%). There has been a

significant decrease in the number and percentage of second stage complaints in year in comparison to the previous 2 years that this metric has been formally reported on as shown in Table 3; the number of initial responses is consistent therefore this is a true reduction. This demonstrates an improved and overall high level of satisfaction with the quality and content of the initial complaint response, however there is a need to continue to monitor and review the reasons why families remain dissatisfied in order to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter therefore Figure 26 shows the comparison of monthly initial responses to monthly second stage complaints received.

Table 3: Second stage complaints

Year	Initial response	Second stage	%
2020/21	156	25	16%
2021/22	162	24	15%
2022/23	158	13	8%



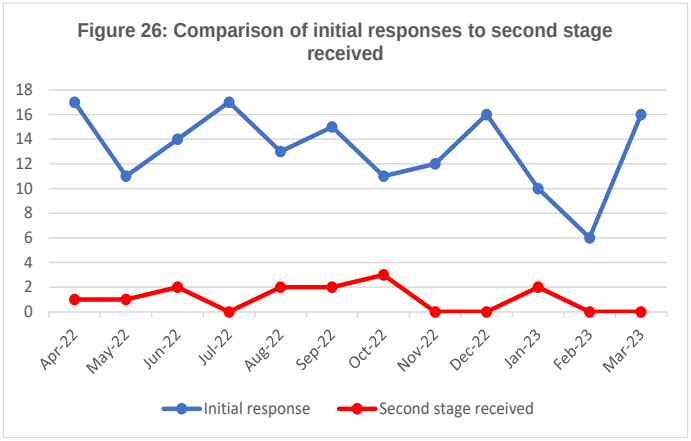


Table 4 below shows the number of second stage complaints in year and performance against key performance indicators. 100% of second stage complaints were acknowledged within 3 days. 8 of the 13 (61%) were responded to within 25 working days. One complaint in the Division of Surgery took in excess of 100 days due to the complexity of the complaint

Table 4: second stage complaints received

Q	Second stage received	3-day acknowledgment	Number of days to respond					
			within 25-days	26-40 days	41-60 days	61-80 days	81-100 days	≥ 100 days
Q1	4	4	2	1				1
Q2	4	4	4					
Q3	3	3	1	2				
Q4	2	2	1		1			

2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no new referrals to the Parliamentary & Health Service Ombudsman in Q4. There are no ongoing investigations.

2.6 Actions and learning from complaints

It is essential that where things go wrong the Trust takes action to remedy any issues. Complaint response letters inform the individual complainant what action has or will be taken, and the Division monitor the actions through to completion. Complaints Officers include a clear breakdown of all actions in the response letter to the complainant.

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

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

Medical Division:

Complaint: Attitude of nursing staff; staff not introducing themselves
Actions: To discuss the importance of clear communication at the staff safety huddle. All nurses involved to complete a reflection account.
Lessons: All staff should introduce themselves and communicate effectively with families

Complaint: Unhappy with the care received in ED.
Actions: Improve communication in ED waiting room for patients who have waited a long time to be seen. The use of a tannoy with announcement and other forms of communication to ensure parents know how long the wait time is and highlighting to them how to raise concerns. ED Matron to ensure comfort round process is monitored and audited every 3 months
Lessons: Ensure clear communication throughout the department for parents to escalate concerns or needs such as water/ fluids and checking parents and carers understanding

Complaint: Concerns not being listened to and diagnosis not discussed with family. Second opinion requested
Actions: Allocate time at the next clinic appointment for questions to be asked.
Second opinion will be offered. Clinic appointment offered
Lessons: To communicate effectively with parents. To consider patient's needs during stressful situations

Complaint: Concerns not listened to; contamination of central line; lack of cleanliness on the unit; uniform policy not being followed
Actions: IPC to complete an additional audit on the Renal Dialysis Unit. Sink drainage and dialysis drainage ports in the Renal Dialysis Unit to be cleaned and regularly maintained. Uniform policy to be recirculated to all staff on the ward/unit.

Surgical Division:

Complaint: Lack of provision of a suitable soft diet following oral surgery; none of the meals previously promised by the Dietician were provided on the ward.

Actions: Improvements will be made to the provision of soft diet options and how information is communicated to staff groups about specific dietary requirements.

Complaint: Delay in receiving blood test results due to patient being transferred to another hospital in the interim.

Lessons: Appropriate handover of information from Neonatal Unit to the ward and other hospitals must be documented on discharge paperwork with plans for following up blood or other test results clearly documented with the following information: Date the action is due by; Which member of staff has been allocated as owner of the task

Complaint: Lack of staff understanding of how Autism, Sensory Processing Disorder and learning disabilities can affect the ability to provide adequate oral hygiene through limited diets.

Actions: Training in specific areas such as Sensory Awareness, Learning Disability and Autism is to be continually updated and available to staff teams

Complaint: Operation cancelled due to pre-operative instructions not being followed correctly.

Actions: Change of process to ensure all patients receive the general anaesthesia information leaflet for parents/carers automatically as part of the Admission Pack

Community and Mental Health Division:

Complaint: Waiting on information from Alder Hey as part of EHCP

Actions: To review the process of how the correct information is identified and made available for Education, Health and Care (EHC) needs assessments

Complaint: No copy of clinic letter following previous clinic appointment, wait for assessment and poor communication regarding progress of assessment, waited over a year for one clinic letter and over 3 months for another.

Actions: Staff training to Community Paediatrics department, to inform them of the ASD Service process and ensure full informed consent is gathered for any referrals made to the service. All Community Paediatric clinics to be validated by senior manager to ensure record keeping and reports are sent out in a timely manner, in keeping with Trust record keeping processes. All ASD Service triage meetings to be validated and audited by Senior Manager to ensure all actions, including letters to family have been completed in a timely manner as per standard operating procedure. he learning from this complaint will be shared in the Divisional Governance meetings to highlight the impact any such delays can have on parents and carers

Lessons: Ensure any referrals identified through validation or other means that have not been actioned in a timely manner after the clinic appointment with parents, are only actioned once a further contact has been made with parents to ensure consent is still fully informed.

Complaint: Confidentiality breach; details of biological parent left in the system of a patient in care

Actions: Remove biological details from PAS. Review of internal processes and policy, associated with the demographics and management of Children in Care information. Staff Training across the workforce including administrative, clinical and nursing staff around awareness of Children in Care and experience of children and families. Further audit of Children in Care demographic processes to be completed to track effectiveness of revised process and training

Complaint: Referral to ASD pathway not processed, then delayed further and not backdated, attitude of staff and request to change consultant.

Actions: Failings in record keeping and referral management highlighted in this complaint to be escalated to the Clinical Director for the Developmental Paediatrics Department. Message to be relayed to all clinicians in the Developmental Paediatrics / ASD / ADHD Teams that if a child/young person needs to be taken out of the room to relieve their anxiety / distress, that this needs to be explained clearly to parents / carers. The facility to retrieve and learn from phone calls to improve the experience for both parents/carers and staff, needs to be used to improve staff training. Doctor to review and amend the clinic letters in light of the comments from complainant. Learning from this complaint to be shared with the Developmental Paediatrics and ASD Teams

Lessons: All clinic notes / letters / referrals need to be completed as soon as possible after a consultation to ensure a complete patient record. Where a referral is made, care and attention is needed to ensure the referral is processed correctly and where the referral has been requested to be backdated that this is escalated to the Head of Service.

Complaint: Frustration with trying to get support mental health support for 17 year old son with learning disabilities and ASD

Actions: Patient's episode of care with Sefton CAMHS, which ended in April 2022, was not closed down on the system so it looked like remained open. Although this did not directly impact on the patient's care, we have taken the learning and a reminder to be clear about discharging and closing episodes of care on the system has been provided. The Crisis Care call could have triggered contact with the newly formed keyworker team provided by the Integrated Care Systems (ICS) who could have potentially supported parent over the weekend. To provide additional support to the family, we will aim to offer check in calls over the weekend by the Alder Hey Crisis Care Team. We recognise that although the referral was entered for planned care, contact was not made by the Crisis Care Team to the Intensive Support Team/Home Based Treatment Team. As a medical appointment was arranged there was no evidence this added a delay to care being provided, but the leaning has been taken back to the teams to promote better patient journeys moving forward

Lesson: If a young person is being discharged, ensure all episodes of care on the system have been closed.

2.7 Healthwatch

Healthwatch Liverpool and Healthwatch Sefton are key members of the PEEG and feedback any issues or concerns raised by children, young people and families. Concerns are also fed back in real time to the Patient Experience lead. Numbers are small and concerns are usually anonymous; there is a process to triangulate any concerns with concerns received by the Trust both by theme and if the complainant shares their name the Trust is able to respond either directly to the individual or through Healthwatch. Healthwatch have identified that whilst the number of informal PALS concerns has increased in 2022/23 this is also a positive marker of an open and listening organisation that has clear and accessible routes for families to raise a concern.

2.8 Achievements in complaint management process 2022/23

Updated Complaints and Concerns Policy (RM6): Policy re-written to provide clear guidance, structure and process throughout, to clearly define roles and responsibilities, and to improve the flow of the policy to assist staff to promptly identify relevant guidance. The policy has been significantly strengthened in regard to the rights of children and young people to raise concerns and the importance of the first contact resolution principle for concerns raised at local level

Quality Ward Round: Undertaken to gauge the views of children, young people, their families and the staff to further understand what information they would like, to understand how staff manage local concerns and to ascertain what information is available on the wards. As a result a QR code has been set up to enable CYP to raise an issue

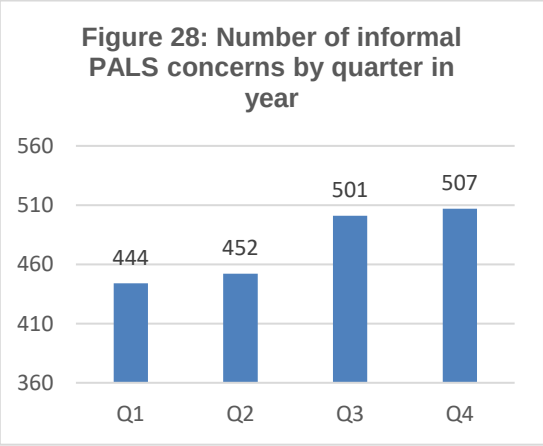
Online feedback: System set up to enable complainants to share feedback regarding their experience of the management and response to their complaint on the Trust website.

Risk Assessment training: Generic and bespoke risk assessment training delivered to assess the risk of formal complaints and identify actions that may be required to address the emerging risks.

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q4 and full year 2022/23

There were 507 informal concerns received during Q4, consistent with 499 reported in Q3 as shown in Figure 28. Figure 29 demonstrates the figure by month in year with 1904 informal PALS received. (It may be noted that the numbers may differ slightly from previous quarterly reports following data cleansing and deep dive)



As shown in Figure 30, 1904 is a significant increase compared to the previous 2 years and the highest number reported. The increase is understood to be partly associated with recovery following the pandemic and increased waiting times to time to see and treat patients

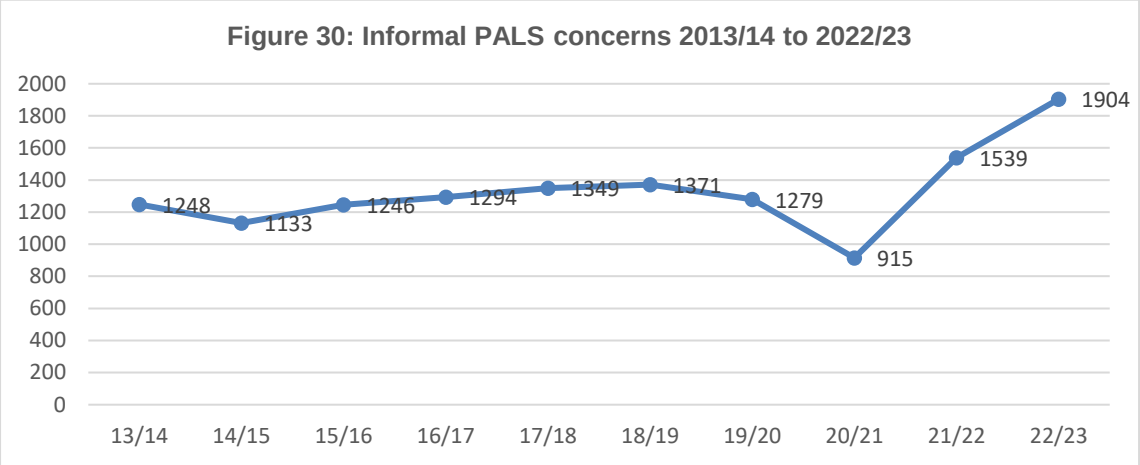


Figure 31 shows the breakdown of informal PALS concerns by Division by quarter and Figures 32-35 show by Divisional services

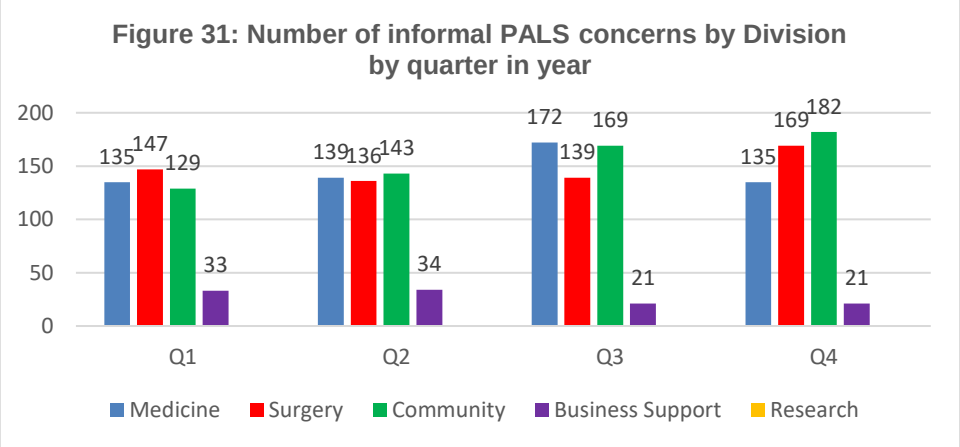


Figure 32: Informal PALS concerns in year Medicine

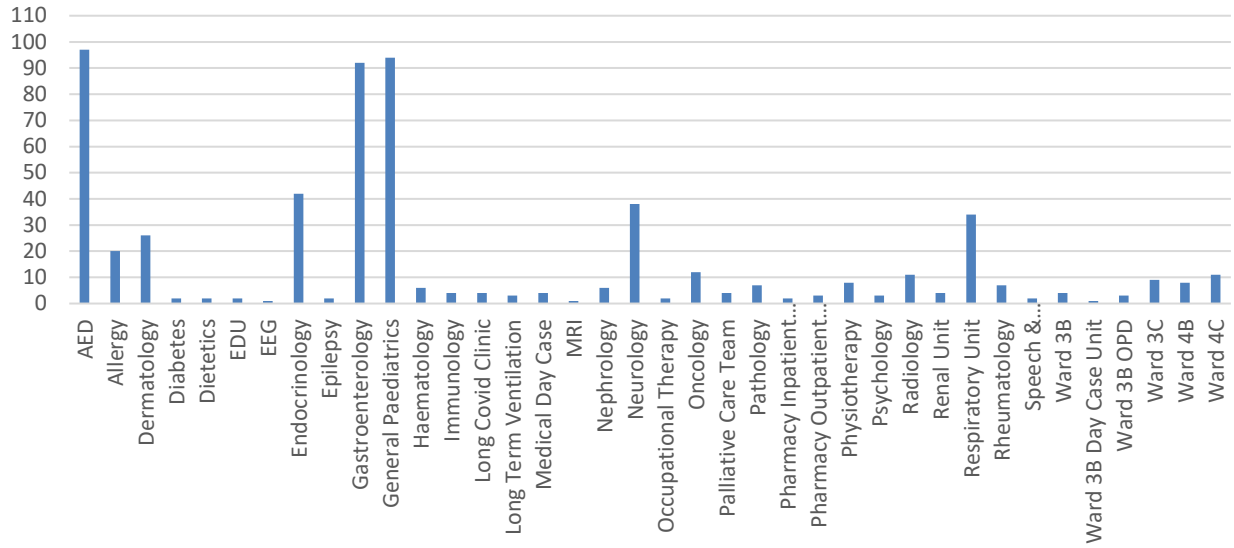


Figure 33: Informal PALS concerns in year Surgery

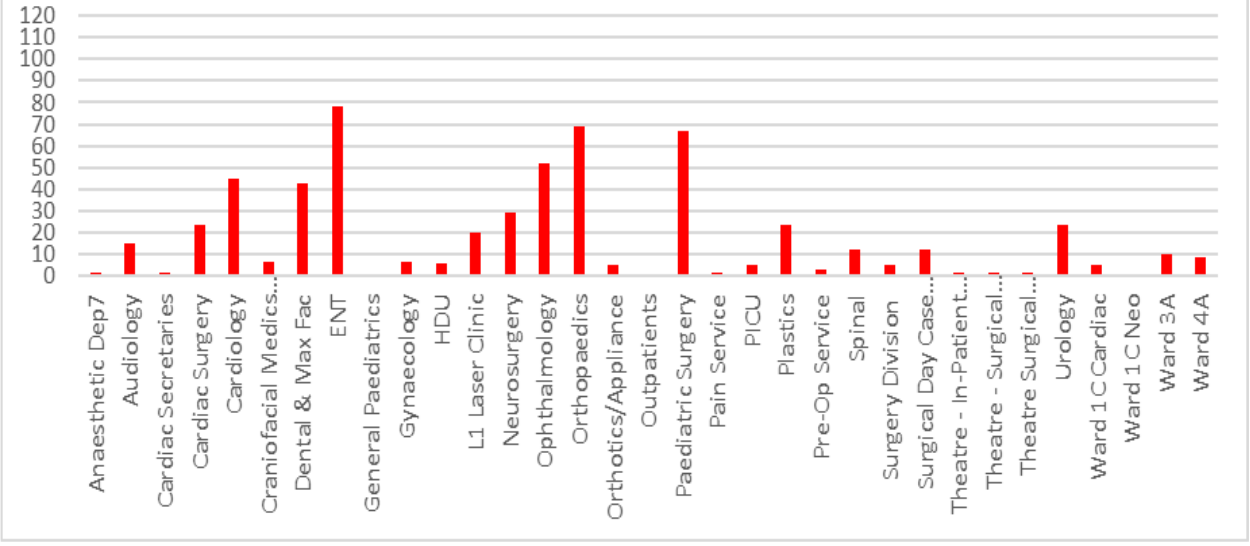


Figure 34: Informal PALS concerns in year Community & Mental Health

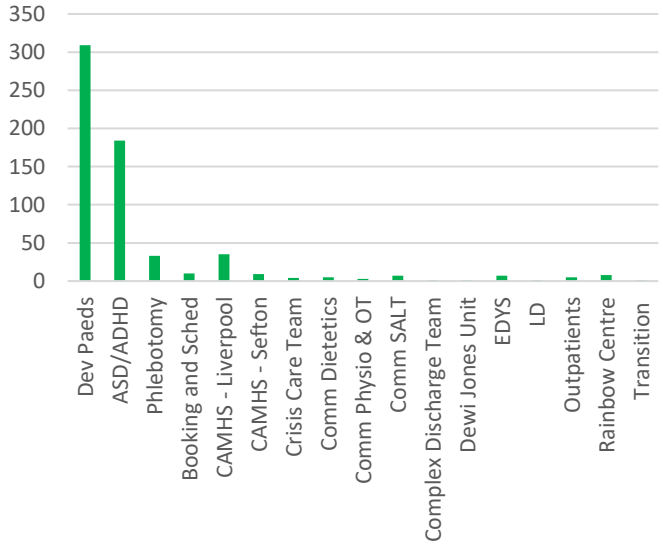


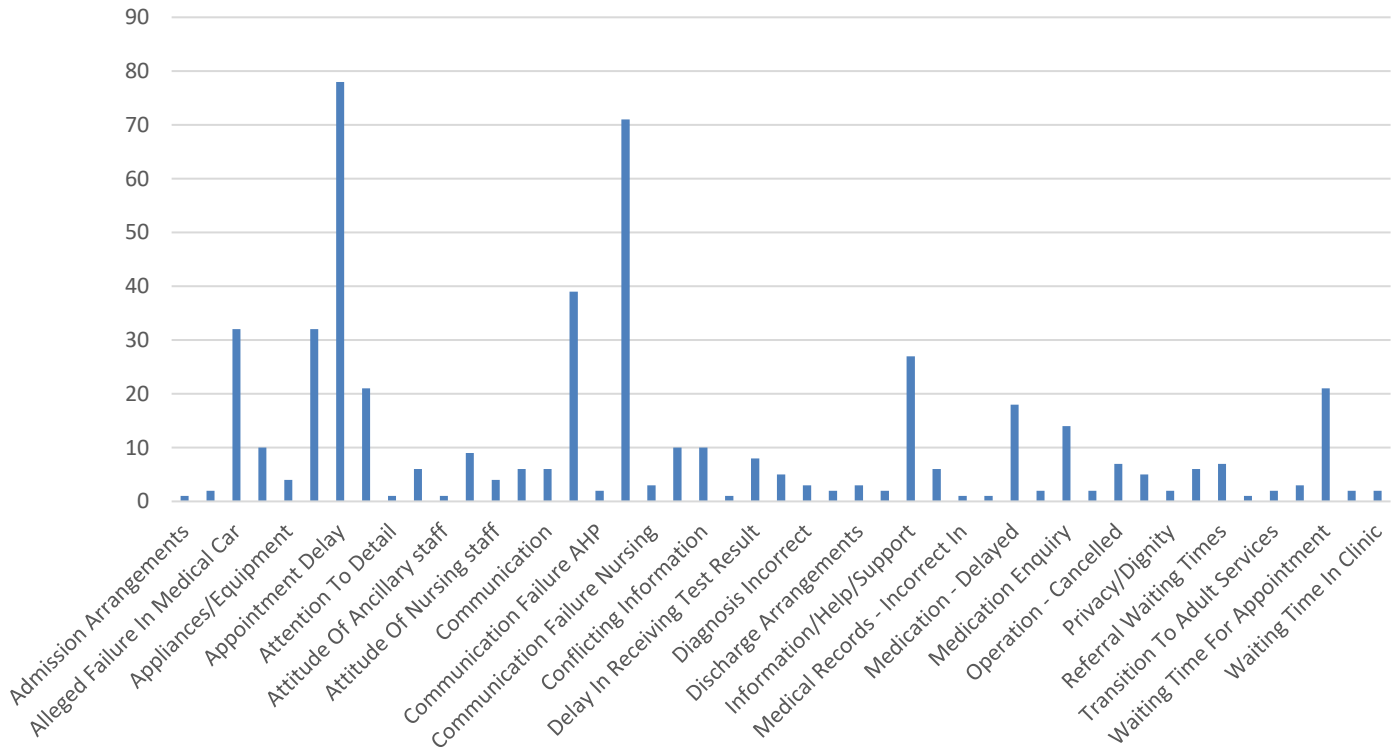
Figure 35: Informal PALS concerns in year Business Services

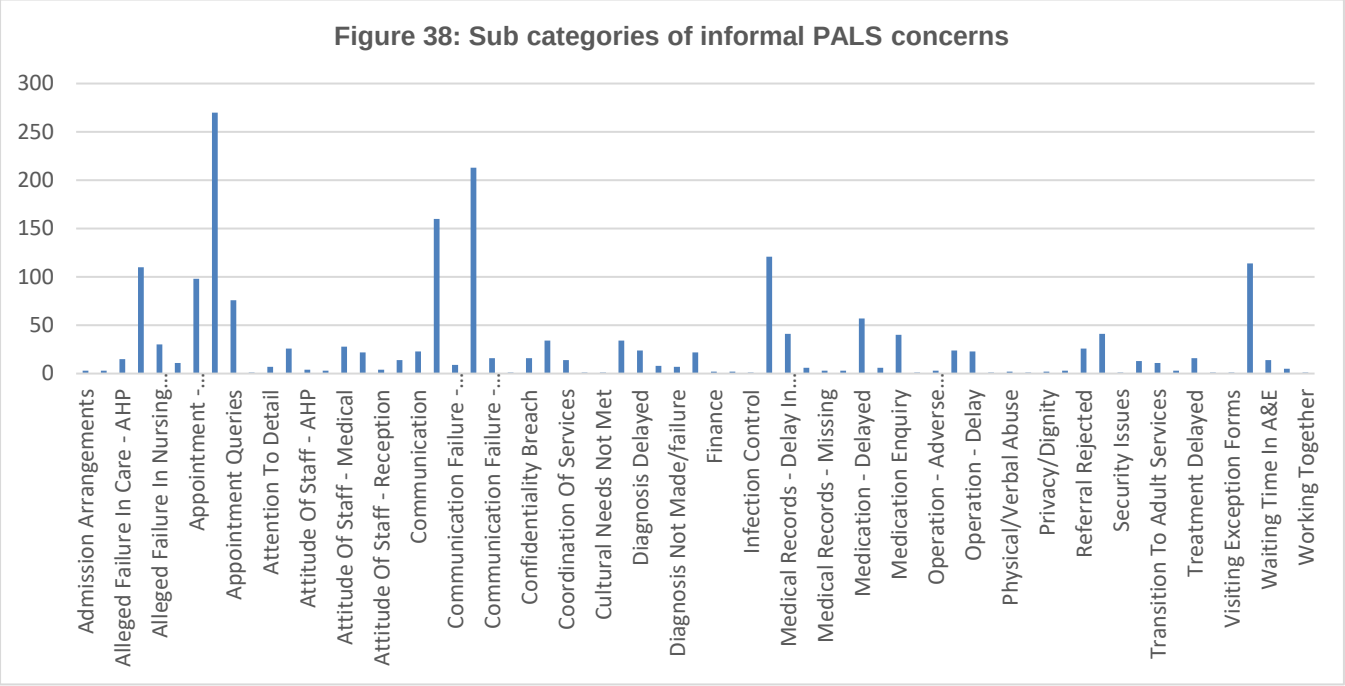
The Clinical Research Division acknowledge that no concerns have been received and the Division are reviewing methods to collate feedback from families which best supports the needs of this patient group.

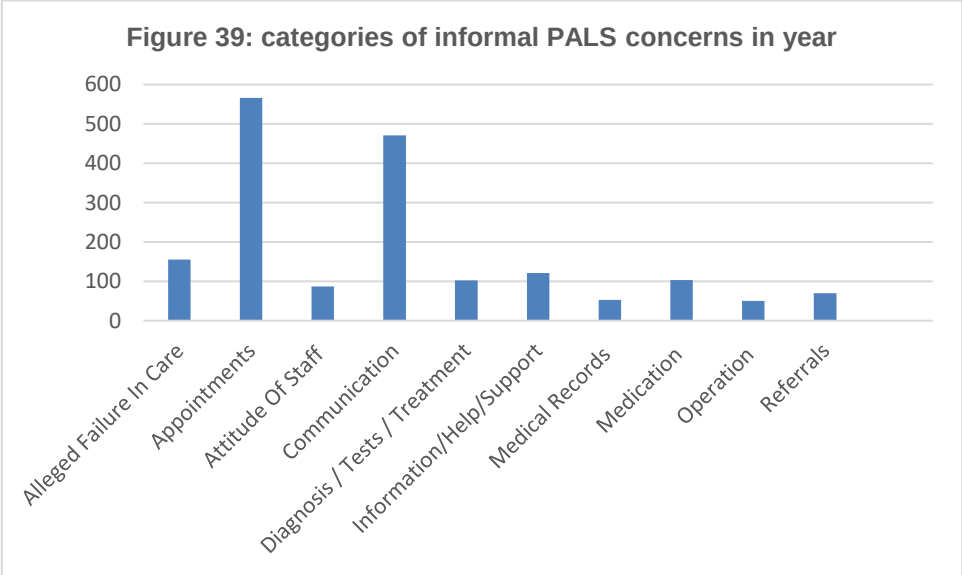
3.2 Informal PALS concerns received by category Q4 2022/232 and full year 2022/23

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q4 continue to relate to communication, appointment waiting times, and alleged failure in medical care as shown in Figure 37; this is consistent with the concerns that are raised as formal complaints and informal PALS concerns received in previous months in 2022/23 as demonstrated in Figures 38 and 39. This analysis demonstrates where the Trust and the Divisions need to focus improvement to improve the experiences of families as outlined in the recommendations section.

Figure 37: Sub categories of informal PALS concerns in Q4



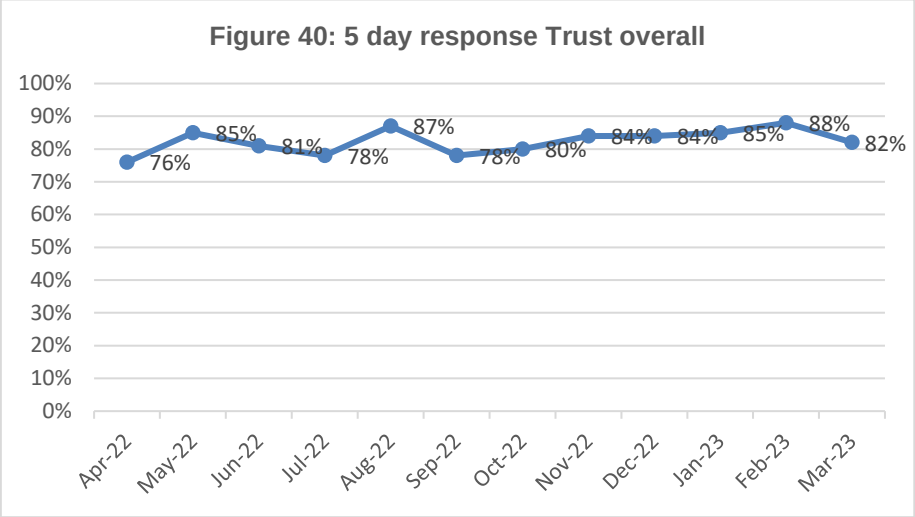




3.3 Trust performance against Key Performance Indicators (KPI): compliance with 5-day response

The standard to respond to informal PALS concerns is within a 5-day timeframe in order to provide a prompt resolution for children, young people and families. In Q4, 85% of PALS were resolved within 5 days. This is a significant and sustained improvement in this standard this year as demonstrated in Figure 40 despite the increase in concerns received. This is testament to the hard work of all the teams involved and a new clearly defined PALS process to work within.

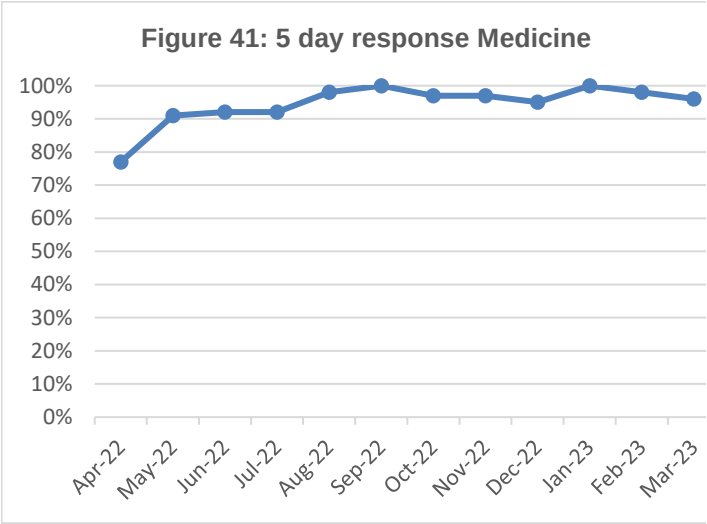
In 2022/23, 1574 of 1904 informal PALS concerns (82%) were responded to within 5 working days.

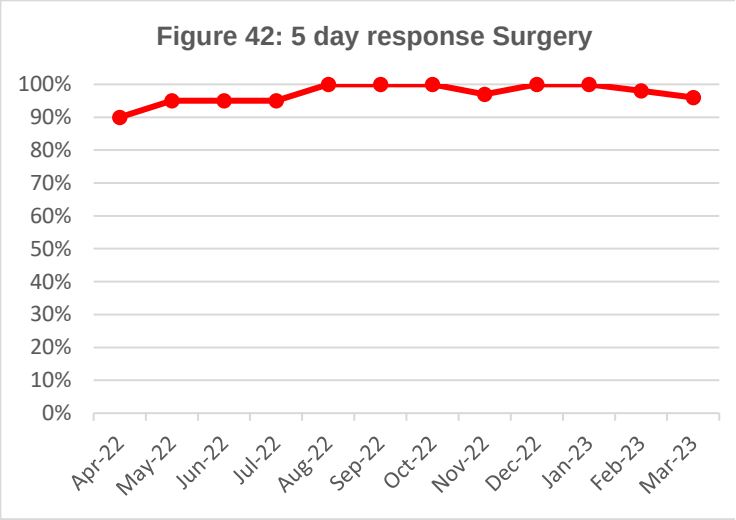


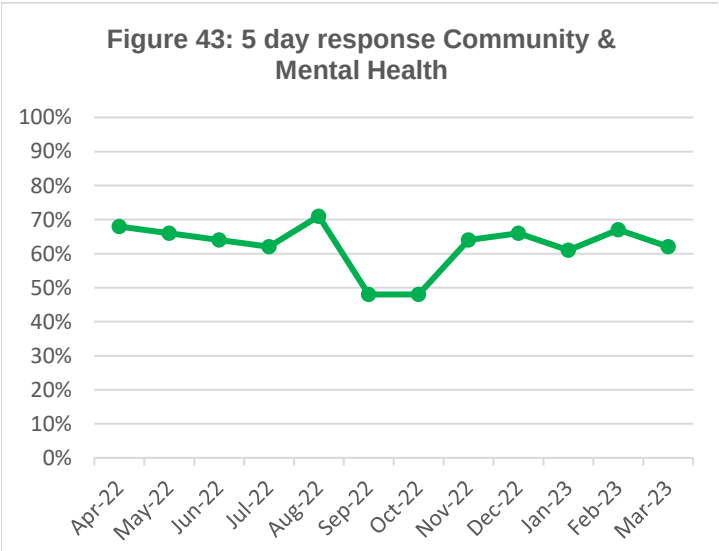
Compliance by Division in year is demonstrated in Figures 41-44 and is as follows:

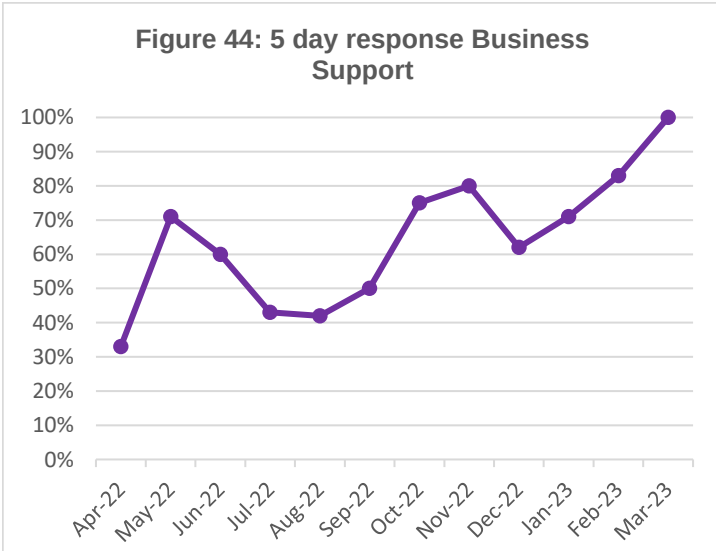
- Medicine: 95% (552 of 581)
- Surgery: 97% (577 of 591)
- Community & Mental Health: 62% (385 of 623)
- Business Support: 61% (67 of 109)

Significant and sustained improvement has been demonstrated in Division of Medicine and Division of Surgery.









3.4 Actions and learning from informal PALS concerns

Themes and trends regarding informal PALS concerns are reviewed at the Divisional Integrated Governance meetings to ensure dissemination, learning and identification of local and strategic actions. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services are:

1. A large number of PALS throughout 2022/23 have been about difficulty getting to speak to someone in relation to Developmental Paediatrics, ASD or ADHD queries.

Action: A business case was developed and following recruitment, more staff are now in place to respond to phone calls to the telephone enquiry line for Developmental Paediatrics, ASD and ADHD. In addition, the options when calls are made to the phone line have changed, to allow people to go direct to a PCO (if known) or to speak to someone from either Developmental Paediatrics, ASD or ADHD. This has reduced the waiting times for calls to be responded to and the number of abandoned phone calls has reduced significantly.

2. Q4 has seen an increase in PALS relating to medication and prescription queries for Developmental Paediatrics and ADHD.

Action: The process for monitoring height, weight and blood pressure is being reviewed, as this may be causing some of the delays to prescription scripts and lead to the frustration of parents / carers. There is an SOP in place for this process and the team are monitoring to ensure the process is being followed; changes will be made to the SOP if needed. The team are also in the process of recruiting more staff to meet the demands.

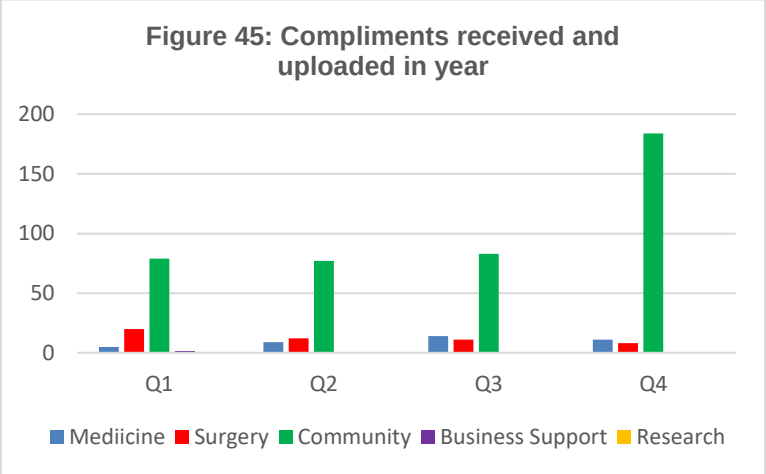
3.4 Historic PALS

In 2022/23, it was identified that there were a significant number of historic PALS concerns (992) pre-dating 2022 calendar year / and or over 100 days, with some concerns dating back to 2012. The historic concerns were stratified and reported on in detail in Q3. All historic incidents have now been closed and there is a high degree of confidence that such legacy issues could not happen again as there is robust oversight and scrutiny of PALS management at both Divisional and Corporate level.

3. Compliments in Q4

5Compliments are an important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback about their experience. This feedback also provides important balance with concerns raised.

514 compliments were centrally recorded in year however it is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit.



Appendix I provides examples of compliments received during Q4.

4. Recommendations and proposed developments in the management of complaints and PALS

The Trust and Divisions will continue to drive improvements in response times to families for formal complaints and informal PALS concerns in 2023/24. However it is recognised that the importance of early intervention and a first contact resolution principle is key; this will ultimately lead to an increase in local concerns recorded (currently very low number reported in Ulysses) with an aim to decrease informal PALS concerns and formal complaints.

The following is recommended and is in line with requirements from the Ockdenden report (2022):

i. Introduce and appoint a Trust Complaint Manager to:
   a. Staff training in complaint management and local resolution
   b. Co-ordinate complex PHSO complaints
   c. Support the Divisions

ii. Implement staff communication training which includes customer service training; in recognition that staff attitudes are a theme in formal complaints and informal PALS concerns

iii. Resource improvement of the PALS office to improve appearance, visibility and approachability

iv. Continue to work with the CYP Forum to encourage children and young people to share their concerns

v. Explore ability of new risk management system to improve reporting and analysis including whether complainant is a child or young person, and protected characteristics such as ethnic background. This data would help identify any groups of individuals who are less likely to raise a concern and support the development of wider inclusive methods to report concerns

5. Conclusion

Trust Board are asked to note the content of this report and support the recommendations and proposed developments outlined in section 5 of this report.

Appendix I: Examples of compliments Q4 2022/23

Medicine Division

ED and Learning Disability Team: *"Went to a&e today with our severely autistic daughter. Would like to send huge thanks to the staff. They put us in a sensory room which helped our daughter and ourselves massively. What a fabulous kitted out room too. Laura and her colleague (think it was Collette) were fabulous and couldn't do enough. checking in on us and making sure everything was OK. Please send our heartfelt thanks to the learning disability nurses involved and staff in a&e environment for making a possible traumatic experience so much easier and better. Thanks again."*

Radiology: *"My son was quite unwell and the consultant had requested an urgent ultrasound to be carried out. This was done with a couple of hours. The consultant radiographer dealt with my baby in a very calming and caring manner. He did not become frustrated when my child kept trying to pull the scanner off him. He actually allowed him to hold it when he doing the scan. He had a very kind way about him and interacted and spoke to my baby throughout the procedure. He put us all at ease."*

Medical Day Care Unit: *"I just wanted to express how amazing Kayleigh was on the medical day ward. She was empathetic, patient and so supportive and understanding. She is an absolute asset to the team. She has such a friendly yet professional approach and it's so obvious she absolutely loves her job. Thank you for making such a stressful day that little bit easier. Can't thank Kayleigh enough really . Your kindness made a huge difference to my daughter today when she was so anxious. She really liked you and we both hope you are there when we have to attend in the future x*

Surgery Division

Anaesthetic department: *"have recently logged a formal complaint about multiple Outpatients experiences we've had with our daughter. However, I now want to balance that with communication about positive experiences we had yesterday. As such, I'm hoping they can be logged, too. At the very least, I'm hoping this can be forwarded to the person involved and anyone in their team. Yesterday, (name) attended surgical daycare for a traction x-ray as part of investigations into potential scoliosis correction. I attended with her. We had quite a wait know the prep room, and as such, x's anxiety became heightened at times. However, the aneasthetist stood out as an example of the incredible things you can do to put patients and families more at ease. So much so, that our overall experience was extremely positive, to the point we didn't really feel like we had been to hospital. At a hospital like Alder Hey, that should always be the case where possible. Sadly, I'm uncertain of the anaesthetist's name, but the procedure was carried out by Mr Davidson, and I'm sure it will be easy to locate who was on duty for this yesterday, which is why I'm emailing so quickly. To outline steps the anaesthetist made, it started in the prep room. When the anaesthetist entered the room, (child's name) was sitting on the floor, visibly anxious but not in any significant way. However, the second the anaesthetist established that x has autism and quite severe anxiety, she moved closer and got down on x's level. She used both vocabulary and appropriate hand touch to talk x through what would happen, presenting as a calming influence throughout. At no point did she move into x's 'space', so to speak, but she used instinct and judgement to navigate the difficulties x was experiencing (and might continue to experience) in an incredible way. We next met the anaesthetist at the point x was about to*

enter theatre. I was there throughout and watched in amazement as x was put under general anaesthetic in a calm and extremely soothing manner. Again, the anaesthetist worked on x's level, kept her engaged in conversation and was completely patient-centred throughout. In a very active (but subtle way), the anaesthetist regulated any anxiety x was experiencing at that time, using a manner and language that simply worked from start to finish. Honestly, I couldn't have asked for more for x, and I can only say we probably all have a lot to learn from this anaesthetist. Please pass on our sincere gratitude for her excellence throughout."

Dental: *"Hello, This is not a complaint (the opposite). We have just been in to see a dentist for my daughter with a rare genetic condition and profound learning difficulties. Both the Dentist (Ciara Feeney) and the dental nurse/technician assisting her today (didn't catch their name sorry) were just amazing from start to finish. Please please can you pass on this thanks to them as too often people complain but don't take the time to compliment. Having a child with complex needs is tough but today they made things a little bit better for us and for that all we can say is thank you so so much. Please can you pass this along."*

ENT: "*I'd like to pass on my thanks to everyone involved with I(child's name) since we first got referred to ENT. Dr SHARMA listened to my concerns, and so did the consultant I saw back in December with x. The care we got on the 6th of march was faultless. Everyone introduced themselves, both the surgeon and anesthesiologist explained everything and made me feel more at ease that she was in good hands. The staff in theatre were amazing in trying to distract x along with doing their job & trying to keep me calm! My mum, x's grandma also came with me as her dad has a hospital phobia and she also agreed how lovely everyone was & how clean the hospital is. I've been with x for numerous reasons before ENT as have felt other hospitals haven't listened to my concerns, and have always felt that alder hey is the place I would ever take my two girls should they need it. Alder hey has been one of my top recommendations to fellow friend and family parents when they have also been in similar situations. Again, Thankyou! We hope this is x on the upwards now, and that we don't see alder hey for a good while! In a nice way of course!*

Community Division

EDYS*: "Carmel and Paul have both worked with my daughter and they have both helped me with my daughters needs it's been very tough but they are always there to help with any problems me or my daughter might need. thank you. The service has been acceptional. Everybody at EDYS has been fantastic Thank you for all the great work you do"*

Community Physio and OT: *"Thankyou soooooo much for making hydro happen, you don't know how much that means to us. Harry has none stopped talking about it & is counting down the days till next week! He wants to fast forward the week to next Thursday and said it's his best day ever!! X"*

CAMHS SPA / Crisis Care Team: *"I just want to repeat how grateful we as a family are for all the support we have received from the CAMHS crisis team. During the Christmas period whilst my daughter was experiencing a crisis we felt so lost and inadequate in the face of her distress. The support my daughter and we as a family experienced was incredible and made a difficult time so much more bearable. The staff who called my daughter (the names I remember are Ash and Claire) found exactly the right words and offered such a safe space for my daughter which helped her so much. Your own input throughout has been outstanding and we always know we can trust your insight and advice. I have such respect for the clear, honest advice and support you offer my daughter and us as a family. Thank you so much"*

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Trust Mortality Report Quarter 4**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass, Julie Grice

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☒ Regulation ☐
Summary / supporting information:	
Action/Decision Required:	To note ☒ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

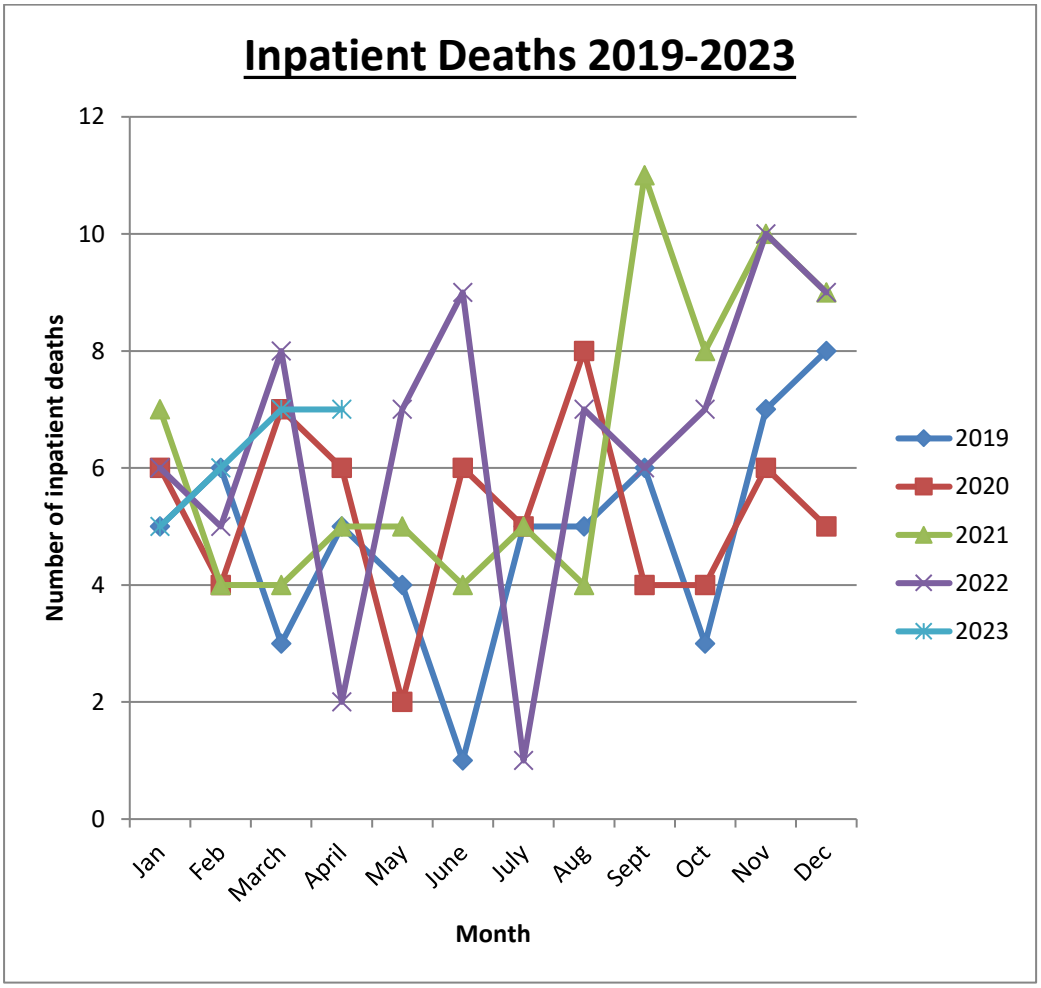
The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 4 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)

Inpatients Deaths 2018 -2022

Month	2019	2020	2021	2022	2023
Jan	5	6	7	6	5
Feb	6	4	4	5	6
March	3	7	4	8	7
April	5	6	5	2	7
May	4	2	5	7	
June	1	6	4	9	
July	5	5	5	1	
Aug	5	8	4	7	
Sept	6	4	11	6	
Oct	3	4	8	7	
Nov	7	6	10	10	
Dec	8	5	9	9	
Total	58	63	76	77	25



Looking at the 5-year figures, there was an increase in total case numbers in 2021 However, significantly in 2021, there were changes in the way that the data was recorded because of the national child death mortality process. The children /YP that died in ED, were not included in the figures prior to this, as these cases had minimal clinical input due to being in such a precarious state that unfortunately nothing could be done. These cases already had rapid external reviews, discussed in ED M and M's and went down the coronial process so there did not seem much learning that could be achieved by reviewing them in HMRG. However, these are now all reviewed at HMRG and recorded in the figures..

The mortality figures remain high later in the years post Covid due to a variety of factors such as the number of viruses that have been more virulent post COVID lockdowns and last year an increase in Group A infections with some unfortunately causing sepsis and deaths nationally.

The mortality process in the Trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes:

1) One of the most significant changes is the introduction of the Medical Examiner (ME) process. This was due to be a legal requirement in April 2023 but has now been delayed till April 2024. Alder Hey has appointed two paediatric medical examiners to join the LHUFT Medical examiner team. The AHCH process had been planned and is to be instituted in the next few months following training across the Trust. The aim is for minimum impact on the families and clinicians.
2) Another change over the next 6-12 months is the introduction of the new PSIRF framework and how this will work with the internal mortality process and the coronial system. It will take time to transition to this new system.

3) The way that learning is shared across the organization is currently changing and should be far more effective and in a timelier manner.

Current Performance of HMRG

Summary of 2022 Deaths

Number of deaths (Jan. 2022 – Dec. 2022)	77
Number of deaths reviewed	71
Departmental/Service Group mortality reviews within 2 months (standard)	74/77 (96%)
HMRG Primary Reviews within 4 months (standard)	65/77 (84%)
HMRG Primary Reviews within 6 months	57/58 (98%)

The percentage of cases being reviewed within the 4-month target has decreased minimally due to the junior doctor's strike impacting on that month's HMRG meeting. The HMRG members readily increase meeting frequency and duration when the need has arisen.

The HMRG consists of members with a considerable variety of expertise so ensuring that the case is reviewed as comprehensively as possible. This includes NWTS (the regional paediatric transfer team), LWH (neonatology expertise), psychology, Snowdrop (bereavement) team aiming for as robust process as is possible.

Most cases are very complex for a variety of reasons and often require multiple discussions so entailing a considerable amount of time, but this is vital to ensure that the correct conclusions and learning is achieved. The meetings are once a month and held on TEAMS enabling more people to attend including the DGH clinicians involved if they wish.

Outcomes of the HMRG process 2022

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
							Internal	External		
Jan	6	6	5	5	6	2				2
Feb	5	4	5	4	4					1
Mar	8	8	8	7	8	2			1	2
April	2	2	2	2	2	1				2
May	7	7	7	6	7	3			1	2
June	9	9	9	8	9					2
July	1	1	1	1	1					
Aug	7	7	7	6	7	1				
Sept	6	6	6	5	6					3
Oct	7	7	7	7	7	3				1
Nov	10	6	9	6					1	2
Dec	9	8	8	8		1				1

Potentially Avoidable Deaths

There have been no potentially avoidable deaths in this reporting period although some complex cases are still awaiting final coding whilst waiting for further information.

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 71 cases, so far reviewed in 2022, 19 (27%) were identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are

recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend / issues in patients with learning disabilities which can occur at any age not just over 4. Over the last year HMRG reviewed 23 deaths of children /YP with Learning disabilities whom are summarised in the below table.

Number	Date discussed at HMRG	Age	Primary Diagnostic Code	Secondary Diagnostic Codes	Recurring Themes
1	13/01/2022	2yo	D6	D7	R9
2	13/01/2022	10yo			
3	11/08/2022	3yo	D12	D7	R9
4	27/01/2022	12yo	D2	D10	R11, R4, R9
5	14/04/2022	7yo	D7	D9	R11, R9
6	14/07/2022	11yo	D9	D6, D8	R11
7	09/06/2022	9yo	D7	D6	R11, R3a, R4
8	14/07/2022	6yo	D5c	D7, D9	R9
9	11/08/2022	10yo	D5a	D6, D7	R10, R9
10	11/08/2022	12yo	D5b		R11, R4b
11	08/09/2022	4yo	D5a		R4b
12	08/09/2022	9yo	D9	D7	R11, R2a, R3a
13	13/10/2022	12yo	D6	D8	R11, R3a, R9
14	13/10/2022	12yo	D11	D7	R11, R9
15	10/11/2022	5yo	D11	D7	R11, R4b, R9
16	10/11/2022	2yo	D5a	D7	R4b
17	09/03/2023	15yo	D10	D5a, D6	R11
18	09/02/2023	9yo	D6	D7	R9
19	09/02/2023	1 month	D5b	D7, D8	R4b
20	09/03/2023	7yo	D9	D6	R9
21	20/04/2023	2yo	D10		R4
22	20/04/2023	14yo	D10		R11
23	11/05/2023	12yo	D3	D10	R10, R11, R4

Reviewing all the deaths there are no concerning trends which is reassuring. The commonest diagnostic codes are chronic medical condition which often corresponds with some of the complex chromosomal syndromes. There were 3 cases where the cause of death was infection although none were hospital acquired and 2 COVID deaths.
In the recurrent themes, there were nearly half who had withdrawal of intensive care which indicates how unwell they were, and all treatment options had been

considered. The second most common theme was that was inevitable prior to admission so regardless of the care and expertise provided the outcome was inevitable.

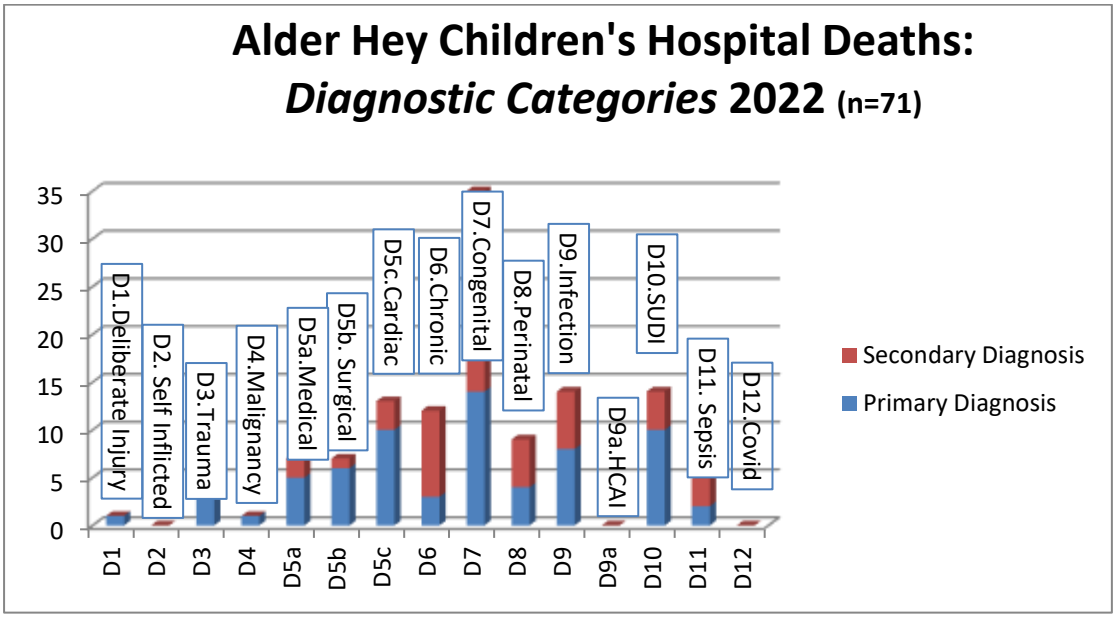
Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide. The Snowdrop team will be involved in the discussion about the introduction of the ME process to minimise the impact on the families.

External Benchmarking

In the last year, AHCH has engaged with Birmingham Children's hospital with the opinion that it was the Trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other.

Primary Diagnostic Categories

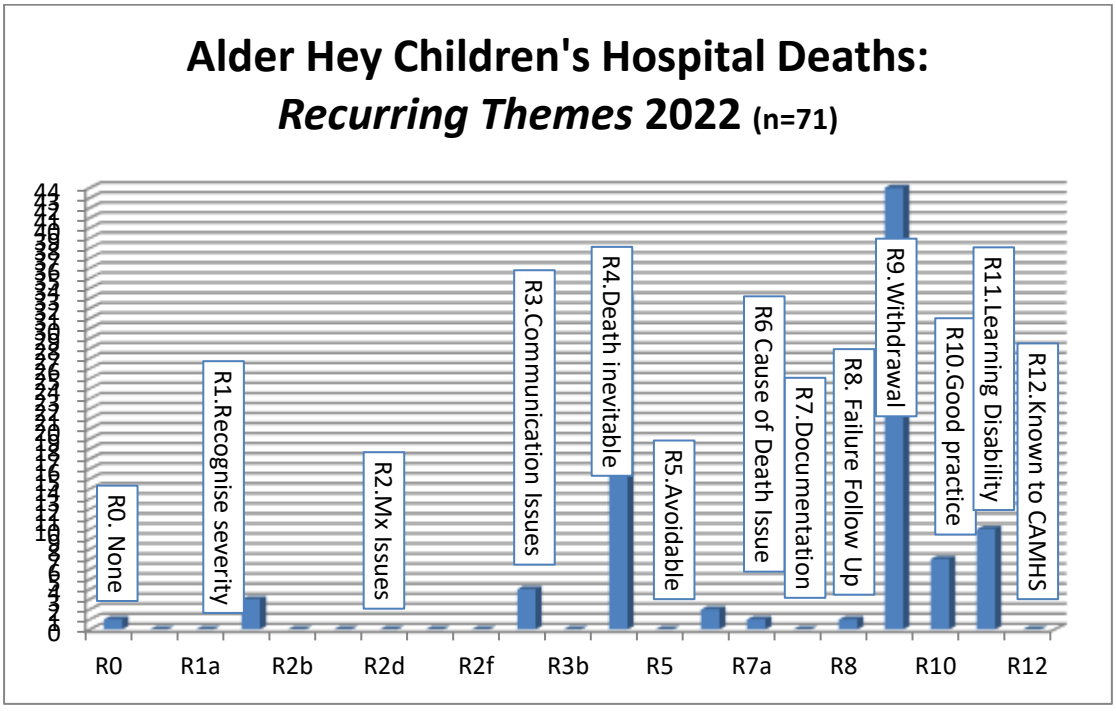


Diagnostic/Disease Categories

D1. Deliberately inflicted injury, abuse or neglect
D2. Suicide or deliberate self-inflicted harm
D3. Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4. Malignancy
D5. Acute Medical or Surgical condition – subcategories:
D5a. Medical D5b. Surgical D5c. Cardiac
D6. Chronic medical condition
D7. Chromosomal, genetic and congenital anomalies
D8. Perinatal / Neonatal event
D9. Infection (proven or clinical) – subcategory:
D9a. Healthcare-associated infection (home or away)
D10. Sudden unexplained, unexpected death / SUDI / SUDC – *excludes SUDE (D5)*
D11. Sepsis (proven or clinical)

The cases reviewed so far in 2022 show that the highest diagnostic code is 'children with underlying congenital conditions' (20 %), these are often the most complex with several issues on going and are the most vulnerable patients. Next, is sudden unexplained, unexpected death', with 14% of the cases being coded with this. This is the initial coding and when the case is reviewed with more information there is a high possibility that a more specific diagnosis will be allocated. Also with 14 % is the diagnostic, code cardiac condition which relates to the fact that AHCH is a regional cardiac centre and over this period there have been some very complex cases.

Recurrent Themes



Recurring Themes

R0. No RT
R1. Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review
R2. Possible management issues – subcategories:
- R2a. External
- R2b. Delay in Transfer
- R2c. in Alder Hey
- R2d. Delay in supporting services or accessing supporting service
- R2e. Difference of opinion re: Rx – Patients & families
- R2f. Difference of opinion re: Rx – Clinical teams

R3. Communication issues – subcategories:
- R3a. Patients & families
- R3b. Clinical teams

R4. Death inevitable before admission
R5. Potentially avoidable death – subcategories:
- R5a. Alder Hey
- R5b. Medical
- R5c. External

R6. Cause(s) of death issue – subcategories:
- R6a. Incomplete or inaccurate Death Certificate
- R6b. Should have had a post-mortem
- R6c. Not agreed
- R6d. Failure to discuss with the Coroner

R7. Documentation – subcategories:
- R7a. Recording
- R7b. Filing

R8. Failure of follow-up
R9. Withdrawal / Limitation of care
R10. Example of Good Practice
R11. Learning disability
R12. Known to CAMHS

The main recurrent code for 2022 was withdrawal of care (62 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child / young person suffers unnecessarily when all treatment options are explored but are not suitable.

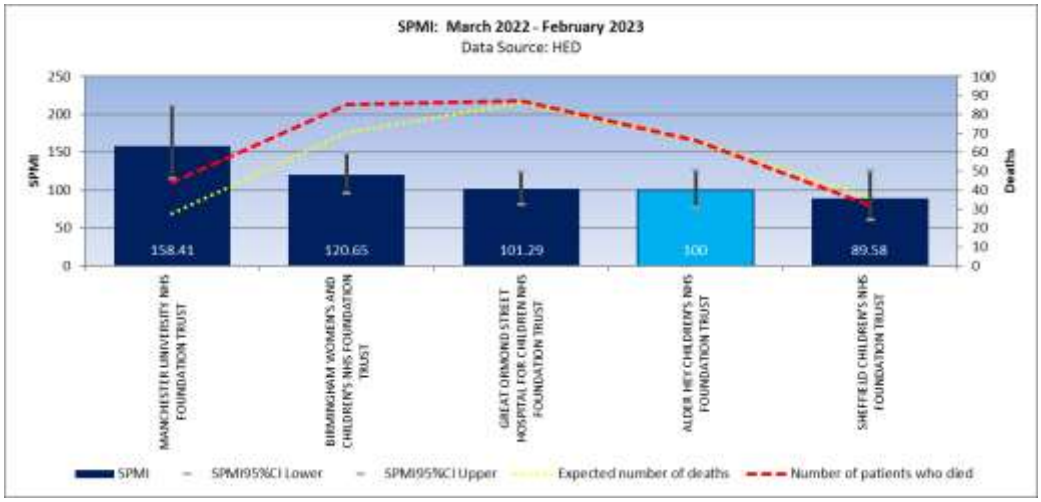
Death was concluded to be inevitable in 46%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.
It is interesting to note that the group recorded 10% of the cases as good practice the members tend to be very reserved at allocating this as they believe the standard of care, we aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'.

Section 2: Quarter 4 Mortality Report: January 2023 – March 2023

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering March 2022 to February 2023.



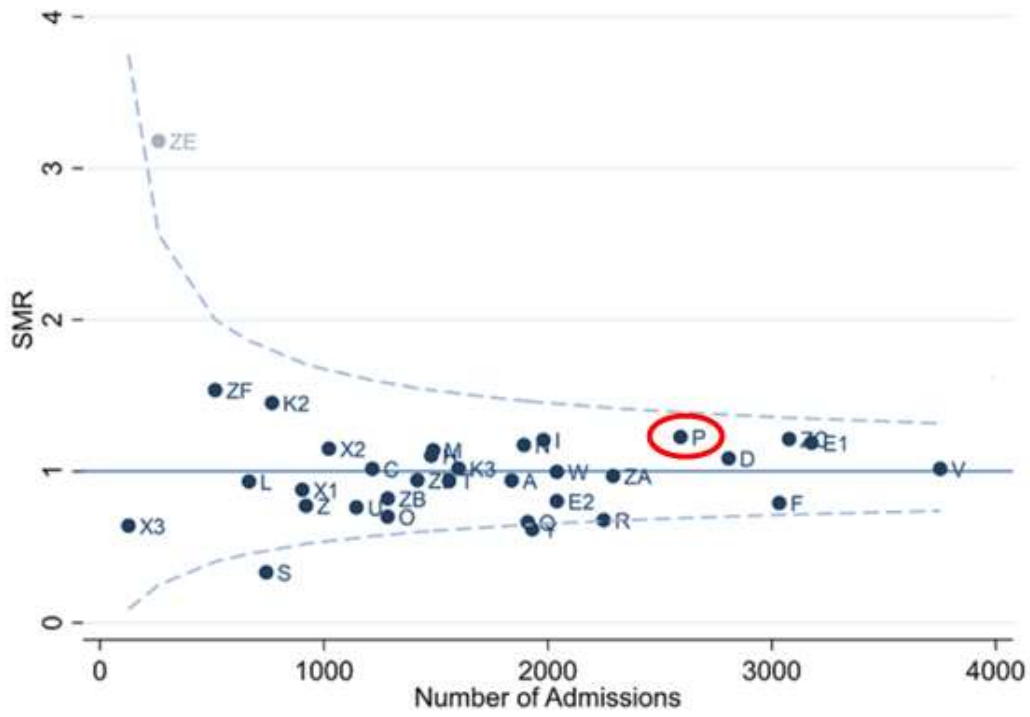
The chart shows that Alder Hey has performance of 66 deaths against 66 expected deaths. Indicating our mortality rate is acceptable in comparison to national performance. The closest Trust in terms of similar caseload and demographics is Birmingham Children's Hospital

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2021 Annual Report of the Paediatric Intensive Care Audit Network 2019-2021), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.

There was no evidence that any PICU had an excess mortality rate compared to what would be expected based on the level of sickness at the time of admission across the three-year reporting period. This is illustrated in Figure 5 based on inclusion of all SMR estimates being contained within the control chart limits.

Figure 5: Risk-adjusted Standardised Mortality Ratio (SMR) by health organisation for under 16 year olds, 2019–2021

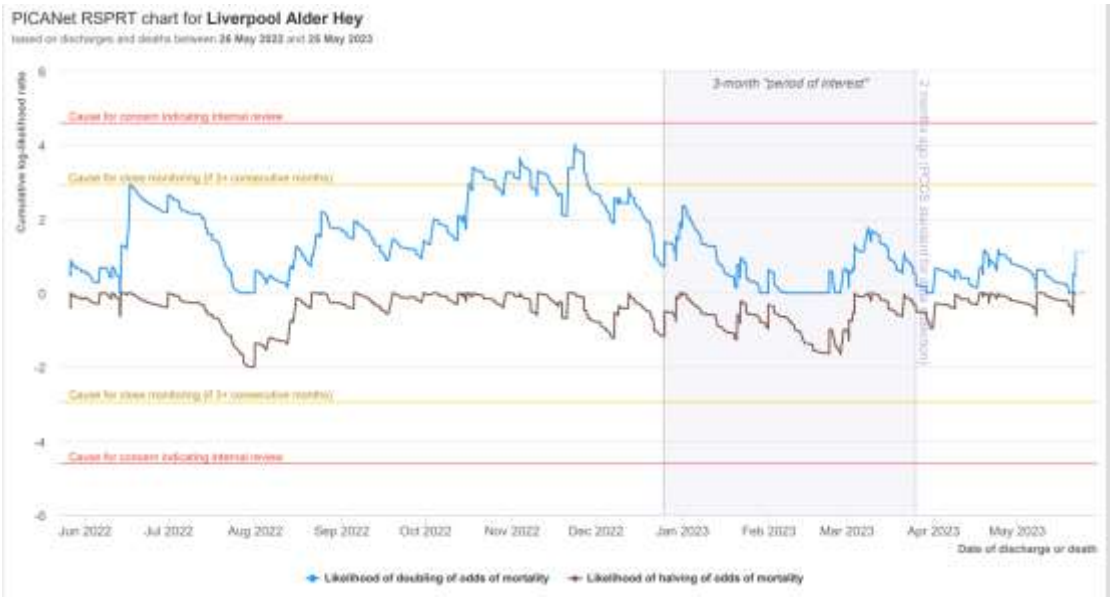


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control. Alder Hey PICU continues to be amongst the units receiving the highest numbers of admissions in the UK.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.

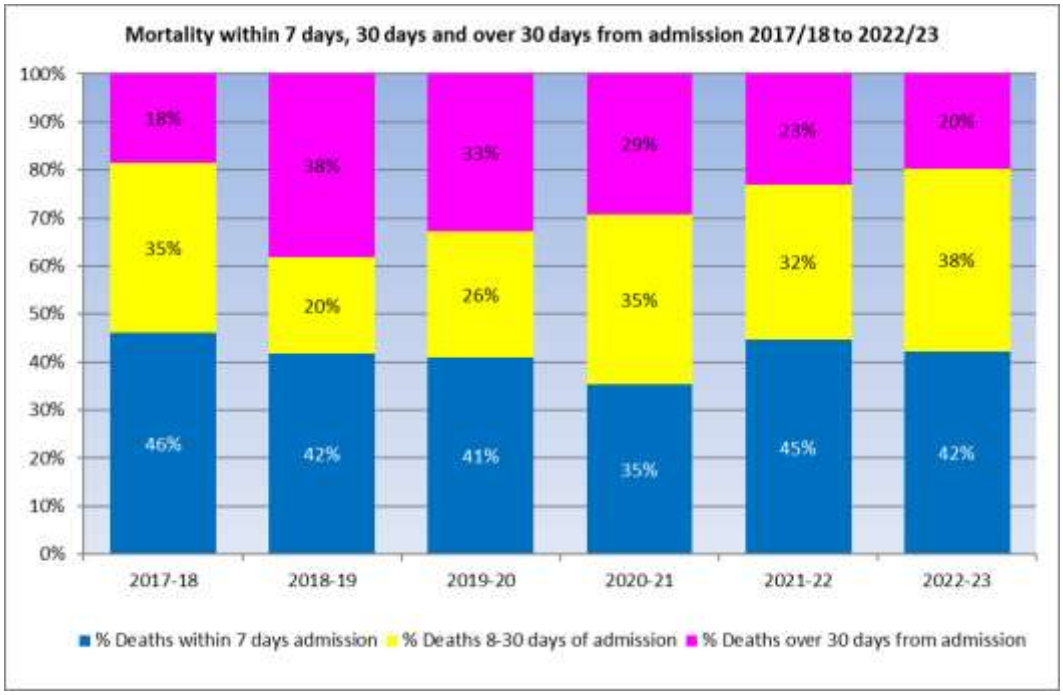


In the last quarter (Jan – April 2023), ICU reviewed 19 deaths at their departmental meeting. They have continued to be within the 'safe zone' for risk adjusted mortality. In line with national trends, there were a number of challenging cases, particularly regarding increasing patient complexity and managing parental expectations at end of life. All cases were felt to be adequate / above standard of care provided.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the financial year April 2022 – Mar 2023, 42% occurred within 7 days of admission, 38% occurred within 8-30 days from admission, and 20% deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, and the 4-month target is running at an acceptable level in view of the workload and the complexity of the cases.
There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them.

Alfie Bass
Medical Director

Julie Grice
Trust Mortality Lead

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 9**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	17th May 2023 – Summary 19th April 2023 – Approved Minutes
Report of:	Fiona Beveridge, Non-Executive Director
Paper Prepared by:	Fiona Beveridge

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 17th May 2023, along with the approved minutes from the 19th April 2023 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

The Safety Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting

- SQAC received the Patient Safety Strategy Board update
- SQAC received the 'Diagnostics Notification in Meditech: Managing historic risk and developing safe and sustainable processes' update, with clear recommendations which are proportionate and appropriate, clearly reflecting the learning within the report. SQAC commended this review as thorough and clear, and providing the required assurances.
- SQAC received the Annual Assurance Report 2022/23 and Forward Plan for 2023/24 which would now be aligned to the new strategy, with ongoing work required regarding the 2030 plan on a page to identify the assurance processes regarding the different strands. SQAC noted the substantial progress.
- SQAC received the DIPC Exception Report.
- SQAC received the DIPC Annual Report, with good and interesting discussion held. SQAC agreed to moving from a monthly reporting cycle to a quarterly DIPC report, with SQAC also receiving an Annual DIPC report.
- SQAC received the ED MH Attendance Quarter 4 report, which was extremely clear in the new format with risks identified, with the aim of all future reports presenting in this format in the future.
- SQAC received the Assurance Emergency Department Activity Monthly update, noting the ongoing pressures within the Emergency Department, and the impact of Industrial Action and bank holidays.
- SQAC received and noted the Changes to Trust wide mandatory Safeguarding Training Report.
- SQAC received the Quarter 4 Children & Young People Engagement Leads report, which detailed a wealth of activities.
- SQAC received the Safe Waiting List update, and the indication regarding the new group which has been established to take this forward.
- SQAC received the Quality Account. SQAC commended the Quality Account as an interesting document, which clearly reflected the improvements made, and the range of activities undertaken over the year. SQAC noted that the Quality Account would be shared at various other relevant forums and into the public domain.
- SQAC received the CQSG Annual Report and noted the pending disbandment of CQSG.
- SQAC received the Quarter 4 2022/23 summary position report: National Institute for Health and Care Excellence (NICE) Guidance Compliance. SQAC noted the substantial progress made to provide assurance on compliance to most guidelines, and the much stronger process for timely review and response to new guidelines now in place. SQAC agreed that a deep dive would be required to review areas not making appropriate progress. SQAC agreed that this would be escalated to Board of Directors for awareness.
- SQAC received the Divisional Clinical Governance Monitoring Closure Report, and formally expressed thanks to colleagues. SQAC were in agreement that the report captures the changes that had taken place over the last 2-3 years across the organisation.

- SQAC received the National Confidential Enquiries Report – Quarter 4 2022/23 summary position report
- SQAC received the new SQAC Workplan, Terms of Reference and Subgroup reporting structure and Terms of Reference.
- SQAC received the Organ Donation Annual Report, with good discussion held, SQAC noted that the report required realignment to present future Organ Donation Annual Reports to SQAC and noted the substantial progress made to date.
- SQAC received the Board Assurance Framework
- SQAC received the Divisional update new template with good discussion held.
- SQAC received the Quarter 4/Year End 2022/23 Complaints, PALS & Compliments report
- SQAC received the Annual Patient & Family feedback quarterly report

3. Key risks / matters of concern to escalate to the Board (include mitigations)

- Quarter 4 2022/23 summary position report: National Institute for Health and Care Excellence (NICE) Guidance Compliance, SQAC agreed that a deep dive would be required to review those areas not making appropriate progress and for this to be shared with the Board of Directors for awareness/information.

4. Positive highlights of note

Following agreement to the new terms of reference, a new governance architecture for addressing issues across the Safety and Quality spectrum is in place and operational, with agreed review points.

5. Issues for other committees

6. Recommendations

The Board is asked to note the Committee's regular report.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Confirmed Minutes of the meeting held on Wednesday 19th April 2023 Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(ABa)
	Adam Bateman	Chief Operating Officer	(AB)
	Lisa Cooper	Divisional Director, Community & Mental Health Services	(LC)
	Urmi Das	Divisional Director, Medicine Division	(UD)
	Dani Jones	Director of Strategy	(DJ)
	Benedetta Pettorini	Divisional Director, Surgery Division	(BP)
	Paul Sanderson	Acting Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
In Attendance:	Lynsey Boggan		(LB)
	John Chester	Director of Research & Innovation	(JCh)
	Will Weston	Medical Services Director	(WW)
	Kim Hewitson	Sepsis Nurse Specialist	(KH)
	David Porter	Consultant infection & immunology, Sepsis Lead	(DP)
	Dan Hawcutt	Interim Director of Research	(DH)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jill Preece	Governance Manager	(JPr)
	Jane Ratcliffe	Acting Chair of Clinical Ethics Committee and Acting Chair of Clinical Professionals Support Group	(JR)
	Jason Taylor	General Manager, Clinical Research Division	(JT)
	David Reilly	Associate Director of Digital Systems	(DR)
	Jackie Rooney	Associate Director of Nursing Governance	(JR)
	Julie Creevy (notes)	EA to Chief Medical Officer & Chief Nursing Officer	(JC)
Apologies:	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	John Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Christine Hill	Head of Operations–Laboratory Services – Safety Lead	(CH)
	Bea Larru	Director Infection Prevention Control	(BL)
	Jo Revill	Non-Executive Director	(JR)
	Sarah Wood	Safety Lead, Surgery Division	(SW)

23/24/01 Welcome and Apologies

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

23/24/02 Declarations of Interest

SQAC noted that there were no items to declare.

23/24/03 Minutes of the Previous Meeting held on 22nd March 2023 – Resolved:

Committee members were content to APPROVE the notes from the meeting held on the 22nd of March 2023.

23/24/04 Matters Arising and Action Log

The Action log was received and updated.

23/24/05 Patient Safety Strategy Board update

- WW advised on the 11 workstreams covering insight, involvement and improvement
- Patient Safety colleagues continue to apply careful scrutiny to workstreams 1, 7,16, 17 & 21 with continued success in month regarding the review of data for the patient safety profile. A slide deck had been developed in relation to this and Associated Stakeholders are in receipt of this.
- Patient Safety colleagues had been requested to review the data collected, and following the review this would enable feedback via a sense check survey to ascertain if the data is relevant, accurate and aligned with what experience in their respective clinical environments.
- Key success regarding the introduction of the Hospital Optimisation programme, which is aligned into the Patient Safety Board and allows feedback through a variety of workstreams. The overarching aim to deliver highly responsive care, balancing workforce, well-being, capacity and demand, whilst focussing on patient safety out of hours.
- Meditech notices workstream would be presented to SQAC in May 2023 meeting.
- Patient Safety Strategy Team colleagues welcomed programme updates regarding safety metrics, patient safety partners, learning disabilities and antimicrobial resistance.
- Patient Safety Strategy Team colleagues had continued to enhance governance, with a robust formal review of programme risks.
- There are some areas that had not progressed as originally planned with regards to governance documentation, a programme stocktake is planned for the next Patient Safety Strategy meeting to allow for a more targeted approach to address any areas of improvement in governance, delivery and utilisation of quality improvement processes.

SQAC welcomed the progress made in month, and were pleased to see the continuous improvement across an array of patient safety workstreams.

FB referred to the amber workstreams and the consequences regarding Learning Disabilities in workstream 16. FB referred to the number of amber workstreams, the due dates and progress and sought clarity whether any support is required from SQAC with regards to the timeline.
WW advised that several of the issues are as a result of a change in personnel in terms of leadership.

NA advised that the national patient safety strategy has 4/5 areas of focus for Learning Disabilities and that this workstream initially had struggled as the national strategy is very adult focussed, with areas that are not appropriate for children and young people. NA advised that the team are continuing to work extremely hard, and had taken time to really refine those areas of focus, however progress had been compounded by a change in leadership.

FB queried whether the due dates would be rescheduled for some of the activities, or whether the activities would be changed, FB envisaged this would be reflected within the next update.
NA confirmed that this was correct.

AB advised that within the previous six months, detailed analysis had been undertaken, which had Identified that patients with a learning disability take on average six weeks longer to complete their treatment compared to other patient groups. AB stated that Alder Hey are committed to including information within the Integrated performance report to highlight the inequalities. AB stated it would be beneficial to align the work with the improvement team, given the commitment and endeavour to address gaps in inequality.

FB alluded to the process regarding amber workstreams, the methodology and the rescheduling as it is not evident from the presentation, FB requested colleagues to give some thought regarding how this is displayed within future updates to enable appropriate assurance to SQAC.

FB referred to workstream 17 and those amber workstreams, in particular the proposed Board commitment, and sought clarity regarding whether the statement referred to the Board of Directors or referred to the Patient Safety Strategy Board. ABa advised that this would be presented to the Board of Directors as a top down principle, as a statement of commitment from the Board.

ABa advised that the update is due to come as part of the Infection Prevention Control update at Trust Board at the May 2023 meeting.

WW advised that during the governance documentation stock take that the amber and red milestones would be included in the review process.

FB thanked WW and colleagues for comprehensive update.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy Board update.
Delivery of Outstanding Care
Safe

23/24/06 DIPC Exception Report

The DIPC Exception Report was received and **NOTED**.
NA advised that the DIPC report is a very thorough report, and welcomed the analysis within the report, which provided insight into several issues.

NA acknowledged the significant efforts and improvement made, as a result of the ongoing work by the advanced vascular access team with regards to CLABSI rate per 1,000 line days, to enable the recording of data, with vascular access team working really closely with wards outside of PICU and critical care.

FB sought clarity whether this would now allow the Trust to benchmark. NA advised that other Trusts measure slightly differently, however GOSH, Boston, Cincinnatil Childrens Hospital use 1,000 line days, and that this would allow national and international comparison.

FB stated it would be good to review the benchmark information in the future.

Resolved: SQAC received and **NOTED** the DIPC Exception Report.

23/24/07 Assurance Emergency Department Activity Monthly update

- 6,049 Children & Young People attended ED Department during March 2023, this was an increase of 1,033 Children & Young People compared to February 2023, equating to 21% increase.
- 78% of Children and Young People were treated within 4 hours. Compared to the previous year the department seen 381 less Children and Young People, during this period performance against the four hour target was at 65%.
- Triage targets are being achieved. The ED department are continuing to experience significant challenges achieving the four hour target, particularly during the weekend compared to weekdays.
- Medicine Division acknowledged that improvements had not been on trajectory over the last 3 month period, and despite increased measures in place improvements had stagnated. Ongoing work had taken place with real focus to ensure appropriate skill mix, particularly out of hours, and during surges.
- Immediate actions had been agreed to have a dedicated consultant in place effective from week commencing 24th April 2023 from Monday – Friday, Medicine Division would review the impact of what they envisage will have a positive impact.
- Division are undertaking a review of the weekend baseline staffing model, given the challenges at weekends. Division continue to focus on ensuring that there are the right staff in place 24/7.
- Performance reporting and exception reporting had been revised, with the aim/target during April 2023 to reach 85%, with evaluation of those measures planned, with the expectation to increase the target in May 2023. CW advised that the Division are confident that within the next 3-6 month period, that this would have a positive impact.

FB advised on the importance of SQAC continuing to receive the ED monthly reports, and acknowledged that the ED reports had been previously been a starred item. SQAC acknowledged the significant patient volume during March 2023 and the significant ongoing issues.
FB thanked CW for comprehensive update.

Resolved: The Assurance Emergency Department Activity Monthly update was received and **NOTED**

23/24/08 Sepsis update

DP provided the Sepsis update and provided an overview of the current position; key issues as follows:-

- Colleagues continue to work on elements regarding 60 minute target. Improvements made with regards to training.
- The ED sepsis nurse is leaving this post resulting in the requirement for a new ED sepsis nurse to be recruited.
- Inpatient timings of antibiotic administration within 60 minutes - during the last quarter this was close to 100%, this may not be sustained given the fluctuation regarding numbers.
- Monthly data -100% in the last month
- The slightly longer 90 minute target to administer antibiotics had been above 90% for the last 10 month period.
- ED – figures above 80% last year, month by month 80-90%
- Training – there had been a marked improvement in the % of staff trained, amongst the medical staff particularly, although DP expressed caution as these were relatively low numbers and relate to 11 people. Training work is progressing well, with further work to do. KH is liaising with wards regarding training.
- DP advised that on review of the data that there are a number of staff who are not listed as required to undertake sepsis training, although training is required, this required review. DP welcomed any advice regarding correct role assignment and support to interrogate the information/data.
- Work is continuing with regards to 60 minute data recording
- Sepsis Dashboard – no significant progress had been made, DP had shared information with the BI team, and the BI team had not yet been able to review, DP is planning on improvements over the coming months.

FB referred to the recommendations within DP Sepsis report and stated that it would be helpful to understand where these issues are being discussed. DP advised that in terms of 4.1 Intramuscular and intraosseous antibiotic dosing, & 4.2 Sepsis reporting systems streamlining, that these issues are ongoing within the sepsis team with no external support required, with plans to address Sepsis Reporting system in the near future.

DP advised that he had not been able to meet with D Reilly, DR advised that he had sent a request to the lead of the BI team to ensure BI Lead to meet with DP and sepsis team once the Sepsis team are ready to meet.

FB sought clarity regarding staff exemptions regarding Sepsis training and requested clarity on who would be involved in discussions regarding exemptions.
CW advised that this issue had been identified approximately 6 weeks ago, there had been ongoing discussions with J Guy and HoN, CW provided assurance that this issue is currently being reviewed and addressed, the Medicine Division envisage improvements over the coming months.

DP queried whether the data regarding sepsis exemption should be cascaded to wards/departments to review the data. NA advised that the data/information would need to be reviewed by the central Learning and Development team. Sepsis training should be assigned based on role and individual staff can apply for exception if sepsis training is not applicable to their role, the L&D process would be detailed within the next quarterly Sepsis update, with any challenges to be escalated to Chief Nursing Officer and Chief People Officer.

FB advised that SQAC would welcome an update regarding sepsis mandatory training and exemptions

DP referred to Harmonisation of the sepsis nurse work practices (ED&Inpatients) and the need to harmonise data collection and advised that these issues are being addressed within team, no external support is required.

Resolved: SQAC received the Sepsis update and **NOTED** the good evidence regarding ongoing work and NOTING new issues raised regarding exemptions of training, with plans in place to review this further.

FB thanked DP for Sepsis update.

23/24/09 Trust wide Clinical Audit Annual Work Programme 23/24

JR presented that the Trust wide Clinical Audit Annual Work Programme 23/24 and advised that the Clinical Audit Annual Work Programme 23/24 was previously presented to SQAC at March 2023 meeting, with a request from KB to present a further update, given that there were some audits which were aligned to divisions, which were felt to be trust wide, as a result there are now 14 Trust wide priority audits.

FB commended JR for the clarity within the report and the level of assurance that the Trust wide Clinical Audit Annual Work Programme 23/24 provided.

Resolved: SQAC received, **NOTED** and approved the Trust wide Clinical Audit Work Programme for 23/24.

23/23/10 Trust wide Safeguarding & Statutory Services Assurance Group Update

LC provided an overview of the Safeguarding and Statutory Services Assurance Group Meeting held on 21st February 2023, the meeting had focussed on Quarter 3 reporting and feedback from Cheshire & Mersey ICB feedback regarding the Safeguarding submission for Quarter 3.

- The Trust Risk Register had been revised, and there are now new separate categories created relating to Safeguarding.
- In depth discussion had taken place with Associate Chief Nurses and it had been agreed that monthly operational safeguarding meetings would be held jointly across Divisions, chaired by the Name Nurse Safeguarding Children & Young People, to share learning, review incidents, enable challenge, particularly regarding compliance and assurance regarding mandatory training, to ensure appropriate assurance.
- A quarterly report regarding safeguarding within the divisions would be submitted to the Assurance Group.
- Agreement that the Assurance Group would move to quarterly meetings to support the operational group to undertake actions and improvements.
- SQAC to receive Safeguarding training compliance across the Trust report at the May 2023 meeting
- A Safeguarding mandatory training report had recently been submitted to the Education and Governance Committee which would be shared with SQAC at the May 2023 meeting.

FB thanked LC for comprehensive update and welcomed the Safeguarding training compliance report at May 2023 SQAC meeting.

Resolved: SQAC received and **NOTED** the Trust wide Safeguarding & Statutory Services Assurance Group update.

Clinical Governance Effectiveness

23/24/11 Health Inequalities Steering Group update

DJ, presented the Health Inequalities Steering Group update, which provided a comprehensive update and overview, detailing the 4 goals, the prevention pledge, poverty proofing, the role of the NHS in reducing inequalities, the Core 20 plus approach, Alder Hey action plan – progress, NHSE Nationally mandated actions for tacking Health Inequalities, Beyond programme, One Liverpool, and update on the HIP Steering group progress to date and key actions for the next 12 months, which included Investment/resource, new leadership and expertise, Development of Alder Hey's Health Inequalities and Anchor Plan to 2030, Embed Health Inequalities as core in Divisional plans and performance, poverty proofing and Core 20+5CYP – metrics clear approach to drive change

- DJ expressed her thanks to A Hughes for ongoing support over the last 12 month period, AH is transitioning from the Health Inequalities role
- Health Inequalities Steering Group had broadly delivered plans set in December 2021. Thirteen out of fourteen commitments had been completed, a closure report would be submitted to ICS. Alder Hey have been requested to showcase work at ICS level.

- Successful prevention pledge (ICS) - Alder Hey has demonstrated strong commitment to the pledge.
- Emergent agenda – core to Strategy 2030
- Leadership/Terms of Reference being refreshed
- Expertise secured for a 6 month period to shape the Health Inequalities forward plan.
- DJ provided informative update on ongoing work regarding poverty proofing, transport, Sophie's legacy recognising poverty, a proposal is being developed regarding a wellbeing hub.
- DJ provided update on the Core 20 plus 5 detailing the five clinical areas of health inequalities. Beyond programme is taking entire system overview, key clinical areas of health inequalities, Asthma. Diabetes, Epilepsy, Oral Health and Mental Health, with oral health and mental health a focus over the next 12 months to continue to embed Core 20.
- Action plan – ongoing work/in progress, which is very live with an emerging agenda. Define role as anchor institution, currently there is no dashboard, ongoing work to measure change activity, research, education and innovation strategy.
- Partnership - Alder Hey had a successful bid to co designing a health framework for children.
- Healthy weight community grant, with partnership prevention project and targeted practical work, with Tuebrook, West Derby, Speke, Garston, Norris Green, Knotty Ash, Dingle, Toxteth, Everton and Anfield.

FB referred to the quality of outcomes which is extremely important focus for SQAC. FB alluded to how colleagues would track in real time regarding patient outcomes through different divisions. DJ advised that core programmes and projects would need to report on this systematically over the next 12-24 months. DJ advised this would need to be on a case by case basis, with the requirement for a workplan to enable colleagues to review outcomes. DJ stated that SQAC should receive quarterly updates, with SQAC receiving an update on a range of issues over the next 12-24 month period.

FB advised on the importance of measuring successes across areas.
DJ referred to the long term impact and outcomes, given that there is only short term resources and the challenges in this regard.

FB alluded to a potential need for a separate offline discussion with DJ & JG and regarding capacity to link research initiatives, from the University perspective and Alder Hey perspective. FB stated that for some particular projects a separate follow up discussion may be beneficial.

Resolved: DJ to liaise offline to enable offline discussion

FB on behalf of SQAC expressed thanks to A Hughes & DJ for ongoing work.

Resolved: SQAC received and **NOTED** the Health Inequalities Steering Group update

Well Led

23/24/12 Clinical Ethics Annual Report

JR, Acting Chair of Clinical Ethics Committee presented the Clinical Ethics Annual Report, which provided an overview on introduction, background, current CEC membership, and recommendations, key issues as follows:

- JR advised on the importance of reinvigorating and strengthening the Clinical Ethics Committee in the Trust, and advised on the need to increase membership, with the aim of including more nurses and AHP's onto the Clinical Ethics Committee and embed the Clinical Ethics Committee throughout the organisation.
- JR had been liaising with colleagues from Great Ormond Street Hospital who have been helpful and supportive in sharing the Clinical Ethics model from Great Ormond Street Hospital. JR advised that GOSH have a dedicated lead half time in Research and Ethics and Law.
- Clinical Ethics Committee at Alder Hey have excellent support from the University of Liverpool and JR is working with Liverpool University's Faculty of Law, with plans to develop a local education programme.
- JR referred to financing and remuneration, to enable remuneration or appropriate allocation of time within Job Description/Job Plan for people who chair the Clinical Ethics Committee, with the aim to

appoint an internal chair, external chair and internal deputy chair to promptly action and address issues as appropriate.

- JR alluded to the Clinical Professional Support Group which meet on a weekly basis, JR is keen to embed this further across the Trust and advised that there is an away day planned during week commencing 24th April 2023 with Medical Divisional colleagues.
- JR referred to multi-disciplinary working and to challenges for families, which are increasing, as families are wanting issues resolved in Clinical Ethics Committee that are not always in the child's Best Interests.

LC advised that she is fully supportive of increasing Clinical Ethics membership and promoting Clinical Ethics Committee across the organisation.

Clinical Ethics Committee Report Recommendations:-

- The Clinical Ethics Committee should appoint an internal and external Chair
- Remuneration of the two Chairs should be agreed
- For non-virtual meetings, travelling expenses should be agreed
- Updated Terms of Reference would require ratification – this is actively being addressed by J Ratcliffe.

Resolved: Divisional Directors to meet with JR regarding future scope, and multi-disciplinary engagement in the ethics process.

FB alluded to wider remit and stated that some of the most difficult issues within Clinical Ethics are negotiating consent and care arrangements, and that it would be helpful to think about some exemplar cases. Whilst noting that Clinical Ethics Committee is not a decision making body, and is an advisory committee, and that this could be made more strongly to colleagues.

SQAC acknowledged that Clinical Ethics is currently in a transition point across the Trust.

FB thanked JR for Clinical Ethics Annual Report and wished JR well with regards to the next phase of Clinical Ethics. Transition.

Resolved: SQAC received and **NOTED t**he Clinical Ethics Report.

23/24/13 Research Annual Report

DH, Interim Director of Research presented the Research Annual Report:-

- Clinical Research Facility had been renewed within the last financial year, resulting in £2M, five year investment.
- Clinical Research Facility had maintained Gold Standard Accreditation
- Clinical Research Facility adhere to all ward rules and regulations as appropriate and are managing high quality areas.
- Patient Feedback - Laura Rad, is working to amalgamate different feedback mechanisms for both clinical research and evaluations.
- DH referred to a Harmonie study which is a phase 3 study, looking at how strongly babies can be protected from serious illness due to RSV infection, with Clinical Research Division being the highest recruiter in the Northwest, and 10th most successful recruiting hospital in the country, despite joining the study late, the Clinical Research Facility had demonstrated successful links with primary care partners.
- The Clinical Research Facility had upskilled local practices, to ensure a good recruiting centre.
- Clinical Research Facility are undertaking the first dosing of a gene therapy research study, the patient is currently an inpatient, with appropriate comms to be shared at the relevant time.
- Sustainability and growth – a capital grant for £3M for an additional MRI scanner had been submitted, currently awaiting feedback. NIHR offering 100% funding if successful.
- DH advised that there are robust safety and quality processes in place across the Clinical Research Division
- Clinical Research Division had appointed a research governance manager and advised that the Clinical Research Division Head of Nursing ensures the appropriate mechanisms and processes are in place. DH referred to the high level of national and international scrutiny and advised that the Clinical Research Division are performing well.

JC referred to the gene therapy study and advised that this is an exceptional high quality study/trial and highlighted the importance of such studies/trials which are complex and high quality. JC advised that such studies are much harder to undertake. JC advised that his preference would be for the Clinical Research Division to undertake fewer patients, with more of these types of complex and challenging high quality studies/trials.
NA commended DH and colleagues for the format, content and clarity of the Research Annual report which was echoed by FB and welcomed by SQAC. NA alluded to the HR metrics and the phenomenal improvement, noting that although staff turnover looks high, that this is on a downward trajectory.
NA and FB expressed thanks to DH, JC and CRD colleagues for ongoing support. SQAC welcomed the continuing development of leadership within the Research Division and **NOTED** the decrease in staff turnover and acknowledged the need to focus on quality of research interventions alongside levels of participation.

Resolved: SQAC received and **NOTED** the Research Annual Report.

23/23/14 SQAC Annual Report

FC presented the SQAC Annual Report and sought comments or feedback from SQAC.

NA stated that the SQAC Annual Report is lengthier this year regarding the sheer volume of improvement work undertaken by SQAC. NA alluded to the real focus on data driven methodologies over the last 12 months enabling appropriate monitoring and assurance. NA stated that the SQAC Annual Report captures a significant amount of achievements to date. NA expressed his thanks to SQAC.
FB echoed NA comments and expressed her thanks to SQAC. FB stated that the standard of discussion at SQAC and the challenge over the last year had aided improvement to gain appropriate assurance on a whole range of matters that are presented to SQAC.

ES expressed her thanks to JP for continued support.

Resolved: SQAC received, **NOTED** and Approved the SQAC Annual Report.

23/24/15 External Visits & Accreditation Report

ES presented the Annual External Visits Register for 2022/3
ES advised that the Trust had experienced a significant decrease in the ability of external organisations being able to undertake visits to the Trust.

ES referred to the possibility that there had been more activity than what is currently portrayed within the Register. ES requested for any additional information/action plans or recommendations to be submitted to J Preece to enable the Register to be updated.

ES highlighted the importance of reviewing the outcomes of processes, remarking on excellence, following visits to the Trust, together with any completed action plans, with feedback sought from each of the Divisions.

Divisions of Medicine, Surgery and Community & MH all provided assurances that there are clear processes in place for recording such visits and provided assurance of appropriate governance mechanisms in place across the Divisions.

JC referred to the constant scrutiny within the Clinical Research Division give clinical trials, particularly with commercial trials, and that there is low level monitoring, and suggested that unless SQAC feel differently then this would not necessarily be included in the Register as they are not formally listed as they are ongoing and constant. ES advised that she envisage that those details are held locally .

SQAC received and **NOTED** the External Visits & Accreditation report.

23/24/16 Drugs Accountable Officer/Accountability Report

SQAC received the Drugs Accountable Officer/Accountability Report, with offline approval would be sought from KB & JR.

SQAC were supportive of the Drugs Accountable Officer/Accountability report.

Resolved: SQAC received, **NOTED,** and supported the Drugs Accountable Officer/Accountability Report Offline approval to be sought from KB & JR.
FB thanked PB for Drugs Accountable Officer/Accountability Report.

23/24/17 Board Assurance Framework

SQAC received the Board Assurance Framework, noting that the Board Assurance Framework is currently entering a transition period toward alignment of the new strategy.

SQAC recognised the importance of capturing the impact of and potential risks from Industrial Action for the short to medium term, given the strategic threat. NA & AB to review gaps in assurance.

ES anticipated that the three risks for SQAC would be stable.

Resolved: SQAC received and **NOTED** the Board Assurance Framework
Resolved: SQAC were supportive of incorporating the Risk regarding Industrial Action.

23/24/18 Divisional reports

Community & MH Update:-

- Friends & Family Test scores remain at 93%, including mental health services and outpatients
- Division had seen an increase in PALS for March 2023 relating to access and appointment times for ADHD and Community Mental Health services
- Two incidents in Tier 4 mental health unit regarding the use of restrictive intervention for a young person, both incidents related to a young person who required gastric feeding
- Division continue to see an increase in referrals for ASD & ADHD services

Medicine Division:-

- Diagnostic performance is 86% within 6 weeks, Division are focussing on six week compliance for diagnostics
- Elective and outpatient recovery rates had maintained despite Industrial Action
- PDR and mandatory training compliance is 93%/94%
- ED performance is a concern for the Division, with stagnated performance over the last 3 months. This is a significant priority for the Division, the General Manager in Medicine is producing an exception report enabling further scrutiny and appropriate action.
- Division Appointed new Head of Nursing, who is working with the Nursing Staff on nights and during the evening shifts
- Division have a focus is sickness, with listening events held to review issues and focussing on staff retention

Surgery Division:-

- Division are on trajectory regarding Governance and have no PALS complaints overdue.
- Division had three moderate harm incidents in the last month, RCA is being undertaken, no clusters had been identified
- Despite Industrial Action the Surgery Division remained safe, with challenges regarding activity
- A couple of specialities are behind trajectory, which are being addressed in terms of waiting lists and waiting times, despite Industrial Action activity is well above 105% for some specialties, with a continuation with tailored approach.

Clinical Research Division:-

- Staff retention is improving with positive work underway to address
- CRD recognised that the process of opening studies and their performance management requires improvement and steps are being undertaken to review, and revise performance management.
- There are a number of divisional leadership changes underway, Division are interviewing for a new Director of Research, Head of Operations and Head of Nursing in May 2023.
- CRD have a potential issue with radiology regarding staffing issues, CRD are working to quantify this to enable positive steps to be undertaken to address.

FB thanked Divisions for update.

23/24/19 Any Other Business - None

23/24/20 Review the key assurances and highlights to report to the Board

- SQAC received the Patient Safety Strategy Board update including a specific update on the Deteriorating Patient Safety Workstream, together with an update on the Workstreams of particular focus in the reporting period: Safety Metrics; CYP as Patient Safety Partners; Learning Difficulties. AMR; Hospital Optimisation.
- SQAC received the DIPC Exception report.
- SQAC received the Assurance Emergency Department Activity Monthly update, noting the ongoing pressures within the Emergency Department.
- SQAC received Sepsis update, with good evidence regarding ongoing work and with some new issues raised regarding exemptions of training, with plans in place to review this further.
- SQAC received an amended report on the Trust wide Clinical Audit Annual Programme, following discussion held at 22nd March 2023 SQAC meeting. The Report was approved and commended for its clarity and the level of assurance it offers.
- SQAC received Trust wide Safeguarding & Statutory Services Assurance Group update
- SQAC received the Health Inequalities Steering Group update, which detailed exciting developments, with interesting questions and discussion regarding monitoring and tracking of progress in the future.
- SQAC received the Clinical Ethics Annual Report, and acknowledged the transition point in clinical ethics across the Trust. Discussion will take place between JR & Divisional Directors regarding future scope and multi-disciplinary engagement in ethics processes.
- SQAC received the Research Annual Report, which was commended for the format and clarity of the report. SQAC welcomed the continuing development of leadership within the Research Division and noted the decrease in staff turnover. SQAC also acknowledged the need to focus on quality of research interventions alongside levels of participation.
- SQAC received and approved the SQAC Annual Report, noting how busy SQAC had been in a positive way, as the Committee had become more data led and with an increased evidence base, and had focused on the transition towards the new Patient Safety Strategy.
  SQAC noted that it had been a dynamic year in terms of issues explored, and that the quality of reports had improved, giving strong assurance to SQAC members on a range of issues. All members were thanked for their contributions.
- SQAC received the External Visit & Accreditation report, with assurance provided from all the Divisions that the policy is being adhered to, to ensure good oversight of external visits and follow-up of action plans. Appropriate information/material would be captured within the Trust Annual Report and Accounts
- SQAC received the Drugs Accountable Officer/Accountability Report, which was Approved by SQAC, offline approval was confirmed from KB & JR. Thanks were expressed to Interim Chief Pharmacist.
- SQAC received the Board Assurance Framework, noting that we are entering a transition period towards alignment with the new strategy. SQAC recognised the importance of capturing the impact of and potential risks from industrial action.
- SQAC received verbal Divisional report updates, with a new written report being trialled at May 2023 SQAC meeting.

Date and Time of Next Meeting: 17th May 2023 at 2.00 pm

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Highlight Report – People Plan**
Report of:	**Chief People Officer**
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.1, 2.2, 2.3

1. Introduction

The purpose of this paper is to provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during April/May 2023.

2. People Metrics

The detailed people metrics can be found within the Integrated Performance Report (IPR); however it is worth noting in this report that:

- Total sickness absence in April is 5.28% which is below the 5.5% target. A reduction from March at 5.91%. This comprises STS at 1.78% and LTS at 3.5%. This month is the first time the sickness absence rate has fallen below the target for the last 2 years (since May 2021)

- Staff Turnover remains 15% in April and has been stable since December with no further increases. However this remains a significant concern and this level of staff turnover is creating substantial risk for the Trust. This is being closely monitored by the Trust People and Wellbeing Committee. Retention initiatives underway which will be captured in the Trust long term plans on attraction and retention.

- Trust wide PDR compliance at 90%.

3. Industrial Action and Agenda for Change pay 'offer in principle'

On 16th March 2023 the government made a pay 'offer in principle' to the trade unions representing staff on NHS Agenda for Change Terms and Conditions, this pay offer has now been accepted. The pay award will be paid in June salaries back dated to 1st April 2023. All staff on NHS Terms and Conditions of Service (AFC) will receive this pay.

An overview of the pay offer is as follows:

- 2022/23: a non-consolidated payment, made up of two parts - a 2 per cent non-consolidated award for all staff plus an additional backlog bonus, equivalent to an extra 4 per cent of the AfC pay bill.
- 2023/24: a consolidated pay uplift, made up of a 5 per cent headline pay uplift, combined with the introduction of a band 2 spot salary – for staff entering NHS employment at this level - which is worth a further 0.2 per cent investment onto the AfC pay bill. This is a total investment of 5.2 per cent for consolidated pay changes in 2023/24.
- A series of non-pay measures to support the NHS workforce *(NHS Employers)*

NHS Employers have provided detailed pay posters to help all staff at each band understand what this means for them, and this has been communicated to staff.

The RCN did not accept the pay offer. The RCN are currently balloting members in relation to further strike action and we await a further update, the current ballot closes on 23rd June 2023.

Further Junior Dr Strikes have been announced and this 72-hour strike action is planned for 14th to 17th June 2023.

The Trust continues to work closely with all staff side colleagues, as well as providing frequent Trust wide communications and updated FAQ's. Gold/tactical command structure is in place as well as ongoing staff support through the Trust SALS Service.

Sharon Owen
Deputy Chief People Officer
May 2023

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 8th June 2023

Paper Title:	**Highlight report – Equality, Diversity, and Inclusion**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angela Ditchfield, Head of Equality, Diversity, and Inclusion

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.3

1. Introduction

The purpose of this paper is to provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to Equality, Diversity and Inclusion (ED&I) during March/April 2023.

2. Equality Reporting

This year's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data is currently being collated.

- We aim to analyse the current data comparing this to our 2022 data. A report with an agreed action plan will be developed in collaboration with key stakeholders.
- The Equality Delivery System 2022 (EDS22) will be implemented this year and a meeting will be held in June 2022, inviting key staff members to participate and engage with the implementation of this key piece of work. The EDS22 is an equality improvement tool which will allow us to evaluate our organisational position in regard to Equality Diversity and Inclusion. It will encourage engagement, whilst providing insight and accountability.

3. Staff Networks and support

Our staff networks are starting to develop and take shape. The appointed chairs/deputy chairs are committed to drive forward positive change, supporting the workforce, which will allow us to understand how it feels to work at Alder Hey', and working together to make ongoing improvements.

- The launch of the reasonable adjustments policy was a huge success with staff members attending the day to learn more about the policy. We also promoted the launch of the Disability and long-term conditions staff network which was well received.
- The first meeting for the Disabilities and long-term conditions staff network will take place in June and we will be circulating communications to encourage engagement.
- Our staff network chairs/deputy chairs will be taking part in the Employee Network Leadership programme delivered by Radius Training. The programme will provide them with information about how to run an effective staff network and influence change.
- Our executive sponsors also have the opportunity to attend an Executive Sponsor Programme which will provide them with ideas and skills about how to effectively champion their staff network and mentor to inspire success.
- Our Armed Forces staff network held their second meeting and are currently asking for nominations for the role of chair/deputy chair.
- June 21st is Reserves day and the Armed Forces staff network are planning a series of events, which will take place across the trust.
- The Menopause support group is growing and now has over 125 members supporting each other, offering guidance and providing education and training.

4. Learning and Development

We are currently reviewing our training and development opportunities, working closely with the learning and development team to identify areas which we can develop equality, diversity, and inclusion support, education, and training.

- We will work with our staff networks, listening to the learning needs of our staff, ensuring that we are developing appropriate training opportunities which will meet the needs of staff with protected characteristics
- We are working closely with the Clatterbridge Cancer Centre, planning a series of bite size training sessions to raise awareness of Neurodiversity.
- Learning and development team are supporting the development of an in house training programme for managers which is aimed at providing them with support and resources to better support staff with disabilities.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
May 2023

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 29th March 2023
Via Microsoft Teams

Present:	Dame Jo Williams	Trust Chair **(Chair)**	(JW)
	Alfie Bass	Chief Medical Officer	(AB)
	Fiona Beveridge	Non-Executive Director	(FB)
	Asia Bibi	ACOO – Research	(AB)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Rachel Greer	ACOO – Community & Mental Health	(RG)
	Melissa Swindell	Chief People Officer	(MSW)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
In attendance:			
Item 22/23/134	Kerry Byrne	Non-Executive Director	(KB)
	Angela Ditchfield	EDI Lead	(AD)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Kerry Turner	Freedom to Speak Up Guardian	(KT)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Natalie Palin	Associate Director of Transformation	(NP)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Chloe Lee	Associate COO – Surgery	(CL)
	Nathan Askew	Chief Nursing Officer	(NA)
	Garth Dallas	Non-Executive Director	(GD)
	Adam Bateman	Chief Operating Officer	(AB)
	Kathryn Allsopp	Head of Operational HR	(KA)
	Katherine Birch	Director, Alder Hey Academy	(KB)
	Jill Preece	Governance Manager	(JP)
	Pauline Brown	Director of Nursing	(PB)
	Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
	Mark Carmichael	ACOO - Medicine	(MC)
	John Grinnell	Deputy Chief Executive	(JG)
	Urmi Das	Director, Division of Medicine	(UD
	Ian Quinlan	Non-Executive Director	(IQ)
	Jacqui Pointon	Associate Chief Nurse	(JP)
	Clare Shelley	Associate Director of Operational Finance	(CS)
	Maisie StJohn	Service Manager	(MSt)
	Jeanette Chamberlain	Staff Advice & Liaison Service Manager	(JC)
	Adrian Hughes	Deputy Medical Director	(AH)
	Gill Foden	HR Manager	(GF)
	John Chester	Director of Research & Innovation	(JC)
	Lisa Cooper	Director of Community & Mental Health Services	(LC)
	Rachel Hanger	Associate Chief Nurse – Surgery	(RH)
	Neil Davies	HR Business Partner	(ND)
	Jacqui Lyons-Killey	Associate Chief Nurse – Research	(JLK)
	Sarah Marshall	HR Business Partner, Community & Mental Health	(SM)
	Phil O'Connor	Deputy Director of Nursing	(POC)
	Julie Worthington	Staff Side Rep	(JW)

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22/23/131 **Declarations of Interest**
No declarations were declared.

22/23/132 **Minutes of the previous meeting held on 18th January 2023.**
The minutes of the last meeting were approved as an accurate record.

22/23/133 **Matters Arising and Action Log**
Action log was updated accordingly.

22/23/134 **Risk Profiling Tolerances – Workforce Risks**
ES introduced a presentation detailing the risk appetite statements that were approved at February 2022 Trust Board. The presentation set out the proposed risk tolerance levels for workforce risk types including:

- Workforce Sustainability (medium)
- Workforce – EDI (medium)

ES went on to explain that the introduction of these risk tolerances was aimed at ensuring a consistent approach for risk owners in terms of setting targets and closing risks. The Committee was informed that the Trust has already defined the impact descriptors for human resources / organisational development / staffing / competence risks which had been set out in the presentation but that impact descriptors did not yet exist for workforce EDI.

Discussion ensued regarding the suggested tolerances being too lenient given the current profile of workforce risks across the Trust, which for the most part, sat within the medium (suggested tolerance) range meaning they would close. KB welcomed this thought process and thanked committee members for their engagement and contribution and suggested a working group to be established to discuss and agree the accepted tolerance range.

MSW queried oversight of all workforce risks that sit Trust wide that are monitored divisionally and not through PAWC and was advised that risks scored 15 and over are monitored through the Risk Management Forum and suggested deep dive into people risks at this meeting.

JW highlighted the importance of considering any impact of the Cheshire & Merseyside system on our workforce and risk appetite.

Resolved:
For each of the risk types, the Committee was asked to:

- consider the Risk Appetite Statements and confirm support or suggest any changes to be fed back to Board.
- review the risk impact descriptors for the human resources / organisational development / staffing / competence risks and either confirm support or suggest any changes to be fed back to Board.
- define the risk descriptors and review the associated risk tolerances for those risks where impact descriptors do not exist.
- A working group to be established to further discuss and agree tolerances.

A further update would be presented at the July RABD.

Alder Hey Children's NHS Foundation Trust

People Plan 2030

22/23/135 **People Plan 2030**

Following launch of the Trust's Vision 2030, MSW delivered a presentation on the People Plan embedded within this.

She explained that work had been undertaken with Strasys Consulting to help understand the current workforce dynamics and how we will address the four areas of need for staff and children: looking after each other; create a sense of belonging; embrace new ways of working and learn and grow for the future.

Challenges to delivery including operating environment and the market were acknowledged and how these will be addressed thinking differently about the different groups of staff, how we support, retain and help staff develop in their roles and attract future workforce.

The committee endorsed the direction of travel and current proposals and welcomed a further update following work up of the propositions and future plan for Alder Hey.

Next steps: New metrics for 2023/24 are now in development which will be reported to the committee in due course.

22/23/136 **Monitor Progress against the People Plan – Divisional Metrics (February 2023 data)**

Community & Mental Health Division:

The Committee received the divisional metrics report. RG reported that divisional overall compliance continued to increase and drew specific attention to the following:

- PDR compliance achieved ahead of month end (92.7%)
- Divisional data packs had been received from the feedback of the staff survey and plans are now in place to support process.

Next steps: Team continues to monitor data and drive improvements across the division.

Research Division:

Committee received research division metrics report and noted progress to date. AB highlighted the following:

- Following on from feedback received regarding staff morale and retention, a Staff Engagement Forum has now been established within the division led by staff. QR code and virtual suggestion box now in place including a positivity tree for better engagement and communication.

Next Steps: Team continues to monitor data progression and drive improvements across the division.

Medicine Division:

The Committee received the medical division metrics report. CW reported that divisional overall compliance continued to increase and drew specific attention to the following:

- PDR's remained on track to reach 90% by 31st March 2023.
- Mandatory Training has increased reaching 95% target – divisions continue to manage with a focus on sepsis. Good plans in place to support.
- Return to work has increased and continues to drive forward with support from Ward Managers and department Leads.
- Long term sickness is slightly reducing – challenges remain, and teams are continuing to manage and maintain monitoring with support from HRBPs.
- Cancer Services continues with challenges relating to sickness, a new Cancer Service Lead has now been appointed to help support including advanced practice in order to stabilise flow.
- Listening Event had a successful launch with numerous themes and conversations achieving over 400 feedback items. All feedback will be reviewed and responded to over the coming weeks – overall, good engagement.

Next steps: Team continues to monitor data and drive improvements across the division.

Surgical Division:

The Committee received and accepted the divisional metrics report noting progress to date.

Division remains stable and good progress is being made to achieve compliance across departments with support from colleagues.

Corporate:

Committee received and accepted the corporate metrics report and noted progress to date.

22/23/137 **Progress against the Internal Communications Plan**

Committee received the Internal Communications Plan report and noted progress to date.

New intranet has now launched successfully, further feedback on developments will be shared in due course.

Resolved:
Committee was assured the new intranet launch project remains in good development.

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Looking After our People

22/23/138 **Staff Survey Results 2022**

Committee received the full staff survey report. JP noted the following headlines:

- Development of divisional packs remains on course and will be distribution in due course – more information will be communicated.
- Departments continue to be encouraged and supported to have big conversations with colleagues. In relation to previous feedback, the team are working to develop training sessions which will involve a short video supported by HRBP.

Action: Divisions to work together to establish a framework to capture the outputs from the Big Conversations taking place locally. An update to be brought back to the Committee in four months time to review progress made and changes implemented as a consequence of the big conversations being held divisionally.

Resolved: Committee noted the progress made and agreed further exploring into the key challenges highlighted.

Belonging to the NHS

22/23/139 **Workforce Race Equality Scheme – Action Plan 2022**

The Committee received the Workforce Race Equality Standard (WRES) Action Plan 2022/24 and Workforce Disability Equality Standard (WDES) Action Plan 2022/24 for approval.

AD informed the Committee that following receipt of the most recent data set, further key areas of focus would be included within the action plans. An EDI Sub-Group Meeting has been created to work with divisions including the Network Chairs for further development and action planning

Resolved: The Committee noted progress contained within the action plans and approved both documents for publication on the Trust website.

22/23/140 **Gender Pay Gap Report 2022**

Gender Pay Gap report 2022 was received by the Committee noting a mean gender pay gap of 27% and median gender pay gap of 19% mainly within our Medical and Dental staff groups and is reflective of an ageing male workforce within this staff group. Medical & Dental female workforce profile is evolving with an increased number of female consultants being appointed. The reasons for a gender pay gap were noted as multi-factorial; terms and conditions, length of service, gender mix, pension and flexible working arrangements – all impacting on the overall gender pay gap results. Assurance was received that actions have been identified to ensure an equitable workforce and reduce this gender pay gap which have been incorporated into the People Plan, progress against these actions will be reported to PAWC during 2023/24.

Resolved:
Committee noted progress made within the Gender Pay Gap report.

22/23/141 **Workforce Equality, Diversity and Inclusion Annual Report 2022/23**

The Committee received the Workforce Equality, Diversity and Inclusion Annual Report 2022/23 highlighting progress against actions to ensure we are meeting equality responsibilities as set out in the Equality Act 2010 and the Public Sector Equality Duty.

It was noted that the EDI Steering Group would act as the main vehicle to support and drive the EDI agenda during 2023 and beyond.

Resolved:
The Committee approved the Workforce Equality, Diversity and Inclusion Annual Report 2022/23.

Equality Delivery System for the NHS – EDS2
AD informed the Committee that the EDS2 progress report was still being finalised and would be presented to the committee for final approval in due course.

AD advised that a divisional sub-group would be formed to disseminate the great work being undertaken within divisions and feed into wider organisations as part of learning and sharing.

Action: AG to share EDS2 report when complete for ratification by the Committee.

Resolved:
The Committee received and noted the latest position.

Governance

22/23/142 **Trust Trade Union Partnership Agreement**

SO introduced the Partnership Agreement and Framework.

Signals how we will work in partnership with staff side colleagues on employment matters going forward – look to resolve employment matters through effective dialogue informally rather than entering into formal processes.

Time has now been allocated to unison colleagues to support lead roles and was welcomed. Significant progress has been made and a formal thank you to Kerry Turner, Julie Worthington and Jillian Jenkins was given for all their continued help and support in achieving this.

MSW recorded her thanks to SO for her leadership on this piece of work and collaborative working with staff side.

Resolved: The Committee approved the Trade Union Partnership Agreement and noted the significant progress in partnership working and positive relationship with the Trust's Staff Side Group.

22/23/143 **Board Assurance Framework – Monitoring of Strategic Workforce Risks**

ES introduced the Board Assurance Framework reflecting the February 2022 position.

ES explained that work would be undertaken over the coming months to revisit the BAF risks in line with the 2030 Vision and that this work would indeed consider the wider system implications.

The Committee noted the Board Assurance Framework update for the month of February 2022.

Ratify HR / Health & Safety Policies

22/23/144 **Doctor Job Planning Policy**

MSW highlighted that this was an existing Policy which has been updated to reflect:

- the new system for e-job planning (L2P)
- new grades introduced nationally
- clarity on responsibility and roles including allocation of time re specialist PAs and SPAs

Resolved:
Approved by the Committee.

22/23/145 **Reasonable Adjustment Policy**
Reasonable Adjustment Policy was introduced to the Committee. An overview had been submitted to the Committee.

SO explained that this was new Trust Policy and that guidance regarding reasonable adjustments had previously embedded within other Policies. Following feedback from the staff survey, it was now fundamental to ensure we have a very clear policy in respect of reasonable adjustments to support staff.

JW very much welcomed this document and stressed the importance of effective monitoring going forward given its direct link with staff survey results regarding disabled colleagues. FB agreed that this document was vital to ensure early recognition of flexible needs. JW sought assurance regarding implementation of the new policy and was informed that the this was being taken forward by the Operational HR Team within their training.

Resolved:
Approved by the Committee.

22/23/146 **Health & Safety Committee (HSC)**

The Committee received the approved minutes of the HSC meeting held on (December 2022).

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22/23/147 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on (February 2023).

22/23/148 **Local Negation Committee (LNC)**

The Committee received the approved minutes of the LNC meeting held on (December 2022).

22/23/149 **Education Governance Committee (EGC)**
The Committee received the approved minutes of the EGC meeting August 2022.

22/23/150 **Any Other Business**

No other items of business were raised.

22/23/151 **Review of Meeting – Chair's Report to Board**

People Plan: People Plan was introduced to the Committee with good goals of achievement across the organisation – further plan to being back in few month's time to review progress.

Divisional Metrics Update: Divisional metrics remains stable and on track, challenges remain a focus and divisions have plans in place to address and stabilise.

PDRs / Turnover & sickness absence remains a key area of focus with plans in place to monitor.

New Intranet Update: New intranet has now launched and remains stable, feedback from all areas continue to be explored for further progression of the development.

EDI: EDI making good progress, EDS2 to be shared with the Committee for final review and approval once ready for circulation. Good progress being made.

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments.

Date and Time of Next meeting
Wednesday 24th May 2023 at 2pm via MS Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	Transformation Assurance Programme
Report of:	Natalie Palin, Associate Director of Transformation
Paper Prepared by:	Natalie Palin, Associate Director of Transformation Hannah Thompson, Programme Manager Ellie Johnson, DMO Change Programme Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report
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 identified in this report

1. Executive Summary

The purpose of this report is to provide the Trust Board with assurance around the adherence to the programme management standards; for programmes designated as strategically important as part of the 2022/23 Operational Plan (*this paper focuses only on multi-year programmes, which have not yet fully realised benefits).*

The Delivery Management Office (DMO) resource has now pivoted towards the mobilisation of the 2030 Strategy Programme. We are currently managing the transitioning towards a single transformational programme for 2030.

Delivery and Assurance results Qtr.1 April – May 23 (6 programmes): **-**

- **Only Brilliant Basics is rated at Green** are rated for both 'Governance and Delivery'

- **Workforce planning** has been rated as amber for both governance and delivery, meaning evidence was not available to provide assurance to demonstrate on-going management of risks and delivery progress.

- **Governance:** The remaining four programmes have been rated amber (67%), meaning that evidence was not available at the time of assessment (*Patient Safety, Alder Care, Genomics and Greener*).

- **Handover to BAU:** Two Recovery projects have been handed over to BAU (*Advancing Outpatients and Productive Theatres*). They have not formed part of this governance review as control plans have been provided to the operational leads.

Assurance approach 23/24

- The Programme Governance Framework is updated, to ensure that it adequately provides assurance against our 2030 Strategy needs approach.

The recommendations, following this report -

- Note: The Delivery Management Office, will be supporting the delivery of the 2030 Strategy deployment.
- Approve: The proposed improvements to the Governance and Assurance Framework, as detailed in section 4.

2. Background

Why: The governance of change is an important control framework for ensuring authority and accountability for the proposed 'programme / project' outcomes and benefits. Any change within an organisation provides potential benefits and risks. There is a key

relationship in the management of change with both culture and interpersonal relationships, which are essential considerations for managing change.

The assurance rating is devised to support the 'Change teams' alongside the SRO (Senior Responsible Officer), to rate the level of confidence that the programmes will achieve their intended benefits, with quality, cost, and time scale. It is designed to improve control and therefore the achievement of sustainable change.

How: The primary purpose of the assurance review, is to provide a semi-independent assessment on governance of change: -

a) **Programme management standards**, which underpin successful delivery are being adhered i.e., stakeholder engagement, risk management.
b) **Delivery assurance**, assessment that the programme is on track, to deliver its intended benefits, within timescales, resources, and meeting areas of need.

The assurance rating is undertaken in a semi-independent manner utilising documented evidence '*opposed to verbal reassurance'*. Table 1 details the key areas which the assurance assessment is undertaken against. There is transparency with the programme teams, around the expected standards and the evidence required. The SRO is accountable at a programme level to ensure the adherence to the standards.

The assurance ratings form part of the monthly reporting to strategic executives and are also provided to the appropriate committee. There are three ratings, Green (standards achieved), Amber (standards achieved in part), Red (No evidence of standard being achieved).

Table 1: Assurance categories – Governance and Delivery

Overall Governance					Overall delivery rating		
Project Team	Scope	Risk management	Stakeholder engagement	EIA / QIA*	Targets	Milestones	QI approach

*Equality Impact Assessment / Quality Impact Assessment

3. Assurance Assessments

This report details only strategically important programmes and being delivered under a change project management (PMO) methodology.

Table 2 details the current high-level assurance ratings, appendix (1) provides the further narrative descriptions that detail the rationale in the assessment scoring; to provide full transparency and identification of areas for improvement.

**This paper does not include the performance against the key driver measures, as this is detailed within the Integrated Performance Report*.

Table 2: Programme and Rating

Programme *(SRO)*	Driver *	Governance rating	Overall Delivery rating
Patient Safety *Chief Medical Officer / Chief Nursing Officer and AHP/HCP Lead*	25% Reduction in harms		
Brilliant Basics Chief Nursing Officer and AHP/ HCP Lead			
Workforce Planning Chief People Officer	>80% of staff recommend a place to work		
Digital – Aldercare Chief Digital and Information Officer	100% Safety Compliance		
Genomics Medical Director, Liverpool Women's Hospital (LWH)	Delivery of outstanding care and Ground-breaking Research & Innovation		
Greener Director of Marketing and Communications	Net zero by 2035		

Overall Assessment

- **Brilliant Basics** has been rated as green for overall programme delivery (*Brilliant Basics and Alder Care*). Alder Care rating is an improved position and demonstrates the significant management and oversight of the programme.

- **Four programmes have been rated amber for delivery (67%)**, meaning that evidence to demonstrate achievement was not available at the time of assessment.

    - **Alder Care** – this a vastly complex programme and the governance documentation is consistently of a high standard. The governance controls to manage decisions and change are robust and effective. The programme has been rated as amber due to its position at gateway 3.

      There is excellent evidence of 'mitigation and control management', and risks are understood and reviewed regularly by the programme team. An improved position against key milestones would be required to enhance the delivery rating.

    - **Patient Safety** – whilst this programme is rated as amber for delivery there was evidence of improved compliance on EIA /QIA for individual workstreams. To improve the delivering ratings benefits and milestones require updating (reviewed evidence not updated since April 23).

    - **Genomics –** is a relatively new to the programme assurance framework, and feedback has been provided to support the SRO and team, to meet the required standards. Were Milestones have been reprofiled improved

evidence of 'Management of Change Control' alongside a specific scoring is required.

- **Greener:** To achieve a green rating the development of a benefit tracker is required and milestones updating is needed.

- **Workforce planning:** has been rated as amber for governance and delivery, meaning the standards were only partially met. To improve the assurance rating improvement are required in the management of risk and achievement of milestones. Feedback has been provided to enable improvement actions to be completed.

  The 2030 Strategy incorporates 'Our People Plan' delivered through the three strategi initiatives. In the development of the new initiatives a review of current activities and resource allocation is included, this will therefore provide an opportunity to review the current 'workforce planning programme'.

- **Handover to BAU:** Two Recovery projects have been handed over to BAU (*Advancing Outpatients and Productive Theatres*). They have not formed part of this governance review as control plans have been provided to the operational leads (Detailed in Appendix 1).

4. Assurance approach and forward plan – 2023/24

The Trust's Delivery Management Office resources are fully assigned to the Strategy 2030 mobilisation (Appendix 2- Plan on a page). This is a shift to previous resource allocations; the expertise of professionals in both programme and change management, will assist the successful deployment and oversight. We are currently managing the transition towards a single transformational programme for 2030.

As we manage the transitional arrangements, we will continue to maintain the governance and assurance of the current programme (Table 2). Until such time that the current programmes, have either been 1). completed, 2). transferred into operational delivery, 3). Aligned into 2030 Strategic Initiatives and or, 4) Closed. We are managing this in a controlled manner to ensure resource allocation is viewed against a single transformational plan. The decision-making is being over seen through Strategic Executives, to ensure alignment of resources, value creation, and financial principles.

Table 3: Current programme and alignment to our 2030

Strategic Goal: 2030	22/23 Programme	2030 – Strategic Initiatives

Unrivalled Experience	Patient Safety Brilliant Basics	1.1 CYP Experience and Engagement
Supporting our colleagues	Workforce Planning	2.1 Thriving @ Alder Hey
Pioneering Breakthroughs	Genomics	3.1 Futures
Collaborating for CYP	Greener	4.1 Building Communities
Smartest ways of working	Alder Care	5.2 Digital and Data: Alder Care

Development of our Strategic Initiatives 2030

The Delivery Management Office is leading the development of our 2030 Strategy Programme programme. A co-ordinated oversight of the programme initiation is designed to support planning, prioritisation, interdependencies, and benefit mapping. A standard mobilisation framework aligned to our Brilliant Basic principles ensures that CYPF needs, engagement and intelligence is established from the start. Each of the Strategic Initiatives are supported by three facilitated workshops, which are designed to allow a current state analysis, onboarding, prioritisation, and capability building.

2030 Governance and Assurance

The new strategy is a fundamental pivot towards a CYPF needs based approach and will need to be reflected in our programme management and assurance framework for 23/24. In considering our approach for 23/24 we have objectively reviewed current practice, engaged with key stakeholders, and reviewed research evidence from sources including, Association of Programme Management and NHS Project Futures.

Our assessment identified areas of improvements, that we are recommending that we incorporate into our approach for **2023/24 Programme Governance Framework** as detailed below: -

- **Governance and Assurance Approach**: To continue to undertake a 'information evidence' led assessment against agreed programme governance and delivery standards.

- **Assurance Standards Governance standards**: To update the below standards definitions and evidence requirements. All other standards will remain the same.
    - Project Team: To reflect the resource skills and time allocation.
    - Scope and milestones: To reflect the needs-based approach and align benefit achievement to overall 'delivery confidence'.
    - QI approach: To reflect the testing and Collobrative leadership approach

- **Assurance reporting:** The current reporting approach, provides a monthly indication of assurance. In future we will move towards showing trends over time (recognising that the current view hides any significant variation / improvement in performance).

The Strategy 2030 (Board paper, 30th March 23) outlined the intended approach to governance of the 2030 Strategy Programme, into Strategy Board.

- **Programme management documentation**: To be updated to align with the new Trust strategy (additional areas of need).

5. Conclusion

This report provides the Trust Board with a semi-independent assessment of the adherence against our own programme management standards. The report highlights good practice and areas to enhance delivery performance. Governance continues to be an area whereby most programmes are demonstrating good habits and adherence. Improvements to delivery ratings, could be achieved in the main, through consistent benefit tracking and milestone management.

The paper details the approach for proposals for enhancing the Governance and Assurance Framework for 23/24, to ensure alignment with our 2030 Strategy. The formal governance assurance ratings will commence for the new 2030 Strategy Programme, following approval of individual PIDs.

6. Recommendations

- Note: The Delivery Management Office, will be supporting the delivery of the 2030 Strategy deployment.
- Approve: The proposed improvements to the Governance and Assurance Framework, as detailed in section 4.

Appendix 1: Full Governance assurance table

Programme *(SRO)*	Driver *	Overall Governance rating	Overall Delivery rating	Summary Comments
Advancing Outpatients *Chief Operating Officer*	104% Activity Elective & Daycase and outpatient	**N/R**	**N/R**	Moved to business as usual as of April 23 and being managed operationally / at service level. Recovering paediatric services: relative to pre-Covid we are treating more patients who outpatient care (115%)
Productive Theatres *Chief Operating Officer*		**N/R**	**N/R**	Moved to business as usual as of April 23 and being managed operationally / at service level. Recovering paediatric services: relative to pre-Covid we are treating more patients who require elective care (103%)
Patient Safety *Chief Medical Officer / Chief Nursing Officer and AHP/HCP Lead*	25% Reduction in harm			**Last rated 02/06/23** **Effective Project Team:** is in place, evidence of regular meetings. **Scope and Approach:** Is well defined. **Stakeholders Engagement:** Clear evidence of excellent stakeholder engagement across the trust. **Risks:** Risk register in place, reviewed regularly and within date. **EA QIA's:** 7/10 EA QIA's in place, 3 remaining to be rated green on this metric. **Targets/benefits:** Large benefit tracker in place, only 2 metrics are being tracked monthly up to May 23. There is clear progress within the month however the project needs to finalise the tracker and ensure all metrics are tracked monthly to gain a green rating. **Milestones:** A high-level milestone plan is in place for individual workstreams with clear progress of completed milestones, some spillage which is not expected to impact the project. Overall delivery rating: Amber **(Rated 02/06/23)**
Brilliant Basics Chief Nursing Officer and AHP/HCP Lead				**Last rated 10/05/23** **Effective Project Team** is in place, evidence of regular meetings. **Scope and Approach:** There is no formal PID however the 23/24 BB Delivery Plan, is acting as the PID to describe the scope and approach. **Benefits:** There is good evidence of impact and benefits evidenced with case studies available on SharePoint. **Milestones:** There is a comprehensive milestone plan in place for 23/24, deliverables are being tracked and progress recorded. **Stakeholder engagement:** There is evidence of good stakeholder engagement across the Trust. **Risks:** There are 1 remaining risk logged on Ulysses (2498) with a risk score of 16, this is within review date. Risk 2899 was closed 5/5/23. **EA QIA:** There is EA QIA in place, signed off Sept 22. Overall delivery rating: Green
Workforce Planning Chief People Officer	>80% of staff recommend a place to work			**Last rated 02/06/23** **Effective Project Team:** Project meeting have recommenced in May 23 after a 2 month pause, an effective project team is now in place. **Scope and Approach:** There is a project brief available but no PID at this stage which would not be expected given the nature of phase 1. **Stakeholder Engagement:** There is no evidence of highlight reports to the executive team since 10/02/23. Rating was reduced to amber. **Risks:** There is no evidence the risk register has been reviewed and updated since 10/01/23. Rating reduced to red. **EA/QIA**: N/A. No EIA/QIA is required for phase 1. **Benefits:** N/A A benefit tracker is expected once the project moves to Phase 2. **Milestones:** A milestone plan is in place up until the end of March 23 but needs updating. Rating reduced to Amber. **Overall Deliver Rating:** Rated Amber The project should review and update their risk register, milestone plan and provide evidence of stakeholder engagement to regain green ratings.

Programme *(SRO)*	Driver *	Overall Governance rating	Overall Delivery rating	Summary Comments
Digital - Aldercare Chief Digital and Information Officer	100% Safety Compliance			**Last rated 02/06/23** **Effective Project Team:** An effective project team is in place. **Scope and Approach:** Is well defined, there is a comprehensive PID in place. **Stakeholder Engagement:** Evidence of good stakeholder engagement across the trust. **Risks:** There is a comprehensive risk register and a well utilised RAID log which are within review date. **EA/QIA:** An EA QIA has been completed, approved, and signed (Nov 2022). **Benefits:** There is a Statement of Planned Benefits (SoPB), baselines and targets to be identified by June 23. There are 3 key Alder Care metrics tracked monthly with 2/3 showing an increase between April - May 23. **Milestones:** An overarching project plan and individual plans for each key workstreams are in place and up to date. Only 1/14 steams (Reporting) is off track but with a recovery plan in place and daily monitoring. **Overall Delivery Rating**: Green.
Genomics Medical Director, Liverpool Women's Hospital (LWH)	Delivery of outstanding care and Ground-breaking Research & Innovation			**Last rated 02/06/23** **Effective Project Team:** An effective project team is in place. **Scope and Approach:** Is well defined, there is a comprehensive PID in place. **Stakeholder Engagement**: There is evidence of a regular stakeholder engagement. **Risks:** There is a local risk register in place which is within review date. **EA/QIA:** There is a signed off EA QIA in place. **Benefits:** A benefit tracker is in place; 6 benefits are now begin tracked monthly (since Feb 23) however it's not clear if benefits are **on track** as the numerical data doesn't match the % target – the project should update the tracker to gain a green rating. **Milestones:** Comprehensive milestone plan shows some slippage by way of revised milestones although not impacting on the programme at this time, the completed milestones need to be clearly defined using the scoring system. **Overall Delivery rating: Amber**
Greener Director of Marketing and Communications	Net zero by 2035			**Last rated 02/06/23** **Effective Project Team:** An effective project team is in place. **Scope and approach:** The PID was drafted April 22 but is incomplete however the Greener Strategy, signed off at Board in January 23, describes the scope and approach very well. Project team should complete their full to gain green rating. **Stakeholder Engagement:** Detailed comms and engagement plan in place. Evidence of fantastic stakeholder engagement taking place across the trust. **Risks:** Two project risks sit on Ulysses these are within review date, no local risk register. **EA QIA:** An EA QIA was drafted in May 22 but is incomplete - the project should complete this to gain green rating. **Targets and benefits:** Progress against target metrics is monitored through the project team meetings but no formal benefit tracker is in place. **Milestone plan:** There is detailed milestone plan in place, however it has not been updated since the beginning of April - project team should update and track milestones monthly to gain green rating. **Overall rating: Amber**

Appendix 2: Our 2030 Plan on Page

Development of programmes

Vision	Objectives	Delivered Through (Exec Lead)		Outcomes	Measures
Healthier, happier, fairer futures where every child & young person achieves their full potential	Delivering the best possible outcomes and experience for CYP&F	**1. Outstanding care and experience**	1.1 Improved Safety 1.2 CYP & Families Engagement and Experience	• Happier children, young people and families • Rated as Outstanding • Designing our care around the needs of CYPF	• Family QALY [H] • CYPF Experience • System Service Experience Management Quotient (SEMQ [H] • Staff Thriving Index [H] • Social Value [H • (Happy) Community Index [M] • Variation in Health and Care Outcomes [L] • Clinical Service Capacity [H] • Resource Optimisation [L] • Ecosystem Contribution [H] • Innovation Adoption Rate [M] • Productivity / Economic Gain [H]
	Supporting our colleagues to have fulfilling careers in a community that thrives	**2. Supporting Our People**	2.1 Thriving @ Alder Hey 2.2 Professional development hub 2.3 Future Workforce	• **Our People are thriving: -** a. have a sense of belonging and are actively engaged b. have the time, space and opportunity to improve the quality of care and meet the needs of CYPF • We invest in our people and their teams to ensure they can have amazing careers • New skills and capabilities across a dynamic and flexible workforce • Right sized workforce renowned for new ways of working • A borderless CYP workforce across communities	
	Ensure delivery of the very best health and care outcomes for CYPF locally, regionally, nationally and internationally	**3. Smartest Ways of Working**	3.1 New Care Models 3.2 Digital and Data 3.3 Insight led decisions	• Accessible models of care implemented around the needs of CYPF • World class resilient specialist services • Digital Centre of Excellence driving productivity, speed, scale and quality • Collaborating across communities to ensure CYPF only need to tell their story once • Insight Unit recognised as a global centre of excellence for CYPF intelligence	
	Pioneering to find novel solutions and treatments	**4. Pioneers Breakthroughs**	4.1 Futures	• State-of-the-art "Hospital Without Walls" • Northern Institute for Child Health & Well -Being • International Post-Graduate School • National Forum on Health Inequalities • Integrated paediatric data network	
	Working with partners to improve life chances of CYP	**5. Collaborating for Children and Young people**	5.1 Building communities 5.2 CYP system	• The heart of a CYP health and care system renowned, regionally and nationally • A convener of the system with frictionless, sustainable and shared CYP resources • We will be a valued anchor institution that attracts inward investment and creates opportunities across our communities	
CYPF Needs (Get me well, Make my care more personal, Improve my life chances, Bring me the Future Today)					

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 8th June 2023

Paper Title:	**Board Assurance Framework Report 2023/24 (April)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

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

000256

Board Assurance Framework 2023/24

1. Purpose

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

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

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

2. Review of the BAF

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

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	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.	Research & Innovation Committee

3. Overview at as 9th May 2023

BAF Risk Register - Overview at 9 May 2023
1.2: Children and young people waiting beyond the national standard to access planned care and urgent care (S)
3.4: Financial Environment (S) 4.2: Digital Strategic Development & Delivery (S)
3.5: ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system compl (S)
1.4: Access to Children and Young People's Mental Health (S) 2.1: Workforce Sustainability and Development (S)
2.3: Workforce Equality, Diversity & Inclusion (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S)
1.3: Building and infrastructure defects that could affect quality and provision of services (S)
3.2: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of (S)
4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)
1.1: Inability to deliver safe and high quality services (S) 2.2: Employee Wellbeing (S)
3.6: Risk of partnership failures due to robustness of partnership governance (S)

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 9th May 2023

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	**4x5**	3x3	STATIC	STATIC
1.3 AB	**Building and infrastructure defects that could affect quality and provision of services**	RABD	4x3	2x3	STATIC	STATIC
1.4 LC	**Access to Children and Young People's Mental Health**	RABD / SQAC	**3x5**	3x3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**	PAWC	**3x5**	3x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	**3x5**	4x1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	RABD	3x4	3x2	STATIC	STATIC
3.2 DJ	**Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships**	RABD	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	RABD	**4x4**	4x3	STATIC	STATIC
3.5 DJ	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment**	Board	**4x4**	3 x3	STATIC	STATIC
3.6 DJ	**Risk of partnership failures due to robustness of partnership governance**	RABD	3x2	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**	Research & Innovation	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development & Delivery**	RABD	4x4	4x1	STATIC	STATIC

5. Summary of April 2023 updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Actions, controls and evidence reviewed and updated.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score in month. Review of all ICS related activity included in May 23 Growing Great Partnerships board report - updated in evidence.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; score remains at target rating. Actions and controls checked.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed, no change to risk rating.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  There have been several high profile corroded pipework issues in April which led to clinical areas being closed off whilst the repair and clean up operation took place. Whilst the response was swift and the issues dealt with in a timely manner it has highlighted the seriousness of the issue and that replacement of the pipework , in some form, is required in areas across the site where the pipework has some form of corrosion. Weekly meetings with the SPV, LO'R & Mitie continue to discuss the remaining and newly identified risks. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding although this will require evidence to support. In response to out-of-range temperatures we have local mitigation's in place such as filters on water outlets, and later this year we will introduce an chemical dosing system across the site. The chiller works continue and the temporary ones will be removed late May. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement although this has not been accepted by Trust reps.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  ED Performance in April against 4 hour target was 84%. This is above the national standard (76%) and the highest rate of compliance in 6 months - but needs to be sustained to demonstrate consistent underlying improvement in access. Diagnostic wait <6 weeks continues to improve, towards our 90% target for 2023/24. Significant concerns remain regarding long waits for ENT, Dental, ASD and ADHD services - with a growing number of Children & Young People waiting >65 weeks. Further actions are required in these challenged specialties, with investment proposals to be reviewed by 12 May.

- ***Inability to deliver safe and high-quality services (NA).***
  Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

- ***Access to Children and Young People's Mental Health (LC)***
  Risk reviewed and action closed relating to workforce plans as all actions in place and impact being monitored.

- ***Financial Environment (JG).***
  Risk reviewed and actions updated with progress and revised time frames to reflect latest position and ongoing work. Risk score kept same currently however recognise the challenging plan for 23/24 and as we progress into the year, the score will be reviewed and may change to reflect the change in risk profile.

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

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, score remains static due to the level of imminent change and interdependencies in 23/24. Good progress being made in preparation for Aldercare go live in September 2023. In phase go live commenced 2.5.23.

- ***Workforce Sustainability and Development (MS).***
  Actions reviewed against plan, no change in risk score this month.

- ***Employee Wellbeing (MS).***
  Risk reviewed. Actions updated. No change to risk rating.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  No change, to be reviewed in line with FM Associate recommendations report when completed and development of financial strategy for Futures.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000261

BAF Risk 1.1 Inability to deliver safe and high-quality services (3x3=9)

Strategic Aim: Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
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	1.2 & 1.4
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	1.2
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	1.2 , 2.1 & 1.4
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	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2100	Risk of inability to provide safe staffing levels	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.2
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	2.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	2.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	2.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	2.1
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	
2779	There is a risk of uncontrolled and/or negative media attention and/or increased traction on social media outlets, which may include members of the public, patients and staff.	
2667	Back logs in Manchester Heart Centre (MFT) could cause delays to treatment resulting in potential harm to patients	
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	1.2 & 1.4

000262

BAF Risk

1.2

Children and young people waiting beyond the national standard to access planned care and urgent care
(4x5=20)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
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.	1.1 & 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.	1.1 & 2.1
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	1.1
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	1.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	1.1 & 1.4

000263

BAF Risk

1.3 Building and infrastructure defects that could affect quality and provision of services (4x3=12)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

1.4 Access to Children and Young People's Mental Health (3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
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	1.1 & 2.1
2073	Risk that young people are not able to access timely intervention by the Clinical Health Psychology Service	1.1 & 1.2

000264

BAF Risk

2.1 Workforce Sustainability & Development

(3x5=15)

Strategic Aim

The best people doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.2
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	1.1 & 1.2
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	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2
2741	The ability to maintain OFSTED ratio's as a result of staff availability/turnover Health and Safety concerns operating the nursery in its current position in the centre of a building development	
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	1.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	1.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	1.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	1.1

000265

BAF Risk

2.2 Employee Wellbeing

(3x3=9)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.1

BAF Risk

2.3 Workforce Equality, Diversity & Inclusion

(3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000266

BAF Risk 3.1 Failure to fully realise the Trust's vision for the Park (3x4=12)

Strategic Aim: Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk 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)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2717	The programme will not be sufficiently funded to be able to deliver agreed outcomes beyond 2022/23	
2806	The Beyond Programme will not be able to effectively deliver transformation due to lack of non pay budget	

BAF Risk 3.4 Financial Environment (4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000267

BAF Risk

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)

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.6 Risk of partnership failures due to robustness of partnership governance (3x2=6)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000268

BAF Risk

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)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

4.2 Digital Strategic Development and Delivery
(4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000269

Board Assurance Framework 2023-24

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: 2229, 2441, 2383, 2597, 2100, 2654, 2332, 2450, 2463, 2627, 2516, 2517, 2196, 2631, 2632, 2327		
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 and learning from RCA's shared at the meeting
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. Thematic analysis across the QAR meeting monitored through 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.
Oversight of progress with RCA actions and implementation plans is monitored through CQSG	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
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

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
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2023	The sepsis leads have presented an updated position and action plan to SQAC giving increased levels of assurance. This will continue to be monitored through the reporting on the IPR and quarterly reports to SQAC

Executive Leads Assessment

May 2023 - Nathan Askew
Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

February 2023 - Pauline Brown
Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

December 2022 - Nathan Askew
This risk has been updated based on feedback from SQAC and now should be aligned. Controls remain in place and progress has continued in relation to gaps in control, notably in increasing compliance with ABx administration

Board Assurance Framework 2023-24

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, 2597, 1902, 2501, 2501, 2463, 2517		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Capacity and Demand modelling undertaken during March 2023 shows that a small number of specialties have a long term challenge relating to waiting times for planned care, and risk to achieve the national standard of eliminating waits >65 weeks by March 2024. Our challenged specialties include ENT, Dental, Spinal Surgery, ASD/ADHD and CAMHS. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families.

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 65 weeks for treatment to reduce the long-wait backlog for planned care
2. In urgent and emergency care, consistently exceed national standard of 76% of patients treated within 4 hours (aspire to 85%) and a time to clinical assessment of 60 minutes

Board Assurance Framework 2023-24

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Focus on the five areas identified in the national UEC Recovery Plan, with collaboration at Place and with the Cheshire & Merseyside systems: 1. Increasing capacity, via the Paediatric UTC, piloting a Paediatric Assessment Unit and expanding the Virtual Ward. 2. Growing the workforce, including pushing the boundaries of advanced roles. 3. Improving discharge: implementing pathways that enable an experienced clinician to discharge CYP with low-risk conditions directly from triage with appropriate advice. We will use the SAFER patient flow bundle to increase discharges completed by midday. 4. Expanding care outside hospital: our virtual ward capacity will double from 15 to 30 beds. 5. Making it easier to access the right care: with expanded paediatric virtual urgent care service through a paediatric telehealth and video clinical assessment service. Low acuity patients will be treated in the new Urgent Treatment Centre.	30/06/2023	Actions refreshed in line with 2023/24 Annual plan presented at Trust board on 30 March 2023
Each specialty has local recovery action plan, with themes including: 1) Investment in additional capacity, with Insourcing, LLP, Business cases 2) Improved productivity, with focus on reducing WNB rate (through use of AI predictor tool and associated interventions) and focus on increased theatre utilisation to achieve 85% touch time 3) Robust referral management to ensure appropriate categorisation of urgent and routine referrals and redirection of inappropriate referrals to the correct setting	30/06/2023	Actions refreshed in line with Annual Plan presented to Trust Board on 30 March 2023

Executive Leads Assessment

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

May 2023 - Andrew Mccoll
ED Performance in April against 4 hour target was 84%. This is above the national standard (76%) and the highest rate of compliance in 6 months - but needs to be sustained to demonstrate consistent underlying improvement in access.

Diagnostic wait <6 weeks continues to improve, towards our 90% target for 2023/24.

Significant concerns remain regarding long waits for ENT, Dental, ASD and ADHD services - with a growing number of Children & Young People waiting >65 weeks. Further actions are required in these challenged specialties, with investment proposals to be reviewed by 12 May

April 2023 - Andrew Mccoll
Full review of risk and updated description and actions, in line with the annual plan presented to Trust Board on 30 March 2023.

Access to elective care is now our biggest operational challenge. We have virtually delivered the standard of having no patients wait over 78 weeks by March 2023. However, the waiting list size and number of patients waiting over 52 weeks is growing, compounded by industrial action. In response, we have approved investments in high demand specialties to increase capacity. Moreover, we will review opportunities for improving productivity by addressing under-utilised theatre lists and reducing the level of was-not-brought to clinics.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Building and infrastructure defects that could affect quality and provision of services		
Related CQC Themes: Safe		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Adam Bateman	Type: External, Resource And Business Development Committee	Current IxL: 4x3	Target IxL: 2x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Existing Control Measures	Assurance Evidence (attach on system)
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Undertake regular inspections on known issues/defects	31/12/2023	Regular inspections continue on a weekly basis

Executive Leads Assessment

May 2023 - Graeme Dixon
There have been several high profile corroded pipework issues in April which led to clinical areas being closed off whilst the repair and clean up operation took place. Whilst the response was swift and the issues dealt with in a timely manner it has highlighted the seriousness of the issue and that replacement of the pipework , in some form, is required in areas across the site where the pipework has some form of corrosion. Weekly meetings with the SPV, LO'R & Mitie continue to discuss the remaining and newly identified risks. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding although this will require evidence to support. In response to out-of-range temperatures we have local mitigation's in place such as filters on water outlets, and later this year we will introduce an chemical dosing system across the site. The chiller works continue and the temporary ones will be removed late May. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement although this has not been accepted by Trust reps.

April 2023 - Graeme Dixon
SPV & Trust board members met on the 16th March to discuss and agree a way forward. Regular meetings are to be arranged to ensure progress and provide updates to exec leads. Weekly meetings with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding. In response to out-of-range temperatures we have local mitigation's in place such as filters on water outlets, and later this year we will introduce an chemical dosing system across the site. The chiller works continue and the temporary ones will be removed late April. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review.

March 2023 - Graeme Dixon
The SPV board members have agreed to provide a report on the corroded pipework and the associated cold water temperatures. Weekly meetings continue with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding. In response to out-of-range temperatures we have local mitigations in place such as filters on water outlets, and later this year we will introduce an chemical dosing system across the site.

The chiller works continue and we await a date for the removal of the temporary ones. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review. The next liaison committee is set for the 16th March.

Board Assurance Framework 2023-24

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: 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.

Executive Leads Assessment

May 2023 - Lisa Cooper
Risk reviewed and action closed relating to workforce plans as all actions in place and impact being monitored

March 2023 - Lisa Cooper
Risk reviewed and remains the same. Phase 1 for PROMS is now live but awaiting date for Phase 2 completion. Action date therefore amended to 31 March 2023

February 2023 - Lisa Cooper
Risk reviewed and update below:

Job description review this is progressing well and on course for target date

ROMs app progressing well but some delays so date extended to end February 2023.

All controls remain the same and in place for this month.

Board Assurance Framework 2023-24

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: 2383, 2100, 2597, 2528, 2535, 2450, 2516, 2517, 2196, 2312, 2624, 2719, 2741		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to deliver consistent, high quality services for children and young people 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
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	78 international nurses recruited since 2019
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. Lack of inclusive practices to increase diversity across the organisation
7. COVID related sickness impacting upon service delivery
8. Increasing turnover rates
9. Industrial action planned

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
5. Recruitment Strategy currently being developed in line with the actions set out in the NHS people plan	30/06/2023	amanded timeframes due to operational pressures
Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	31/05/2023	HRBP's continue to review hot spot areas where absences are high and agree key actions with managers.
3. Development of a methodology to roll-out across the organisation.	30/05/2023	as above

Board Assurance Framework 2023-24

Executive Leads Assessment
May 2023 - Sharon Owen Actions reviewed against plan, no change in risk score this month.
April 2023 - Melissa Swindell deep dive into risk undertaken at PAWC in 2023. risk remains high at 15. actions reviewed.
March 2023 - Melissa Swindell risk reviewed and actions updated

Board Assurance Framework 2023-24

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 effectively support employee health and wellbeing and address mental ill health which can impact upon the delivery of care and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
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
Celebration and Recognition Group relaunched after being on hold during the peak of the pandemic	Celebration and Recognition Meetings established; reports to HWB 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 Health & 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
Regular Schwartz Rounds in place and Team Time in development in high pressure areas (e.g. ED and ICU)	
Network of SALS Pals recruited to support wellbeing across the organisation	
Drop in support sessions offered to ED staff during high pressure times to help to manage rising levels of moral distress and burnout	
Staff support plan for all staff to manage social and emotional impacts of strike action. Plan reviewed and communicated as part of tactical command and developed in consultation with nursing community and local strike committee	

Gaps in Controls / Assurance

Board Assurance Framework 2023-24

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way
3. Rising demand for SALS support and permanent resource not yet in place to ensure sustainability of provision for staff
4. Increase in self-reported rates of burnout and work-related stress as assessed via 2022 Staff Survey and consistent with national picture for NHS staff
5. Lack of private space to support staff and wellbeing activities
6. Likely psychological impacts on staff due to impacts of industrial action

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	30/06/2023	Date amended as action not closed
Business case in development 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.	08/06/2023	Business case to go to IRG. No date specified.
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	31/07/2023	No draft policy as yet. Review meeting to be arranged
Task & finish group established, led by SALS Manager and with mixed role attendance across the Trust to develop an action plan. Outputs to report to HWB Steering Group	30/06/2023	Task & finish group established and an initial action plan drafted to be reported to the HWB Steering Group in April for initial feedback

Executive Leads Assessment

April 2023 - Joanne Potier De La
Risk reviewed. Actions updated. No change to risk rating

March 2023 - Joanne Potier De La
Risk reviewed and actions updated. No change to risk rating

February 2023 - Joanne Potier De La
Risk reviewed and actions updated. No change to risk rating

Board Assurance Framework 2023-24

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: 3x5	Target IxL: 4x1	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 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
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
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
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

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
	01/07/2023	work required to further develop the networks - led by Head of EDI Angela Ditchfield

Executive Leads Assessment
0 - Sharon Owen Risk reviewed and actions progressing. Temporary collaborative EDI Lead now in place, progressing actions.
May 2023 - Melissa Swindell risk reviewed, no change to risk rating
April 2023 - Melissa Swindell risk reviewed, actions updated. no change to risk rating

Board Assurance Framework 2023-24

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: 3x4	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
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
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.
Weekly Programme Check.	The Project Team run a weekly programme check.
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
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
Programme and plan (agreed with LCC and LPA) to return the park back by November 2023.	Updates on progress through Campus report .

Gaps in Controls / Assurance

1. Planning approvals for modular buildings to allow demo of Catkin and continuation of park works.
2. Successful handover of IP2 to allow temporary car park to be closed and continuation of park works.
3. Successful realisation of the moves plan.
4. Agreement to MUGA location and planning approval from LPA.
5. Funding availability and potential market inflation.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Set up Joint Planning meeting with community	30/09/2023	Agreed to postpone action until more substantive completion of park
Establish timeline and plan for the Police station upgrade and conversion	30/06/2023	Initial plan created, now in delay. Re-work required,
Appoint community engagement team and green volunteer squad	31/05/2023	Agreement of in-principle paper

Executive Leads Assessment

May 2023 - David Powell
Following Exec Design Review

April 2023 - David Powell
End of Financial Year review

March 2023 - David Powell
Prior to March Board

Board Assurance Framework 2023-24

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)
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.
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 Sept 22 - NWPPB Chairs Report to Trust Board attached
'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 2030 Vision development underway with Trust Board - will succeed Our Plan once approved in early 23/24
'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
Implementation of the 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH confirmed.	Inaugural HC&F meeting held 24.1.23 - pack attached
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. Healthy Children & Families - Segment agreed at Provider Alliance Summit March 23
C&M "Beyond" Children's Transformation Programme - AH host and lead for C&M	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 Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached Nov 22 - Presentation to ICB Chair (Children's Champion) at St Helens Town Hall; supported to cement further the CYP governance at ICB level - proposal under development

	Dec 22 - Beyond presented to Alder Hey Trust Board
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed. - Sept 22 - Trust Board approved strategy overview / baseline paper - agreed next steps to begin wider engagement (see attached evidence) - Jan 23 - 2030 Vision update paper to Trust Board, and Trust Board Strategy session (update & Futures) - Jan 23 - Council of Governors strategy session (full overview) - Jan & Feb 23 - Divisional Strategy 'tester' sessions - Surgery, MH & Community, Medicine - all completed to date. Excellent feedback, iterating. Strategy 2030 - Approved at Trust Board March 23 Strategy 2030 wider Staff Launch - 3rd May 23
Growing Great Partnerships - Quarterly Trust Board assurance report	- June 22 - Sept 22 - Jan 23 - May 23

Gaps in Controls / Assurance

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Full completion of 2030 Vision and delivery plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	Action updated as above 4/11/22
6.Develop Operational and Business Model to support International and Private Patients - Connected to 'Futures' element of 2030 Strategy	29/09/2023	International - developing as part of Futures element of 2030 strategy.

Executive Leads Assessment

May 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions, controls and evidence reviewed and updated.

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions reviewed and evidence updated.

March 2023 - Dani Jones
Risk reviewed; no change to score in month. Vision 2030 progressing - scheduled update to March Trust Board.

Board Assurance Framework 2023-24

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Strong Foundations	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2637		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Organisation-wide financial plan.	Monitored through Corporate Report and the monthly financial report that is shared with RABD and Trust Board.
NHSi financial regime, regulatory and ICS system.	Specific Reports submitted monthly and anually as part of business plan process (i.e. NHSI Plan Review by RABD)
Financial systems, budgetary control and financial reporting processes.	- Daily activity tracker to support divisional performance management of activity delivery - Full electronic access to budgets & specialty performance results - Finance reports shared with each division/department monthly - Financial in-month and forecast position reported through SDG, Exec Team, RABD, and Trust Board - Financial recovery plans reported through SDG and RABD - Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	Capital management group chaired by Exec lead to regularly review schemes and spend 5 Year capital plan ratified by Trust Board
Quarterly performance review meetings with Divisional Clinical/Management Team and the Executive	Quarterly Performance Management Reporting with divisional leads ('3 at the Top')
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD and SDG 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
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DDOF with action plan detailing mitigation to bring back into budget.

Gaps in Controls / Assurance

1. Changing financial regime and uncertainty regarding income allocations and overall financial position of Trust.
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 high risk recurrent CIP programme
7. Increasing inflationary pressures outside of AH control

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/08/2023	Annual planning process complete and bridge completed by division. However further delays to the completion of the LTFM and the productivity work has resulted in this not being completed in the time-frame initially set. This will form part of the 2030 financial strategy to be completed in Q2.
2. Five Year capital plan	30/06/2023	23/24 Capital plan submitted in final plan. Due to changes in CDEL limits for the future years, further work is ongoing on the next 3 years including a review with each capital lead. This work will be complete and presented to executive team early June and reported back through RABD and TB once full risk is known.
1. Monitor closely impact of inflation increases 2. Ensure procurement processes followed to obtain value for money 3. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2024	Target date extended as action will need to be re-monitored in 23-24 as risk continues.

Executive Leads Assessment

May 2023 - Rachel Lea
Risk reviewed and actions updated with progress and revised time frames to reflect latest position and ongoing work. Risk score kept same currently however recognise the challenging plan for 23/24 and as we progress into the year, the score will be reviewed and may change tor reflect the change in risk profile.

April 2023 - No Reviewer Entered
In Year CIP and Control Total met. Key risk is now the financial environment for 23/24 which will be monitored accordingly as with 22/23.

Board Assurance Framework 2023-24

March 2023 - Rachel Lea Risk reviewed and updated with progress on actions underway. No change in risk score due to current position of draft plans and ongoing uncertainty with the financial allocations.
February 2023 - Rachel Lea Risk reviewed, actions and controls updated. No change in risk score due to current uncertainty on the 23/24 financial plan and longer term position.
January 2023 - Rachel Lea Risk reviewed. Updated action plans and control measures to reflect current position following release of the national planning guidance and expected completion dates.

Board Assurance Framework 2023-24

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 CMAST & LDMHC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST - Governance paper and TOR for Committee in Common approach presented to Trust Board in September 22 and approved. CMAST - paper to CEO's group scheduled for May to outline CYP system proposals (attach as evidence once finalised) 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
Beyond - 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 Beyond Impact Assessment submitted to ICS Feb 23 Beyond update included in Trust Board Growing Great Partnerships paper May 23 (attached as evidence to Trust Board control line)
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22 Update to Trust Board July 22 Update to Council of Governors Sept 22 Update to Trust Board Sept 22 Update to Trust Board Nov 22 Jan 23 Growing Great Partnerships Trust Board report incorporated HCP and ICS update Update to Trust Board March 23 May 23 - Growing Great Partnerships Trust Board report inclusive of all ICS developments
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	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development) C&M CMAST Provider Collaborative proposals (under development) May 23 - Update on Delegation of Specialist services included in Growing Great partnerships Board report Joint letter of response to Specialist Commissioners from Alder Hey and Manchester Children's in August 22 Deputy CEO represents Alder Hey at the C&M Specialist Delegation group Likely delegation will not take place until April 24 - though work will continue through DoF, DoS and partners inc. CHA and NWPPB to

	shape the direction for CYP specialist services
Monitoring and influencing the direction of SpecCom delegation into ICSs	Joint letter to SpecCom from NW - AH & RMCH outlining the need to work at a NW footprint Nov 22 - Development of joint NW SpecCom delegation plan with Alder Hey and RMCH - outline shared position discussed at NWPPB Nov 22 - to be jointly developed further during Dec/Jan
ICS CYP Board - under development, to enable single oversight of CYP at ICS level and coalescing CYP priorities, resource and delivery	

Gaps in Controls / Assurance

Uncertainty over future commissioning intentions (see BAF 3.4 re finance)
Future delegation of Specialist Commissioned services into ICSs - shadow arrangements under definition

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/08/2023	Delegation of SpecCom services to ICS's delayed nationally. 23/24 shadow running year - arrangements in NW as yet unclear. AH represented at NW SpecCom development group through DCEO. Continued work with RMCH to shape NWPPB supporting role and through CHA to assess impact of delegation on range of specialist services.
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/08/2023	As previous

Executive Leads Assessment

May 2023 - Dani Jones
Risk reviewed; no change to score in month. Review of all ICS related activity included in May 23 Growing Great Partnerships board report - updated in evidence.

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions and controls reviewed, evidence updated.

March 2023 - Dani Jones
RIsk reviewed; level of system complexity currently sustaining higher risk rating, but architecture under construction (e.g. CYP board) to help reduce risk level. Actions and evidence reviewed.

Board Assurance Framework 2023-24

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: 2733		
Exec Lead: Dani Jones	Type: External,	Current IxL: 3x2	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	Control embedded.
Escalation process for risks and issues pertaining to ODNs and Joint Services	North West Paediatric Partnership Board is the escalation route for all - example papers attached. Control embedded.
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). PQAR Framework now tested with LNP to positive effect. Development of the process and framework underway, supported by Jacqui Rooney, in line with evolving CQC quality statements approach. NorCESS joint management team have agreed to pilot PQAR for the North West - to be scheduled in Q4.
Identification of 'pilot' partner for Partnership Quality Assurance Round - Liverpool Neonatal Partnership	PQAR Pilot scheduled with LNP for October 22 with Non-Exec representatives from both partner Trusts. Pilot of Partnership Quality Assurance Round approach agreed with LWH MD. Liverpool Neonatal Partnership and presented PQAR to LNP Board in June 22 - agreed next action to identify NED rep from both Trusts to do a full PQAR with LNP (under identification/scheduling) PQAR completed with NEDs from both Alder Hey and LWH 14th October. Positive process, plus some learning to shape PQAR pack for future sessions. Draft minutes attached (one amendment pending - ABR was not in attendance) will update once final minutes agreed. Action plan and next steps within.
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - Sept 22 Quarterly Board paper - June 22 Quarterly Board paper - Jan 23
Twice-annual ODN oversight report to RABD	May 22 Report attached Nov 22 report attached.
MIAA Audit - Partnership Governance	Audit complete - MIAA returned verdict of significant assurance. To be presented to January Audit Committee. Final report attached

Gaps in Controls / Assurance

Sign up from further partners to engage in PQAR - in development (dependent on both parties subscribing)

Executive Leads Assessment

May 2023 - Dani Jones
Risk reviewed; score remains at target rating. Actions and controls checked.

April 2023 - Dani Jones
Risk reviewed; no change to score in month. Actions and evidence reviewed.

March 2023 - Dani Jones
Risk reviewed; score reduced to target rating, based on MIAA audit and significant assurance against partnership governance. Ongoing programme of PQAR to be undertaken as business as usual within each strategic partnership.

Board Assurance Framework 2023-24

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: 2694		
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
New Commercial partnerships SOP approved at IC and RABD OCT/NOV 22	
Innovation risk register expanded and included in Risk Management Group (RMG)	

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.

Executive Leads Assessment

May 2023 - Emma Hughes
No change, to be reviewed inline with FM Associate recommendations report when completed and development of financial strategy for Futures

March 2023 - Emma Hughes
no change to risk score, active development of strategic outline case ongoing for infrastructure funding and to increase investment.

February 2023 - Claire Liddy
Reviewed FEB 23. Strategic investment action updated including timetable to March 23. Risk score no change.

Board Assurance Framework 2023-24

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: 2327		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x4	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
iDigital Service Model in Place	iDigital Service Model and Partnership Board Governance

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
Mobilisation of Y1 of Digital and Data Futures Strategy	01/06/2023	Programmes in progress, some key deployments progressed
1. Proposed change freeze of all digital programmes from April particularly in the context of preparation for Aldercare go live 2. Review of all other programmes with implementation to be achieved before April	01/07/2023	Formal decision for change freeze expected W/C 8th May. EPR changes already in progress, wider digital projects freeze anticipated in line with Aldercare training commencing.
Implementation of Alder Care Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023

Executive Leads Assessment

May 2023 - Kate Warriner
Risk reviewed, score remains static due to the level of imminent change and interdependencies in 23/24. Good progress being made in preparation for Aldercare go live in September 2023. In phase go live commenced 2.5.23.

March 2023 - Kate Warriner
Risk reviewed, score remains static. Discussions ongoing regarding change freeze from May, progress with agreement of go live window for Aldercare in Aug/Sept 2023.

Good progress with recruitment to key roles.

February 2023 - Kate Warriner
Risk reviewed, score remains static. Work continues regarding timing of key programmes deployments in 2023.