Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 5th October 2023, commencing at 11:00am

Lecture Theatre 4, Institute in the Park

AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (11:00am-11:15am)							
1.	**23/24/135**	**11:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/136**	**11:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/137**	**11:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **7th September 2023.**	**D**	Read enclosure
4.	**23/24/138**	**11:19 (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.	**23/24/139**	**11:20 (10 mins)**	**Chair/CEO's Update; including:** • **Trust Strategy Board update.**	Chair/ L. Shepherd L. Shepherd	To provide an update on key issues and discuss any queries from information items. To provide an update on decisions made during October's Trust Strategy Board.	**N** **N**	Verbal Verbal
Operational Issues							
6.	**23/24/140**	**11:30 (60 mins)**	• **M6 Flash Report/overview.** • **Integrated Performance Report for M5, 2023/24.** • **Forward look for winter 2023/24.** • **Implementation of Alder Care – update.** • **Staff vaccination status.** • **Finance Update for M5, 2023/24.**	Executives/ Divisions A. Bateman I. Gilbertson N. Askew R. Lea	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. For information purposes. To provide the Board with an update. To provide the Board with an update. To receive an update on the current M4 position.	**A** **A** **A** **A** **A**	To follow Report Report Presentation Report

7.	**23/24/141**	**12:30 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	R. Lea	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Lunch (12:40pm-13:00pm)							
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	**23/24/142**	**13:00 (10 mins)**	**Liverpool Neonatal Governance.**	A. Bass/ N. Askew/ E. Saunders	For information and discussion.	**N**	Read report
9.	**23/24/143**	**13:10 (10 mins)**	**Patient Safety Incident Response Framework (PSIRF) Governance Structure and Plan.**	N. Askew	For ratification.	**D**	Read report
10.	**23/24/144**	**13:20 (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
11.	**23/24/145**	**13:25 (5 mins)**	**PALS and Complaints Report, Q1.**	N. Askew	To receive the PALS and Complaints report for Q1.	**A**	Read report
12.	**23/24/146**	**13:30 (5 mins)**	**Mortality Report, Q1.**	A. Bass	To receive the mortality report for Q1.	**A**	Read report
13.	**23/24/147**	**13:35 (5 mins)**	**DIPC Report, Q1.**	B. Larru	To receive the DIPC Report for Q1.	**A**	Read report
14.	**23/24/148**	**13:40 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's highlight report from the meeting held on the 20.9.23.** - **Approved minutes from the meeting held on the 19.7.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 19.7.23.	**A**	Read enclosures
The Best People Doing Their Best Work							

15.	**23/24/149**	**13:45 (5 mins)**	**Fit and Proper Persons Policy.**	E. Saunders	For approval	**D**	Read report
16.	**23/24/150**	**13:50 (10 mins)**	**Wellbeing Guardian Dashboard.**	J. Revill	For information and discussion.	**A**	Read report
17.	**23/24/151**	**14:00 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Update.**	M. Swindell	To receive an update on the current position. To provide an update on key areas and updates from the system on the workforce.	**A** **A**	Read report Read report
18.	**23/24/152**	**14:10 (5 mins)**	**People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 13.9.23.** - **Approved minute from the meeting held on the 11.7.23.**	F. Marston	To escalate any key risks, receive updates and note the approved minutes from the 11.7.23.	**A**	Read enclosure
Sustainability Through External Partnerships							
19.	**23/24/153**	**14:15 (5 mins)**	**Vision 2030 - Collaborating in Communities.**	D. Jones	To provide an update on current position.	**A**	Read Report
Strong Foundations (Board Assurance)							
20.	**23/24/154**	**14:20 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 25.9.23.** - **Approved minute from the meeting held on the 30.8.23.**	R. Lea	To escalate any key risks, receive updates and note the approved minutes from the 30.8.23.	**A**	Read enclosure
21.	**23/24/155**	**14:25 (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							
22.	**23/24/156**	**14:30 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
23.	**23/24/157**	**14:34 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 9th November 2023, 9:00am, Lecture Theatre 2, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in September for the Deed of Settlement re: • Transfer document for Police Station (11th September 2023) • Lease for Police Station (11th September 2023) • Letter of Indemnity – Neonatal Urgent Care (18th September 2023)

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M5, 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 7th September 2023 at 9:00am**
Lecture Theatre 4, Institute in the Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Managing Director / CFO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mrs. D. Jones	Director of Strategy, Partnerships and Transformation	(DJ)
	Mrs. R. Lea	Director of Finance and Development	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Transformation Officer	(KW)
Item 23/24/107	Ms. J. Halloran	Acting Deputy Development Director	(JH)
Item 23/24/110	Ms. N. Palin	Director of Transformation and Change	(NP)
Item 23/24/111	Ms. P. Brown	Director of Nursing	(PB)
Item 23/24/115	Ms. H. Blackburn	Medical Education and Revalidation Manager	(HB)
Item 23/24/119	Ms. K. Turner	Freedom to Speak Up Guardian	(KT)
Apologies	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)
	Mr. D. Powell	Development Director	(DP)
	Ms. J. Revill	Non-Executive Director	(JR)

23/24/101 Welcome and Apologies

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

23/24/7102 Declarations of Interest

There were none to declare.

23/24/103 Minutes of the previous meetings held on the 27th June 2023 and the 6th July 2023
Resolved:
The minutes from the meeting held on the 27.6.23 were agreed as an accurate record of the meeting.

The minutes from the meeting held on the 6.7.23 were agreed as an accurate record of the meeting pending the following amendment:

- Record Fiona Marston's apologies in the minutes.

23/24/104 Matters Arising and Action Log

Matter Arising
There were none to discuss.

Action Log

It was confirmed that all actions are on track.

23/24/105 Chair's and CEO's Update

Louise Shepherd formally recognised the impact that the Letby case has had on everybody across the National Health Service and the country. It was reported that Alder Hey held a session for staff w/c 28.8.23 in order to have an open discussion about the circumstances of the case and to assure staff that Alder Hey's Trust Board recognises the critical importance of listening to staff.

The Board was advised of the meeting that was arranged by NHS England (NHSE) that brought the leadership of all trusts and ICBs together for a day of reflection and to discuss the current challenges of the NHS and the Letby case. One aspect of the discussion was around the issues relating to the regulation of management and it was felt that this is something that needs to be addressed in an appropriate way.

Attention was drawn to the importance of Alder Hey being open to any concerns that are raised and it was agreed that a formal report will be submitted to the Board in the aftermath of the Letby case.

23/24/105.1 Action: ABASS/NA

The Chair advised of the recent changes in the membership of the Trust's governors following the 2023 summer election. The Council of Governors will elect a new Lead Governor as Marilyn Mornington was unsuccessful in retaining her seat.

The Chair informed the Board of a session that took place with Lisa Cooper and two of her colleagues about how they can help Board members learn about what it's like as a young person to sit on a governing body. A number of young governors would like to present to the Board in the new year to share details of the work that they have been conducting. They are also going to present during November's informal governors meeting with the Chair.

Vision 2030 Strategy Update

The Board received an update on the mobilisation phase of the Trust's 2030 Strategy. The report provided an assessment of this phase of the strategy based on the current state, key findings, areas of concern and positive areas of progress. The key message is that progress has continued to be sustained during quarter two and early deliverables from our strategic initiatives will be delivered imminently.

It was reported that a lot of work has taken place to determine how the Trust will develop the 'Plan on a Page'. A third version of the plan is now available following an

engagement session with the Children's Forum and will be submitted to the Strategy Board in October. Attention was drawn to the importance of the plan in terms of sharing the vision at meetings with key partners.

The image that is to be applied to the strategy document is that of a sunflower which has been chosen by the children and young people as they said that it made them feel happy. It was confirmed that during September the 'Plan on a Page' will be finalised as will the brochure. A request was made for a small subset of the Board to meet in order to review the image, the 'Plan on a Page' and the final draft of the brochure. Following discussion, Dani Jones agreed to circulate a date in which to meet.

23/24/105.2 Action: DJ

Natalie Palin drew attention to the following points:

- CYP have agreed the design.
- There is to be a focus on outstanding milestones.
- The aim is to start translating the Trust's strategic vision into tangibles.
- There are delays in the initiation of three strategic initiatives *(Professional Development Hub, Future Workforce and CYP System).* It was reported that discussions are taking place with the Chief People Officer from a thriving perspective (2.1) in relation to the CYP system and people initiatives.
- *Strategic Score Card* – Work is continuing on the measuring of benefits supported by a suite of measures. Further detail will be submitted to the Strategy Board in October.
- *CYPF Areas of Need* – During July and August the Trust focussed on encouraging its people to sign up to be actively involved in 'Get me well', and 'Personalise my care' new models of care.
- *New Models of Care* - Eighty members of staff attended the clinical summits that were hosted by the Trust. It was confirmed that further diagnostics of that work will be submitted to the Strategy Board is October.
- It was confirmed that the Paediatric Assessment Unit (PAU) was implemented in August 2023.

It was reported that the Finance team is going to arrange for a further session to take place to address the Financial Strategy, with the view of submitting it to the Board in January 2024.

For noting
The Board agreed that work should continue on the Financial Strategy via the Resources and Business Development Committee (RABD).

Resolved:
The Board noted:

- The Chair's and CEO's update.
- The update on the Vision 2030 Strategy.

23/24/106 Operational Issues

Operational Plan Progress

The Board was advised that August has been dominated by operational challenges especially in relation to industrial action which was managed well and dealt with

professionally. It was confirmed that the team are going to regroup to look at mitigating the impact of forthcoming industrial action when both junior doctors and consultants will be taking strike action at the same time.

An update was provided on the progress that has been made on the Trust's 2023/24 operational priorities, as detailed in the Operational Plan progress summary;
1. Delivery of the Patient Safety Strategy. **2.** Increase people availability and wellbeing. **3.** Advance the clinical research portfolio and innovation pipeline. **4.** Handover of Springfield Park to the community. **5.** Improve access to care and reduce waiting times. **6.** Financial sustainability. **7.** Safely deploy the Alder Care Programme.

The Chair felt that the progress that has been made is remarkable and is a reflection of everyone's hard work.

M5 Flash Report
Resolved:
The Board received and noted the Flash Report for month 5 (August *2023*).

Integrated Performance Report (IPR), M4

The Board received the Integrated Performance Report (IPR) for Month 4. An update was provided on the following areas of the IPR:

Accessible Services - Effective

- ED is consistently achieving the national standard, reaching 91% in July.

Accessible Services - Responsive

- There has been a significant improvement in CAMHS with only 3 young people waiting more than 52 weeks. Diagnostic waits continue to achieve target and the Trust continues to achieve national access standards for cancer care.
- Staffing issues in surgery are impacting RTT patients waiting more than 65 weeks, primarily in ENT and Dentistry.
- Industrial action will have an impact on the enhanced approach to activity forecasting and recovery plans in September.

Unrivalled Experience - Safety

- ED and In-patient sepsis screening has improved above target for this month.
- There has been a reduction in medication errors and pressure ulcers.
- It was reported that unplanned admissions to critical care continue to reduce.
- There has been an increase in reporting that has had an impact on numbers in a positive way.

Unrivalled Experience – Caring

- Complaints response rate within 25 days is at 100% in month.
- Friends and Family Test continues to be on an upward trajectory towards target.

The Chair asked as to what is making the difference in terms of the improvements that are being seen. It was reported that the Trust has made a number of key appointments during the last twelve months, teams are taking ownership, tackling issues, willing to do things in a different way and a lot of hard work has taken place. It was pointed out that the leadership at the Patient Safety Board is starting to make a difference, and the Trust has involved CYP in many areas of work which has been invaluable.

Louise Shepherd highlighted the importance of involving CYP in the work that is taking place at the Trust and advised that discussions have commenced about developing the Children's Forum and potentially having a CYP Board. Reference was made to a patient who died at Kings College Hospital from sepsis and it was reported that the Trust has set time aside to think about this case and work has been conducted with a number of teams to look at the organisation's policies and escalation process. It was suggested looking at this via the Safety Group in a broader sense and also from an innovation perspective. Louise Shepherd highlighted the importance of ensuring that the Trust has done everything possible to ensure that this type of incident doesn't occur at Alder Hey.

Community and Mental Health Division

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

A query was raised about the decrease in the Was Not Brought (WNB) position and the reason for this. It was pointed out that the resources originally used to identify patients at risk have been redirected in activity around AI and there is less of a focus on WNB due operational pressures/issues. It was confirmed that work will continue on WNB once the focus on Expanse reduces.

Division of Medicine

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

Division of Surgery

The Board was advised of the impact that industrial action is having on the Division of Surgery. It was pointed out that during the summer the Division was in a good position to address waiting lists/access but due to staff sickness and huge staff pressures a decision was made to reduce theatre sessions. The Division has commenced a recruitment process and a report is to be presented to the Exec Team about hiring agency staff to provide support for the next six months.

Following discussion it was agreed to conduct a piece of work on theatres and provide an update to the Board.

23/24/106.1 Action: JG/BP

Corporate

It was reported that the Corporate Services Collaborative is continuing to monitor a range of key metrics each month. One of the areas that the Collaborative is focussing on is the establishment of a vacancy control process.

Public Health

It was confirmed that the Chief Medical Officer, Alfie Bass is the Executive Lead for Health Inequalities and the Director of Strategy and Partnerships, Dani Jones is the SRO for Health Inequalities. Work is underway to look at three metrics (two of which are core metrics) from a system and Trust perspective. It was pointed out that learning disabilities has proven to be the most challenging area and reflection is taking place to see how this

can be referenced against the priorities. It was confirmed that Public Health update will be shared with the Board on quarterly basis.

Resolved:
The Board received and noted the content of the IPR for Month 4.

Finance

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

- The Trust has reported a £9K surplus in M4, whilst YTD is a deficit of £1.49m which overall remains in line with the plan.
- There is a continued trend of benefits in the Community Divisions which is offsetting the impact in the Division of Surgery in terms of loss. Work is being undertaken to understand the issues being experienced in terms of reduced income.
- The Trust has received a number of technical benefits but it was reported that energy costs are starting to increase.
- CIP
  - All Divisions are now on plan to achieve their CIP target.
  - It was reported that there is a £2.8m gap relating to transformation schemes. A number of sessions have been scheduled to address this issue.
  - The plan for the year is £17.7m of which £9.3m has been posted.
- The Trust has launched a new governance framework, and a finance pack to increase financial awareness.

The Board was advised that there are seven organisations across the system who are off plan to date. A group has been formed to enable these organisations to provide updates on the actions that they are undertaking to address matters. The Trust has informed RABD of the organisation's compliance.

A discussion took place around the importance of the Trust challenging itself to understand the impact of more/less activity, and the anxiety that is being felt across the country about organisations losing control of their finances. It was felt that time needs to be set aside to take stock of the situation and it was suggested submitting a half yearly report on the cash share model that is emerging and how it is being managed from a risk perspective in the system.

23/24/106.2 Action: RL

Resolved:
The Board noted the finance update for M4, 2022/23.

Digital Data and Information Technology

The Board was provided with an update on Alder Care Meditech Expanse and the readiness for implementation on the 9.9.23. A number of slides were shared that provided the following information:

- It was confirmed that the Go/No Go programme criteria was met for the go live date.
- An operational Go/No Go readiness decision is to be made on the 8.9.23.

- Cut over is scheduled from the 8.9.23 to the 11.9.23 *(switch to paper from 4:00pm on the 8.9.23 and have a staggered approach to bringing Alder Care online from 2:00pm on the 9.9.23).*
- 'Day 1' is the 11.9.23.
- It was confirmed that there are post go live plans in place including a stabilisation period, optimisation programme and phase 2.
- Support is also in place for staff

On behalf of the Board, the Chair thanked the Chief Digital and Information Officer; Kate Warriner and her team for the way in which they have managed the Alder Care programme.

Resolved:
The Board noted the update on Alder Care programme and received the Digital Data and Information Technology report.

23/24/107 Alder Hey in the Park Campus Development Update

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

- *Catkin/Sunflower House* - It was confirmed that there are two additional steps that need to be taken prior to going out to tender for the car park sprinkler system.
- *Fracture and Dermatology Outpatients* – Regular SPV meetings continue to take place and a Provisional Programme is to be submitted. Mitie have appointed an experienced Project Manager who will commence in September and manage the formal response to TVE 390. The completion date currently remains as assessed, March 2024.
- *Neonatal and Urgent Care Development* – It was confirmed that the contract for the construction is to be signed imminently. Following this, work will commence on the development. It was reported that construction costs have increased as a result of inflation therefore a meeting has been arranged to take place w/c 11.9.23 to discuss any impact to the programme.
- *Park Reinstatement* – It was confirmed that the MUGA has been opened and the football pitches are underway.

The Board was advised of the progress made during meetings that have taken place between Liverpool City Council (LCC), the Friend of Springfield Park (FOSP) and Alder Hey. There are still a number of frustrations being expressed by members of the community and FOSP in relation to the lighting in the park, the size of the football pitches and the SWALES (drainage system). A meeting has taken place today to look at designing the SWALES in collaboration.

A number of questions were raised and responded to in relation to issues with the football pitches, and discussions around future engagement sessions.

Resolved
The Board received and noted the Campus Development update provided on the 7.9.23.

23/24/108 Resources and Business Development Committee (RABD)

The approved minutes from the meetings held on the 26.6.23 and the 17.7.23 were submitted to the Board for information and assurance purposes.

Resolved:
The Board noted the approved minutes from the meeting held on the 26.6.23 and the 17.7.23.

23/24/109 Alder Hey Community Mental Health Services (Liverpool and Sefton) Proposed Changes to Waiting Time Standards and Reporting.

The Board was provided with an outline of the current position of the Trust's Community Mental Health Services across Liverpool and Sefton, the proposed change to the reporting measures and the planned improvements to meet the Trust's revised internal waiting time standards, as detailed in the report.

Attention was drawn to the predicted improvement trajectory and a request was made of the Board to approve the change to reporting metrics for community based mental health services and note the predicated improvement plan in relation to waiting times for Liverpool and Sefton locality based mental health services.

A question was raised about the national standard target. It was reported that there isn't one at the present time but national guidelines are due to be published.

Reference was made to the metrics chart in the report and it was queried as to whether the new criteria will improve figures in terms of treatment being provided within 18 weeks. It was confirmed that this will be the case.

Resolved:
The Board approved the proposed changes to waiting time standards and reporting.

23/24/110 Brilliant Basics Update

The Board received oversight of the Brilliant Basics (BB) Delivery Plan for 2023/24 and details of the key milestones that will support the development of a culture of continuous improvement. The following points were highlighted:

- There is consistent progress to date against the BB Delivery Plan milestones and there are mitigating actions where milestones have been identified as requiring further management control.
- It was reported that the Trust remains on track to deliver 10 milestones with 4 having been completed.
- Two milestones have been reprofiled to align with NHS Impact; with one being refreshed and one is partially achieved and will be required to move to the 2024/25 plan.
- The scale and spread of BB is delivering broader organisation benefits; for examples, BB helping towards the success of the Patient Safety Strategy and a 20% reduction has been seen in medication errors.
- It was confirmed that there are no risks or issues to escalate to Board and the programme governance assurance is rated green in all areas.

- A comprehensive review of the trusts position against NHS Impact DCIR was undertaken in May 2023 and it was reported that the Trust is in a strong position.

It was suggested that the Alder Hey should invite the Chair of Lancashire and South Cumbria NHS FT; David Fillingham to see the BB work that is taking place across the Trust, the process and the impact.

23/24/110.1 Action: LS

John Kelly drew attention to the importance of having a complete wrap around the change programmes and have one benefit programme. Natalie Palin agreed to look into this suggestion.

23/24/110.2 Action: NP

Resolved:
The Board noted the Brilliant Basics update.

23/24/111 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 1.6.23 to the 31.7.23. The following points were highlighted:

- Zero Never Events were declared during the reporting period.
- The Trust declared one StEIS incident during the reporting period.
- It was confirmed that the Trust is compliant with Duty of Candour.
- The Trust declared **one** internal level 2 RCA investigation during the reporting period
- There were two action plans open during the reporting period; one has been closed and the remaining action plan is due to be closed in September which is within the expected date of completion.
- Immediate lessons were learnt following a 72 hour review into incident 2023/12980, as detailed in the report.

Resolved:
The Board received the Serious Incident report for the period from the 1.6.23 to the 31.7.23.

23/24/112 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 21.6.23 were submitted to the Board for information and assurance purposes. It was reported that there is going to be a focus on education, recognition and proactive messaging across the Trust.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 21.6.23.

23/24/113 Update on Research

The Board was provided with an update on the performance of the Research Division. Attention was drawn to the following points:

- Alder Hey has been awarded £3.2M to fund 1. 3T MRI scanner, predominantly for clinical research 2. Additional building work required for MRI scanner 3. Laboratory equipment for research sample processing/analysis/storage.
- An update was provided on the opportunities and the various bids that have been submitted by the Research Division.
- *Study Recruitment* - Overall recruitment of participants to studies has declined each month in 2023/24 due to a decrease in other trials owing to a number of reasons.
- *Research Strategy* - Engagement with stakeholders is underway.
- *Staffing Levels* – There is a plan in place to address staffing gaps including recruitment to several secondments, external guidance on efficiencies with digital systems and additional training for staff. It was confirmed that the Division has recently appointed a Director of Research and a Head of Nursing. A number of Associate Directors have joined the team along with a project manager who will lead on 'Starting Well'.

A conversation took place about a venture capitalist scheme and Fiona Marston offered her support in terms of discussing ideas and the partners that the Division of Research are interested in.

Resolved:
The Board noted the update from the Division of Research.

23/24/114 Research and Innovation Committee

The approved minutes from the meeting held on the 18.4.23 were submitted to the Board for information and assurance purposes. This is the second meeting of the new Research and Innovation Committee and it was explained that July's agenda had been divided by topics which it was felt was a positive way forward.

It was reported that the Vice Chancellor of the University of Liverpool; Professor Tim Jones visited Alder Hey recently and was really enthusiastic about the Child of the North concept and subsequently liaised with Louise Kenny to discuss this concept further. Attention was drawn to the importance of connecting with Louise Kenny to wrap around this are of work in collaboration and it was reported that discussions will take place over the next few week going forward.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 18.4.23.

23/24/115 Medical Revalidation Update
Resolved:
The Board received and noted the content of the 2022/23 annual submission to NHSE 'Appraisal and Revalidation and Medical Governance'.

23/24/116 People Plan Highlight Report including; EDI Update

The Board was provided with a high-level overview of the key strategic and

operational issues impacting the organisation in relation to the workforce during July and August 2023. The following points were highlighted:

- *Industrial Action* – The Board was advised of the forthcoming industrial action that is being taken by consultants during September and October (19.9.23 to the 20.9.23 and 2.10.23 to the 5.10.23). It was reported that there is a process in place to manage this issue but it will create challenges for the Trust.
- *NHS Staff Survey* - The annual NHS Staff Survey will open from the 11.9.23 to the 24.11.23. It was reported that the Divisions are scheduled to present feedback on last year's survey to the People and Wellbeing Committee.

The Chair asked for an update on the Trust's Flu vaccine programme. It was reported that planning has commenced, training sessions are to be scheduled for vaccinators and all senior nurses are to be included in the vaccination rota. There will be lots of rolling clinics scheduled and it was confirmed that the Trust will take receipt of vaccines early this year.

A question was raised about the Trust's policy for Covid-19 vaccinations. It was reported that it is staff choice but there is a high uptake of staff wanting to be vaccinated. The Trust hasn't received any Covid vaccines to date but will promote it once the Trust is in receipt of the vaccination. Following discussion it was agreed that an update on the Flu Programme should be submitted to the Board during October's meeting.

23/24/116.1 Action: NA

EDI Update

The Board received an overview of the key strategic and operational issues impacting the organisation in relation to Equality, Diversity and Inclusion (ED&I) during 2023. The following points were highlighted:

- It was reported that the developing staff networks are growing from strength to strength and have been welcomed by the Trust's workforce.
- REACH staff network held the first engagement event on the 18th of July. They are supporting the head of EDI to review the Workforce Race Equality Standard data, supporting the development of a meaningful action plan which will address our weaknesses and look to improve the experiences of our ethnic minority staff.
- The Trust recently participated in the Navajo Charter Mark assessment which involved a lot of work. It was confirmed that the Trust achieved the Charter Mark but further work needs to be done. A report is in the process of being produced which will feed into the organisation's strategic framework to help rectify any areas that need addressing.
- It was reported that the Disability Network have renamed themselves as the ACE Network.

Resolved:
The Board noted:

- The contents of the People Plan Highlight Report.
- The update on EDI.

23/24/117 NHS North West Black, Asian and Minority Ethnic Anti-Racist Framework

The North West Black, Asian and Minority Ethnic Anti-Racist Framework issued by the North West Black, Asian, and Minority Ethnic Assembly in June 2023 was shared with the Board for approval purposes. The Board was asked to adopt the framework across the Trust and commit to supporting the ambition and necessary work to achieve and maintain the gold level of the framework.

It was reported that organisations are asked to undertake an initial self-assessment using the tool provided. This will form the basis for the necessary action plan to achieve the first stage within the Framework and inform the further action required. Once completed the assessment and associated action plan will be shared with and monitored by the People and Wellbeing Committee with regular reports to the Board.

The Board approved the adoption of the NHS North West Black, Asian and Minority Ethnic Anti-Racist Framework.

Resolved:
The Board received and approved the NHS North West Black, Asian and Minority Ethnic Anti-Racist Framework

23/24/118 People and Wellbeing Committee

The approved minutes from the meeting held on the 24.5.23 were submitted to the Board for information and assurance purposes. During July's meeting the Committee focussed on the People Plan, the metrics in the Integrated Performance Report and the forthcoming industrial action. There is a continued focus on staff turnover and sickness absence and it was reported that the Trust is starting to see an improvement in sickness rates. The Chair of the People and Wellbeing Committee paid tribute to Melissa Swindell, Garth Dallas and Angie Ditchfield for the work that this taking place around EDI across the Trust.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 24.5.23.

23/24/119 FTSU Guardian Update

In light of the Letby case it was felt that it would be remiss of the Trust not to stand back and reflect on whether the organisation has a culture that allows people to speak up freely and how it is aligned with a safe culture. It was pointed out that there is a lot of external scrutiny taking place as the NHS prepares for an Inquiry following the Letby case.

Attention was drawn to the importance of speaking with teams to make them aware of the routes for raising concerns. It was reported that the Trust conducted an 'Ask the Execs' session to present the work of the FTSU Guardian. It is going to be proposed that the Board think about these two elements (FTSU/safe culture) during forthcoming meetings to try and link both conversations. It was explained that there are a number of themes emerging that need to be addressed; culture, listening/acting in a timely way, closure and follow-up. Attention was drawn to the importance of developing a health check that brings together brings together levels of workload, incidents and change

alongside safety metrics that is systematic as this will help tell stories and collect soft intelligence.

Lisa Cooper asked that the Safeguarding Team be linked in with this work as the legal duty of a safeguarding person is to report an issue to the Police if managers, Executives, etc. don't take allegations seriously.

The Board was provided with a summary of the activities of the FTSU team in the last quarter and the actions planned for the coming period. Attention was drawn to the following areas of the report:

- Q1 Data – Open and closed cases.
- Reducing Barriers to Speaking Up.
- FTSU mandatory training has been launched.
- FTSUG involvement nationally and regionally.
- FTSU Awareness Raising.
- Next Steps.

The Board was advised of the Away Day that has been planned for the 10th October 2023. This is a three-hour session with the FTSUG and the champions, there will be analysis of the process for raising concerns via the FTSU route, providing clarity to staff, there will also be focus on any action required and lessons learnt from raised concerns. Due to an increase in new FTSU Champions, the FTSU champions training will be delivered. The Chair felt that Board attendance at the session would be beneficial to reinforce the message. Kerry Turner agreed to send an invitation to the Chair, Louise Shepherd and John Grinnell.

23/24/119.1 Action: KT

A number of questions were raised and responded to in relation to having a process for showcasing the work of teams from a best practice perspective, having a procedure that's not number driven so that NEDs don't lose sight of cases and the route a person would take as a last resort to raise a concern.

Kerry Byrne advised that in her role as the SID she would be the person that people would come to if nobody else listened to them but felt that there needs to be acknowledgement about this, although she is also the named NED for raising concerns under the policy.

Resolved:
The Board:

- Received the letter from NHSE relating to the Letby case.
- Received the FTSU Guardian update.

23/24/120 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:

- It was reported that this will be the final time in which the BAF will be submitted in this version. It will be updated following the BAF development session in July in preparation for October's Trust Strategy Board. There will be some testing during the next couple of weeks ahead of developing the paper.
- The Board was advised that the risks on the BAF continue to be scrutinised by the respective Assurance Committees, and a deep dive took place during August's Risk Management Forum on BAF risk 3.1 *(failure to fully realise the Trust's vision for the Park).*

Resolved:
The Board received and noted the content of the Board Assurance Framework report.

Corporate Report
Resolved:
The Board received and noted the content of the Corporate Report**.**

23/24/121 Fit and Proper Person Test Framework for Board Members.

The Board received a report that outlines the new requirements of the Fit and Proper Persons Test (FPPT) Framework published in response to the Kark Review recommendations in 2019. The review highlighted areas that needed improvement to strengthen the operation and effectiveness of the current regime. In response to the seven recommendations made, NHS England published a new Fit and Proper Persons Test Framework on 2nd August 2023 with a more formal reporting mechanism.

Attention was drawn to the onward reporting into the system which is a new feature and the self-assessment documentation is in a different format. The Trust has no concerns regarding this matter as it carries out FPP checks on a regular basis but it was felt that is important for the Board to be sighted on the changes.

Resolved:
The Board received and noted the report on the new Fit and Proper Persons Test Framework.

23/24/122 Governor Election Results.

The Board received an update on the outcome of the 2023 summer governor election round. The Chair reported that Non-Executive Directors will be invited to informal governor meeting on an individual basis to talk about their role and a little bit about themselves.

Resolved:
The Board received and noted the update on the outcome of the 2023 summer governor election.

23/24/123 Audit and Risk Committee

The approved minutes from the meeting held on the 22.6.23 were submitted to the Board for information and assurance purposes. During July's meeting there was focus on the issues being experienced post implementation of InPhase that related to risk management reports being reduced/not available and the lack of notifications to risk owners of risks that are due for review. Since July's meeting the issue relating to

notifications has been addressed and it was confirmed that the Trust is working with InPhase to ensure key reports are available as soon as possible.

Attention was also drawn to a piece of work that was undertaken by the Counter Fraud Service where it was identified that an individual had fraudulently gained employment at the Trust in 2019 and was dismissed in 2021. The Committee was provided with management assurance of process changes and an IT system implementation since that date that should prevent recurrence. The Committee requested that a sample of recruitments in the period to the system implementation be reviewed to check if key documents were present. A further request has been made for further checks to be performed on the files of all clinical staff and senior/technical roles. The Audit and Risk Committee will receive an update on this matter during October's meeting.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 22.6.23.

23/24/124 Any Other Business

There was none to discuss.

23/24/125 Review of the Meeting

The Chair thanked everyone for their contributions during the meeting. It was felt that a number of important discussions took place, especially in relation to safety and the Trust's finances.

Date and Time of Next Meeting: Thursday, 5th of October at 11:00am in Lecture Theatre 4.

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 October 2023							
6.7.23		Staff Story	Meeting to take place with Will Simmons and Christine Hill to discuss the support/resources that the Pathology Service requires to progress the Super Hub model.	L. Shepherd/ J. Grinnell	7.9.23	Oct-23	**1.9.23** - A meeting is in the process of being scheduled. **ACTION TO REMAIN OPEN**
7.9.23	23/24/105.2	Vision 2030 Strategy Update	*Strategy Document* - Arrange for a subset of the Board to meet in order to review the image that is to be included in the strategy document, the 'Plan on a Page' and the final draft of the brochure.	D. Jones	5.10.23	On track Oct-23	
Actions for November 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	Nov-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. **1.9.23** - The ToR will be submitted to the Board in October once they have been reviewed by RABD. **4.10.23** - The ToR will be submitted to the Board in November once they have been reviewed by RABD. **ACTION TO REMAIN OPEN**
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	Nov-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. **1.7.23** - This action has been deferred until September. **1.9.23** - This action has been deferred to October. **4.10.23** - This action has been deferred to November. **ACTION TO REMAIN OPEN**
7.9.23	23/24/105.1	Chair's and CEO's Update	*Aftermath of the Letby Case* - Submit a report to the Trust Board to provide assurance that Alder Hey is an organisation that recognises the critical importance of listening to staff and addressing concerns that are raised.	A. Bass/ N. Askew	9.11.23	On track Nov-23	
7.9.23	23/24/106.1	Operational Issues	*IPR (Division of Surgery)* - Conduct a piece of work on theatres to address the challenges that are being experienced in Surgery.	J. Grinnell/ B. Pettorini	9.11.23	On track Nov-23	
7.9.23	23/24/110.1	Brilliant Basics Update	Invite the Chair of Lancashire and South Cumbria NHS FT; David Fillingham to see the BB work that is taking place across the Trust, the process and the impact.	L. Shepherd	9.11.23	On track Nov-23	
7.9.23	23/24/110.2	Brilliant Basics Update	Look at the possibility of having a complete wrap around the change programmes and having a single benefits programme.	N. Palin	9.11.23	On track Nov-23	
Actions for March 2024							

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
7.9.23	23/24/106.2	Operational Issues	*Finance* - Submit a half yearly report on the cash share model that is emerging and provide detail in terms of how it is being managed from a risk perspective in the system.	R. Lea	7.3.23	On track March-24	
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
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	Closed	**4.10.23** - A member of staff has been invited to October's Board meeting. **ACTION CLOSED**
7.9.23	23/24/116.1	People Plan Highlight Report	Provide an update on the Flu Programme during October's meeting.	N. Askew	5.10.23	Closed	**4.10.23** - This item has been included on October's agenda. **ACTION CLOSED**
7.9.23	23/24/119.1	FTSU Guardian Update	Invite the Chair, Louise Shepherd and John Grinnell to the FTSU Away Day that is planned for the 10.10.23.	K. Turner	5.10.23	Closed	**4.10.23** - This action has been addressed. **ACTION CLOSED**

Integrated Performance Report | September 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -September 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for September
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**2**
		Number of Serious Incidents (Steis reported)	0	**1**
		Number of Never Events	0	**1**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**1**
		FFT - % Recommending Trust	> 95%	**92.7%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***12.2%***
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**Completion for new park is now Dec 23 and residual works to existing park are scheduled for end of March 24**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	**77.5%**
		Number of RTT Patients waiting >65weeks	0	**202**
		Number of ASD & ADHD Patients waiting >65weeks	0	**Not Available : AlderCare**
		Elective Recovery (Vol)	> 106%	**86%**
		Diagnostic Performance	> 90%	**Not Available : AlderCare**
	Financial sustainability	Revenue position – Year End forecast	12.3m Surplus	**£12.3m surplus**
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	**Deployed in Sept 2023**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 3 October 2023

Strategic Goals	2023-24 Operational Priorities	Progress in September 2023	Areas of challenge	Half 2 Forward Look: priority metrics and high impact changes planned
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Reduction in harm related incidents and increase in no harm reporting • Good compliance with inpatient sepsis management • Ready to approve the PSIRF plan and governance with policy in development	• ED Sepsis compliance • Unplanned admission to critical care • Continued reporting challenges in InPhase	• Response team now fully in place 24/7 • ED sepsis focus with case review by HoN • Transition to PSIRF and recruitment of investigation
Supporting our Colleagues	**2. Increase people availability and wellbeing**	Thriving Leaders framework: actions and timescales agreed and workstream meetings set and have commenced. Significant early focus on partnership work with Strasys to identify areas for potential early scale and spread accelerated by recent IHF award and opportunities created by this internationally. Needs based HWB: meetings in place to commenced 6th Sept with	• Resource has been confirmed as a challenge from the outset and this remains whilst the business case for additional HR resource has not yet been approved.	• To achieve revised in year target of 13% Turnover and a reduced sickness in year target of 5.5%, with a further reduced target agreed for 2024/25 • An established metric to be in place for the Thriving index and staff churn. • Head of HR Business Partners in place to release capacity to drive froward the diverse and accesible recruitment strategic initiative

		work underway on Staff Thriving Index. Actions and timescales set		
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• £200k Government knowledge assets grant funds secured for scaling and commercialisation of LHAH into other services and organisations. • Integration of Anywhere patient portal MVP with Expanse. The ability to share digital resources (videos / instructions) • Research patient feedback platform live • Research MRI scanner and associated infrastructure funded (£3.2m) • Alder Hey charitable funding awarded to future research leaders • 23/24 Alder Hey Research Ambassador scheme launched (18 schools signed up so far) - linked with Collaborating for CYP	• Tight budgets to progress key projects Seeking to secure external grant monies • Clarifying priorities during transition to Futures • Secure funding for wider As One adoption in C&M with. • Reduced research commercial income due to delayed study set-up • Reduced clinical support service capacity for clinical trials • Reduced participant recruitment due to end of large scale study	• Work with clinical teams (such as therapies and Day Surgery) to maximise benefits of Alder Hey Anywhere platform. • Secure final investment (£4m) from the Liverpool City Region Life Science Investment Zone, enabling new innovation projects to start in our priority areas of 'healthcare anywhere' and 'prevention'. • Complete and launch the Research Strategy • Research MRI scanner staffing business case to build capacity • Improved research portfolio performance
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Preparations are well underway to playgrounds, foot paths and the soiling of new pitches. • New Swale has been excavated and soiling and planting is due to commence. • Tree pits have been formed in preparation for the planting of a further 200 trees in Oct- Nov.	• Coordination with areas of residual site infrastructure from old Catkin & Histopathology. • Inclement weather is challenging installation of drainage and ultimately seeding which could be delayed until March 24	• The finalisation of the infrastructure installations we will review the park programme to mitigate delays.

Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Delivered activity levels above plan. Elective recovery at 86% is strong performance in context of Industrial Action and Alder Care Deployment • Diagnostic performance remains strong with expectation of returning to >90% within 6 weeks, and continued improvement trajectory within Sleep service.	• Number of RTT patients waiting >65 weeks has increased from 150 (Aug) to 202 (Sept) - with Industrial Action (IA) a significant challenge. • Significant demand for ASD / ADHD pathways. • ED 4 hour performance at 78% in Sept (> national target of 76%) – more challenging month with IA, Alder Care Deployment and increase in attendances.	• Driver metric: Deliver > 85% of patients seen within 4 hrs and secure ED capital monies. Action: Increase virtual ward utilisation, and establish respiratory hubs • Driver metric: reduce rate of WNB to 8% Action: commence Brilliant Basics Programme to deliver better interventions that help families attend clinic • Driver metric: eliminate > 65 week waits. Action: agree extra-contractual rate of pay, transfer some activity to elective hubs and ENT in-sourcing • Driver metric: reduce overdue follow-ups. Action: Mobilise Safe Waiting List Management Follow-Up Programme.
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month surplus of £14k in Sept (M6) and £1.48m deficit year to date (Q2). This is in line with the plan. • Industrial action continues to impact on delivery of activity and incurring additional costs with an ongoing risk to the plan. • Financial assessment continues on strategic initiatives to quantify savings. • Improved CIP identified to 88% in year.	• IYE CIP improvement however risk on recurrent with less than 41% identified. • Ongoing action including cost control within divisions and manage pressures where possible with non-recurrent mitigations, risk to delivery of plan for H2.	• Priority metric will be continued focus on delivery against the £12.3m surplus requirement. • Urgent focus required on recurrent CIP with current gap at £10.5m, which is not sustainable to carry into 24/25 financial year. • Full scenario analysis on forecast for the rest of year to be taken through RABD in October to assess risks and mitigation for delivery of plan given the continued pressures being faced.

Smartest ways of Working	**7. Safely deploy Alder C@re**	• Prior to Go-Live the Clinical Safety case was approved and all Critical Criteria met. • Training attendance reached 82% across the organisation. • AlderC@re was successfully deployed over the period – 8th – 12th September. • 3 weeks of 24/7 floorwalking support was provided to all areas.	• Certain activities took longer than planned, which led to a 24-hour delay in EPMA and Outpatients coming online. • During the transition there were key issues relating to system access and administration, which have now progressed.	• Programme is now in the stabilisation phase with 4 priority issues to be resolved. All issues have associated mitigations and action plans. • All clinical safety areas will be reviewed prior to moving into an Optimisation Phase. • A list of key priorities will be agreed with each Division which will formulate the Optimisation Programme. • Following Optimisation, Phase 2 of AlderCare will be established.

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Integrated Performance Report

Published: September 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

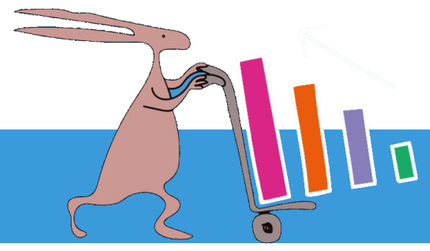
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

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

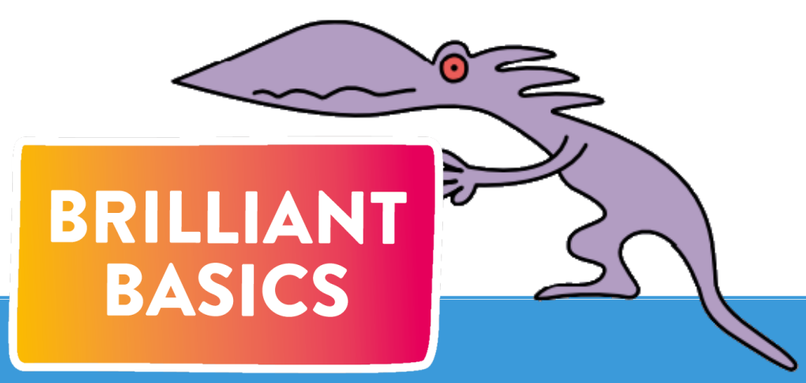
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2-week referrals & C.Difficile demonstrates performance is consistently achieving target with an improving trend	A&E performance, Never Events, F&F Recommend the Trust, Mandatory training & Level 1 patient safety training are inconsistently achieving target with an improving trend	Staff Turnover, Diagnostics, CAMHS >52 wks. and ED F&F are not achieving targets but demonstrating improvement
	Common Cause	Cancer and MRSA metrics are achieving targets	Complaints & PALs, Sepsis, EL/DC/OP Recovery, Cancelled Operations, WNB, Sickness, stranded patients PDRs & ERF are inconsistently achieving target and are yet to evidence statistical improvement	RTT >65 Weeks, PALS, Theatre Utilisation, Clinic Letters completed, Medical Appraisal, Long Term Sickness, and Oral Health >52wks are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern			>65 Wk waits ASD/ADHD are not achieving targets with a declining trend

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

- 14.6% of our metrics are consistently achieving target
- 60.4% of our metrics are inconsistently achieving target
- We are not achieving the target for 25% of our metrics but experiencing improvement in 4 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:

No serious incidents in month and no Never Events for 12 consecutive months. Demonstrable culture of reporting incidences of physical restrictive intervention. Reduction in Category 2 pressure ulcers

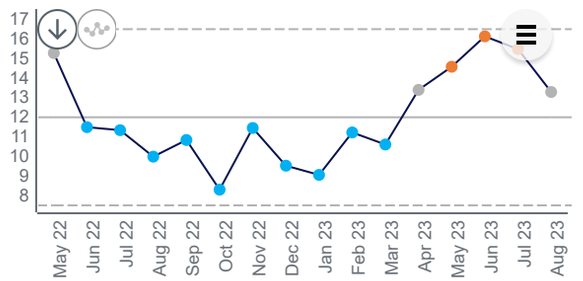
Areas of Concern:

Antibiotics not always administered within the 60 minute response time for sepsis in ED

Forward Look (with actions)

Continue with delivering improvements and CQUINs relating to restrictive interventions and tissue viability monitoring. ED continued focu on administration of antibiotics in 60 minutes for sepsis

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



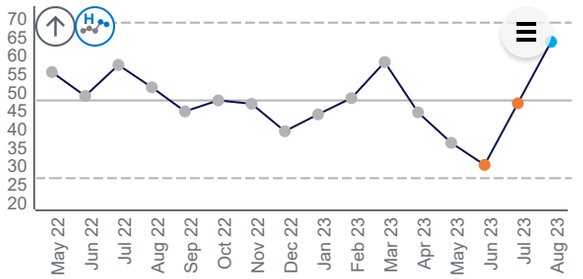
Technical Analysis:

Reduction in rate of harm per 1,000 bed days which also mirrors increase in Incidents of No Harm increasing,

Actions:

Continue to monitor and themes and trends in incident reporting; disseminate findings within governance structures and identify opportunities in the themes to review using PSIRF

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



Technical Analysis:

Special cause variation has been observed which also correlates with InPhase going live from May-23. Rates currently assessed on Physical Harm only.

Actions:

Continue to monitor and themes and trends in incident reporting; disseminate findings within governance structures and identify opportunities in the themes to review using PSIRF

NHS
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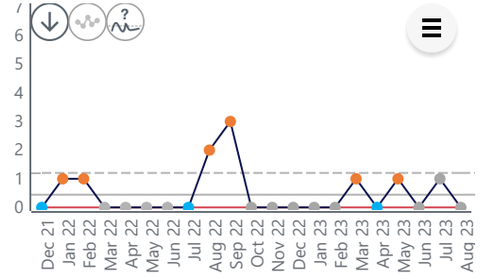
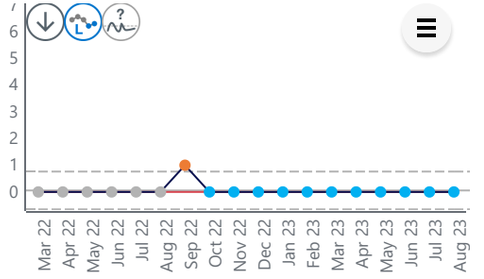
Unrivalled Experience - Safety - Watch Metrics

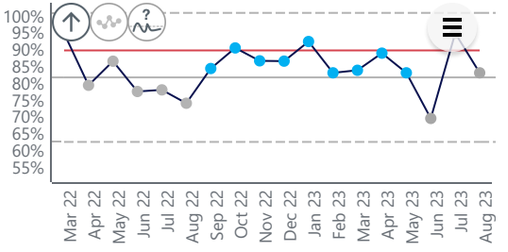
Number of Serious Incidents (Steis reported)



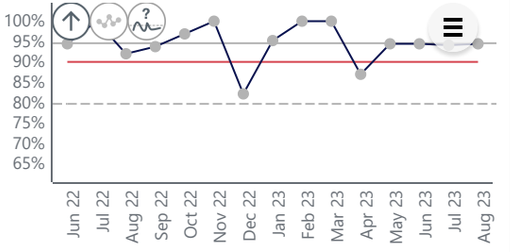
Number of Never Events



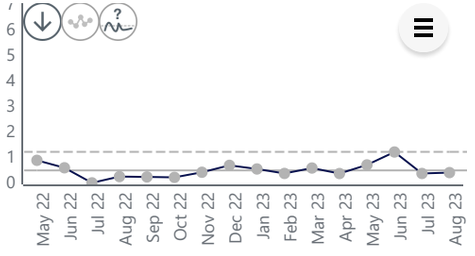
Sepsis % Patients receiving antibiotic within 60 mins for ED



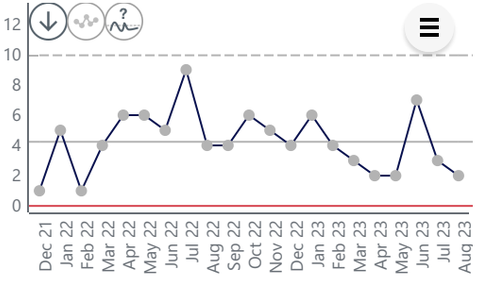
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



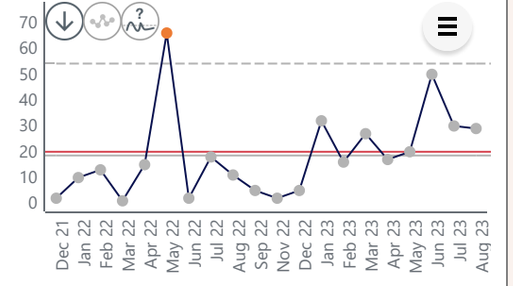
Medication Errors rated Minor harm and above per 1,000 bed days



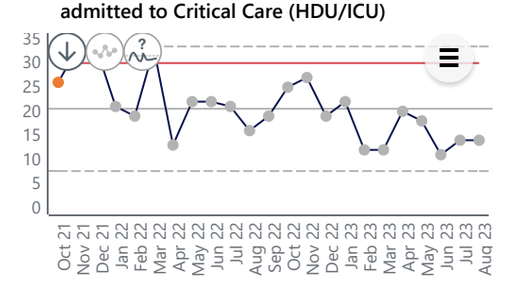
Pressure Ulcers G2-4



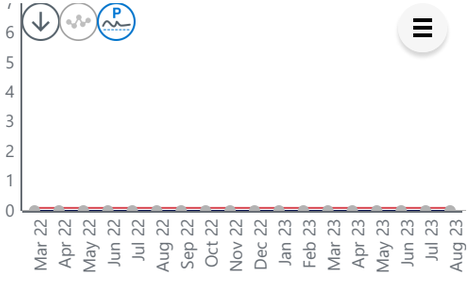
Use of physical restrictive intervention



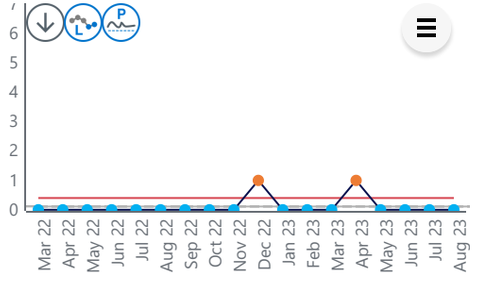
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



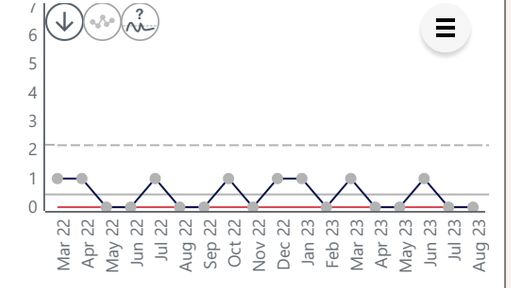
Hospital Acquired Organisms - MRSA (BSI)



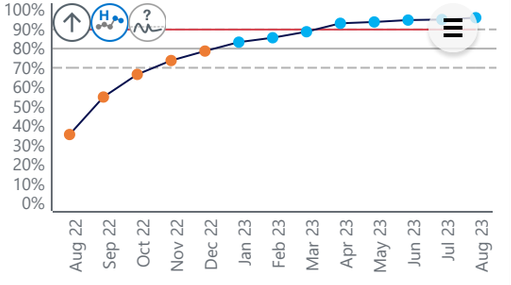
Hospital Acquired Organisms - (C.Difficile)



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:

96% of families who completed the FFT said that they would recommend the Trust and an improvement in the ED score in month to 93%

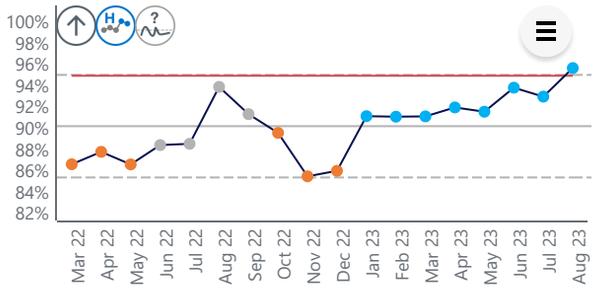
Areas of Concern:

Time taken to respond to families raising a PALS concern or a formal complaint not 100% - times 84% and 86% respectively. Divisions to continue focus on resolving issues for families in a timely manner

Forward Look (with actions)

Divisional teams to ensure compliance with the response times for PALS and complaints

F&F Test - % Recommend the Trust



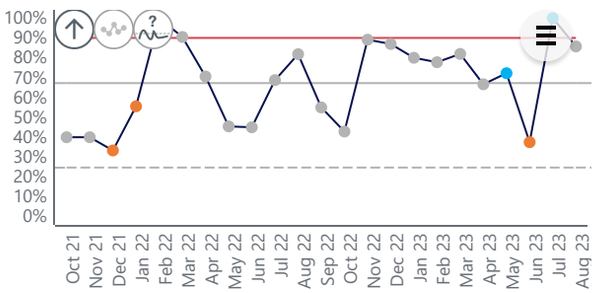
Technical Analysis:

Consistently not achieving the 95% target although Special cause variation has been observed. Performance of 96% represents a 8th consecutive month above the 12 month average of 90%, which is first month above target in 18 months.

Actions:

Work continues to improve the FFT scores, improvement has been seen within ED and further work is ongoing in the department to increase satisfaction

% Complaints Responded to within 25 working days



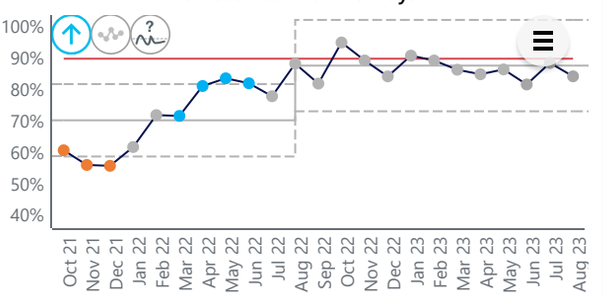
Technical Analysis:

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

Actions:

To maintain the performance in relation to this metric

% PALS Resolved within 5 Days



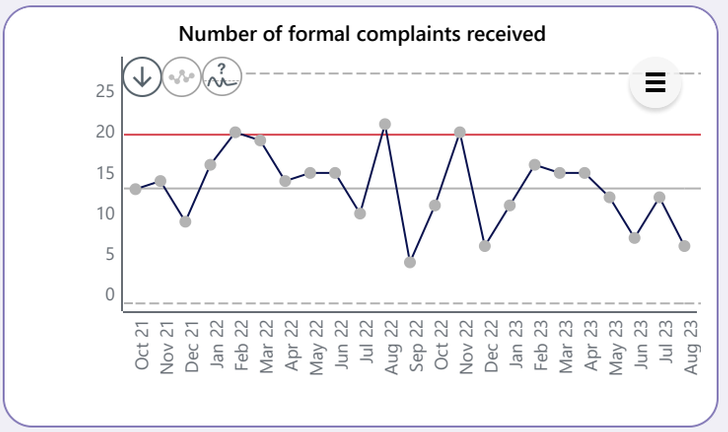
Technical Analysis:

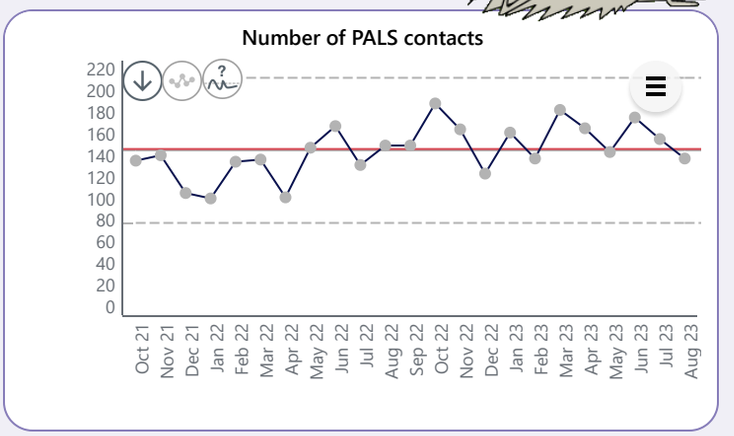
Common cause variation has been observed with a 12 month average of 88%. Inconsistently achieving the 90% target. August 2023 performance was 84%.

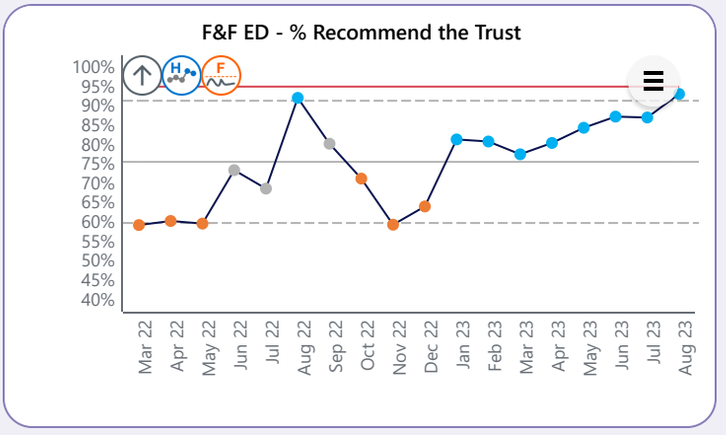
Actions:

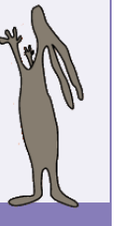
To ensure that divisional teams are responding in a timely way to PALS concerns, although this continues to be a marked improvement

Unrivalled Experience - Caring - Watch Metrics









Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Sustained improvement in ED performance with special cause variation showing evidence that improvement actions have been effective and achieving >90% in July and August • Reduction in super stranded patients with <30 in 3 of the last 4 months

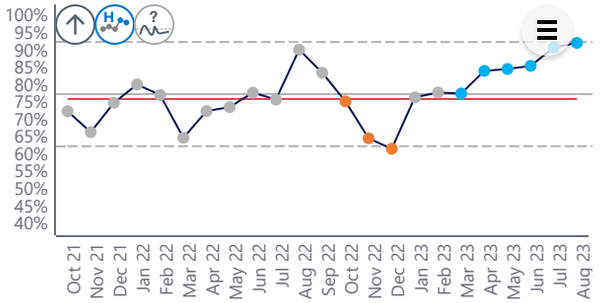
Areas of Concern:

• WNB rate at highest point for 12 months: seasonality may be a factor, but no statistical evidence of improvement from interventions • Static performance regarding Cancelled Operations and Clinic Letters

Forward Look (with actions)

• Implementation of winter plans to optimise benefits from Virtual Ward, UTC, and PAU • Full benefit assessment of WNB interventions using PDSA cycle to improve effectiveness of interventions

ED: % treated within 4 Hours



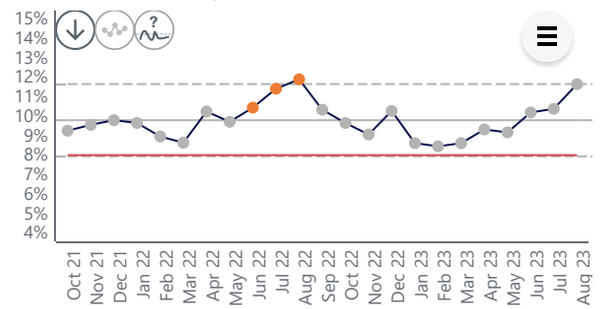
Technical Analysis:

Special cause improving variation has been observed towards achieving the new national target of 76%, the Trust has achieved the target for the past 8 months with performance at 92.2% which was further increase on July 23 performance at 90.8%. ED Performance of 92.2% highest since April 2021.

Actions:

• Prompt resolution of Alder Care post-implementation issues
• Implementation of winter plan to optimise benefits from Virtual Ward, UTC and PAU
• Measles preparedness plan and preparation

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



Technical Analysis:

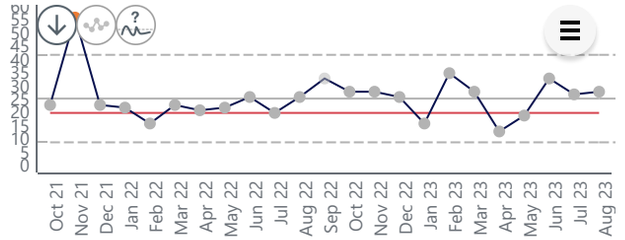
WNB rates demonstrates common cause variation. Performance in August 2023 of 11.6% is the highest rate since August 2022 (11.9%) which identifies seasonality impact of summer school holidays.

Actions:

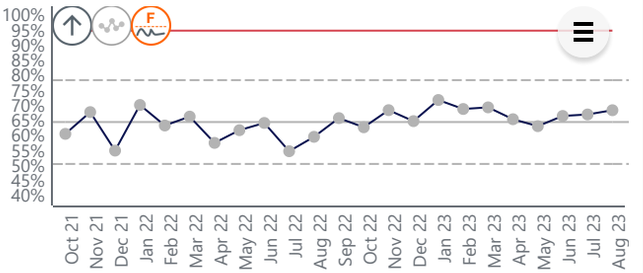
• Targeting 9 clinical teams with highest WNB %
• Making >500 calls pcm based on Ai predictor
• Full benefit assessment using PDSA cycle to improve effective of interventions and overcome barriers (eg transport, children, language interpretation)

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

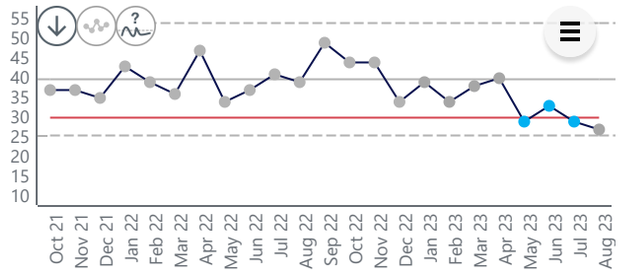
Number of Cancelled Operations (on day of admission for a non-clinical reason)



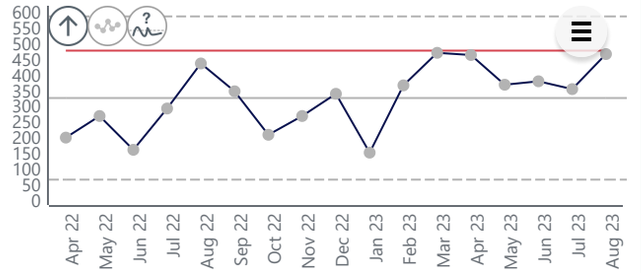
% of Clinical Letters completed within 10 Days



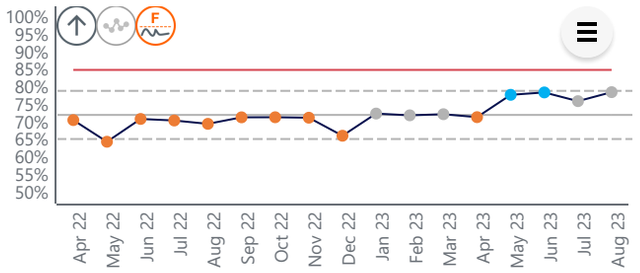
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• 21% reduction in >65wk breaches (from 190 in June to 150 in August). We are also seeing reduction in >52 week breaches • Strong levels of recovery volume (104% for IP&DC; 129% for OP) in the context of Industrial Action • Maintaining improved access to Diagnostics (88% due to IA), CAMHS (now only 1 >52ww) and exceeding national standards for cancer services

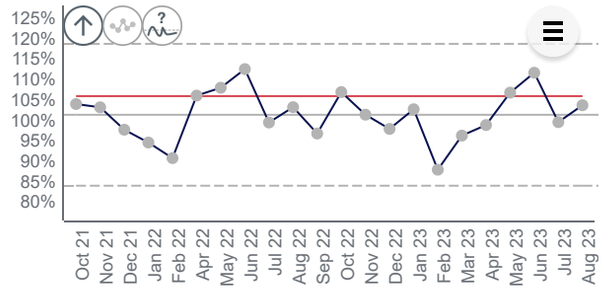
Areas of Concern:

• Waiting times for ASD and ADHD showing special cause variation with increased number of Children and Young People waiting >65 weeks for diagnosis (1,436 in August, up from 1,277 in July) • Ongoing Industrial Action with potential impact on recovery levels and access, especially when combined with seasonal Winter pressures

Forward Look (with actions)

• Implementation of recruitment plan for ASD and ADHD in line with agreed investment and reprofiling of waiting time improvement plan • Industrial Action: Safe management of activity levels and mitigating impact on waiting times

% Recovery for DC & Elec Activity Volume



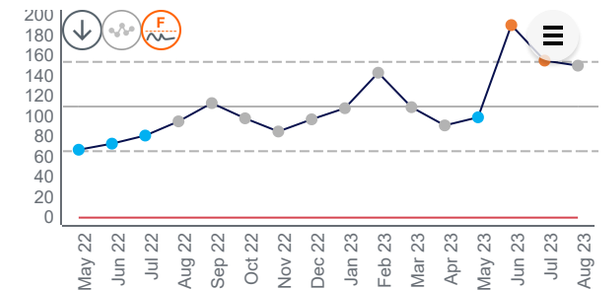
Technical Analysis:

August-23 performance of 104% by volume is below target but improvement of 4% compared to Jul-23. August experienced 6 calendar days of industrial action which resulted in 46 operations cancelled in advance, in addition 28 operations cancelled on the day (non-clinical). Measure continues to demonstrate common cause variation.

Actions:

• Activity levels managed safely during ongoing Industrial Action
• Implementation of winter plan to optimise elective programme

Number of RTT Patients waiting >65 weeks



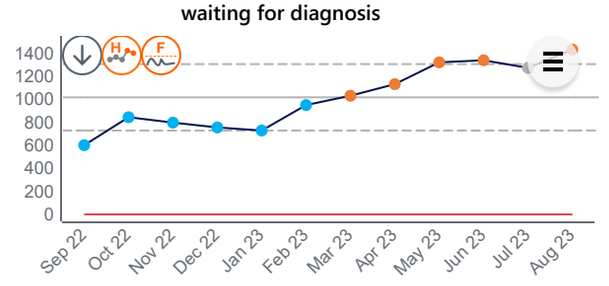
Technical Analysis:

Number of patients waiting > 65 weeks has decreased in August to 150 patients from 155 in July. Dentistry (n = 48) and ENT (n=99) have 147 patients >65 weeks, 98% of the Trust total.

Actions:

• Maintain focus on 3 most challenged specialties: ENT, Dental and Spinal surgery
• Frontload OP New appointments by end of December, to allow for conversion to IP pathways and commencement of treatment by 31 March 2024

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



Technical Analysis:

On average 1020 patients are waiting for an ASD or ADHD diagnosis per month. August shows 1436 patients which is above the outer control limits, now showing special cause varation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

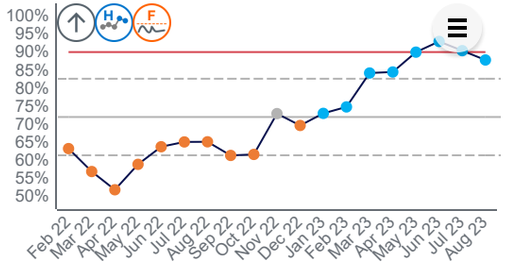
Actions:

• Implementation of recruitment plan for ASD and ADHD in line with agreed investment and reprofiling of waiting time improvement plan

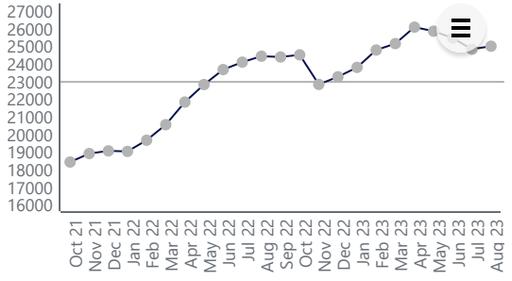
NHS
Alder Hey Children's
NHS Foundation Trust

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

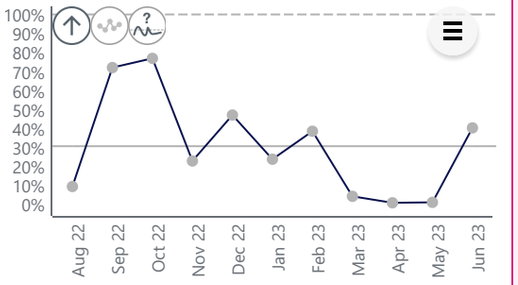
Diagnostics: % Completed Within 6 Weeks of referral



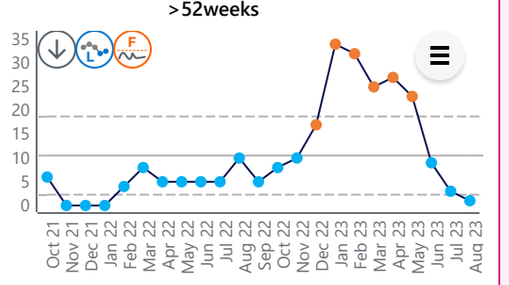
Waiting List Size



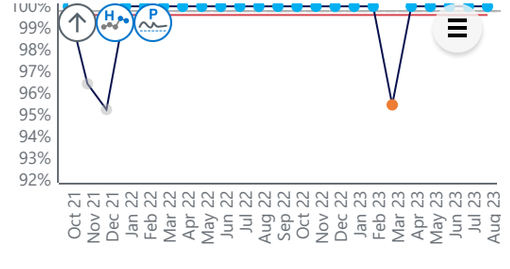
IHA: % complete within 20 days of referral to Alder Hey



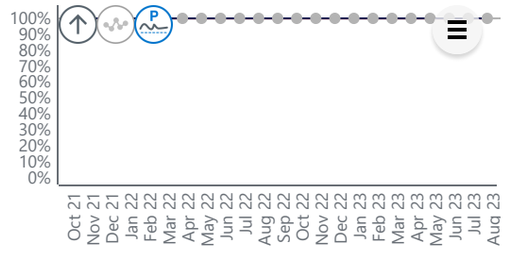
CAMHS: Number of children & young people waiting >52weeks



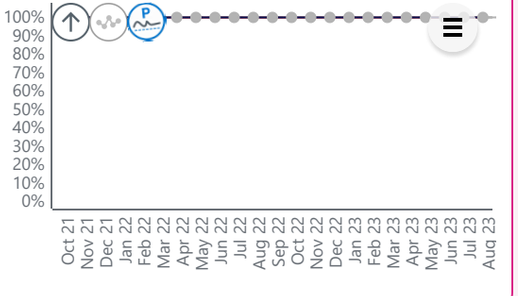
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



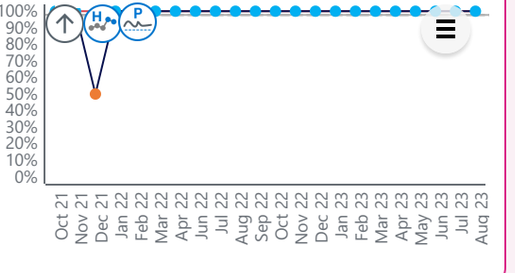
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



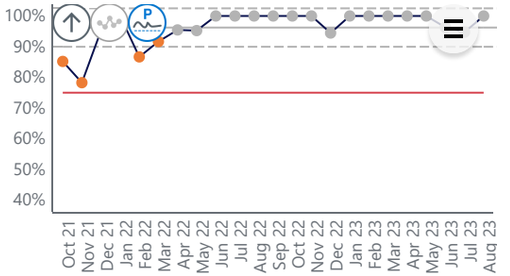
All Cancers: 31 day wait until subsequent treatments



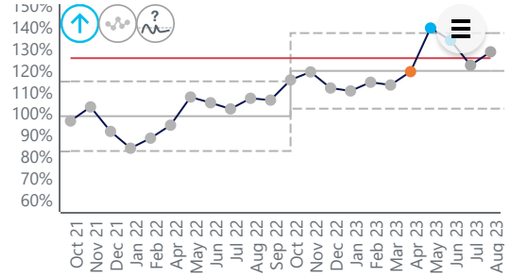
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Collaborating for CYP - Reducing Health Inequalities: Responsive

SRO: For collaborating in communities – Dani Jones & Exec Lead for Health Inequalities – Alfie Bass

Highlights:

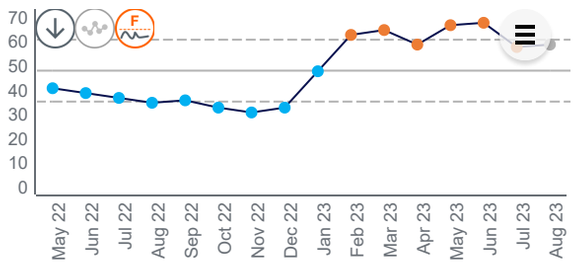
• These measures will be updated on a quarterly basis given the nature • This is a new direction of reporting for the integrated performance report, recognising both the Trust's ambitions in terms of reducing the impact of health inequalities and new strategic drivers such as Core20+5CYP. • A 'learn and shape' approach to these metrics will be undertaken, with programmed activities throughout the year. These metrics are 'owned' through the Trust's Health Inequalities and Prevention (HIP) Steering group, which reports to Safety and Quality Committee. • Quality improvement approaches will be assigned to drive positive change against these metrics during 23/24 – these are under development through HIP Steering group

Areas of Concern:

Forward Look (with actions)

• Prevention in pathways work mobilising (Mini Mouth Care Matters / Health Inequalities Toolkit and Advice on Prescription
•Liverpool City wide Oral Health Strategy in development supported by Beyond
•Alder Hey led Wellbeing Hub in scoping phase

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



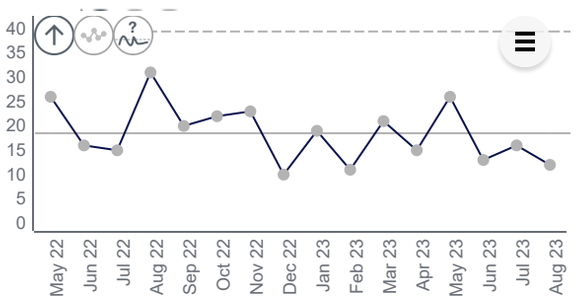
Technical Analysis:

Steady decline in children waiting >52 weeks up until Jan 23 where we have since seen a sudden increase. Currently 59 children waiting >52 weeks, which increased by 1 from July 2023. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Number of children waiting >52 weeks remained static, mainly due to lost capacity during Industrial Action periods. Ongoing action plan to reduce waiting times which includes additional capacity via both new medical staff and continued insourcing during the coming months. Ongoing risk with further lost capacity as a result of continued IA which includes Radiography.

Alder Hey Community Mental Health Services: Number CYP of BAME background referred



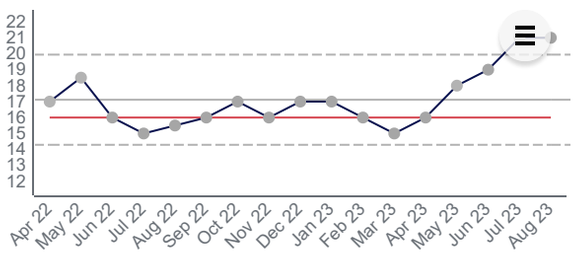
Technical Analysis:

New Metric which shows on average 19 referrals of BAME background are accepted per month, August shows 12 patients. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Defining metric and accurate capture of data as in progress, including national reporting of data

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



Technical Analysis:

Median wait of Learning and Disability (LD) patients (RTT open pathways) was 21 weeks as end of August above the previous 12 month baseline target of 16 week median wait for non-LD patients and a further monthly increase. Waits for non LD patients have remained steady at 17 weeks. This will require a deep dive to identify cause behind this gap.

Actions:

Metric and associated improvement plan are work in progress.

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

Turnover and sickness absence rates are both seeing sustained improvements, achieving the in year revised targets over recent consecutive months. Work is ongoing to further reduce the rate of both turnover and sickness absence.

Areas of Concern:

PDR's now take place on a rolling 12month basis, but the Trust wide position is only at 67%. Given the importance of effective and meaningful PDR's on wellbeing, retention and turnover it is imperative that these discussions for those staff that remain outstanding are completed imminently.

Forward Look (with actions)

Task and finish group to continue to progress actions in respect Turnover.

L&D team to compile detailed progress reports on PDR compliance and escalate areas of concern

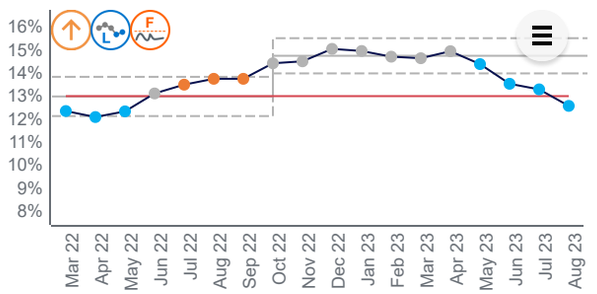
Colleague Satisfaction – Thriving Index - In Development

Technical Analysis:

Actions:

NA

Staff Turnover



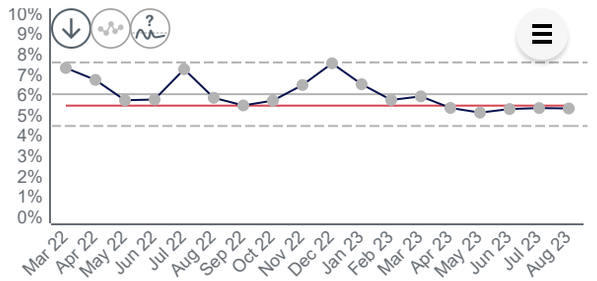
Technical Analysis:

Staff Turnover has demonstrated special cause varation, reducing to 12.5% which is the 5th consecutive month with a reduction, also first month within target since May-22. This should continue to be monitored as high levels of staff turnover create substantial risk for the Trust but this represents continued reduction and signals start of improvement

Actions:

Turnover, whilst still higher than the original baseline of 10%, is stabilising and achieving the in-year target of 13%. Turnover is reported Quarterly to PAWC and detailed analysis is presented of the actions from the turnover Task and Finish group. These actions are supporting the reduction in % rate of turnover.

Sickness Absence (Total)



Technical Analysis:

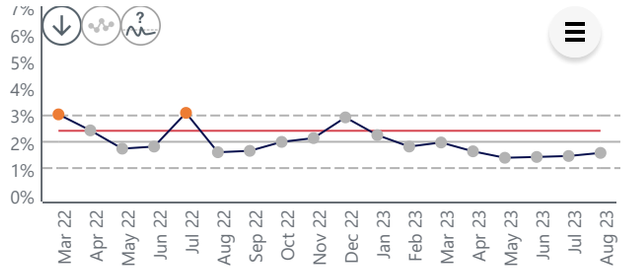
Total sickness absence in August is 5.39% which is in line with the 5.5% target. A slight decrease from July at 5.45%. August performance comprises STS at 1.86% and LTS at 3.54%. Still demonstrating common cause variation, consecutive months below the target.

Actions:

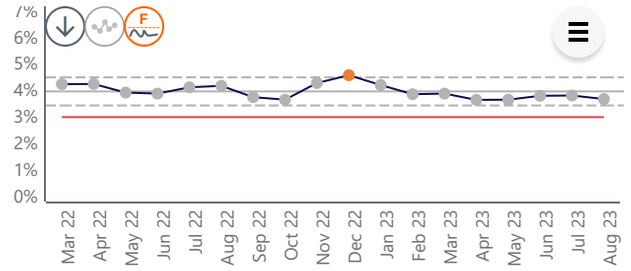
Designated HR support for all Depts and divisions in the Trust in respect of managing absence, which is supporting a reduction in absence. HR training and support is in place with further improvements planned, including revised sickness absence policy and associated toolkits.

Well Led - Supporting Our People - Watch Metrics

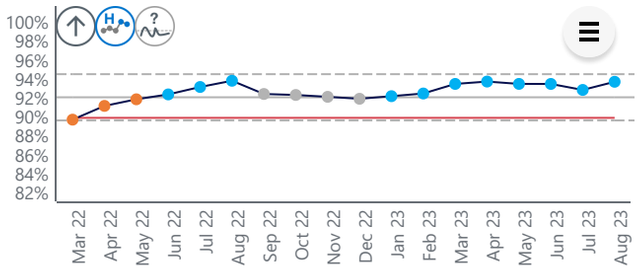
Short Term Sickness



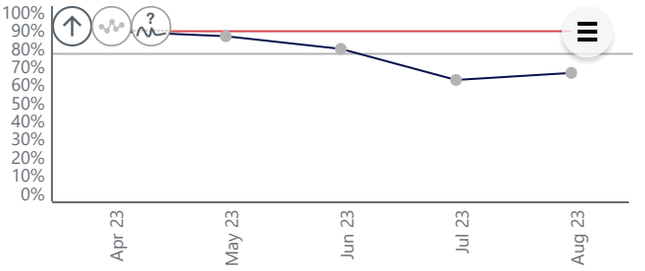
Long Term Sickness



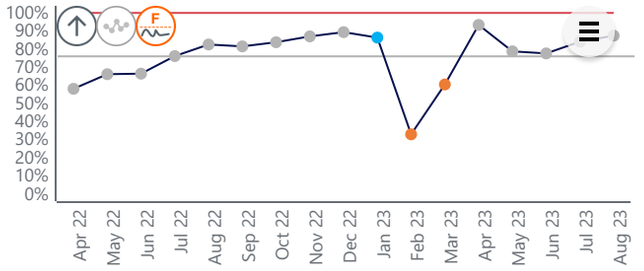
Mandatory Training



% PDRs Completed (Rolling 12 Months)



Medical Appraisal



Staff movement / Churn rate - In Development

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

In August (M5), the Trust is largely reporting a break even position (£1.5m deficit ytd) which is in line plan. Forecasting to achieve £12.3m surplus subject to CIP risk & activity levels. CIP £0.9m behind plan ytd. Overall £9.3m CIP has been transacted with £5.6m in progress. Gap of £2.8m relating to transformation & transactional schemes. Cash has remained high in line with plan & capital in line with expectations.

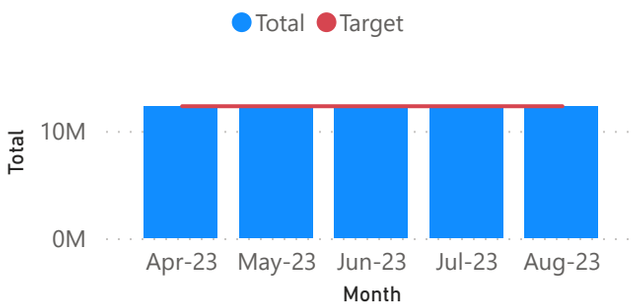
Areas of Concern:

CIP gap closing in year but transformational schemes still being worked up and represents a high proportion of the unidentified schemes. Challenging £12.3m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets.

Forward Look (with actions)

Continued cost control to reach the £12.3m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further divisional finance panel meetings scheduled in September along with SDG to focus on Divisional CIP including enabler areas.

Revenue Position (Year End Forecast)



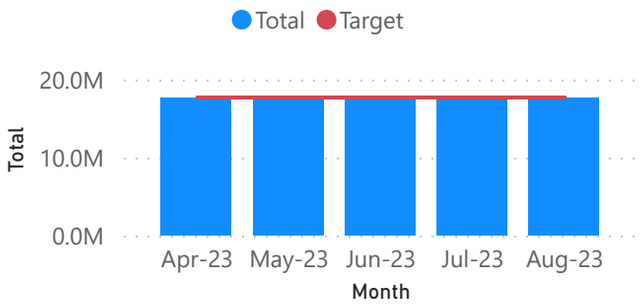
Technical Analysis:

Current forecast remains to achieve plan however risks to delivery of this is linked to achievement of CIP.

Actions:

Continue to monitor CIP schemes and cost control for arising pressures to be managed through SDG meeting

CIP Position (Recurrent Full Year Effect)



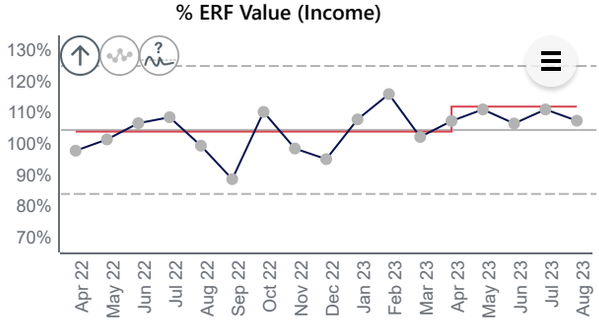
Technical Analysis:

In year CIP identified and in progress is £14.9m. Of this, £6.8m is recurrent.

Actions:

In year CIP identified and in progress is £14.9m. Of this, £6.8m is recurrent. Support required with exec leads and transformation to identify the large scale opportunities. Paper to be submitted to execs. Divisions have identified plans to meet their gap in full in year only. Still large gap recurrently of £10.9m

% ERF Value (Income)



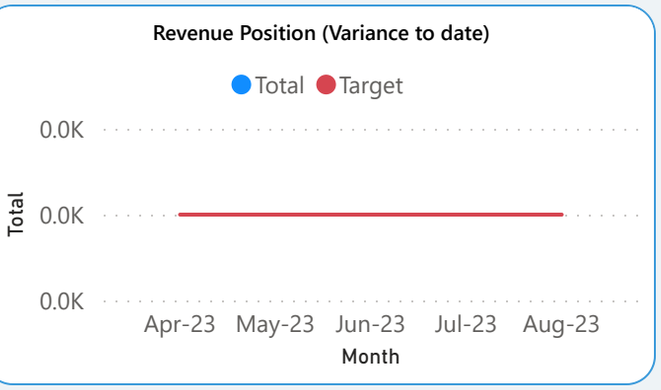
Technical Analysis:

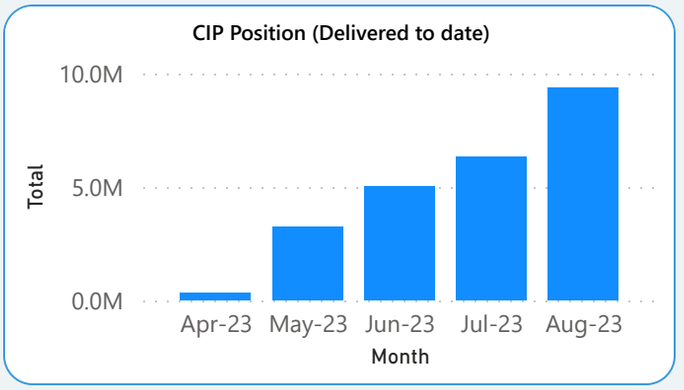
August performance estimated at 107.5%. YTD performance estimated at 108.3%.

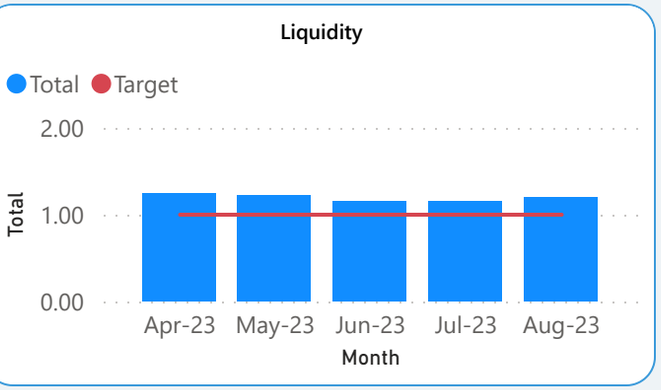
Actions:

Continue to monitor those areas (at POD and speciality level) that are under performing versus plan.

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







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

•Risks are being reported and fully managed via InPhase. Support continues to be offered by the corporate / divisional governance teams to staff in reporting and managing risks via InPhase and via divisional / corporate risk oversight meetings. • Automatic notification for upcoming / overdue risk reviews now rectified by InPhase-Weekly notifications to be sent each Friday commencing 22/9/23 • InPhase now engaged in daily huddle - minor queries are being dealt with immediately • Work arounds for reporting timeframes (i.e. complaints • Report requests streamlined and now only 7 reports required

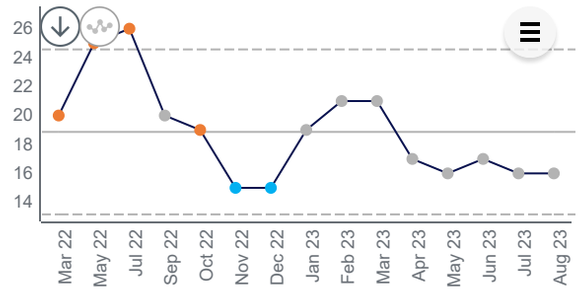
Areas of Concern:

• InPhase implementated in community provider service so a number of elements not currently build within the system. Ongoing oversight at Programme Board • Current admin arrangements not sustainable to support develeopment of dashboards etc .Under dsicussion with LHC at Programme Board

Forward Look (with actions)

• Continue to support staff via the risk oversight meetings / 1:1 basis • 4 staff (across AHCH / LHCH) have received advanced report designer training to support staff across the wider Trust to create more accurate reports • Risk 22 – InPhase post implementation (current score – 12) – is being actively managed with mitigations and appropriate oversight in place • Manual extraction of data can be undertaken to provide detail required for assurance reports • iDigital BI specialists to work directly with corporate/division governance leads to enhance reporting and dashboard

Number of High Risks (scored 15 and above)



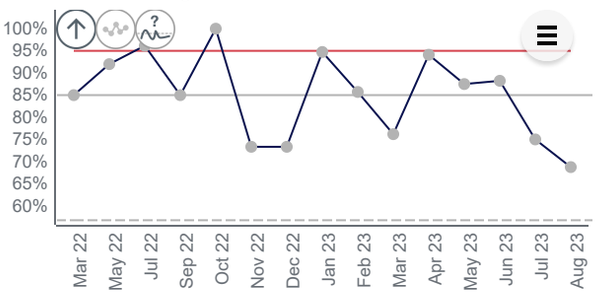
Technical Analysis:

There are 16 High Risks on the risk register at the end of August. Overall, this remains stable and is within the normal range.

Actions:

As of end August 16 high risks (score of 15 or more) recorded on the risk register

% of High Risks within review date



Technical Analysis:

Compliance of reviewing High risks within date is variable, with 5/16 risks overdue at the end of August. Action is required to ensure consistent compliance with the 95% target.

Actions:

68.75% of high risks (11/16) were within the review date at the of August. The remaining 5 risks overdue a review date were escalated to the individual risk owners. At the time of reporting 81% (13/16) risks are within review date

Smartest Ways of Working - AlderC@re - Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

• Aldercare went live over the weekend 8th-11th September in Labs, Radiology, ED and In Patient areas. Pharmacy went live on 11th September and Outpatients and Theatres went live on 12th September • The new system is in use across all clinical areas in Alder Hey • Feedback is being received from staff across the Trust

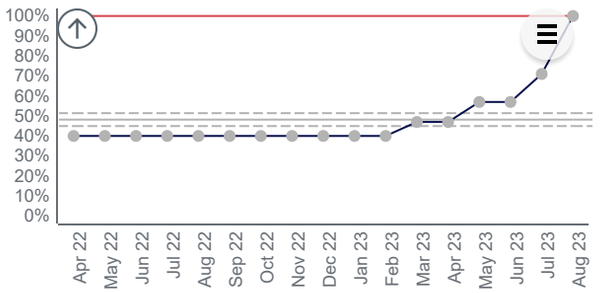
Areas of Concern:

• The cut over plan to implement the new system was delayed over the weekend which has had a risk to a slight delay on reporting timescales • Post deployment priority issues and resolution of issues logged continue to be resolved through the programme stabilisation phase • Hot spot areas for support and development are prioritised as they arise

Forward Look (with actions)

• Conclude stabilisation phase of programme • Commence Aldercare optimisation programme • Consider planning for Phase • Commence benefits tracking

Alder Care - Divisional Critical Criteria



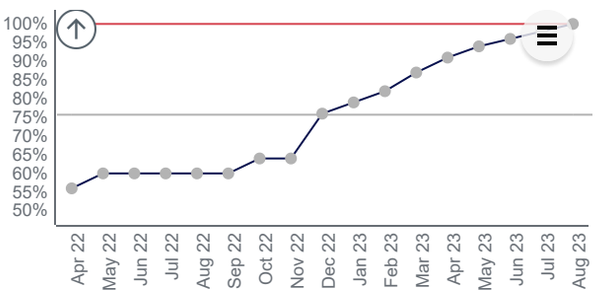
Technical Analysis:

100% complete

Actions:

Actions complete prior to go live

Alder Care - % System Build Completion



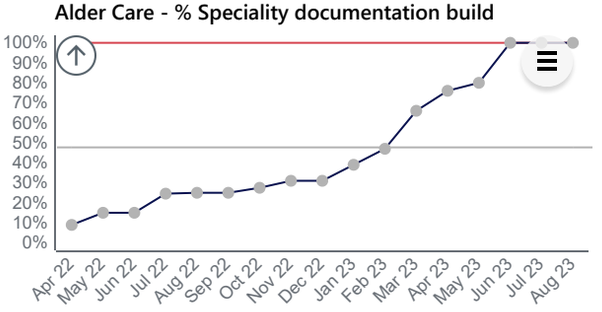
Technical Analysis:

100% complete

Actions:

Actions complete prior to go live

Alder Care - % Speciality documentation build



Technical Analysis:

100% complete

Actions:

Actions complete prior to go live

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

Best CHP reliability for over 5 years (ever??) after SPV and MITIE improvements.

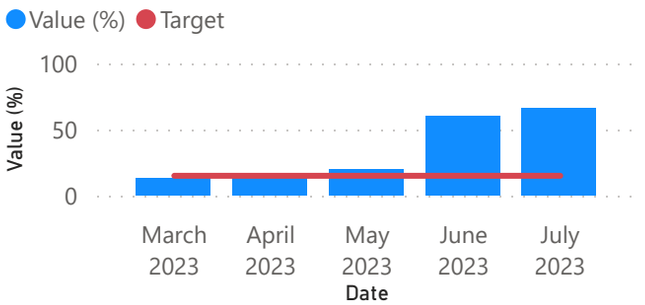
Areas of Concern:

Energy usage up during ROCK water treatment works.

Forward Look (with actions)

LED tender underway for car park. ROCK works will complete this phase enabling heating problems to be addressed.

Green Plan: Reduce Carbon Footprint



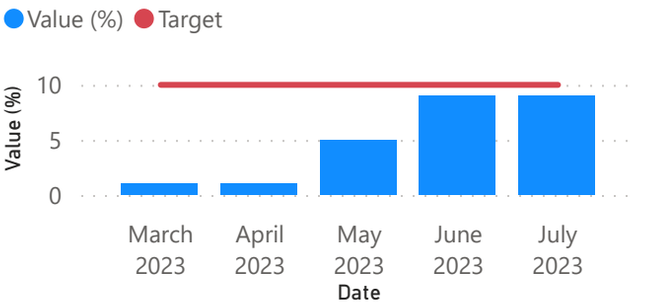
Technical Analysis:

6% rise

Actions:

Finish ROCK works. Complete PV business case.

Green Plan: Reduce Energy Usage



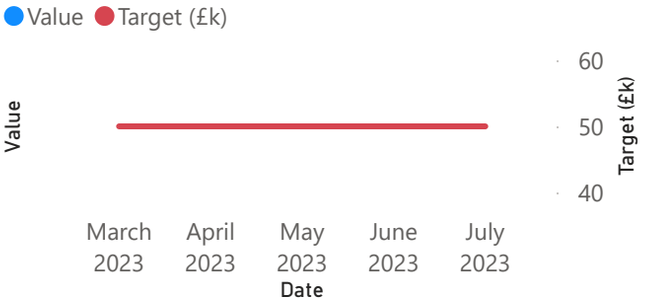
Technical Analysis:

9% vs target of 10%

Actions:

Finish ROCK works

Green Plan: Reduce Waste



Technical Analysis:

£0

Actions:

Compactors on order

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Continued reduction in the longest waiting times in CAMHS (1 over 52 weeks at end Aug 2023) and forecast for zero over 52 week waits by 30 September 2023.

• YTD the division is £1.6m ahead of plan and forecasting to deliver £1.5m favourable variance by the end of financial year. The division has delivered £1.4m of CIP target (88%).

• Continued reduction in staff turnover, with turnover rate at 14% in August 2023 (compared to 17% January 2023)

• Sickness absence rates remain below 5% (4.7%)

• 59% PDRs and 95% medical appraisal completed by 30 August 2023

• Further improvement in percentage of people who would recommend outpatients to family and friends to 96% in August 2023

• Alder Care Service Preparedness plans completed for all services including addressing outstanding data compliance issues to ensure completeness of data for migration.

Areas of Concern

• Continued focus on completion of clinic letters within 30 days of appointment is resulting in improvement performance.

• Increase in time to access Initial Health Assessment for children who are new into care due to reduced capacity over the holiday period. Actions to address this underway with additional external staff being recruited during September.

• ASD and ADHD waiting times remain high and a focus of improvement for the division.

• Continued challenges in WNB rates in CAMHS with a divisional improvement project established to identify improvement actions including trial of a transport scheme due to go live end of Q2.

• There has been an increase in the number of breaches (5) of routine Eating Disorder waiting time standard in August 2023. This has been due to patient choice of appointment time rather than capacity and is expected to improve throughout September.

Forward Look (with actions)

• Recruitment plan to support reduction in waiting time to access Initial Health Assessments is under development

• Recruitment commenced for additional roles within ASD and ADHD in line with agreed investment and a reprofiling of waiting time improvement plan is due by 30 September 2023

• Mental Health recruitment plan in place and monitored monthly by Divisional Board

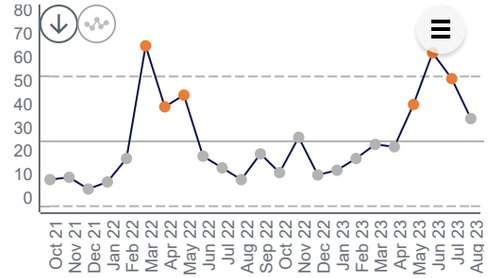
• Strengthened controls established within Divisional Recruitment panel including greater oversight of all additional activity requests (WLIs) now in place

• Divisional leadership team focussed on support to clinical and operational teams following Go Live of Alder@care. Daily check in process established.

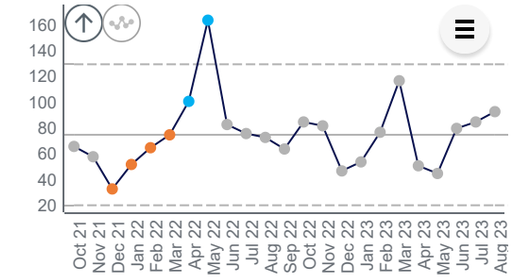
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

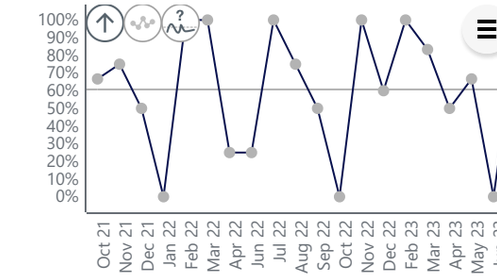
Number of Incidents rated Minor Harm and above



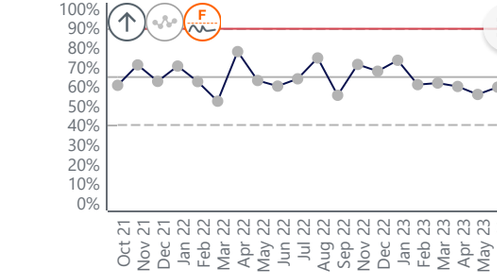
Number of Incidents rated No Harm and Near Miss



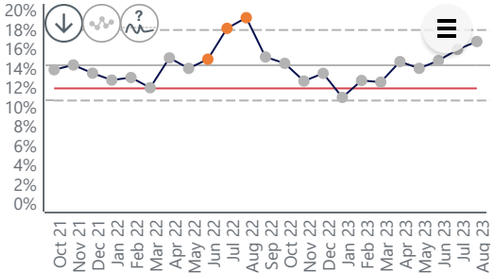
% Complaints Responded to within 25 working days



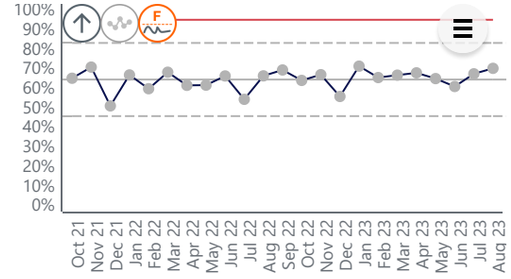
% PALS Resolved within 5 Days



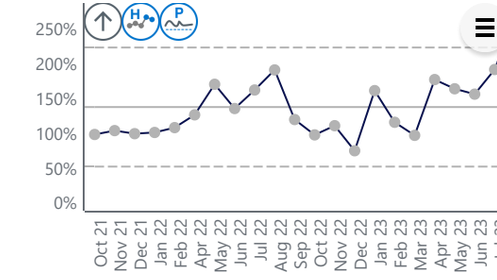
% Was Not Brought Rate (All OP: New and FU)



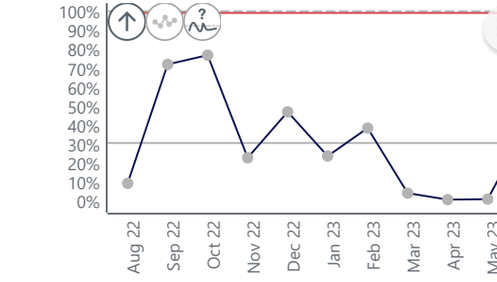
% of Clinical Letters completed within 10 Days



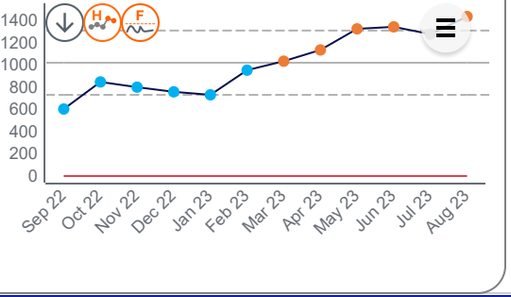
% Recovery for OP New & OPPROC Activity Volume



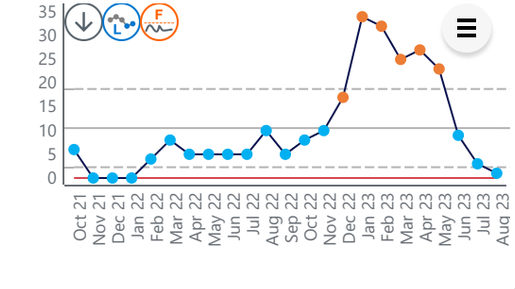
IHA: % complete within 20 days of referral to Alder Hey



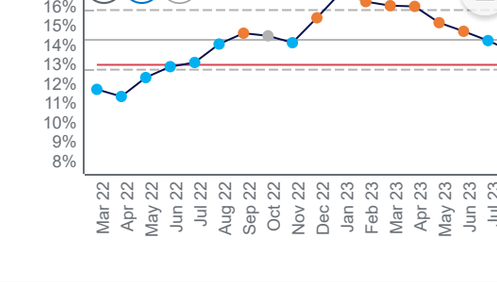
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



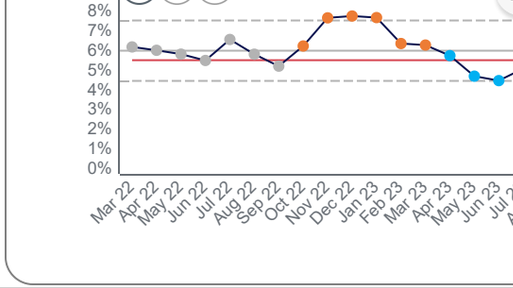
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



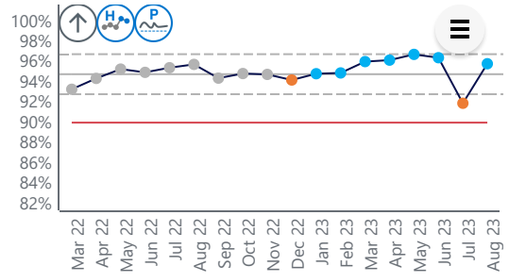
Sickness Absence (Total)



Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Community & Mental Health

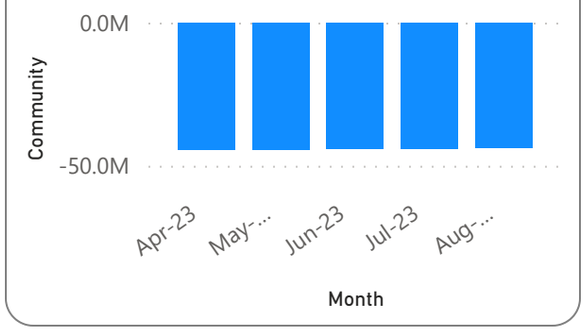
Mandatory Training



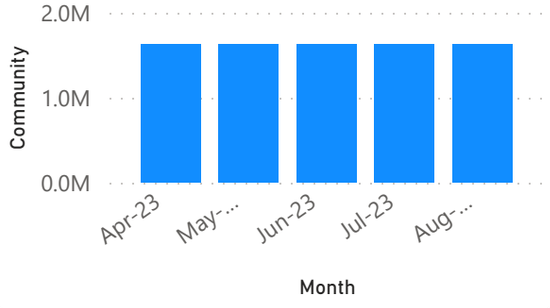
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

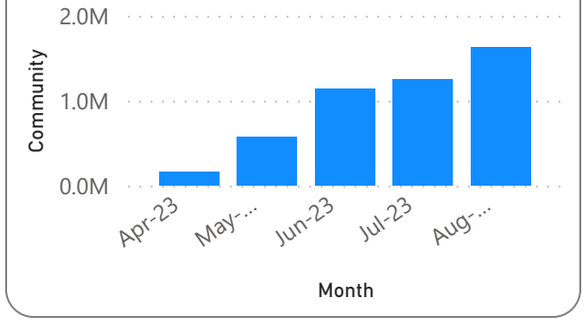
Revenue Position (Year End Forecast)



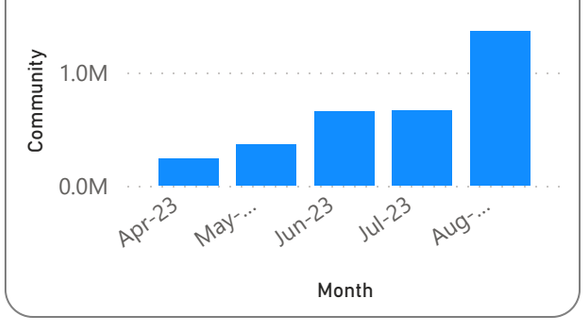
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Inpatient Sepsis (delivering antibiotics within 60 minutes) remains compliant. • ED performance continues an improving trend, achieving 92% in 4 hours in month; improved utilisation of the UTC and GP stream is supporting this position; PAU pilot commenced 8th August primarily focused on improving this indicator by offering direct assessment for GP and other health professionals to a Paediatric assessment. • Sustained compliance with all standards for cancer care. • Division remains compliant with mandatory training YTD • No 65 week waiters. • Divisional recovery remains strong, however some specialities considerably behind plan @M5 due to workforce restrictions and the impact of continued industrial action.

Areas of Concern

• Emergency Department Sepsis (delivering antibiotics within 60 minutes) compliance remains variable; Head of Nursing has reviewed all breaches over the last 6 months and submitted the themes to SQAC. • Performance against the 18-week RTT standard is stagnant, however, waiting list size has marginally reduced, signalling a positive recovery despite the impact of industrial action. Concerns remain regarding Dermatology, Gastroenterology and Neurology recovery. • The Division has a deteriorating financial position, driven by pay costs relating to Bank HCA spend across the medical wards and Consultant pay costs as a result of locum/agency expenditure providing cross cover for absent and restricted colleagues. • Virtual Outpatient rates remain below 25%; priority for OPFA both from a recovery and industrial action perspective means reduced OPFU clinics. • The number of Clinical letters signed off within 10 days remains non-compliant; however, a slight improvement in month; the Division has implemented a failsafe process monitoring all aspects of elective care performance. • Despite a positive CIP position at M4 (£2m) the Division is challenged in delivering recurrent savings and achieving the full £3.6m in year; A3 plans underway • Theatre utilisation continues to be underperforming based on the Capped utilisation indicator; further review required to balance the reporting e.g. removal of the IOMR from the data, assessment of case per clinician at speciality level as current presentation of data is misrepresenting. Slight dip (89%) in 6 week diagnostic target therefore marginally failing to achieve the 90% target for the first time since May 2023. Increased WNB rate and stagnant PDR position.

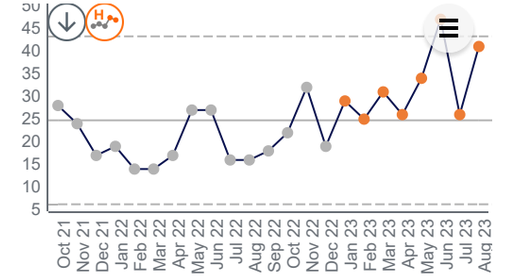
Forward Look (with actions)

• Although the Divisional PDR plan aims for 90%+ compliance by 31st October, there is significant challenge to this in light of ongoing industrial action and Expanse upgrade. However, all PDRs are being scheduled by grade/ month • Enhanced financial controls made some impact in month and will continue. • Continue to develop recurrent CIP plans in line with the trust strategy • Root/branch review of controls for the management of Sepsis in ED • Associate Chief Nurse has introduced additional controls to reduce the escalating HCA spend across the medical wards • Dedicated HR meeting to go through increased consultant spend due to ongoing and deteriorating position regarding consultant sickness. Challenges to elective plan remain due to reduced activity from Expanse upgrade and ongoing industrial action. Staff still getting used to new Meditech system which in its infancy is slower therefore taking longer to process patients, particularly in ED but working through tactical command to ensure dedicated Digital support for this. Change in model from EDU to PAU has reduced the number of EDU beds from 12 to 2 which is impacting speciality patients that are waiting longer in ED and may impact overall ED performance. Working through the PAU project group to look at options for this that may include developing a surgical decisions unit.

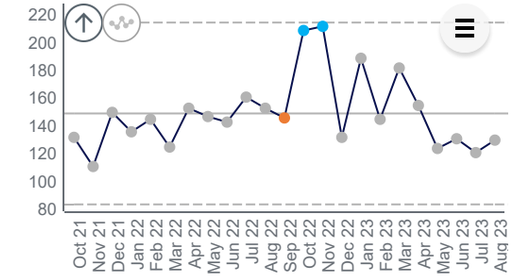
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

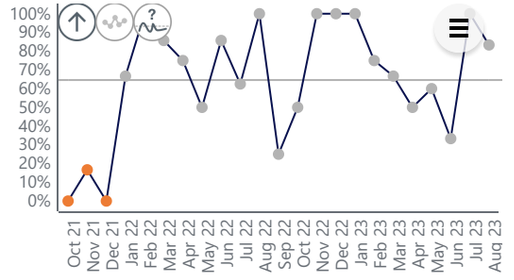
Number of Incidents rated Minor Harm and above



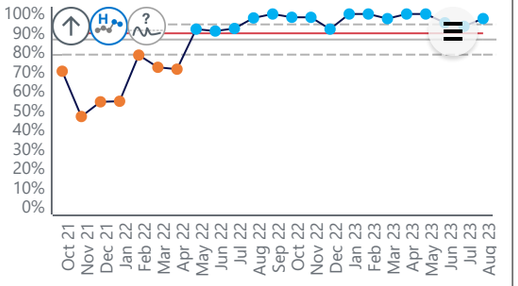
Number of Incidents rated No Harm and Near Miss



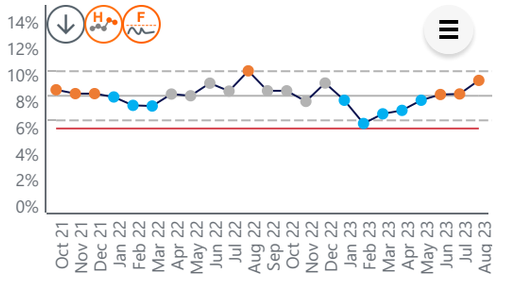
% Complaints Responded to within 25 working days



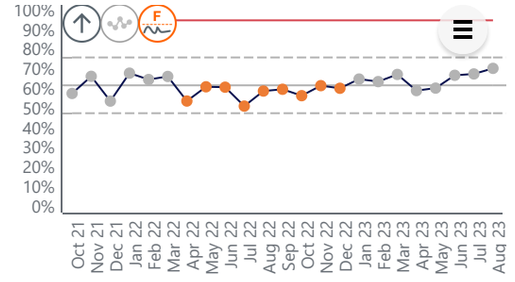
% PALS Resolved within 5 Days



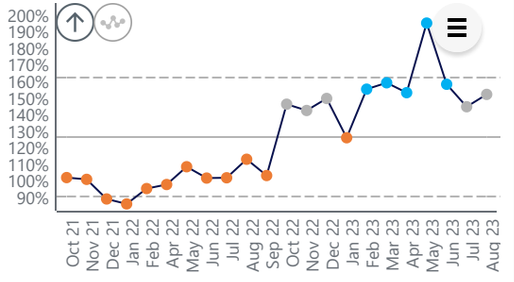
% Was Not Brought Rate (All OP: New and FU)



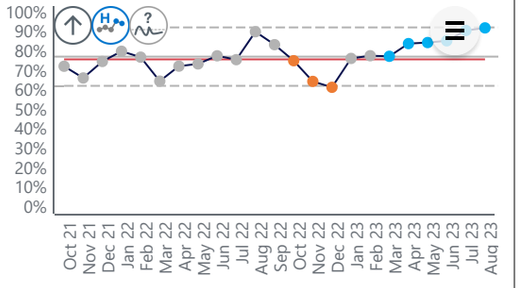
% of Clinical Letters completed within 10 Days



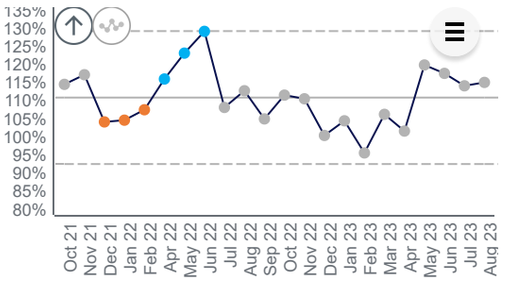
% Recovery for OP New & OPPROC Activity Volume



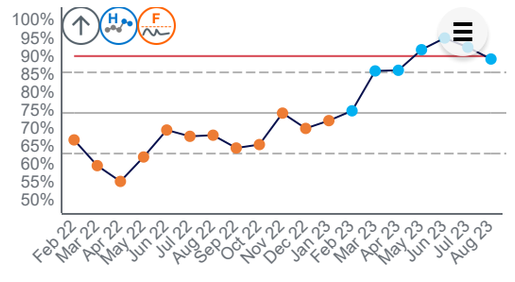
ED: % treated within 4 Hours



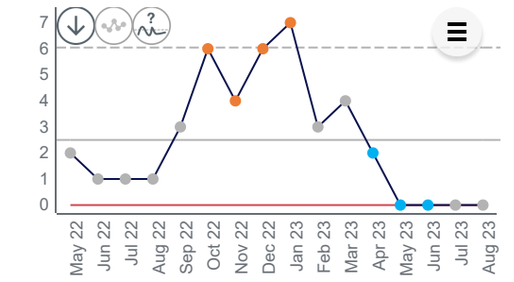
% Recovery for DC & Elec Activity Volume



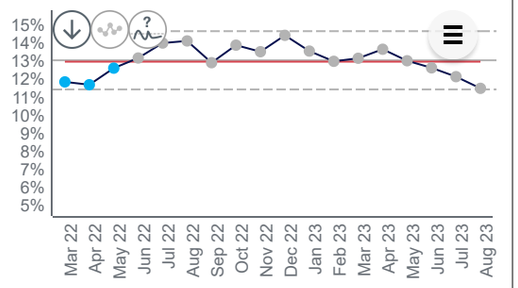
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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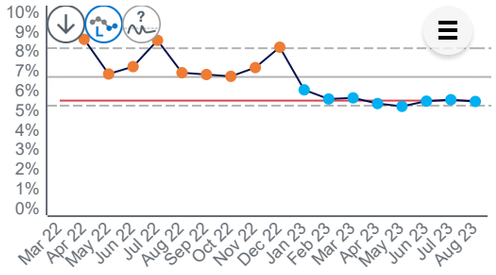
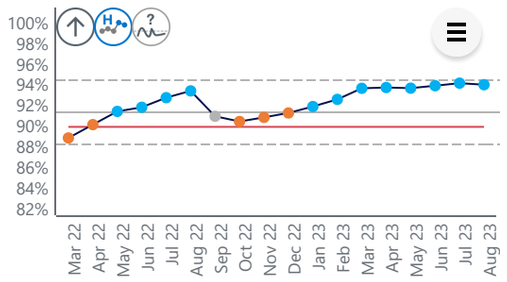
Divisional Performance Summary - Medicine

Sickness Absence (Total)



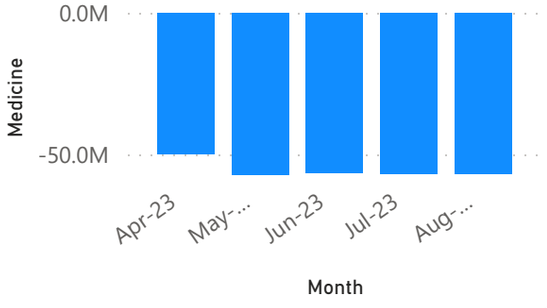
Mandatory Training



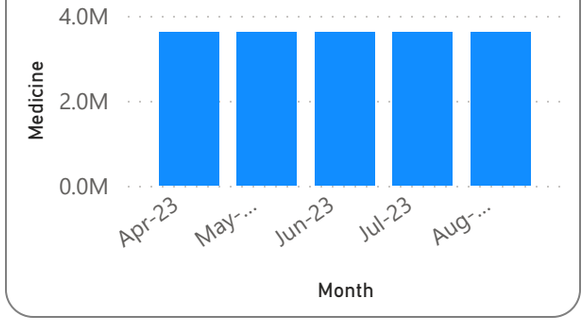
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

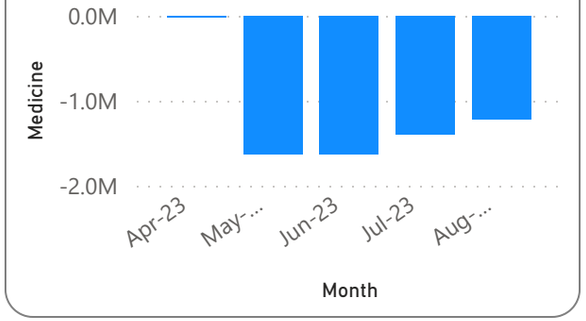
Revenue Position (Year End Forecast)



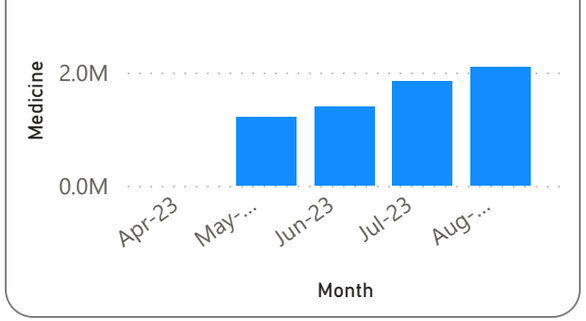
CIP Position (Recurrent Full Year Effect)



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 within the division with response targets for PALS and formal complaint.
• % Recovery for OP New and OPROC was above target and saw an increase in month at 106% which is a significant achievement with ongoing impact of Industrial Action
• % Recovery for DC and Elective activity increased in month at 91%. Whilst below target, this is a significant achievement based on the number of elective cancellations due to ongoing Industrial Action. 86 elective operations were cancelled in M5 due to lost capacity.
• In month improvement in Theatre touch time utilisation at 75%. Uncapped utilisation continues to align more closely showing an improvement in overruns.
• Sickness absence decreased in month in line with trust average. Decrease in long term sickness with improved management of cases.
• Rolling staff turnover rate continued to reduce in M5 and is now in line with trust average for the first time since October 2022. Plans are in place to continue to reduce this rate with a particular focus on retention improvement schemes.
• The number of patients waiting over 65 weeks decreased for the second month to 150 patients. The majority of patients are awaiting intervention from ENT or Dental and both have plans to even further increase capacity.
• Mandatory training compliance increased in month and continues to be above trust target.
• The division exceeded CIP target delivery in M5.

Areas of Concern

• % Clinical letters signed within 10 days remains static. Significant improvement in some areas- particularly Audiology and Dentistry. Challenges remain in a few key areas- those most affected are those with high volume pressures- Orthopaedics (fracture), ENT and Cardiology.
• Although sickness absence reduced in M5, we had a significant challenge with short term sickness within theatres which has continued into September, leading to loss of planned theatre sessions.
• Although the number of patients waiting over 65 weeks decreased in month, this remains an ongoing risk to achieve 0 by March 2024 due to ongoing strike action. Currently due to lost capacity our trajectory for Spinal electives shows that we will not achieve 65 weeks and there are ongoing mitigating actions being put in place which will be discussed further at Operational Delivery Board in October.
• Diagnostics completed within 6 weeks remains static in M5 which is due to some lost capacity within radiology due to the strikes and some required improvement work within Cystoscopy.
• WNB increased significantly to 11%. Areas of challenge: Community Ophthalmology, Audiology, Burns, Fracture. There was a high in month WNB rate in Cardiac Surgery which is unusual and is being reviewed.
• Revenue position (both YTD and year end forecast) are below plan which is mainly related to ongoing industrial action. YTD we have £0.8m expenditure relating to step down cover and an income loss of £1.8m.

Forward Look (with actions)

• Return to work compliance continues to be a specific area of focus within the division with increased support from HR team.
• Specific focus on specialities with lower theatre touch time utilisation and therefore opportunity around productivity. These specialities will feed into weekly Task & Finish group. Continued work on reviewing Orthopaedic trauma capacity as this continues to significantly impact their elective capacity and touch time data.
•Continued focus on specialities with high WNB rate which is part of an A3 brilliant basics improvement plan.
• Division continues to monitor lost activity & income via divisional tracker due to ongoing Industrial Action
• Continue to action plans around increasing capacity for Spinal, ENT and Dental long waiting patients via both additional in week sessions, WLI activity and insourcing support.
• Improvement work continues within Diagnostic areas (mainly Cystoscopy) to bring division back to compliance by November.
• Those clinical areas with significant volumes of unsigned letters have specific actions plans as issues are varied relating to individuals, junior doctor processes and volume of trauma (Orthopaedics). The division has an A3 improvement plan which is being monitored but there are remaining trust wide issues that are under review.
•A3 action plan in place to improve compliance with unsigned letters, actions include: 1 page guide created for clinicians to support dictated not signed option, new process implemented to mitigate junior doctor changeover, engagement with PCOs around outstanding actions which causes delays in signing, request for slot on junior doctor induction.
•Continued actions around improving year end financial position, with a particular focus on CIP delivery and areas of expenditure outside of budget. The division has implemented new controls around discretionary spend with increased levels of authorisation.

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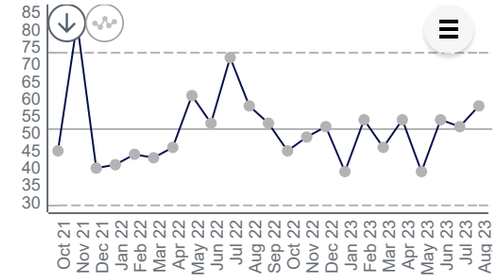
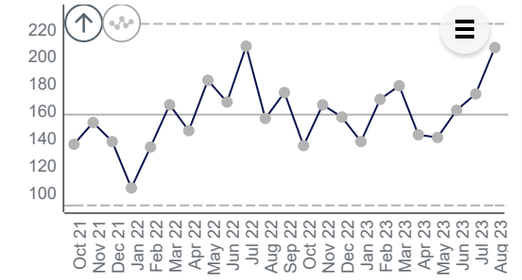
Divisional Performance Summary - Surgery

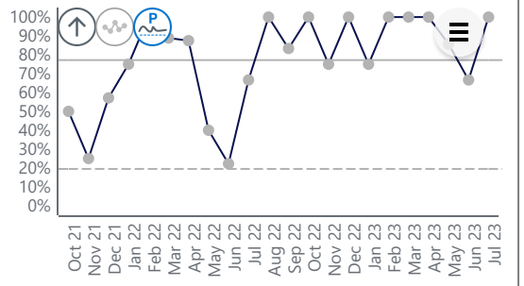
Number of Incidents rated Minor Harm and above



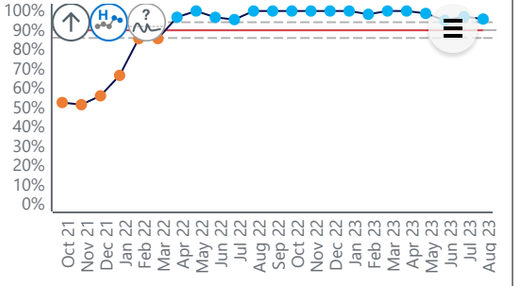
Number of Incidents rated No Harm and Near Miss



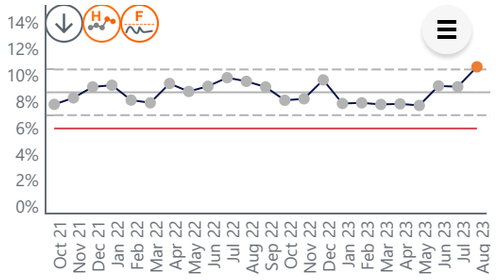
% Complaints Responded to within 25 working days



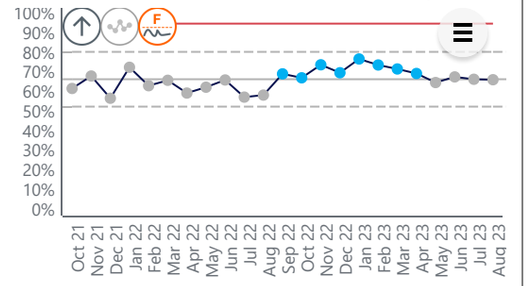
% PALS Resolved within 5 Days



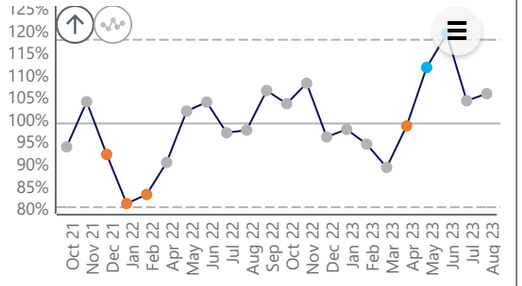
% Was Not Brought Rate (All OP: New and FU)



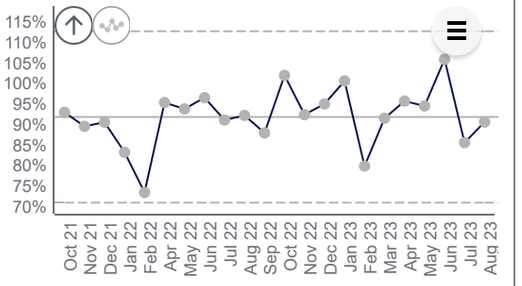
% of Clinical Letters completed within 10 Days



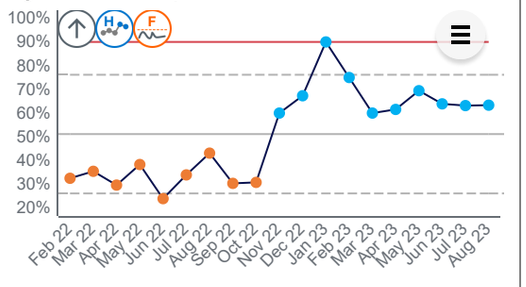
% Recovery for OP New & OPPROC Activity Volume



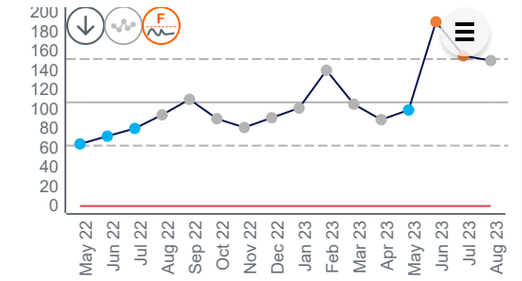
% Recovery for DC & Elec Activity Volume



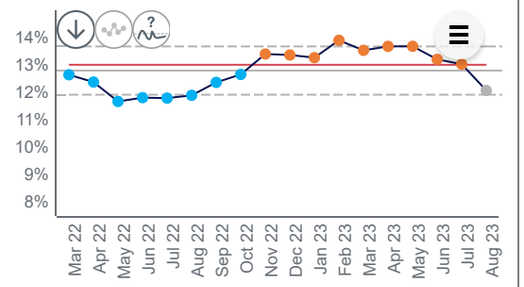
Diagnostics: % Completed Within 6 Weeks of referral



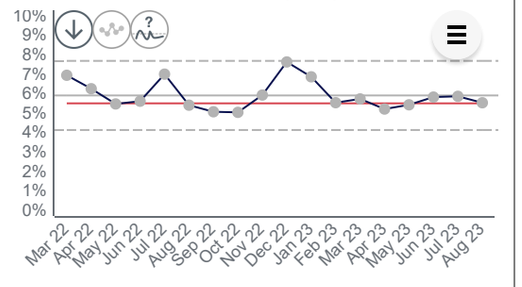
Number of RTT Patients waiting >65 weeks



Staff Turnover



Sickness Absence (Total)



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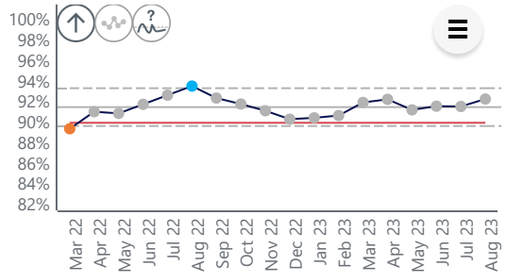
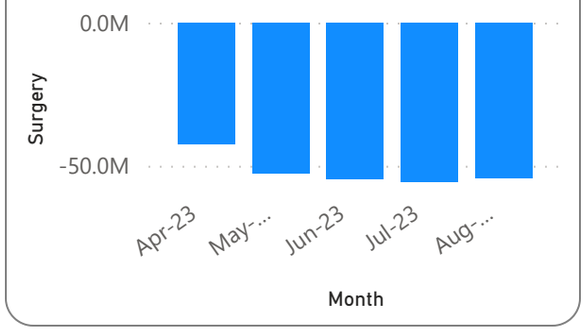
Mandatory Training



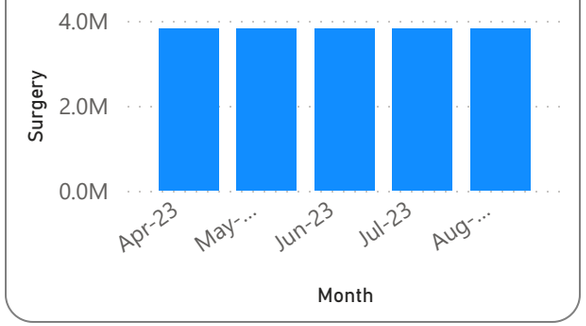
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

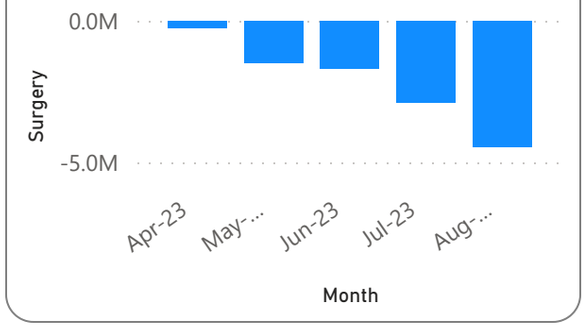
Revenue Position (Year End Forecast)



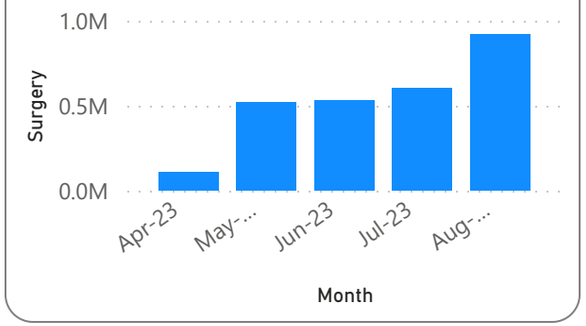
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

• Research Strategy - Patient and Public Involvement and Engagement activity to inform research strategy including engagement with children and young people and PI community.

• Patient Experience - New research patient experience feedback platform attracting increased number of responses.

Areas of Concern

• Study Recruitment - Recruitment of participants to studies is off-track.

• Support Levels - Reduced support from some clinical support services impacting pace of study setup and opening.

Forward Look (with actions)

•Study Recruitment - Engagement with study teams re study recruitment performance and engagement with PI groups to review study performance and expectation to see updated recruitment strategies

•Support Levels - Engagement with support teams re prioritisation. Evaluation Survey underway to understand barriers and how we can work more efficiently to confirm capacity for study support.

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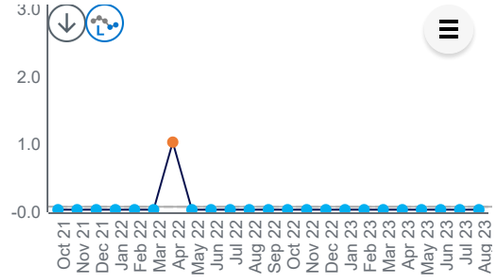
Divisional Performance Summary - Clinical Research

Number of Incidents rated Minor Harm and above



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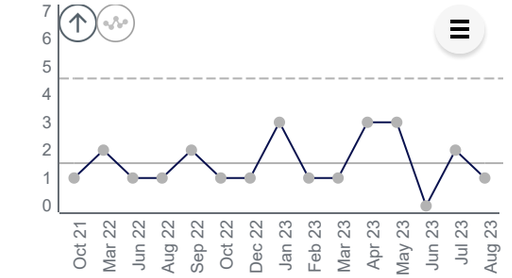
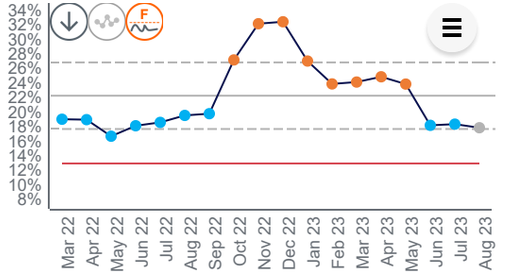
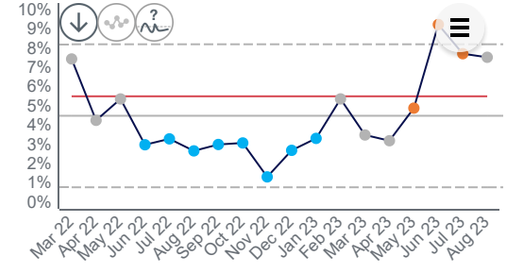


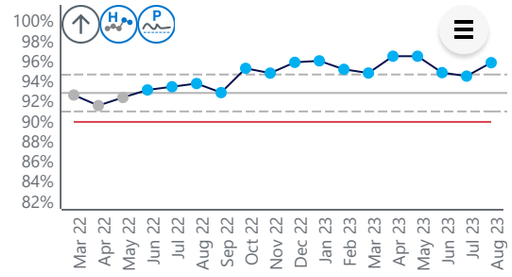
Staff Turnover



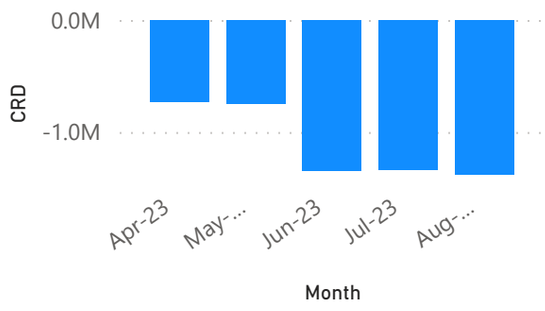
Sickness Absence (Total)



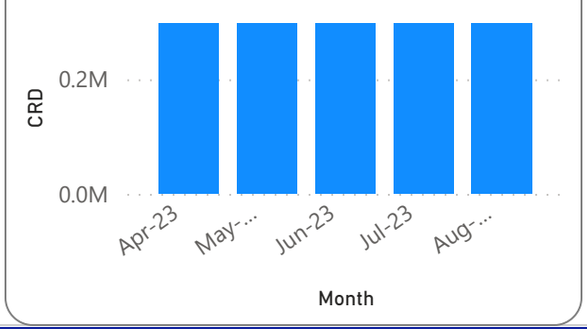
Mandatory Training



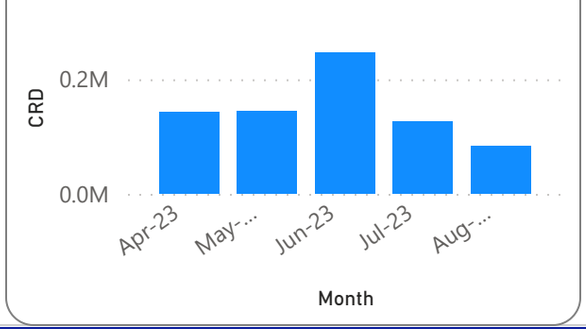
Revenue Position (Year End Forecast)



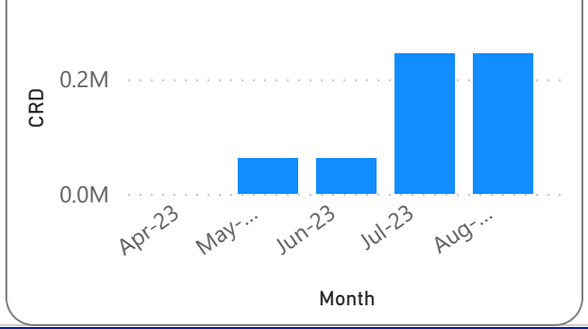
CIP Position (Recurrent Full Year Effect)



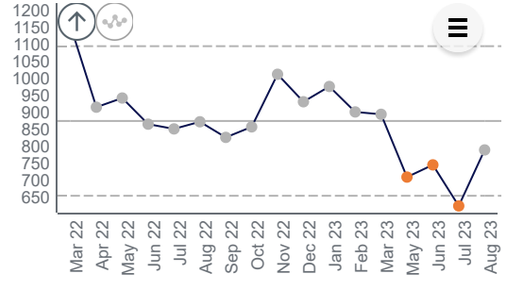
Revenue Position (Variance to date)



CIP Position (Delivered to date)



Number of Patients Recruited into Research Studies



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 August 2023:

• Mandatory training for Corporate Services remains above the 90% target at 93% • Short term sickness absence is currently sitting at 1% • Income at M4 was ahead of plan • 93% of CIP already identified and/or delivered

Areas of Concern

Long term sickness absence currently sitting at 4%, despite this being under the Trust threshold this remains an area of focus within the Collaborative

Forward Look (with actions)

Return to work compliance has been a specific area of focus with compliance consistently around 80% since September 2022, work is ongoing to increase compliance to meet Trust target. This month compliance sits at 75%. Reports are shared with managers to highlight absences where RTW shave not been recorded.

NHS
Alder Hey Children's
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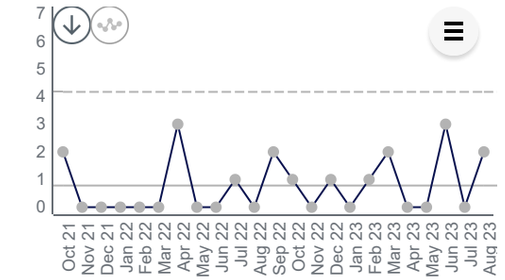
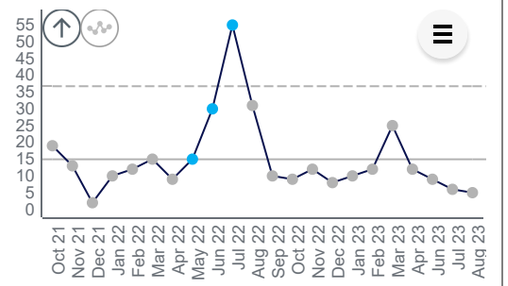
Divisional Performance Summary - Corporate

Number of Incidents rated Minor Harm and above

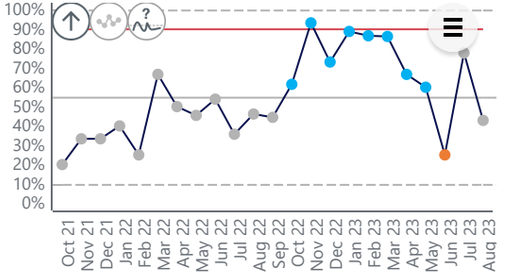


Number of Incidents rated No Harm and Near Miss

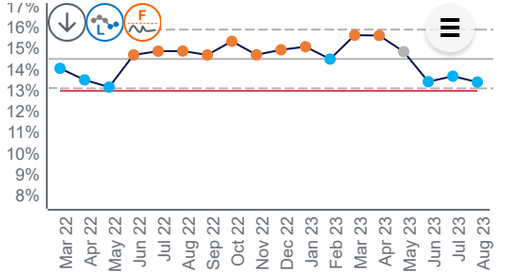


% Complaints Responded to within 25 working days

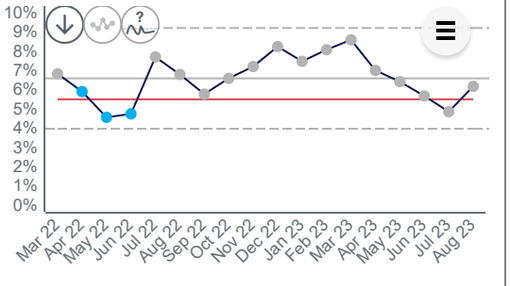
% PALS Resolved within 5 Days



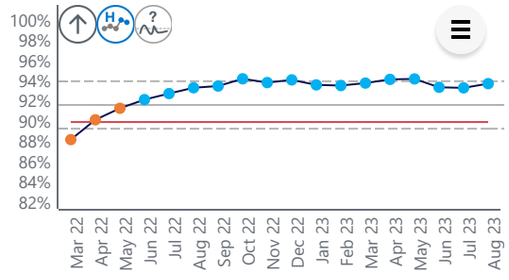
Staff Turnover



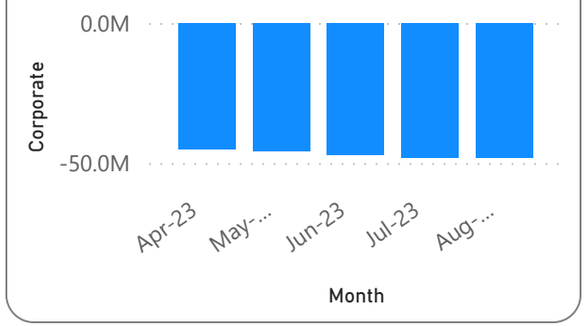
Sickness Absence (Total)



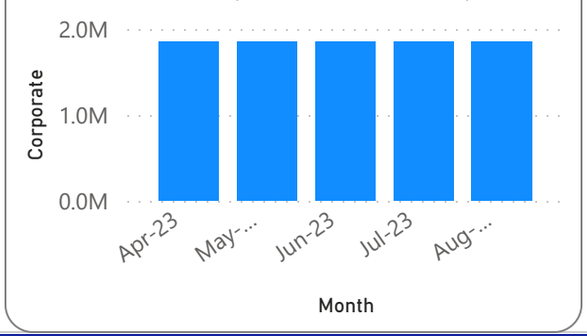
Mandatory Training



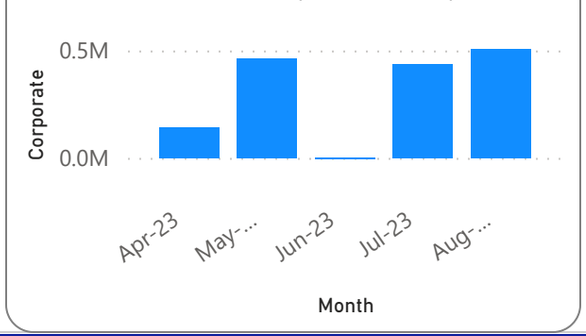
Revenue Position (Year End Forecast)



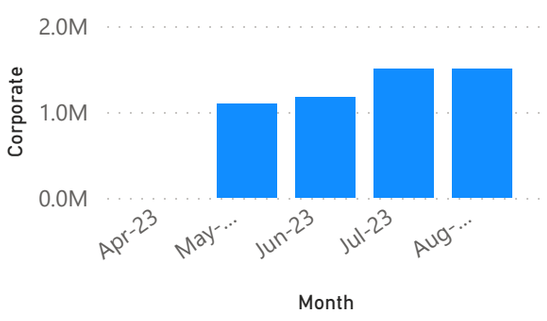
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Safe Staffing & Patient Quality Indicator Report
May 2023 Staffing, CHPPD and benchmark
September 2023 Board Paper

	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	98%	-	100%	-	2014	75	26.85	17.38	-1.00%	0.00%	0.00%	0.00%	3.01%	0.00%	5	17	0	1	7	100%	0	0
HDU	70%	94%	63%	103%	7360	313	23.51	32.33	6.00%	-4.00%	0.67%	0.00%	4.95%	1.09%	12	29	0	2	2	100%	1	0
ICU	84%	144%	84%	100%	17938	421	42.61	32.33	9.00%	0.00%	0.00%	0.00%	9.43%	0.00%	11	53	0	1	3	66.67%	2	2
Ward 1cC	86%	94%	83%	83%	6854	471	14.55	7.88	2.00%	-4.00%	3.54%	0.00%	3.95%	23.11%	5	24	0	6	5	100%	0	0
Ward 1cN	67%	33%	83%	-	4686	213	15.10	15.10	15.00%	5.00%	0.00%	0.00%	0.95%	0.00%	1	11	0	7	1	100%	0	0
Ward 3A	91%	74%	94%	100%	7476	680	10.99	10.94	-10.00%	3.00%	0.00%	0.00%	9.56%	13.92%	4	20	0	4	38	97.37%	2	0
Ward 3B	70%	73%	69%	-	4292	262	16.38	15.62	3.00%	-14.00%	2.53%	0.00%	8.56%	42.92%	3	3	0	5	8	100%	0	0
Ward 3C	88%	88%	80%	122%	8504	736	11.55	10.17	6.00%	1.00%	0.00%	0.00%	5.54%	16.79%	9	35	0	0	12	100%	1	0
Ward 4A	81%	62%	81%	81%	7816	722	10.82	10.91	7.00%	-2.00%	0.00%	0.00%	7.24%	3.01%	8	27	0	1	29	89.66%	0	0
Ward 4B	66%	89%	55%	95%	8440	575	14.68	10.21	13.00%	-21.00%	0.00%	0.00%	13.68%	11.89%	6	42	0	1	7	85.71%	0	0
Ward 4C	87%	81%	87%	91%	7098	782	9.08	12.93	36.00%	-3.00%	0.00%	0.00%	5.04%	13.36%	22	89	0	2	31	90.32%	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

The over establishment on 3B for unqualified vacancies are the additional supernumerary staff who are awaiting a pin or occupational health clearance which has impacted the fill rate for registered as they are not yet counted in the numbers. During this month the ward has had to cover a high number of maternity leave posts and request additional bank shifts to cover the number of 1:1s on the ward. There was a slight increase in short term RN sickness and HCA sickness equates to 2.0WTE who were off for the whole of May, and 1 housekeeper on STS.

HCA sickness on 3C is high as a percentage but is only 2 members of staff.

Ward 4B RN sickness levels have reduced in May but remain high at 13.68%. Sickness for HCAs has increased to 11.89% however it equates to 2.45 WTE. 2.0 WTE RNs were also seconded to cover maternity leave roles on the ward. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention. The over establishment on 4B for unqualified vacancies, includes the international nurses awaiting a pin or occupational health clearance which has also impacted the fill rate for registered as they are not yet counted in the numbers. The ward has also had to cover a high number of maternity leave posts, 4.84 WTE RNs and 1.53 WTE HCA.

Ward 4C continue to have a high RN vacancy rate, increasing to 36% in May due to high turnover rate. 9.0 WTE new staff have been recruited starting from October so this will slowly start to improve over the next few months. They also had 1.3 WTE HCA off sick and the over recruitment in HCA's is due to 1:1 cover.

Medication incidents on 4C continue to be notably higher than other areas but a deep dive into incidents shows mainly near misses and good reporting culture.

A weekly forward look meeting is established within the Division of Medicine to proactively move staff within the division to ensure safe staffing across all wards.

Surgery

Ward 1cNeo staffing is overseen by safer staffing and supported by the Liverpool Neonatal Partnership, with nurses being deployed from LWH if required. Recruitment for the new neonatal unit is ongoing, and supernumerary staff are allocated on to most shifts during the initial training period. Issues relating to staffing are discussed with the Surgical Matrons and support is offered where needed. All patients are nursed in line with BAPM standards, acuity information shared at all safer staffing meetings to ensure that staffing levels are supportive of patient acuity.

4A, 3A and 1CC have all had vacancy, LTS and maternity, this is expected to be a consistent theme until November. To mitigate, there are new starters commencing in post in October, following a period of induction and supervision they will commence in the numbers from November.

STS remains quite low and LTS is being managed with support from HR and in line with policy.

A weekly forward look meeting has been set up in Surgery to proactively move staff within the division to ensure safe staffing across all wards.

Critical Care

HDU continue to have a number of international nurses that are working as band 4 prior to gaining NMC registration. Three international nurses that started in April were still supernumerary in May, two of them have gone into the numbers in September and one of them is still training. An additional 3 international nurses started in July and will be supernumerary for some time.

HDU have ongoing RN vacancies that are presently being addressed recruited to which is largely why the fill rate is between 63% - 70%. In addition, they continue to have patients that required HCA 1:1's on the unit, as well as usual HCA workload and this accounts for the fill rate of 103% at night.

During May, ICU had significant sickness, both short term and long-term sickness. Vacancies remain high in May but are improving from August.

Summary

There are some differences in CHPPD benchmarks for the month of May. Wards 1cC, 4B, 4C, Burns, ICU and HDU are notable.

Burns CHPPD remains higher than the national benchmark, this is explained by Alder Hey incorporating a day case clinic nurse within the unit and numbers which is being addressed.

HDU CHPPD is lower to previous months, to note there are significant vacancies, international nursing waiting for a pin and sickness/maternity leave.

ICU during the month of May had reduced activity and patients resulting in higher than average CHPPD.

1C cardiac activity reduced in May again due to industrial action resulting in higher-than-average CHPPD.

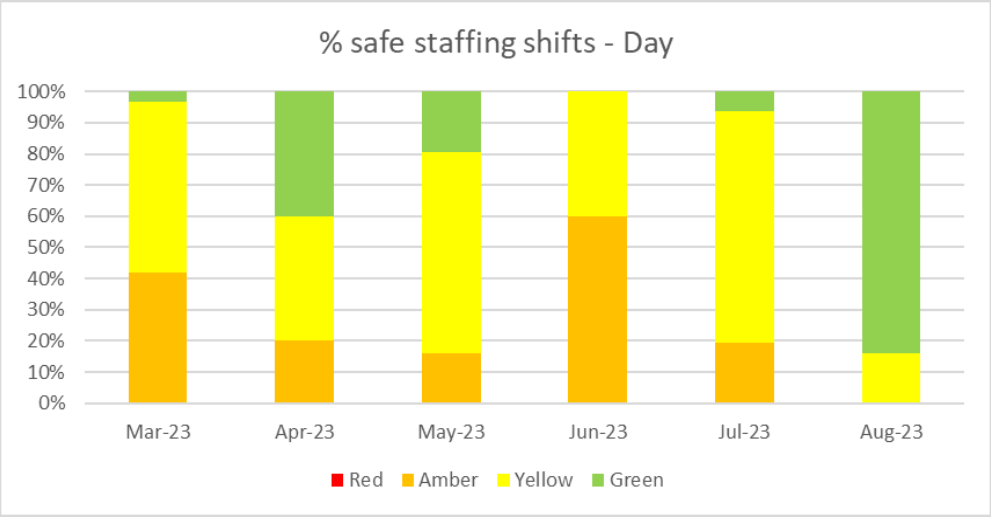
There is a consistent difference from the National benchmark for Ward 4B. Ward 4B has been consistently higher over the last few months. Deep dive into capacity and staffing has been undertaken and a full review of the nursing model is currently being undertaken with the aim to changing the nursing patient ratio. This is being piloted in August.

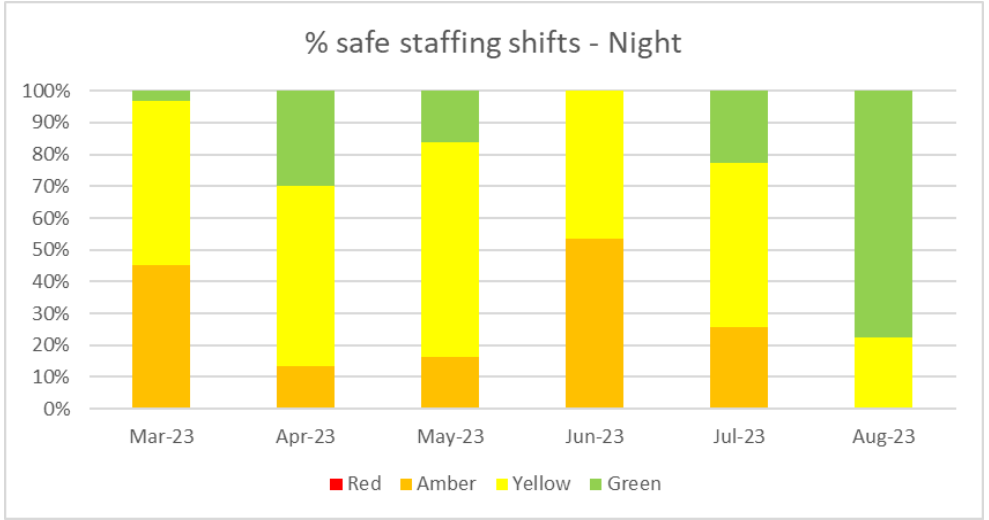
Wards 4C CHPPD is lower as was particularly busy during this period and were at full capacity with high acuity patients. This is a consistent theme and with the staffing review is being addressed.

During this period reported, staff moves on NHSP were not recorded on E-Roster.

<u>Summary of August 2023 staffing</u>

Staffing rag has improved during August with a big increase in green day and nights. 0 red days have been recordered since November 2022.





BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Winter Plan 2023/24**
Report of:	The Trust's Winter Plan 2023/24 noting key initiatives to manage anticipated demand.
Paper Prepared by:	Sian Calderwood, Senior Divisional Manager- Medicine

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The report provides an overview of the Trust's Winter Plan for 2023-24 including high impact schemes in place to manage the anticipated demand.
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:	

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

0065

Alder Hey

Autumn & Winter Emergency Response Plan

September 2023

Version 2

Contents

1. INTRODUCTION

Winter planning is essential to ensure we can safely manage the rise in emergency demand for health care services associated with the increase in prevalence of a range of winter viruses. Our planning scenarios include readiness for potentially higher rates of admission for children and young people experiencing winter viruses, above previous years. Maintaining access to elective services is a key priority too, given the increase in waiting list backlogs.

Seasonal influenza and other respiratory conditions, such as bronchiolitis and STREP A disproportionately affect children and young people (CYP), adding to the complexity of increased ED presentations and seasonal variations in admissions.

This plan therefore sets out the modelling, escalation framework and capacity interventions that underpin this year's winter plan. This plan is focused on delivering outstanding safe care for C&YP while also keeping our staff safe, through this period of higher demand.

1.1 Our goals

Our Winter Emergency Response Plan has four clear goals:

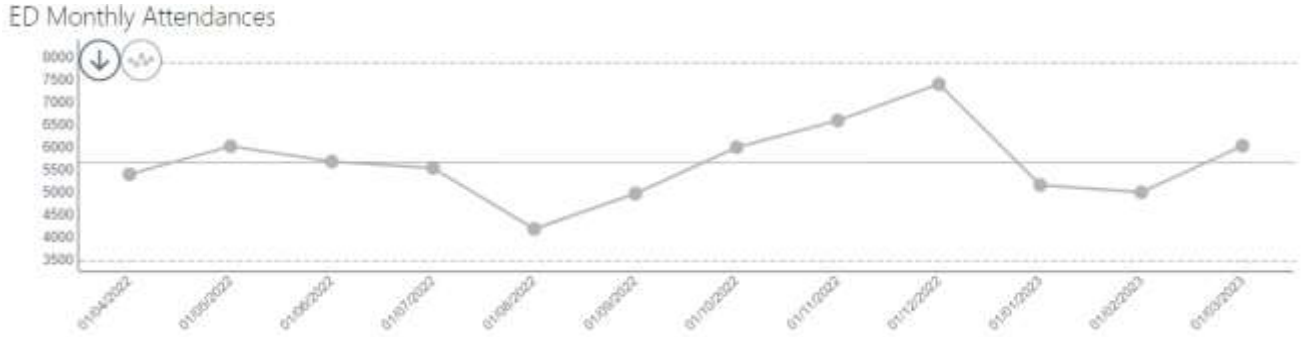
- Provide safe care
- Keep staff safe
- Deal effectively with increases and peaks in emergency demand
- Maintain elective care services

1.2 Key Principles

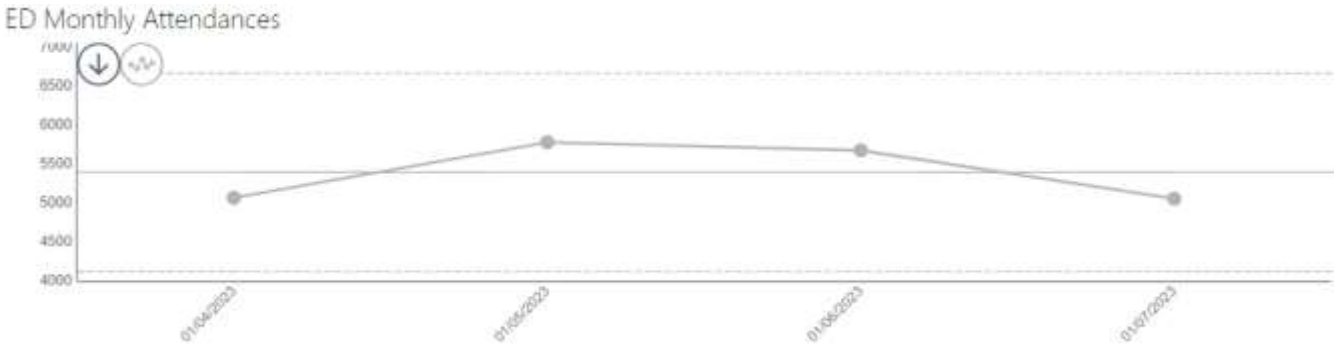
In order to achieve the goals established the plan is centred around four key principles.

1.3 Demand modelling

2022-2023 ED Attendances



2023 ED Attendances YTD

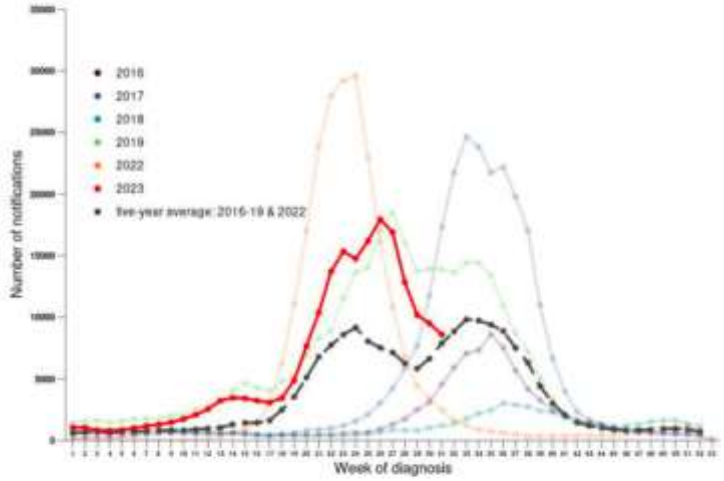


Year to Date average attendances are in line with 2022-23 at 5500 per month; however, it is not anticipated we will experience a respiratory surge as seen in Q3 2022-23. Based on information from Australia winter months.

1.4 Australian Influenza 2023

Positively, cases of influenza in Australia so far have been lower than 2022 season. However, the 2023 flu season there was similar to 2019 flu season, which saw the largest number of cases pre-pandemic.

Figure 3: Notifications of laboratory-confirmed influenza, Australia, 1 January 2016 to 6 August 2023, by year and week of diagnosis*



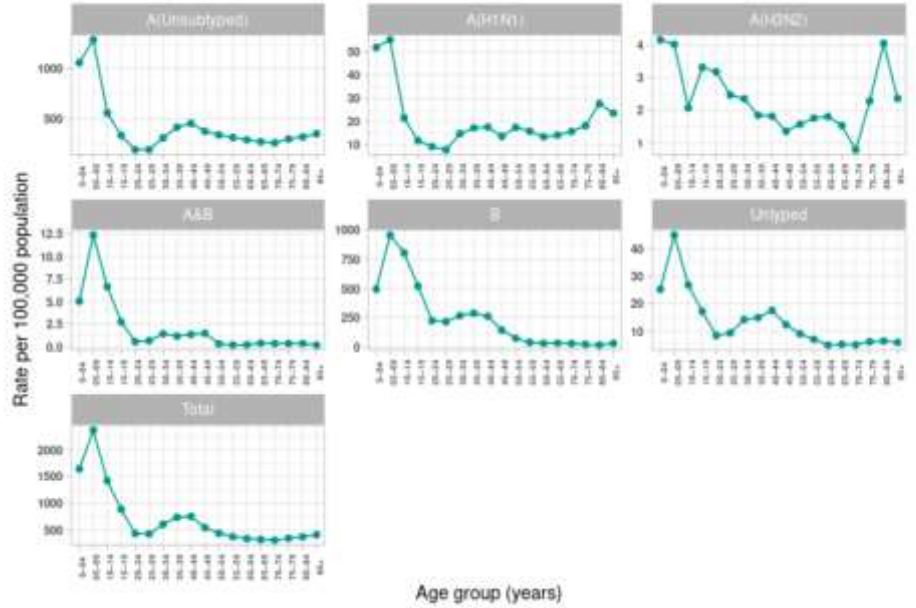
Source: NNDSS

*NNDSS notification data provided for the current and most recent weeks may be incomplete. All data are preliminary and subject to change as updates are received, with most recent weeks considered particularly subject to revisions. The years 2020 and 2021 are excluded when comparing the current season to historical periods when influenza virus has circulated without public health restrictions. Please refer to Data considerations for interpretation of the five-year average.

Unfortunately, the 2023 Australian flu season had a disproportionate impact in children (80% of admitted cases to hospital were children). In Australia they argue that the low immunisation rates in children was the underlying reason (in 2020, 40% of children <5yrs were vaccinated for flu compared to 20% now).

This signals the urgent need to increase a comprehensive vaccination program.

Figure 7: Rate of notifications of laboratory-confirmed influenza, Australia, 1 January to 6 August 2023, by age group and subtype*



Source: NNDSS
*All data are preliminary and subject to change as updates are received.

Alder Hey Children's NHS
NHS Foundation Trust

2. NATIONAL URGENT AND EMERGENCY CARE RECOVERY PLAN

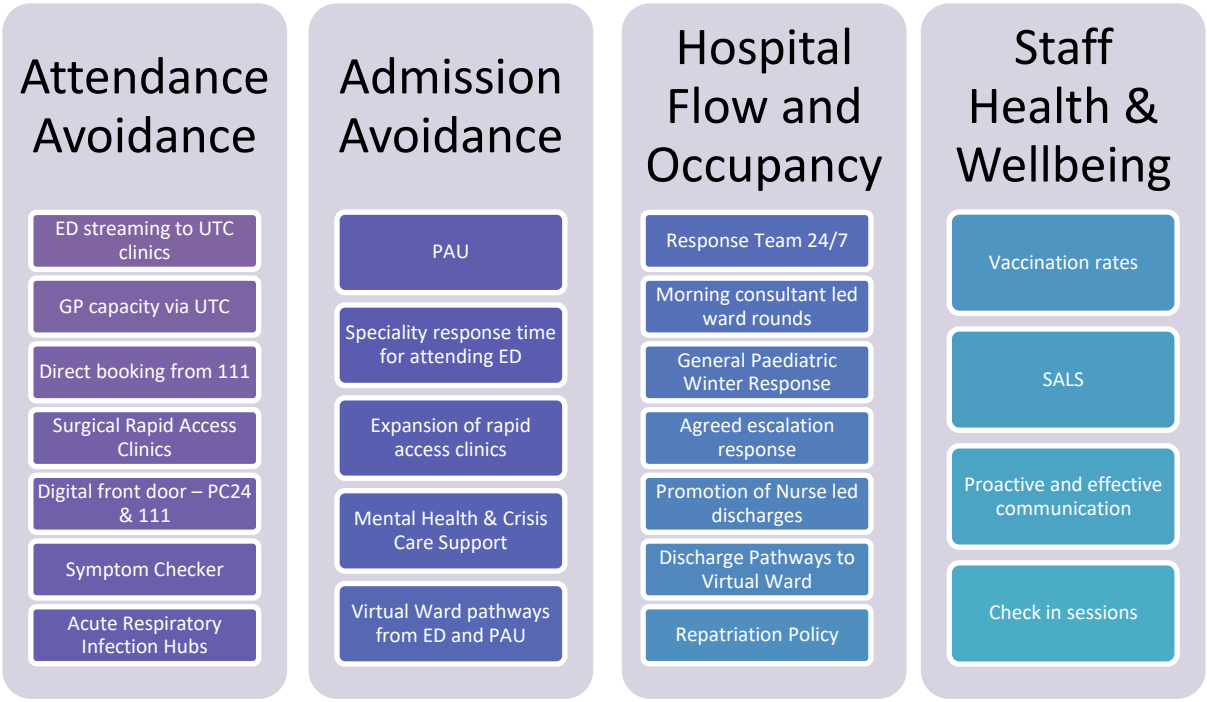
This year's national winter plan is based on the Urgent and Emergency Care (UEC) Recovery Plan issued earlier in the year. The 10 key pillars for improvement are noted below. Although not all are relevant to Alder Hey as a Paediatric Trust, those that are play a key role with our high impact schemes this winter.

Those schemes highlighted in green are noted as the national priorities for implementation this winter. Alder Hey have winter initiatives which fall under 3 of the 5 priorities for this winter: Same Day Emergency Care Pathways, Virtual wards and Acute Respiratory Infection Hubs.

- **Same Day Emergency Care**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
- **Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
- **Inpatient flow and length of stay (acute)**: Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
- **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
- **Care Transfer Hubs**: Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
- **Intermediate care demand and capacity**: Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
- **Virtual wards**: Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
- **Urgent Community Response**: Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
- **Single point of access**: Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
- **Acute Respiratory Infection Hubs**: Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

3. HIGH IMPACT SCHEMES AND INICATIVES

Based on the UEC Recovery Plan and following regional engagement sessions, the table below provides an overview of the high impact schemes and initiatives developed and implemented this winter at Alder Hey.



3.1 Attendance Avoidance

ED Streaming to UTC clinics- This winter we have a full year effect of the Urgent Treatment Centre (UTC) whereby the Emergency Department can stream (divert) C&YP to appointment slots if they meet the low acuity criteria. The streaming is conducted by a senior registered nurse or consultant to ensure the most appropriate C&YP are seen in the most appropriate location by the most appropriate staff group. Consultant presence streaming at the front door will be extended this winter to ensure senior decision making early on in C&YPs pathways to ensure they see the 'right clinician in the right location' to best meet their needs. This will reduce the number of C&YP needing to be seen within the ED department also supporting with risks of overcrowding.

Primary Care Streaming- We continue to utilise the primary care clinicians on site based from the UTC ensuring a high proportion for low acuity presentations are directed from the Emergency Department to appointment slots in the UTC. From October- March Primary care capacity will also increase to support with the anticipated increase in demand.

Direct Booking from 111- We are exploring the ability for 111 to book direct into appointment slots in the UTC to avoid C&YP and their families attending the emergency department directly. Supporting with the management of flow and capacity and ensuring the most appropriate staff group see the most appropriate patient cohort. We anticipate a commencement date of October 2023.

Surgical Rapid Access Clinics- We established surgical rapid access clinics from July 2023 running three days a week from the UTC to support with demand management for Paediatric Surgery. If C&YP attend ED and meet the criteria, they will be scheduled into an appointment slot with an associated ultrasound scan to manage patient demand and presentations more effectively. The clinics are ran by the surgical APNP from the UTC, Monday, Wednesday & Friday.

Digital Front Door – This winter we are collaborating system wide with external partners to ensure our digital Urgent and Emergency Care offer if effective for C&YP across Liverpool. Alongside PC24, 111 and the Paediatric Network operating the Paediatric CAS we are mapping the current service offer available in C&M, before identifying gaps and considering which organisations are best suited to mitigate with collaborative support. The aim of this scheme is to keep C&YP at home once they have made contact with an already established digital offer. The current offers are anticipated to be expanded with a proposal expected to be in place by the end of September 2023.

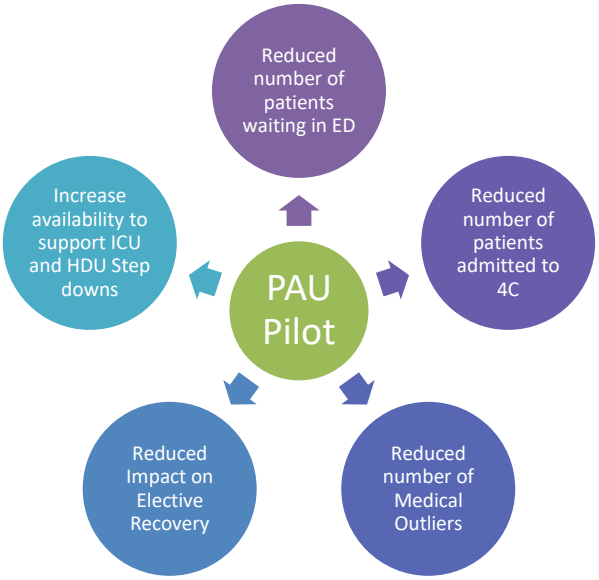
Symptom Checker- The already established symptom checker will be promoted and further developed this winter to support self-care and management at home, while also directing C&YP and their families to the most appropriate services available.

Acute Respiratory Infection Hubs- The Hubs are scheduled to be live by the end of October. The all age hubs were established across C&M last year following the increase in respiratory demand. The Paediatric hub for Liverpool was established at AHCH last year; however, through collaboration with system partners we are mapping out whether the hubs should be community based for this winter keeping care closer to home.

3.2 Admission Avoidance

Paediatric Assessment Unit (PAU) - The PAU pilot launched 8th August and is intended to reduce the number of admissions to wards through a thorough assessment pathway led by Consultant Paediatricians and ACP's. The unit operates 24/7 and will also accept direct admissions from community services including primary care. Ward occupancy and LOS (4C) is being monitored during the pilot ahead of peak winter months. The unit's success will also be measured by the anticipated reduction number of paediatric outliers in surgical beds due to high occupancy on 4C. The PAU repurposes the original EDU (short stay ED assessment beds) into a fully operational

24/7 medical assessment unit. Key impact statements from the pilot are summarised in the diagram below.



Speciality Response Time to ED – we have initiated conversations across specialities to ensure we have agreed response times of speciality teams to attend ED to review their patients with the aim of reducing the time C&YP wait in ED.

Extension of Rapid Access Clinics – considering the development of a surgical rapid access clinic we have approached other specialities across both divisions to consider any further requirements anticipated this winter.

Mental Health

The Crisis Care Team provide a 24/7 service to C&YP experiencing a mental health crisis, as well as parents/carers and professionals involved in their care, with the aim of avoiding attendance at ED. The service also offer an intensive support and home based treatment service, to support children and young people who are on the brink of admission, to avoid the need to admit to a paediatric ward.

Virtual Ward - Another key element of our plans for this winter period is ensuring that care is delivered as close to home as possible. This ensures that bed spaces at Alder Hey are free for those C&YP who need them most, and that C&YP who need care across the healthcare system this winter have it delivered in the most co-ordinated way possible. For winter 2023/24 the virtual ward capacity has increase from 15 to 20 beds through non-recurrent ICS funding.

There are several elements to this scheme:

- Condition specific virtual ward that link community care teams with specialist teams on Alder Hey site
- Development of hybrid model of care offer through to extend virtual ward offer to other services

- GP referral scheme to Alder Hey Community nursing teams to avoid admission.
- CCNT staffing resilience for complex discharge caseload
- CCNT led community drop-in clinics to support admission/attendance reduction

The model is summarised below:

New pathways to the virtual ward have been developed for this winter to improve flow out of the Trust from PAU, General Paediatrics and Complex Medical Specialities. Further conditions and pathways are being explored and developed.

3.3 Hospital Flow and Occupancy

Response Team 24/7- This winter we have a fully established Response Team and Bed Management team who will be working to well established patient flow systems, processes and policies (see section 3). We therefore have Senior Site Practitioners on site 24/7, working alongside Bed Managers to minimise delays in the elective and non-elective pathways.

Morning Consultant led ward rounds- Ensuring all key specialities have consultant led ward rounds held in the morning rather than the afternoon, learning from the periods of industrial action, recognising that senior clinical decision making earlier in the day has improved in the number of discharges earlier in the day which inevitably improves Trust occupancy and flow.

General Paediatrics Winter Response – with the development of the PAU Pilot this winter the General Paediatric Team aim to reduce the number of patients admitted to the acute medical ward by promoting a short stay quick turnaround pathway from PAU. The team have increase the senior consultant cover for PAU 5 days a week ensuring senior decision making early on in C&YPs pathways. In addition, if the trust escalates and an increase occupancy level is met for the volume of General Paediatric Patients on the Post Take Ward Round a second consultant will be assigned to support the

ward round to avoid decision making delays and support flow out of the hospital. This will be escalated by the Consultant on call for the Post Take Ward Round.

Promotion of Nurse Led Discharge- Recognising that improved flow and occupancy is associated with clear discharge planning which could be enabled with recognised nurse led discharge planning.

Agreed Escalation Response- Trust escalation response detailed in the next section; however, further operational escalation response has been established within the Emergency Department (ED) escalating to the ED manager of the day who will co-ordinate any escalation required across specialities or to the Hospital Manager of the Week if required.

Weekly LOS Meetings – The Medical Division has a well-established weekly LOS meeting chaired by Head of Nursing and attended by ward leads and the Complex Discharge teams. The Paediatrics Matron/Ward manager undertake daily huddles on 4C to review inpatients with an out of area (OoA) post code with a view to repatriation; bed managers actively manage repatriations to local DGHs once identified.

3.4 Staff Health and Wellbeing

Vaccination Rates - On the 10th August the government released details of the Autumn/Winter (AW) 2023-24 Flu and COVID-19 Seasonal Campaign

The groups to be offered a COVID-19 booster vaccine are:

- Residents in a care home for older adults
- All adults aged 65 years and over
- **Persons aged 6 months to 64 years in a clinical risk group, as laid out in the Immunisation Green Book, COVID-19 Chapter (Green Book)**
- **Frontline health and social care workers**
- **Persons aged 12 to 64 years who are household contacts (as defined in the Green Book) of people with immunosuppression**
- Persons aged 16 to 64 years who are carers (as defined in the Green Book) and staff working in care homes for older adults.

The JCVI also advises primary course vaccination for individuals in the above cohorts who have not had any previous doses should be offered. They should receive a single dose of COVID-19 vaccine during the campaign period.

Eligible cohorts for the flu programme remain unchanged from those set out in the National flu immunisation programme 2023 to 2024 letter (here).

The age cohorts for flu and COVID[1]19 vaccinations have been aligned and will allow for co-administration. All those who turn 65 years by 31 March 2024 are eligible for both vaccinations.

All staff working in the NHS have a personal, moral and professional responsibility to ensure they do all they can to reduce the spread and transmission of respiratory viruses to those who are vulnerable, and to protect themselves from winter viruses through vaccination.

It is of paramount importance to vaccinate those at risk of contracting and spreading respiratory viruses in order to protect as much of the population as possible and minimise further impact on the NHS and social care.

In 2023-24 there are a range of vaccination activities which will help in the reduction of the spread of viruses.

Key points of the campaign this year:

- All health and social care staff will be offered a COVID-19 vaccination booster starting October 2023 and this will boost immunity against COVID19
- The flu vaccine will be offered to all school age children and young people through the school vaccination programme, opportunistic vaccination will be available in the OPD on site at AH.
- There is a requirement that 100% of AH staff are offered the flu vaccination. This will also include other members of the workforce, for example students and staff within our partner organisations
- Staff will be able to book their flu vaccine the first two weeks in October, with roving vaccinators in place in November.
- Increased numbers of peer vaccinators across the trust
- Live dashboard that will inform the flu steering group of registration status, completion of vaccination and areas of low uptake to be targeted in order to drive focus to the local delivery of the vaccinations
- Divisionally led plans and named leads to support direct and local communications to maximise uptake

SALS- Staff wellbeing support is included within a separate section below.

Alder Hey Children's NHS
NHS Foundation Trust

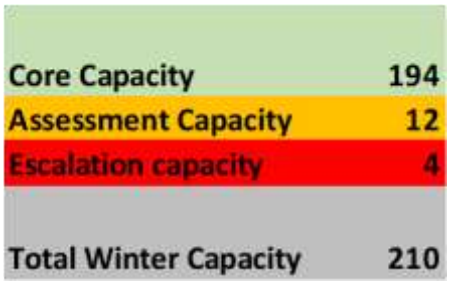
4. CAPACITY & ESCALATION PLAN

4.1 Trust-wide escalation framework

Measure	Green	Yellow	Amber	Red
Ambulance Handover (mean transfer time in mins)	< 15 mins	15-30 mins	31-60 mins	> 60 mins
Ed attends	160-170	>170	>190	>200
Time to initial assesment within 15 mins (% of patients)	> 95%	80%-95%	50% -79%	< 50%
Mean time to clinical assessment	< 60 minutes	60-90 minutes	90-120 minutes	>120 minutes
Mean time in department	< 4 hours	4-8 hours	8-12 hours	> 12 hours
Patient in ED over 12 hours	No patients at risk of 12 hour wait	Risk of one or more patients in next 2 hours	One or more patients waiting currently over 12 hours with plans in place	One or more patients waiting over 12 hours with no plans to resolve
ED room space occupied	< 80%	80-100%	100%	>100%
Resus occupancy	>1	1	0 but likely to be available in next 2 hours	0 and none available in next 2 hours
DTAs awaiting beds	<=10%	>10%	>20%	>40%
G&A Bed Capacity	<80%	>85%	>90%	>95%
PICU	>= 2 beds	1 bed open with at least one step down identified	1 bed with no step downs / no beds with 1 step down	No beds / No step downs
Staff absence	5- 7.5%	7.5- 10%	10- 17.5%	> 17.5%
Referrals (external admissions)	All have plans to admit	Referral waiting with no plan to admit	More than 1 with no plan to admit	More than 4 with no plan to admit
Outliers (% of inpatients)	<=2	>2-<4	>4<8	>8
Elective work	Proceeding	Under review with potential cancellations	Cancellation of routine electives	Cancellation of urgent electives

4.2 Additional Hospital Bed Capacity

The table below demonstrates the total winter bed capacity including escalation.



The location of all general and acute beds is noted below:

Ward	Baseline Capacity	Escalation Beds
1c Cardiac Ward	22	
1c Neonatal Ward	9	
3a (General Surgery) *reduces to 28 Sat/Sun	32	
4a (Neurology/Orthopaedic)	32	
3c (Specialist Medicine)	28	4
4c (General Medicine)	32	
3b (Cancer Services)	13	
4b (Complex Medicine)	21	
Burns Ward	5	
Total bed capacity	**194**	**4**

Compared to last year's 9, only four escalation beds are proposed for this winter. With a number of new schemes in place for winter predominantly focused around Admission Avoidance including the PAU & Virtual Ward, it is anticipated that we will require fewer escalation beds during peak seasonal months.

Ward 3A can flex Saturday night up to 4 extra beds, this was not required winter 22-23 and has implications for theatre starts Monday morning therefore will be avoided wherever possible.

Where low staffing availability or high patient acuity affects staffing levels and ratios and capacity requires review, the following process will be followed to request the closure of bed capacity: Opening and Closing of Wards Policy .

4.3 Paediatric intensive care unit and high dependency care

Our priority is to maintain, throughout the winter period, critical care services to children requiring emergency or urgent access. Therefore, our plans are centred on resilient staffing and service arrangements to provide care for paediatric patients and not adult patients. If the situation changes to a worst-case scenario either nationally or regionally, we will work with

colleagues in the network and support as needed based on the balance of clinical need across all age ranges.

	Level 3 beds	Level 2 beds	Total
A. Baseline (commissioned)	21	15	36
B. Severe pressure surge	23	18	41
C. Extreme pressure surge	28	20	48

There is physical space in critical care for 43 beds. Therefore, in level 3 'severe pressures' scenario it is possible to flex capacity up to 41 bed spaces (23 ventilated ICU + 18 HDU). This would be dependent on staffing levels with additional support to ensure safe nurse to patient ratios.

In extreme pressure the additional surge beds in reserve would be opened on the Burns Unit and a business continuity plan for Burns would be enacted re-providing the service in a Surgical Ward.

The staffing for the extreme surge beds would need to come from other departments across the trust, therefore there would need to be a reduction in elective activity to facilitate this.

4.4 Staffing Escalation

Daily Safer Staffing meetings take place to review nurse staffing levels and arrangements. Where possible the trust will work to maintaining the nationally recognised levels of nursing care. There may be times when the ideal nursing levels will fall short and then the Safer Staffing chair or out of hours is the 8a ANP for the ACT team who will make decisions to balance the risk across all areas of the organisation.

At times this may lead to working to alternative ratios. The ward mangers and senior nursing team have agreed the minimum staffing requirements which are articulated through a red, amber or green staffing model and describe the skill mix required for each ward. Where an alternative staffing model is in use the nurse in charge of the relevant area will need to make alterations to how staff work to facilitate safe care for all children and young people. This may involve, for example, the use of task allocation nursing. Core key standards relating to staffing will be maintained as referenced in the Respiratory syncytial virus 2021 preparedness Children's safer nurse staffing framework for inpatient care in acute hospitals (2021) which is supported by relevant professional bodies and trade unions.

The action card in section 8 refers to key actions required as the hospital flows through relevant escalation points. The monitoring of safer staffing is through the safer staffing meeting and is ultimately the responsibility of the Chief Nurse.

If the Trust is escalating through capacity levels staff may be required to change their working commitments to support The Emergency Department or Wards. All options will be considered via the Safer Staffing group; however, considerations would include:

- Staff in educational or training roles returning to patient facing roles
- A suspension of non-urgent meetings for clinical managers
- Requesting support from nurse specialities who are not usually base on the wards

All escalation protocols are included in the Trust Escalation Plan Trust Escalation Plan

5. PATIENT FLOW

A detailed Patient Flow Policy is in place.

The arrangements and routines for the management of patient flow (including transfers from critical care, emergency and elective admissions are managed as follows) are summarised below:

Daily Bed Meetings and Trust Status Report: Bed meetings run at 08:30 hrs, 12:00 hrs and 15:30 hrs. The aim of the daily bed meetings is to establish the predicted admission rates from an emergency and elective perspective and ensure patient flow is maintained by ensuring timely discharges and inter hospital transfers.

The bed meetings are chaired by the Bed Management Team and supported by the Hospital Manager of the Week.

Safer Staffing Huddle: This meeting runs prior to all the bed meetings to review nurse staffing across and agree the staffing models to be deployed. The meeting is chaired by a member of the trust's senior nursing team and attended by a matron from each clinical division. This staffing model confirms the staffing on each ward and advises it is safe to proceed with the established bed numbers for each ward.

Daily Forward Look/ Bed Meeting: At the 15:30 Bed Meeting, the next day's staffing, elective demand, and capacity is reviewed. This may mean that actions are required to expedite discharges, prioritise TCI's, and in extreme circumstances reduce elective admissions. These actions and decisions are taken by the Hospital Manager of the Week.

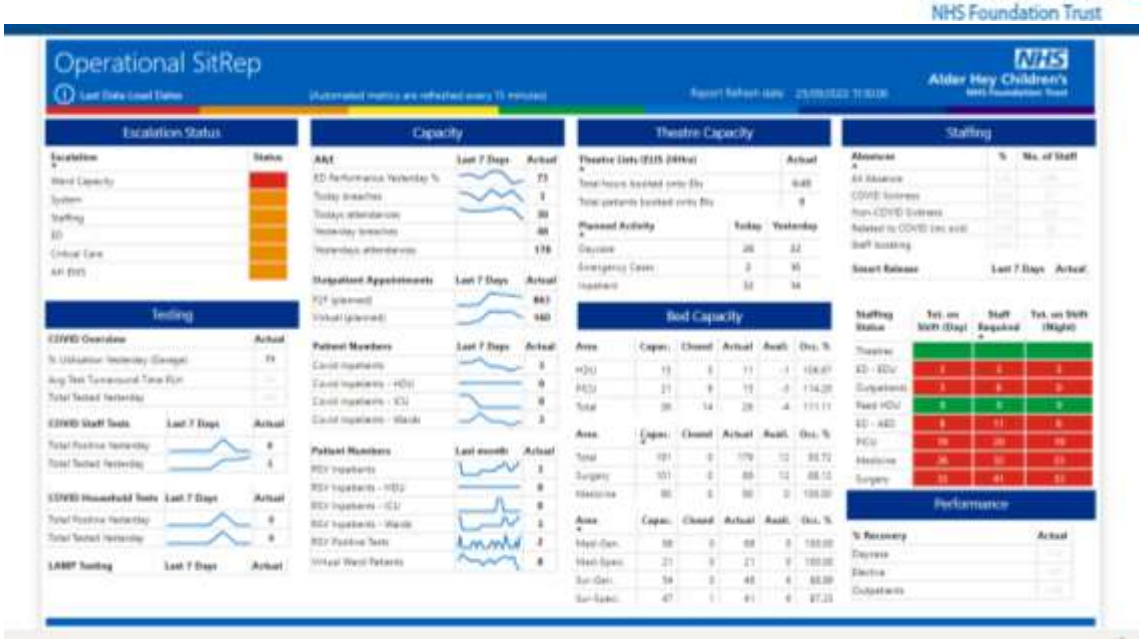
Emergency Department Safety Huddle: This daily meeting is held at 17:15 and is attended by the Senior Clinical Site Coordinator, Bed Management Team, Emergency Department Nurse in Charge, the Emergency Department Consultant in Charge, and the Senior Manager On Call when required.

Weekend Planning: Every Friday by midday a detailed weekend plan will be issued by the Bed Management Team.

Tactical Command: In periods of heightened and sustained levels of escalation the establishment of an operational Tactical Command Room will be deployed. This will run by a Tactical Commander appointed by the Chief Operating Officer.

Data monitoring:

To provide oversight of the Trust's level of escalation a Power BI app is available to capture and present the relevant information:



Management of Outliers: The Winter plan schemes aim to avoid C&YP placed in an 'outlying' acute bed; however, there may be occasions whereby suitable patients are admitted to wards where they would otherwise not be admitted due to bed availability. The Trust has agreed the following principles on the management of outliers:

- Wards will note any outlying patients at the start of each day to be reported at safer staffing meetings and identifying any needing priority for review. It is the responsibility of the ward to notify the clinical team, but Patient Flow should be informed to enable rapid escalation if required.
- Patients placed in an outlying bed will be moved to the ward originally requested at the earliest convenience with each patient being reviewed at the daily bed meetings.
- The plan to outly, and the timescales for moving to the most appropriate ward will be explained to the patient and family on admission.
- All clinical teams will have an agreed plan to review outlying patients as part of their daily ward round structure.

This is to ensure:

- Optimisation of patient care in the most appropriate clinical setting
- Staff familiarity with specialist medications patients may be on as part of their care
- Efficiency and timeliness of ward rounds for clinical teams

6. STAFF WELLBEING, SUPPORT & ADVICE

Key challenges

The NHS People Plan sets out the vision to create a healthy, psychologically safe, improvement-focused, compassionate, inclusive and learning culture to enable the delivery of outstanding care to our children and families. Key to the development and sustainability of such a culture are healthy, well-supported staff who feel safe, connected to each other and valued for their unique role in the delivery of care at Alder Hey.

During Winter months when demand for services is at its greatest there is never a more important time to ensure our staff are physically and mentally well. During this period the challenges in ensuring such are also greater owing to the pressures teams are working under to delivery safe care to an increase demand of C&YP. Owing to this several schemes have been drafted to support staff throughout this time.

Staff support at Alder Hey

At Alder Hey, staff have access to a range of support for their health and wellbeing including the Staff Advice & Liaison Service (SALS) (incorporating the Alder Centre staff counselling service), and Occupational Health services, Staff in Medical Specialties and Critical Care can also access support from Clinical Health Psychology services via Clinical Psychologists embedded in teams.

There is also a focus in SALS on systemic intervention, including team support following debriefs and training, and contribution to the development of a culture which challenges the stigma associated with help seeking in the healthcare and support services. Considerable focus is also given to supporting staff to both transition to and navigate through services, providing a “safety net” of support during what can be extremely difficult journeys and processes.

Feedback gathered has been overwhelmingly positive not only in terms of individual outcomes but also in terms of its impact on the wider organisational view of wellbeing. The service promotes the message “it’s OK not be OK” which has been helpful in promoting access to support and in reducing the stigma associated with help seeking and expressed vulnerability in health care professionals. The service has also attracted regional and national interest as a best practice model including funding to undertake research into its efficacy, effectiveness, replicability and scalability to benefit the wider health service and further develop the staff support evidence base.

An organisational health and wellbeing approach

Given the evidence and our learning to date through SALS and other support mechanisms in the organisation, we take an organisational health and wellbeing approach based on the NHSE Organisational Health & Wellbeing Framework (see below).

Staff Health and Wellbeing Initiatives for Winter

All areas recognise that ongoing and continuous wellbeing is important to support staff thought the winter period. A number of initiatives have been drafted and are continuing to be developed under the Trusts People Strategy, personalised to meet staff needs at the time of most demand.

Examples of schemes scheduled for implementation this winter:

1. Increase visible senior leadership- SLT will walk the floor on a scheduled plan to ensure all areas have the access and availability senior members of the team on a regular basis
2. Monthly Drop-in Sessions (Division of Medicine) will commence from September 2023 ensuring an ‘open door policy’ and accessibility for all staff within the division
3. Improving communication through monthly senior leadership video ‘Medicine Sound Bite’
4. Access to coaching and mentoring available across the Trust
5. Division of Medicine Wellbeing Week scheduled during the winter months providing access to information session, healthy eating, physical and mental health information and participation sessions
6. Festive calendar of events in the run up to Christmas and the New Year
7. Continue to embed team development initiatives through Team Away Days and Team Building Sessions both in house and externally supported.

Initiatives will be rolled out across divisions subject to staff need and personalisation based on teams demand.

7. DEPARTMENTAL ESCALATION PLANS

Departmental escalation plans (including for Paediatric Intensive Care Unit and the Emergency Department) are contained in the Trust Escalation Plan.

Winter at Alder Hey 2023-24

The presentation provides a synopsis of key initiatives in place this winter. All align with the National Urgent and Emergency Care Recovery Plan.

Attendance Avoidance

Scheme	2022/23	2023/24	Detail
UTC Appointments	Jan – March only	Full Year	80 appointments available daily
ARI Hubs	Jan – March Only	October – March	System wide collaboration to increase community access for CYP
ED Consultant Streaming	Ad Hoc	Mon-Fri rota shift into the evening	Monday, Tuesday, Wednesday cover until 22:00.
ED Weekend Consultant Shift 12:00-20:00	Ad Hoc	Saturday and Sunday shift every week	Increase in consistent weekend senior cover
ED Clinicians overnight	2 minimum	50% increase	5 nights a week rota'd into establishment with 2 nights covered with locum shifts
ED Senior Nurse Cover over night	3-5 nights a week	7 nights a week	Providing senior nursing leadership in ED 24/7

Admission Avoidance

Scheme	2022/23	2023/24	Detail
Paediatric Assessment Unit	0 beds	8 beds	Improved access to Paediatrics from Community settings and ED
Paediatric Consultant EDU/PAU	3 days a week	5 days a week	Monday – Friday consultant cover until 19:00.
Paediatric ACPs EDU/PAU	0	7 days a week	ACP cover 7 days a week
Virtual Wards	15 Beds	20 beds	Increased pathways to VW
Surgical Rapid Access Clinics		3x clinics a week	3 clinics established weekly from the UTC
Crisis Care Service	24/ 7 support for ED	24/ 7 support for ED	Essential support when C&YP experiencing a MH episode attend ED

Hospital Occupancy & Flow

Scheme	2022/23	2023/24	Detail
Response Team	5 days a week	24/ 7 cover	Supporting safe management and flow across the Trust
Repatriation Policy and Process (GM beds)	Implemented	Embedded with ward round huddles	Focus also provided during the daily bed meetings
Repatriation Policy and Process (CC beds)	Ad Hoc from HDU	Network leading discussions to secure pathways to DGH	Key initiative to ensure C&YP receive care close to home & to secure GA beds at AHCH
GM beds	9	4 (reduction of beds owing to admission avoidance schemes)	Reduction if GA beds opening owing to the focus on admission attendance schemes
System Escalation	System Meetings 3x Week	System meetings weekly & Improved system working	3x weekly system meetings to collectively discuss demand challenges and agree support required

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	Alder C@re Programme Update
Report of:	Alder C@re Programme
Paper Prepared by:	Alder C@re Leadership Team

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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:	

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
4.2	BAF Digital Risk					16
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

This paper is to provide the Board of Directors with an update on the AlderC@re deployment. The AlderC@re system went live for all hospital and community services over the period 8th to 12th September 2023. A series of Go No Go decision were taken before going live and all the criteria were either fully met or noted as “green” status.

The system transition to Meditech Expanse took longer than expected delaying go live plan by c. 24 hours. There were two delays with regards to the drugs dictionary and scheduling data migration.

Despite the initial delays, the transition was largely successful with positive feedback received from users, most notably from the Clinical Teams. As expected, there were priority issues raised during the transition period with the majority resolved in a timely manner. One of the main themes within the issues raised related to Access and System permissions. A lesson learned review for the entire programme is underway.

Looking forward, an optimisation programme has started to be scoped linked to divisional priorities and Vision 2030. Additionally, a second phase of the programme including nursing enhancements will be scoped in due course.

The Board of Directors is asked to note that the AlderC@re system is now live for all services.

The next steps for the programme are:

- Complete Programme Stabilisation phase including resolving outstanding actions, issues and capturing lessons learnt
- Initiate Aldercare optimisation programme and commence planning for Aldercare Phase 2.

2. Background

The Alder C@re Programme is overseeing the deployment of a new version of the MEDITECH Electronic Patient Record (EPR) referred to as Alder C@re, with MEDITECH Expanse 2.1 to be delivered in the first phase.

3. Programme Plan

Prior to go-live all of the required activities were completed including sign off of clinical safety case, resolution of all pre go live Priority 1 issues, and mitigation of risks. A series of Go/No-Go decisions were taken before deployment with the final decision at 23:00 on 8th September. It was at this point old Meditech EPR was taken out of service. All go live criteria were either fully met or noted as “green” status. The criteria are included in Appendix A.

Training attendance reached 82% pre go live and the Reporting workstream reached 95% pre go live, 98% by 15/09. A plan is in place to provide data to users post go live whilst the data warehouse repopulates, and is tested.

A lessons learned review for the entire programme is underway.

4. Go Live Summary

The AlderC@re system went live for all hospital and community services over the period 8th to 12th September 2023. The old Meditech EPR was taken out of service from 23:00 on 8th September and the system was then transitioned to Meditech Expanse. This took longer than expected, delaying

go live from 9th September to the 10th. Emergency and inpatient services went live on AlderC@re from the 10th but electronic prescribing was delayed further until 11th September. This delay was due to a slow load process for the drugs dictionary. Elective services, in outpatients and theatres, went live on Tuesday 12th September.

To support the first 2 weeks of transition there has been a robust Trust Incident Command and Control structure in place. This has started to reduce with Strategic Command meeting daily from w/c 25th September. To compliment the structure there has been visible 24/7 digital support in clinical areas and on the Mezannine for all staff during the first two weeks which was reduced to business hours from w/c 25th. This was agreed through the Command structure and based on feedback from users and divisions.

During the post go live period, a number of priority issues have been raised and resolved with the number of issues reducing each week as expected.

The main challenges post go live included access issues and administration issues. There were some hot spot areas where intensive support to help to resolve issues were put in place proactively. The service desk calls received were marginally below the planning assumptions. Ongoing work is in place to receive and resolve issues logged by colleagues.

5. Benefits Realisation and Forward Look

In addition to key learnings, work is underway with regards to benefits realisation and the forward look in terms of an optimisation programme and phase 2. Some of the positive feedback received thus far include aspects in relation to the speed of the system, aesthetics of the record for clinicians and easier to use in clinics for clinicians than the previous system. A full benefits report will be collated.

6. Summary and Conclusion

The Board of Directors is asked to note that the AlderC@re system is now live for all services.

The next steps for the programme are:

- Complete Programme Stabilisation phase including resolving outstanding actions, issues and capturing lessons learnt
- Initiate Aldercare optimisation programme and commence planning for Aldercare Phase 2

Appendix A Go / No Go Criteria

No	Criteria	Outstanding Actions Status	Target Date
1	P1 Resolution	All Gateway criteria met	Complete
2	Risks / Issues	All Gateway criteria met	Complete
3	Clinical Safety	All Gateway criteria met	Complete
4	Critical Criteria	All Gateway criteria met	Complete
5	EPMA	All Gateway criteria met	Complete
6	Safe Waiting List	All Gateway criteria met	Complete
7	Theatre	All Gateway criteria met	Complete
8	Nursing	All Gateway criteria met	Complete
9	Clinical Documentation	All Gateway criteria met	Complete
10	Data Migration	All Gateway criteria met	Complete
11	Interfaces	All Gateway criteria met	Complete
12	Policies/SOPs	All Gateway criteria met	Complete
13	Reporting	Completion of reports (110/116). Final date 15/09 if required	15/09
14	Additional funding for Resource	All Gateway criteria met	Complete
15	Funding for Marketing	All Gateway criteria met	Complete
16	Resource	All Gateway criteria met	Complete
17	Programme Plan	Complete cutover timeline plan – approved by Execs	Complete
18	Core Build	All Gateway criteria met	Complete
19	Training	86% booked, 82% trained.	08/09
20	Testing	All Gateway criteria met	Complete
21	Communication & Engagement	All Gateway criteria met	Complete
22	Benefits	Present benefits realisation plan.	Post Go Live

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Staff Vaccination Status**
Report of:	**Nathan Askew, Chief Nurse, AHP & Experience Officer**
Paper Prepared by:	**Nathan Askew, Chief Nurse, AHP & Experience Officer**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The Green Book Chapter 14 The Green Book Chapter 19 National immunisation programme 2023-24 UK HSA Measles update
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:	• **CQUIN01- Flu 80% required = 0.25% contract Value £230k** • **COVID – as per standard contract payment schedule.** • **Above used to offset operational and staffing costs**

Does this relate to a risk? Yes ☐ No ☐					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

This paper provides and overview to the Trust Board on the seasonal vaccination program at Alder Hey Children's NHS Foundation Trust. The plans will cover our approach for all eligible Children and Young People alongside our staff vaccination program.

This year the vaccination program will cover seasonal influenza and COVID 19 booster. Given the increased prevalence of measles in the community, alongside a national decline in MMR vaccination uptake, an update is provided on the response to this situation for the Trust.

The seasonal influenza vaccine is linked to **CQUIN01** with 0.25% value of contract (£230K) payable on achievement of target. COVID booster is paid on a per vaccine administered basis as outlined in the variation to standard contract. These resources are utilised to cover the operational and staffing costs associated with the vaccination program.

This paper will provide assurance to the Trust Board in regards of the vaccination program.

2. Background and current state

Vaccination is seen as an important part of our response to winter planning and preparation. It reduces the impact of seasonal respiratory viruses on our children and young people and our staff by offering protection against influenza and COVID. Vaccination reduces staff absence relating to respiratory viruses and provides protection when working with the paediatric population who are disproportionately affected by the winter respiratory diseases. Vaccination is given in line with recommendations by the JCVI and in accordance with the schedules in the green book (see supporting information on cover sheet).

Alder Hey has a strong history of high levels of uptake of the seasonal vaccinations although this declined last year which was symptomatic of vaccine fatigue amongst staff following the numerous covid vaccination requirements.

We have been actively involved in the COVID 19 national vaccination program with eligible cohorts including the at risk groups in the 6 month – 16 years cohort.

3. Main body of report

<u>Flu Vaccination Program - Staff</u>

Aim – to achieve 80% uptake of the seasonal Flu vaccine by all front-line health and social care staff

The program will run throughout the winter period and will begin with a 2 week focussed vaccination hub on the Mez opens w/c 4th October. Flu vaccines will continue to be available form room 8 on the Mez (acute site) as a 'grab a jab'

0094 drop-in ad-hoc basis. Outreach to clinical areas who find it hard to release staff (theatres, ITU etc) will be arranged with local leads and roving vaccination through wards and departments will be available.

Community sites will again use the local flu vaccination champions model to enable vaccination to be available across a range of our community sites.

A comprehensive communications plan has been developed and booking of vaccination will utilise simply book. The vaccine has arrived on site in preparation for the launch of the program.

Where possible staff attending for flu will be offered there COVID booster at the same time. This is not always possible due to different extensive training requirements of the covid vaccine and is therefore based on available staff with the required training and competency.

Whilst our CQUIN relating to flu is for the vaccination uptake of front-line staff, all staff (including volunteers, contractors, nursing and medical students and other staff working on behalf of the organisation) will be offered the opportunity to receive the vaccine.

<u>COVID booster – Staff</u>

JCVI have recommended a booster vaccination for front line health and social care workers. Where possible this will be delivered alongside the flu vaccination. A dedicated covid vaccination hub will run for two weeks commencing 18th October. In addition, we will continue our 'every green' offer for anyone who is yet to undertake a primary course of covid vaccination.

Due to restrictions on movement of the vaccine it is not possible to vaccinate on community sites and the program will be required to run from the main acute site.

A comprehensive communications plan has been developed and booking of vaccination will utilise simply book. The vaccine has arrived on site in preparation for the launch of the program.

Whilst there is no set target regarding the uptake of the COVID 19 booster we will be ensuring that all staff are aware of the rationale and importance of uptake of the booster offer and encouraging as many as possible to participate.

<u>Children and Young People Vaccine program</u>.

The following children and young people are eligible for flu and covid vaccination:

- Children 2-3-year-olds
- school-age children (reception to year 11)
- Persons aged 6 months to 16 years in a clinical risk group, as laid out in the Immunisation Green Book, COVID-19 Chapter (Green Book)

0095 As with previous vaccination programs inpatient Clinicians will be required to refer patients for vaccination. Our infectious diseases clinical nurse specialist will continue to assist with the identification of eligible children and young people for vaccination.

Following the staff vaccination program, children and young people who are eligible for the Flu vaccine will be offered the opportunity to obtain the vaccine whilst attending OPD appointments.

Additional support

Vaccine clinics will be made available over weekends for all eligible groups, both Flu and COVID vaccines will be offered for staff, eligible children and young people.

Measles – Children and young people

There has been concern nationally regarding the declining uptake of MMR vaccination in children and across other age ranges where young adults may have not had the MMR. In Liverpool 82.1% of children have received the first does of MMR by their second birthday, which is lower than the national average of 89.2%.

The MMR vaccine is complex in timing of administration with 2 doses required in infancy and a pre-school booster. Working with local system partners it has been decided that Alder Hey will not actively vaccinate children and young people but would increase our role in public health messaging in relation to the importance of the MMR vaccine for children and young people.

We have increased information in our OPD's, used social media and our website for public messaging, engaged CYP and families attending in conversations on the importance of vaccination and produced a short video clip which has been used nationally by NHSE in their messaging campaign.

We will continue to work with partners relating to this public health messaging.

Measles – Staff

Given the increased prevalence in the community we have undertaken a review in collaboration with occupational health in relation to staff vaccination status.

Total Staff	Confirmed measles vaccination	No match found	% compliance
4348	3628	720	83

The 720 staff with no match for vaccination include several staff who have a paper record with occupational health due to being employed at the trust prior to digital records. All these staff are currently being reviewed to exclude:

- Staff on paper record with confirmed vaccination
- Staff who are medically exempt from vaccination

0096 Once this review has been completed, we will write personally to all remaining staff to highlight the importance of obtaining MMR and offer this through occupational health or through their GP practice.

4. Conclusion

There is a robust plan in place for the seasonal vaccination programme of influenza and covid both for our staff and children and young people. Pending the outcome of the final review of staff records a personal letter to staff who currently do not have a MMR vaccination will be completed.

4. Recommendations & proposed next steps

The Trust board are asked to:

- Note the contents of this report
- Approve monitoring of vaccination numbers through the executive board
- For a final learning document to be shared with the board at the end of the vaccination program.

0097

Alder Hey Children's NHS
NHS Foundation Trust

OUR PLAN
INSPIRED BY CHILDREN

Financial Performance Report
Month 5 23/24
Trust Board

Contents

Alder Hey Children's NHS Foundation Trust

1. Financial Performance Report Month 5 – Executive Summary (full report included in information pack)

2. Key Risks – Month 5 status

OUR PLAN
INSPIRED BY CHILDREN

1. Financial Performance Report Month 5 – Executive Summary

Executive Summary

Alder Hey Children's NHS Foundation Trust

0100

Executive Summary for August 23-24

The Trust has reported a £1k surplus in August (M5), whilst year to date is a deficit of £1.49m which overall remains in line with the plan.

Although the Trust is reporting in line with plan with a £1.49m deficit, this position includes the release of £0.7m contingency and £1.9m benefit from unutilised provisions/accruals & non-operating items, including interest receivable and therefore without this benefit would be a £4.2m deficit. The financial plan is becoming increasingly challenging to maintain, with Industrial Action impacting on overall performance at c.£2.8m including lost income (£1.9m)and costs (£0.9m). We have reviewed the data available to calculate the lost income from IA, using data provided by the divisions & Informatics, which results in the M4 YTD being restated as £1.3m compared to £1.1m lost income reported last month. The Q2 financial profile moves to a break even position, so delivery against plan will become more challenging given the uncertainty of future strike action and will represent a risk for the remainder of the financial year which we have reported to C&M ICB as part of the key monthly returns. We are awaiting any further confirmation of funding for IA nationally.

Key factors impacting on the year to date position include :

- Income £6.85m ahead of plan due to assumed additional income for increased PBR activity above planned levels (ICB activity), income from long stay patients as well as private patient income. The income budget has been uplifted to reflect the additional income to account for the Medics pay award. We have also increased the interest receivable budget for the full year to reflect the higher interest the Trust will receive on its cash for the year creating a non recurrent benefit.

- Pay £5.72m adverse to plan due to continued HCA 1-2-1 & sickness levels, waiting list initiative spend, Industrial Action and non-delivered CIP. The pay position also reflects the Medics Pay award which is an estimated pressure of £0.7m for the year and £0.3m year to date.

- Industrial Action impact YTD of £2.8m, including additional costs and income loss.

- In month Divisional performance is varied with Surgery reporting an adverse position (£1.59m) whilst the remaining areas showing a surplus (£1.4m). Year to date Surgery (£4.46m) & Medicine (£1.21m) are off plan. This is post the divisional review of unutilised balances as explained above.

In terms of forecast for the year, there is a heightened risk given the pressures arising in month 5 including Industrial Action and the requirement to deliver CIP in full. However as reported last month, the divisional forecast produced is showing a likely achievement of the £12.3m plan surplus. This is being managed through increased oversight, a programme approach including escalation finance meetings, launch of a finance awareness programme, tighter expenditure controls and approvals and CIP oversight at Sustainability Delivery Group meetings.

The level of CIP posted to date is behind plan by £0.89m. The plan for the year is £17.7m, of which £9.35m has been posted so far, which is a £3m increase to M4. A further £5.59m of plans are in progress, and a £2.82m shortfall overall (including £2.8m cross cutting & transformation). The CIP programme is red status until delivered in full in year with a continued focus on recurrent delivery, but needs radical remedial action if we are to get near annual targets. A leadership workshop took place in July with areas put forward that are being worked on through SDG. All schemes posted as NR are being reviewed by the DOF to understand the scope for delivering recurrently. A stock take of the strategic initiatives is also underway with SROs to understand risks of non delivery and mitigations to reduce undelivered CIP into 24/25.

C&M ICB Position

C&M remains under considerable financial pressure, with 7 providers and the ICB all falling behind their planned position. The impact of Industrial Action is an area of focus across the ICS, recognising the impact this is likely to have on the ability to achieve activity plans and recovery. Recurrent CIP across the ICB is not currently forecasted to achieve plan which will impact on the exit run rate for 24/25. E&Y are engaged by the ICB to work on the 3 year financial model.

RAG ratings are based on assessment of the risks around delivery of the forecast out turn for each measure

	G	A	R
Divisional Income & Expenditure			R

The collective position of the divisions at the end of M5 is £3.5m adverse to plan, with the two most challenging areas being Surgery (£4.5m off plan) & Medicine (£1.2m off plan). The rating has moved to red given the current pressure and at the October RABD business review will provide further detail on recovery plans and action being taken.

The Medicine division has seen significant pressures within non pay (£0.9m YTD). This is largely due to a change in clinical practice relating to Respiratory Panel testing. Medicine is also experiencing pressures in pay associated with HCA sickness and 1-2-1 cover. There are new pressures associated with consultant spend with cover to provide non-clinical duties and costs associated with Industrial Action. Plans are being implemented to monitor and reduce HCA 1-2-1 expenditure.

The Surgery division is reporting continued pressures associated with waiting list initiative spend and cover for gaps in the medical workforce. The impact of Industrial Action on the division is costs (£0.8m YTD) and under performance on activity income (£1.8m YTD). Reviews are ongoing with specialities looking at factors driving non-pay expenditure, and the division is looking to introduce new process for sign off of non-budgeted expenditure.

Cost Improvement Programme (CIP)			R

The CIP target for 2023/24 is £17.7m.

The CIP unachieved year to date is £0.89m. £1.46m was posted in M5 against a plan of £1.2m. A total of £9.35m has been posted for the year as at M5, with a further £5.6m in progress. There remains a gap of £2.82m to be identified and transacted, including £2.77m transformation and Trust-wide transactional schemes.

Further work has taken place since the M4 reporting which now means the divisional CIP gap has been closed in year only. Further work remains on the Trust-wide transactional and transformational schemes in year delivery. Recurrent CIP remains a significant risk with a gap of £10.93m.

Executive Summary for August 23-24

Metric	Definition	YTD Plan £000	YTD Actual £000	Annual Plan £000
Income & Expenditure YTD	Distance from Financial Plan Year to Date	(1,500)	(1,490)	(1,500)
Income & Expenditure Forecast	Distance from Financial Plan Full Year	12,300	12,300	12,300
CIP	Distance from Cost Improvement Target required to meet overall Financial Plan	5,897	5,010	17,700
Liquidity	Days of Operating Costs held in cash or Cash-equivalent forms, including wholly committed lines of credit available for drawdown.	>1	1.20	>1
Activity Recovery	Internally set plan to deliver 112% of 19/20 activity. Reflects the aggregate financial value of our variable PODs.	34,365	32,941	82,177
Capital	Distance from CDEL (Capital Departmental Expenditure Limits)	(4,267)	(3,629)	(14,573)

	G	A	R
Agency Cap	G		

The agency cap for the Trust is £3m for the year. The Trust is below this cap at £0.66m year to date and a forecast of £1.46m for the year. The Trust continues with the agency Cost Control Policy for Staffing Agencies or Consultancy (Non – Medical Staffing). Bank spend, however, remains high and is being looked into further to understand the drivers.

Liquidity	G		

The cash balance at the end of August was £84.46m and remains in line with the cash flow forecast to the end of the financial year.

Activity Recovery		A	

The internally set plan was to deliver 112% of 19/20 activity. However YTD achieved is 108.3% which is under the internal target set, but overperforming against the external plan.

Capital Programme	G		

Total capital spend to August was £3.629m against a total plan of £4.267m. This results in a difference to plan of £0.638m which is due to profiling differences. The overall capital programme remains in line with the plan for the year.

2. Key Risks – Month 5 status

23/24 Key Risks – M5 Position

Alder Hey Children's NHS

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	Initial Risk	Initial RAG	M5 Position	RAG M4	RAG M5	Change
Income	Internal target set above mandated target. Unknown impact of IA and Alder Care Go Live	Medium	M5 continued underachievement of higher internal target ICB performing well but specialist activity is under overall Estimated loss income £1.9m to M5 due to IA. National guidance reduces the annual mandated target by 2% (in relation to April and May IA), further changes could follow.	High	High	⟷
Inflation	Unknown future levels inflation, variable energy contract	Medium	Potential risk on medic pay award – awaiting final detail following month 6 reporting but current estimation indicates a pressure of £0.7m No other issues raised – continue to see benefit on energy	Low	Medium	↑
System Position	Deficit plan with challenging assumptions. Restrictions may be imposed. Retract resources/time to support system position	High	Increase to 7 providers off plan at M5 including ICB position On national radar with some of biggest variances to plan Recurrent CIP concern both nationally and regionally – impact on exit run rate and 24/25 ICB Expenditure controls group to start imminently – AH not included at this stage but focus on internal cost controls 14 workstreams commenced supporting 3 yr recovery plan	High	High	⟷
CIP	Plan assumes delivery of £17.7m recurrent. Highest level saving and lack of schemes in place.	High	85% CIP identified in year – increase 5% Only 50% recurrent identified – small improvement but not enough CIP workshop held – action in train but needs shift and focus.	High	High	⟷
Capital	Limited CDEL allocation 23/24 and 24/25 Significant capital investment and number high risk projects	Medium	Cost pressures continue to emerge in campus (neonatal/Park) and Digital (Aldercare) – managing through slippage other areas but impact future years, bid made for Aldercare ICB supportive £4m additional CDEL from incentive model – now confirmed Incentive model launched national £150m fund if meet UEC targets	Medium	Medium	⟷

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Development Directorate - Projects Update**
Report of:	**Development Director**
Paper Prepared by:	**Acting Deputy Development Director** **Jayne Halloran**

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	The purpose of this report is to provide a Campus and Park progress update. The Board is asked to confirm acceptance of the update and advise if reassurance has been provided.
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

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
BAF Risk 3.1	Failure to Fully Realise the Trust's Vision for the Park					3x4
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Campus Development Report on the Programme for Delivery

October 2023

1. Introduction

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

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Service diversion impact to programme and risk of inflation	Multiphase contract to allow continuation works with phase 1 complete and service diversion to commence. Ongoing discussions regarding programme and inflation impact of any delay with output and possible mitigations to be reported at RABD.
Catkin/Sunflower House Building	Car Park Sprinkler System Contract Claim	Tender publication 06.10.23 with returns submitted by 06.11.23. Indicative programmes to be returned as part of tender submissions. Contractor submission of Compensation Events (CEs). Review process commenced with Trust legal and cost consultants.
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 and Day PM. Revised scope of priority works to be determined. Options being developed.
Eating Disorder Day Case Unit	Full SoA cannot be accommodated within footprint of the building. Full scope of works exceeds available budget.	RIBA stage 1 completed. A revised set of floor plan drawings has been developed to accommodate the completion of the first phase (EDYS) by summer 2024. The Division is developing a business case for the second phase to include development of the master site plan to be reviewed by Executives.
Main Park Reinstatement	Work Package Risks Affecting Phase 3 Reinstate Park.	Revised completion dates assessed with Trust advisors and Beech. Mitigation plans 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 Service Diversions & Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation								
Temporary Modular Office (3SM)								
Catkin/Sunflower House Building								
Police Station Construction								
Main Park Reinstatement (Phase 2/3)								
Demolition/Infrastructure (park)								
Mini Master plan (Eaton Rd Frontage) 3 phase plan								
Fracture / Dermatology								
Eating Disorder Day Case Unit (EDYS)								
Elective Surgical Day Case								
Nursery								
Rainbow Centre Refurb								

4. Project Updates

Neonatal and Urgent Care Development

Current Status	Risks/Issues	Actions/Next Steps
Next phase of works to commence with service diversions works on 02.10.23 with 6-month programme ahead of main construction works starting.	Increased construction inflation costs due to market conditions and delay to unit opening.	Detailed cost, programme and risk meetings have commenced. Agree EDU design and decant plan. Complete EDU charitable bid.
Phase 1 of the neo-look patient monitoring system has been signed off by the clinical team.	Coordination of technologies and flow of patient data between neo-look at the vital signs monitoring systems.	Philips workshop scheduled for November 2023 with a demo booked for 29.11.23.

Catkin & Sunflower House Building

Current Status	Risks/Issues	Actions/Next Steps
Finalising contract position working with legal advisors.	Possible contract claim.	Trust reviewing contractual position with legal advisors on next steps and actions to be taken. Resources to be identified to review and respond.
Sprinkler system to be installed within the under-croft car park. Tender to be published 06.10.23 with returns submitted by 06.11.23. Business case drafted for approvals via IRG and RABD during October 2023. Final works completion estimated 8-12 months.	Fire compliance.	Tender returns to be reviewed upon receipt, and costs available for RABD approvals November 2023.
Water safety issues are on-going and remain under review of the Water Safety Group via regular monitoring / testing.	Continued contamination.	Remediation of water mains and back fill.

Modular/Office Buildings

Current Status	Risks/Issues	Actions/Next Steps
Following approval of the Space Utilisation paper at 03.08.23 Executive Director's meeting, subject to consultation with senior leaders and staff affected, it is proposed that immediate priorities are progressed -: • Long-term solution for staff not allocated space in the refurbished police station. • Local re-allocation of space within the Histopathology building to accommodate Morgan Sindall contractors. • Capacity and environment review of 2A, 2B & 2C in the main hospital. • Environmental review Institute in the Park. • Consider embargo on new requests for space, pending agreed strategy/action plan. The lease for the new police station (Catkin/Sunflower) has been signed. This allows works to progress to refurbish the former police station: • Site set up meeting proposed for 2 October 2023. • Completion date expected April 2024. • The lease of the 3-storey modular building (3SM) has been extended for an initial 3-month period.	Potential resistance from teams to new ways of working, sharing space with other teams and re-locating. Lack of funding for minor works/kit. Operational date currently assessed as April 2024.	Develop action plan for each project and establish reporting / approvals mechanism. Any further extension to the lease for 3SM to be confirmed with Laing O'Rourke by 22.11.23. Possible mitigation for a phased completion and part early occupation being developed. Costs and operational implications currently being assessed.

Park Reinstatement

Current Status	Risks/Issues	Actions/Next Steps
Public meeting held 11.09.23 involving members of LCC, Trust and FOSP. The main points of action/to note include: • Review the plan to remove 3 willow trees – proposal is to retain 1 large mature tree and remove the 2 smaller ones. • Swales design and safety review. • Park maintenance and handover to LCC. • Size of the football pitches. • Café/facilities in the park. Site progress continues, including construction of the football pitches & play area. Existing Infrastructure works are still present in the park area.	Concerns raised by FOSP in relation to the size and depth of the swales, and the size of the football pitches agreed within the planning approval. Delays in completion of preparation, soil and seeding of complete football pitches.	Future meeting dates to be agreed. Continued and maintained input & communications from all key stakeholders. Monitor over the coming months as works progress, attempting to work round the retained tree, reporting back if the risk increases. The aim would be to retain this long term if possible. Continued bi-weekly coordination meeting to closely monitor infrastructure and park development site works to maintain the park programme.

Fracture and Dermatology Outpatients

Current Status	Risks/Issues	Actions/Next Steps
The completion date is revised as May 2024. Costs currently remain within budget. Planning has commenced on the development of the tender package submission for appointment of a construction contractor.	Timely appointment of a construction contractor. SPV/Mitie have not achieved dates set out in the programme.	Regular meetings. Close monitoring of critical risks. Regular SPV meetings continuing. Project Management arrangements within Mitie strengthened providing additional assurance, provisional programme to be submitted for assessment.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Current Status	Risks/Issues	Actions/Next Steps
Phase 1 - High level programme to be fully agreed. Phase 1 completion March 2024.	Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost certainty. Budget to be identified for phases 2 &3.	Finance to confirm funding options. Update presented at Executive Design Review 26.09.23.

Elective Surgical Day Case

Current Status	Risks/Issues	Actions/Next Steps
Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.	Programme, available budget.	Revised scope of priority works to be determined. Options being developed. Stakeholder meetings to be scheduled.

Eating Disorder Day Case Unit (EDYS)

Current Status	Risks/Issues	Actions/Next Steps
Draft proposal developed between the Division and the Development Team to consider a phased development: First phase to include re-provision of EDYS, and essential enabling works. RIBA stage 1 completed. A revised set of floor plan drawings has been developed to accommodate the completion of the first phase (EDYS) by summer 2024. Second phase to include the completion of building works, final service re-provisions and development of the master site plan.	Programme, available budget.	The Division has developed a business case for the second phase to include development of the master site plan which will be presented to Trust Executive.

Nursery

Current Status	Risks/Issues	Actions/Next Steps
Anticipated construction period advised as January – October 2024.	Outputs from survey works. Confirmed programme.	Regular meetings scheduled.

Rainbow Centre Refurbishment – minor works

Current Status	Risks/Issues	Actions/Next Steps
Room layouts reviewed for sign off 15.09.23.	Programme, available budget.	Final design pack to be issued. TVE to be updated and submitted to SPV for costing and programme.

5. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 5 October 2023.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Liverpool Neonatal Partnership Governance**
Report of:	**Alfie Bass, Medical Director, Nathan Askew, Chief Nurse and Erica Saunders, Director of Corporate Affairs**
Paper Prepared by:	The above

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	Update on the progress of the Liverpool Neonatal Partnership
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:	

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

This paper provides the board with an update in relation to the governance arrangements of the Liverpool Neonatal Partnership (LNP) and sets out the next steps which will be incorporated into a more formal review.

2. Current Position

The governance and oversight arrangements of the LNP were devised and jointly agreed prior to inception of the formal partnership commencing and adhere to principles of good governance. The main purpose of the governance arrangements was to ensure effective monitoring and oversight, not only within each sovereign organisation, but across the service in Liverpool in its totality. The agreed governance structure remains in place and adhered to by both partners.

Risks, incidents, mortality and quality improvement pertaining to each organisation follow the agreed process for that organisation, in accordance with local governance systems, with each site of the partnership reporting into the integrated governance meeting for the LNP.

The LNP integrated governance meeting is attended by the leadership team for the LNP and relevant staff from each site which includes consultants, Matron / ward manager and governance managers from each organisation. Where possible the safety champions form each organisation also attend. The output of the integrated governance meeting is presented to the LNP Board monthly.

The ward manager at AH attends the weekly risk meeting and the surgical division DIG and in LWH a paper is submitted to Family health Board. The governance managers on both sites are involved through these processes.

Any serious incidents and associated 72-hour reviews are led by the governance team from the organisation where the incident took place, with the LNP leadership team and appropriate clinical teams being involved in the reviews.

There is a high level of assurance that individual patient incidents, issues and risks are managed safely in line with each organisation's governance structures.

3. Rationale for formal review

The current governance arrangements adhere to those developed prior the formal start of the partnership. As the partnership has matured several factors have led to the need for a formal review of the governance arrangements. It should be noted that this review is in the context of an evolving partnership and a changing external landscape, not due to a failing in the current arrangements.

Since the inception of the partnership the move from the incident response framework to the Patient Safety Investigation Response Framework (PSIRF) has been mandated for all NHS organizations. The focus of the PSIRF is on learning from incidents and therefore even with each organisation required to implement PSIRF we must ensure that there are robust open, transparent and clear methods of sharing learning across the partnership, this will require some refinement and further development as PSIRF is embedded nationally.

A review will help test if the current reporting and oversight processes through each organisation has provided the correct level of assurance at all levels of the governance process, from ward to board and through the monitoring and assurance committees of the sovereign organisations, in addition to the requirements of the LNP. This will include a review of the oversight processes for all aspects of governance including risks, incidents, mortality and quality improvement.

Whilst each organization in the partnership remains responsible for the care to patients on its respective site there is inherently a level of risk in partnership arrangements which requires fully open and transparent culture, as well as robust reporting processes at each organization to mitigate the risk associated with partnership functions and multi-site working.

In addition, post the conviction of Lucy Letby, it is essential that the governance process is reviewed, especially in a service where staff will rotate between each site.

4. Recommendations & proposed next steps

The executive teams of each trust will meet in October 2024 to discuss and agree the remit of the formal governance review. It is anticipated that the outcome of the review that result in a revised governance model and process to move forward with.

The Trust board are asked to:

- Note the contents of this report
- Approve the course of action
- Set a date by which to receive an update on the review

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	PSIRF Governance Process
Report of:	Associate Director of Nursing and Governance
Paper Prepared by:	Associate Director of Nursing and Governance

Purpose of Paper:	Decision ■ Assurance ■ Information ■ Regulation □
Background Papers and/or supporting information:	National Patient Safety Strategy Alder Hey Patient Safety Strategy
Action/Decision Required:	To note ■ To approve ■
Link to: Trust's Strategic Direction Strategic Objectives	Delivery of outstanding care ■ The best people doing their best work ■ Sustainability through external partnerships ■ Game-changing research and innovation ■ Strong Foundations ■
Resource Impact:	N/A
Associated risk (s)	N/A

1. Purpose

This paper provides the Patient Safety Board with an overview of the proposed Patient Safety Incident Response Framework (PSRIF) internal assurance processes and external assurance arrangements with the Cheshire and Merseyside Integrated Care Board (ICB), in line with the national PSIRF requirements by Autumn 2023.

Introduction

The Patient Safety Incident Response Framework (PSIRF) changes the way Alder Hey Children's NHS Foundation Trust, and the Cheshire and Merseyside Integrated Care Board (ICB) will seek assurance on patient safety risks identified from incident reporting.

Within the new framework, Alder Hey's Trust Board will be accountable for the approval and closure of all Patient Safety Incident Investigations (PSIIs) which are externally reportable.

This paper provides an overview of the internal assurance process for PSIRF and external assurance arrangements with the ICB.

2. Background

Under PSIRF, the Trust is required to produce and publish both a Patient Safety Incident Response Plan (PSIRP) and policy, both of which will set out how the Trust will investigate and respond to patient safety incidents and approved by both the Trust Board and ICS, prior to publication on the local public facing website.

The Trusts PSIRP incorporates not only those incidents that will be investigated as a Patient Safety Incident Investigation (PSII), but also alternative methods for review of incidents that no longer meet the new national reporting criteria, which will be known as patient safety responses (PSRs).

PSII reports will no longer be submitted to the ICB for sign off; the Trust Board will be accountable for approval and closure of all PSIIs, with the responsibility being delegated to the Trusts Patient Safety Incident Response Investigation (PSIRI) Panel for oversight and approval of PSII reports and actions plans, prior to submission to Trust Board.

3. PSIRF Assurance Process

3.1 Initial Incident Notifications and Reporting

Alder Hey will take a flexible approach in deciding what patient safety incidents should be investigated through the PSII or PSR process, informed by both national and local patient safety priorities, our patient safety profile and those Trust incidences that identify the most potential for learning and identifying improvements that reduce risk and/or prevent or significantly reduce recurrence.

From September 2023 Alder Hey will cease reporting to NRLS and make the switch to recording to the new Learning from Patient Safety Events (LfPSE) service which will replace NRLS. This is currently in place and operational via InPhase.

Reporting of serious incidences (SIs) to the Strategic Executive Information System (StEIS) will also be superseded by LfPSE. However, to reduce complexity during the transition period and to maintain data flows it has been agreed nationally that organisations will continue to use StEIS to record any incidents that are subject to PSII. A new incident type has been added to StEIS that allows organisations to record incidents which are responded to using PSII.

NHS England and Cheshire and Merseyside ICB will monitor this reporting system to obtain information on the number of PSIIs/PSRs being undertaken by the Trust. Cheshire and Merseyside ICB will review Alder Hey's PSIRP to ensure that we are delivering within our plan and the resources identified.

3.2 Duty of Candour

Under PSIRF not every incident of moderate harm or above will be subject to a PSII. However, the statutory obligation for the Trust to complete Duty of Candour (DoC) for moderate harm and above remains.

Under PSIRF, the timescale for DoC to be completed within 10 days has been removed, however Alder Hey will continue to adhere to the 10-day timescale to ensure compliance with DoC legislation.

Alder Hey, together with Cheshire and Merseyside ICB, have agreed that where DoC has not been issued within 10 days, that this will be discussed within the regular Quality Review meeting with the ICS leads, to understand reasons for delays: but Alder Hey will not incur any penalties.

3.3 Designated Trust Executive Patient Safety Leads

As designated Trust Executive Patient Safety Leads, the Chief Nursing Officer and Chief Medical Officer will:

- Delegate all incidences reported as moderate harm or above to the Patient Safety Incident Response Investigation (PSIRI) Panel for review and agreement of action as per agreed Trust PSRIF process

- Delegate authority for the approval of downgrading of any moderate harm incident following divisional review of rapid review findings to the PSIRI panel

- Receive a weekly tracker from PSIRI of all incidences received by PSIRI panel, including the decisions made for each incident presented plus any areas/incidences for escalation.

- Receive all completed PSIIs for oversight and approval for presentation to Trust Board

3.4 Patient Safety Incident Response Investigation (PSIRI) Panel

The PSIRI Panel will:

- Review all incidents reported as moderate or above on a weekly basis. This detail will be presented to the PSIRI panel by the relevant divisional and clinical/nonclinical lead for the PSIRI panel to determine the appropriate learning response required (PSII or PSR).

- Receive a copy of all local rapid reviews undertaken in the preceding week, again presented to the PSIRI panel by the relevant divisional and clinical/nonclinical lead to determine the appropriate learning response required (PSII or PSR).

- Approve any local rapid reviews undertaken in the preceding week that the divisional /clinical leads feel (based on findings of the rapid review) can be downgraded from moderate harm or above.

- Receive national and local priority PSII reports at a Trust level to review and approve the quality of the investigations carried out by the investigator. These reports will include safety actions and learning to be shared and inform improvement plans.

- Receive and approve all appropriate safety improvement plans to reduce the likelihood of a similar incident happening again ensuring the quality improvement approach is consistent in using the Trusts Brilliant Basics methodology.

- To identify any trends, clusters or risks which cannot be actioned and take appropriate action, escalating when required to appropriate group / committee.

3.5 Divisional Patient Safety Incident Reporting Group

The Divisional Patient Safety Incident Reporting Group will:

- Provide and present findings from any local rapid reviews undertaken in the preceding week to the weekly PSIRI panel by the relevant divisional and clinical/nonclinical lead to agree with the PSIRI panel if a PSII or PSR is relevant.

- Present for approval any local rapid reviews undertaken in the preceding week to the PSIRI panel that the divisional /clinical leads feel (based on findings of the rapid review) can be downgraded from moderate harm or above.

- Receive national and local priority divisional PSII reports and divisional PSR reports for review and approval at a divisional level prior to submission to the weekly PSIRI panel. Reports will include safety actions and learning to be shared and inform improvement plans.

- Develop and approval of all divisional safety improvement plans, showing where relevant clear evidence of high quality A3 thinking, prior to submission to the weekly PSIRI panel for oversight and assurance of embedding of learning.

- Escalate any identified trends, clusters or patient safety risks which cannot be actioned to the PSIRI panel.

3.6 Weekly Patient Safety Meeting (PSM)

The weekly PSM will

- Be one of the Trust wide forums for any member of staff/teams to present and discuss patient safety incidents and shared learning in a supportive, open, and honest manner.

- Uphold the principles of a Just Culture for all those presenting/attending.

- Continue to be held on Thursday mornings at 8.15am

- Actively share weekly learning bulletin across the Trust.

- Receive monthly lessons learnt updates from the Patient Safety Incident Response Investigation (PSIRI) Panel in line with PSIRF.

- Continue to recognise staff via the excellence reports noting their involvement in patient safety incidents/events.

3.7 Wider Trust learning

In line with PSIRF and the Trusts Brilliant Basics Quality Improvement methodology, greater depth of learning from patient safety incidents will be developed outside of the week PSM as we transition and start to embed PSIRF.

3.8 Safety Quality Assurance Committee (SQAC) and Trust Board

SQAC and Trust Board will:

- Receive all completed PSIIs for oversight and learning prior to Trust Board sign off.

- Receive regular reports via the Patient Safety Programme Group regarding the reporting and monitoring of investigation and safety improvement plans for all PSIIs meeting the national or local reporting criteria and all PSRs.

- The report will provide a review of any trends or clusters of incidents to ensure appropriate action is taken or escalation.

3.8 Patient Safety Board (PSB)

The PSB will:

- Receive bimonthly reports via the PSIRI panel providing oversight of investigations and safety improvement plans for all PSIIs meeting the national or local reporting criteria together with findings of any PSRs.

- Receive all completed PSIIs for sign off and learning purposes.

- The report will provide a review of any trends or clusters of incidences to ensure appropriate action, learning or service improvement is undertaken, plus suggestions of areas of patient safety for consideration for inclusion in the quality improvement arm of PSIRF.

3.9 Integrated Care Board (ICB) Contract and Quality Review Meeting

Bimonthly Contract and Quality Review Meetings (CQRM) are the established method of seeking assurance between Cheshire and Merseyside ICB, Liverpool PLACE, NHSE Specialist Commissioners, Welsh Commissioners and the Trusts Corporate Governance Team, Director of Nursing and key Trust Directors on those aspects of patient safety outlined in the NHS Quality Contract Schedule. This forum will receive assurance that an appropriate response is being taken for incidents and actions under PSIRF.

The PLACE lead will be invited to have a nominated member/representative in attendance at the Trusts PSIRI Panel and weekly PSM which will allow them to gain assurance on the integrity of information on quality matters submitted to the Trust's SQAC and Trust Board regarding patient safety incidents.

4.Recommendations

This paper provides a summary of the internal and external assurance processes and governance arrangements for Alder Hey Children's NHS Foundation Trust Hospital on the management and learning from all patient safety incidences in line with PSIRF.

The PSB is asked to note and approve the PSIRF Assurance processes as set out above.

Jackie Rooney

Associate Director of Nursing Governance and Risk

July 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Patient Safety Incident Response Plan and Governance process**
Report of:	**Associate Director of Nursing Governance and Risk**
Paper Prepared by:	**Associate Director of Nursing Governance and Risk**

Purpose of Paper:	Decision ☑ Assurance ☐ Information ☐ Regulation ☐
Action/Decision Required:	To note ☐ To approve ☑
Summary / supporting information	The Trust Board is asked to approve the Trust Patient Safety Incident Response Plan (PSIRP), and governance process presented prior to submission to Integrated Care Board and publication of the Trusts PSIRP on the public facing website.
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:	

Does this relate to a risk? Yes ☐ No ☑					
Risk Number	Risk Description				Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

This paper provides the Trust Board with a copy of the approved Patient Safety Incident Response Plan (PSIRP), the internal and external assurance processes and governance arrangements for Alder Hey Children's NHS Foundation Trust Hospital on the management and learning from all patient safety incidences in line with PSIRF.

2. Background and current state

Under Patient Safety Incident Response Framework (PSIRF), the Trust is required to produce and publish a Patient Safety Incident Response Plan (PSIRP) and Policy, which sets out how the Trust will investigate and respond to patient safety incidents and approved by both the Trust Board and Integrated Care Board (ICB), prior to publication on the local public facing website.

The Trusts PSIRP incorporates not only those incidents that will be investigated as a Patient Safety Incident Investigation (PSII), but also alternative methods for review of incidents that no longer meet the new national reporting criteria, which will be known as patient safety responses (PSRs).

PSII reports will no longer be submitted to the ICB for sign off; the Trust Board will be accountable for approval and closure of all PSIIs, with the responsibility being delegated to the Trusts Patient Safety Incident Response Investigation (PSIRI) Panel for oversight and approval of PSII reports and actions plans, prior to submission to Trust Board.

3. Local Context

PSIRF changes the way Alder Hey Children's NHS Foundation Trust, and the Cheshire and Merseyside Integrated Care Board (ICB) will seek assurance on patient safety risks identified from incident reporting.

This paper provides an overview of areas of patient safety that will be reviewed under PSIRF based on our patient safety data, our internal assurance process, and the external assurance arrangements with the ICB in line with the implementation of PSIRF.

Both papers have been presented and approved at Patient Safety Board on 24th August 2023 and ratified at Safety Quality Committee (SQAC) on 20th Sept 2023.

4. Recommendations

The Trust Board is asked to approve the PSIRP, and governance process presented prior to submission to ICB and publication of the Trusts PSIRP on the public facing website.

Patient Safety Incident Response Plan

Effective date: October 2023

Estimated refresh date: October 2024

	NAME	TITLE	SIGNATURE	DATE
Author	Jackie Rooney	Ass. Director of Nursing Governance and Risk		
Reviewer	Chris Talbot	Trust Patient Safety Specialist		
Authoriser	Nathan Askew Alfie Bass	Chief Nurse Chief Medical Officer		

Contents

1. Introduction

This patient safety incident response plan (PSIRP) sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

This plan is not a permanent rule that cannot be changed. The Trust will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more child or young person in our care receiving healthcare.

There are many ways to respond to a patient safety incident. This PSIRP covers responses conducted solely for the purpose of system learning and improvement and that reduce risk and/or prevent or significantly reduce recurrence.

The plan will data driven, remain flexible and may change to consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

It will be underpinned by the existing Trust Managing Incidents and Serious Incidents Policy and the new Trust Patient Safety Incident Response Policy.

Responses covered in this Plan include:

- Patient Safety Incident Investigations (PSIIs)
- Patient Safety Reviews (PSRs)

Other types of responses exist to deal with specific issues or concerns, for example: complaints management, claims handling, human resources investigations into employment concerns, professional standards investigations, coroners' inquests or criminal investigations. The principle aims of each of these responses differ from the aims of a patient safety response and are therefore outside the scope of this Plan.

2. Our Services

Alder Hey Children's NHS Foundation Trust is one of Europe's biggest and busiest children's hospitals, caring for over 330,000 children, young people and their families every year.

Located in Liverpool UK, we treat everything from common illnesses to highly complex and specialist conditions. We also have a number of community outreach sites enabling us to deliver care closer to children and young people's homes in local clinics locations from Cumbria to Shropshire, in Wales and the Isle of Man.

We know that a children's hospital is different and that our job is more than just treating an illness. To us, every child is an individual. As well as giving them the very best care, we set out to make them feel happy, safe, and confident as they play, learn, and grow. At Alder Hey, we are here to look after a child and their family and that includes mums, dads, brothers, and sisters.

Alder Hey is one of the two accredited major trauma centres for children in the Northwest and nationally commissioned as one of four epilepsy surgical centres, a service we provide in partnership with Manchester Children's Hospital.

As the regional cardiac surgical centre, we continue to lead in developing the cardiac network across the region to provide seamless care pathways for children with congenital heart problems. The Trust also is one of four commissioned paediatric national craniofacial units.

We have a number of well-established Children and Young Peoples' Forums which help us develop new ideas for how they can be at the centre of the Trust's plans and activities helping us keep children and young people's voices at the forefront, including continuing to play a key role in the recruitment of key Board level posts.

The Trust is supported by a number of charities and through the work that they do to support the hospital, we can ensure that Alder Hey's pioneering work continues to make a difference to the lives of children and young people. Our relationship with our charitable partners remains hugely important to us and never more so than during the Covid-19 pandemic and into the recovery period, during which time they worked tirelessly alongside us to support our patients, families and staff.

Alder Hey has a strong history of quality improvement and our Brilliant Basics approach supports team to make small changes that lead to big improvements and healthier futures for our children, young people and families. Brilliant Basics is our approach to improving quality, safety, effectiveness and experience. As we move into 2023/24 the focus will be on maturing and sustaining our approach to continuous improvement by:

- Supporting leaders at all levels to adopt the style and approach that will support improvement efforts.

- Supporting divisions to go further to align, enable and improve.

- Utilising the voice and ideas of children, young people and families that Alder Hey work with.

3. Defining our patient safety incident profile

Patient safety incidents for Alder Hey have been profiled using available organisational data between January 2019 to December 2022 from:

- Patient safety incident reports
- Clinical and non-clinical incident data
- Top 10 incident cause groups
- Complaint's themes
- Legal claims
- Staff survey results
- Mortality and in patient death thematic reviews
- Trust wide quality improvement and harm reduction workstreams

Additional resources reviewed included: Freedom to Speak up reports, Annual Quality Accounts, Trust wide Quality Round and Quality Assurance Round insight reports and presentations, complaints and PALs reports, child deaths and mortality review reports, safeguarding data, patient safety quality improvement dashboards via our quality improvement programme Brilliant Basics, risk data, and direct consultation with children, young people and their families via open forums and through a range of children and young person's forums that we have in place.

3.1 Data sources

A data review of the Trusts Risk and Incident Management System (Ulysses) was conducted for patient safety risks and incidents reported between January 2019 to 31st December 2022, to establish the number of reported patient safety incidences, reported harm levels and any subsequent patient safety investigations that took place as outlined below.

Chart 1

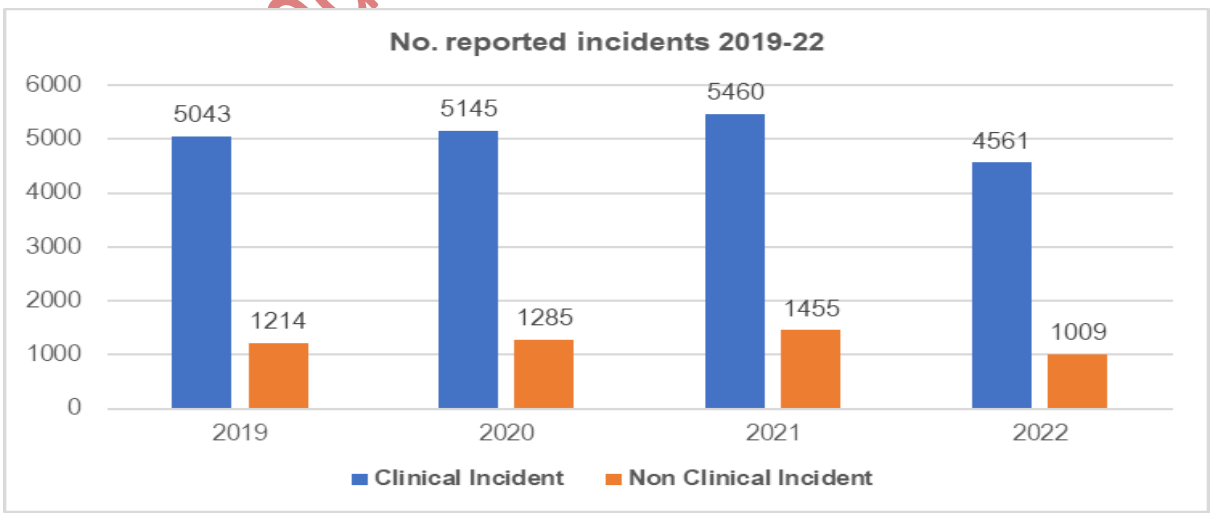
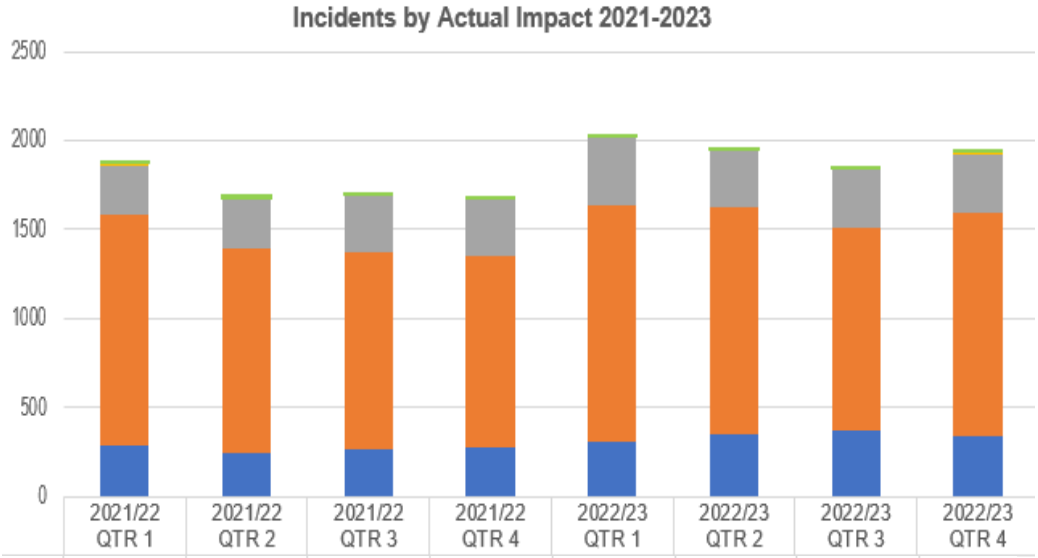


Chart 2



	2021/22 QTR 1	2021/22 QTR 2	2021/22 QTR 3	2021/22 QTR 4	2022/23 QTR 1	2022/23 QTR 2	2022/23 QTR 3	2022/23 QTR 4
Total	1887	1691	1700	1682	2017	1951	1842	1934
Classification not assigned	14	17	9	6	1	2	2	1
Never Event	0	0	0	1	0	1	1	0
E - Severe, Permanent Harm	0	0	2	1	0	0	0	1
D - Moderate, Semi Permanent Harm	11	3	5	6	3	8	4	6
C - Minor, Non Permanent Harm	279	274	313	319	379	318	324	327
B - No Harm	1291	1154	1099	1069	1324	1269	1137	1259
A - Near Miss	292	243	272	281	310	353	374	340

3.2 Stakeholder Engagement

The key stakeholders that have been consulted throughout the process to agree the identified priorities and Alder Hey's Patient Safety Incident Response Plan include:

- Our children, young people their families and carers
- Our staff
- Our commissioners
- Our Trust Board, Non-Executive Directors, and delegated committees

3.3 Stakeholder activity

Feedback and information provided by internal stakeholders, our children, young people, their families and carers and subject matter experts were considered in the development of our patient safety profile via a series of PSRIF events that included:

- Presentation of the patient safety data at:
  - Trust wide divisional and corporate levels meetings,
  - Speciality and sub speciality team meetings
  - Trusts Patient Safety Programme Board
  - Corporate Service Collaborative Meeting

- Trust Safety Quality and Assurance Committee

- Trust Board

- Attendance and discussion at a range of children and young person's forum events
- Open forums during Safety Month November 22
- PSIRF Big Conversation Event November 22

Qualitative and anecdotal feedback from our children, young people, their families and carers and our staff were also sought and collated via QR code to inform potential future categories for local patient safety incident investigation and system improvement.

The review also highlighted areas which required the collation of further intelligence to inform subsequent future plans.

4. Defining our patient safety improvement profile

A range of staff, including our Trust Board, Non-executive Directors and Trust leads for each of the above data collection systems, were consulted and a prioritised list of patient safety areas for the year ahead agreed.

Our patient safety profile and subsequent plan was discussed, shared, and approved by our local PSIRF implementation team and presented to our established Patient Safety Board for agreement and ratification.

All patient safety improvement workstreams that currently report into our Patient Safety Board together with other patient safety initiatives ongoing across the Trust were also considered as noted below.

4.1 Current Patient Safety Board Improvement workstreams:

- Sepsis
- Neonatal Safety
- Medication Safety
- Parity of Esteem
- Learning Disabilities
- Antimicrobial Resistance (AMR)

4.2 Other Trust Patient Safety Improvement Programmes:

- Safer Theatres at Alder Hey (STAT) Programme and Mini-STAT (Junior Doctor Induction)
- Meditech Unacknowledged Notices Workstream
- Hospital Optimisation: The Acutely Unwell Child, Get Me Well – Specialist Pathways, Get Me Well – Acute Medical Pathways
- ED at its Best
- Advancing Outpatients Care
- Infection Prevention Control - Isolation of Patients
- Prevention of Infections related to the Hospital Environment
- Safety Huddles in ED
- Urgent Treatment Centre (UTC)
- Zero Tolerance

All the above patient safety programmes are supported and delivered using our Brilliant Basics Quality Improvement (QI) methodology that is widely embedded across the Trust.

In addition, a review of the resource and activity associated with the current Serious Incident Framework for the period 2019 - 2022 was also undertaken to determine how many PSIIs can be supported during 2023/24.

This review was carried out alongside the NHS National Incident Response Standards for Patient Safety Investigation to ensure that all future PSIIs are compliant with these standards.

This review included oversight of the current level of resource required for PSRs, using different review techniques where a PSII is not indicated.

Category	2019	2020	2021	2022
Patient safety incident investigation into Never Events	4	1	1	2
Mortality Reviews	58	63	76	58
Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/Public Health England (PHE)) for independent PSII	2	1	1	0
Deaths of persons with learning disabilities reviewed at HMRG and submitted to LeDeR	9	8	0	6
Child Safeguarding Critical Incident Reviews/rapid reviews	17	13	25	9
Local Child Safeguarding Practice Review (LSCPR)	9	5	14	3
Domestic Homicide Reviews (DHRs)	0	5	2	2
Safeguarding Adult Review (SARs)	0	4	2	0
Incidents in screening programmes	0	0	1	0
Coroner initiated patient safety incident investigations [ward]	NA	12	19	16
Coroner initiated patient safety incident investigations [ED]	NA	6	10	11
Patient/family/carer complaint-initiated patient safety incident investigations	21	23	22	30
Serious Incident investigations (Investigations under the current NHS Serious Incident Framework and reported to StEIS)	15	17	10	6
Level 2 incident investigations utilising a systems framework for review	28	16	17	18
Level 1 incident investigations utilising a systems framework for review	23	11	21	31
Patient Safety reviews/Rapid reviews/Thematic reviews	4	11	140	306

This review has been led by the Patient Safety Team with support and involvement from the Corporate and Divisional Governance leads, senior leadership Nursing and Allied Health

Professional Team, Heads of Nursing /Allied Health Professions and Matrons, Medicines Safety Pharmacists, Trust Mortality lead, Freedom to Speak up Guardian, Safeguarding

team, Human Resources team, Head of Quality Improvement and our children and young people.

Incident types, recurrence and severity were explored, together with careful consideration of safety improvement opportunities and knowledge, together with plans and quality improvement interventions already in place.

5. Our Patient Safety Incident Response Plan: National Requirements

National patient safety priorities are set by the PSIRF and other national initiatives for the period 2023 to 2024. These priorities require a Patient Safety Incident Investigation (PSII) to be conducted by the Trust to identify and maximize opportunities for learning.

Patient Safety Incident Investigations (PSIIs) include a range of techniques (such as interviews and observations) to systematically identify the circumstances surrounding incidents.

While most PSIIs will be conducted locally by our organisation, some may be conducted independently and funded by our organisation or regionally/nationally.

In addition to a PSII some patient safety incident types will require specific statutory reporting and/or review process to be followed. All types of incidents that have been defined nationally as requiring specific responses are outline below and will be reviewed according to the national suggested methods.

National Focus Priorities		
Patient safety incident type	**Required response**	**Anticipated improvement route**
All incidents meeting the Never Events criteria (2018) or its replacement	Patient Safety Incident Investigation	Create local organisational actions and feed these into the Patient Safety Board as part of the QI process for Trust wide/Divisional action
Any incident meeting the learning from deaths criteria i.e. death thought more likely than not due to problems in care	Patient Safety Incident Investigation	
All child deaths (including children with learning disabilities)	All child deaths are reviewed as part of the Trusts HRMG process and referred to the Trusts Mortality lead. If relevant, any child death will be referred to the child death overview panel (CDOP) via the Trusts safeguarding team for investigation. Refer	Safeguarding team to liaise with CDOP as locally led PSII may be required. Respond to recommendations from

	to the Child death review statutory and operational guidance.	external parties for learning purposes.
Neonatal incidents: Incidents which meet the 'Each Baby Counts'	Referred to Healthcare Safety Investigation Branch for independent patient safety incident investigation (https://www.hsib.org.uk/maternity/) All cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme All perinatal deaths must be referred to MBRRACE.	Respond to recommendations as required from external referred agency and feed actions into the Patient safety Programme Board to be considered as part of QI process. All local MBRRACE recommendations to be presented and monitored via Clinical Outcomes and Effectiveness Group (CEOG)
All Safeguarding/ Rainbow Centre incidents	Incidents must be reported to the Trusts safeguarding team/Named safeguarding leads for review/multi-professional investigation and possible local authority referral.	Respond to recommendations as required from external referred agency and feed actions into the Trust Safeguarding and Statutory Services Assurance Group to be considered as part of QI process.
Incidents in screening programmes	Incidents must be reported by Director of Infection Prevention Control (DIPC) to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)	Respond to recommendations as required from external referred agency and feed actions into the Patient safety Programme Board to be considered as part of QI process.
Mental health-related homicides by persons in receipt of mental health services or within six months of their discharge	Incidents must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)	Respond to recommendations as required from external referred agency /Divisional oversight and improvement.

6. Our Patient Safety Incident Response Plan: Local Focus

Local patient safety priorities are set by the Trust in collaboration with all key relevant stakeholders (see sections 3 and 4) for the period 2023 to 2024. In addition to analysing our local patient safety profile, we have taken the following considerations into account when defining our local patient safety priorities.

Criteria	Considerations
Potential for harm	• People: physical, psychological, loss of trust (patients, family, caregivers) • Service delivery: impact on quality and delivery of healthcare services; impact on capacity • Public confidence: including political attention and media coverage
Likelihood of occurrence	• Persistence of the risk • Frequency • Potential to escalate

Our local patient safety priorities require a Patient Safety Review (PSR) and include several techniques to identify areas for improvement, immediate safety actions and to respond to any concerns raised by the affected child, young person, family, carer, or staff.

Note: There may be patient safety incidents not outlined in the priority list below for which a PSR is undertaken based on the request or views of those affected, including patients and their families.

There are several Trust wide patient safety quality improvement workstreams/programmes of work already being undertaken (section 4) and are therefore not included in the priority list below.

All PSRs are conducted locally by our organisation with different PSR techniques adopted depending on the intended aim and required outcome.

There are five broad categories of PSRs agreed with stakeholders to be utilised at Alder Hey Childrens NHS Foundation Trust

- Rapid Review
- Situation, Background Assessment, Recommendation (SBAR) review
- Thematic Review
- Multi-disciplinary team (MDT) review

- Safety Huddle incorporating a Hot/Cold debrief.

Local Focus Priorities		
Patient safety incident type or issue	**Planned response**	**Anticipated improvement route**
Any medication incident regarding TPN and omission/delay of criterial medications	PSII/Thematic review	Via Medication Safety Group that feeds into Patient Safety Programme Board as current QI workstream
Access, Admission, Transfer and Discharge: Incidents regarding issues with movement of patients particularly delays to outpatient follow-up	PSII where agreed /Thematic review/SBAR	Via Trusts Safer Waiting List Management Group/Divisional oversight/Commissioning Quality Contract Meeting
Acutely unwell child - Any emerging themes identified from via the Hospital Optimisation working group	PSII where agreed/ Thematic review/Rapid review	Via Hospital Optimisation working group that feeds into Patient Safety Programme Board as current QI workstream
Incidents resulting in moderate or severe harm to child/young person	Statutory Duty of Candour Rapid review/SBAR PSII if indicated.	All Moderate/severe harm rapid reviews presented to the Patient Safety Incident Response Investigation (PSIRI) Panel for discussion/ decision on requirement for PSII /improvement route (if applicable)
Clinical management/diagnosis including delays to follow up/imaging incidents	Rapid review/Thematic review/safety huddle	Local cross divisional review
Invasive procedure incident (including injury) following surgery	Safety huddle /PSII where agreed	Via STAT programme /Theatre /Surgical divisional governance meetings
Health Care Acquired Infections (HCAIs)	SBAR/safety huddle	Via Infection Prevention Control Committee
Medication, prescribing, and administration including any 10-fold medication errors or incident involving controlled drugs	SBAR/safety huddle /Thematic review if required	Via weekly Medication safety officer review meeting/Divisional and ward meetings
No/Low harm patient safety incident	Safety huddle	Via divisional daily huddles

Medical device/Equipment failure	Safety Huddle/SBAR if indicated	Medical dives group that feeds into Patient Safety Programme Board
IT System/Documentation	MDT review/safety huddle	Via Digital oversight Committee/Divisional governance meetings
ED/Trauma related incidents	SBAR/safety huddle /Thematic review if required/Debrief	Via Trauma huddle/cross divisional governance meetings
Haemovigilance (MHRA/SHOT reportable incidents)	It is a regulatory and legal requirement to report all serious adverse events (SAE) and serious adverse reactions to the MHRA/SHOT http://www.shotuk.org/reporting. 'Appropriate level of investigation of contributing factors using a systems approach and application of human factors principles'	Appropriate corrective and/or preventative actions identified and taken in response to investigation. Transfusion committee oversight and improvement
Ionising radiation CQC notifiable incidents (IR(ME)R)	All significant accidental or unintended exposure incidents (SAUE) are notifiable to regulator within 2 weeks of event. PSII or PSR to be decided locally and report available to regulator within 12 weeks	Respond to regulators recommendations following internal investigation. Divisional oversight and improvement

7. Conclusion

This patient safety incident response plan (PSIRP) supports the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF) and sets out how Alder Hey Childrens NHS Foundation Trust (the Trust) intends to respond to patient safety incidents reported by our children and young people, their families and carers and our staff, as part of work to continually improve the quality and safety of the care we provide.

The Trust acknowledges that PSIRF is a new approach to patient safety incidents advocating a co-ordinated and data-driven response to patient safety incidents, prompting a significant cultural shift towards systematic patient safety management.

As we move into adopting this new way of managing our patient safety incidents and learning reviews, we accept that we may not get it right at the beginning, but we will continue to monitor the impact and effectiveness of our PSIRF implementation, responding and adapting as needed if our approach is not achieving what we expect it to.

In this we have been supported by our children and young people, their families and carers, our staff, our commissioners and other stakeholders to allow us to embark on this nationally driven change.

Most importantly, PSIRF offers us the opportunity to learn and improve to promote the safe, effective, and compassionate care of our children and young people, their families and carers whilst also protecting the well-being of our staff. We welcome PSIRF's implementation and are ready for the challenges ahead.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st August 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 – 31st August 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 considered at Divisional Assurance Boards, Patient Safety Board and Safety Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

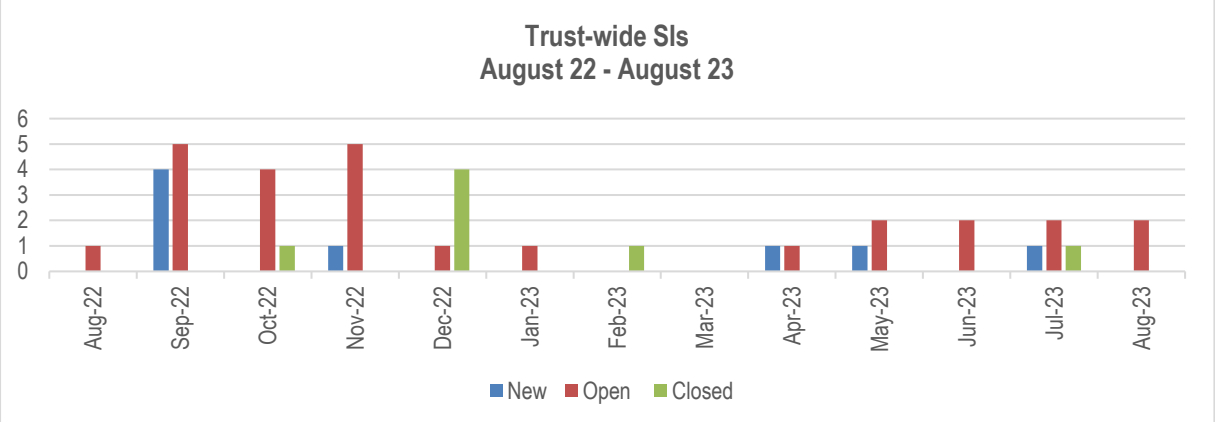
3. Local context

3.1 Never Events

The Trust declared **0** Never Events during the reporting period (1st – 31st August 2023).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status August 2023



3.2.1 Declared Serious Incidents

The Trust declared **0** StEIS incidents during the reporting period (1st – 31st August 2023).

3.2.2 Open Serious Incidents

2 SIs were open during the reporting period as outlined in table 1.
0 SI investigations were completed in this reporting period (1st – 31st August 2023).

Table 1 Open SIs August 2023

StEIS reference	Date reported	Division	Incident	Summary
2023/10739	23/05/2023 (reported to StEIS 31/05/2023)	Medicine	Delayed diagnosis of bone malignancy.	Refer to appendix 1.
2023/12980	02/07/2023 (reported to StEIS 05/07/2023)	Surgery	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	Refer to appendix 1.

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 31st August 2023), **1** SI action plan remained open which is within the expected date of completion.

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

3.3 Internal level 2 RCA Investigations

The Trust declared **0** internal level 2 RCA investigations during the reporting period (1st – 31st August 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.

1 final Duty of Candour response was required and completed within expected deadlines during the reporting period (1st – 31st August 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 Patient Safety Board, 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.

0 SI action plans were completed during the reporting period (1st – 31st August 2023). Immediate lessons learnt from all SIs are outlined where applicable in this report.

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/ 10739 **InPhase ID - 783**	Delayed diagnosis of bone malignancy.	Limping child guidelines should be followed. Number of attendances should be reviewed and taken into consideration. Multiple attendances resulted in no clear diagnosis even though there were ongoing symptoms.	Referred to Orthopaedics. Child has now been referred to the oncologist for a biopsy, staging and subsequent treatment. Potential amputation required as the tumour is extensive. **August 2023:** Email received from the GP surgery confirming records will be sent and a representative would like to attend the panel meeting on 08/09/23.
2023/ 12980 **InPhase ID - 1802**	Death of a patient on PICU 2/7/23 – due to a possible invasive bacterial infection.	Escalation could have happened sooner. Line could have been removed sooner. Antibiotic usage was appropriate. Unclear escalation plan in place.	Review of escalation of patients in and out of hours so it is clear for the Neonatal Unit. Review as to why the line was not removed earlier. **August 2023:** Draft report compiled by Associate Chief Nurse for Surgery pending Consultant review .

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	Number of extensions
2022/23391	10/08/2022	02/11/2022	Clinical Research	Never Event – wrong side biopsy.	30 1 action outstanding.	30/09/2023		0

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Quarter 1 Complaints, PALS and Compliments Report**
Report of:	**Nathan Askew, Chief Nurse**
Paper Prepared by:	**Sarah Balough, Divisional Governance Manger**

Purpose of Paper:	Decision ☐ Assurance ☐ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	• 35 formal complaints received in Q1: 4 subsequently withdrawn therefore 31 in total. • The top reasons for formal complaints received in Q1 are treatment and procedures, communication, referral waiting times/rejected. • Compliance with the 3 working day acknowledgement for formal complaints is 82% in Q1. • Compliance with the internal Trust target of 25 working day response time is 67%. • 3 second stage complaints were received in Q1. • No new referrals to the Parliamentary & Health Service Ombudsman during this period and no ongoing investigation. • There were 330 informal PALS concerned raised in Q1. • 80% Compliance with the 5-day target to resolve informal concerns. • 68 compliments for Q1.
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

0145

Does this relate to a risk? Yes ☑ No ☐						
Risk Number	Risk Description					Score
BAF Risk 1.1	Inability to deliver safe and high-quality services					3x3
Level of assurance (as defined against the risk in InPhase)	☑	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

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 April to June 2023 (Q1). Due to some ongoing data quality issues the reports provide a focus on performance and uses analysis where possible, it has not been possible to present the usual depth of learning from concerns and complaints which will be included in the Q2 report.

2. Formal Complaints

2.1 Number of formal complaints

2.1.1 Number of formal complaints received Q1 2023/24

35 formal complaints were received in Q1 of which 4 were subsequently withdrawn resulting in a total of 31 which is a decrease since the last quarter.

The number of complaints received by each division is shown in figure 1:

0146

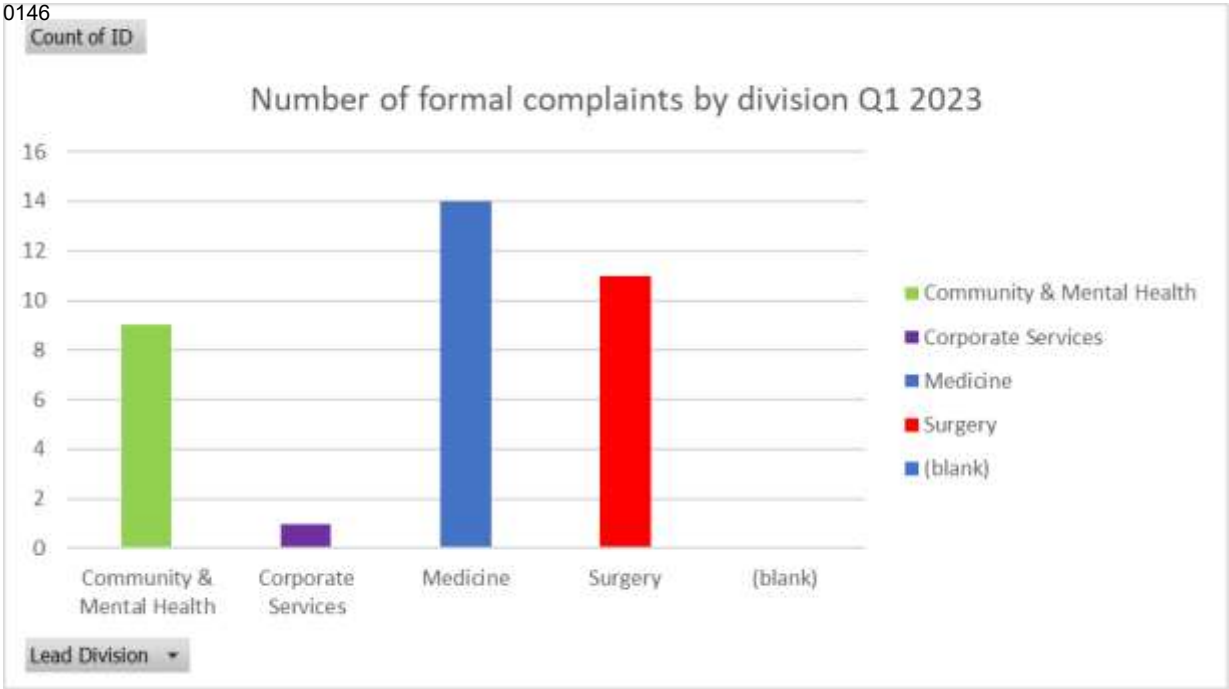
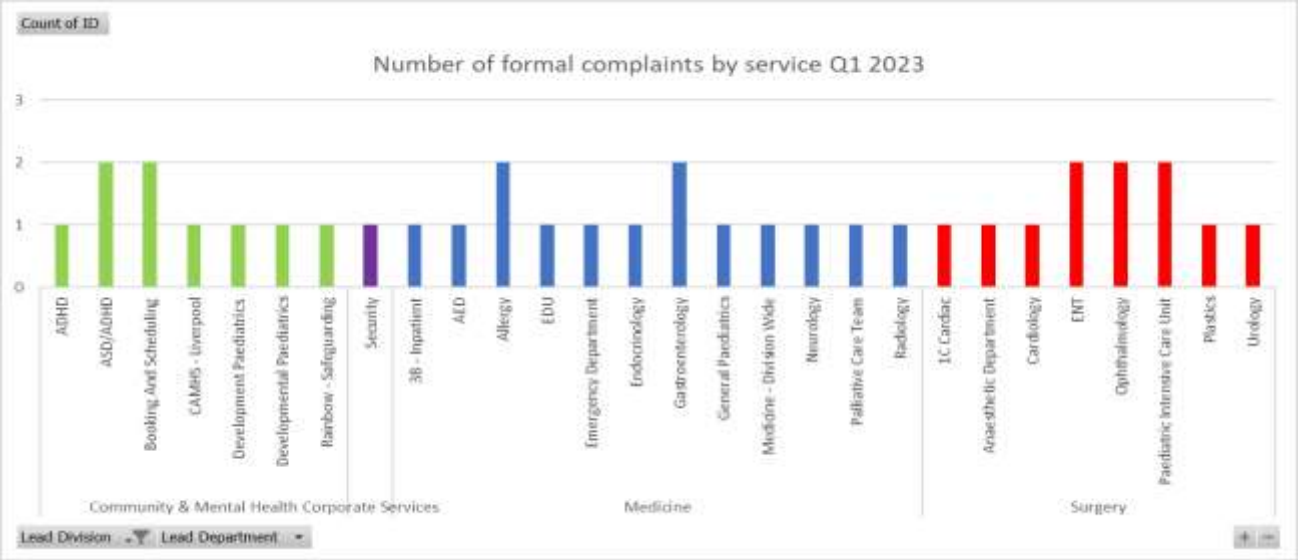


Figure 1

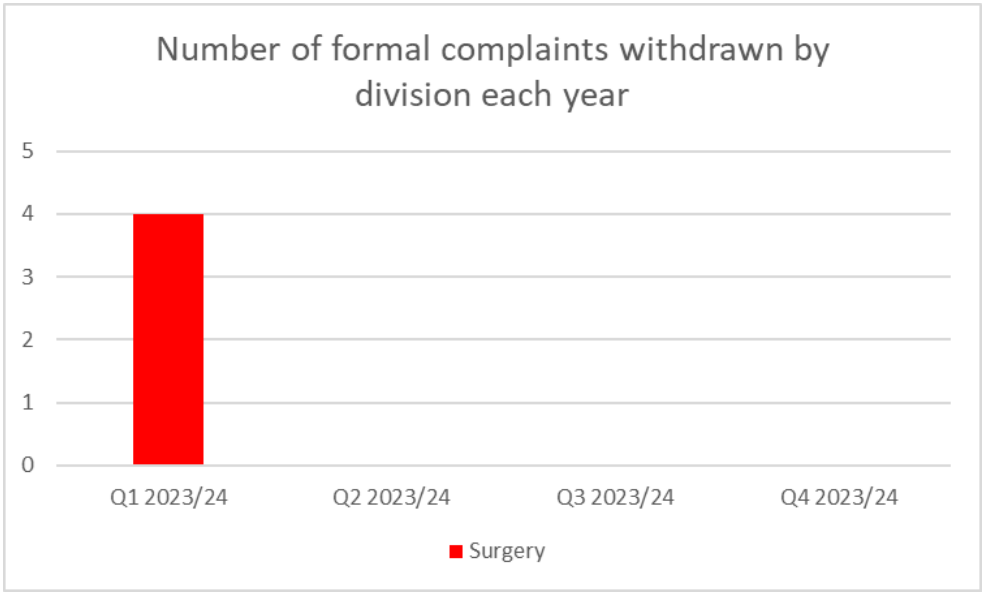


2.1.2 Trend over time of formal complaints

The trend over time is variable but as shown in figure 2 demonstrates a reducing number of formal complaints.

Figure 2

Table 1: Number of complaints 2023/24			
Quarter	**Received**	**Withdrawn**	**Actual**
1	35	4	31
2			
3			
4			
Total	**35**	**4**	**31**



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 2015-2018 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 2023/24.

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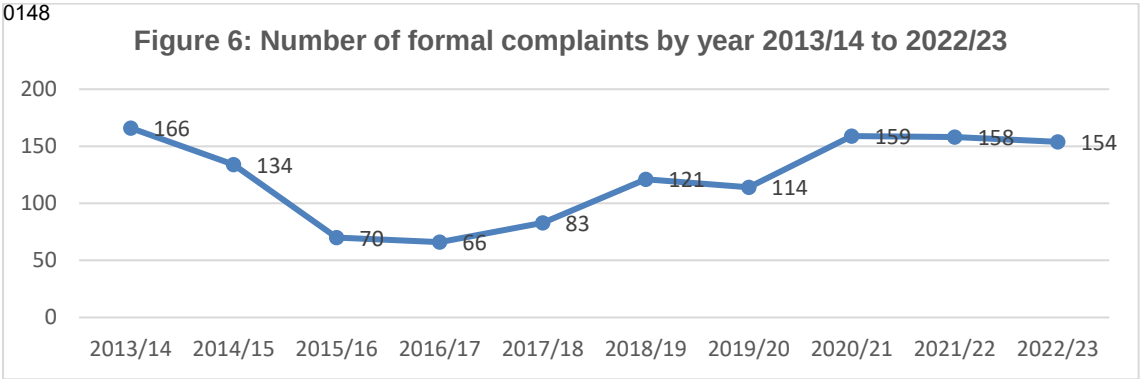


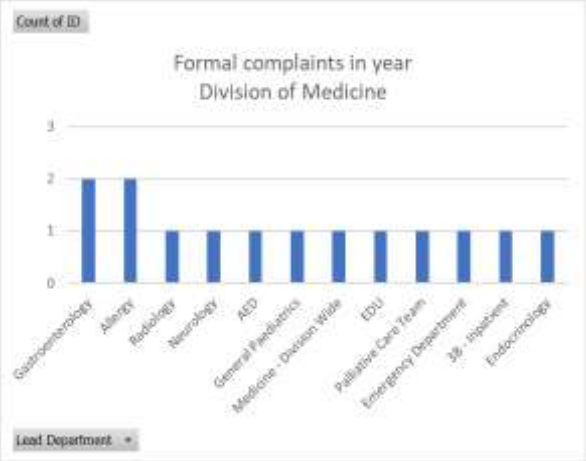


Figure 7

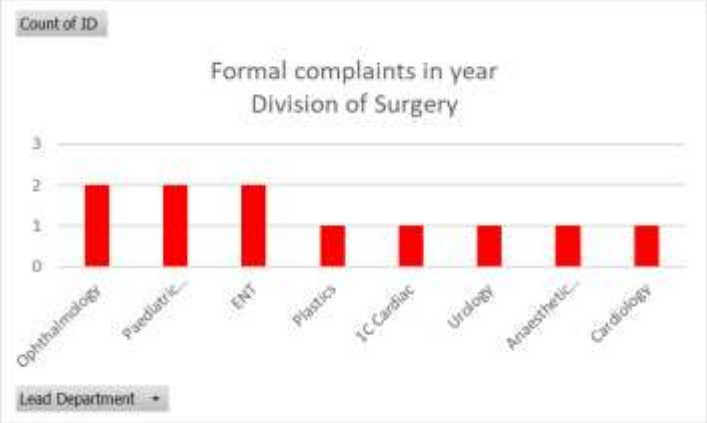


Figure 8

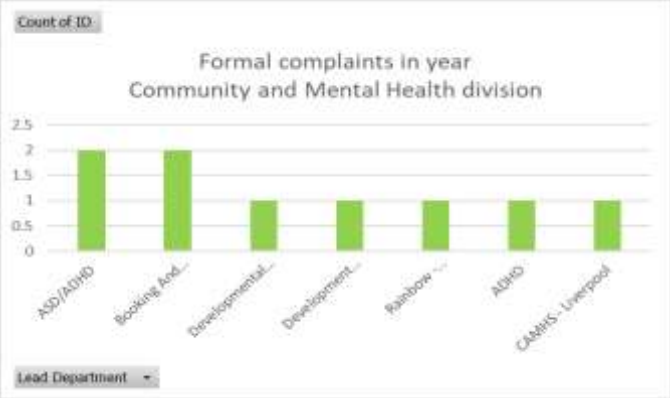


Figure 9

Figure 10

2.2 Complaints received by category Q1 2023/24

Complaints are categorised by subject as set in the Trust InPhase 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.

Figure 11 demonstrate that the main theme in this quarter continues to be in relation to treatment and procedure with a total of 9 complaints (29%) in Q1.

0149

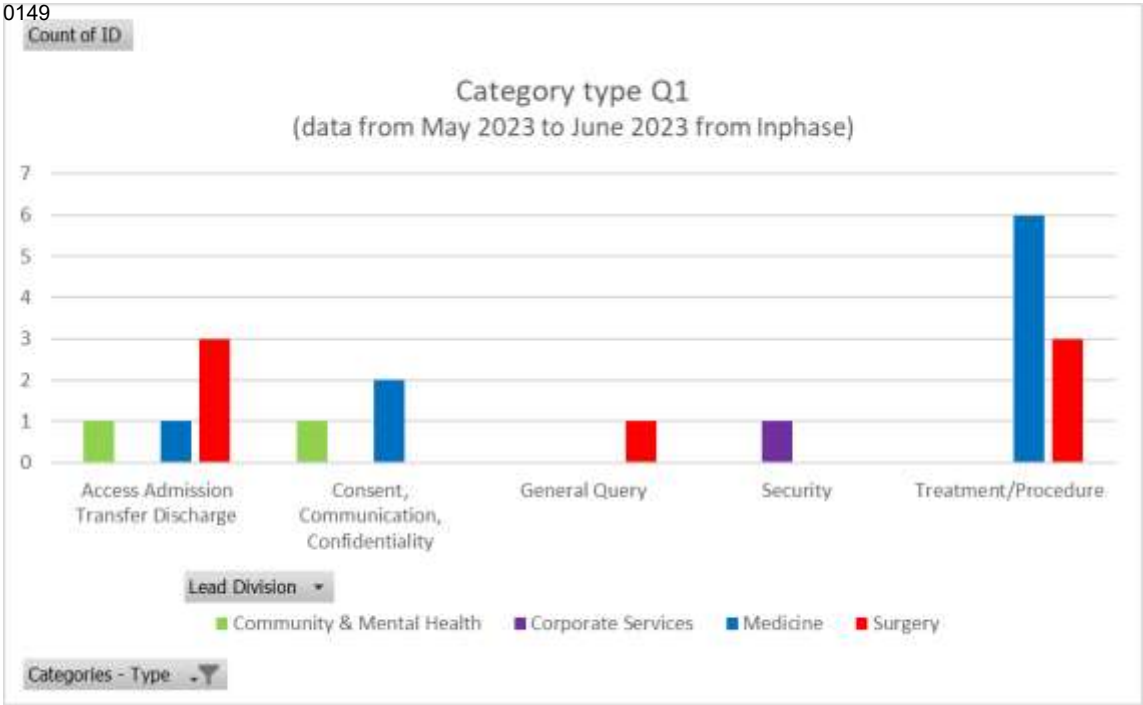


Figure 11: NB re primary categories: 'ADT' = Admission / Discharge / Transfer; 'Communication' = Consent / Communication / Confidentiality; 'Documentation' = Documentation (Records, Identification, IT System)

Sub-category identification provides further detail regarding the primary issues raised by families. Figures 12 demonstrate that the main theme within the treatment and procedure category is in relation to alleged failure in medical care with 5 complaints (16% of all complaints) in Q1.

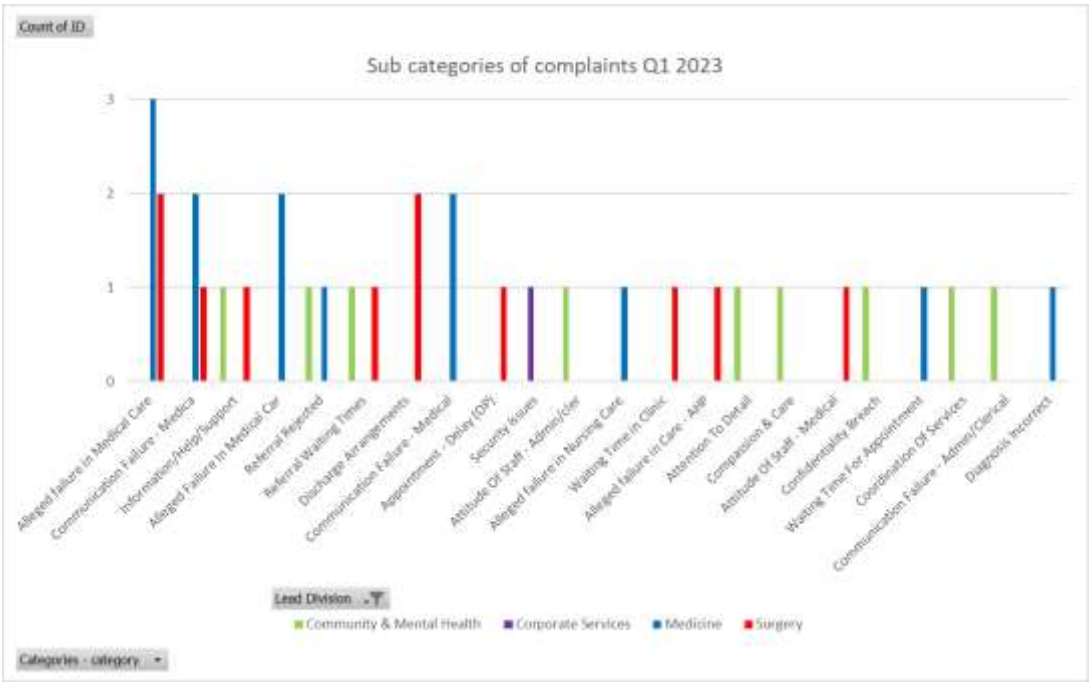


Figure 12

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 2023/24

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 Q1, 82% of the formal complaints received were acknowledged within 3 working days, those not acknowledged were responded to 1 day outside of the time frame.

2.3.3 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 Q1, 67% of complaints were responded to within 25 working days as demonstrated in Figure 13. There has been a significant decline in compliance with the 25-day target. The number of complaints has reduced and the complexity of some of the complaints has led to a number being agreed for a longer response time with the families. Families are regularly kept updated on the progress of their complaint when it is over 25 working days.

0151

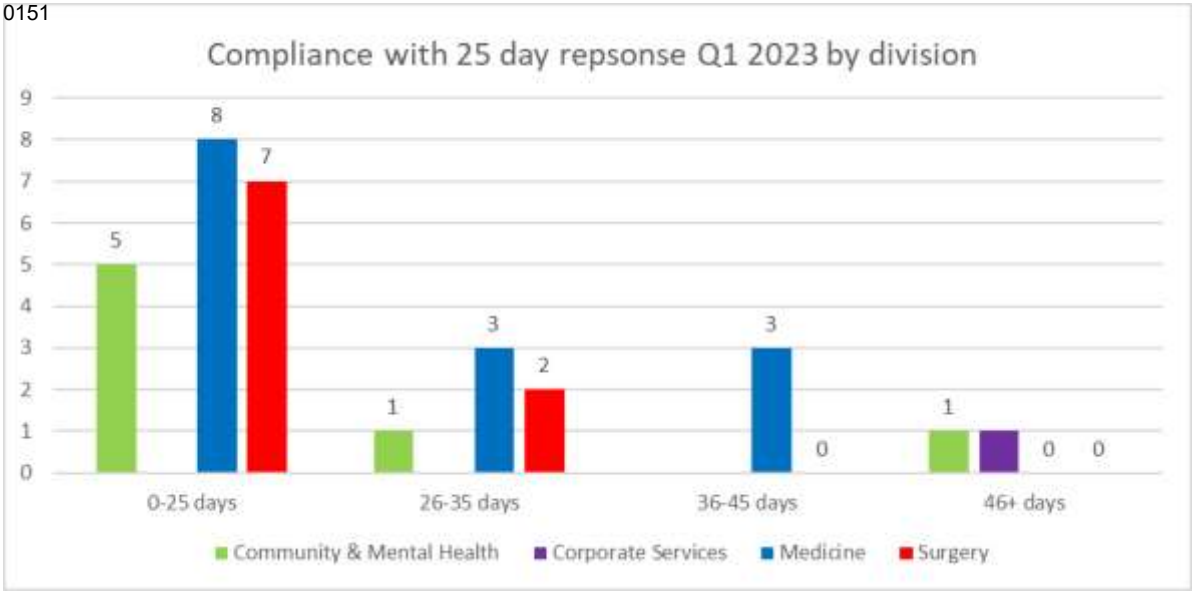


Figure 13

Figure 14 shows the Trust wide monthly percentage performance with this standard.

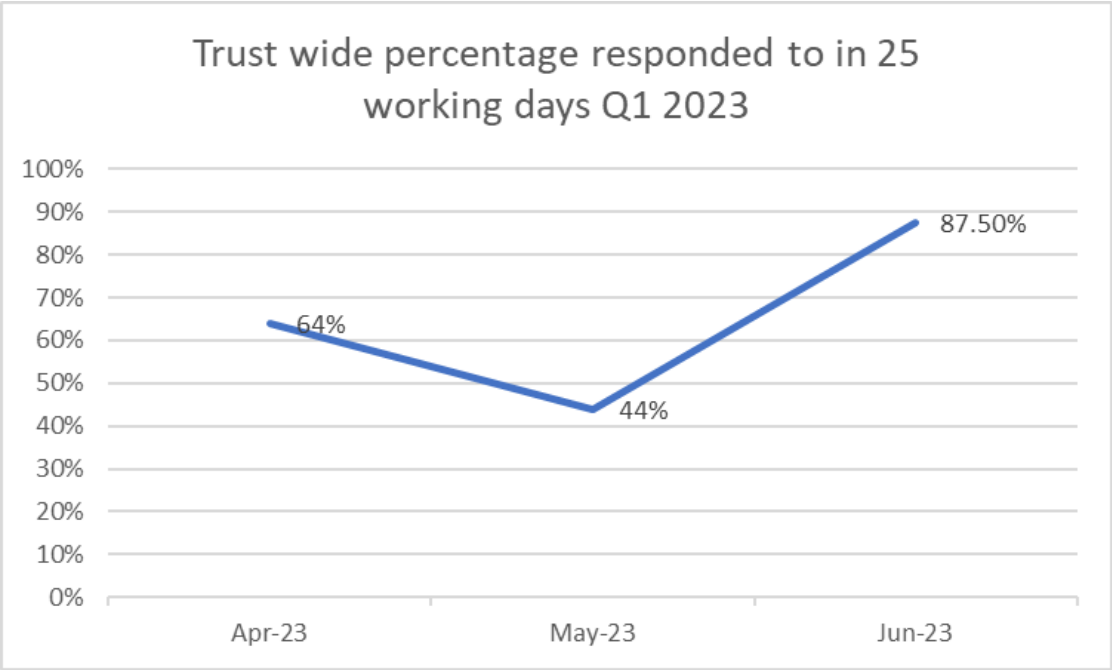


Figure 14

It is recognised that improvement work related to responding to families in a timely manner is a continued priority, there has continued to be variable performance in this area and more work is needed to increase a more consistent response time.

2.3.5 Number of open and closed formal complaints by month.

Table 2 shows the monthly numbers of complaints received and status of complaints being investigated. Data quality issues have affected some of the data contained in table 2 which will be updated in the Q2 report.

0152

Table 2: Formal Complaints received 2023/24													Cumulative to date
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received (includes withdrawn)	14	11	9										**35**
Withdrawn and closed	0	4	0										**4**
New complaints (adjusted from withdrawn)	14	7	9										**31**
Open (first stage)		1	1										**2**
Investigated, responded to and closed		6	8										**14**
Re-opened (Second stage)	3	0	0										**3**

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 was compliant with the NHS Digital deadlines.

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 Q1 5 (33%) of complaints were upheld; 4 (26%) were partially upheld, and 6 (40%) were not 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 15 shows the outcome of complaints by Division for Q1

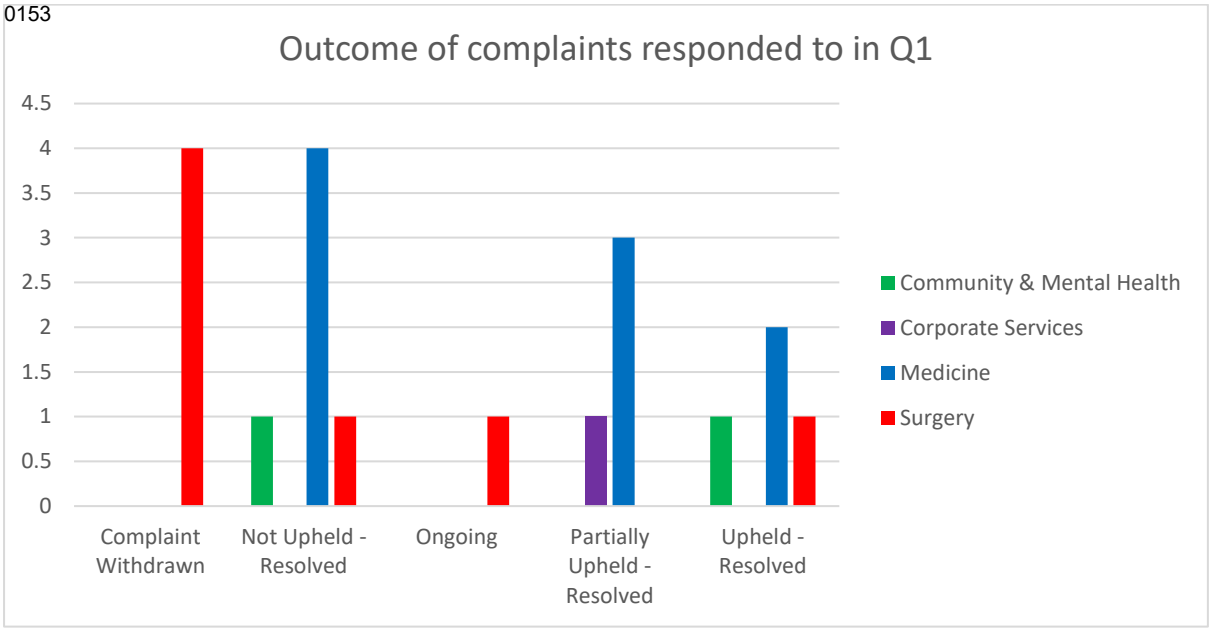


Figure 15

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.

3 complaints progressed to a second stage review in Q1.

2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no new referrals to the Parliamentary & Health Service Ombudsman in Q1. 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.

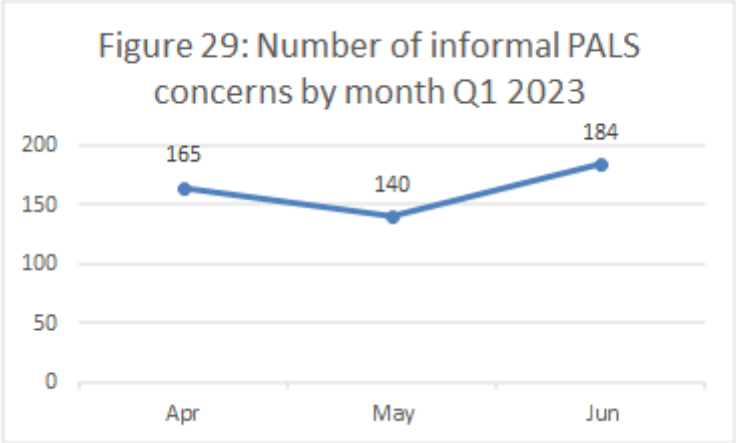
Due to ongoing reporting issues with the complaints module in InPhase it has not been possible to provide examples of learning and actions taken form complaints in Q1. This will be addressed in the Q2 report.

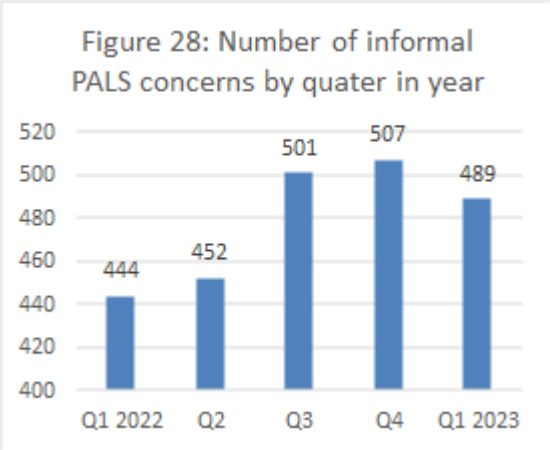
2.7 Healthwatch

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.

3. PALS informal concerns

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





There were 489 informal concerns received during Q1 which is a slight decrease in trend compared to previous quarters.

Figure 31a shows the breakdown of informal PALS concerns by Division in Q1 and Figures 32 – 35 show by Divisional services

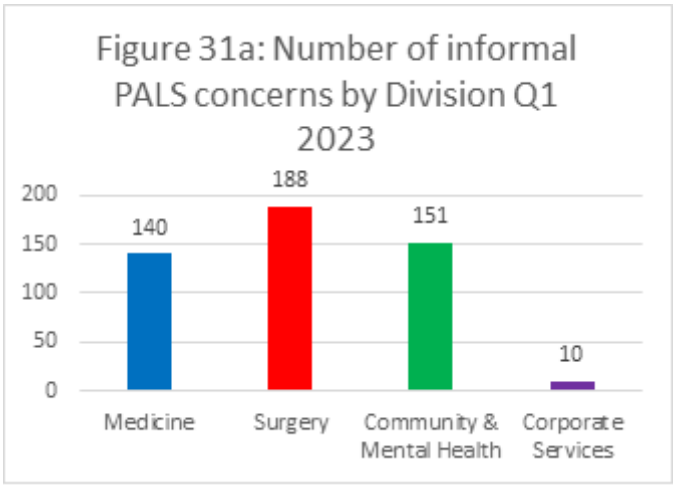


Figure 32: Informal PALS concerns in Q1 Medicine

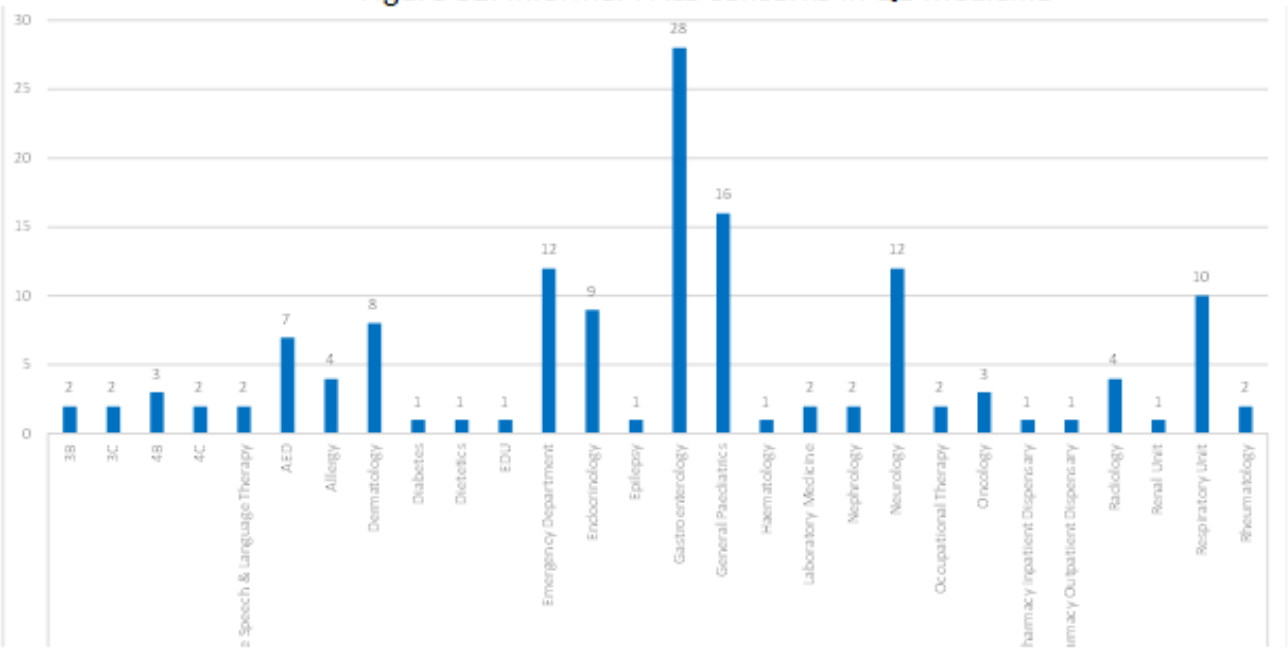


Figure 33: Informal PALS concerns in Q1 Surgery

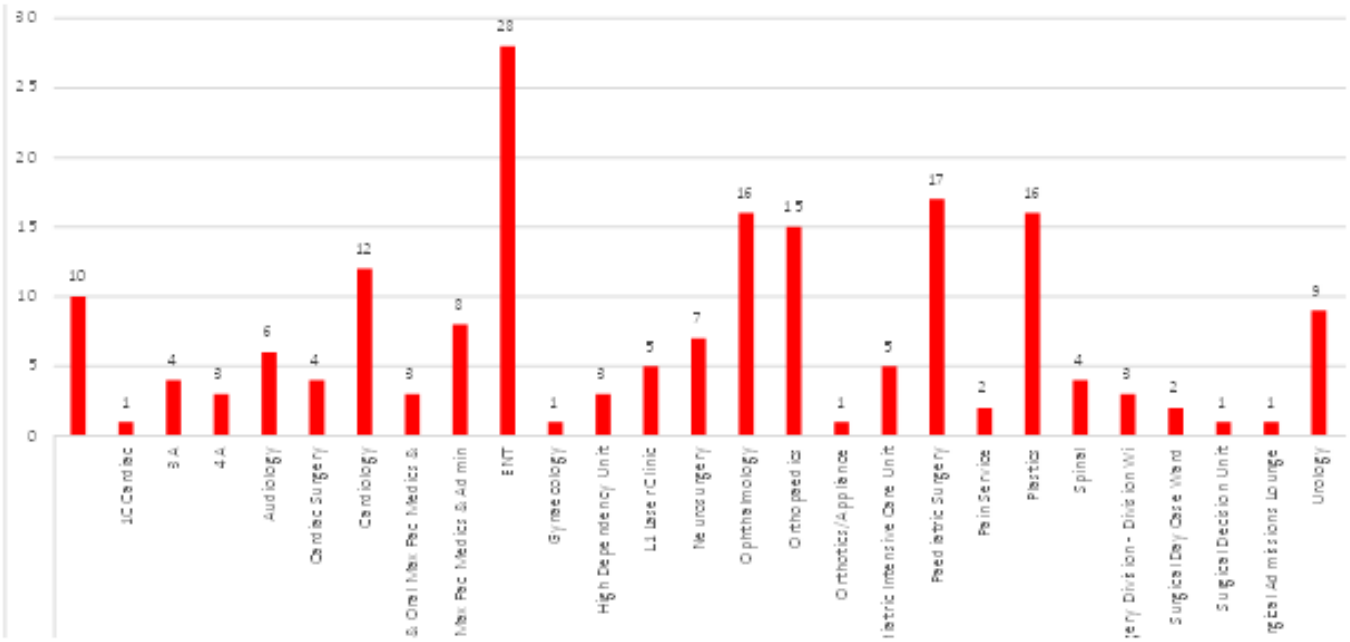


Figure 34: Informal PALS concerns in Q1 Community and Mental Health

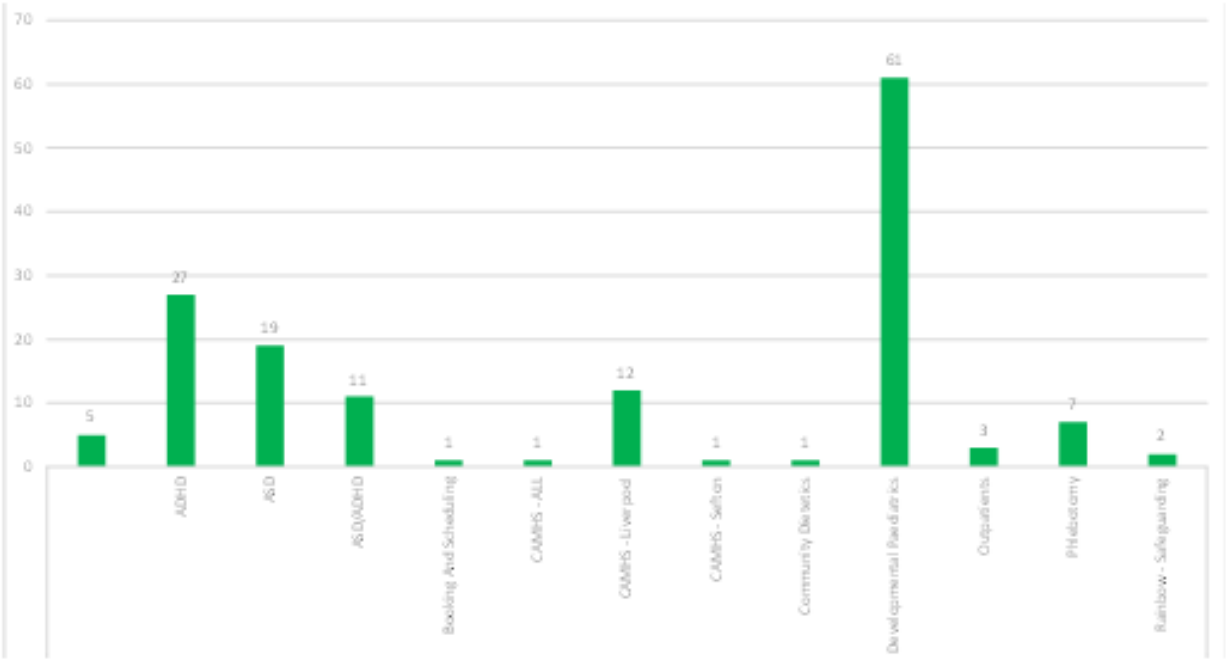
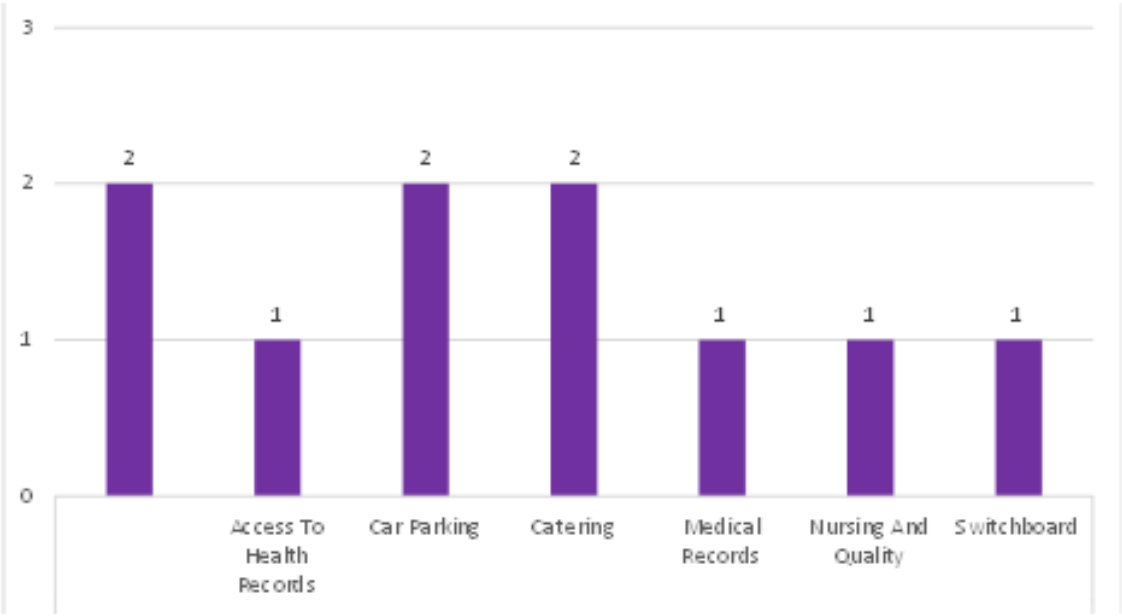


Figure 35: Informal PALS concerns in Q1 Corporate Services

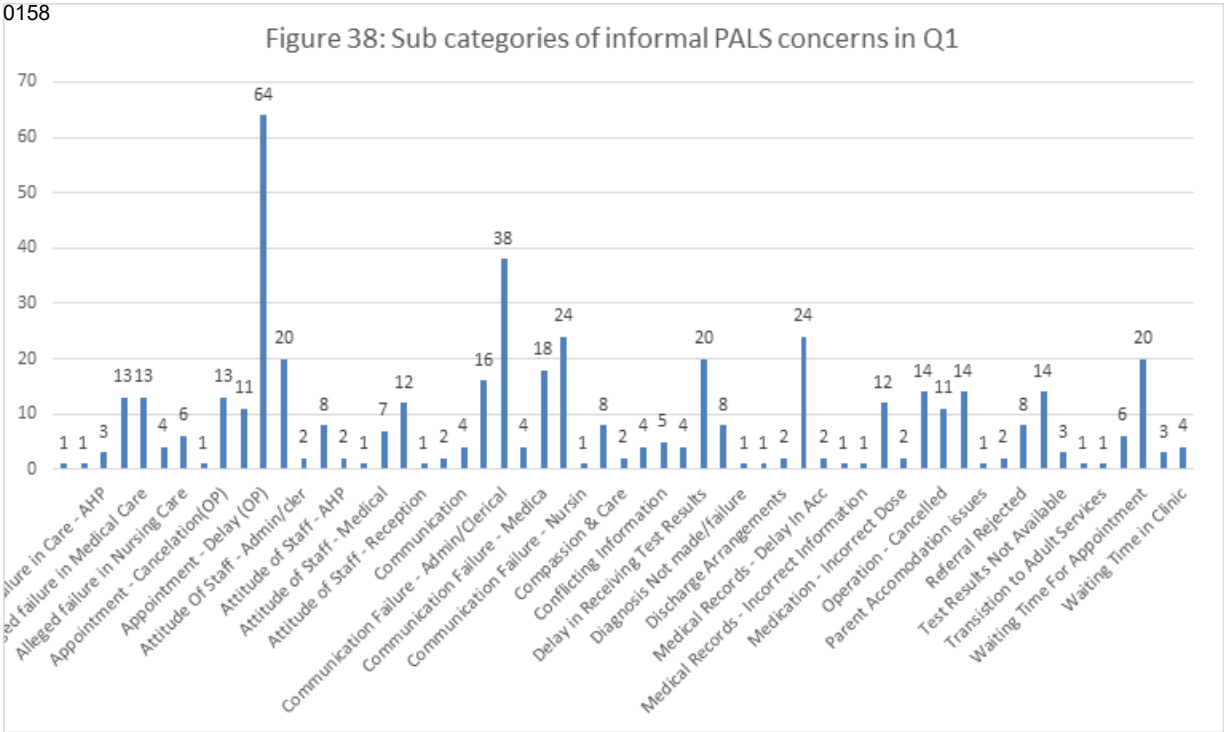


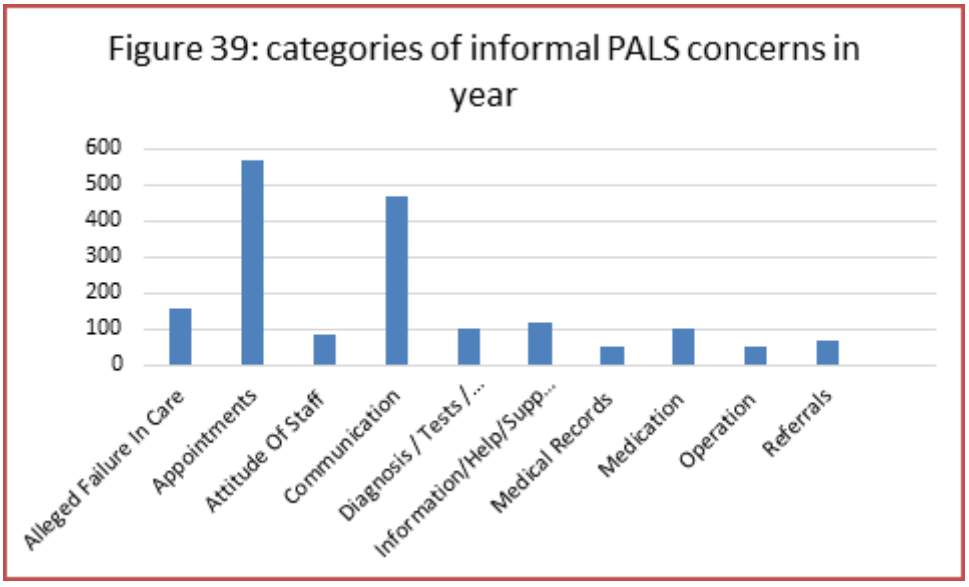
The Clinical Research Division acknowledge that no concerns have been received and the Division are reviewing methods to collate feedback from families which best supports the needs of this patient group.

3.2 Informal PALS concerns received by category Q1 2023/24 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 Q1 continue to relate to communication, appointment waiting times, and discharge as shown in Figure 38 this is consistent with the concerns that are raised as formal complaints and informal PALS concerns received in previous reports.

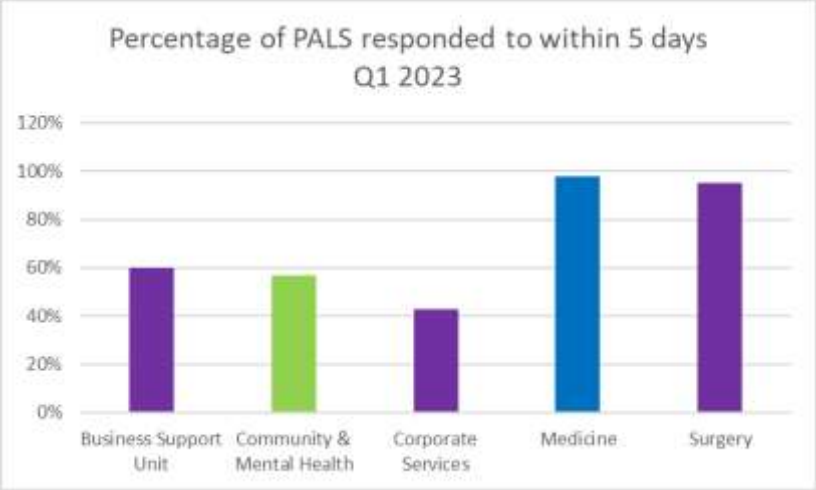
0158





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 Q1, 85% of PALS were resolved within 5 days. This is a significant and sustained improvement in this standard. This is testament to the hard work of all the teams involved and a new clearly defined PALS process to work within.



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

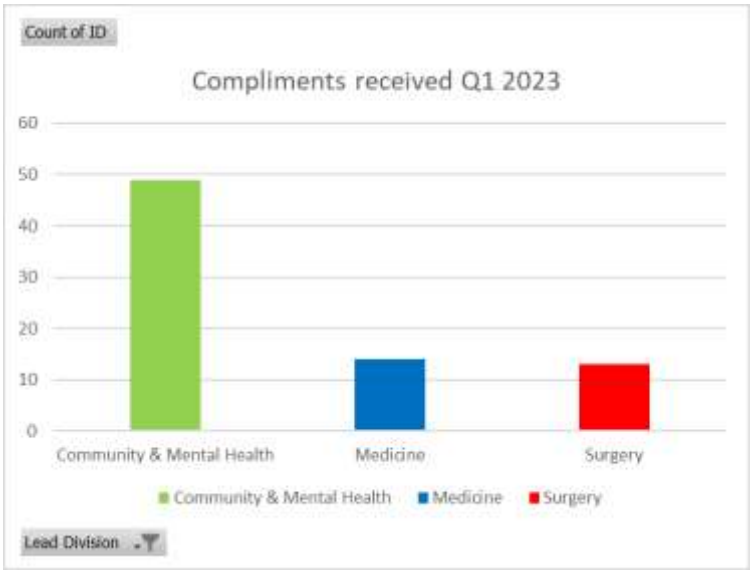
3.4 Actions and learning from informal PALS concerns

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 Patient Engagement and Experience Group.

4.0 Compliments in Q4

Compliments 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.

68 compliments were centrally recorded in Q4 however it is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit.



5. Recommendation:

- Trust Board are asked to note the content of this report
- Work will continue to improve reporting for the Q2 report

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Trust Mortality Report Quarter 1**
Report of:	**Hospital Mortality Review Group (HMRG)**
Paper Prepared by:	Alfie Bass/Julie Grice

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☑ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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:	

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

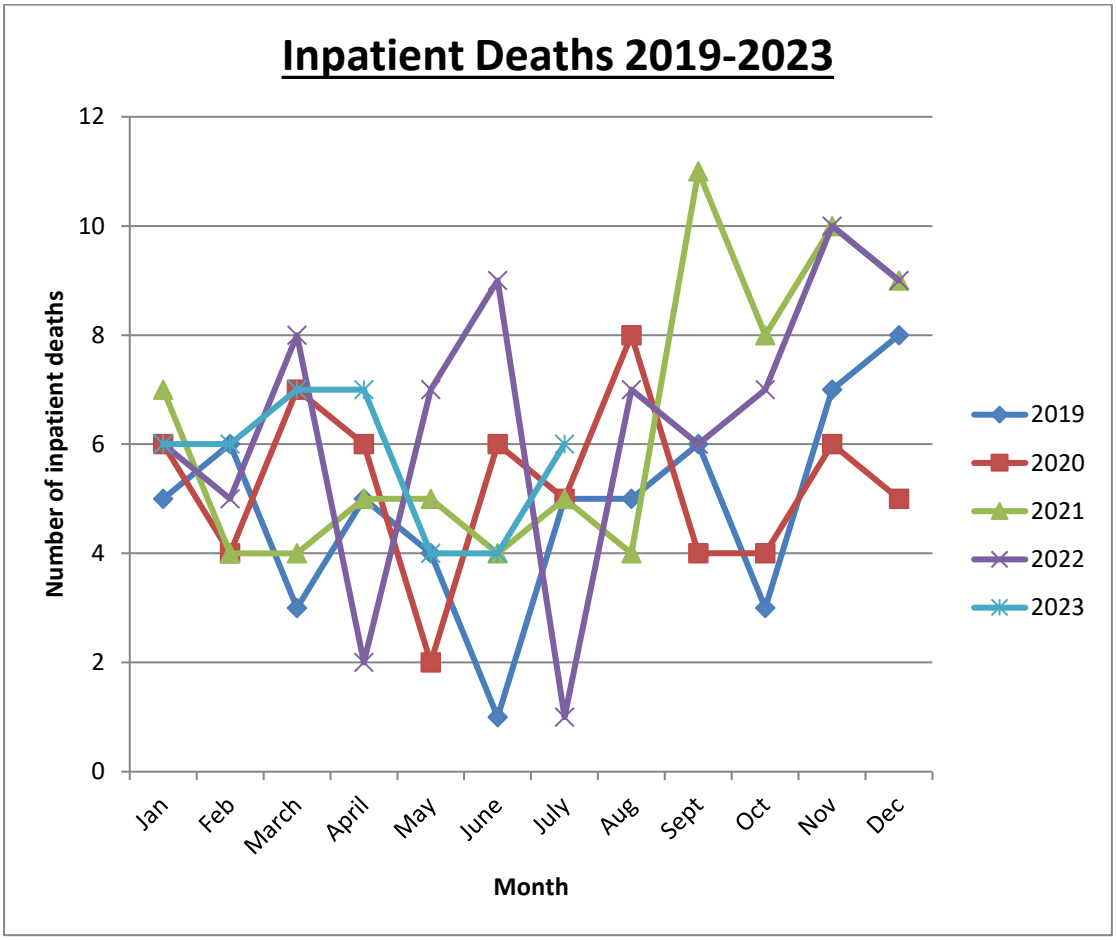
MORTALITY ASSESSMENT AT ALDER HEY

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 1 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 versus observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG)



Looking at the 5-year figures, currently the number of deaths is the highest for this period. The number of deaths has averaged out over the last 2 years following the increase in 2021, which was when the way deaths were recorded changed following Child Death Review Guidance. This year there have several infectious diseases including strep A circulating at higher rates than normal, resulting in increased mortality. There are no concerning trends, as will be discussed later in the report.

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 until April 2024. Alder Hey has appointed two paediatric medical examiners to join the LHUFT Medical examiner team. The AHCH process had been planned but introduction has been delayed due to IT issues which are being addressed.

2) Another change over the next 6-12 months is the introduction of the new Patient Safety Incident Report 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) From the 1st July, there is no longer the requirement to report any child's/ YP's death to LeDeR. This a service improvement programme for people with a learning disability and autistic people. It was aiming to ensure that any themes or concerns relating to these cases were highlighted at a national level. In the future they should be reviewed locally by the child death review teams and then shared nationally.

4) Over the next few months there will be an update of the HMRG policy, terms of reference and HMRG forms following advice from Trust legal team because of Coroner's cases.

Current Performance of HMRG

Summary of 2022 Deaths

Number of deaths (Jan. 2022 – Dec. 2022)	77
Number of deaths reviewed	76
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	75/77 (97%)

Summary of 2023 Deaths

Number of deaths (Jan. 2023 – Aug. 2023)	40
Number of deaths reviewed	12
Departmental/Service Group mortality reviews within 2 months (standard)	28/30 (93%)
HMRG Primary Reviews within 4 months (standard)	12/12 (100%)
HMRG Primary Reviews within 6 months	12/12 (100%)

The percentage of cases being reviewed within the 4-month target had decreased minimally due to the impact of junior doctors' industrial action. However, an extra meeting was held to ensure that the backlog was addressed and hospice deaths with significant AHCH input were also covered. The HMRG members are very flexible and committed to their role to ensure that the reviews are completed in a timely manner with comprehensive scrutiny. To achieve this the group consists of members with a wide range of expertise including NWTS (the regional paediatric transfer team), LWH (neonatology), psychology, Snowdrop (bereavement) team aiming for as robust process as 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 held monthly on Teams, enabling more people to attend allowing the DGH clinicians involved if they wish.

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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	0				2
July	1	1	1	1	1	0				
Aug	7	7	7	6	7	1				
Sept	6	6	6	5	6	4				3
Oct	7	7	7	7	7	3				1
Nov	10	6	9	6	9	3			1	2
Dec	9	8	8	8	9	2				1

Outcomes of the HMRG process 2023

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	6	6	6	2				4
Feb	6	6	6	6	6	2				2
Mar	7		6							
April	7		6							
May	4		4							
June	4									
July	6									
Aug										
Sept										
Oct										
Nov										
Dec										

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 85 cases, reviewed in 2022 and the start of 2023, 28% 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 was a legal requirement for the Trust but has recently changed as clarified above.

HMRG will continue to record these cases to ensure that there are no trends or any issues that need to be acted upon.

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 and this will continue.

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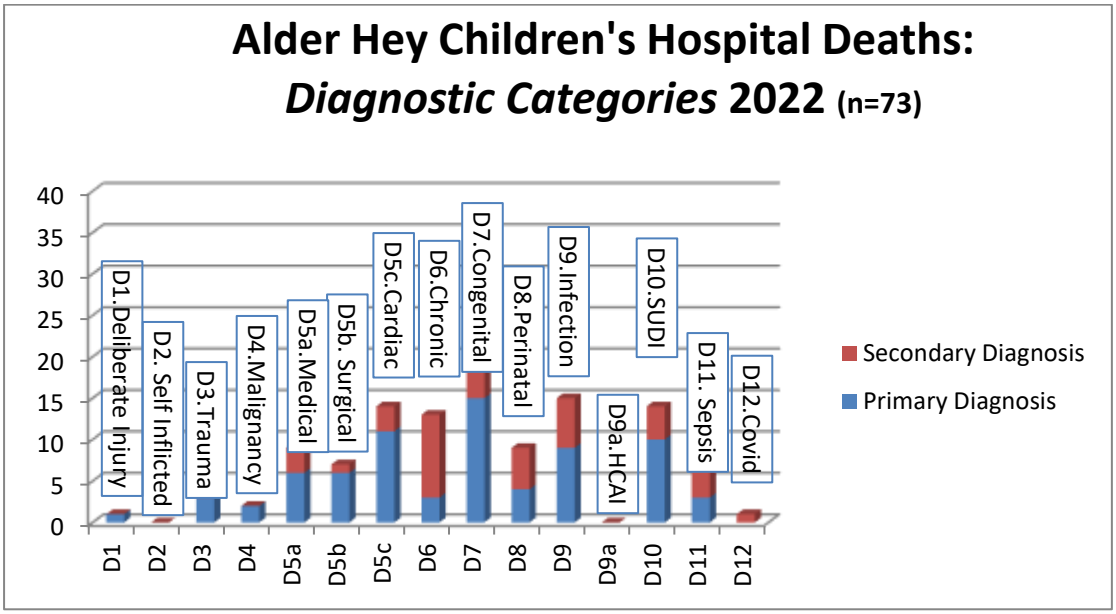
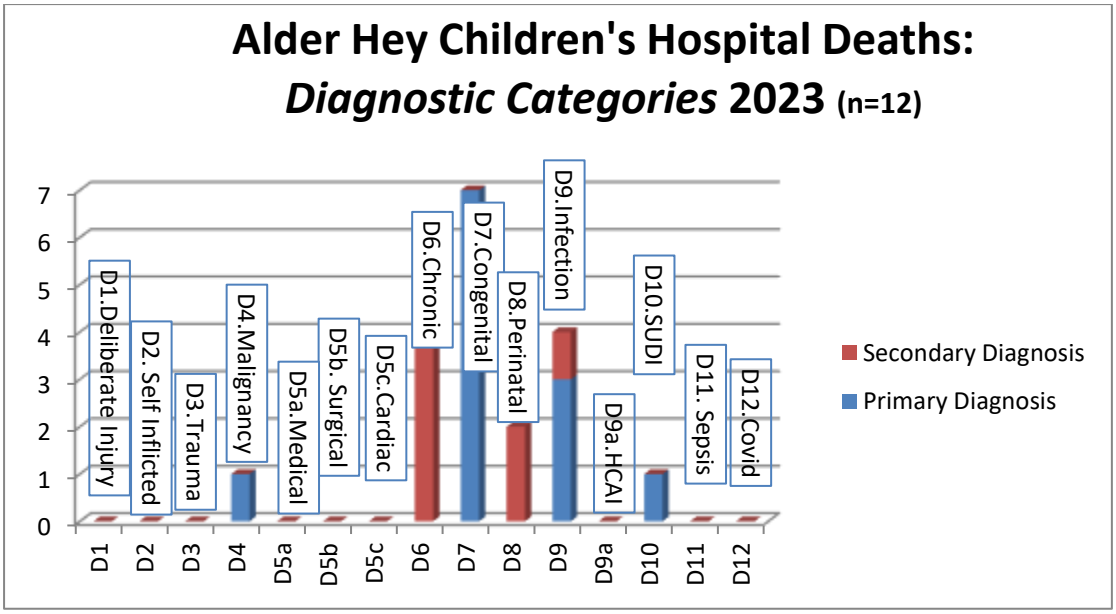
Primary Diagnostic Categories



Diagnostic/Disease Categories

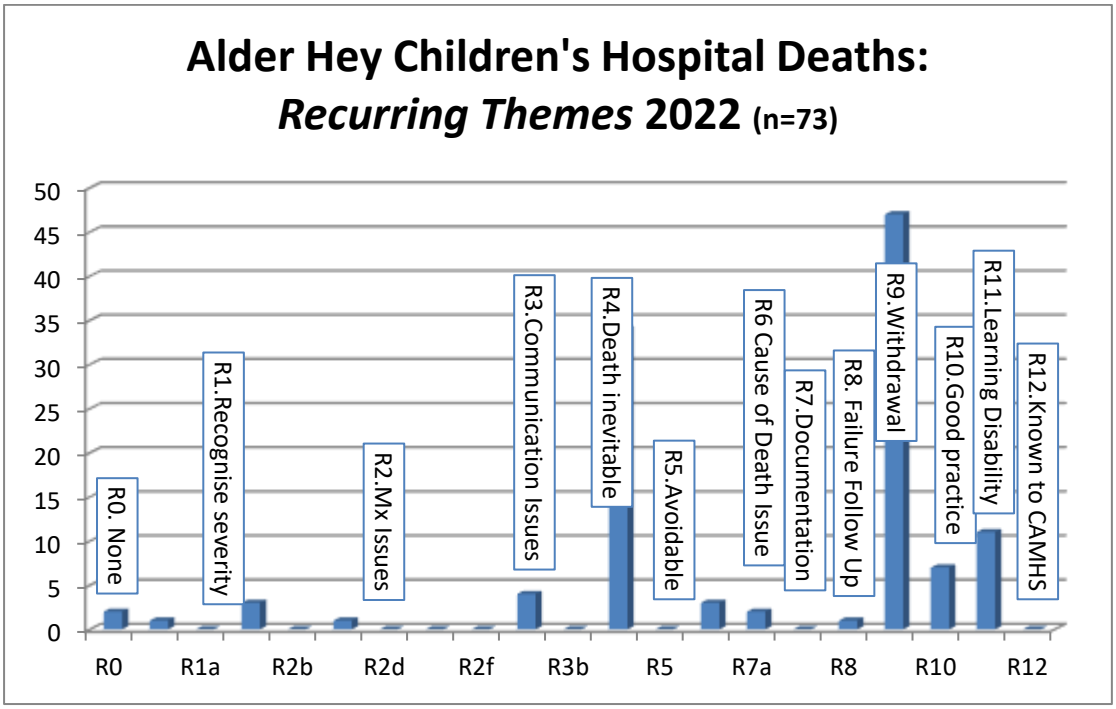
D1. Deliberately inflicted injury, abuse or neglect
D2. Suicide or deliberate self-inflicted harm
D3. Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4. Malignancy
D5. Acute Medical or Surgical condition – subcategories:
D5a. Medical D5b. Surgical D5c. Cardiac
D6. Chronic 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)

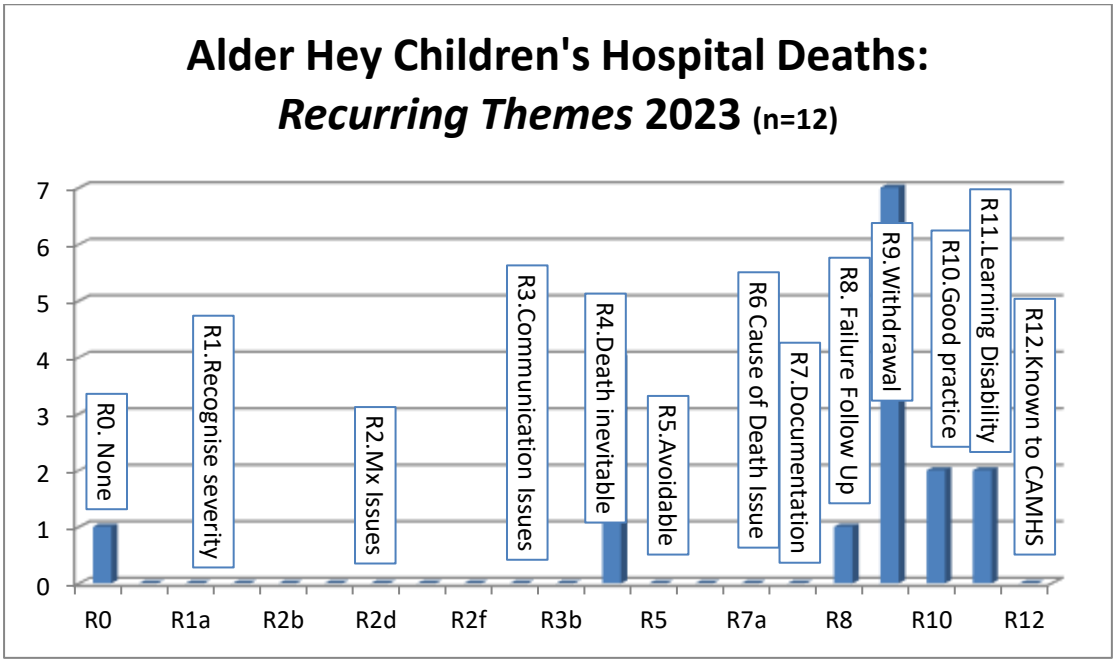


The cases reviewed in 2022 show that the highest diagnostic code is ‘children with underlying congenital conditions’ (20 %), these are often the most complex with several issues on going and are the most vulnerable patients. Next, with 15 % is the diagnostic code: ‘cardiac condition’ which relates to the fact that AHCH is a regional cardiac centre and over this period there have been some very complex cases. Close to this with 14% is ‘sudden unexplained, unexpected death’. 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.

In 2023, in the cases reviewed so far. The commonest diagnostic code is again children with underlying congenital conditions for the reason stated above with 58%. In second place is infection with 25% which relates to the high rate of infections that have been circulating in the population this year.

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 47%, 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.

The main codes for 2023 were identical despite the much lower number of cases reviewed. The figures were 58% for withdrawal and 33% for death inevitable category.

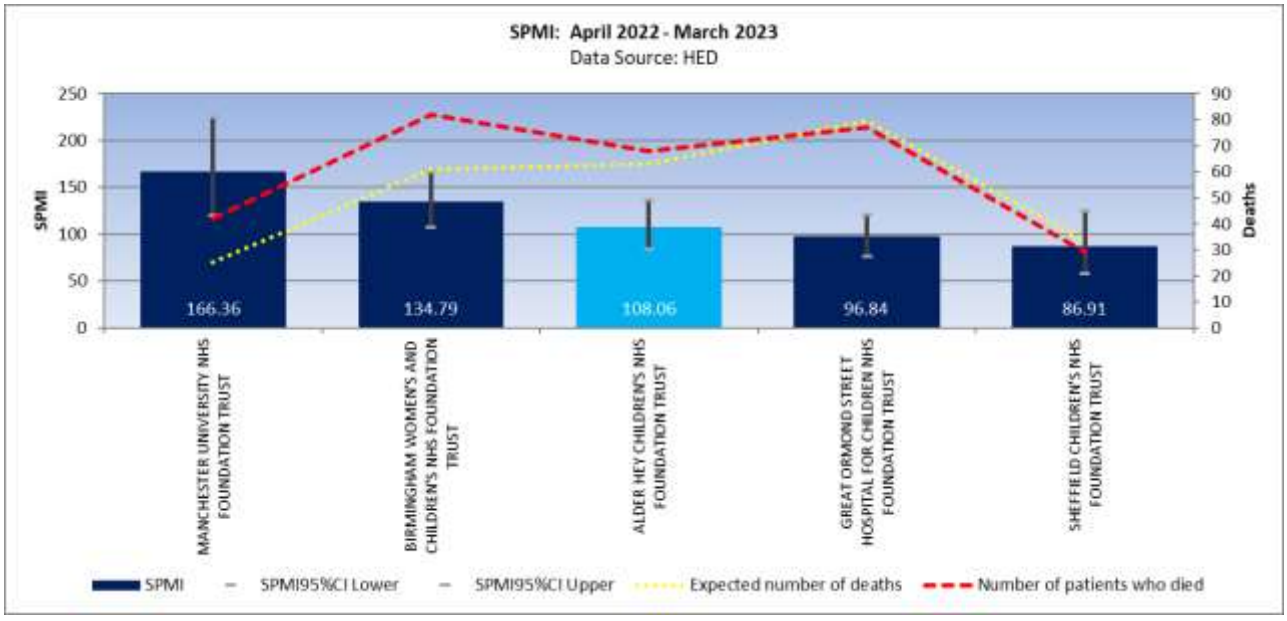
It is interesting to note that the group recorded 10% of the cases in 2022 as good practice since the members tend to be very reserved at allocating this as they believe the standard of care, we aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'. In the cases reviewed so far in 2023 there are already 17% that the group have felt to achieve this standard.

Section 2: Quarter 1 Mortality Report: April 2023 – June 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 April 2022 to March 2023.



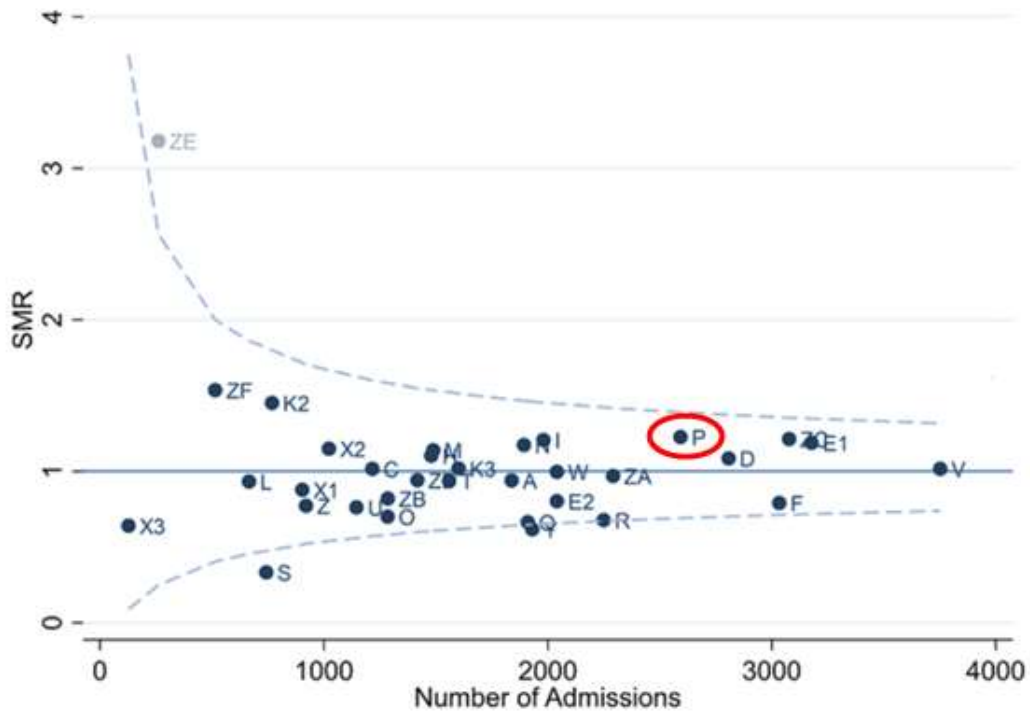
The chart shows that Alder Hey has performance of 68 deaths against 62.9 expected deaths over the period of April 2022 to March 2023. This is similar to Birmingham Childrens Hospital, who are the most comparable Trust to us with their workload and demographics. Looking at the recurrent themes, with the death inevitable being such a high percentage more so than previous years. It does raise the point are we importing mortality so increasing our number of actual deaths above expected deaths.

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 severity of illness 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

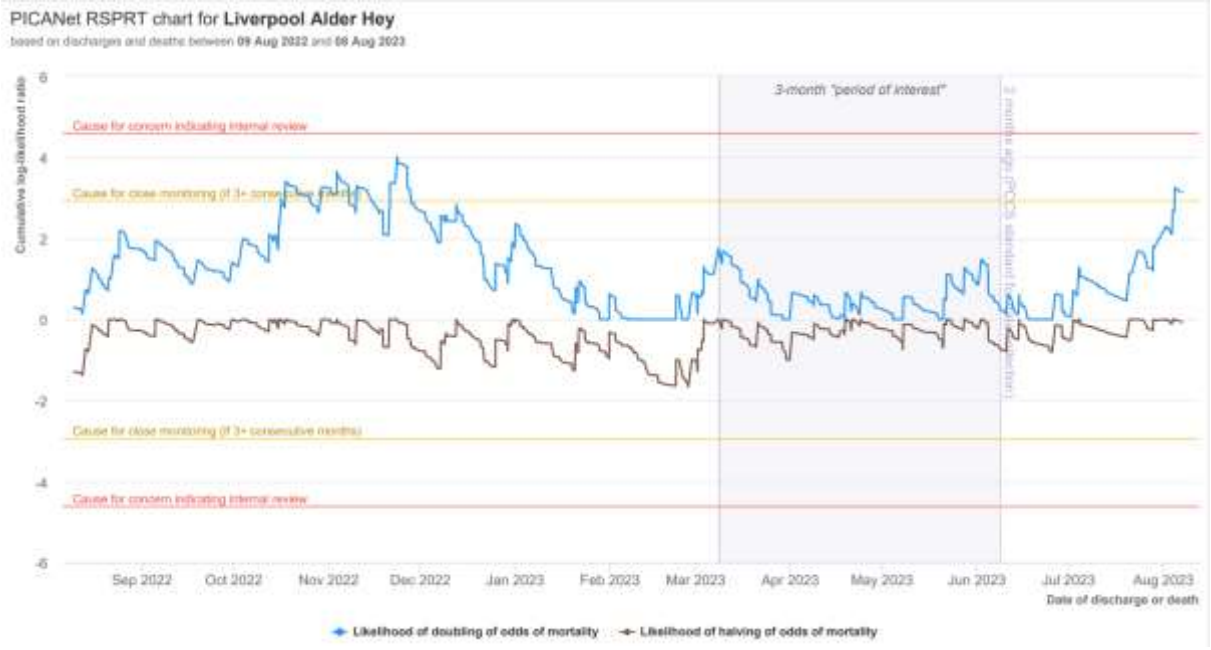


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

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.

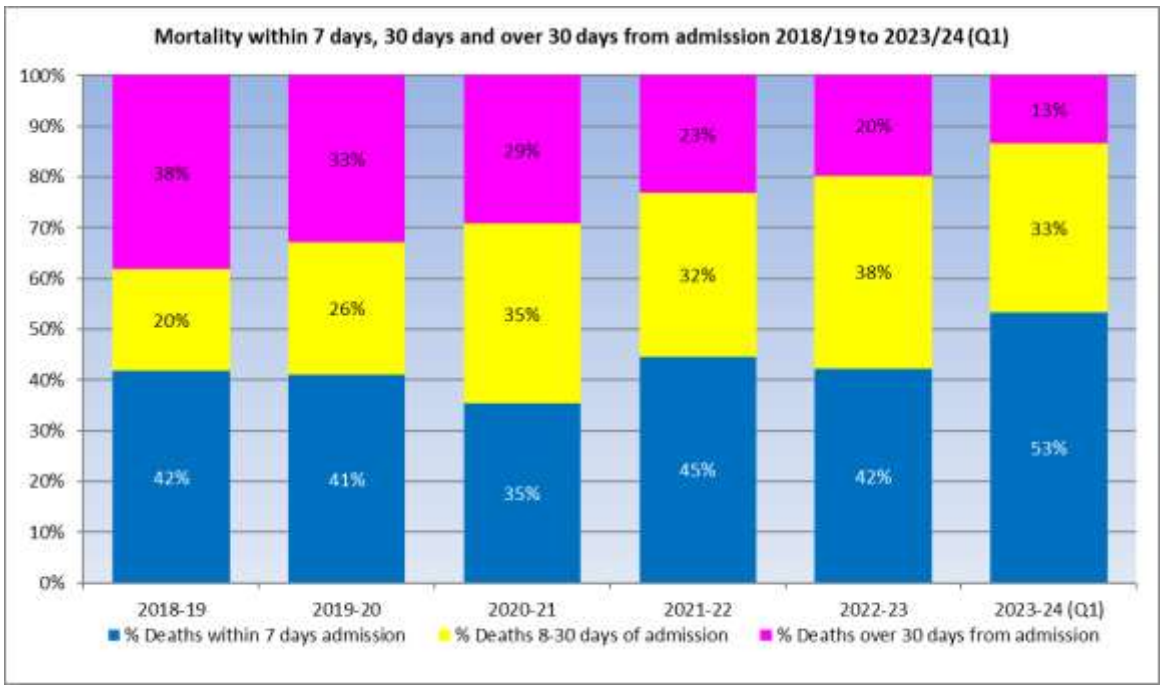


In our PICU mortality review meetings we continue to monitor the RSPRT on a regular basis, often noting a transient rise prior to risk adjustment which 'corrects' the likelihood ratio based on outcomes of ongoing admissions. Subsequently, although anticipated, previous rises did not in fact result in the graph hitting the red line and resetting, rather this trended down over subsequent months. At the time, we relooked at cases over the period Oct – Dec 2022 and found no concerning trends

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 quarter one of the financial year April 2023 – June 2023, 53% occurred within 7 days of admission, 33% occurred within 8-30 days from admission, and 13% 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. It is important that we continue to review the cases that are transferred to AHCH to ensure that the appropriate decisions are made as to whether there is care that can be offered at AHCH with the

recognition of the impact on the families on moving away from their support networks.

It is important that we start the ME pilot so that any issues can be resolved before it is a legal requirement and minimising the impact on families and clinicians. 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). **Pg 10**

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 11**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**DIPC Quarter 1 report**
Report of:	Infection Prevention and Control Team
Paper Presented by:	Dr. Beatriz Larru, Director of Infection Prevention & Control

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	
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:	

Does this relate to a risk? Yes ☐ No ☑						
Risk Number	Risk Description					Score
Level of assurance (as defined against the risk in In Phase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

Principle Targets and Outputs

Table 1- 2023-24 targets and Q1 2023 healthcare-associated infection (HAIs) results

Metric	Target 2023-4	Target figure	Actual figure	2022-23 Total Numbers
Clostridiodes difficile infection (CDI)	Zero tolerance	0	1	
Methicillin resistant *Staphylococcus aureus* (MRSA) bacteraemia	Zero tolerance	0	0	
Methicillin sensitive *Staphylococcus aureus* (MSSA) bacteraemia	Reduction from 2022-23	<8	2	
Escherichia coli bacteraemia	Reduction from 2022-23	<16	6	
Klebsiella spp. bacteraemia			5	
Pseudomonas aureginosa bacteraemia			0	
Hospital-onset RSV infection	Reduction from 2022-23	<12	0	

Infection Prevention & Control Team Summary

On 19th April, the IPC team its post-pandemic relaunch with a team away day supported by Brilliant Basics. As a team, we selected the following workstreams to prioritize our improvements: 1) development of automatic IPC dashboards, 2) review of process of how to promptly identify patients in isolation precautions, 3) alignment of our post infection reviews with PSIRF, and 4) promoting parents/visitors IPC education.

During QTR1, the IPC leadership team has continued the revision of the IPCC and governance processes with the reconvening of the IPCC on 14th June 2023. The IPCC workplan was developed for 2023-4 based on the board assurance framework and approved by the IPC committee (IPCC).

INFECITON PREVENTION & CONTROL QUARTERLY REPORT

Quarter 1, April – June 2023

1) Bacteraemias Surveillance[#]

Blood culture processed	+ve blood culture	*S. aureus* bacteraemia	Gram-negative bacteraemias*	Skin Contaminants
April 2023	659	1 MSSA	2	25
May 2023	649	3 MSSA	5	28
June 2023	659	1 MSSA	4	34

[#] Includes all bacteraemias (community and hospital onset)
* Only includes *E. coli*, *Klebsiella spp.* and *Pseudomonas aeruginosa* specimens.

1.1 Healthcare-associated Gram-negative bloodstream infections

Preventing healthcare-associated Gram-negative blood stream infections (GNBI) is a priority for NHSE, as these infections are associated with severe clinical outcomes, prolonged hospital stays and antimicrobial resistance. While children and young people have different risk factors to develop GNBI and require focused preventive measures, the multifaceted approach proposed by NHSE to achieve GNBI reductions, continues to be applicable to the Trust. Surveillance of GNBI is the first component of the NHSE GNBI reduction toolkit.

The IPC team reports to UKHSA monthly all cases of healthcare-associated bloodstream infections. A summary of all cases identified in the Trust alongside the annual thresholds set up by UKHSA is as follows:

<table>
<tr>
<td> 
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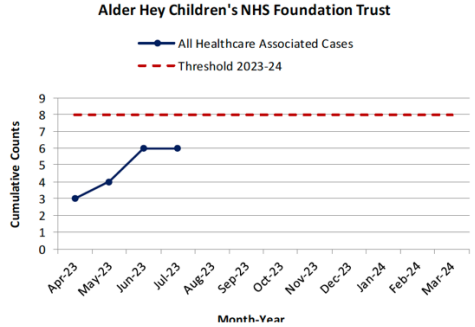
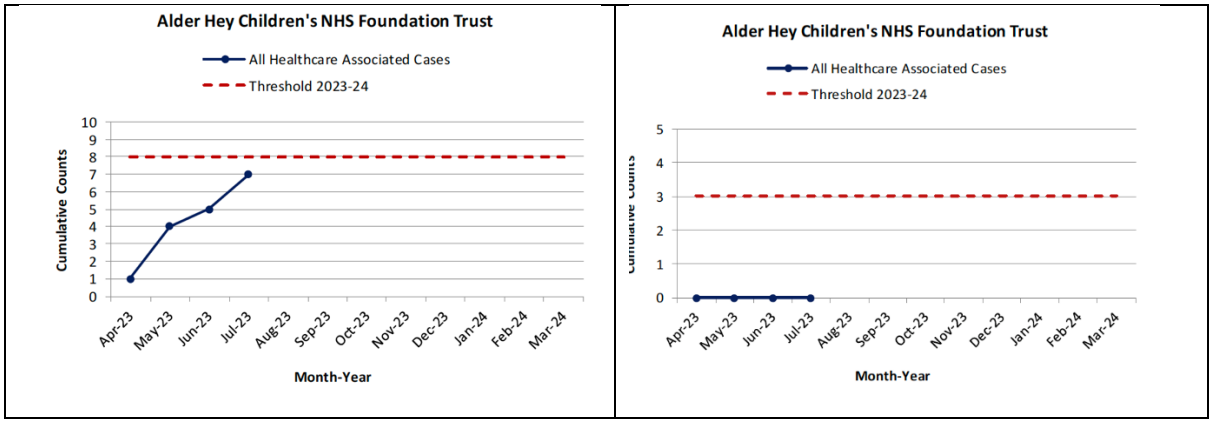
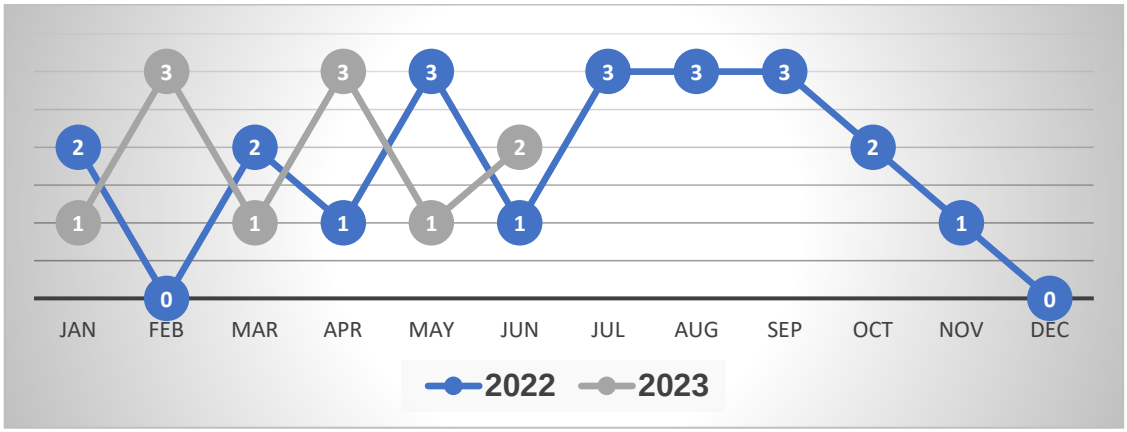
<td>E. coli bloodstream infections
 
</td>
</tr>
<tr>
<td>Klebsiella spp. bloodstream infections</td>
<td>P. aeruginosa bloodstream infections</td>
</tr>
</table>



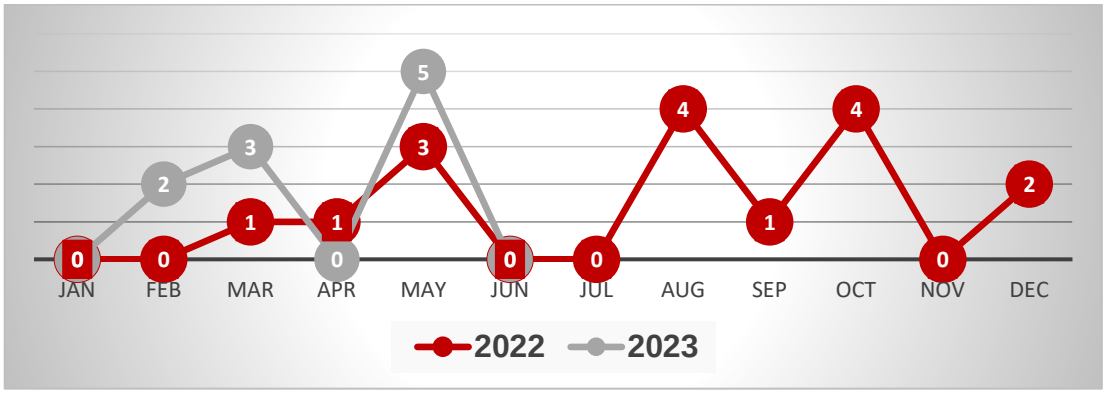
1.2 *Escherichia coli* blood bloodstream infections (BSI)



During QTR1 there were 8 episodes of *E. coli* BSI in 7 patients. Out of those, 6 episodes were healthcare-associated (*i.e.,* occurred in patients who have received healthcare in either the community or hospital in the previous 28 days), which represented a monthly rate of 36.2/100,000 bed days.

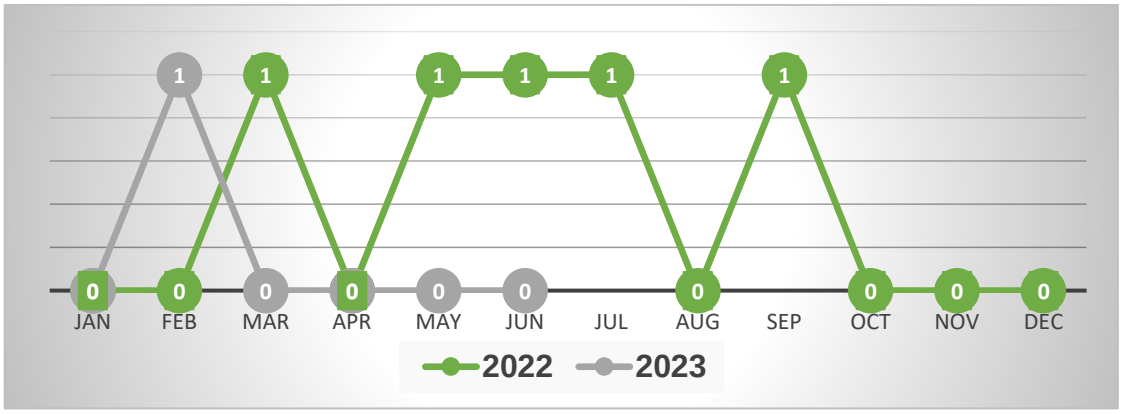
All *E. coli* BSI episodes were subject to a post-infection review from April 23 to identify any avoidable factors or learning points for dissemination. Review of the cases identify abnormal gastrointestinal tract, immunosuppression and frequent hospital admissions as common unavoidable predisposing factors. Cleanliness monitoring scores <98% and ANTT compliance scores <100% were also identified during PIRs which have led to the relaunch of the environmental and cleanliness group in Aug 23 and the adoption of surgical ANTT for non-emergent direct access to central vascular catheters in the PICU in Oct 23. The DIPC has also joined the TPN steering group to work collaboratively with the TPN nursing specialists to minimise the risk of GNBI in short gut patients.

1.3 *Klebsiella spp*. bloodstream infections (BSI)



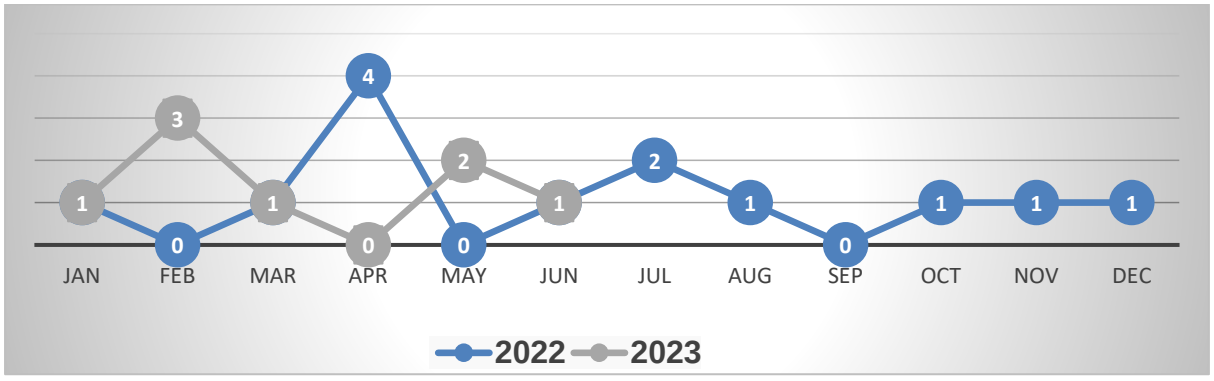
During QRT1 there were 5 episodes of *Klebsiella spp*. BSI in 4 patients. All episodes were healthcare- associated which represented a monthly rate of 30.2/100,000 bed days. These episodes also underwent PIR with similar findings and actions plans as *E. coli* BSI.

1.4 *Pseudomonas aureginosa* bloodstream infections (BSI)

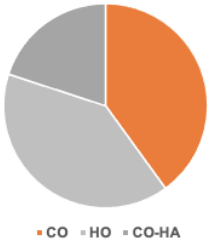


There were no cases of *P. aureginosa* bloodstream infection reported during QTR1.

2) Healthcare-associated *Staphylococcus aureus* bloodstream infections



During QRT1 there were 5 episodes of methicillin-sensitive *S. aureus* BSI (MSSA) in 5 patients. Out of those 2 had community onset and 3 were healthcare associated. These episodes also underwent PIR with similar findings and actions plans as *E. coli* BSI. During QRT1 there were no cases or methicillin-resistant *S. aureus* (MRSA) BSI.



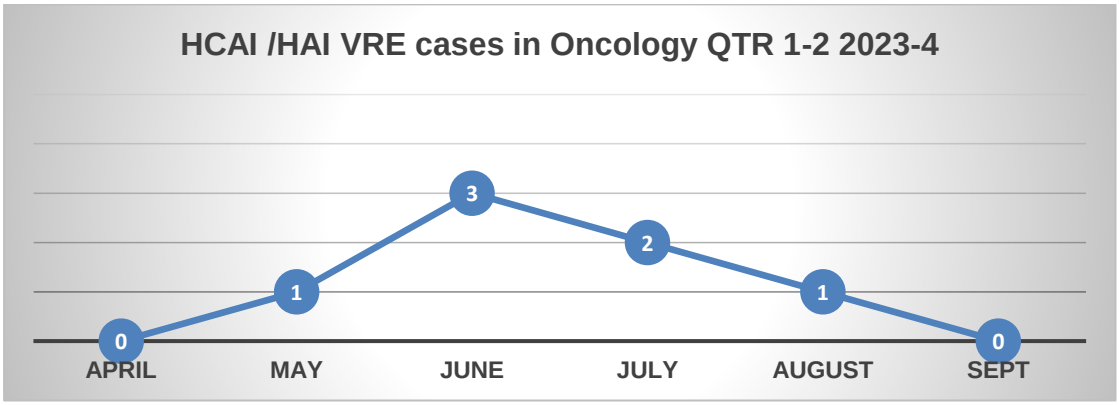
3) C. difficile infection

During QTR1 there as 1 case of severe *C. difficile* infection in an Oncology patient. The PIR did not identify any lapse in care.

4) Colonisation with Multidrug Resistant Organisms (MDRO)

4.1 Vancomycin Resistant Enterococci (VRE)

During QRT1 there was an increase in healthcare- associated VRE cases in Oncology. During the PIR it was noted that no routine screening for VRE was conducted in Oncology patients which limited our capacity to promptly identify and isolate these patients. Since Jul 2023, routine VRE screening on admission is performed in the oncology ward. The updated UKHSA recommendations on surveillance of MDRO are included in the Trust surveillance and screening policy approved in Sep 23 IPC committee.



The 7 VRE isolates from Oncology were sent to UKHSA reference laboratory for typing. This confirmed that 6 isolates had similar typing results, which supports cross-transmission of VRE in oncology patients. An outbreak investigation was launched in Sep 23 which identified challenges in 1) prompt identification of colonised patients, 2) communication of results, 3) cleanliness of medical equipment and environment and, 4) facility to isolate colonised patients. The development of an action plan with medical and nursing staff is ongoing.

5) **Healthcare acquired viral infections**

4.1 Respiratory viral infections

During QRT1 there were 7 cases of healthcare acquired Adenovirus infections and 4 cases of HAI COVID-19. Since May, all nosocomial viral infections have been included in our PIR framework, which identified the following common themes:

- Lack of awareness among staff of need to use PPE accordingly to patient's symptoms, not just testing results
- Lack of awareness among staff of the burden of nosocomial viral infections in hospitalised paediatric patients
- Previous visits from a friend or relative with symptoms
- Frequent contact outside the ward in families with long-term patients (particularly in 1C cardiac ward).

To reduce the nosocomial transmission of respiratory viral pathogens, an updated isolation policy was approved in June 23 IPCC after in depth discussion in the Clinical Advisory Group (CAG). The IPC team also performs daily "isolation walks" among all areas of the Trust to communicate to staff the appropriate IPC precautions and has developed visual graphics to identify contagious patients.

4.2. Gastrointestinal viral infections

During QRT1 we have 3 cases of healthcare-associated Norovirus infections. Two of these cases were potentially cross transmitted between 2 patients in 4B, which lead to an outbreak investigation to promptly identify all symptomatic patients and staff, enhance environmental cleaning and closure of common spaces in the ward. The incident was stepped down in 5 days, no staff was affected, and no beds were closed.

6) **Other Notable Infections**

5.1 Group A Streptococcus

During QRT1 the microbiology lab isolated Group A Streptococci in 172 patients. Out of those, one case was isolated in a patient who underwent surgery within the previous week. An outbreak investigation was completed which did not identify epidemiological link with other patients.

5.2 Measles

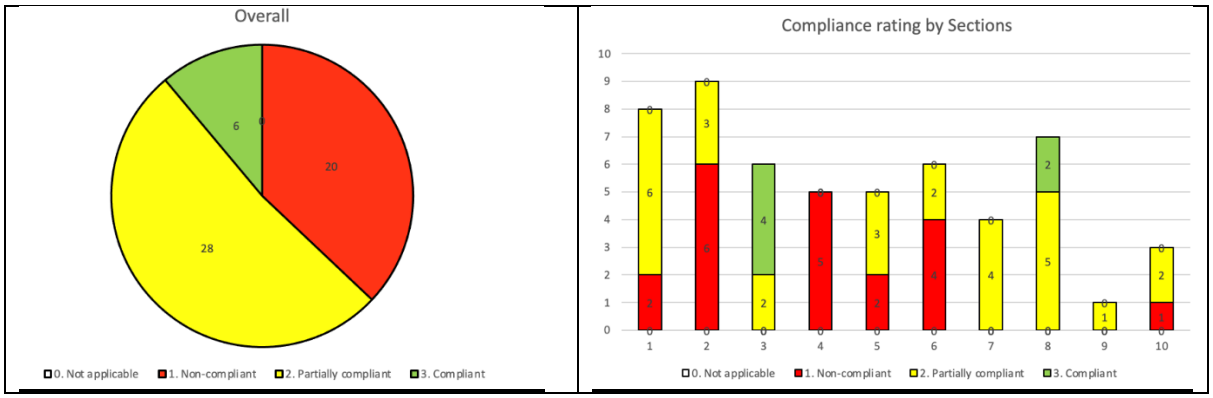
During QRT1 the microbiology laboratory processed 17 measles tests. None of them were positive for natural measles infection. The DIPC actively collaborates with UKHSA, NHSE and Liverpool City Council to integrate the Trust in the Chesire and Merseyside measles preparedness response.

4. Incidents, outbreaks and Emergency Preparedness

During QRT1 the IPC lead the investigation of 2 varicella exposures (ward 3A and HDU), 1 pertussis (PICU), as well as 4 potential measles exposures in the ED.
In June, we identified 4 cases of *Serratia marcescens* infection in 1C cardiac. An outbreak was declared to promptly identify and isolate all affected patients, reinforce appropriate hand hygiene and enhance medical equipment/ environmental cleaning. The isolates were sent to UKHSA reference laboratory for typing. This confirmed that 3 out of 4 isolates had similar typing results, which supports cross-transmission of *Serratia* in 1C patients. The results of water and medical equipment testing that was performed as part of the outbreak investigation revealed negative results.

5. Infection Prevention and Control Work Plan 2023-2024

The IPC workplan was developed for 2023-24 based on the board assurance framework and presented on 12th Jul 2023 IPC committee (attached at the end of this report). The Trust Board Assurance Framework showed that the following level of compliance according in each of the 10 selected sections:



QTR1 has seen the revision of the IPCC and governance processes with the reconvening of the IPCC in June 2023. In addition, workplans have been developed for the IPCC subgroups identified in C15 Infection Control policy which will be reported quarterly at the IPCC and reported to SQAC.

- Environment and Cleanliness
- Hand Hygiene Improvement Group
- Clinical Advisory Group (CAG)
- AMR Steering Group
- Sharps Safety
- IPC Champions

6. Infection Prevention & Control associated Risks

Risk Number InPhase ID	Ulysses ID	Risk Description	Initial Risk score	Target risk score	Risk score Q1 23/24	Risk movement	Mitigations in place Q1
00002754	2788	Non-compliant with FIT testing for clinical staff in scope	12	2	12	⟷	Secondment of 1 band 6 Nurse to provide FIT testing and vaccinations
00002713	2747	Inability to maintain IPC standards due to limited availability of curtains and lack of timely response to the rapid cleaning pathway	9	4	9	⟷	Agreed with Domestic manager to leave window curtains for amber clean. Trial of wall mounted Screens on 4C to replace bay privacy curtains agreed by Kwik screen. Business case in development.
00002714	2748	IPC Policies are not up to date and not reflective of current IPC practice	9	4	9	⟷	Recovery plan developed. Plan to reinstate IPCC in Q2 with policies ready for ratification
00002715	2749	Lack of advanced data skills within IPC team resulting in inability to monitor and recognise IPC standards and trends. Lack of real time data	12	3	12	⟷	Risk linked with Micro lab and AMS – escalated to Medical Director to discuss ICNET solution
00002710	2744	Non delivery of IPC standards due to insufficient IPC staffing levels	12	6	12	⟷	Recruitment to vacancies, some bank shifts offered to cover absence. Brilliant Basic team interventions to review processes.
00002682	2716	Confidential information could be accessed and used inappropriately – patient letters stored on the K drive and not in Medisec	12	3	9	↓	Training of the team complete and 75% of letters migrated date range 2023 – 2016.

8. Discussion and next steps

In QRT1, the IPC team started a transformation programme to become a national leader in paediatric infection and control. Supported by Brilliant Basics we have used A3 process to understand the limitations of our current work practices and develop improvement workstreams to become more efficient.
We have continued to liaise with other clinical teams to design and implement action plans that help us prevent nosocomial transmission or respiratory viruses as well as reduce the burden of Gram-negative blood stream infections in our TPN, immunocompromised and critically ill patients.
Despite all these improvements, we continue to experience daily the limitations of not being a data driven IPC programme due to the limited surveillance infrastructure that the IPC team has at present. This hinders our capacity to prevent patient harm. A proposal to acquire an electronic surveillance program has been shared with the executive team with an accompanying funding bid to the Trust charity.

Alder Hey Children's NHS
NHS Foundation Trust

2023-24 Infection Prevention & Control Work Plan

Section 1 Implementation plan

Mission Statement: The IPC department's mission is to promote safe care by reducing the risk of acquiring and transmitting infections among patients, visitors, and healthcare workers*. This will be achieved by ongoing surveillance, educational activities and evidence-based modifications of services led by regulatory standards, scientific studies, and professional guidelines.

Vision: Our vision is to achieve "Healthcare without avoidable infections" by optimizing the process for prevention of healthcare-associated infections (HAIs). We aim to impact and reshape the way that health care is delivered to prevent patient harm and create a safer environment for patients and health care workers. The IPC programme will be built on a foundation of data integrity and evidence-based practices.

This Work Plan has been developed using the National infection Prevention and Control board assurance framework published on April 23 to effectively assess the Trust compliance set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by UK Health Security Agency (UKHSA). This Work plan also includes the evidence-based WHO *Guidelines on core components of IPC programmes*.

Compliance Criterion with H&SCA 2008: Code of Practice on the Prevention and Control of Infections and related Guidance	WHO core IPC component
Criterion 1- Appropriate management and monitoring arrangements	Structure of IPC Programme
Criterion 2- Clean environment	Ensure the Safety of Environment
Criterion 3- Antimicrobial use	Surveillance
Criterion 4- Information on Infections	Education & Training
Criterion 5- Those at risk for Infection	Education & Training
Criterion 6- Trust provider responsibility to healthcare workers	Education & Training
Criterion 7- Isolation facilities	Acute Event Response
Criterion 8- Laboratory support	Surveillance
Criterion 9- Policies	Performance Improvement
Criterion 10- Occupational Health	Collaboration with Occupational Health

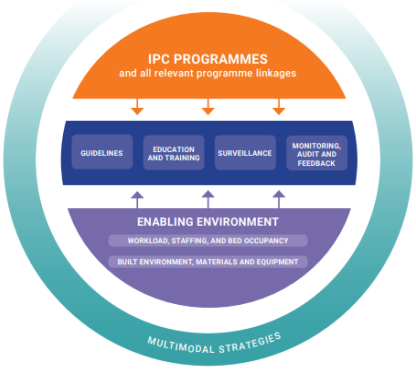


Figure -1: World Health Organization infographic IPC core components

*the term "healthcare worker" is used to refer to anyone whose normal duties involve providing direct care to service users, for example clinical staff, nurses, healthcare assistants, care assistants as well as volunteers.

Objective 1	Criterion 1 Health & Social Care Act 2008 - Appropriate management and monitoring arrangements

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1[1]	Q2	Q3	Q4	
1.1	Submission to the Trust charity a funding application for ICNET					B Larru / V Greenwood
1.2	Review of IPC structure during the Trust external review of the Infectious Diseases services					B Larru / V Greenwood
1.3	Development of PIRs process in alignment with PSIRF					L Case
1.4	Development of Trust wide report of device associated HAIs					B Larru / V Greenwood
1.5.	Liaison with clinical teams for shared responsibilities of audits (including all aspects covered on NIPCM)					IPC Team
1.6	Development of an automatic area specific IPC compliance dashboard					J McLean / N Murphy
1.7	Provide risk assessment training for all IPC members					J McLean / V Greenwood
1.8	Update SQAC reports to provide data trends, PIRs theme learning and other required elements (*i.e.*, PLACE reports, AMS report…)					B Larru / J McLean
1.9	Develop competencies of IPCT. B6 development IPC postgraduate certificate. B4 to undertake Assistant Practitioner qualification					J Mclean / V Greenwood
1.10	Develop Competencies for B4 IPC Practitioner					J McLean
1.11	Development of IPC workplan & GAP analysis with BAF					B Larru /V Greenwood / J McLean

Objective 2	Criterion 2 Health & Social Care Act 2008 - Clean environment

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
2.1	Approval of RM49 Hospital Cleaning policy					J McLean / Domestics / Decon
2.2	Create Trust Ventilation Safety Group					L Stark / B Larru
2.3	Development of Programme Plan Maintenance policy					Building services / Mitie / Estates / IPC
2.4	Development of ICRA (Infection Control Risk Assessment) for Construction, Renovation and Demolitions					Building services / Mitie / Estates / IPC
2.5.	Submission of business case for curtain replacement across the Trust					L Stark / J McLean
2.6	Create Task & finish group to improve cleanliness of Pantries and staff food preparation areas					J McLean / L Cooper/ S Declouet
2.7	Implement food hygiene training program for Clinical areas					J McLean / S Declouet
2.8	Implement MDT Technical & Efficacy audits for Cleanliness monitoring					J McLean / L Cooper
2.9	Implementation of Cleanliness charters					L Cooper / J Fitzpatrick / Peter
2.10	PLACE audit incorporated into SQAC report annually					Anne Doyle
2.11	Implement Joint auditing IPC/Decontamination for Dentistry /Mortuary					T Caseberry / J McLean
2.12	Develop & Implement NIPCM waste management audit					J McLean / M Devereaux

Objective 3	Criterion 3 Health & Social Care Act 2008 - Antimicrobial use

Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
3.1	Submission to the Trust charity a funding application for ICNET to monitor antimicrobial use across the Trust					B Larru / V Greenwood

Objective 4	Criterion 4 Health & Social Care Act 2008 - Information on Infections

Provide suitable accurate information on infections to patients/service users, visitors/careers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
4.1	Development of IPC educational packages for families and visitors					L Case
4.2	Create IPC/AMS relevant PIL					IPC Team
4.3	Establish Trust wide IPC bundles of care to prevent HAIs					IPC Team
4.4	Collaborate with Innovation to develop electronic resources to disseminate IPC information to Staff and patients					B Larru / N Murphy
4.5	Gap analysis for PIL for IPC /AMS					J McLean

Objective 5	Criterion 5 Health & Social Care Act 2008 - Those at risk for Infection

Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
5.1	Approval of C58 Screening & Management of MDRO policy					J McLean / B Larru
5.2	Development of ward entrance IPC signage					B Larru / N Murphy
5.3	Update C19 Major Outbreak policy					J McLean / B Larru
5.4	Develop daily IPC status indicators within Aldercare 2.2.					IPC Team
5.5	Introduce weekly surveillance screening for RDU					B Larru / N Dwyer
5.6	Introduce monthly Surveillance screening for long stay patients (> 1 month)					B Larru / N Dwyer
5.7	Develop IPC Transfer information process in Aldercare					J McLean / Peter
5.8	Revision of SQAC IPC Template					J Mclean /B Larru

Objective 6	Criterion 6 Health & Social Care Act 2008 - Trust provider responsibility to healthcare workers

Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
6.1	Review Trust IPC E learning package to cover all NIPCM aspects					J McLean / B Larru
6.2	Implementation of NHSE IPC Education framework					J McLean / B Larru / E&T
6.3	Develop an educational strategy for HCID training across the Trust					L Case / B Larru
6.4	Undertake Gap analysis for IPC Educational framework					J McLean / B Larru / P Ashall
6.5	Implementation of Quality control Hand hygiene audits & BBE audit					J McLean / V Lam
6.6	Include PPE element of NIPCM into E learning package and audit					J McLean
6.7	Incorporation of IPC as Objective in Staff PDR					M Swindell
6.8	Fit testing compliance presented at H& S committee					C Brindley / L Hughes
6.9	ANTT incorporated into Competency passports for Medics					S Melville / P Carney

Objective 7	Criterion 7 Health & Social Care Act 2008 - Isolation facilities

Provide or secure adequate isolation precautions and facilities						
Activities		insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
7.1	Revision of the current isolation spreadsheet					L Wall / BB team
7.2	Development of IPC internal transfer documentation					IPC Team
7.3	Implementation of NIPCM audits & Feedback to areas / departments					IPC Team

Objective 8	Criterion 8 Health & Social Care Act 2008 - Laboratory support

Provide secure and adequate access to laboratory/diagnostic support as appropriate

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
8.1	Approval of HCID SOP					L Case / B Larru
8.2	Update C19 Major Outbreak policy					J McLean / B Larru
8.3	Enhance microbiology training for IPC team members					B Larru / Micro team
8.4	Approval of MDRO surveillance /Management policy					IPCT
8.5	Implementation of Diarrhoea sampling flowchart					J McLean / IPCT
8.6	Cost benefit analysis for introduction of POU testing for Influenza / RSV					N Dwyer

Objective 9	Criterion 9 Health & Social Care Act 2008 - Policies

Have and adhere to policies designed for the individual's care and provider organizations that will help to prevent and control infections

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
9.1	Develop a programme to update IPC outdated policies					J McLean / B Larru
9.2	MDRO screening & management policy, Revised RM21 Hospital cleaning Policy					J Mclean / B larru
9.3	Revision of C19 Outbreak Policy					B Larru / J McLean
9.4	NEW HCID Policy					B Larru
9.5	NEW Management of Gastrointestinal virus clusters & Outbreaks policy					B Larru / J Mclean
9.6	NEW Immunization of service users /OCH policy					J McLean/ Optima Rep
9.7	NEW TB policy					J Mclean / B larru
9.8	NEW Dissemination of information policy					J McLean / B Larru

Objective 10	Criterion 10 Health & Social Care Act 2008 - Occupational Health

Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

	Activities	insert year here				Lead Person, organization or applicant partner
		Q1	Q2	Q3	Q4	
10.1	Develop Trust OCH policy					
10.2	Develop Risk assessment process for staff at risk of infection					J McLean / Optima
10.3	Gap analysis of Optima contract against IPC requirement for staff safety					B Larru / M Swindell
10.4	Re Introduce review process for investigation of NSI					J McLean / A Kinsella
10.5	SOP for getting external information about staff for externally based staff in event of IPC incident					M Swindell / Optima Rep

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	Safety Quality Assurance Committee
Report of:	Fiona Beveridge, Non-Executive Director
Paper Prepared by:	Fiona Beveridge

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 20th September 2023, along with the approved minutes from the 19th July 2023 meeting.
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:	

Does this relate to a risk? Yes ☑ No ☐

Risk Number	Risk Description	Score
1.1	Inability to deliver safe and high-quality services	3x3
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	4x5
1.4	Access to Children & Young People's Mental Health	3x5

Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☑	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

1. Executive Summary

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 noted the issues with Inphase, and understood the plan to address issues.
- SQAC received a good update on Sepsis mandatory training compliance, with the expectation that Divisions would continue to monitor trough their governance meetings and present a further report to SQAC in December 2023.
- SQAC received a Patient Safety Strategy update, with good progress noted across all of the workstreams.
- SQAC received an ED monthly report: Mental Health attendance and ED@ its best update, which demonstrated improvements in ED, and improvement with ED reporting, with positive impact evident as a result of changes made with regards to management of patient flow within ED.
- SQAC received a comprehensive and thorough mortality report, with discussions held regarding the move to the new system, and when working collaboratively or in partnership with other organisations to understand how this works and ensuring that the necessary processes are in place.
- SQAC received the CQUIN quarterly report and noted that the report is work in progress with the system to understand the full impact of all of the standards within the Trust.
- .SQAC received good divisional updates, and in addition received a Deep Dive regarding NICE compliance in Medicine. SQAC welcomed progress made.
- SQAC received the Clinical Effectiveness and Outcome Group Interim Chair's Highlight report, SQAC was pleased to note that two Clinical Effectiveness and Outcome Group Chairs had been appointed, whilst noting the ongoing focus on audits across the organisation.
- SQAC received, noted and approved the Patient Safety Incident Response plan and Governance processes and approach. FB expressed thanks on behalf of SQAC to all involved for ongoing support regarding the introduction of the new Patient Safety Incident Response Plan.
- SQAC received and noted the Quality Assurance Rounds Report, with good discussion held.
- SQAC received the Ward Accreditation report, and discussed the need to separate out the key safety issues from the ward assurance process to ensure safety is business as usual. SQAC noted the safety issues reflected within the report and the suggestions for different approaches to be developed to proper ongoing accountability around these.
- The Quarterly Infection Prevent Control Report and the PALS & Complaints report was deferred to 18th October SQAC meeting, with SQAC acknowledging that the 18th October 2023 SQAC meeting would be a busy meeting.

4. Recommendations & proposed next steps

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 July 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)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Divisional Director Community & MH Division	(LC)
	John Grinnell	Managing Director/Chief Financial Officer	(JG)
	Bea Larru	Director of Infection Prevention & Control	(BL)
	Jo Revill	Non-Executive Director	(JRe)
	Paul Sanderson	Acting Chief Pharmacist	(PS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)
In Attendance:			
23/24/66	Dr. Mathew Neame	Chief Clinical Information Officer, Medicine Division	(MN)
	Mark Carmichael	Chief Operating Officer – Medicine Division	(MC)
	Camille Cortez-James	Risk & Governance Lead , Surgery Division	(CCJ)
	Jayne Guy	Head of Nursing & AHP's for Diagnostics & Clinical Services	(JG)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jill Preece	Governance Manager	(JPr)
	Laura Rad	Head of Nursing-Research	(LR)
	Jane Ratcliffe	Consultant, Complex Care	(JR)
	David Reilly	Associate Director of Digital Systems	(DR)
	Linda Wain	Corporate Governance and Risk Manager	(LW)
	Peter White	Chief Nursing Information Officer	(PW)
	Julie Creevy	EA to Chief Medical Officer & Chief Nursing Officer (notes)	(JC)
Apologies:	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Dani Jones	Director of Strategy	(DJ)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)

23/24/63 Welcome and Apologies
The Chair welcomed everyone to the meeting and noted the apologies received.

23/24/64 Declarations of Interest
None

23/24/65 Minutes of the Previous Meeting
Committee members were content to **APPROVE** the notes of the meeting held on 21st June 2023 pending the correction of 23/24/51 which should read C-GULL (children growing up in Liverpool).

23/24/66 Matters Arising and Action Log
The action log was received and updated.

High Risk unactioned diagnostic notifications in meditech
MN provided an overview of the High Risk unactioned diagnostic notifications in meditech.

- The process for managing the backlog of diagnostic notifications had been presented to the Trust legal team, who had approved the suggested approach.
- Alder Care reporting workstream is currently at risk, with potential implications for reports and dashboards that colleagues would be using to monitor compliance with the updated system. MN alluded to an approach for implementing reports to ensure oversight of clinician's compliance with the updated

system, which is closely being monitored through Alder Care Programme. MN advised that there is a recovery plan in place.

- MN referred to identifying the high risk notifications within the backlog, over 900,000 unacknowledged notifications within the Meditech system. MN advised that he had met with the clinical systems reporting team to review the parameters which should be used to extract any unacknowledged notices within the backlog. MN had also communicated this request to the Medical and Divisional Directors and written communication had also been sent to Clinical Directors to obtain advice regarding which investigations are likely to meet the higher risk classification, and to receive any requests from Clinical Directors regarding notifications which they would like to be aware of. This had also been scheduled as an agenda item for each Divisional board meeting.
- To date colleagues had not received any requests from clinicians and Clinical Directors for high risk notifications, this aligns with previous feedback received from Clinical Directors, following previous discussions with clinicians that their advice had been that although the unacknowledged notifications are acknowledged, that it is unlikely to relate to investigations that had not been reviewed and actioned using alternative approaches.
- Next steps are to raise this issue again via Divisional Board meetings.

FB referred to obtaining positive affirmation that the teams that they are satisfied, and that there are no issues that colleagues are particularly concerned about. FB advised on the importance of SQAC receiving assurance in the future that the requests to Clinical Directors are receiving traction, and that responses are being received, and teams are considering the issues and are appropriately responding.

ABA expressed his thanks to MN for ongoing support for significant work undertaken by MN with regards to this significant risk for the Trust. FB echoed her thanks to MN for ongoing support.

ABA advised that the legal advice provided was dependent on this reporting structure going forward, the legal team had also outlined that it was mandatory for the Trust to provide feedback to clinicians when accumulating unacknowledged notices in an automated way. ABA stated that there is a significant risk within reporting in Alder Care and advised that the Trust could not return to this situation again in the future. ABA reemphasised on the importance of the mandatory reporting structure being in place and ensuring it is functional.

FB referred to importance of receiving positive engagement regarding high risk notifications within the backlog and SQAC receiving assurance going forward that the new system is operating appropriately and is receiving traction.

FB referred to the reporting frequency and monitoring process. ABA stated that he would need to discuss this offline with NA to agree the most appropriating reporting forum.
Resolved: Offline discussion to take place with ABA and NA

Clinical coding errors – FB referred to the clear set of recommendations and next steps within the update, most of which apply to the clinical coding team. FB queried whether the clinical coding team required any additional support/buy in from others and queried whether the team are being restricted in their confidence and queried if improvement in other areas is required.

NA alluded to the table for primary and secondary procedures which the Trust which are above the exceeded levels of attainment, with further work required to achieve this in primary diagnosis and secondary diagnosis, this is addressed within the recommendations and actions for teams.

FB advised that colleagues should admire the ambition and support this team and expressed thanks to AG for comprehensive report.

Resolved SQAC **NOTED** the Clinical coding errors report.

Assurance on Key Risks
23/24/67 *Delivery of Outstanding Care*
Safe

DIPC Quarterly Report

BL alluded to hospital acquired infections and a theme with regards to acquired blood stream infections (BSI), with multiple CLABSI'S during the months of May and June 2023. BL advised that the Trust is achieving a more standardised approach in how patients are followed up who are colonised, with a stricter process in place in detecting patients with pseudomonas, these patients are followed up, with systematic IPC approach to investigate water, however water was never found to be the cause. Information is shared with Water Safety Committee.

BL referred to hospital acquired bacteraemia's, as the Trust undertake a large number of blood cultures, BL advised that a number of the blood culture are contaminates, i.e., if the skin has not been cleaned on obtaining the blood culture. The rate of contaminates that a hospital should have should equate to under 1% and at present Alder Hey Children's NHS Foundation Trust have a rate that is higher than 5%. 10% of blood cultures are positive, and out of 10% - 50-60% are contaminate, with further work to do to improve on this. IPC had requested microbiology lab to provide contaminate report for Infection Prevention Committee to address this.

BL advised on an Outbreak in 1C Cardiac in June 2023 relating to Serratia – a Gram-negative bacillus, 4 patients had been identified who were colonised with Serratia, 3 of these patients developed invasive disease. IPC colleagues had met with colleagues on 1C, and agreed how to improve cleaning and decontamination of equipment, environmental swabbing took place to swab thermometers, with no Serratia found on thermometers, water testing had also been tested in the microbiology lab, with no Serratia link with the water or with the equipment that had been shared by patients. Since the enhanced cleaning and decontamination of equipment IPC colleagues had not seen any other further case during the last 3 week period.

BL advised that when there are an increased number of unusual infections in a particular area, information is sent to Public Health England for typing, BL confirmed that 4 isolates were sent to PHE and findings confirmed that 3 of these are related, which indicate cross transmission of patients within 1C, within the Blue and Green pods. BL stated that this does not have to relate to the environment, and it is likely to be related to hand hygiene of staff, and to the medical equipment that is shared between patients.

- Increase in hospital acquired Covid 19 cases with 5 cases within the reporting period, this is not unexpected as increases in cases are reported across multiple hospitals, following cessation of routine testing or universal mask wearing.
- IPC colleagues are reviewing all hospital acquired viral infections to further enhance engagement with teams to highlight that these cases are preventable and should be preventable

FB expressed thanks to BL for comprehensive update

Resolved: SQAC received and **NOTED** the DIPC Quarterly Report.

23/24/68 ED MH attendance & ED @ its best update report

MC presented the ED MH attendance & ED @ its best report

- Team continue to progress against the 4 hour standard, demonstrating an upturn in month, on trajectory, to date with further positive improvements against this indicator.
- Slight deterioration in month regarding the 60 minute review with clinician.
- PAU pilot is scheduled to go live on 8th August 2023, newly formed small team supporting this initiative, utilising existing EDU physical space, one of the driver metrics for PAU is to reduce the length of time children wait in ED awaiting assessment, colleagues continue to review this indicator whilst monitoring the effectiveness of PAU.
- There had been a significant decrease with regards to Sepsis compliance in month, this had been discussed at the divisional governance meeting in month, the Head of Nursing for urgent care had been requested to undertake a patient level audit of all of the children within the last 6 month period when the Trust had not met this standard, to establish whether there are any themes regarding timing or presentation and effectiveness of triage. MC stated it is the intention to share a summary update report with SQAC meeting pack for August 2023.
- MC alluded to the plans to refresh the A3 improvement plan which was developed in 2022.

- MC referred to ED at its Best and advised that BI colleagues are focussing on Alder Care reporting information, and that it may be that it is not possible to obtain run charts SPC until post EXPANSE in October/November 2023. MC expressed apologies that due to timing of the meeting and submission of reports that all of the June data had not been available for inclusion in the report, therefore this was detailed as 'to be confirmed'.

ABA sought clarity regarding the number of patients who are being triaged to the urgent care centre and stated that it would be helpful to have this data included within the report. ABa referred to the staff table within the end of the report, and alluded to the 'green arrows', which suggests increasing better staff experience and retention, however there is an increase in the amount of stress. MC advised that the information would be available for UTC, however this would not be in SPC form, however narrative could be included within future reports.

MC referred to the sickness indicator and would review this offline, MC suspected that looking at the proportion of absence that relate to stress, however absence is decreased, and stress remained static month on month. MC advised that there is further work required regarding this indicator. MC stated that one of the issues relate to Workforce data which is a manual extraction process, and that it may be more appropriate to include as a quarterly update to ensure a detailed quarterly analysis.

NA stated that he welcomed the evolvement of the report and acknowledged the improvement within the report to date. NA also welcomed the continued improvement with regards to patient experience.
NA alluded to the 3% of patients who leave ED without being seen and sought clarity whether the length of time within the ED department is recorded. MC advised that the patients left before seen are audited in that week by a clinician to ensure that the presenting clinical information is not a concern, with calls made if clinician is concerned. MC stated that he was not aware of any analysis with regards to the reasons left before seen and suggested that perhaps this is something worth consideration for the future. MC advised that over the last few months there had not been a significant number of long waits and alluded to a couple of days with additional pressure. NA advised that supporting detail would be helpful.

NA referred to clinician review and sought clarity whether there is any analysis regarding whether there are differences regarding time of day, MC confirmed that he would need to review this offline and that the Medicine division would need to undertake an audit, MC would liaise with BI team to analyse.

LC referred to Page 5 of the report within the Mental Health section within table 1 relating to the 11 children and young people who had not been referred to crisis care which is usually around 85% for referral to crisis care, and referred to the 3 cases that were under 18 months old, LC confirmed that these children were not deemed appropriate for children and young people Mental Health Services. LC referred to the 11 children and referred to coding, as these patients are coded as a mental health attendance.

SQAC received and **NOTED** the ED MH attendance & ED @ its best update report

23/24/69 Drugs & Therapeutics Committee quarterly report and Annual Report

PS presented the Drugs & Therapeutics Committee quarterly report, key issues as follows:-
PS advised that this was the first time that this report had been presented to SQAC, given the disbandment of CQSG. PS sought assurance from committee members whether this is the correct forum to present the report. PS advised that the report is likely to evolve over a period of time and the intention is to generate Quarterly Drugs & Therapeutics Committee Quarterly Reports to SQAC.

- PS appointed as interim Chief Pharmacist on 8th September 2022 by Chief Medical Officer and continues in this role. PS is responsible for MMOC and had delegated this responsibility to Andrea Gill, MSO with oversight by PS.
- Proposing a review of the current Drugs & Therapeutic Committee, to strengthen the structure, PS in discussion with Chief Medical Officer and Chief Nursing Officer in this regard.
- Role of Controlled Drugs Accountable Officer, which is a legal responsibility within the Trust had been transferred from CMO to Interim Chief Pharmacist, which aligns Alder Hey Children's NHS Foundation Trust with the majority of other organisations.

- Continued progress had been made against policies and guidelines to ensure they are updated and reviewed in a timely manner.
- Risks related to medicine are being monitored through the Medicine Management and Optimisation Committee (MMOC) and Medicine Safety Committee.

Recommendations and next steps

- A review of the governance arrangements for the management and approval of Non-Medical Prescribers within the Trust is being undertaken.
- Improved financial governance and reporting required around PBR and non PBR drug spend, the Trust is over reliant on an extremely small team, which are vulnerable.
- A review of the Drugs & Therapeutics Committee structure is planned and associated reporting
- PS continues to support Patient Safety Board in all aspects of medication safety
- Parental Nutrition to be added to the Patient Safety Board agenda.
- SQAC receiving Deep Dive report into management incidents

PS requested feedback from SQAC.
FB thanked PS for update, and advised that the offline discussion regarding the governance route with PS, ABA & NA would be extremely helpful, and suggested that the issue relating to drugs spend would be appropriate for discussion at RABD, this was welcomed by JG.

FB alluded to reporting on medication errors and advised that this should be shared at SQAC, however not directly through to SQAC and should be shared at one of the subgroups prior to SQAC. FB welcomed the report which set out the risks with the risk descriptions which provided context.

PS stated that he had undertaken an offline discussion with NA/ABa and agreement was reached that this would evolve over time. PS advised that the four Quarterly Drugs & Therapeutics Committee Reports would encompass the Annual Report.

JRE referred to the risk regarding gene therapy products, as the Trust cannot manufacture currently, and sought clarity whether there is a plan in place to mitigate risk. PS advised that there is a dedicated gene therapy suite within the aseptic unit, which is 1 isolator where colleagues can make the gene therapy with the correct filters. An alternative room has had to be repurposed in the aseptic suite, this is in the process of being validated, due to staff pressures validation has not been completed, it is envisaged that within the next month that the intention is to move the manufactured products into that suite, and providing all of the other kit is working as it should this would then release the gene therapy suite, with some validation required to ensure it is fit for purpose.

Resolved: SQAC received and **NOTED** the Drugs & Therapeutics Committee quarterly report and Annual Report and **NOTED** that the report is work in progress which will evolve over time, whilst ensuring right discussions are taking place and are being addressed.

Resolved: Offline discussion to take place with PS, NA & ABa re governance/reporting mechanisms.

FB thanked PS for Drugs & Therapeutics Committee quarterly report and Annual Report.

23/24/70 Divisional updates and deep dive regarding Medication Safety

Surgery Division – NA referred to a number of overdue actions and overdue review dates for risks and sought clarity whether there is a plan in place to address those overdue risks. CCJ advised that there are weekly review meetings across the division with teams and individuals to review overdue risks. CCJ advised that the current position had significantly changed since the report had been submitted. FB welcomed the detail within the report and the detail within the charts.

Clinical Research Divisional Report – FB referred to the reference to staff departures, given that it is envisaged that turnover is going to increase in August 2023, FB sought clarity whether LR had any insight regarding recruitment. LR advised that recruitment is progressing well and referred to 3 of the retirees retiring over the summer months. Team leaders had been recruited and are just going through recruitment checks, all are internal candidates. There is a plan in place with regards to leadership cover,

with a natural reshape of some of the roles, LR advised that there are no particular recruitment concerns at present.

Medicine – MH advised that there are 34 overdue risks within the Division of Medicine, MC is working with the governance team, regarding extracting a report for overdue risks as there are legacy actions and there are some live actions, showing on the report, despite being updated and transferred to new owners, work is underway to review and update as appropriate. MC stated that he is hopeful that the report for August 2023 will be back in date. Division of Medicine had undertaken Deep dives regarding Inphase and Risks and the governance lead within the division continue to support the team.
Community

Medication Safety Deep Dive

- Classification of incidents had changed in line with national guidance regarding NCC-MERP grading, therefore there is an additional category regarding monitoring intervention precluded harms.
- PS referred to PSIRF management and total parental nutrition, which is a key PSIRF priority for the Trust which had been approved at Patient Safety Strategy Board.
- PS alluded to a temporary 8A pharmacist, PS stated that he would like to make this post a permanent role, with excellent work generated regarding the extra individual undertaking the temporary role.
- 3 minor harm incidents within the first quarter.
- Target for minor harm incidents for the year is 38, compared to 47 in 2022.
- 13 incidents within Quarter 1, including the 3 whereby there was no intervention.
- PS alluded to the types of incidents occurred which is different as there are extra categories for Inphase compared to the previous system used, with slight nuance regarding performance as some of the categories had changed in line with Inphase.
- PS referred to the total number of incidents, particularly with regards to near misses and advised that colleagues had not seen a significant change in reporting the actual number of near misses, and that incidents had increased since quarter 4, and referred to the implementation of Inphase in Quarter 1, and on review it appears that the implementation of Inphase had not affected how incidents are being reported by staff across the Trust.

FB advised that SQAC could not comment regarding the Pharmacy resource request and that this should be routed differently. FB referred to the new category regarding monitoring and mitigation and queried whether the Trust is set up to capture, and that it is obvious for staff regarding how they record these incidents.
Resolved: PS confirmed that he would consult with his team in this regard.

KB referred to Appendix 1 of the pie chart with the new categories and stated that she did not think that SQAC needed to see this within future reports. KB referred to the significant difference between category E and Category H, both being in the same colour and same category.

KB alluded to chart within Appendix 2, and referred to the line graph regarding medication errors reported by month and referred to April 2022 where prior to this date the Trust was mostly under target line of approximately 105 and after this timeframe figures are mostly above 105. KB sought clarity whether this difference is due to some difference in classification or reporting at that point. PS advised that it would not be due to a difference in classification at that point, PS stated he was uncertain whether there is a change in culture, with regards to encouraging people to report more.

PS stated that it had been difficult to obtain any benchmarking information from other Trusts, other Trust not entirely happy to share information. PS advised that Alder Hey Children's NHS Foundation Trust report more incidents that other Trusts.

FB reflected that this was during covid period and whether colleagues were treating fewer patients.
DR queried whether this may correlate to change in process or meditech errors which may have led to more medication errors being reported.

NA expressed his thanks to PS for comprehensive report, NA referred to chart on page 96 of the meeting pack. NA advised that the administration error rate had not improved during the period and had

increased as a % of the total errors, despite significant work undertaken on prescribing. NA sought clarity on how the benefits are being assessed of the ongoing improvement work undertaken by the Medicine Safety Team and whether or not there is something unusual regarding prescribing.

PS advised that he review this offline. PS stated that when seeing those increasing trends, it is new as the categories are different, and there is a need to review those increasing trends, PS confirmed that he would address this with his team.
Resolved: PS to review assessment of ongoing improvement work undertaken by Medicine Safety Team and investigate any unusual circumstances regarding prescribing.

FB referred to reporting incidents and sought clarity regarding triangulation of data to identify unreported errors that may have taken place. PS stated that he is uncertain how the Trust would review and monitor the unknowns, given they are unknown. FB queried whether there were any appropriate audit techniques, PS advised that he consider this offline.
FB welcomed future updates to SQAC, acknowledging further thought required regarding the correct reporting route via correct governance process. PS to discuss offline with NA & ABA.

Resolved: PS to have an offline discussion with NA/ABa regarding reporting routes.

Caring
Effective

23/24/71 Patient & Family Feedback quarterly report

NA presented the Patient & Family Feedback quarterly report

- NA drew the attention of the committee to the A3 information which the team had been working on.
- SQAC **NOTED** the Advocacy report and the ongoing work to provide additional support regarding parking, food and how to raise a concern within the organisation.
- Friends & Family Test uptake across all areas with the exception of Surgery, Surgery Division had already been scoring highly with no concern raised.
- NA alluded to Volunteers, in terms of recruitment and those number of volunteers deployed together with the range of projects undertaken.

LC referred to page 5 within the report with regards to ward advocacy support and stated this could be confused with other roles in the trust and suggested it was renamed.
NA stated that as part of the new strategy that this falls within new section of family support, and that it is likely that this is what it will be called in the future.
LC requested whether thought could be given on volunteer potentially working with complex and challenging children and young people, particularly in ED, who could respond well for additional support from volunteers.
NA agreed he would review name for future reporting.
FB expressed thanks to NA & PB for report.
SQAC received and **NOTED** the Patient & Family Feedback Quarterly Report

23/24/72 Children & Young People Engagement Leads Report – Quarter 1

LC presented the Children & Young People Engagement Leads Report - Quarter 1 which highlighted the breadth of activities from Children & Young People Engagement Leads.

- LC alluded to the participation within the National Youth Bank and the exceptional engagement, working with local Children and Young People Groups, the learning and development of the Children & Young People had been exceptional.
- A British Sign Language Course had been commissioned, which takes place every Thursday evening on site

JRe stated that this is fantastic work which is being undertaken which is extremely positive, with an excellent recruitment process which is well embedded, JRe, congratulated LC and team on ongoing achievements.

Resolved: SQAC received and **NOTED** the Children & Young People Engagement Leads Report – Quarter 1

23/24/73 Board Assurance Framework

ES advised that the full Board Assurance Framework is not yet available due to Inphase reporting issues.

ES referred to the summary of updates for the 3 risks for SQAC. ES advised that since the Board of Directors had last met, that the Trust are in a transitional phase regarding the strategic risks on account of the implementation of 2030 strategy, ES advised that colleagues start to see revised documentation from September 2023.

ES advised that during discussion held at RABD on 17th July 2023, that some of their risks would move into the new Strategy Board.

ES stated it would be helpful to have a broader discussion at the September SQAC meeting regarding risks around Access, Safety and Mental health to obtain a sense check.

FB referred to the risks for Safety and Quality which would potentially not feed into the Strategy Board and referred to Partnership and risks as most pressure is relieved from other parts of the system, and that ensuring the correct relationships is critical. ES highlighted the need to be mindful of the new governance arrangements.

FB thanked ES for update.

Resolved: SQAC received and **NOTED** the Board Assurance Framework and welcomed a broader discussion on Access, Safety & Mental Health at the September 2023 SQAC meeting.

23/24/74 Quarter 4 NICE Compliance Update

Review update/deep dive on compliance and progress with outstanding NICE guidance

NA commended the report and welcomed any comment or feedback. NA advised that a detailed update would be provided on the small number of outstanding NICE guidance which had not progressed at the September 2023 SQAC meeting.

MC advised that within the Medicine Division that there are 3 outstanding guidance that should have been shared at speciality meetings. Dr. Ghatak, Governance Lead had provided MC with updates. MC referred to 2 items which were red 1 of which has now been allocated to a consultant, with a single consultant providing chronic fatigue service to complete this as soon as possible. MC is hopeful this will be on trajectory in August 2023.

The other outstanding item is currently with a renal consultant for completion, MC is hopeful that this will also have progressed by August 2023. MC expressed apologies that these are still overdue.

KB referred to the report and particularly chart 2, which clearly articulated the progress made, of note within the Division of Medicine, which had reduced the open guidance by two thirds, with significant improvements with this report. FB echoed this.

LW alluded to chart 5 which demonstrated in months the open guidance of recommendations and actions with 5 over the period of 56 months and following review of these they all relate to Community & MH. With further work required to help managing the correlation of this, to demonstrate those overdue. Offline discussion would be welcomed by Community & MH Divisional colleagues and LW.

Resolved: SQAC received and **NOTED** the Quarter 4 NICE Compliance update

Resolved: SQAC welcomed an update/deep dive on compliance and progression outstanding NICE guidance at September 2023 meeting.

23/23/75 Clinical Audit & Effectiveness Assurance Report

LW presented the Clinical Audit & Effectiveness Assurance Report, review period covers Quarter 4 2022/23 (1st January 2023-31st March 2023)

From April 2022 all registered audits are aligned to the Trust strategic objectives, to the audit registration process and supporting the development of thematic reports and learning.

- 21 national and 13 local Trust priority audits, which are included in the Trust Annual Audit plan 2022/23
- Combination of 64 local and regional audits which are currently registered with the Clinical Audit team

- 32 audits had been completed within Quarter 4
- 32 emerging audit themes ranging from staff training and education, documentation and information, further audit work and Clinical Pathway Review.
- Ongoing support had been offered from the Corporate Governance team to support divisions with compliance on audit completion and embedding of Lessons Learned.

FB expressed thanks to LW and stated that the report is extremely clear and confirmed that the breakdown by Divisions and themes is extremely helpful.

KB sought clarity from SQAC whether SQAC would be content for KB to work with JR & LW to further strengthen and enhance reporting. FB and NA welcomed the offer of support by KB support to JR and LW and expressed thanks to Kerry for offer of support, LW requested Jane Ratcliffe be included in any offline discussions.

Resolved: SQAC received and **NOTED** the contents and findings of the Clinical Audit & Effectiveness Assurance Report and **NOTED** the audit activity in Quarter 4 2022/23.

SQAC **NOTED** the themes and findings from completed audits and agreed the level of assurance provided.

23/24/76 Trust Divisional and Corporate Services Clinical Audit Plan for 2023/24

LW presented the Trust Divisional and Corporate Services Clinical Audit Plan for 2023/24:-
LW advised that a review of the divisional clinical audit approval and oversight processes for clinical audit meetings across all clinical divisions was undertaken in December 2022, which identified that there were no formal processes in place for approval of the annual audit plans across any division.
Corporate services audits were registered and managed in the same way as divisional audits however further work was required to formalise a corporate audit plan that informs the Trust annual audit plan.
Oversight of audit activity is monitored at Divisional audit meetings and assurance of delivery of audit and activity is currently reported at SQAC.

A standardised robust governance process for the identification of approval of non mandatory audits and clinical audit activity within divisions and at corporate services collaborative would be developed during 2023/24.

- There are a total of 121 divisional/corporate service audits which are currently included on the Trust Annual Audit Plan for 2023-24.
- The Trust Annual Audit Plan would develop as part of an iterative process, being updated as divisional/corporate services audits are identified throughout 2023/24.

Resolved: SQAC received and **NOTED** the Trust Divisional and Corporate Service Clinical Audit Plan for 2023/24, and **NOTED** the requirement for discussion with LW, JR & KB regarding how this is presented in a meaningful way for SQAC.
FB alluded to the breadth of Audit activity across the organisation.

23/24/77 Policy Ratification

C15 – infection Prevention & Control Policy
Resolved: SQAC received, **NOTED** and **RATIFIED** C15 Infection Prevention & Control Policy

C17 Isolation Precautions Policy
Resolved SQAC received, **NOTED** and **RATIFED** C17 Isolation Precautions Policy

C57 – Policy on the Management of Intrathecal Chemotherapy (ITC) Policy (Includes administration via a lumbar puncture or intraventricular route)
Resolved: SQAC received, **NOTED** & **RATIFIED** C57 ITC Policy on the Management of Intrathecal Chemotherapy (ITC) Policy (Includes administration via a lumbar puncture or intraventricular route)

Clinical Governance Effectiveness
Well Led

23/24/78 Transition Report

LC expressed apologies that the Transition report was delayed and provided overview of Transition Report which detailed successes and achievements, summary of key challenges and areas for escalation.

- 7th Annual national transition conference was held on 14th June on MS teams, with good engagement with 300 delegates in attendance. Excellent feedback had been received to date from delegates.
- Healthcare transition awareness week (19th – 23rd June 2023), with stalls within the atrium providing information and advice to staff and families about healthcare transition. During the week support was provided by Citizens Advice Bureau and Contact.org. Event was used also to promote the use of meditech documentation.
- Healthcare transition Grand Round was held on 16th June 2023 which was well received.
- Challenges regarding data collection, which should be resolved with Alder Care.
- Challenge regarding adult services availability, further exploration of meeting with adult partner agencies and Place to seek flexible solutions to young people's healthcare transition needs.
- LC advised on the need to identify who is going to be the lead within ICB going forward, as support is required for those complex young adults regarding access to adult services, particularly when young adults are presenting as an Emergency.

KB stated that she is unable to provide any comments on the report given that the report had only been received 1 hour prior to the meeting, and that it is unrealistic to have a discussion at the meeting.

NA acknowledged the really good work within the report and alluded to ongoing challenge regarding the accuracy of data and alluded to the original question from SQAC regarding what is the scale of the problem, and how this is being addressed within each service.

NA recommended that SQAC acknowledged the late Transition Report, and **NOTE** the information within the report detailing the work undertaken by the team, with a further detailed report to be provided January 2024.

FB referred to whether there is good transition arrangement in place across the Trust at the appropriate age. FB stated it would be helpful to know that work is taking place in the background to ensure a robust and reliable update report. FB requested SQAC receive an update on progress of the programme in October 2023 with regards to how well the preparations are progressing to produce a robust report for January 2024.

SQAC agreed it beneficial to receive an update against the data reporting issues at October 2023 SQAC meeting and a detailed update report in January 2024.

Resolved: SQAC received and **NOTED** the Transition Report and welcomed an update at October 2023 regarding update against the data quality reporting issues, with a detailed Transition Report at January 2024 meeting.

23/24/79 Any other Business - None

23/24/80 Review the key assurances and highlights to report to the Board

- Useful updates received following previous meetings regarding Sepsis/unacknowledged notification and clinical coding, with progress in these areas
- Detailed DIPC report received detailing ongoing work with challenges with regards to increases in Hospital Acquired infections
- Good report on ED at its Best,addressing patient experience issues, good discussion regarding patients had left without being seen, identifying a need for further analysis between interaction of waiting times and patients not being seen. Report demonstrated persistent high levels of stress within ED.
- Drugs & therapeutics Quarterly Report and Annual Report, work offline regarding Governance structure for Drugs & therapeutics, SQAC welcomed Quarterly Report

- Received Deep Dive regarding Medication safety
- Patient Family Feedback Quarterly Report
- Children & Young People Engagement Lead Report focussing on family experience
- Clinical Audit & Effectiveness Assurance report, good reports, further work to do on report themselves which KB will work on offline3 policies for approval.
- C15 Infection Prevention & Control Policy, C17 Isolation Precautions Policy and C57 ITC Policy– SQAC RATFIED policies.

FB expressed thanks to SQAC

Date and Time of Next Meeting: FB advised that the intention is not to hold a meeting on 16th August 2023, unless there is anything within the data pack which would be circulated which cause SQAC concern. FB advised that the date would still be held in colleagues diaries with the aim of cancelling the meeting invitation nearer the time, following review of the data pack. FB highlighted the importance of SQAC reviewing the data and responding by email.

FB advised that the Date of the next meeting is planned for 20th September at 9.30 am

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Fit and Proper Persons Policy**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ☑ Assurance ☑ Information ☐ Regulation ☑
Background Papers and/or supporting information:	**Checklist for policies / guidelines / SOPs:** Reviewed by subject matter expert Yes☑ No☐ Reflects best practice / national guidance / current practice Yes☑ No☐ Approved by Operational Committee Yes☐ No☐ Changes included in version history (and summarised below) 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:	N/A
Associated risk (s)	

Alder Hey Children's NHS Foundation Trust

Exx – FIT AND PROPER PERSONS POLICY

Version:	1
Name of ratifying committee:	Board of Directors
Date ratified:	5th October 2023
Name of originator/author:	Jill Preece
Name of approval committee:	Council of Governors
Date approved:	December 2023
Executive Sponsor:	Erica Saunders
Key search words:	
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Review date:	October 2026

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	October 2023		New Policy	

Record of changes made to Policy for Engagement of External Auditors in Non-Audit Work			
Section Number	**Page Number**	**Change/s made**	**Reason for change**

Contents

1 Introduction

1.1 The 'fit and proper persons' test set out in Regulation 5 of the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2014* (updated 2022) came into force on the 27th November 2014 and is aimed at making sure that those individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care, and as such can be held accountable if standards of care do not meet legal requirements.

1.2 The 2014 regulations were introduced in response to the failings at the Winterbourne View Hospital and the Francis Inquiry into Mid Staffordshire NHS Foundation Trust. A new Fit and Proper Framework was introduced by NHS England in 2023.

2 Aim

Whilst providers have a general obligation to ensure that they only employ individuals who are fit for their role, the 'fit and proper persons' test must be applied for all new Directors and Governors; and there must be systems and processes in place to provide ongoing assurance that the requirements are met. There is a duty on the organisation to take such action as is necessary and proportionate to ensure ongoing compliance.

The requirements are that:

(a) The individual is of good character;

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) None of the grounds of unfitness specified in part 1 of Schedule 4 apply to the Individual.

The grounds of unfitness specified in Part of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(b) the person is the subject of a bankruptcy restrictions order

or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

The good character requirements referred to in Regulation 5 as specified in Part 2 of Schedule 4 to the Regulated Activities Regulations relate to:

(a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence

(b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

3 Scope

This Policy applies to all Board Directors – Executive and Non-Executive; (voting and non-voting) attendees of the Board and Governors. It applies to all permanent, acting and interim Board level positions.

4 Roles and Responsibilities

4.1 The Chair

The Trust Chair is accountable for taking all reasonable steps to ensure the FPPT process is effective and that the desired culture of their NHS organisation is maintained to support an effective FPPT regime. As such, chairs' responsibilities are:

a) Ensure the NHS organisation has proper systems and processes in place so it can make the robust assessments required by the FPPT.

b) Ensure the results of the full FPPT, including the annual self-attestations for each board member, are retained by the employing NHS organisation.

c) Ensure that the FPPT data fields within ESR are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full FPPT (including the annual self-attestation) are complete and adequate for each board member.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how this fits with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation that they themselves are in continued adherence with the FPPT requirements. On an annual basis, chairs should confirm that all board members have completed their own FPPT self attestation and that the FPPT is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the FPPT, they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual FPPT submission form to the relevant NHS England regional director.

4.2 Senior Independent Director

Annually, the senior independent director (SID) will review and ensure that the Chair is meeting the requirements of the FPPT.

4.3 All Directors (Executive, Non-Executive, Permanent, Acting, Interim) and Governors

To make annual self-declarations in a form prescribed by the Chair and to provide any additional information or evidence requested in order to demonstrate compliance with Fit and Proper Persons requirements.

4.4 Director of Corporate Affairs

Must inform the Chair of any concerns relating to individual self-declarations or arising from other checks such as insolvency registers and registers of disqualified directors.

4.5 Chief People Officer

It is the responsibility of the Chief People Officer to:

- maintain oversight and due diligence in respect of appointment processes including pre- employment checks and adequacy of references;

- ensure that employment contracts (T&Cs for NEDs) refer to the requirement to comply with the Regulations and Code of Conduct for Board Directors;
- ensure DBS checks are conducted on appointment and thereafter at intervals of no greater than 3 years.

4.6 Nominations Committee

The Trust has two Committees dealing with the appointments of Non-Executive Directors and Executive Directors; the Nominations Committee and the Appointments and Remuneration Committee respectively. These Committees are responsible for ensuring the assessment of candidates for Board positions and in the case of Non-Executive Directors, the recommendation of candidates for appointment by the Council of Governors. Each committee must ensure that the appropriate due diligence is undertaken in respect of the preferred candidate, prior to appointment. Where any issue comes to light, this must be investigated and documented in support of the final recruitment decision.

For issues arising in respect of existing Directors, the Chair may refer any concerns of on-going tenure to the relevant Committee. Any interim arrangements required pending a Fit and Proper Person investigation will be considered by the relevant Nominations Committee.

The removal of an Executive/Associate Director will be a decision for the Appointments and Remuneration Committee (Executive).

4.7 Council of Governors

The removal of a Non-Executive Director will be a decision for the Council of Governors following a recommendation from the Nominations Committee.

5 Procedure

5.1 New Appointments

In order to confirm that the individual is of good character, the Trust will make pre-employment checks which will include the following:

- Full employment history with documented explanation of any gaps
- Obtaining two references (using the Board member reference template), one of which should be from the most recent employer;
- qualification and professional registration checks;
- right to work checks;
- proof of identity;
- occupational health clearance;
- appropriate DBS clearance;
- search of insolvency and bankruptcy register;
- due diligence in relation to (or privy to) previous misconduct, mismanagement or professional disqualification

The selection process for all Director posts will be robust ensuring that the specific skills and experience required for the role are set out in a person specification and thoroughly tested.

The above will be overseen by the Chief People Officer and evidence of the checks will be documented on the individual's personal file.

On appointment, the individual will be required to complete a 'Fit and Proper Persons' self-declaration (Appendix 1). This will be retained on the individual's personal file.

5.2 **On-going review of existing Directors**

An assessment of on-going fitness will be undertaken each year as part of the annual appraisal process and all Directors will be required to update their self-declarations (Appendix 1) annually. DBS clearance will also be renewed every three years. The Chair is accountable for maintaining oversight of ongoing fitness.

5.3 **Joint appointments across different NHS organisations**

For joint appointments across different NHS organisations, the full FPPT would need to be completed by the designated host/employing NHS organisation and in concluding their assessment they will need input from the chair of the other contracting NHS organisation to ensure that the board member is fit and proper to perform both roles.

The host/employing NHS organisation will then provide a 'letter of confirmation' to the other contracting NHS organisation to confirm that the board member in question has met the requirements of the FPPT.

The chair of the other contracting NHS organisation has the responsibility to keep the host/employing NHS organisation abreast of changes and any matters that may impact the FPPT assessment of the board member.

For the avoidance of doubt, where two or more organisations employ or appoint (in the case of a chair or NED) an individual for two or more separate roles at the same time, each organisation has a responsibility to complete the FPPT.

If the FPPT assessment at one organisation finds an individual not to be FPP, the chair should update their counterpart of any other NHS organisation(s) where the individual has a board-level role and explain the reason. To note, the issue at one organisation may be one of role-specific competence, which may not necessarily mean the individual is not FPP at the other organisation

5.4 **Dealing with Concerns**

If the Trust discovers at any point, information that suggests an individual Director does not meet the 'Fit and Proper Persons' criteria, the matter shall be referred immediately to the Chair (or the Senior Independent Director, if the concern relates to the Chair).

The Chair shall take appropriate and timely action to investigate and rectify the matter, taking expert advice as necessary and ensuring any issues are dealt with in accordance with the Trust's HR policies. Any concerns will be referred

to the relevant Nominations Committee. Where appropriate, findings in relation to a person's fitness may be referred to the relevant professional/regulatory body/bodies.

The Chair, in discussion with the relevant Nominations Committee, will put in place interim arrangements, if required, during any period of investigation. The removal of any Director will be in accordance with the Trust's Constitution, with decision to remove resting with the Appointments and Remuneration Committee (Executive) for Executive/Associate Directors and Council of Governors for Non-Executive Directors.

Removal of a Governor will be in accordance with the Trust's Constitution.

5.5 Personal Data

Personal data relating to the FPPT assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR).

FPPT outcomes must be entered onto ESR and ESR FPPT Dashboard generated for Chair review. Once satisfied with the test the Chair must update and sign off each Board member on ESR. An annual submission form will be generate for Chair sign off and submitted to the NHSE Regional Director. The NHSE FPPT central team will collate records from NHSE regions.

5.6 Board Member Reference Request

NHS organisations will need to request board member references (Appendix 2), and store information relating to these references so that it is available for future checks; and use it to support the full FPPT assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally on ESR.

Board member references will apply as part of the FPPT assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a) New appointments that have been promoted within an NHS organisation.
b) Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.
c) Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.
d) Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

6 Policy Implementation

The Director of Corporate Affairs will oversee implementation of this Policy.

The Governance Manager will manage the annual self-declaration process on behalf of the Chair.

7 Training and Support

There are no specific training requirements associated with this policy.

8 Monitoring

The Director of Corporate Affairs will maintain the policy and support the Chair in compiling an evidence checklist for each Director; and will maintain a system of annual review of self-declarations by the Board of Directors.

9 Further Information

Associated Documentation

Appendix 1 – Annual Self Declaration Form

Appendix 2 – Board Member Reference Template

Appendix 1 Fit and Proper Person Declaration

In line with the requirement for Directors of an NHS Foundation Trust to be a fit and proper person, I hereby declare that:

Declaration	Confirmed (Yes/No)
I am of good character	
I have the qualifications, competence, skills and experience which are necessary for me to carry out my duties	
Where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals	
I am capable by reason of health of properly performing tasks which are intrinsic to the position	
I am not prohibited from holding office (e.g. directors disqualification order)	
Within the last five years: • I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more • been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged • nor is on any 'barred' list.	
I have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.	

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	

Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Appendix 2 Board Member Reference Template

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants: To be used only AFTER a conditional offer of appointment has been made. Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.		
1. Name of the applicant (1)		
2. National Insurance number or date of birth		
3. Please confirm employment start and termination dates in each previous role *A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)* *B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)*		
Job Title: From: To: Job Title From: To: Job Title: From: To:		
4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A): *(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)*		
5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □
Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross	Yes □	No □

misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Initial Equality Impact Assessment (EIA) Form	
This section must be completed at the development stage i.e. before approval or ratification. For further support please refer to the Equality Impact Assessment (EIA) Policy on DMS.	
Part 1	
Name and Job Title of Responsible Person(s): Jill Preece, Governance Manager	**Contact Number:** 0151 282 4512 or via Teams
Department(s): Executive Governance	**Date of Assessment**: 27/09/2023
Name of the policy / procedure being assessed: Fit and Proper Persons Policy	
Is the policy new or existing? New ☑ Existing ☐	
Who will be affected by the policy (*please tick all that apply*)? Staff ☑ Patients ☐ Visitors ☐ Public ☐	
How will these groups / key stakeholders be consulted with? New Fit and Proper Persons Framework presented to Board on 7th September 2023.	
What is the main purpose of the policy? Whilst providers have a general obligation to ensure that they only employ individuals who are fit for their role, the 'fit and proper persons' test must be applied for all new Directors; and there must be systems and processes in place to provide on-going assurance that the requirements are met. There is a duty on the organisation to take such action as is necessary an proportionate to ensure on-going compliance.	
What are the benefits of the policy and how will these be measured? To ensure that Directors and Governors are fit for their role. This will be measured via an annual self assertation.	
Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes ☑ No ☐ *If yes, please give brief details:* Recruitment and Selection Policy	
What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please use the **Equality Relevance** guidance (see on DMS) to specify who would be affected (e.g. patients with a hearing impairment, staff aged over 50).* *Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*	

Protected Characteristic	Tick either positive, negative or no impact			Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact		
Age	☐	☐	☑	The policy provides a framework to ensure that Directors and Governors are fit for their role and does not seek any of the information listed under protected characteristics.	No further mitigation or adjustment required.
Sex	☐	☐	☑		
Race	☐	☐	☑		
Religion or belief	☐	☐	☑		
Disability	☐	☐	☑		
Sexual orientation	☐	☐	☑		
Pregnancy and maternity	☐	☐	☑		
Gender reassignment	☐	☐	☑		
Marriage and civil partnership	☐	☐	☑		
Other (specify)	☐	☐	☑		
If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) The policy ensures no impact					
Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? Yes ☐ No ☑ *See **Equality Relevance** guidance (on DMS) for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal)*					

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete a Full Equality Impact Assessment. Please speak to the Head of Equality, Diversity and Inclusion and see the Full Equality Impact Assessment (EIA) Form on DMS.			
Action	**Lead**	**Timescale**	**Review Date**
N/A	N/A	N/A	N/A

Declaration	
I am satisfied this document / activity has been satisfactorily equality impact assessed and the outcome is:	Tick one box
Continue – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken	☑
Justify and continue – EIA has identified an adverse impact but it is felt the policy cannot be amended. ***You must complete a Full Equality Impact Assessment (EIA) Form before this policy can be ratified***.	☐
Make Changes – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ***You must ensure the policy has been amended before it can be ratified.***	☐
Stop – EIA has shown actual or potential unlawful discrimination and the policy has been removed	☐
Name: Jill Preece	Date: 27/09/2023

Approval & Ratification		
Policy Author:	Name: Jill Preece	Job title: Governance Manager
Approval Committee:	Pan-Liverpool Policy adopted	
Ratification Committee:	Board of Directors	Date ratified: 05/10/2023
Person to Review Equality Analysis:	Name: Jill Preece	Review Date: 01/10/2026
Comments:		

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 5th October 2023

Paper Title:	**Wellbeing Guardian: Dashboard**
Report of:	**Wellbeing Guardian**
Paper Prepared by:	Jo Revill, Jeanette Chamberlain, Jo Potier and Sarah Robertson

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

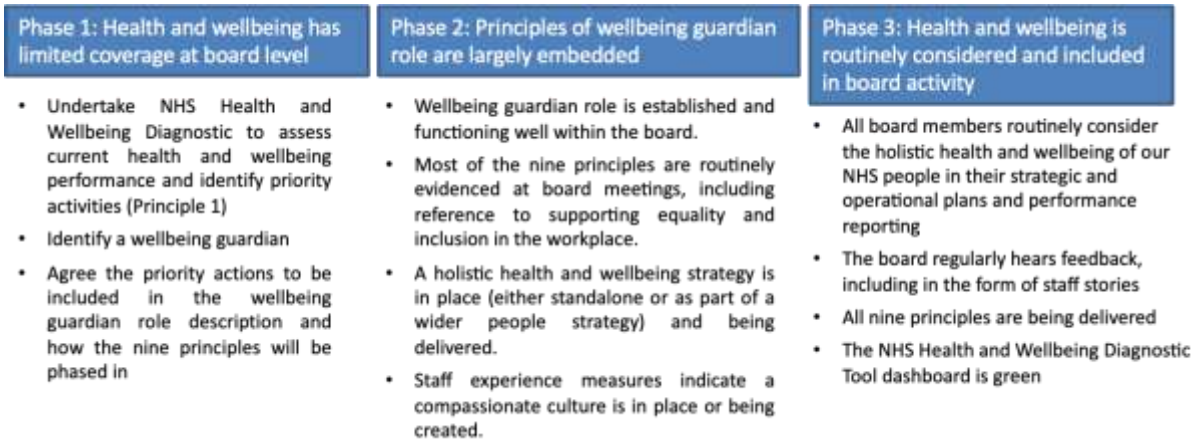
1. Introduction

This paper is an update to the Board by the Wellbeing Guardian on the current progress of the Wellbeing Guardian Nine Principles with the action plan attached to this paper.

2. Background

The Wellbeing Guardian (WBG) is a Non-Executive Director who:

There are nine Board principles supported by the WBG and the recommended approach to implementation is:



Alder Hey's appointed WBG, Jo Revill, is working with SALS, Organisational Development and HR to advance and oversee the implementation of the nine Board principles. The Board was previously advised that the NHS Health & Wellbeing Diagnostic had been completed for Alder Hey, and the Board formally approved the priority actions and the move to Phase 2 of implementation.

The Wellbeing Steering Group created a Dashboard to summarise the action plan for the nine principles supported by the WBG, which was initially presented to the Board at its meeting on 29th September 2022. The attached version of the Dashboard for September 2023 demonstrates the good progress that has been made to implement the nine principles of the Wellbeing Guardian.

PAWC will monitor the Dashboard and action plan, as we move to Phase 3, with the aim of approving the of implementation of the nine principles of the Wellbeing Guardian.

Attached to this summary is the current action plan and next steps that the team are currently working on.

The Board is therefore asked to:

(i) Note the actions and
(ii) Approve the current action plan and comment where required.

0233

Health & Wellbeing Strategic Group

	Wellbeing Principle Description	RAG	Progress	Next Steps	Lead(s)
Principle One	The health and wellbeing of our NHS people and those learning and working in the NHS should not be compromised by the work they do for the NHS.		**Work to address 'hygeine' factors. Sharing themes and hotspots with wellbeing gaurdian in SALs meetings. Natalie to link with Sarah Marshall and do thematic analysis in exit interviews. Agreed in principle at Execs and PAWC. Plan to role out over winter in Theatres and wards. In dicussion with Rachel Lea for an assistant psychologist (utilising Ground Truth Tool). Where does funding come from to back fill?**	**The Staff Advice and Liaison Service embedded within organisation. Network of SALS Pals now within the Trust (78 trained SALS Pals). SALS Pals trained in mental health first aid and the Ground Truth . SALS Pals only funded for a period of time by NHSE and therefore risk of future funding streams.**	**SALS**
Principle Two	Where an individual or team is exposed to a particularly distressing		**Jo Potier is part of the Patient Safety Board to help**	**Jo Revill to pick this up in terms of Board Time for**	**SALS/Jo Revill**
Principle Three	Regular assurance will be provided to the wellbeing guardian to ensure		**Health and Wellbeing Conversation for New Starters**	**Policy to be ratified by PAWC. To be presented by**	**Jeanette**
Principle Four	The wellbeing guardian will receive assurance that all our NHS people		**Staff can be referred to Occupational Health by their**	**No futher action**	**Occuapational Health/H&W**
Principle Five	The death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.e death by suicide of any member of our NHS people or a learner working in an NHS organisation will be independently examined and the findings reported through the board to the wellbeing guardian.		**Fiona to provide contact (if possible) from Liverpool Samaritans. Formal mechanism in place to support National Rail.**	**Sarah Robertson to pick up with HR colleague to pull all information together and write protocol/procedure. Jo Revill to link in with her contacts to see if there are any learning outcomes that would be helpful for us to use. (updated August 2023)**	**Sarah Robertson**
Principle Six	The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing		**Established wellbeing steering group. Some projects teams using psychological safety questionnaires. Have fedback themes from listening events. Establishing a disability task force led by new EDI lead (Angie Ditchfield leading), agreement to set up network.**		**SALS/WB Steering Group/Academy links)**
Principle Seven	The NHS will ensure that the cultural and spiritual needs of our NHS people and those learning in the NHS are protected, and equitable and appropriate wellbeing support for overseas NHS people and learners working in the NHS.		**Evidence, staff survey, EDI, WRES data.**	**EDI lead now in place and making good progress in establishing networks as well as a EQI Board of which Jo Potier attends. It would be useful for us to invite EQI lead to one of our meetings to think about measures that would support this principal**	**Meeting with J Revill/SALS/EDI lead to be arranged**
Principle Eight	The NHS will ensure the wellbeing and make the necessary adjustments for the nine groups protected under the Equality Act 2010 (including consideration for how intersectionality may impact wellbeing).		**Disability listening event took place on 29th June. Feedback shared with HR. BAME network launch at beginning Decmber. 3 disabilty listening sessions converted to actions plans (Angie). Health and wellbing conversations.**	**EDI lead now in place and making good progress in establishing networks as well as a EQI Board of which Jo Potier attends. It would be useful for us to invite EQI lead to one of our meetings. SALS to ensure our demographic information is complte and updated for all referrals or all staff accessing the service.**	**(EDI lead/HR/SALS)**
Principle Nine	The wellbeing guardian will provide suitable challenge to the board to be		**Good progress, conversations flowing through to**	**Jo Revill to pick this up in terms of Board Time for**	**WB Guardian to report)**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 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 ☐
Action/Decision Required:	To note ☑ To approve ☐
Summary / supporting information	None
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

Does this relate to a risk? Yes ☑ No ☐					
Risk Number	Risk Description				Score
BAF risk 2.1, 2.2, 2.3					
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

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 August 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 for the month of August was 5.4% which is in line with the revised in-year 2023/24 target of 5.5% and a further reduction from last month. This reduction has been sustained over the last 5 months. The split of sickness absence comprises of Short-Term Sickness (STS) of 1.86% and Long Term Sickness (LTS) of 3.54%
- Turnover has been stable since December 2023 and is now seeing a reduction and achieving the revised in-year target of 13% with a position of 12.5% for the months of August.
- A focused effort from the whole Trust is required in respect of PDRs with an August position of 67% against the target of 90%.

3. Industrial Action

The Trust continues to respond to industrial action through the tactical command structure and weekly meetings are in place. In addition, frequent Trust wide communications and updated FAQ's are issued and available on the Trust intranet for all staff, as well as ongoing staff support through the Trust SALS Service.

List of next dates of strike action are listed below:

.

4. Annual Staff Survey 2023

The annual NHS Staff Survey launched on **Wednesday the 20th of September** and will run for just over 9 weeks, closing on the **24th of November 2023.**

The team, made up of colleagues from OD, SALS, HR and Communications are working alongside divisional leads to ensure that as many staff as possible share their opinions on what it's like to work at Alder Hey to help the Trust to understand where it can improve.

Within the first week, 11% of the Trust had already completed their survey.

Sharon Owen
Deputy Chief People Officer
September 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 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 ☐
Summary / supporting information:	This report provides the board with a progress update on the Northwest BAME Assembly Anti-Racist Framework and the Equality Delivery System 2022. It also presents an overview of the recent equality, diversity, and inclusion activity undertaken in the trust.
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:	

1. Introduction

This paper aims to give the Board a high-level overview of the critical strategic and operational activity regarding Equality, Diversity, and Inclusion (EDI) during July/August/September 2023.

2. Northwest BAME Assembly Anti-Racist Framework

Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role to be focused on tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems. The recent national Workforce Race Equality Standard (WRES) data showed an increase in the percentage of Black, minority ethnic staff who experienced harassment, bullying or abuse from colleagues. Our ambition is to eradicate racism and we will work hard to create a culture that embraces inclusion. The Northwest BAME Assembly's anti-racist framework will support us on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability, and action. Through the embedding of the recommended themes, deliverables and actions into our structures, processes, policies, and culture, we will start to create important change within our workforce and service delivery. The recommended framework is organised into three levels of achievement: Bronze, Silver, and Gold. Each level builds on the next, assisting organisations to make incremental changes and take consistent actions towards eliminating racial discrimination.

We are currently undertaking the suggested self-assessment tool developed by the Northwest BAME Assembly to identify gaps in our current performance. These gaps will allow us to formulate a robust action plan, prioritising activities that will help us achieve a bronze status in the next 12 months, aligning to the Workforce Race Equality standard action plan. Once we achieve the bronze status, we will continue to measure our actions, helping us to progress to silver status. It must be noted that as an organisation we are working towards achieving bronze status and the Northwest BAME Assembly and the Integrated Care System are supporting us in implementing the direct deliverables and achieving bronze status in the next 12 months.

3. Equality Delivery System 2022

We are continuing to gather information and support to ensure that we successfully deliver and implement the EDS2022. We are working closely with other regional trusts to gain insight into the process and peer support. We have started to engage with service leads and key stakeholders to support data collection and analysis, reviewing our Workforce health and well-being, which is part of Domain 2, which is an area designed to promote understanding of our workforce health and well-being. We are on schedule to complete the report before the end of the year, allowing time for review and feedback.

4. Staff Networks

Our fantastic developing staff networks are growing from strength to strength and have been welcomed by our workforce.

- LGBTQIA+ staff network attend and celebrated at Liverpool Pride in July. It was a fantastic event which saw the local community support the LGBTQIA+ community. We also saw The Navajo Charter Mark assessment take place during August and September. The Navajo assessment panel carried out several interviews with various members of the Alder Hey team. It was an intense assessment, and we would like to thank everyone who took part. We are extremely pleased to report that we were successful and have been awarded the Navajo Chartermark. This is a great achievement, and we will continue to work hard to ensure we are an inclusive organisation which understands and supports our LGBTQIA+ staff, patients, and their families. The Navajo award ceremony will be taking place on the 5th of October where we will be the first Children's Hospital to be presented with the Chartermark.
- REACH staff network continues to make some positive changes and has continued to hold meeting for our staff. They have supported the development of the Workforce Race Equality Standard action plan which looks to improve the experiences of our ethnic minority staff. The network is working hard on the plans to celebrate Black History Month and have several activities planned throughout October.

- Armed Forces staff network are working towards Remembrance Day in November. They are engaging with the local Armed Forces community and will be holding a series of events to mark this occasion.
- The **ACE** Disabilities and Long-Term Conditions staff network continues to grow. They renamed themselves the ACE network as they want to look at disability positively, celebrating difference of all staff and educating the wider workforce around seen and unseen disability. The meetings continue to be extremely positive and full of ideas to make Alder Hey a great place to work. They are currently planning to celebrate Dyslexia and ADHD month in October.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
September 2023

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Minutes of the last meeting held on 11th July 2023
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director **(Chair)**	(FM)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(AB)
	Adam Bateman	Chief Operating Officer	(AB)
	Fiona Beveridge	Non-Executive Director	(FB)
	Garth Dallas	Non-Executive Director	(GD)
	John Kelly	Non-Executive Director	(JK)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)

In attendance:

Sarah Jones Bowman	Service Manager – Surgery	(SJB)
Angela Ditchfield	EDI Lead	(AD)
Gill Foden	HR Manager	(GF)
Sharon Owen	Deputy Chief People Officer	(SO)
Rachel Greer	Associate Chief Operating Officer, CAMHs	(RG)
Jill Preece	Governance Manager	(JP)
Jo Potier	Associate Director of Organisational Development	(JP)
Clare Shelly	Associate Director of Operational Finance	(CS)
Jason Taylor	General Manager – Research	(JT)
Kerry Turner	FTSU Guardian	(KT)
Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Nicola Norris Guest	E-Roster Manager	(NN)

Apologies:	Chloe Lee	Associate COO – Surgery	(CL)
	Kerry Turner	Freedom to Speak Up Guardian	(KT)
	Mark Carmichael	ACOO – Medicine	(MC)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	Rachel Greer	ACOO – Community & Mental Health	(RG)
	Asia Bibi	ACOO – Service Improvement	(AB)
	John Grinnell	Deputy Chief Executive	(JG)
	Kelly Black	Matron – Surgery	(KB)
	Julie Worthington	Staff Side Rep	(JW)
	Emma Palmer	Compliance Lead	(EP)
	Katie Jones	HRBP – Surgery	(KJ)
	Katherine Birch	Director, Alder Hey Academy	(KB)
	Emma Hughes	Managing Director – Innovation	(EH)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Natalie Palin	Associate Director of Transformation	(NP)
	Julie Worthington	Staff Side Rep	(JW)
	Kathryn Allsopp	Head of Operational HR	(KA)
	Pauline Brown	Director of Nursing	(PB)
	Urmi Das	Director, Division of Medicine	(UD
	Ian Quinlan	Non-Executive Director	(IQ)
	Jacqui Pointon	Associate Chief Nurse	(JP)
	Maisie StJohn	Service Manager	(MSt)

Jeanette Chamberlain	Staff Advice & Liaison Service Manager	(JC)
Adrian Hughes	Deputy Medical Director	(AH
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)

22/23/172 **Declarations of Interest**
No declarations were declared.

22/23/173 **Minutes of the previous meeting held on 22nd March 2023.**
The minutes of the last meeting were approved as an accurate record.

22/23/174 **Matters Arising and Action Log**
Action log was updated accordingly.

Industrial Action Update

MS shared the upcoming industrial action key dates for awareness to the committee noting there are steps in place ahead of the planned strike action to cross examine all significant risks to service provisions. Regular meetings continue to take place.

- BMA Consultant will take strike action between 20/07/2023 to 22/07/2023 &
  - 25/07/2023 to 26/07/2023.
- Society of Radiographers will take strike action between 25/07/2023 to 27/07/2023.
- Junior Doctors will take strike action between 11/08/2023 to 15/08/2023
  - Junior Doctors have been asked to re-ballot which will close on Thursday 31st August 2023.

The Chair asked for assurance as to the impact this will have to our organisation during all industrial action. AB commented the number of days in July will affect our access to care and potentially increase to waiting times for children and young people; senior leadership teams are working to reduce those risks to stabilise services across the trust. He provided assurance that action plans are in place to maintain and manage a level of stabilisation to ensure safety across the organisation for staff, patients and families.

MS noted there continues to be weekly drop sessions around industrial action lead by key members to review and strategize to ensure that safety continues to be our priority.

22/23/175 **Progressing Year 1 of the People Plan 2030**
Following launch of the Trust's 2030 Vision, MS provided 12-month plan update on the current position of the People Plan pulling focus to:

- People Plan 2030 vision was shared at Trust Board in July 2023.
- 'Thriving at Alder Hey' progresses with good developments from colleagues across the organisation
- 5 initial areas have been identified as key priorities:
  - Identified a new approach to recruitment.
  - Enhanced induction & orientation programme
  - Thriving Leaders Framework
  - Preceptorship
  - Needs based approach to health and wellbeing

A new Induction Programme intro has been introduced to embed new starters to ensure all colleagues receive the best experience.

FB asked if Alder Hey would consider working in partnership with other organisations to help lighten the burden. FM agreed advising we could look at what other trusts are currently doing to explore all options.

Action: Celebration & Recognition will be added to the agenda in Septembers Committee for oversight on progression.

Action: The process for Employee of the Month will be shared at a future committee meeting

Resolved: People Plan 2030 vision continues to make good head way and continues forward.

22/23/176 **Monitor Progress against the People Plan – Divisional Metrics**

Medicine Division:

The Committee received the medicine divisional metrics report (June data 2023) and noted progress to date. GF highlighted the following:

- Turnover remains on course following reduction in June data. A deep dive into turnover revealed there were 44 leavers within the last 3 months and conversations continue to take place and remains in line with the attraction & retention piece of work
- Sickness figures remain stable showing an improvement compared to the last 12 months position. Division continues to have plans in place with HRBP support.
- PDR trust position is at 91% for B7s and continues to be monitored.
- Mandatory Training compliance continues to be reviewed across the division with regular monthly briefings for oversight and assurance.
- Return to Work deep dive revealed a reduction in compliance when HR involvement was reduced. HR continue to offer assistance ensuring better understanding and importance of inputting data onto trust systems – work in progress.
- Big Conversations continue to be supported across the division ensuring action plans are followed and feedback to colleagues.

Action: Medicine will undertake a review around work life balance for a better understanding on the division's current position in terms of how colleagues are effected.

Resolved: Divisions continues to progress forward.

Research Division:

The Committee received the research division metrics report (June data 2023) and noted progress to date. JT highlighted the following:

- Turnover position has reduced and is showing improvement.
- Exit Interviews: conducted a deep dive analysis, and the breakdown will be shared with committee members for oversight in due course once that data is available.
- Sickness remains slightly under trust target for short term with an increase to long term
- Mandatory Training figures remain stable with plans in place for assurance.
- Big Conversations conducted in May provided positive outcomes – structures have been aligned to ongoing projects with support of ownership and accountability.

Resolved: Division continues to progress forward.

Community & Mental Health Division:

The Committee received the Community and Mental Health division metrics report (June data 2023) and noted progress to date. RG highlighted the following:

- Sickness displays a significant improvement for short and long term - Division continues to maintain across services.
- Reasons for leaving shows an increase for fixed term contracts including short-term investments. Division is conducting a piece of work with HR to review potential risks involving any impact around those contracts – plans in place to address.
- Mandatory Training remains above trust target – good improvement.
- Staff survey / Big conversations position is reaching trust target with continued focus across departments upheld with action plans in place. Actions identified for reward and recognition including celebrating achievements.

A new communication plan was launched in connection to the new digital plan around announcing nominations for achievements and a new water bottle will be gifted. Divisions continue investigating new ways to reward staff.

Resolved: Team continues to monitor data and drive improvements across the division.

Surgery Division:

The Committee received the Surgery division metrics report (June data 2023) and noted progress to date. SB highlighted the following:

- Turnover reports 14% which presents a cause for concern within the division. HR are working closely with senior managers as part of the attraction and retention resulting in the exit strategy being strengthened.
- Sickness for May data reported 5.5% showing slightly above trust target and remains stable. Short term is at 2% with long term at 4% - all action plans are being managed in line with trust policies.
- Return to work is 60% for May data – division remains focused with clear action plans.
- Mandatory Training has decreased from April at 91% - monthly reports are being shared with managers for clear actions. Data is reviewed and addressed at senior leadership meetings for initial focus.
- PDR compliance remains clear of deadline 31/08/2023 with division currently standing at 78% as of May 2023 for B7s and above.
- Time to Hire is 32 days for the month of May which shows an increase since April.
- Staff Survey results have been shared with managers to include action planning with continued focus on conducting big conversations with a deadline of 30th June 2023 - 3 received to date.

Resolved: Team continues to monitor data progression and drive improvements across the division.

Corporate Metrics:

Committee received the corporate metrics and noted progress to date. ES highlighted the following:

ES presented corporate metrics data as the Chair following the last corporate services collaborative which took place on 21st June 2023 which presented good engagement from colleagues across all 12 areas.

- Turnover remains above trust target. A deep dive analysis is being conducted in order to identify what roles are most effective including any underlaying causes which can be addressed.
- Sickness remains high for long term absence and continues to be well managed with support from HR.
- PDR continues to be managed and remains stable.
- Big conversations remain underway in all areas and will bring an update back to the next Committee for assurance.

Action: Team will explore a breakdown on overpayments to be added into the metrics in order to provide an update on progress against data reporting for assurance and oversight.

FB asked for assurance and further understanding behind the reasons for leavers within the organisation. FM commented advising a deep dive has been conducted and continues to be an ongoing development process and will be considered and factored into the strategy 2030 plan.

Resolved: Team continues to monitor data and drive improvements across the division.

22/23/177 **Monitor progress against the Internal Communications Plan**

Committee received the internal communications plan and noted progress made to date within the report.

Resolved: Committee noted good progress being made.

22/23/178 **EDI Update Report**

AD introduction the new NHS EDI improvement plan which was published in June 2023. The improvement plan presents a framework which provides 6 high impacts that are targeted actions of addressing prejudice and discrimination within the organisation. Plan is to align this framework to the people plan 2030 vision and develop a future platform which produces a variety of resources.

AD gave an EDS22 position update advising that, following the last ICB meeting attended in July 2023, the group set out the support that's needed to implement the equality delivery system. There is an ongoing process to identify three services which will involve working with stakeholders and service leads to ensure correct data collection is being sourced. Support continues to be received from JP and SALs to review our workforce health and wellbeing aligned to the domain of the equality delivery system – now on track to start pulling that evidence together in order to finalise ahead of publication in February 2024.

AD drew the committee's attention to the summary of activities over the last couple of months highlighting the following:

- Plan to attend Pride at the end of July 2023 – all welcome, organised by Alexandra Bowman, Staff Network Chair.

- Navajo applications have been submitted in support of our LGBTQIA staff and will now enter the next section. The Navajo team plan to attend Alder Hey in August 2023 to look at our policies and procedures including training to ensure they can support the trust inclusive to our LGBTQIA community. Navajo will conduct some short interview sessions with senior colleagues coordinated by AD.

- REACH Network are holding their first network event on 18th July 2023.

- Armed Forces Day was celebrated on 21st June 2023.

- 1st Disability & Long-Term conditions meeting took place on 30th June 2023 – good attendance and outcome – agenda for the next meeting is in progress.

Resolved: Committee noted good progress being made.

22/23/179 **Annual Health & Safety Report 22/23**

Committee received the Annual Health & Safety Report 22/23 and noted progress on the following:

- Summary of activity over the last 12 months continues to be reviewed and analysed to maintain stability.
- 1400 incidents reported within 22/23 – plans are in place to address and manage.
- Health & Safety Team have been involved in various building/campus projects and maintains good working relationships across the trust to help reduce and resolve safety issues or concerns including water safety occurrences.
- Manual Handling is being well managed across the organisation.

All complex risk assessments are continually monitored to enable roles to link in with disability network and provide support where possible in order for colleagues to remain safe while in work.

Resolved: Committee noted good progress being made.

22/23/180 **Annual Non-Clinical Claims Report**

Committee received the Annual Non-Clinical Claims Report and noted progress.

Non-clinical claims compared to 2022 shows a reduction in claims. Health and safety have put measures in place in terms of risk mitigation and this will be presented at the next Health & Safety Committee Meeting.

Senior Management are conducting ongoing projects to ensure all staff members are trained in accordance with all mandatory training / trust policy regulations to mitigate those risks.

Resolved: Team continues to effectively manage risks.

22/23/181 **E-roster Update – Benefits Realisation**

Committee received E-Roster updated presented by NN in relation to the benefits realisation highlighting the following:

- To date the trusts current position is at 82% of colleagues moved onto the roster. Team continues to break down by staff groups with plans in place.
- 26 teams are being reviewed by working with those who are remaining to be added and providing support to staff where needed to ensure correct training is applied.
- Internal challenges have been identified and plans in place to resolve.
- There are 66 cost centres remaining.
- Levels of attainment – level 0 for NHSEI are reported by staff group, plans in place to get over the 90%.
- Cost savings;
    - a reduction relating to bank holidays as per the trust policy guidance. Teams are working closely with HR and recruitment to ensure all hours are correct on ESR.

- AFC pay breaks – working with HR to ensure correct data is inputted and continues a work in progress.
- Wrong enhancements are being investigated to ensure corrections are identified.
- Time owing for ward-based areas working long days have been identified and the team is working to resolve and correct throughout the trust.

- Flowers case - remains in work in progress to remove manual calculations

Committee will receive future updates for oversight and assurance on the development of the roster in connection to savings costs and efficiency.

Action: Finance to help support e-roster team with deep dive to identify which KPIs will be reported to board.

Resolved: Team remains making good progress and continue to push through ongoing projects.

22/23/182 **Board Assurance Framework**

ES introduced the Board Assurance Framework reflecting the May 2023 position.

The new risk management reporting system is now in transition phase which will align to the 2030 Strategy.

There are 3 workforce risks to date and continue to be well managed and reviewed regularly.

The Committee noted the Board Assurance Framework update for the month of May 2023.

Ratify HR / Health & Safety Policies

22/23/183 **Waste Management Policy**

Committee reviewed the Waste Policy that was approved at the last Health & Safety Committee in April 2023.

Resolved:
Ratified by the Committee.

22/23/184 **Health & Safety Committee (HSC)**

The Committee received the approved minutes of the HSC meeting held on (April 2023).

22/23/185 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on (May 2023).

22/23/186 **Any Other Business**

Trust Nursery:

MS shared with the committee the nursery inspection report is now available to be shared with colleagues, noting we are rated as "Good" and that it was a really positive inspection / outcome.

MS formally thanked Sharon Owen, Deputy Chief People Officer and all colleagues within the nursery that took part on the day of inspection.

22/23/187 **Review of Meeting – Chair's Report to Board**

Industrial Action: Position update was provided with initial key dates to ensure safety across the trust. Focus remains.

People Plan: People Plan presented to the Committee with good goals of achievement across the organisation – further plan to bring back at future meetings 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.

EDI: EDI making good progress, NHS EDI Improvement Plan was introduced to the Committee for ratification and was approved by the Committee. Good progress being made.

E-Roster: E-Roster update was provided to the committee with good oversight and assurance. Senior Teams continue to monitor and drive forward.

Waste Policy was re-submitted and approved by the Committee.

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments and welcomed any feedback on content and discussion of the meeting.

Date and Time of Next meeting
Wednesday 13th September 2023 at 2pm via MS Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	Vision 2030 - Collaborating in Communities *(previously "Growing Great Partnerships")*
Report of:	Dani Jones, Chief Strategy and Partnerships Officer
Paper Prepared by:	Dani Jones, Chief Strategy and Partnerships Officer Abby Prendergast, Associate Director of Strategy and Partnerships Jenny Dalzell, Strategic Partnership Lead (Place) Dr Liz Crabtree, "Beyond" Programme Director

Purpose of Paper:	Decision **Assurance X** **Information X** Regulation
Background Papers and/or supporting information:	Link to Board Assurance Framework Risks 3.2 Strategy Development 3.5 System working to deliver 2030 strategy
Action/Decision Required:	**To note X** To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Collaborating in Communities
Resource Impact:	N/A

Vision 2030: Collaborating in Communities

1) Introduction

Alder Hey can only truly deliver our Vision 2030, and healthier, happier, and fairer futures for children and young people (CYP), if we work alongside our partners in the communities we serve, through a collaborative health and social care system that has a shared focus on the needs of CYP.

This quarterly Board assurance and update paper (previously titled 'Growing Great Partnerships') has been refreshed in light of Vision 2030 and now reflects the Collaborating in Communities strategic initiative, inclusive of the CYP system.

2) Cheshire and Merseyside (C&M)

Q2 of 2023 has seen significant strides in establishing key aspects of the collaborative CYP system in C&M. Alder Hey continues to play a lead role with partners to shape this. Three new elements of the CYP system architecture are described below. These are essential to bring to fruition the C&M Integrated Care System's (ICS) recognition of CYP as a priority population cohort, and to bring different collectives of partners together around a collaborative health and care system focused on the needs of CYP.

The C&M Integrated Care Board (ICB) CYP Committee

A new committee of the C&M ICB chaired by the C&M ICB Chair, met informally for the first time in September 2023, to develop a shared understanding of the priorities and needs of CYP and refine the terms of reference. The CYP Committee will ensure a 'single line of sight' for CYP across the C&M system, bringing together several interconnected, but distinct, system delivery units (described below). The committee will oversee the systems' CYP strategy, developing over Autumn/Winter 2023.

Bringing together health delivery for CYP

Ongoing system discussions have identified that there is much to be gained by coming together as health providers to share knowledge and experience, and identify where health can add genuine value by working together, whether by sharing new models of care/innovations that are successfully tackling real challenges, identifying and setting common standards for CYP services, offering mutual aid/support to each other where services are struggling, either between acute and specialist trusts, or across mental health, learning disabilities and community (MHLDC) providers.

As a result, both of C&M's provider collaboratives are prioritising a focus on CYP and are represented at the CYP Committee; this will ensure that all efforts are coming together in the single line of sight described above.

C&M Acute and Specialist Trust (CMAST) CYP Alliance

The CMAST CYP Alliance is currently under establishment, following widespread engagement and agreement to progress by the CMAST CEOs in July 2023, supported through CMAST Chairs in July 2023.

The Alliance will be led by Alder Hey on behalf of CMAST, bringing together hospital partners across C&M to drive action on a collaborative CYP programme. Proposed priorities include

elective recovery, CYP diagnostics, workforce, urgent care systems and paediatric virtual wards.

CMAST members have identified named senior leaders within their Trusts to represent, taking leadership for CYP in their Trusts as a whole. This is a major step forward, as in secondary care trusts it can be difficult to identify consistent senior CYP leads who have the overview of CYP as a population; many leads are more often condition/service/pathway specific.

The CMAST CYP Alliance will meet and co-design its terms of reference and work programme during Q3 of 2023. The Alliance will report into the CMAST Clinical Pathways programme and up to CMAST CEOs, with a dotted reporting line into the C&M ICB CYP Committee.

Mental Health, Learning Disabilities & Community (MHLDC) Provider Collaborative – CYP Programme

The MHLDC provider collaborative will bring together member partners in Autumn to co-design a CYP workstream for the collaborative. Member Trusts, at the request of Alder Hey's CEO as sponsor, have nominated senior colleagues to take part and agree the CYP programme which is likely to include work on speech and language therapy access (already in scheduling) and may include further priorities such as a focus on neurodiversity services and CYP mental health (to be finalised). The collaborative's overall value proposition is being finalised and will be brought to Trust Board for consideration in the coming months.

These newly established functions will work in harmony with the existing delivery units:

- **Beyond** – Whole-system (health & care) integrated transformation/delivery programme.
- **Directors of Children's Services (DCS) Network** - 9 Local Authorities leading on both DCS shared priorities and integrating on system-wide partnership priorities with Beyond.

Work will continue into Q3 and beyond to further establish and embed these mechanisms, and a continual focus on simplifying and aligning the system for CYP will be maintained. Trust Board will be kept appraised of these proposals as they develop.

Beyond Programme – Leading collaborative C&M CYP Transformation

Health Inequalities

Beyond continues to support the CYP Health Equity Collaborative (HEC), a collaboration between Barnardo's, the Institute for Health Equity and 3 ICSs (C&M, South Yorkshire, and Birmingham & Solihull).

The initial focus of the programme has been the development of a draft evidence-based HEC framework and initial review of data sets. Over 300 CYP have been consulted on what matters

most to them. This is being thematically reviewed to ensure that their views are reflected within the framework. CYP HEC champions are being recruited (2-3 from each ICB) to provide input over the lifetime of delivery, and to co-design pilot interventions.

Beyond is also linked with the “All Together Fairer” (Marmot) programme. Core20PLUS5 for CYP aligns closely with Beyond objectives and key deliverables will be included in workstream objectives.

Strategic Influence

The ICB has reviewed all transformation programmes through a rigorous transformation funding bidding process. The Beyond programme has been successful in this and is now funded for Q3/Q4 23/24 and for 24/25. This funding demonstrates the priority of CYP to the ICB, and the confidence the system places in the programme. The funding puts Beyond on a solid footing to deliver against key transformation programmes that will improve outcomes for CYP over the next 18 months.

Strong system engagement is in place with Place, Provider and Clinical involvement reflected in both the Beyond Board and workstream leadership. This reflects partnership working that recognises the complexity and multiple stakeholders involved within the CYP arena.

Beyond is working with system partners to develop the newly developed ICB Children’s Committee, and leading key pieces of complex system working – for example:

Appropriate Places of Care: meeting the needs of CYP with complex needs

When the health response to the North-West Children and Adolescent Mental health Services (CAMHS) review concluded in 22/23, it was identified that there remained a cohort of CYP who needed support that cross organisational delivery boundaries and:

- cannot be supported in their family home;
- are not assessed as being suitable for Tier 4 inpatient CAMHS provision;
- and where Local Authorities are unable to source regulated provision that can meet the breadth of CYP needs.

Data indicates a rising prevalence in children experiencing complex social and emotional difficulties within the context of a changing commissioning landscape due to:

- clearer criteria for Tier 4 admission and a move to admission avoidance;
- an amendment to the Care Planning, Placement and Case Review Regulations in Sept 2021 that made it illegal for children under the age of 16 years to be placed in an unregulated placement;
- and a changed residential care market of reduced availability and increasing cost.

The Beyond Programme and the DCS Network, are bringing stakeholders together from across Local Authorities, ICB and providers to agree a work programme to make long term and significant change in the way we meet the holistic needs of CYP and their families. This work will identify innovative, Place based responses to support children presenting with complexity.

3) Horizon Scanning

National Major Conditions Strategy

The Department for Health and Social Care (DHSC) published an interim case for change and strategic framework as part of the Major Conditions Strategy[1] in August 2023, which aims to improve health outcomes and better meet the health and wellbeing needs of local populations over the next 5 years through a multi-morbidity approach. It recognises the challenges facing society, noting that people with two or more conditions account for around 50% of hospital admissions and over half of NHS cost. The strategy focuses on six major conditions:

- Cancers
- Cardiovascular disease, including stroke and diabetes
- Musculoskeletal disorders
- Mental ill health
- Dementia
- Chronic respiratory disease

DHSC has proposed prioritising change in managing personalised risk factors, embedding early diagnosis and treatment in the community, managing complexity by aligning generalism and specialism, better integration between physical and mental health services, and shaping services and support around people, giving them more choice and control over their care. This is strongly aligned with the ambitions of Alder Hey's Vision 2030 and strategy.

The implications for paediatrics and Alder Hey as at today are minimal, as this is an interim long-term strategy, and levels of influence are currently unknown. However, CYP are referenced within the strategy, recognising that the conditions focused on can be all-age, and that preventative action at a younger age can support healthier lives later. The strategy specifically references:

- **Severe Obesity** - *"expanding access to intensive support for children living with severe obesity through 30 specialist clinics, doubling the ambitions set out in the NHS Long Term Plan for 15 clinics".*
- **Family Hubs** - *"investing around £300 million in Family Hubs and Start for Life programmes in 75 local authorities with high levels of deprivation to support parents and carers to nurture their babies and children".*
- **Childhood Cancer** - *"NHSE has introduced the under-16 Cancer Patient Experience Survey for patients and their parents or carers so that we can learn from their experience…. NHSE is working with DHSC on initiatives to ensure that carers are fed, and children can access play facilities and therapy."*

These priorities align with existing Alder Hey plans at Place (Local) and North West level.

As the final Major Conditions Strategy is published, and the implications for paediatrics and Alder Hey further emerge, the Board will be kept updated.

4) Childrens Hospital Alliance (CHA) – collaborating nationally with our CYP Trust partners

Alder Hey continues to play an active role in leading and supporting the workstreams of the CHA as the host trust for the partnership. This network continues to support an active and

[1] Major conditions strategy: case for change and our strategic framework - GOV.UK (www.gov.uk)

growing range of peer-to-peer groups - including for CEOs, COOs, Chief Nursing and Medical Directors, Finance Directors, Comms Directors, Innovation leads, Pharmacists and Allied Health Professionals.

Under the guidance of the CHA Programme Steering Group there are also a wide range of live programmes including, notably:

Developing a CHA bid for a forthcoming landmark National Institute of Health Research (NIHR) call focused on child health challenges

The NIHR has announced the forthcoming launch of a Programme Development Grants call on 22nd November, which aims to bolster research capacity, capability, and sustainability in some of the most complex and challenging areas of paediatrics.

The research will focus on addressing some of the most challenging issues in paediatrics, including safeguarding, disability/neuro-disability, mental health in children and young people, health inequalities, social care issues and obesity. The NIHR is looking for research teams that are national in scope, multisectoral and multi-professional with collaboration across social care, public health, education, and allied professions strongly encouraged.

The CHA team is working with senior research leads across the CHA and a project manager based in Alder Hey to develop a collaborative national bid. This process is initially collating information through focus groups and data collection on research expertise and priorities across the themes identified within our community of 12 member trusts. The aim is that these ideas will be rationalised to develop a compelling joint proposal to benefit children across England – both for the initial programme development grant, and a larger call that is expected to follow thereafter.

Advocacy on specialised commissioning delegation

The CHA team have prepared an analysis on the challenges that our member trusts, their ICBs, and most importantly their patients and families may face as part of the delegation of specialised services from NHSE to ICBs in 2024/25. This work is focused on supporting member hospitals to continue to apply a reasonable level of constructive challenge in their discussions with ICBs, who are currently completing their pre-delegation assessment process; and on helping to inform the national team's work to develop their own recommendations for risk mitigation.

The Alder Hey finance team is currently reviewing a set of mitigations developed by our CHA analysts which include detailed work to identify the more specialised procedures which should be lifted out of the delegation process, bespoke data collection to develop more accurate costing models for block contacts; and establishing 'approved' status for specialised providers to prevent any proliferation of specialised services in less specialised centres.

5) North West – Collaborating for excellent, resilient Specialist Services

CYP Specialist Services – Delegation to ICSs

A formalised North West Specialised Services Committee (multi-ICS Committee) is now operational, with the first meeting commencing in September 2023. John Grinnell is the nominated representative for CMAST at this group, ensuring connectivity for both C&M and Alder Hey. Most children's specialised services fall into the 'multi-ICB' category, and therefore having clarity on the North West wide arrangements and responsibilities is essential for Alder Hey. From April 24 ICBs will be responsible for:

- Commissioning select specialised services including service planning, needs assessment, provider selection, contracting, assurance and financial oversight;
- Driving integration of patient pathways;
- Supporting NHSE with National Transformation Reviews;
- Jointly managing Clinical Networks (including Operational Delivery Networks (ODNs)).

Alder Hey, Royal Manchester Children's Hospital (RMCH) and colleagues from Lancashire and Cumbria ICS are considering, with North West NHSE, the necessary and appropriate CYP strategy for the region, given the commissioning arrangements will be multi-ICB for most paediatric services. The next discussion with system colleagues is scheduled in November, and the Board will be kept updated as this evolves.

Women's and Childrens Transformation Programme (Spec. Commissioning)

2023/24 will see the full development of the North West Specialist Commissioning Women and Children's 'case for change' (Gateway 2 March 24), which is driving 3 transformation programmes to ensure equitable access and standards of care across the North West:

- the *Neonatal Transformation (Critical Care) Review*
- the *Paediatric Critical Care (L1 &2) and Surgery Review*
- the *Children's Cancer service specification* (Primary Treatment Centres (PTC) and Paediatric Oncology Shared Care Units (POSCUs))

At the most recent NHSE Women's and Childrens Transformation Board (Sept 23), developments were shared which outlined the strategic intention for these services:

- Ensuring Neonatal units meet the minimum activity requirements;
- Ensuring non-specialised paediatric activity is done in a District General Hospital where appropriate;
- Support commissioning of Level 2 high dependency beds in region where appropriate to improve flow of Level 2 and 3 beds in tertiary centres;
- Support development of enhanced POSCUs.

Alder Hey continue to be actively engaged in this programme of work in multiple ways. The North West Paediatric Partnership Board (NWPPB) (joint board between Alder Hey and RMCH) will continue to work in partnership with North West Specialist Commissioning and partners across the system to support both the content of the case for change where appropriate and to implement the recommendations. All relevant jointly hosted ODNs (Alder Hey and RMCH) are engaged in the transformation programme. In addition, Dr Adrian Hughes continues a part-time role as clinical lead with the North West Specialist Commissioning team for the W&C programme.

Now that the programme is gaining momentum, the Trust will mobilise our internal response, ensuring appropriate representation from Alder Hey to play into the work streams as they develop, and that we are kept informed on progress, and can influence the strategic direction as appropriate.

Operational Delivery Networks (ODNs)

The bi-annual ODN host assurance report was received at RABD Committee in September 2023. Going forward, All ODNs will be governed by a new NHSE service specification in 23/24 (currently in draft). They are likely to be renamed 'Clinical Networks' and have specified responsibilities in relation to system wide transformation. The draft specifications also state

that ODNs and their budgets should be ringfenced and not be subjected to cost improvement plans by the Host Trust. Final specifications will be shared when published.

The Neonatal ODN, Paediatric Critical Care, Surgery in Children and Long-Term Ventilation (PIC/SIC/LTV) ODN and Cancer ODN continue to work with NHSE on the National Women's and Childrens Transformation Review, which will consider the optimal model of care across the region for each of these services.

6) Place – Collaborating with our local communities.

One Liverpool Programme: Healthy Children & Families

As previously reported, this programme continues to gain momentum with three core areas of focus; Better Start, Good Respiratory Health and Mental Health and Emotional Wellbeing. Each area has an active plan with good progress across each -

- **Better Start** – Key focus is the mobilisation of the Family Hub model across the City and exploiting the opportunities to work collaboratively to provide joined up services for CYPF. The first Family Hub in the North of the City opened in August 2023 with two further planned in the Centre and South for Spring 2024. The Trust is fully engaged in the delivery model with considerations underway for an Alder Hey offer to be delivered from each. For Liverpool, the national areas of expectation are listed below;
    - Parent and Infant relationships and perinatal mental health support
    - Parenting support
    - Early Language and home learning environment
    - Infant feeding support

- **Good Respiratory Health** – Mobilisation progress of all component parts of the asthma bundle directed by the Beyond Programme (Core20PLUS5CYP) is monitored through the segment group as well as the City Council's Clean Air Agenda and Healthy City badge. Clean Air Day hosted by Alder Hey on 15 June 23 has generated further actions for the group to ensure a collective response across the city including for example, engagement with social housing partners through the installation of clean air monitors.

- **Mental Health and Emotional Wellbeing** – Agreed priorities focus on prevention (being mentally healthy), early help (getting advice and support), more specialist help and high-level specialist support.

All of the above is detailed in the One Liverpool Integrated Business Plan 23/24 and reported through the One Liverpool Partnership governance.

Liverpool - Prevention in Pathways

Alder Hey is leading work in collaboration with Public Health colleagues and system partners to drive community support for 4 initiatives around prevention in pathways. Each initiative will be fully evaluated, reporting through the Trust's Health Inequalities & Prevention (HIP) Steering Group and up to Safety and Quality Committee (SQAC). Projects that can demonstrate impact will be recommended to commissioners for consideration in future service development.

Four schemes have been identified and mobilised, and this quarter the focus of the report will be on the Healthy Weight programme – outlined in the case study below;

Alder Hey's 'Healthy Weight Programme' in partnership with Public Health Liverpool

The Healthy *Weight Programme* which just provided its Q1 Report supported by Liverpool Charity and Voluntary Sector (LCVS). Seven organisations across the City and of note, in areas of significant deprivation, have been providing healthy weight, healthy eating and wellbeing programmes.

Headlines to report to the Board to date include;

- 4700 beneficiaries in the first quarter
- Age profile of recipients ranges from 0 – 19 (25 to include SEND)
- Engagement of community partners with Trust specialties including cardiology and respiratory
- "Queen of Greens" mobile fruit and vegetable service now stopping at Alder Hey to support CYP, families and staff
- University of Liverpool Law students supporting foodbanks and pantries to provide poverty proofing advice.
- Plans afoot for Family Active sessions in Springfield Park for families of inpatients and their children.

The organisations also report engaging and working with:

- Educational institutions, such as local primary schools, community colleges and universities
- Health and wellbeing services, such as GP surgeries, social prescribers, Life Rooms, abstinence, and detox services, PCTs and public health, health visitors and midwifery services
- Voluntary organisations working with specific groups, such as autism and neurodiversity services, housing providers, welfare and employment rights services, asylum seeker, refugee and migrant organisations, children and youth organisations.
- Food providers, such as organisations that support those in food and fuel poverty
- Environmental services, such as Liverpool Zero Waste.

Sefton

The 'Live Well Sefton' plan continues to develop with the final strategy scheduled to be delivered in the autumn of this year. "Start Well" is one of the three ambitions. This will involve children and young people up to age 18, but also those up to age 25 years with additional needs. This ambition will focus on the 4 action areas –

Early intervention and prevention – this element will include health interventions, for example embedding the asthma bundle and the Beyond priorities at Sefton Place.

- Emotional wellbeing and mental health
- Children in care
- Transforming care (LD and autism)

Good respiratory health is an emergent work stream across Sefton, again driven by the Beyond Core20PLUS5 work. The Trust is engaged across the breadth of governance of the Sefton programme and is a key partner within the strategic and operational element of delivery.

Links are also developing with Knowsley Place through both Alder Hey's leadership teams and Beyond at a C&M level.

7) Partnership Governance and Partnership Quality Assurance Rounds

It was agreed at NWPPB in September 23, that the joint Cleft Lip and Palette service between Alder Hey and RMCH would undergo a partnership quality assurance round by end of 23/24.

Appendix 1 provides an assurance summary of the key joint services and strategic partnerships, demonstrating named executive leads, purpose, partners, governance/reporting arrangements, summary progress and any risks for escalation to Trust Board.

8) Risk and Issues to Highlight

The Board is asked to recognise the stage of development of the NW Case for Change for the three specialist reviews (Neonatal, PIC/SIC and Cancer) and the increasing need to galvanise Clinical and Operational leadership for this programme. Note that Trust Board will be kept informed as the case for change develops and potential impact / risks are known.

9) Recommendations

Trust Board are recommended to:

- Receive and note the content of this report including progress made.
- Take assurance that the strategic partnerships are appropriately managed and governed.

Appendix 1: Joint Services / Partnership Assurance Summary

Established partnership	Executive Lead	Purpose	Partners	Established	Governance/ Reporting Arrangements	Summary Progress 23/34	Risks / Issues for Escalation to Trust Board[2]
Liverpool Neonatal Partnership	Adam Bateman	Joint delivery of Level 3 neonatal service	Liverpool Women's Foundation Trust (LWH)	2020	Liverpool Neonatal Partnership (LNP) Governance structure LNP Board (monthly) provides assurance to Trust Boards at LWH & Alder Hey LNP Integrated Governance (monthly) – assurance to Surgical Critical Care Board (Alder Hey) and Family Health Board (LWH) Internal – Division of Surgery	Outlined in LNP Paper to Trust Board October 2023.	

Liverpool Adult Congenital Heart Disease (CHD) Partnership	Alf Bass	Joint delivery of Level 1 adult CHD service	Liverpool Heart & Chest Foundation Trust Liverpool University Hospitals Foundation Trust Liverpool Women's Foundation Trust	2018 – revised Memorandum of Understanding (MOU) Sept 2020	External – Liverpool ACHD Partnership Board (quarterly) Internal – Division of Surgery	-North West wide delivery of seamless all-age CHD service in partnership -Development of joint governance with CHD ODN to remove duplication in the system -Previous plans for a single patient treatment list have been superseded by the development of a CHD database which will have this functionality built in	None for escalation.
NorCESS - North West Epilepsy Surgery	Benedetta Pettorini	Joint delivery of Northern Epilepsy surgical service	Royal Manchester Children's Hospital (Manchester Foundation Trust)	2012	External – North West Paediatric Partnership Board (NWPPB - Alder Hey & RMCH) Internal – Division of Surgery	-Aim to improve the uptake and access to epilepsy surgery in those children for whom surgical control or amelioration for their epilepsy is a possibility - NorCESS is a long-standing specialist commissioned service by NHS England, receiving regular funding and serving CYP across the North West - the multidisciplinary team (MDT) review children with epilepsy who meet the criteria for evaluation for surgical intervention, provide a comprehensive pre-surgical evaluation and co-ordinate epilepsy surgical procedures for children for whom it is identified as appropriate.	Ongoing risks re: persistent problems with specialist recruitment (e.g., neurology and neurophysiology). These are logged within the joint service and escalated via an agreed escalation plan to NWPPB.

North West Obesity Tier 3 service	Dani Jones *NB oversight transition to Medicine Division – now in delivery.	Joint delivery of level 3 obesity hub & spoke model	RMCH (Manchester Foundation Trust) Royal Preston Hospital	Nov 21	External - NHSE monitoring & C&M CYP Programme Board (quarterly) Internal - Division of Medicine	-Service running across 2 hubs (AH & RMCH) and spoke in Preston. -Inequalities uplift in funding for 23/24 -Led for Alder Hey by Dr Senthil Senniappan. -Monitored through divisional routes and NWPPB as a joint service	None for escalation.
Alder Hey & Public Health Liverpool	Dani Jones	Delivery of a shared work plan via joint practitioner resource	Liverpool City Council Public Health	May 21	Internal – Health Inequalities & Prevention Steering group à Safety & Quality Committee	-Joint approach with LCC Public Health to PH Consultant role at Alder Hey -Health Inequalities and Prevention Steering Group continues - coalescing the -Trust's widespread Health Inequalities activity – chaired by Public Health professional -Prevention Pledge commitments – in partnership with the ICS. Priority project work includes: -Prevention in pathways: supporting long waiters with access to preventative support e.g., Mental health, food insecurity etc -Dental / Oral Health -Smoking Cessation (CYP, families and staff)	None for escalation.

						-Healthy Weight & Obesity – community/VCSE local delivery	
North West Paediatric Partnership (NWPPB)	Dani Jones / Alf Bass	Joint oversight of NW ODNs & commitment to collaborative delivery of specific specialist / tertiary paediatric services as mutually agreed.	RMCH (Manchester Foundation Trust)	2019	External – North West Paediatric Partnership Board NWPPB – biannually) Internal – Resource and Business Development – ODN assurance paper (biannually)	-Joint development and oversight of NW ODNs and joint services -MOU's/partnership agreements described on a case-by-case basis at a service/network level, following the principles set out in the NWPPB MOU approved by Trust Board in 2019. -Scoping future NW service models e.g. cardiology, neurology -Aligned models for NW delivery across e.g., PIMS/Long Covid	None for escalation.

Alder Hey Children's NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on
Wednesday 30th August 2023 at 14:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Kerry Byrne	Non-Executive Director	(KB)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Director of Finance and Development	(RL)
	Fiona Marston	Non-Executive Director	(FM)
	Kate Warriner	Chief Digital and Information Officer	(KW)
	Dame Jo Williams	Alder Hey Chair	(DJW)
In attendance:	Asia Bibi	ACCO, Medicine	
	Urmi Das	Clinical Director, Medicine	
	Emma Hughes	Acting Manging Director for Innovation	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Sian Calderwood	General Manager, Surgery	
	Jane Halloran	Acting Deputy Development Director	
	Abby Prendergast	Deputy Director of Strategy and Partnerships	
	Jill Preece	Governance Manager	
	Mark Seddon	Systems Accountant *(observing)*	
	Clare Shelley	Associate Director Operational Finance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Gary Wadeson	Associate Director – Income, Costing & Commissioning	
Agenda Item: 83	Steven Doran	Procurement Manager	

23/24/71 **Apologies:**

Shalni Arora	Non-Executive	(SA)
Mark Flannagan	Director of Communications	(MF)
Dani Jones	Director of Strategy and Partnerships	(DJ)
Catherine Kilcoyne	Deputy Director Business Development	
David Powell	Development Director	
Melissa Swindell	Director of HR & OD	(MS)

23/24/72 **Minutes from the meeting held 17th July 2023**
The above minutes were approved as a true and accurate record.

23/24/73 **Matters Arising and Action log**
The Chair introduced:
Dame Jo Williams, standing in as Non-Executive Director
Kerry Byrne, NED, Observing
Fiona Marston, New NED member of RABD.

All actions due for this month had been completed.

ES noted the Risk Profiling/Tolerance action was being revisited externally and would be updated in due course.

Energy business case is currently in development and will come back to a future RABD.

23/24/74 Declarations of Interest
There were no declarations of interest.

23/24/75 Finance Report
Month 4 Financial Position
£9K surplus was reported for M4. Ytd £1.49m as in line with plan.

RABD noted the continued Industrial Action strikes dates were difficult to manage and placing increased pressure on the financial position. A breakdown on the divisional position was received including Cost Improvement Plan. AB noted pressures within the Surgery Division and asked for the division to include an update at the October Quarterly Division RABD on staffing.
Action: Chloe Lee/Matthew Upton

In terms of the wider Cheshire and Merseyside a number of Trusts have fell behind plan with recovery plans being submitted from those organisations.

A discussion was held on risks in relation to meeting 2023/24 overall control total. RL agreed to present a potential risk and mitigations scenario at the September RABD meeting to assess mitigations if the Trust financial plan fall behind schedule.
Action: RL/CS

Resolved:
RABD received and noted the M4 Finance report.

23/24/76 Month 4 Integrated Performance Report
AB highlighted:
Was Not Brought pilot to 500 families has been carried out, continue to support new ways of reducing WNB.

ED consistently achieving the national standard, reaching 91% in July (target >85%) Theatre Utilisation (touch time) continues to demonstrate improvement during May-July.

Preparing for Winter includes measles plan and enhancing staff protection.

Resolved:
M4 IPR report was received.

23/24/77 Cost Improvement Plan
RL noted a number of opportunities to be worked through including, robotics and estate.

Slides from CIP workshop held on 13th July along with outputs from session and benefits review had been included for information.

Resolved:

RABD received the monthly update for CIP.

23/24/78 Campus update

JH highlighted:
Park: Lighting for rest of the park has been approved. Working with the council on a number of concerns raised through Friends of Park including the size of football pitches.

Resolved:
RABD received the monthly position on Campus.

23/24/79 Aldercare

KW introduced the go/no go slides that had been shared with RABD, due to the fast pace of the Aldercare programme the slides had been updated.

KW noted learnings from Liverpool Women's NHS Foundation Trust who are live with the Aldercare programme.

A training update was received highlighting catering the programme to shift workers needs to ensure the training reaches all clinical/admin teams.

KW noted the support levels expected during the first and second go live weeks.

Resolved:
RABD supported the preparations for Aldercare Go Live and thanked all teams involved for the position Alder Hey is in pre go live.

23/24/80 Trust's National Cost Collection Submission

RABD was asked to review the costing plan and supporting information provided to ensure that it meets the expected requirements noted in the Approved Costing Guidance.

KB asked questions in relation to the process and suggested it should be discussed at Audit and Risk Committee as to whether it was appropriate to consider an internal Audit. It was agreed that this would be actioned through ARC.
Action: ARC

Resolved:
RABD noted the Trust's National Cost Collective Submission as well as the ARC possibly reviewing the process.

23/24/81 Expenditure Control Assurance

RL reported on a letter received from the ICB, in response to an NHS England planning outcome letter that includes a checklist of mandated expenditure controls. The paper outlines the detail of the controls, the Trust response to each of the controls and provide assurance to RABD of the steps being taken to ensure the controls are implemented.

Resolved:
RABD APPROVED the proposed response to the ICB.

23/24/82 Board Assurance Framework
ES gave an overview of the key BAF risks from the July report.

Resolved:
RABD received and noted the Strategic Risks.

23/24/83 Procurement Strategy
The above document had been circulated with RABD papers, SD gave a presentation highlighting aims and objectives.

Resolved:
RABD APPROVED the Procurement Strategy and asked that further opportunities keep being reviewed.

23/24/84 Revised Surgery Investment Summary
MU gave background on the two business cases.

Combined the summary in the latest paper for ease of reference.

APPROVED.

Craniofacial Business Case
MU provided background noting the block contract has not been uplifted for a number of years and a case was submitted to commissioners for funding to provide expansion of services to all patients.

RL went through the process that surgery went through with commissioners over the last three years for the business case to be approved noting good processes/working relationships.

23/24/85 Any Other Business
No further business was reported.

23/24/86 Review of Meeting
JK reviewed the meeting noting the longer agenda than originally planned, the good discussions on the financial position and Aldercare.

Date and Time of Next Meeting: Monday 25th September, 1400, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 5th October 2023

Paper Title:	**Board Assurance Framework Report 2023/24**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☐
Action/Decision Required:	To note ☑ To approve ☑
Summary / supporting information	The Board Assurance Framework has been updated to reflect the developing position with regards to the implementation of Vision 2030.
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:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☑ No ☐						
Risk Number/s	Risk Description					Score
As detailed in the report	This report provides an update against all Board Assurance Framework Risks for the month of September 2023.					As detailed in the report
Level of assurance (as defined against the risk in InPhase)	☐	**Fully Assured** Controls are suitably designed, with evidence of them being consistently applied and effective in practice	☐	**Partially Assured** Controls are still maturing – evidence shows that further action is required to improve their effectiveness	☐	**Not Assured** Evidence indicates poor effectiveness of controls

Board Assurance Framework 2023/24

1. Purpose

The aim of this report is to set out the transition of the Board Assurance Framework to reflect Alder Hey's Vision 2030 following the inaugural Trust Strategy Board and subsequent risk workshop session held on 6th July 2023. Since that time, work has been ongoing to develop the underpinning documentation to describe the way in which the Trust's strategic risk profile is shifting as a result of the adoption of our revised vision and ambitious strategy for the future.

As the Board is aware, the purpose of the Board Assurance Framework is to provide assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees will continue to review the BAF in advance of its presentation to the Trust Board and propose any further changes following Executive 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 identified.

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

Now, with the creation of the Strategy Board the updated BAF will need to be in service of the new governance arrangements that will oversee the deployment and delivery of our agreed strategic objectives. The bridging work that shows the transition to the revised BAF for 2030 is set out below. That said, it is important that the dialogue continues around how our strategic risks are described and subsequently managed in the context of the changing environment, both internal and external.

2. Review of the BAF

The three summary tables shown below at sections 3, 4 and 5 provide an overview of the key changes agreed to date arising from the 2030 Vision and Strategy: the discussion at the initial Strategy Board, the output from the risk workshop with Non-Executive Directors held by the Managing Director and Director of Corporate Affairs and the subsequent analysis undertaken by Executive leads.

Section 3 provides the end point position in terms of current (August 2023) and target risks for the 'Our Plan' BAF.

Section 4 sets out the proposed 13 principal risks aligned to the Trust's new strategic objectives and delivery of the 2030 Strategy. The substantive changes are the reframing of risks: 2.2 (previously Employee Wellbeing), 3.2 (previously failure to deliver 'Our Plan…'), 3.5 (previously 'new ICS' risk) and risk 4.1. It is proposed that risk 3.6 'Risk of partnership failures due to robustness of partnership governance' is closed and incorporated into business as usual given the work that has taken place to move this agenda forward.

Section 5 provides the Board with the descriptions for the revised strategic risks. These were presented to the Strategy Leadership Group on 28th September and agreed to be a reasonable reflection of the high-level change propositions arising from the 2030 Vision. It is anticipated and hoped that they will be further informed by discussion at the Strategy Board in October 2023.

Risk owners. Whilst there remains a system and best practice requirement to designate a sole owner for each risk, the Strategy Leadership Group is keen to adopt a shared approach to ownership, mitigation and management of the BAF risks going forward. The new risks in particular describe a wider standpoint than those that have been previously articulated and it is felt that this requires a recognition that the successful delivery of the strategy will be 'everybody's business.'

3. Summary of BAF to September 2023 reflecting risks to delivery against the strategic ambitions within in 'Our Plan' originally set out in 2019.

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC PILLAR: Delivery of Outstanding Care				
1.1 NA	**Inability to deliver safe and high-quality services**	SQAC	3x3	2x2
1.2 AB	**Children and young people waiting beyond the national standard to access planned care and urgent care**	RABD / SQAC	**4x5**	3x3
1.3 AB	**Building and infrastructure defects that could affect quality and provision of services**	RABD	4x3	2x3
1.4 LC	**Access to Children and Young People's Mental Health**	RABD / SQAC	**3x5**	3x3
STRATEGIC PILLAR: The Best People Doing Their Best Work				
2.1 MS	**Workforce Sustainability and Development**	PAWC	**4x5**	3x2
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	**3x5**	4x1
STRATEGIC PILLAR: Sustainability Through External Partnerships				
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	RABD	3x4	3x2
3.2 DJ	**Failure to deliver 'Our Plan' and developing 'Vision 2030' 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
3.4 JG	**Financial Environment**	RABD	**4x4**	4x3
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
3.6 DJ	**Risk of partnership failures due to robustness of partnership governance**	RABD	3x2	3x2
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
4.2 KW	**Digital Strategic Development & Delivery**	RABD	4x4	4x1

4. Summary of (proposed) BAF risks from October 2023 updated to reflect the developing position with regard to the implementation of Vision 2030.

Ref, Owner	Risk Title	Monitoring Cttee	Risk Rating: I x L	
			Current	Target
STRATEGIC OBJECTIVE: Delivering the best possible outcomes and experience for CYP&F				
1.1 NA	Inability to deliver safe and high-quality services	SQAC	3x3	2x2
1.2 AB	Children and young people waiting beyond the national standard to access planned care and urgent care	RABD / SQAC	**4x5**	3x3
1.3 AB	Building and infrastructure defects that could affect quality and provision of services	RABD	4x3	2x3
1.4 LC	Access to Children and Young People's Mental Health	RABD / SQAC	**3x5**	3x3
STRATIC OBJECTIVE: Supporting our colleagues to have fulfilling careers in a community that thrives				
2.1 MS	Workforce Sustainability and Development	PAWC	**4x5**	3x2
2.2 MS	Failure to deliver the best experience for Staff, Children and Young People and their Families	PAWC	3x3	3x2
2.3 MS	Workforce Equality, Diversity & Inclusion	PAWC	**3x5**	4x1
STRATEGIC OBJECTIVE: Working with partners to improve life chances of CYP				
3.1 RL	Failure to fully realise the Trust's Vision for the Park	RABD	3x4	3x2
3.2 DJ	Strategy Deployment	Strategy Board	4x3	2x2
3.4 JG	Financial Environment	RABD	**4x4**	4x3
3.5 DJ	System working to deliver 2030 Strategy	Strategy Board	4x3	3x2
STRATEGIC OBJECTIVE: Pioneering to find novel solutions and treatments				
4.1 JC	Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.	Research & Innovation	3x3	3x2
STRATEGIC OBJECTIVE: Ensure delivery of the very best health and care outcomes for CYPF locally, regionally, nationally and internationally.				
4.2 KW	Digital Strategic Development & Delivery	RABD	**4x4**	4x1

5. Revised risk descriptions are summarised below.

Ref/Owner	Risk Title / Description
STRATEGIC OBJECTIVE: Supporting our colleagues to have fulfilling careers in a community that thrives	
2.2 MS	**Failure to deliver the best experience for Staff, Children and Young People and their Families:** *Failure to set and develop the cultural conditions to enable staff to embrace the transformational change necessary for the effective implementation of the 2030 Vision.*
STRATEGIC OBJECTIVE: Working with partners to improve life chances of CYP	
3.2 DJ	**Strategy Deployment** *Failure to translate the 2030 Vision into operational plans and systematically execute. Failure to deliver on the strategic ambitions to make a difference to CYP impacting on the delivery of the NHS Long Term Plan and Trust's reputation.*
3.5 DJ	**System working to deliver 2030 Strategy** *Risk of inability to control execution of 2030 Vision due to system complexities and evolving statutory environment.* *Risk of failure to secure sign up from partners to engage in a new Strategy for CYP given the wider NHS context and competing priorities.* *Potential failure to land our 2030 Strategy with key partners within the wider system impacting on our reputation and long-term sustainability*
STRATEGIC OBJECTIVE: Pioneering to find novel solutions and treatments	
4.1 JC	**Failure to deliver against the trust strategy and deliver Pioneering Breakthroughs via game-changing Research and Innovation that has positive impact for Children and Young People.** *The Trust strategy requires the delivery of pioneering breakthroughs via game-changing research and innovation. These will provide future solutions to the current unmet needs of children, young people and their families (CYPF) and, in doing so, enhance the national and international reputation of the Trust.* *Failure to attain a balanced portfolio of activities and a sustainable financial model for growth, including both income-generating and cash-saving activities through a variety of cross-sector collaborations - including commercial partnerships - could delay new discoveries.* *The delivery of the R&I activities via these collaborations may also expose the Trust to ethical challenges and reputational risks associated with the necessary individual data governance, contractual and legal agreements with various partners.*

6. Strategy versus Delivery (for discussion and development) – initial examples

STRATEGIC OBJECTIVE	RISK OF DELIVERY TO 2030 VISION
Delivering the best possible outcomes and experience for CYP&F	Emerging Business Models Right Models of Care
Supporting our colleagues to have fulfilling careers in a community that thrives.	Cultural evolvement Change capacity and capability Workforce profile
Working with partners to improve life chances of CYP.	Sovereignty versus System Competing priorities of partners Resource challenges
Pioneering to find novel solutions and treatments.	Mission creep
Ensure delivery of the very best health and care outcomes for CYPF locally, regionally, nationally and internationally.	Reputation / Brand Investment decision making

7. Summary of August 2023 updates:

Failure to deliver 'Our Plan' and developing 'Vision 2030' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships. (DJ).
Risk reviewed; no change to score. Vision 2030 progressing as per agreed timeframes. Draft Vision 2030 Strategy to Board in September and progression of the next Strategy Board in October.

- ***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. Agreement to proceed with CYP Committee from ICS.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed in month and no change to current score. In the process of refining the partnership quality assurance round pack.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  All staff networks now live with leads recruited and action plans in development. Navajo charter mark assessment (LGBTQIA+) successful with the Trust achieving charter mark status in September 2023.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Discussed at recent liaison committee early June. Regular board to board meetings are in place 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 with the program due to complete in October 2023. 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 a chemical dosing system across the site. Further details on the installation are awaited from the SPV having been chased wb 19th June. The chiller works continue and we are awaiting 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. On site inspection took place wb 3rd July with a view to a new contractor maintaining plus remote monitoring. 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.

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  We are now consistently achieving the 85% national standard for access to ED. Development of winter plans are in progress to ensure enhanced resilience during this time.

  Access to diagnostic tests has now exceeded the 90% target for 6 week waits.

  We have seen a short-term increase in elective patients waiting greater than 65 weeks but investment in ENT and dental is now in place with

expectation of eliminating 65 week waits by March 2024. Ongoing industrial action remains a significant threat which is being actively managed to ensure safe delivery of services.

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk 1.1 has been reviewed. Gaps in assurance continue with controls in place. Progress continues to be monitored by SQAC and receptive subgroups. Gaps in assurance relating to industrial action continue to be regularly reviewed as part of the Trust command and control structure relating to industrial action with appropriate plans in place for each episode.

- ***Access to Children and Young People's Mental Health (LC)***
  Review undertaken and actions in place. I have uploaded approved paper shared with Place leads regarding investment, planned workforce and predicted improvement plans based on this.

- ***Financial Environment (JG).***
  Risk reviewed and score remains static. CIP gap closing in year but recurrent emphasis required ongoing monitoring of financial pressures through RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP).***
  Possession of full site at been awarded to the Park Contractor. Completion of the multi-use games area which is due to open to the public 7th August 2023. Works have commenced on site levels and the setting out of the new infant and junior playgrounds.

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, actions progressed in reporting period. Aldercare progressing for September go live, risks being managed via programme and programme board. Go live preparedness group in place with senior and operational leads identified.

- ***Workforce Sustainability and Development (MS).***
  Risk reviewed. Small reduction in turnover and sickness seen in August 2023.

- ***Employee Wellbeing (MS).***
  Risk reviewed. Additional resource for SALS has been secured to deliver a more comprehensive service. Successful in bidding for seedcorn funding from research function to support a SALS research project into the impact and effectiveness of SALS.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL).***
  No change to risk score this month. However, a provisional £4.5 mill from Investment zone is identified. A resource and financial plan is in development on how to spend £4.5 mill to support strategic growth

8. Recommendation

The Board is asked to note the work undertaken to date to revise the strategic risks in the context of the 2030 Strategy and approve the updated Board Assurance Framework.

Erica Saunders
Director of Corporate Affairs