Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 15th December 2022, commencing at 11:00am

via Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**22/23/219**	**11:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/220**	**11:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/221**	**11:02 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **24th November 2022.**	**D**	Read enclosures
4.	**22/23/222**	**11:05 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/223**	**11:10 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**22/23/224**	**11:20 (50 mins)**	• **Integrated Performance Report for M8.** • **Finance Report for M8 2022/23.** • **IPC Update.**	Exec Leads/ Divisional Leads R. Lea B. Larru	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position.	**A** **A** **A**	Read report Read report Presentation
Strategic Update							
7.	**22/23/225**	**12:10 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To provide an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
8.	**22/23/226**	**12:20 (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
9.	**22/23/227**	**12:25 (5 mins)**	**Complaints and PALS Report, Q2.**	N. Askew	To receive the PALS and Complaints report for Q2.	**A**	Read report
The Best People Doing Their Best Work							
10.	**22/23/228**	**12:30 (5 mins)**	**People Plan.**	M. Swindell	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
11.	**22/23/229**	**12:35 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
12.	**22/23/230**	**12:40 (15 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 12.12.22.** - **Approved minutes from the meeting held on the 24.10.22 and the 29.11.22.** • **Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 14.12.22.** - **Approved minutes from the meeting held**	I. Quinlan F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

Alder Hey Children's NHS Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			on the 16.11.22. • **People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 7.12.22.** - **Approved minutes from the meeting held on the 31.10.22.** • **Innovation Committee:** - **Chair's verbal update from the meeting held on the 12.12.22.** - **Approved minutes from the meeting held on the 10.10.22.**	Dame Jo Williams S. Arora			
Items for information							
13.	**22/23/231**	**12:55 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
14.	**22/23/232**	**12:59 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 26th January 2023, 9:00am, Lecture Theatre 4, Institute in the Park, Alder Hey							

REGISTER OF TRUST SEAL
The Trust Seal wasn't used in November 2022

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M6, 2022/23	R. Lea
IPC Report	B. Larru

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 24th November 2022 at 9:00am** via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
In Attendance	Mr. M. Carmichael	Assoc. Chief Operating Officer	(MC)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mr. I. Gilbertson	Assis. Chief Digital and Information Officer	(IG)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. S. Owen	Deputy Chief People Officer	(SO)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
Staff Story	Ms. K. Birch	Director, Alder Hey Academy	(KB)
	Ms. J. Downes	Vocational Placement Adviser	(JD)
Item 22/23/199	Dr. L. Crabtree	Beyond Programme Director	(LCr)
Apologies	Dr. U. Das	Director of Medicine	(UD)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Ms. J. Revill	Non-Executive Director	(JR)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. M. Swindell	Chief People Officer	(MS)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)

Staff Story

The Chair welcomed Joe who had been invited to November's Board to share his experience of Alder Hey's Supported Interns (SI) Programme and his time with the Trust. Joe's mum, Siobhan, attended the meeting as did Katherine Birch and Joanne Downes in order to support Joe.

Katherine advised the Board that the Trust didn't formally start its SI Programme until the Autumn of 2022 but Liverpool University Foundation Trust (LUFT) had asked if Alder Hey would host one of their interns on placement from March 2022 so that he could broaden his experience. Joanne informed the Board that Joe is an amazing young man who was given an opportunity and embraced it. Everybody at Alder Hey knows Joe and speaks very highly of him. He has a smile on his face every day and has grown into a confident young man who wants to work at Alder Hey.

Joe provided an overview of the range of jobs he covered whilst at the Trust; helping to calm upset patients, family support, patient experience, meeting and greeting people, escorting people

to their destination, administration work, being part of a team, helping on concierge, dealing with car park tokens, making people happy. It was pointed out that Joe is really good role model for the Trust's new volunteers.

Joe's mum, Siobhan, reported that the SI Programme at Alder Hey was a lifeline for Joe and the family when he finished college, and advised that Joe is a different person as his confidence has grown immensely. Siobhan drew attention to the importance of giving children with a disability the opportunity to achieve what they are capable of so that they can live independently. Siobhan thanked everyone involved in supporting Joe during the programme and expressed how proud she is of her son.

The Chair thanked Joe for sharing his story and told him how proud the Board is of all that he's achieved. Katherine offered thanks to Joanne, Anne Doyle and the team who did everything in their power to ensure they were able to offer Joe the position. Siobhan also paid tribute to the team for the recognition that they gave to Joe.

The Chair drew attention to the recent awards that Katherine and her team have received and praised the work that has taken place to achieve these accolades.

22/23/193 Welcome and Apologies

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

22/23/194 Declarations of Interest

The Board noted the declaration received from Fiona Beveridge in relation to agenda item 22/23/205 (University Partnership Arrangements) and her association with the University of Liverpool (UoL).

22/23/195 Minutes of the previous meetings held on Thursday 27th October 2022
Resolved:
The minutes from the meeting held on the 27th of October were agreed as an accurate record of the meeting.

22/23/196 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 22/23/82.1: *Corporate Report (Medicine - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance)* – It was reported that Radiology achieved the diagnostic standard (100%) in October and a trajectory has been set for the end of March to address the reduction in diagnostic performance in all areas. **ACTION CLOSED**

22/23/197 Chair's and CEO's Update

The Chair drew attention to the recent awards that the Trust has received; NHS Pastoral Care Quality Award and the shared Children's Hospital Alliance HSJ Performance Recovery Award for the Paediatric Accelerator Recovery Programme. The Chair thanked Katherine Birch, Adam Bateman and all those involved for the hard work that has taken place to achieve these accolades

The Chair provided an update on the presentation that the Secretary of State for Social Care, Stephen Barclay, gave at November's NHS Provider Conference where he highlighted his priorities for supporting the workforce, recovery, GP access, NHS estate and prevention. It was pointed out that there will be much more difficult targets to achieve going forward, but the message was about short term practical solutions, partnerships and shared responsibility.

The Board was informed that Dame Jo Williams has been asked to chair the Cheshire and Merseyside (C&M) Acute and Specialist Trust meetings going forward. It was pointed out that the Chairs of trusts are keen to make a difference and will address certain strategic elements; deprivation, the workforce, demographics, and key issues relating to primary care and social care. The Chair is also a member of the Health and Care Partnership which is focussed on health inequalities.

Louise Shepherd reported on the session that took place on the 17.11.22 (*CYP Programme Board and Stakeholder Development Session*) that brought the CYP Programme together nationally. The Board was advised of the work that is being conducted by the National Children's Director, Simon Kenny, and the effort that is taking place to ensure that children and young people (CYP) are at the centre of Government policy. It was pointed out that the CYP Programme is based on the premise that it is an organisational programme with local authority leading on it to give it the political supports that is needs. The Chair of the ICB, Raj Jain, is very supportive and has asked the Director of Strategy and Partnerships, Dani Jones, to look at bringing a governance arrangement into the heart of the programme.

It was reported that the One Liverpool Programme is being reinvigorated and Public Health Liverpool have asked Dani Jones and Melissa Campbell for their support to revive the CYP Programme across the city.

An overview of the national picture was provided, and it was reported that guidance on the £3.3b uplift for the NHS will be published mid-December in terms of distribution across the ICSs. The Board was informed that Cheshire and Merseyside (C&M) will receive a slightly less uplift in 2023/24 therefore the Integrated Care Board (ICB) is discussing ways of tackling this matter along with the deficit across C&M.

Attention was drawn to the importance of addressing urgent care locally especially in light of the four-hour target being more closely tracked. There is a lot of work taking place internally but there is a need for the system to wrap around this issue as the Trust can't deal with this matter alone.

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

22/23/198 Integrated Performance Report

The Board was provided with a summary of the performance metrics incorporated in the IPR. It was reported that pressures have increased at the Trust and the Winter Plan has been operating at level three to four. The Emergency Department (ED) are seeing up to an additional 70 families each day and environmentally ED is becoming overcrowded. It was confirmed that further action is being taken to ensure that Alder Hey doesn't get into an internal incident position. The Board discussed staff morale in ED and it was highlighted that the Exec Team have made provisions to ensure that the ED team are supported.

The Board was informed that the Trust has achieved a recovery of 107% in October and received approval of a £5m Elective Hub Bid, of which, the Division of Surgery

are going to conduct a piece of work to look at getting the most value from this funding.

Outpatients is trending positively with 2000 patients having signed over to patient initiated follow-up (PIFU). This is helping to reduce follow-ups as requested by the system.

It was pointed out that diagnostics are not achieving target and are yet to evidence statistical improvement. It was felt that the Trust should see an improvement by the end of March 2023 as a result of the changes that have been implemented. The completion of clinic letters remains significantly below the 95% target but work is continuing to reduce the backlog and meet the ten-day target.

It was reported that the Dental insourcing model is helping to increase capacity and reduce waiting times, but the Dental service continues to be challenged with long waits in terms of patients waiting over 52 weeks for treatment. The Trust is leading on a prevention campaign to tackle oral health in the community to try and reduce the number of children requiring dental treatment at Alder Hey. C&M are also focussed on addressing dentistry as there are long waits in the community as well. A meeting took place in November with NHS England and community dental representatives to discuss a resolution. The Board was advised that dentistry is a national public health issue and it was confirmed that the Trust is participating in a pilot that will see staff provide a service/support outside of Alder Hey.

From a mutual aid perspective, it has been agreed that the Trust's Plastic Surgery department will review cases on behalf of the Royal Manchester Children's Hospital (RMCH) in order to offer support. Alder Hey is also looking to provide orthopaedic support to RMCH in addition to this.

Kerry Byrne drew attention to the increase in super stranded patients and queried as to whether there is anything that can be done to address this matter *(target is 30 and the Trust currently has 45 super stranded patients).* It was confirmed that the Long Patient Stay Group is looking into this issue as there has been an increase in the number of Oncology patients who are having to be treated outside of the hospital's Oncology wards. In additional to this the Trust is looking at reducing the need for admission for patients who are with the Trust less than 24 hours, repatriating patients who have been transferred in locally, and looking at pathways to transfer out patients who require a care package.

The Senior Responsible Officers provided an overview of the highlights, areas of concern and a forward look for their respective areas; outstanding safety, recovery and access and well led as detailed in the Integrated Performance Report for M7.

Divisional Performance

The Divisions of Community/Mental Health, Medicine, Surgery, and Corporate Services gave an update on their respective highlights, areas of concern and provided a forward look as detailed in the new Integrated Performance Report for M6. The following points were raised:

Community and Mental Health

- The Division is starting to see improvements in the provision of interpreters by the service provider.
- The online platform for Neuro has gone live which will reduce the amount of calls received by the service.

- *CAMHS: Number of patients waiting more than 52 weeks for treatment* - It was confirmed that this metric refers to patients waiting for therapy and not waiting to start their journey with the service.
- *Eating Disorder Youth Service (EDYS)* – It was reported that the EDYS did not meet the target in October due to one person wanting an alternative appointment.
- *Initial Health Assessment (IHA) partnership targets* - It was confirmed that the Trust's internal target has improved for this metric but a meeting is to be scheduled with the Directors of Social Care to discuss improvements for the collective target.

Medicine

- There has been a sustained recovery position and cancer standards performance, however there are some underlying challenges in maintaining these standards in Nephrology (renal), Haematology and Oncology. Work is taking place with those teams to deliver short term support whilst sustainability plans are being developed.
- Radiology achieved the diagnostic standard (100%) in October providing opportunity for system support moving forward.
- Attention was drawn to the collaborative work that has been undertaken by the Manager in Urgent Care with commissioners and families around Long Covid. A therapy focused model has been piloted since November and the outcomes are awaited nationally as they may transform the commissioning approach moving forward.
- Work has also been undertaken by the Trust's Histopathology team to secure the contract for post mortems and placenta work for North Wales whilst stepping up to support Birmingham Children's Hospital. Following discussion, it was agreed to invite the Histopathology team to a future meeting.

22/23/198.1 Action: MC/KMC

Surgery

- There has been a recent increase in minor harms therefore the Division is in the process of implementing several workstreams to focus on education and support for staff.

Finance Report (M7)

For M7 the Trust is reporting a £1m surplus in line with plan, and the YTD position is a £0.4m deficit in line with the plan that was approved. Capital expenditure is on plan and the cash at the end of M7 was £82.4m.

The Trust is forecasting to meet its in year CIP challenge of £17.3m subject to the delivery of schemes still in progress. It was reported that there is a risk to the recurrent CIP position given that the Trust has a recurrent efficiency target of £12.5m, however only £5.3m (42%) has been identified, meaning the remaining £7.2m (58%) will be carried forward into 2023/24 if not identified.

The Board was advised of the challenging £4.6m control total surplus that needs to be achieved by the end of the 2022/23 financial year. It was reported that £1m of mitigated risk has been identified to date.

John Grinnell advised of the financial challenges in C&M in terms of the £40m+ unmitigated risk and organisations that are underperforming. The Chief Financial Officer for NHSE/I, Julian Kelly, is meeting with the Integrated Care Boards to discuss the challenges being experienced, and discussions are taking place to see if performing organisations can provide further support to those that aren't.

It was pointed out that there has been a significant reduction in productivity across the NHS over the last two years (pre-Covid), with the Trust reporting a 10% gap therefore Alder Hey has commissioned an internal piece of work to look at triangulating productivity, workforce and money. The Board acknowledged that there are significant risks to the organisation in terms of its position in the C&M system.

Infection, Prevention and Control (IPC) Update

The Board received an update from the Director of IPC, Bea Larru, on the triple threat that could overwhelm the NHS this winter, and what it means for children; Covid, RSV and Flu. A number of slides were shared which provided information on the following areas:

- The number of respiratory viruses reported by North West laboratories for the last ten weeks. It was advised that there is an unprecedented rise in respiratory viruses in children who are presenting earlier than usual, that might overwhelm hospitals.
- The rate of notifications of laboratory confirmed influenza in Australia from the 1.1.22 to the 25.9.22. The metrics show that there has been a sharp increase in flu with mainly those under the age of fourteen being affected.
- Data on RSV, flu and Covid.
- Preparing for uncertainty: Endemic paediatric viral illnesses after the Covid-19 pandemic disruption - A greater percentage of the population is susceptible to a disease after a long period of reduced exposure. This is called immunity debt.
- Comparison of RSV metrics for Alder Hey from 2020 to 2022.
- Data relating to Covid testing in-house. The Board was advised that having an in-house micro laboratory has helped immensely.

It was queried as to whether a system response is in place to address the upward trend in RSV, for example, treating CYP in primary care and in the community. It was reported that a silver command approach has been taken between the Trust and General District Hospitals and there is also the Virtual Ward respiratory component/pathway that could be used in association with community nurses. Following discussion it was agreed to review the system processes that are in place to respond to this issue.

22/23/198.2 Action: AB

Bea Larru responded to a number of questions relating to immunity debt and the period of time it will take for RSV to peak in older susceptible children. A suggestion was made about liaising with the National Children's Director, Simon Kenny, to discuss this matter further.

Staff Flu Vaccination Programme Update

A total of 1,593 (38%) staff members have received a flu vaccination to date, and 1,265 (30.2%) staff members have received a Covid booster. It was reported that data is starting to be collected for staff who have received a vaccination via the primary care route, and work is also taking place to vaccinate staff in the Community Division as the original vaccination plan for the Division has since changed.

The Board was advised that the Trust's vaccination programme is faring better than the national one which is at 31.8%. There is a lot more to do in terms of a Trust wide Flu Campaign and working with community colleagues to increase flu clinics.

The Chair felt that the update highlighted the challenges being experienced locally and nationally, and drew attention to the importance of staff being made aware about protecting themselves from Covid and Flu.

It was reported that the Trust has a vaccination programme for patients on the wards and it was felt that it would be beneficial to offer pregnant women who attend Alder Hey the option to be vaccinated. Louise Shepherd advised the Board that she would liaise with the CEO of Liverpool Women's Hospital (LWH), Cathy Thompson, about this matter.

22/23/198.3 Action: LS

Strike action

The trade unions representing NHS staff have advised the Secretary of State that they are in dispute over the 2022/23 pay award, with unions balloting or signalling an intention to ballot their NHS members across the NHS.

The Board was advised that the Royal College of Nursing (RCN) ballot closed on the 2nd of November with a majority voting to take strike action. Not all Trusts met the threshold but Alder Hey did and therefore is awaiting an update as to when strike action will take place and how it will be planned. It was reported that there is a requirement to provide the Trust with 14 days' notice and it is anticipated that strike action will take place prior to Christmas by RCN members.

The Trust is operating a tactical command structure, with meetings taking place twice weekly in order to look at business continuity plans in readiness for potential strike action. Weekly meetings with staff side colleagues are in situ, initially focusing on the RCN, these have been positive initial discussions. In addition to this there is a weekly call with C&M Human Resource (HR) leads to support a level of consistency across the ICB and national webinars. The Trust is currently completing the self-assessment template to return to the ICB.

Resolved:
The Board received and noted the content of the new IPR for Month 7 and the updates included in this agenda item.

22/23/199 Beyond C&M CYP Programme Update

The Board was provided with background information on the purpose of the Beyond Programme and the work that has taken place to establish it and start to build relationships. A number of slides were shared to present information on the following areas:

- *The voices of CYP and their families:* Key principles for engagement have been developed; inform, listen, discuss, collaborate, empower.
- *Case for Change:* Health inequalities.
- *Tackling Health Inequity:* Via the CorePlus5 approach which is designed to support Integrated Care Systems (ICSs) to drive targeted action in healthcare inequalities improvements; asthma, diabetes, epilepsy, oral health and mental health.
- Update of achievements.
- Feedback from CYP and professionals.
- *Mental Health and Emotional Wellbeing:* Whole family community therapeutic interventions, Team of Life, As One Platform, Next Step Cards, Gateway Programme (*NHSE funded project*), Mental Health in Acute settings (*NHSE funded).*

- *Learning Disabilities, Difficulties and Autism:* Paediatric sensory environments (*NHSE funded*)
- *Respiratory and Asthma*: Respiratory Parent Champions Project, air quality in social housing, INTENT project, asthma bundle of care, asthma friendly schools, pharmacy inhaler techniques (*funded by NHSE Health Futures*).
- *Diabetes and Obesity*: tackling health inequalities by providing increased access to diabetes technology, improving diabetes transition care, improving diabetes technology use during transition, the HENRY Programme and complications of excess weight (*NHSE funded*). It was confirmed that the ICBs across C&M have agreed that all CYP will have access to continuous glucose monitoring.
- Beyond Programme governance.
- Next steps.
- Key messages for the Trust Board;
    - Champion the Beyond Programme.
    - Support required to continually raise the profile.
    - Trust Board to receive a quarterly update and the outcome of an annual deep dive.

Dani Jones thanked Liz Crabtree and her team for the work that has taken place to progress the Beyond Programme.

Garth Dallas asked as to how he can be assured that the differences in health outcomes and inequalities will be embedded in the system that is in place and queried as to how success will be determined and demonstrated.

Liz Crabtree advised that a dashboard is being developed that will overlay the data on the outcomes of CYP and enable the team to focus on the areas that need to be addressed. There is also a need to link in with the third sector in respect to the hard to reach children and make the most impact to those who are impacted whilst making it meaningful for communities. Dani Jones pointed out that every Place has an element of inequality but the Trust has submitted a Health Equity bid so it can work with Barnardo's to target the worst inequalities. It was pointed out that there is still more work to do but the team are building on this.

Resolved:
The Board received and noted the Beyond Programme Update

22/23/200 Integrated Care System (ICS) Update

The Board received a progress update on the ICS. A number of slides were shared to provide information on the following areas:

- System update - What's new since September?
- Provider Collaborative updates appertaining to CMAST and MHLDC.
- Alder Hey's leadership role for CYP; ICB strategy (*CYP element submitted*), success in second stage of Health Equity/CYP bid, Gender Identity Dysphoria Service (GIDS), Children's Health Alliance Paediatric Recovery (HSJ Award winners), national CYP Board governance development.

A discussion took place around Place maturity assessments and the possible risks to the Trust. It was pointed out that a model hasn't been agreed to date and Places are awaiting confirmation of their delegations and budgets. The Board was advised that the Trust is working with Place Directors and at a high level with the ICS.

The Chair drew attention to the Trust's achievements over the last eighteen months in terms of positioning itself as an influencer in the wider world.

Resolved:
The Board noted the update on the Integrated Care System.

22/23/201 Liverpool Clinical Services Review

The Board was provided with an update on the ongoing review of Liverpool Clinical Services. The following points were highlighted:

- *Urgent Care Pathways* - It was confirmed that urgent care pathways between hospitals apply to adult trusts in Liverpool and therefore there were no recommendations for Alder Hey.
- *Safety issues at the Liverpool Women's Hospital (LWH)* – Clinical discussions have taken place around options and opportunities to address the safety issues at LWH. It was pointed out that it is imperative for key players to come together to support LWH once a proposal has been put forward to improve safety.
- It was confirmed that the draft report will be available on the 29.11.22 for comments and will be published on the 1.12.22.

Resolved:
The Board noted the update on the Liverpool Clinical Services Review.

22/23/202 Alder Hey in the Park Campus Development Update.

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

- *Neonatal and Urgent Care Development* – It was reported that Morgan Sindall have submitted a price for the Neonatal contract and have requested that the Trust sign a letter of intent in order to fix a price. A report is to be submitted to RABD in December for review before approving the final contract. The Trust is also continuing to work with Project Co to mitigate the impact of extending the programme and increasing costs.
- *Sunflower House* – A solution has been agreed to address the CLT finish, with an expected 6 week process to complete. The issue of the sprinkler system in the car park of the building has also been resolved with the Fire Service.
- *Reinstatement of the Park* – There is a programme delay to the modular office building (*large unit by the Alder Centre*) which is impacting the demolition of the Old Catkin Building. Mitigations are in the process of being implemented to ensure this issue does not impact progress to the park.

Louise Shepherd advised that the Neonatal and Urgent Care development is a complex project but felt that the Trust should progress the enabling works over the next period whilst Resources and Business Development Committee (RABD) conducts a final review before approving the contract. It was confirmed that the project is still on track to be completed by 2024.

A discussion took place around the increase/decrease in prices of steel and the impact of these two scenarios to the Trust. It was reported that the Trust will not be exposed if it signs the contract however the Board were keen to understand further the implications of a price drop.

Shalni Arora felt that further discussion should take place at RABD before the Trust signs a letter of intent.

The Chair referred to the issues relating to the park and asked that the Trust link in with the community to keep them updated.

Springfield Park Update

The Chair informed the Board of the two community events that took place on the 5.11.22 and the 19.11.22. Feedback was mixed although generally there was a sense of the Trust not communicating its plans as well as it could have and frustrations over the sale of the North East plot for development. A number of slides were presented during the session on the 19th to provide a visual of how the park will look once completed. People were really excited about the new play area and the MUGA. The Chair advised the Board that it is imperative that communication channels remain open with the community and regular meetings take place.

A meeting is scheduled to take place in December which will be chaired by the Councillor Harry Doyle and supported by Liverpool City Council (LCC). The Trust will offer its assistance in order to help address any questions that may arise.

Resolved
The Board received and noted the Campus Development update provided on the 24.11.22.

22/23/203 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 1.10.22 to the 31.10.22. The following points were highlighted:

- A long standing RCA (StEIS Ref: 2021/24660) has been completed and submitted to the commissioners.
- Four SIs were opened during the reporting period.
- The Trust is on track to close its RCAs and action plans prior to moving over to the new framework. This is an area of focus by the ICB.
- Two Duty of Candour responses were required and completed within the expected timeframes during the reporting period.
- Further focus is required on overdue action plans in order to close them.
- It was confirmed that the Trust has completed the procurement element of the process for acquiring a new risk and incident management system. A further update on this matter will be provided during December's meeting.

Resolved:
The Board received the Serious Incident report for the period from the 1.10.22 to the 31.10.22.

22/23/204 Mortality Report, Q2

The Board was provided with an overview of the Mortality Report for Q2. The following points were highlighted:

- In August/September 2022 the Hospital Mortality Review Group (HMRG) process was audited by MIAA and awarded the highest rating possible.
- *Medical Examiner (ME) Process* - The plan currently is for Alder Hey to be covered by the ME team at LUFT of which the process is being worked on. To

enable this to happen Alder Hey will need to provide paediatric expertise in the ME process to support the implementation. This will entail one of the Alder Hey's consultants completing the ME course and then joining the LUFT ME team.

- The Board was advised of the development of an online portal that will provide access to coroners, a template for clinicians to complete, a unified share file and a flow diagram to identify the route for patients.

Resolved:
The Board received and noted the content of the Mortality Report for Q2

22/23/205 University Partnership Arrangements

The Board was informed of the ongoing activities which are taking place to strengthen local academic partnerships. The following points were highlighted:

- The Board was advised that the largest of the Trust's HEI partnerships at the present time is with UoL, and particularly the Faculty of Health and Life Sciences.
    - Discussions have taken place with all three of UoL's faculties about the progression to a 'Campus without Walls' in which research is conducted with primary care, public health and other agencies in the community, not just with secondary/tertiary care.
    - Work has taken place, under guidance from the Alder Hey:UoL Strategic Liaison Committee to develop a small number of "grand challenges" which align the Trust's R&I Strategic Framework with the strategic priorities of each of UoL's faculties.
    - The next steps will be to look at the clinical questions that need to be addressed via grand challenges. These will be addressed partly by a first meeting, just before Christmas, of a new 'research parliament', which draws together the Alder Hey research community
- In addition, the Trust is looking to rejuvenate relationships with other HEI partners in Liverpool who are linked via the Institute in the Park project.
- It was reported that the Liverpool Health Partnership (LHP) 'Starting Well' Programme will continue with involvement from LWH, Alder Hey and UoL. Another LHP Programme, Neuroscience and Mental Health will continue as a three-way collaboration with the Walton Centre and Mersey Care. The Board was advised that Alder Hey is the only Trust involved in more than one of these LHP programmes.

Fiona Beveridge drew attention to the national focus on areas discussed during the meeting, and external funding that can be accessed to help patients locally and across the region. It was felt that progress is being made but agreed that there is still lots more to do.

Louise Shepherd thanked Fiona Beveridge for her support and advice, particularly in facilitating discussions that have taken place between the Trust and Liverpool University.

Resolved:
The Board noted the update provided on university partnership arrangements.

22/23/206 People Plan Update

The Board received a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during October/November

2022. The following points were highlighted:

- It was reported that the update focusses on three main areas; industrial action, sickness, and the Staff Survey.
- SALS is continuing to support the organisation via the work that is being conducting.
- Sickness absence remains above target with an in-month position just under 6%, remaining higher than the Trust's target of 5%.
- Turnover has increased Trust wide in-month and ongoing analysis has been undertaken to identify and plan appropriate action with the areas with highest turnover. Quarterly reports on Turnover are provided to the People and Wellbeing Committee and a task and finish group (a subgroup of the Attraction and Retention group), has been established to review Trust wide actions/ support required.

Staff Survey Update

As of 23.11.22 the overall Staff Survey response rate was 50%, of which, it was confirmed has surpassed the previous year's position. Data will be collated once the survey has closed and the Trust will start to communicate the results with staff.

Equality, Diversity, and Inclusion Steering Group (EDISG) Work Plan

The Board was provided with a high-level overview of the EDISG 2023 Annual Work Plan that was approved on the 21.11.22.

Garth Dallas advised that staff network Chairs are starting to be appointed and drew attention to the renaming of the BAME Network; Race, Ethnicity and Cultural Heritage (REACH). It was pointed out that the REACH network will be focussing on these three areas going forward. Garth Dallas informed the Board of the recent networking that he has been involved in with LUFT, Clatterbridge and the Chairs of external networks. Garth has also joined the Seacole Group for Non-Executive Directors from black minority networks for visibility purposes.

Resolved:
The Board:

- Noted the updates that were received under the People Plan agenda item.
- Noted the approved EDISG 2023 Annual Work Plan.
- Acknowledged that regular updates will be provided by the EDISG on the progress of the Trust's strategic ambitions against the specific EDI objectives.

22/23/207 Board Assurance Framework Report

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

- The Board was advised that all risks on the BAF have been scrutinised in month by the respective Assurance Committees.
- A deep dive into BAF risk 1.4 (*Access to CYP Mental Health*) took place during November's Safety and Quality Committee (SQAC) meeting for assurance purposes.
- It was confirmed that a deep dive will take place into BAF risk 2.1 (*Workforce Sustainability and Development*) in order to update the risk.

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

22/23/208 Board Assurance Committees

Audit and Risk Committee – The approved minutes from the meeting held on the 15.9.22 were submitted to the Board for information and assurance purposes, and an overview of the meeting that took place on the 10.11.22 was provided (as per the highlight report submitted by the Chair of the Audit and Risk Committee).

SQAC – The approved minutes from the meeting held on the 19.10.22 were submitted to the Board for information and assurance purposes. During November's meeting the Committee received the final report on the Sensory Project of which it was felt was good learning for everyone. The Committee noted the appeal of wider engagement to raise awareness across the organisation and beyond. It was suggested using the Sensory Project in association with a patient story. The Chair asked that the report be circulated to Board members.

22/23/208.1 Action: KMC
22/23/208.2 Action: KMC

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

22/23/209 Any Other Business

GIDS

Following a request for an update on GIDS, the Board was advised that progress is starting to be made. A new Programme Manager has been appointed, but there are a number of matters that need to be agreed in terms of the workforce/TUPE, a clinical model, capacity, etc. that won't be addressed before the autumn of 2023. There is a lot of work on-going in the background therefore it was agreed to submit a report to the Board during February's meeting to provide a formal update. The Board was advised that a piece of work is being conducted to look at making the Trust more accessible for CYP who identify to be different. Nathan Askew reported that young people are now able to record their pronouns in their EPR (he/him, she/her, them/they).

22/23/209.1Action: LS

Resolved:
The Board noted the update provided on GIDS.

22/23/210 Review of the Meeting

The Chair highlighted the importance of setting the right amount of time aside in order to receive operational updates and felt that agenda is shifting to reflect the Trust's involvement with the ICS, universities and other trusts. Attention was also drawn to Trust's thinking in terms of the wider system and national profile.

Date and Time of Next Meeting: Thursday the 15th December 2022 at 11:00am via Teams

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for December 2022							
27.10.22	22/23/172.3	Integrated Performance Report Overview	Additional information to be included in the summary page of the IPR on key projects and how the Trust is addressing them.	J. Grinnell/ K. Warriner	24.11.22	Dec-22	
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	On track Dec-22	
24.11.22	22/23/198.2	Integrated Performance Report	*IPC Update* - Review the system processes that are in place to address the upward trend in RSV	A. Bateman	15.12.22	On track Dec-22	
24.11.22	22/23/198.3	Integrated Performance Report	*Staff Flu Vaccination Programme Update* - Liaise with the CEO of Liverpool Women's Hospital (LWH) about the provision of flu vaccinations for patients who attend LWH.	L. Shepherd	15.12.22	On track Dec-22	
Actions for January 2023							
27.10.22	22/23/179.1	Freedom to Speak Up (FTSU) Update	*Deputy FTSUG Position* - Review the current time provided to the FTSUG and consider as to whether this time could be increased. Compile a plan for moving forward.	K. Turner/ E. Saunders/ K. Byrne	15.12.22	Jan-23	
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	On track Jan-23	
Actions for April 2023							
24.11.22	22/23/198.1	Integrated Performance Report - Divisional Performance Update	*Division of Medicine* - Invite the Histopathology Team to April's meeting to provide an update on the work that is being undertaken by the team (post mortems and placenta work for North Wales/support for Birmingham Children's hospital, etc.)	M. Carmichael/ K. McKeown	27.4.23	On-track Apr-23	
Actions for May 2023							
24.11.22	22/23/208.1	Board Assurance Committees	Arrange for a patient story to be shared with the Board in May based on the Sensory Project that was discussed at SQAC.	K. McKeown	25.5.23	On-track May-23	
Actions for October 2023							
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
30.6.22	22/23/82.1	Corporate Report	*Medicine* - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance.	U. Das	28.7.22	Closed	**28.7.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during September's Trust Board. **29.9.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during October's Trust Board. **27.10.22** - A further update will be provided in November. **24.11.22 -** It was reported that Radiology achieved the diagnostic standard (100%) in October and a trajectory has been set for the end of March to address the reduction in diagnostic performance in all areas. **ACTION CLOSED**
27.10.22	22/23/172.2	Integrated Performance Report Overview	Following a discussion on the reporting of metrics for the Research Division it was agreed to look at the possibility of having a quarterly update to make the information more meaningful.	J. Chester/ K. Warriner	24.11.22	Closed	**24.11.22** - This action has been addressed. **ACTION CLOSED**
27.10.22	22/23/182.1	Board Assurance Framework Report	SQAC and RABD to review the risk rating of BAF Risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care*) owing to the large number of factors that is making access to planned care and urgent care very challenging.	A. Bateman	15.12.22	Closed	**9.12.22** - A review of BAF risk 1.2 is to be conducted during SQAC in December and a further review will take place in May at RABD. **ACTION CLOSED**
24.11.22	22/23/208.2	Board Assurance Committees	Circulate the Sensory Project Report to Board members.	K. McKeown	15.12.22	Closed	**9.12.22** - This action has been addressed.

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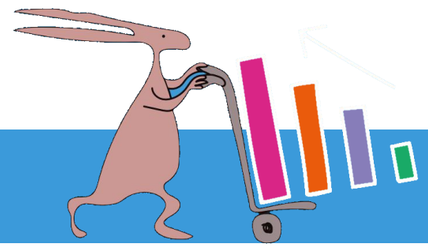
NHS

Alder Hey Children's

NHS Foundation Trust

Integrated Performance Report

Published: December 2022



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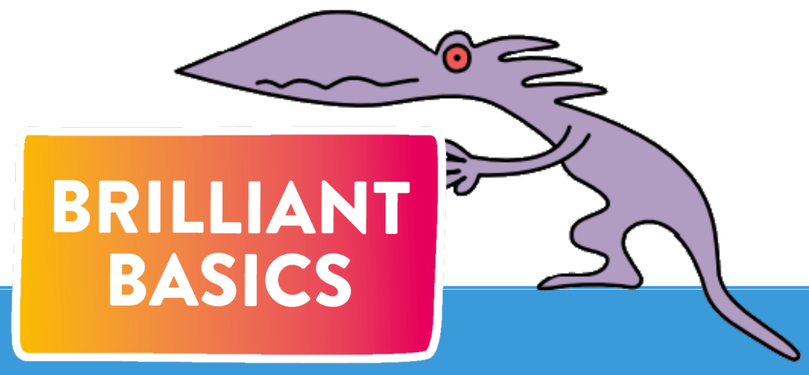


Icon Definitions

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

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

XmR chart

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

Process limits

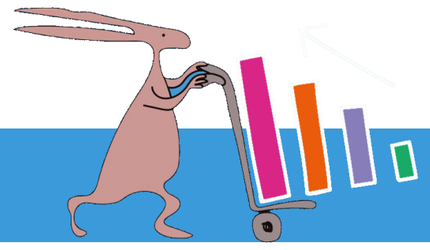
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

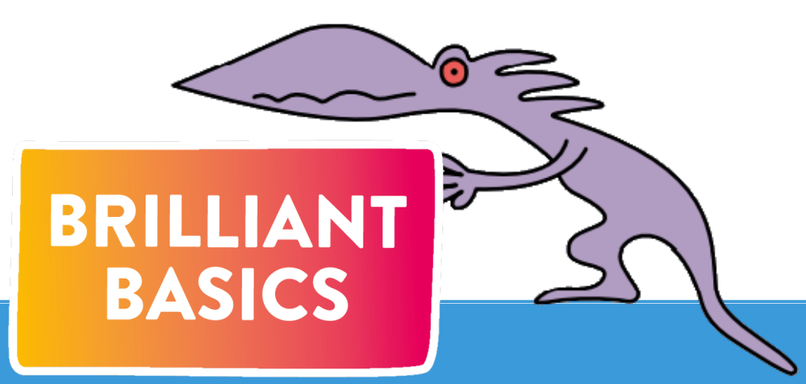
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Faster Diagnosis for Cancer demonstrates performance is consistently achieving target with an improving trend		PALS Complaint Management and Diagnostics are not achieving targets but demonstrating improvement
	Common Cause	Cancer and Overall Financial position metrics are consistently achieving targets	Level of Harm, Sepsis, Recovery and Staff Recommending Alder Hey as place to work metrics are inconsistently achieving target and are yet to evidence statistical improvement	ED Performance and Outpatient Follow up Activity are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern		Virtual Adoption metrics within Outpatients inconsistently achieving target with a declining trend	Access & Staff Turnover metrics are not achieving targets with a declining trend

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

- 12.8% of our metrics are consistently achieving target
- 57.4% of our metrics are inconsistently achieving target
- 29.8% of our metrics are not achieving target, 4 metrics are demonstrating special cause improvement

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



Outstanding Safety - Safe

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

Highlights:

• 100% compliance with administration of antibiotics in Inpatient wards and 91% compliance in ED; significant increase in all areas • No Category 3 or 4 pressure ulcers • Sustained reduction in medication errors leading to patient harm • No hospital acquired infections reported

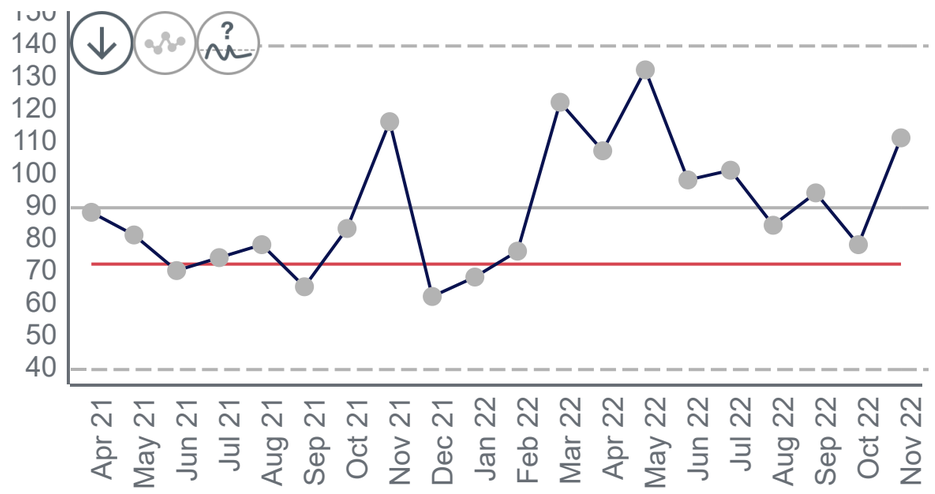
Areas of Concern:

• Never Event declared relating to an incident reported in August 2022; regulatory requirements for Duty of Candour and 72 hour review met, reported to StEIS and Level 2 RCA commissioned and commenced • Number of incidents reported is higher than the target however this is a marker of an open and transparent reporting culture. The majority of incidents reported are no harm or near miss

Forward Look (with actions)

• Targeted work underway to reduce Category 2 pressure ulcers

Number of Incidents rated Minor Harm and above



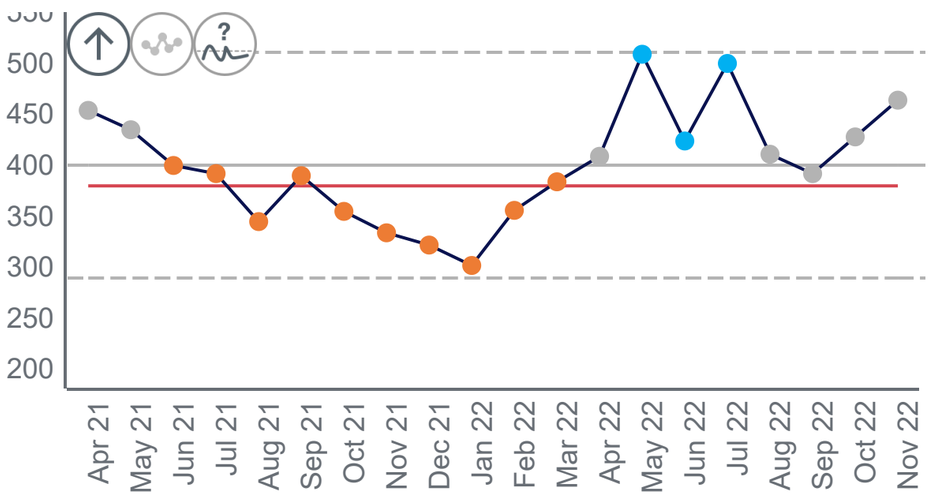
Technical Analysis:

Number of Harms per month remain stable and continues to demonstrate common cause variation. There is no evidence of underlying improvement or reduction in incidences of harm. Of the 113 incidents in Nov, 112 were minor harm and 1 moderate harm

Actions:

Incidents reviewed by Divisions and nominated incidents shared and reviewed at weekly Patient Safety meeting; continue to encourage sharing lessons learned across the Trust

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

A high number of Near Miss and No Harm incidents reflects an open reporting culture. This has been above the target for 8 consecutive months, but shows common cause variation and therefore is still described as inconsistently passing the target.

Actions:

Continue to encourage positive reporting culture

Integrated Performance Report | December 2022

Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	November 2022	111	89	72		?
Number of Incidents rated No Harm and Near Miss	November 2022	464	400	380		?
Number of Serious Incidents (Steis reported)	November 2022	0	1	0		?
Number of Never Events	November 2022	1	0	0	H	?
Sepsis % Patients receiving antibiotic within 60 mins for ED	October 2022	91	85	90		?
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	November 2022	100	88	90		?
Number of Medication Errors resulting in harm (minor harm and above)	November 2022	3	3	4		?
Pressure Ulcers G2-4	November 2022	5	4	5		?
Use of physical restrictive intervention (MH Tier 4)	November 2022	2	14			?
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	November 2022	27	23	30		?
Hospital Acquired Organisms - MRSA (BSI)	November 2022	0	0	0		P
Hospital Acquired Organisms - (C.Difficile)	November 2022	0	0	0	L	P
Hospital Acquired Organisms - MSSA	November 2022	0	1	0		?

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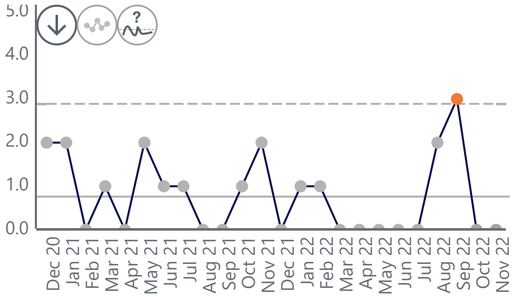
Integrated Performance Report | December 2022

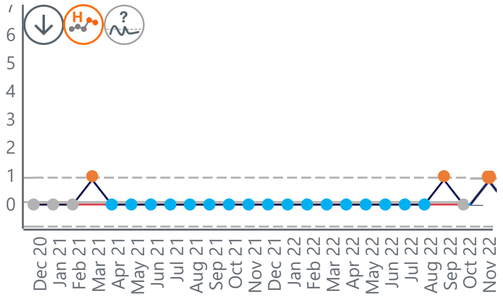
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

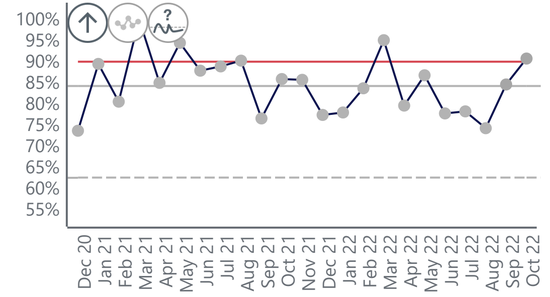
Number of Serious Incidents (Steis reported)



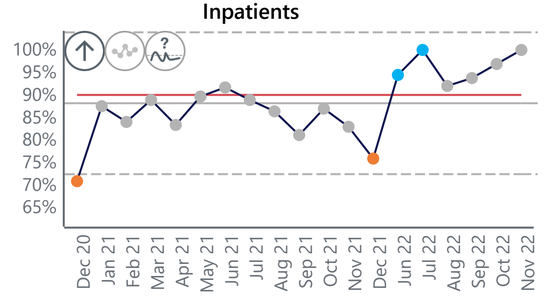
Number of Never Events



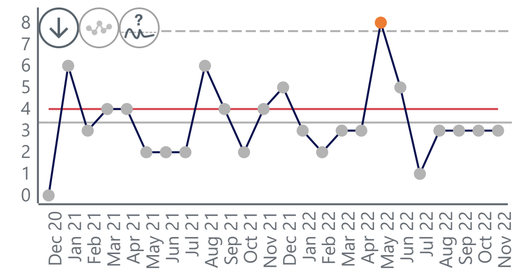
Sepsis % Patients receiving antibiotic within 60 mins for ED



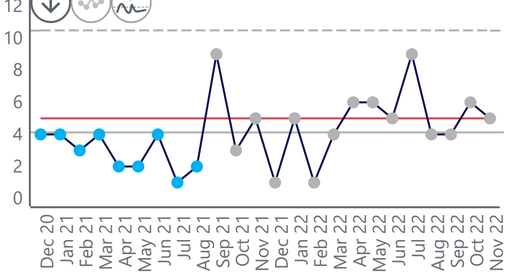
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



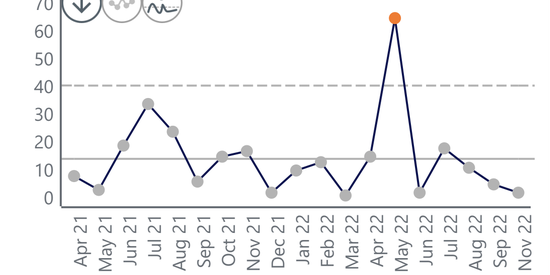
Number of Medication Errors resulting in harm (minor harm and above)



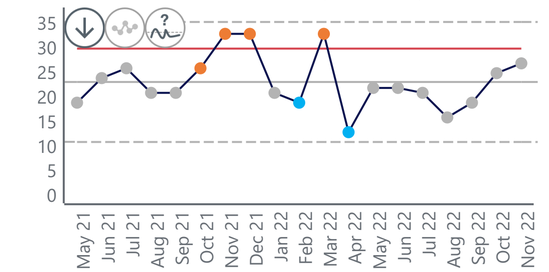
Pressure Ulcers G2-4



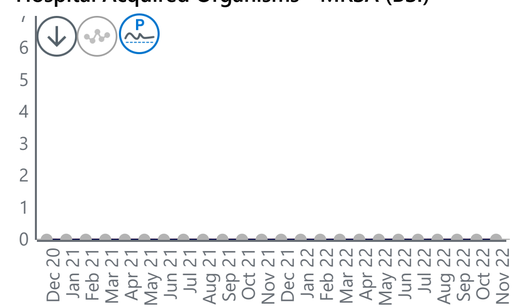
Use of physical restrictive intervention (MH Tier 4)



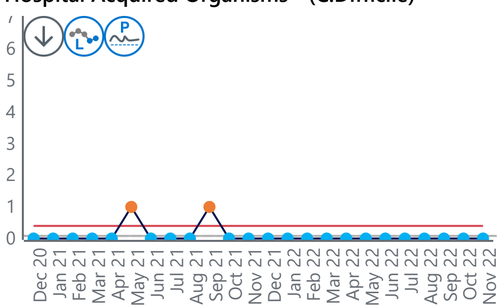
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



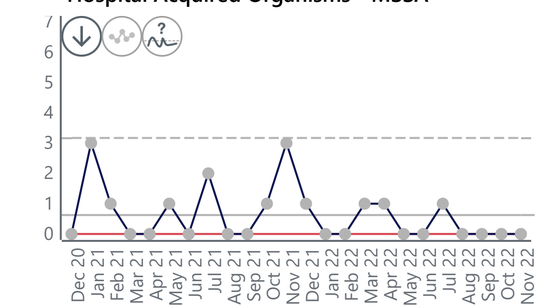
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Outstanding Safety - Caring

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

Highlights:

• 89% of PALS concerns responded to were within the 5 working day KPI (161 of 180). Notably, the Division of Surgery achieved 100% compliance and Division of Medicine achieved 98% • 95% (21 of 22) of formal complaints were acknowledged within 3 working days and 89% (8 of 9) were responded to within the 25 working day timeframe providing these families with a timely resolution to their concerns

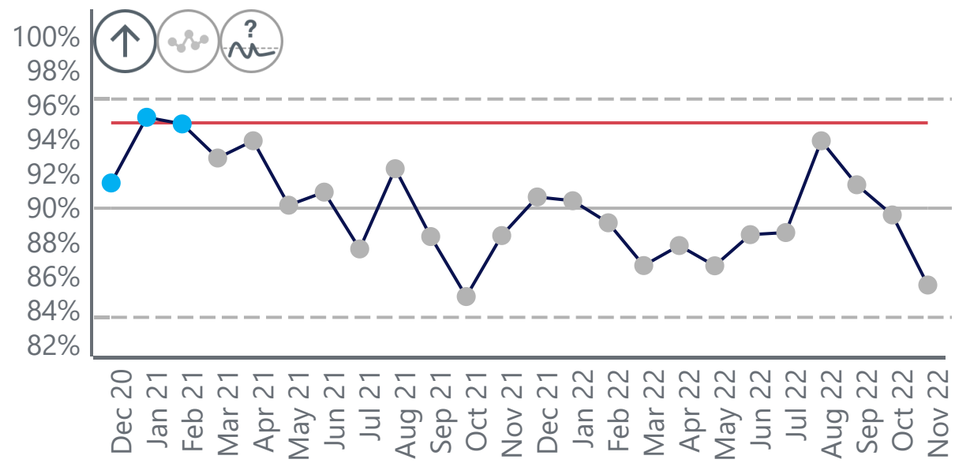
Areas of Concern:

• Reduction in families who would recommend Alder Hey with a low number relating to ED. ED has seen increased attendances in month

Forward Look (with actions)

• Medical Division working with the Patient Experience team to improve the experiences of families in ED with plan to increase volunteers in the waiting room to assist with rounding

F&F Test - % Recommend the Trust



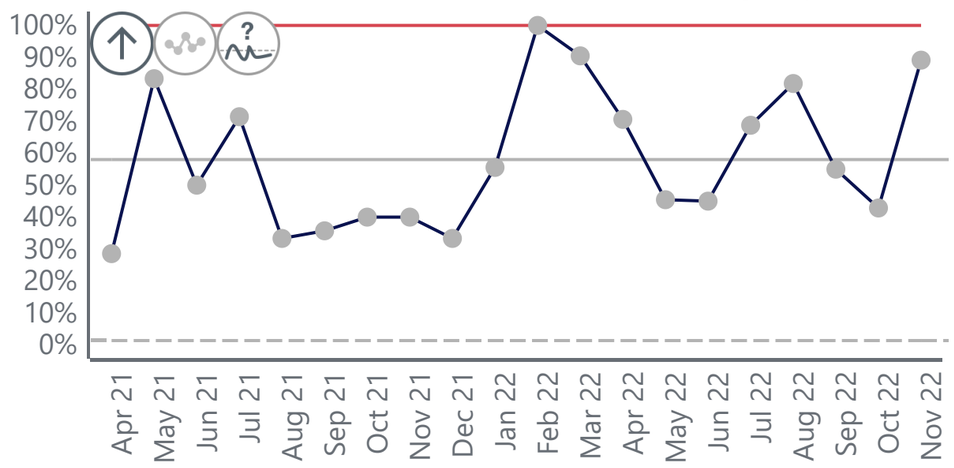
Technical Analysis:

Consistently falling short of the target – ED is at 59.4% and with only Mental Health exceeding the 95% target. Nov figure of 86% is the lowest score in the last 12 months but at this point the trend still demonstrates normal cause variation.

Actions:

Targeted work to increase the response rate; posters with a QR code available in all cubicles

% Complaints Responded to within 25 working days



Technical Analysis:

With an average of 55%, almost half of all complaints are not responded to within the 25 working day target. November performance of 89% consists of only 1 breach with 8 cases responded to in time from 9 complaints due.

Actions:

Divisions monitoring all complaints on an individual basis and report to the Associate Chief Nurse on a weekly basis

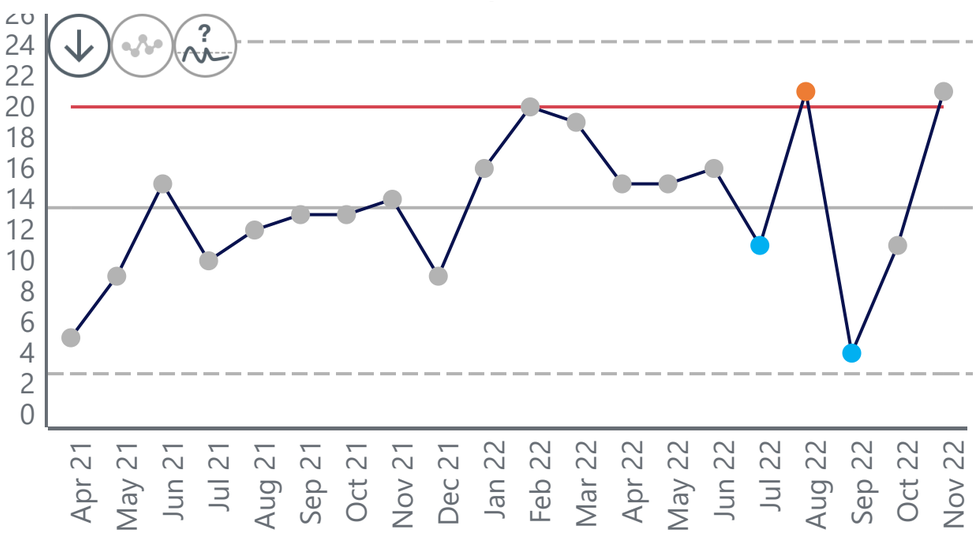
Integrated Performance Report | December 2022

Alder Hey Children's NHS Foundation Trust

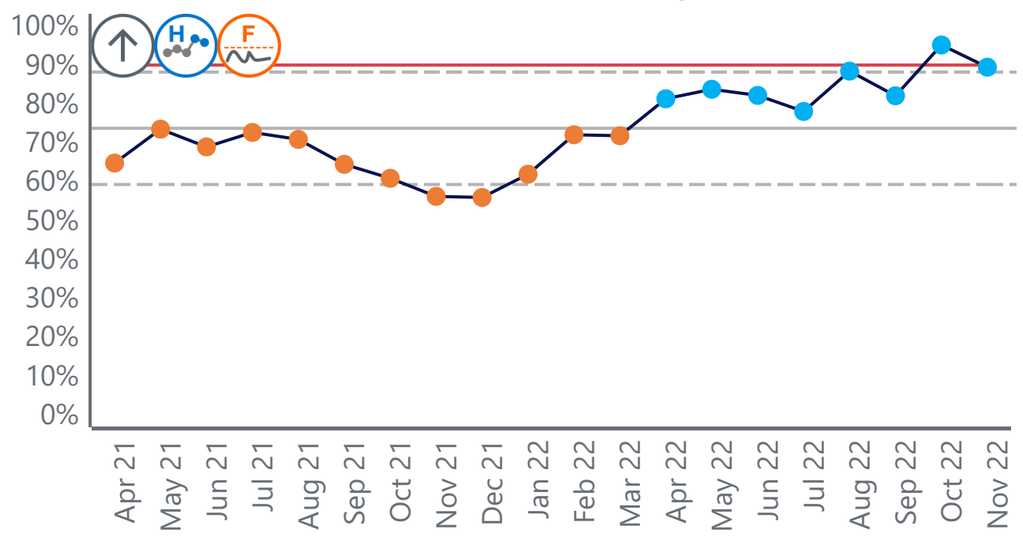
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	November 2022	86	95	90		?
% Complaints Responded to within 25 working days	November 2022	89	100	58		?
Number of formal complaints received	November 2022	21	20	13		?
% PALS Resolved within 5 Days	November 2022	89	90	74	H	F
Number of PALS contacts	November 2022	160	150	134		?
F&F ED - % Recommend the Trust	November 2022	59	95	69		F

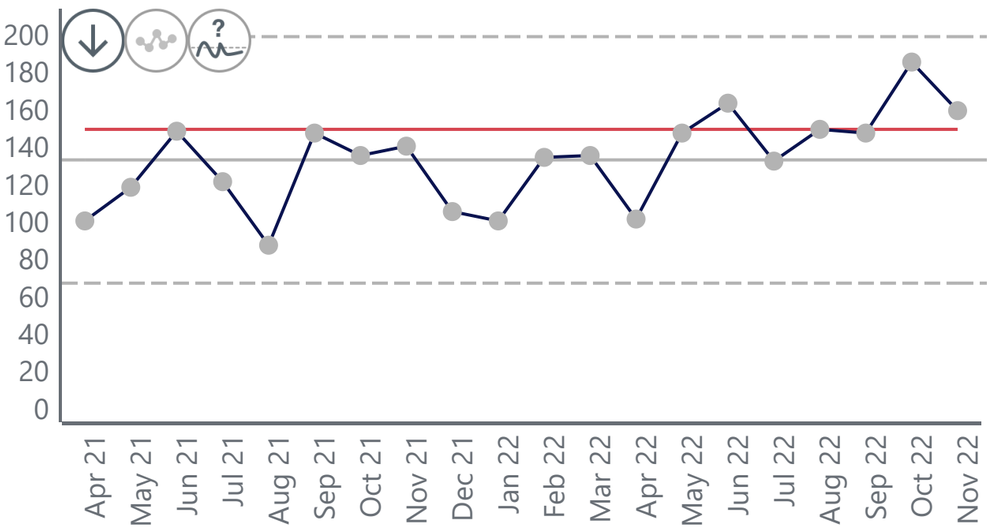
Number of formal complaints received



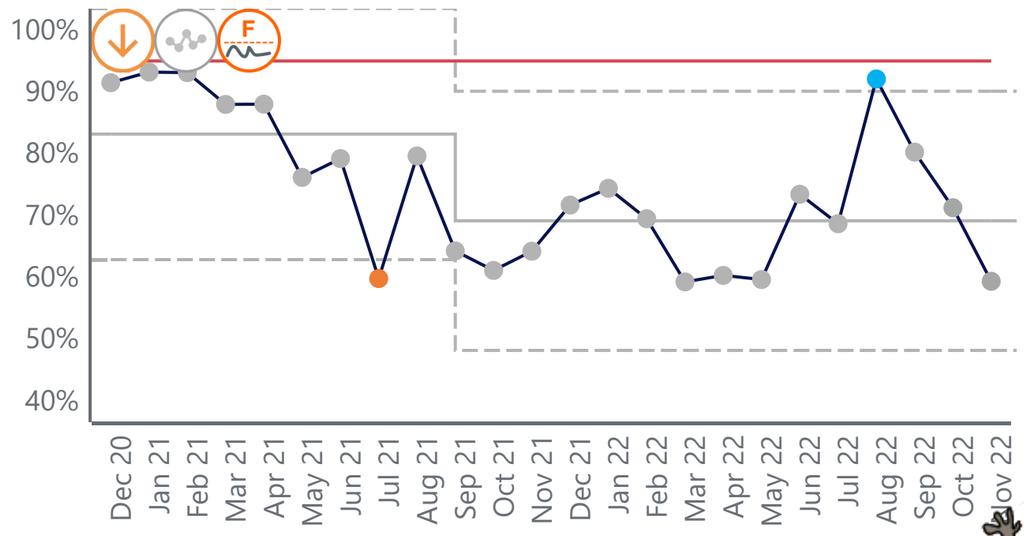
% PALS Resolved within 5 Days

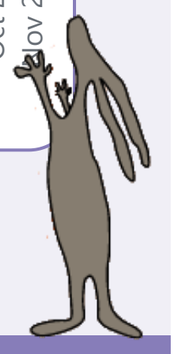


Number of PALS contacts



F&F ED - % Recommend the Trust





Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• WNB rate better than target, and 2 months of improved data co-relates well with the use of AI predictor and targeted actions to support families at highest risk of not attending • Backlog of clinic letters continuing to fall: now <500 longer than >4wks (c.600 in Oct) • New Consultants commenced in ED, improving evening and weekend cover

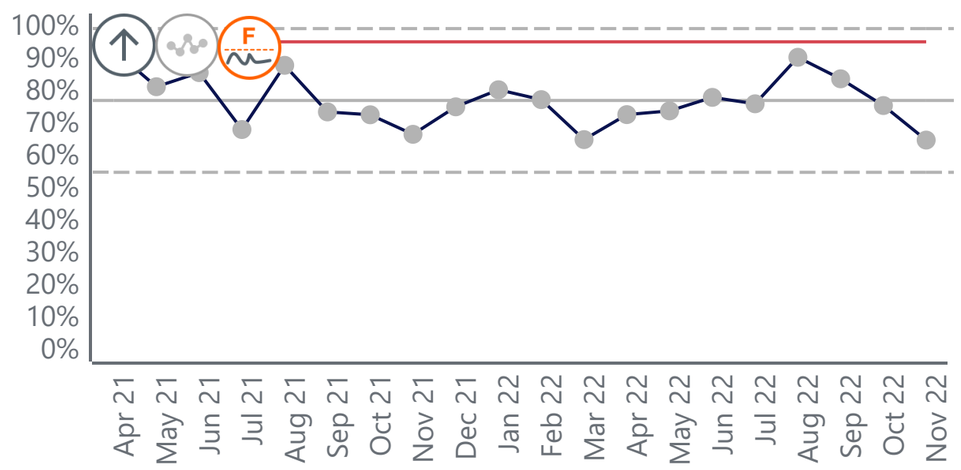
Areas of Concern:

• Exceptional levels of demand in ED: 6,610 attendances in Nov is 10% more than Oct and 7% more than Nov 21. This has contributed to increase in median triage (19mins) and 98 patients spent >12hrs in the department • Cancelled Operations remains above target, due to emergency admissions and high number of long stay patients (>21 day LOS)

Forward Look (with actions)

• Further actions in ED in Dec to include: a) Increased staffing; b) bring forward enhanced streaming; c) introduce "Winter Clinic" for Scarlett Fever and Strep A concerns • Continue use of AI tool to deliver sustained reduction in WNB rate and improve equity of access • Refresh use of SAFER principles to improve discharge planning and flow with reduction in cancelled operations

ED: % treated within 4 Hours



Technical Analysis:

This technically shows common cause variation but it is noted that performance of 65% in Nov is lowest since March 22 and this co-relates to exceptional levels of demand.

Actions:

In Dec: a) Increased staffing including up to 3 GPs per day and additional clinicians / senior nurses overnight; b) bring forward enhanced streaming for Green and GS&T patients from 12 Dec; c) introduce "Winter Clinic" for Scarlett Fever and Strep A concerns from 12 Dec. Modular building to be commissioned in January

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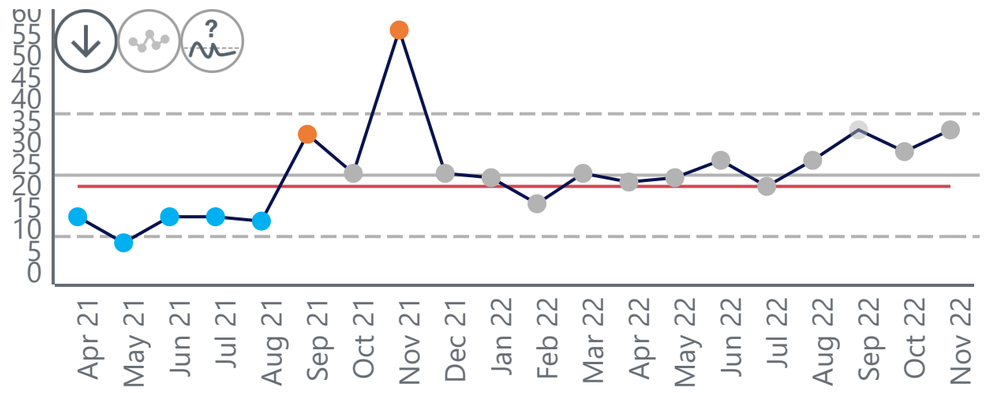
Alder Hey Children's NHS Foundation Trust

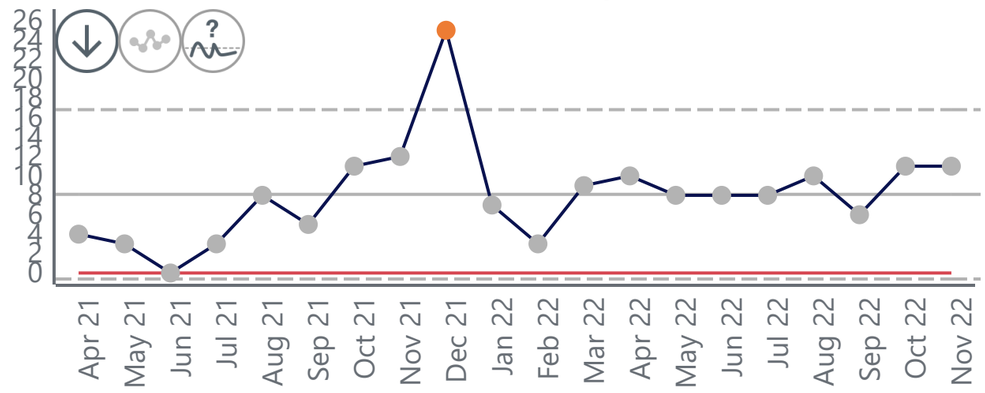
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	November 2022	65	95	76.88		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	November 2022	33	20	23.10		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	November 2022	11	0	8.10		?
Number of Super Stranded Patients (21 days)	November 2022	46	30	37.45		?
% Virtual Outpatients (national standard 25%)	November 2022	23	25	29.80	L	?
% Was Not Brought Rate (All OP: New and FU)	November 2022	9	10	9.82		?
% of Clinical Letters completed within 10 Days	October 2022	63	95	57.52		F

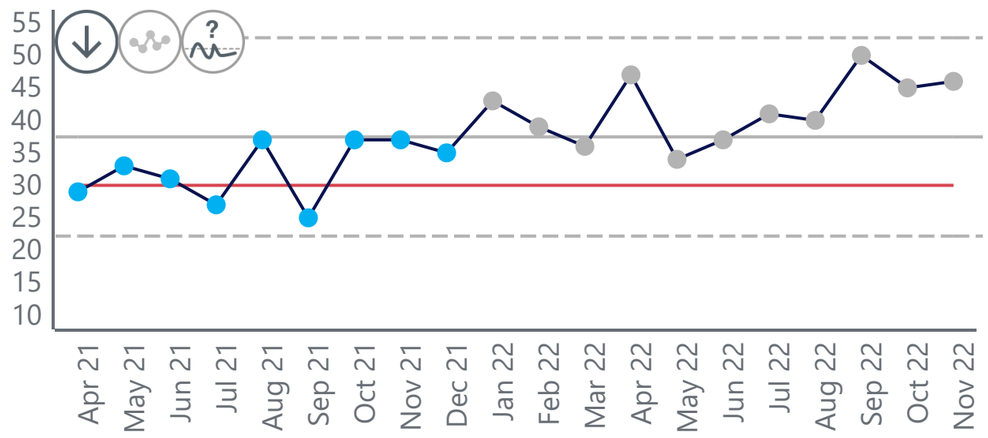
Number of Cancelled Operations (on day of admission for a non-clinical reason)



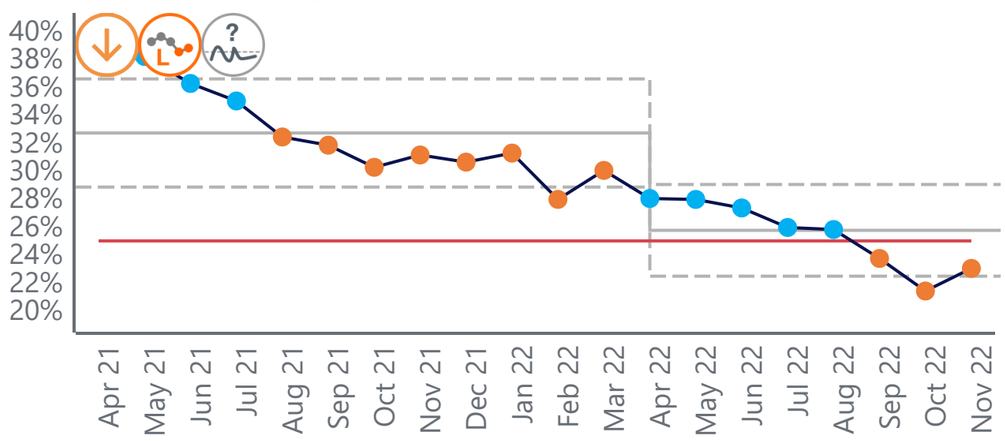
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



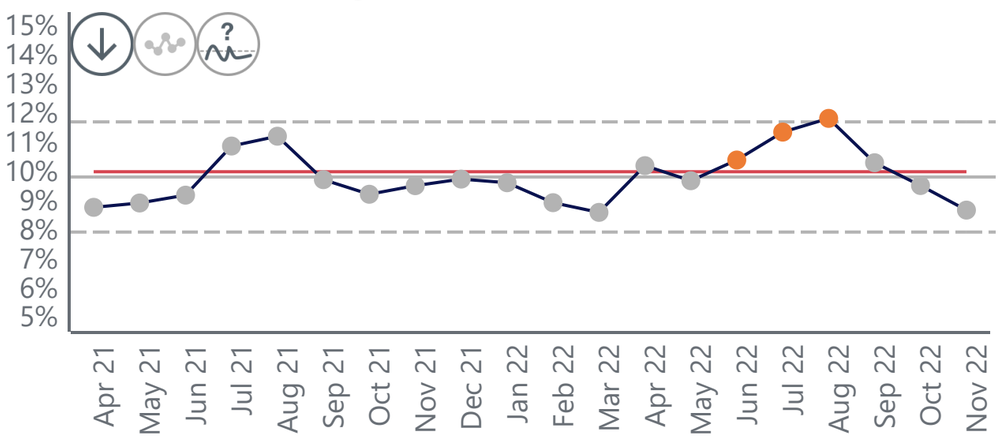
Number of Super Stranded Patients (21 days)



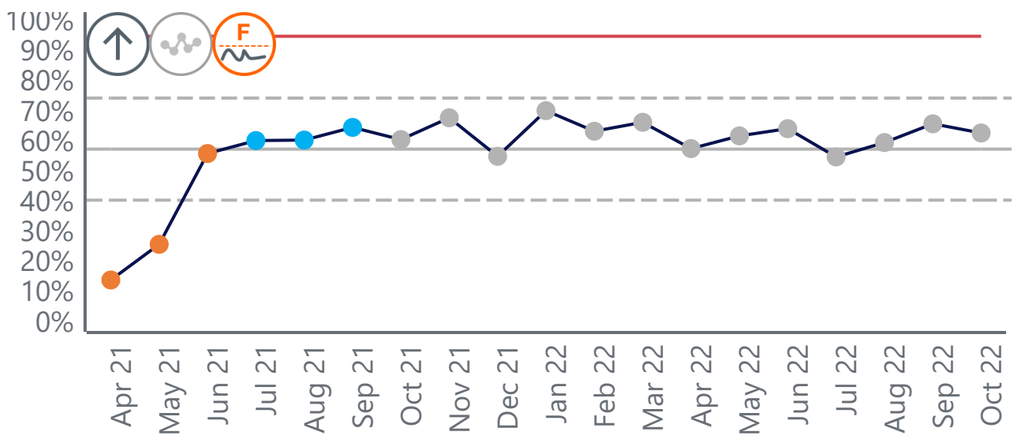
% Virtual Outpatients (national standard 25%)



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



% of Clinical Letters completed within 10 Days



Recovery & Access -Responsive

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Step change in Diagnostic waiting times, up to 73% within 6wks and sustained 100% in Radiology • Continued 100% compliance with Cancer standards • Indication that long waits >52wks reducing, with consecutive improvement each week

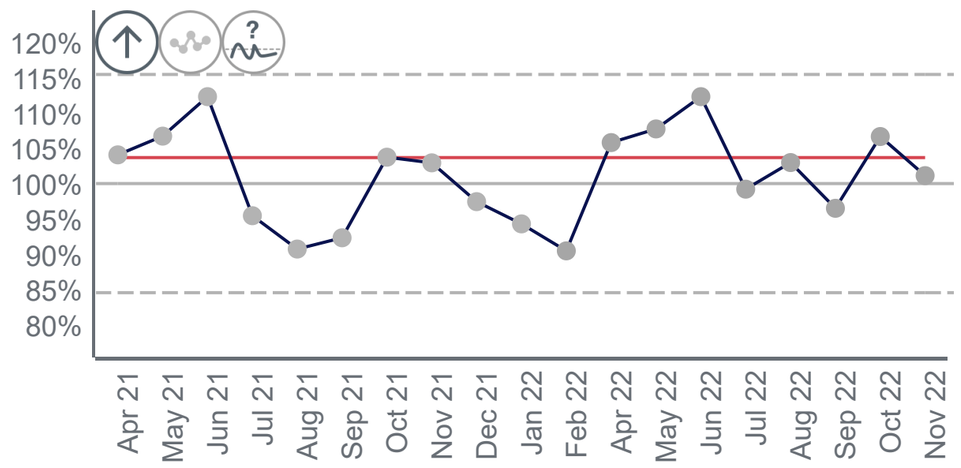
Areas of Concern:

• ERF remains less than 104% target • Some individual specialties continue to be challenged with long waits and monitoring local actions plans in Dental, Spinal, ENT, Neurology • Performance against 18 week pathways shows deterioration due to focus on longest waits >40wks • OPFU remains consistently above the target for reducing activity levels

Forward Look (with actions)

• Industrial Action will inevitably reduce elective care, with long waiting patients rebooked as a priority • Continue driving down longest waiting times, towards 40 weeks for majority of specialties • Dental Insource model to commence in Jan to reduce >52ww • Home Sleep Studies to commence in January (delayed from Nov) to further improve diagnostic waiting times • Increasing PIFU and delivering higher outpatient new capacity

% Recovery for DC & Elec Activity Volume



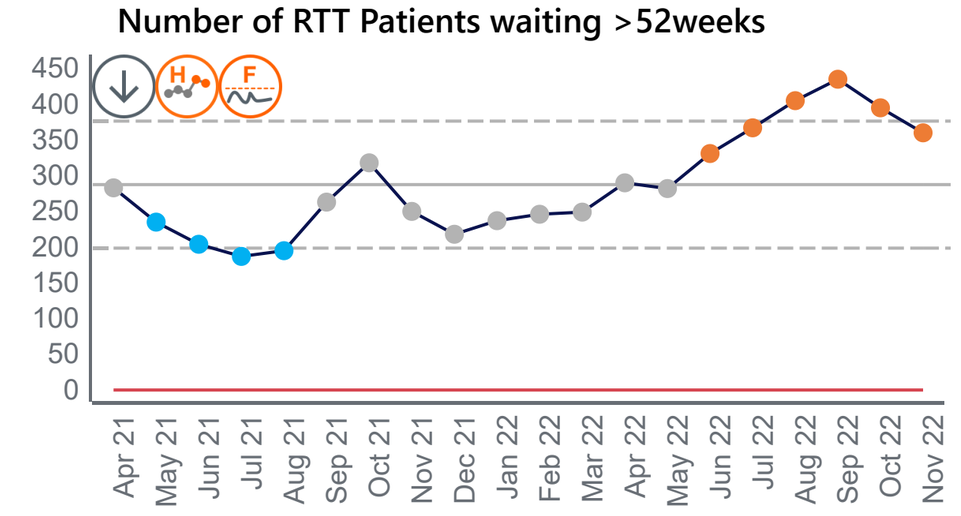
Technical Analysis:

Nov performance of 101% is below the target, is comparable with Nov 2021 as the trend continues to follow a similar seasonal pattern to last year. Despite lower activity volume in month, Gross ERF achieved 105% in Nov (due to case mix and coding) although net ERF falls to 100% (below target) due to OPFU adjustment

Actions:

Continue to prioritise high value specialties (eg Spinal Surgery) to optimise ERF value. Improve productivity and recovery through local plans in ENT and Paed Surg. Bed Management SOP to ensure theatres start on time. Theatre Improvement Group actions to maximise Day Case activity

Number of RTT Patients waiting >52weeks



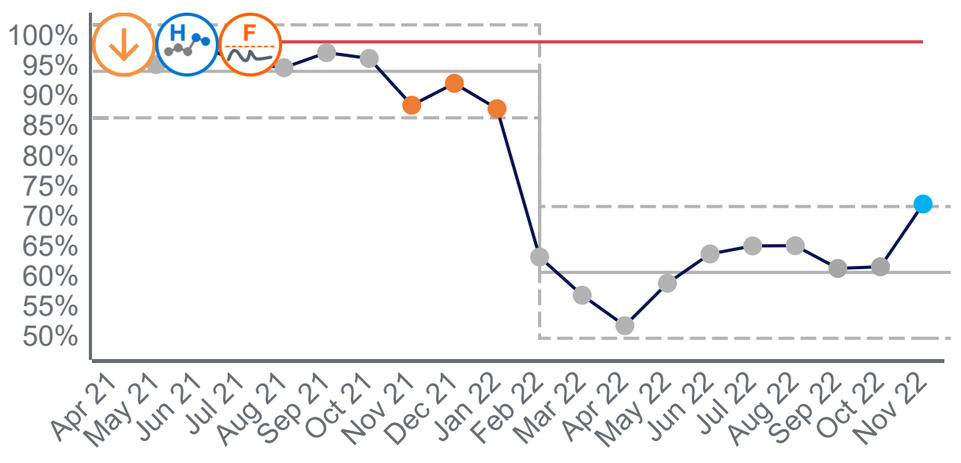
Technical Analysis:

In Nov there were 360 RTT patients >52wks; this includes 9 RTT patients >78wks. Dentistry has 246pts >52wks, 68% of the Trust total. Although this shows common cause variation, the weekly report shows consecutive weekly improvement.

Actions:

Continue driving down longest waiting times, towards 40 weeks for majority of specialties. Dental Insource model to commence in Jan to reduce >52ww. Spinal Surgery monitoring potential 78ww breaches with forward look model

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

The Baseline was reset in Feb following Safe Waiting List Management validation and correction of reporting. Nov performance of 72% is above the control limit which demonstrates the success of the improvement actions taken in Radiology and Urodynamics to reduce waiting times.

Actions:

Home Sleep Studies to commence in January (delayed from Nov) to double capacity from 8 to 16 patients per week. Review Scope patients >6wks and prioritise theatre sessions as required. Maintain improvement in Radiology and Urodynamics

Recovery & Access -Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	November 2022	101	104	101.52		?
Number of RTT Patients waiting >52weeks	November 2022	360	0	287.50	H	F
Diagnostics: % Completed Within 6 Weeks of referral	November 2022	72	99	62.00	H	F
RTT Open Pathway: % Waiting within 18 Weeks	November 2022	55	92	62.95	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	November 2022	100	100	99.37		P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	November 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	November 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	November 2022	100	100	92.11	H	?
Cancer: Faster Diagnosis within 28 days	November 2022	100	75	93.43	H	P
% Recovery for OP New & OPPROC Activity Volume	November 2022	120	104	101.25	H	?
% OPFU Activity Volume	November 2022	103	85	107.08		F
Waiting List Size	November 2022	22894		18,883.95	H	?

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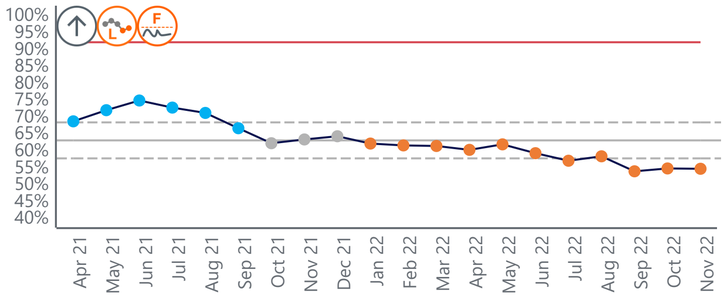
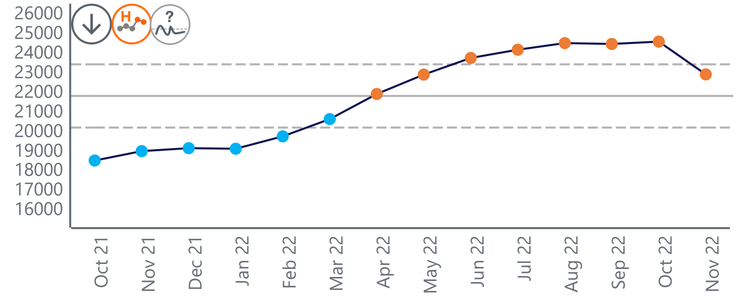
Alder Hey Children's NHS Foundation Trust

Recovery & Access -Responsive - Watch Metrics

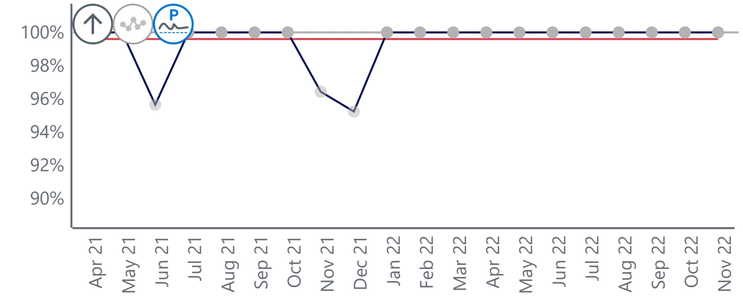
RTT Open Pathway: % Waiting within 18 Weeks



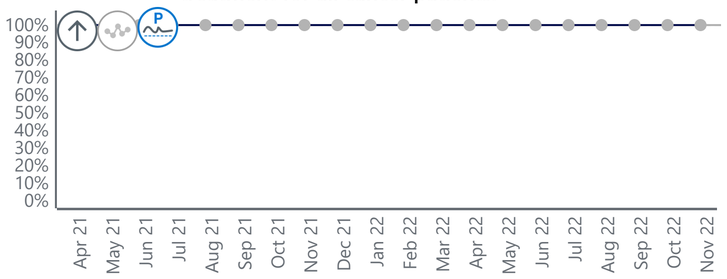
Waiting List Size



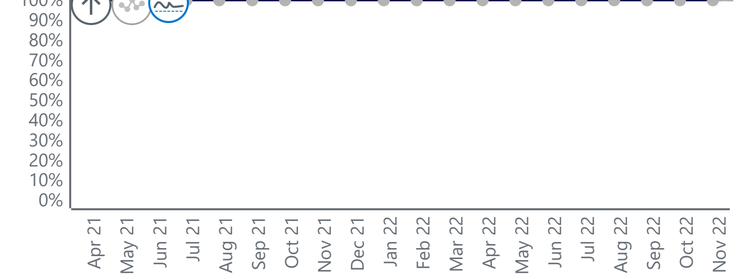
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



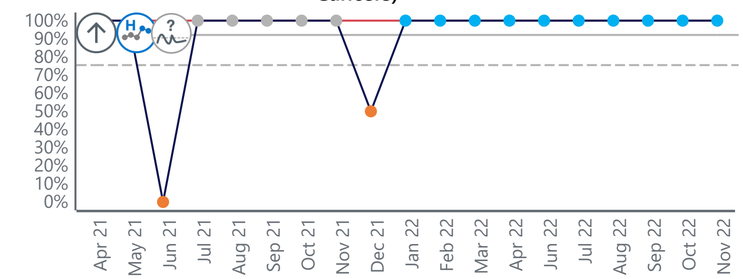
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



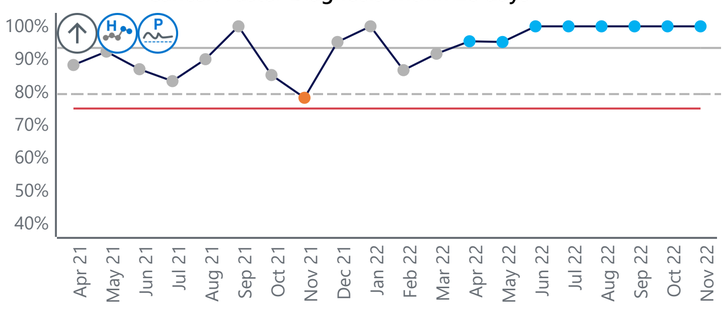
All Cancers: 31 day wait until subsequent treatments



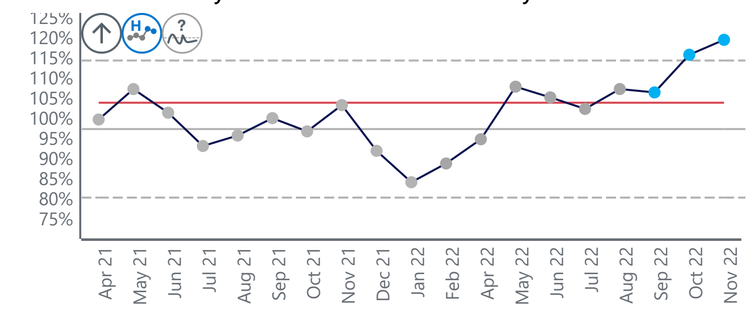
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



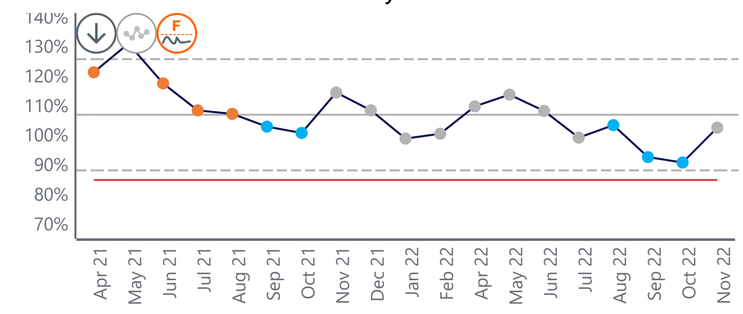
Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



% OPFU Activity Volume



Well Led - Great Place to Work - People

SRO : Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training remains above target at 92% throughout Q2 • Sickness absence remains above the 5% target at 6.2%

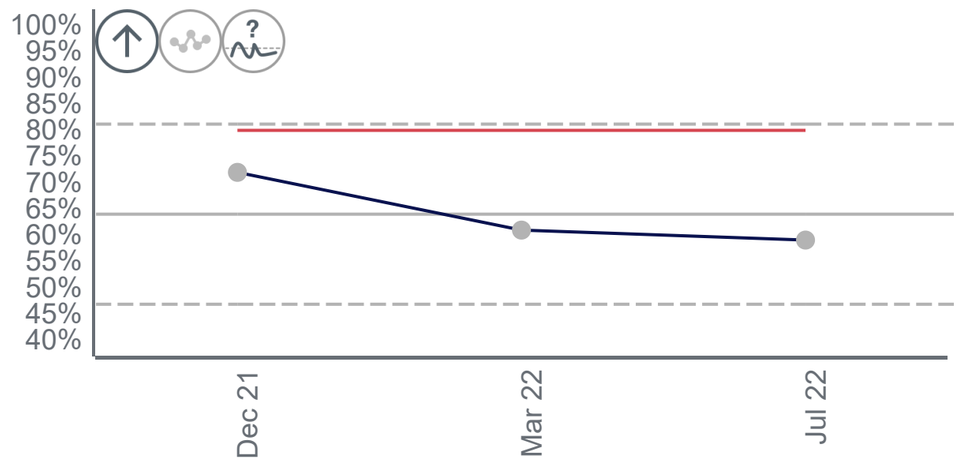
Areas of Concern:

• Reflective of the national position, Trust turnover remains high with an in-month position of 14% • PDR's whilst they are steadily increasing across all bands, for those in band 7+, at 85% completion this falls short of the 90%, which should have been achieve by end of July 2022.

Forward Look (with actions)

• Increased focus on turnover and retention initiatives which will be captured in the Trust long term plan on attraction and retention. A task and finish group has now been established to review turnover data specifically and to review some immediate local interventions.

% Staff who recommended Alder Hey as a place to work



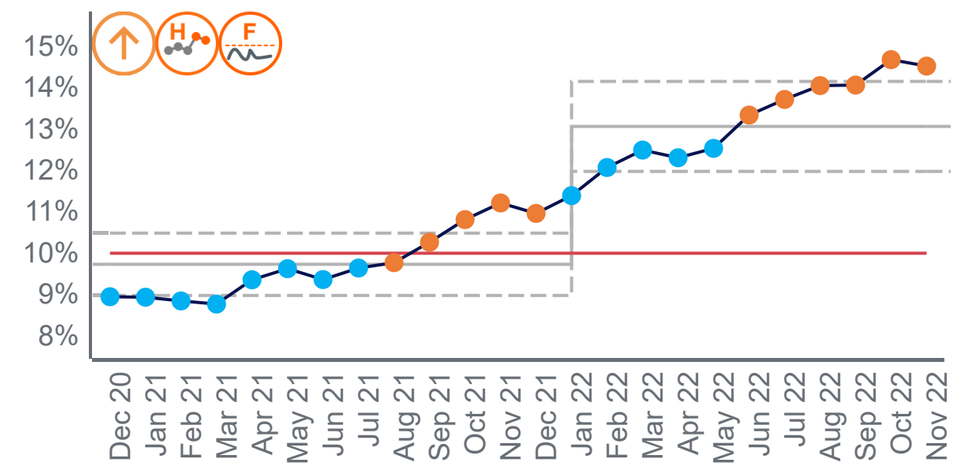
Technical Analysis:

Well Led – People
Only 3 data points, so not possible to analyse data given frequency of the survey (quarterly). Most recent data points at 61% and 59% are significantly below the 80% target. The next data point is expected from the full national staff survey, which closed with a 54% response rate.

Actions:

The 2022 National Staff Survey has now closed with 54% response rate. Results will be available early 2023

Staff Turnover



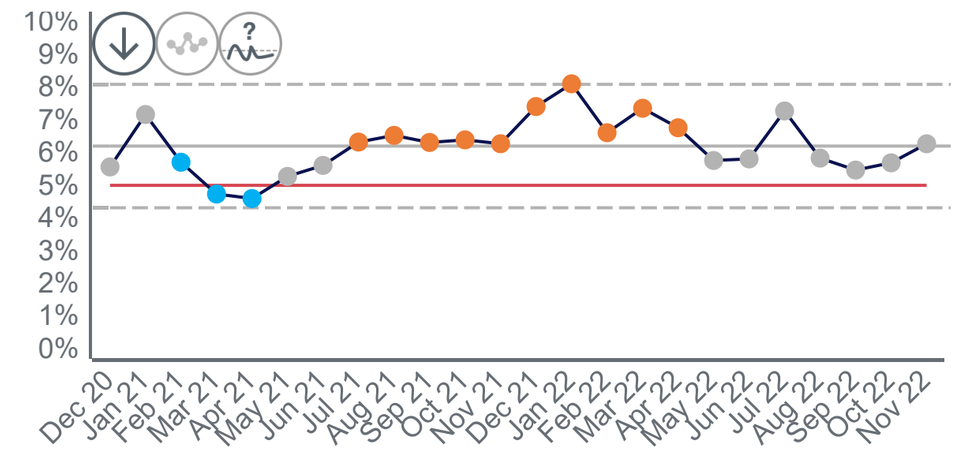
Technical Analysis:

This data raises significant concern due to special cause variation driving a substantial increase in turnover rate. This level of staff turnover is creating substantial risk for the Trust.

Actions:

Reflective of the national position, staff turnover is a concerning trend which is monitored closely and reviewed by divisional boards and PAWC. Sustainable interventions are being considered and presented through a now established task and finish group.

Sickness Absence (Total)



Technical Analysis:

Total absence in Nov is 6.2%, which is above the 5% target. This comprises STS at 2.6% and LTS at 3.7% (both above target). This is still demonstrating common cause variation and further actions are required to demonstrate improvement.

Actions:

Interventions remain in place which include: Early intervention though Occupational Health, launch of new management training, HR surgeries, SALS support, designated HR support per division. Review of all hotspot areas.

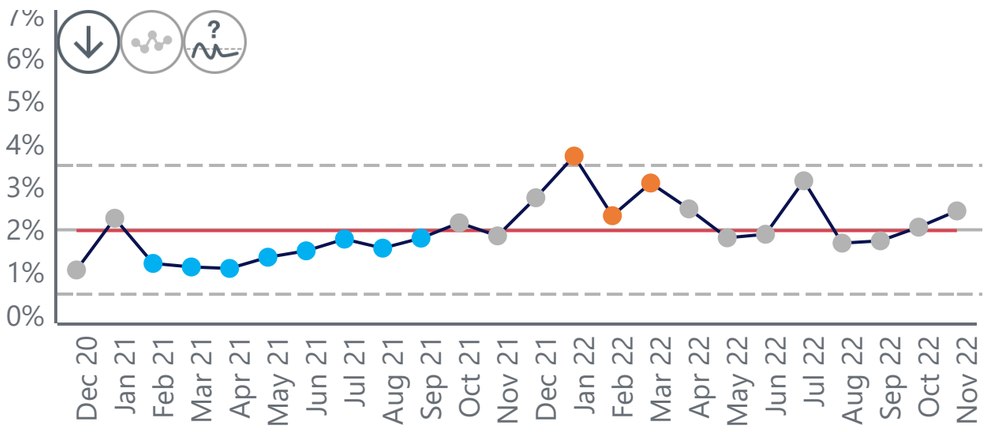
Integrated Performance Report | December 2022

Alder Hey Children's NHS Foundation Trust

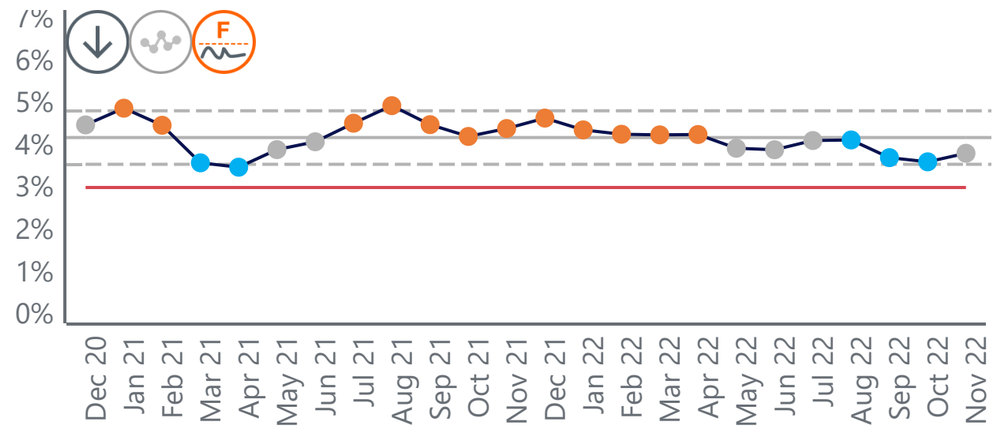
Well Led - Great Place to Work - People - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Staff who recommended Alder Hey as a place to work	July 2022	59	80	64.03		?
Staff Turnover	November 2022	15	10	12.88	H	F
Sickness Absence (Total)	November 2022	6	5	6.20		?
Short Term Sickness	November 2022	2	2	2.02		?
Long Term Sickness	November 2022	4	3	4.18		F
Mandatory Training	November 2022	92	90	92.20		P
% PDRs completed since April	November 2022	48	90	47.63	H	F
Medical Appraisal	November 2022	87	100	62.68	H	F

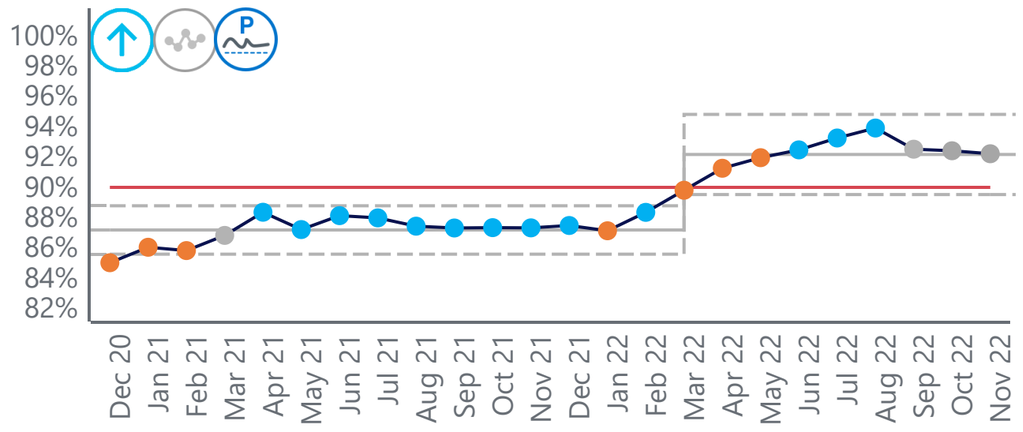
Short Term Sickness



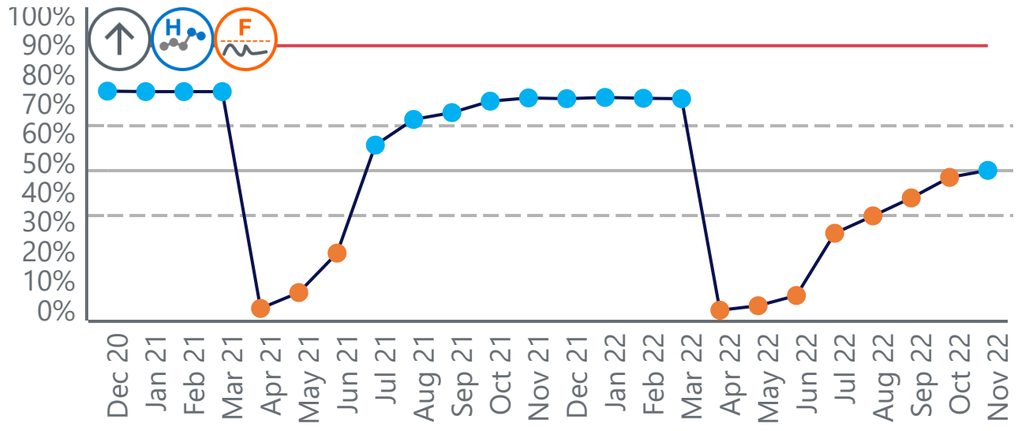
Long Term Sickness



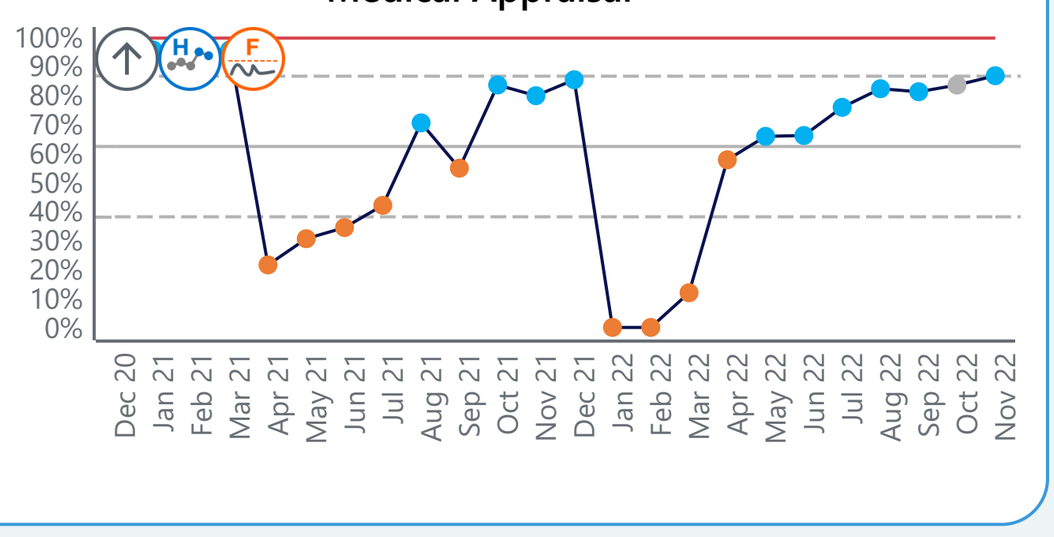
Mandatory Training



% PDRs completed since April



Medical Appraisal



Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Highlights:

For November (M8), the Trust is reporting a surplus of £1m which is in line plan. The year to date position is £0.6m surplus in line with the plan approved. Forecasting to achieve £17.3m in year Cost Improvement Plan target however is predominantly non-recurrent which will result in a pressure carried forward into 23/24. Cash has remained high in line with the plan as capital spend increases in future months.

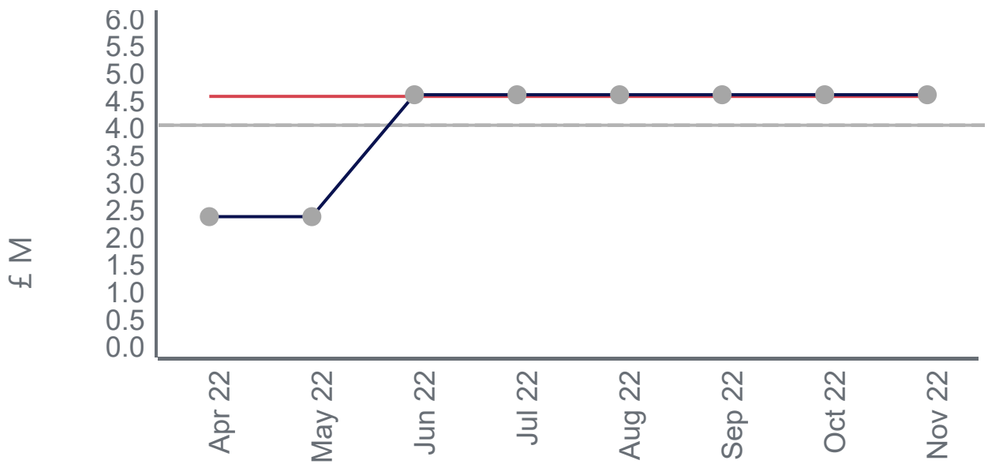
Areas of Concern:

Lack of recurrent CIP identified with no transformational schemes. Challenging £4.6m control total surplus plan by end of the financial year with key drivers including increased energy cost which cannot all be mitigated. Increase in temporary/premium pay despite activity below 19/20 levels. Inflation/high usage pressure in drugs with no additional income. ERF threshold not met with uncertainty on clawback in Q3/Q4.

Forward Look (with actions)

Continued cost control to reach the £4.6m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further divisional finance panel meetings scheduled. Triangulation of costs/activity/workforce. Working groups understanding 3-4 key areas of focus for each division including Junior Doctors/ APNP/ Drug spend. Deep dive continues into drug spend.

Revenue Position (Year End Forecast)



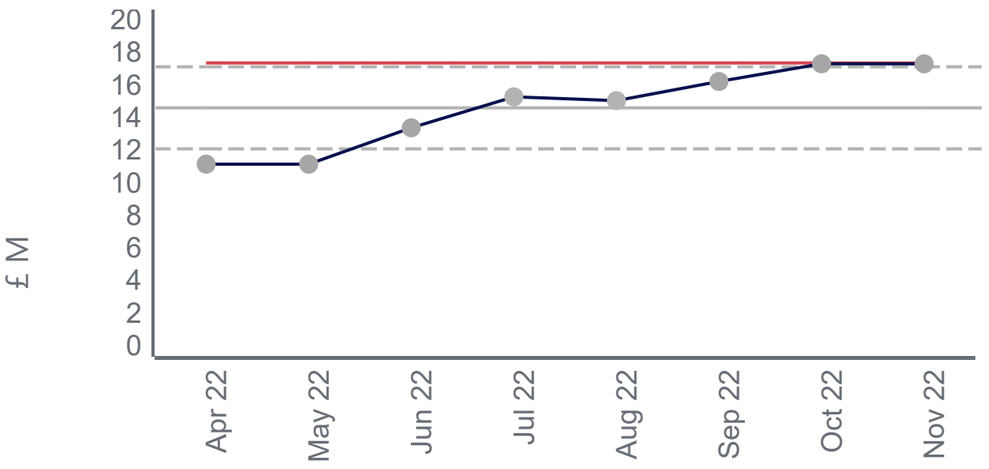
Technical Analysis:

Current forecast remains to achieve plan however risks to delivery of this is linked to inflationary pressures which have been noted to ICB and Trust Board.

Actions:

Continue to monitor inflationary pressures risk and mitigations.

CIP Position In Year (Year End Forecast)



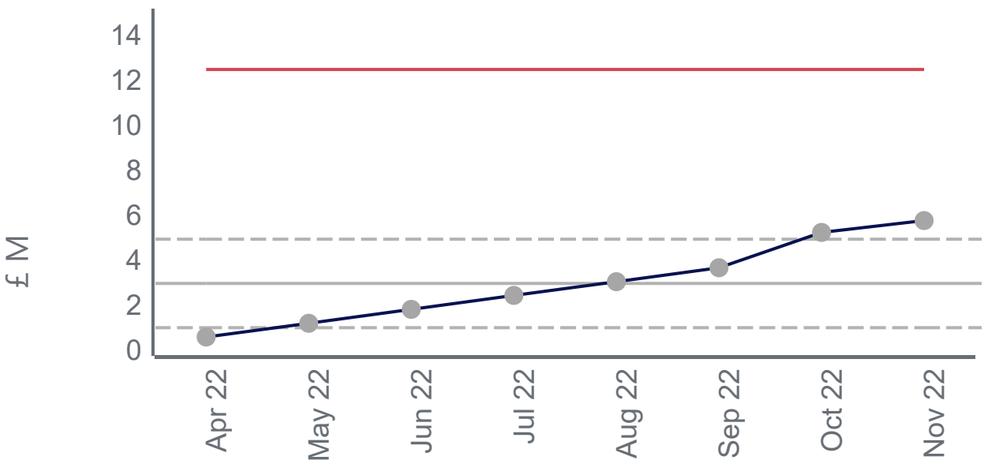
Technical Analysis:

Current forecasts now in line to achieve full £17.3m target assuming schemes in progress deliver as planned.

Actions:

Continue scrutiny and challenge through financial reviews and SDG, across all areas to identify further CIP opportunities.

CIP Position Recurrent/Full Year Effect



Technical Analysis:

Slight improvement in month but only 47% CIP identified as recurrent, with £6.7m left to be identified and delivered in the remaining 4 months. So far a further £2.1m opportunities have been identified which could take the recurrent gap down to £4.6m.

Actions:

Support required with exec leads and transformation to identify the large scale opportunities either through existing programmes/projects or if not likely to deliver and for new schemes to be agreed and supported. Letter to be sent to Trust in December outlining current position.

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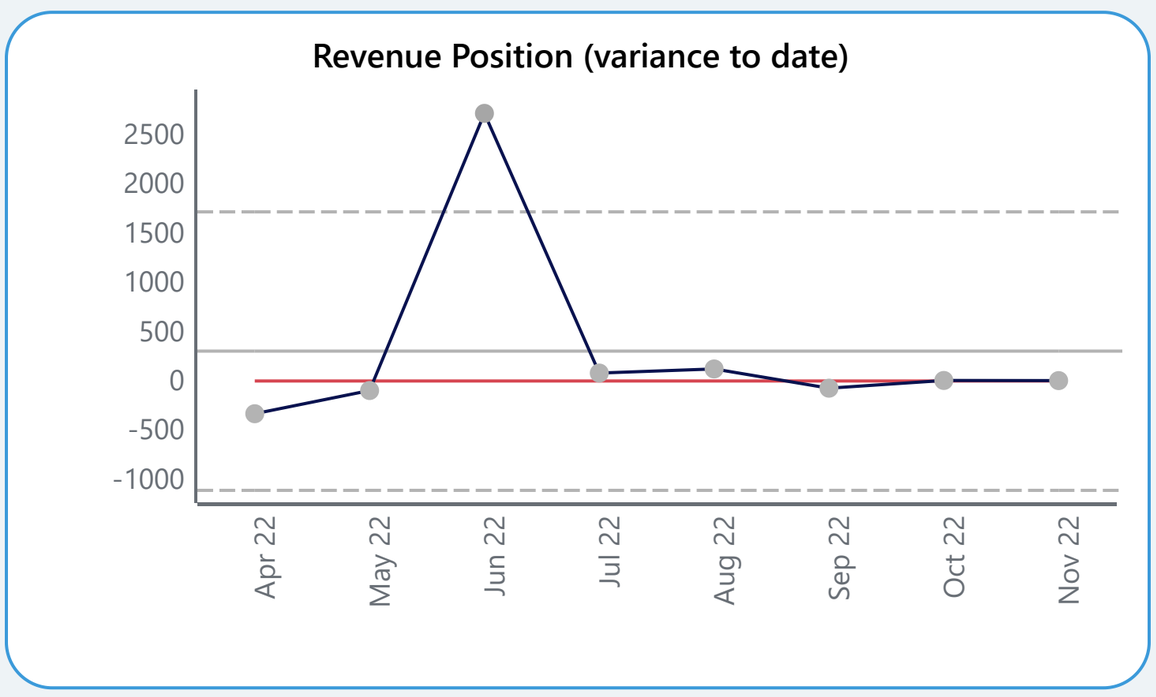
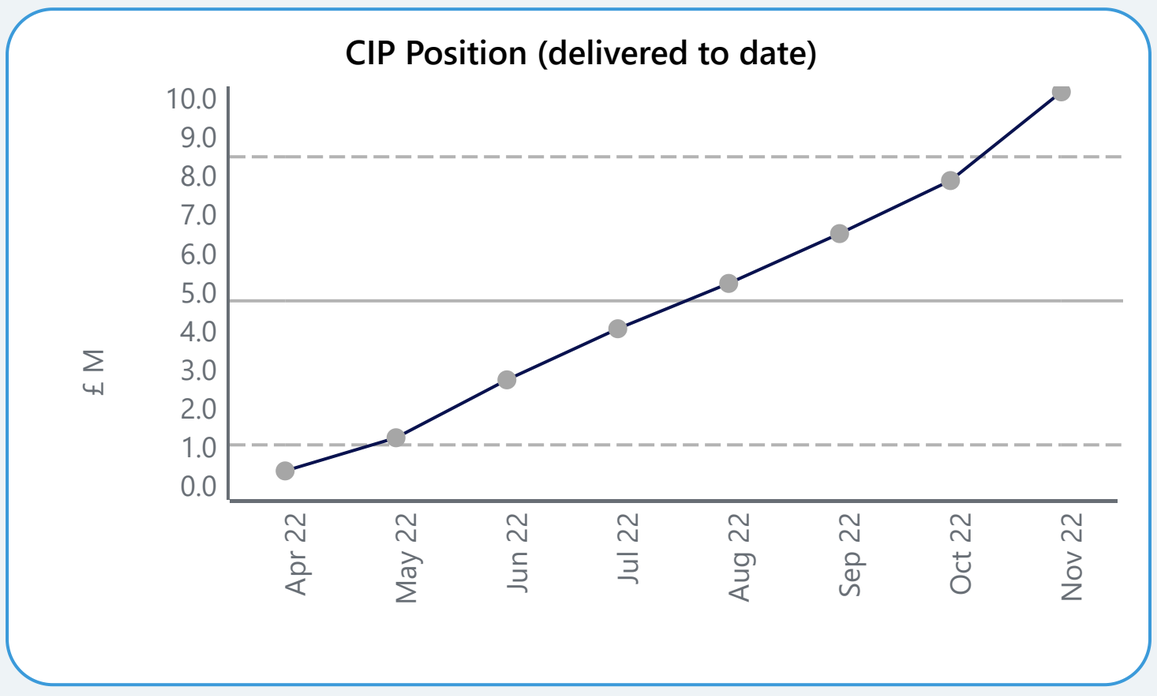
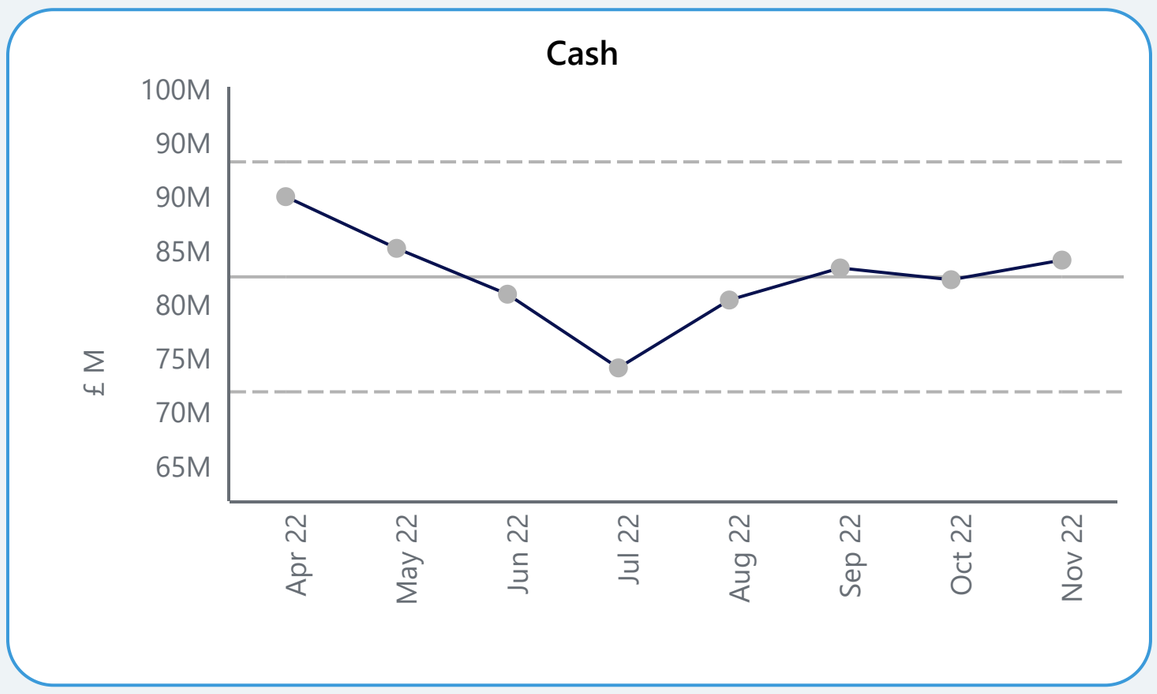
Alder Hey Children's NHS Foundation Trust

Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	November 2022	5	5		
CIP Position In Year (Year End Forecast)	November 2022	17	17		
CIP Position Recurrent/Full Year Effect	November 2022	6	13		
Revenue Position (variance to date)	November 2022	4	0		
CIP Position (delivered to date)	November 2022	10			
Cash	November 2022	84,225,000			







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

• Work remains ongoing with monthly review of all Divisional and Corporate Functions' high risks (including high moderate risk with a score of 12+ on the risk register >12 months) as part of risk revalidation meetings with Corporate Governance/Risk team • Further scrutiny of Corporate Services high risks (risk score 12+) are reviewed via Corporate Services Collaborative • Monthly risk register validation meetings continue with corporate oversight

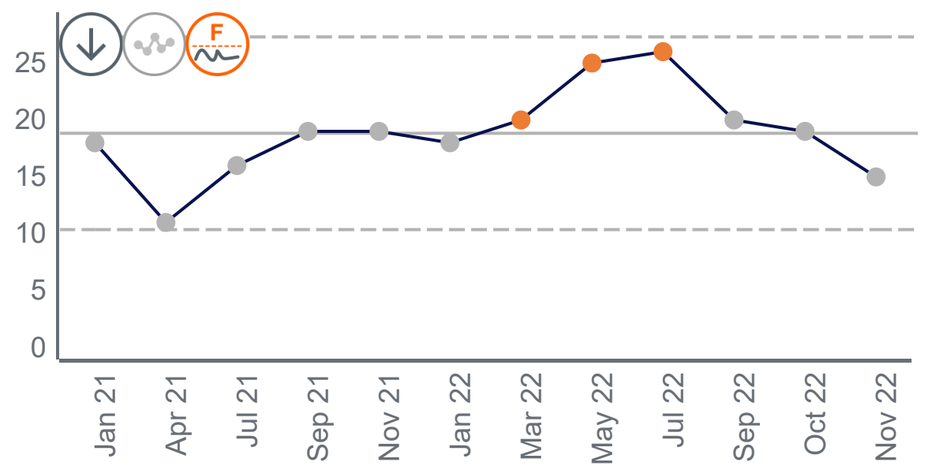
Areas of Concern:

• Continue to observe several risks with overdue risk date and no assigned risk owner • Variable understanding of risk process with individuals/teams

Forward Look (with actions)

• Corporate Service collaborative report developed and will be shared at Risk management forum Dec 22 • Ongoing cleanse and update of risk registers continues on focused work with service leads/divisions with oversight from corporate governance team • Risk training provided as required

Number of High Risks (scored 15 and above)



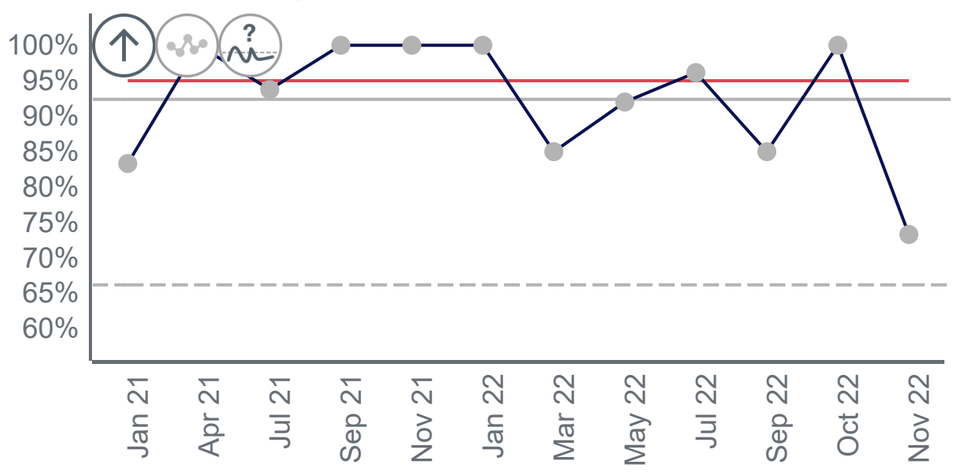
Technical Analysis:

There are a total of 15 High Risks in Nov, which is stable and within the normal range. This data is now being collected on a monthly basis, which will enable more meaningful analysis of trends.

Actions:

Continue to monitor risk and mitigations at monthly risk register validation meetings

% of High Risks within review date



Technical Analysis:

At the end of Nov 4/15 high risks were overdue review, meaning just 73% are within review date. This is close to the lower limit, and is the lowest reported figure since Jan-21. Action is required to address this and move back to the 95% target in future months.

Actions:

The 4 high risks overdue reviews have been escalated to individual risk owners.1 has since been reviewed and updated. Data continues to be monitored monthly via risk register overisght meetings with assurance of mitigation provided at Risk Management Forum

Well Led - Safe Digital Systems - Digital

SRO : Kate Warriner, Chief Digital and Information Officer

Highlights:

• Community Paediatrics Referral Platform is now live • New Models of Care including AlderHey Anyhwhere delivery planning progressing well and on track for March 23 • Business Case for Risk and Incident management to be submitted to finance committees in December aiming for implementation prior to April 23 • AlderCare patient journeys cycle 2 completed successfully

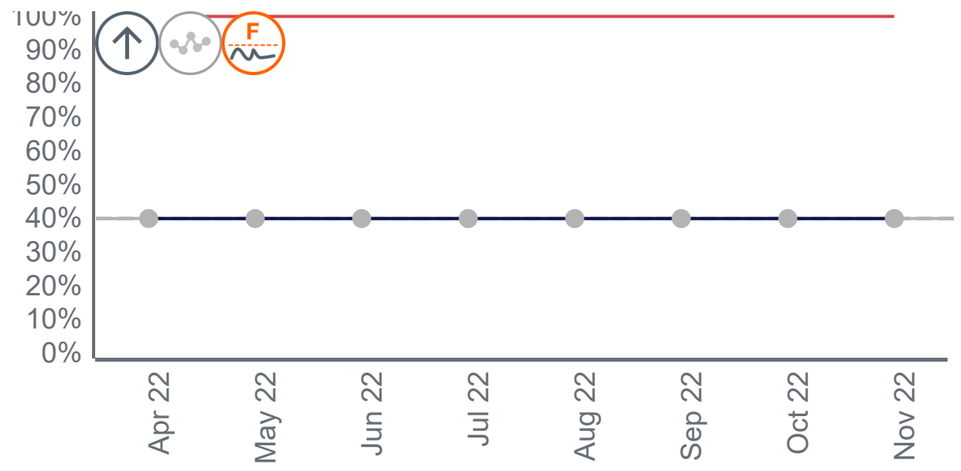
Areas of Concern:

• Aldercare gateway review has 2 outstanding items with actions for completion in December 2022 • Dates have been provided for all P1 issues for AlderC@re however the delivery of the solutions needs closely monitoring • There are dependencies on AlderCare around the deployment of the proposed new theatre system and the timing of its deployment • Resources remain a concern for all programmes and this will also be closely monitored

Forward Look (with actions)

• Formal completion of AlderC@re gateway 1 in December 22 • Intranet design stages underway with stage 2 to be completed in January, project plan to go live Q1 calendar year 2022 • Training and awareness sessions in the New Year for all staff on how to access data through Power BI

Alder Care - Divisional Critical Criteria



Technical Analysis:

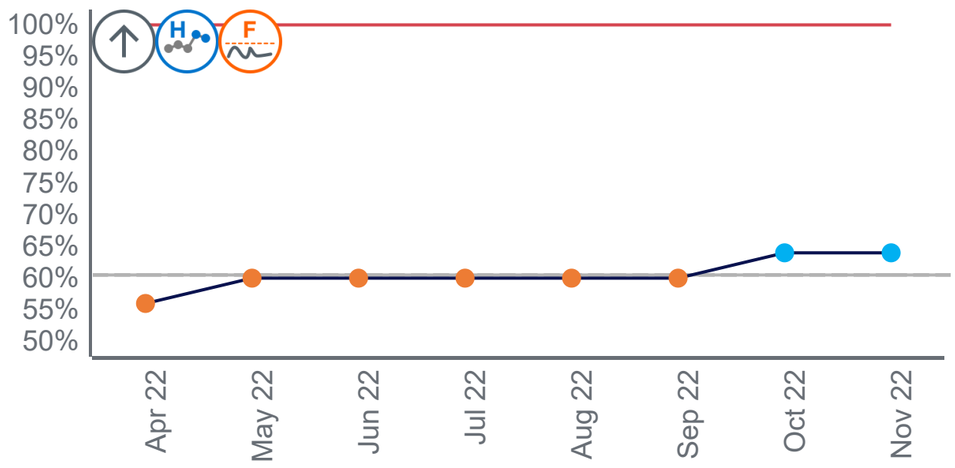
6/15 critical criteria complete. Remainder awaiting system build or key decisions (e.g. waiting list management). Performance metric is for "sign off" so percentage only increases once each item is fully signed off. Three items due for review in December. Critical criteria plans were provided as part of the gateway review for clinical safety

Actions:

1) Ongoing development for remaining items

2) Review 3 items for potential sign off

Alder Care - % System Build Completion



Technical Analysis:

This metric monitors build across all workstreams. Further validation of build continues through cycle 2 of "Patient Journeys" with clinical and operational teams. Build for prescribing started in November.

Actions:

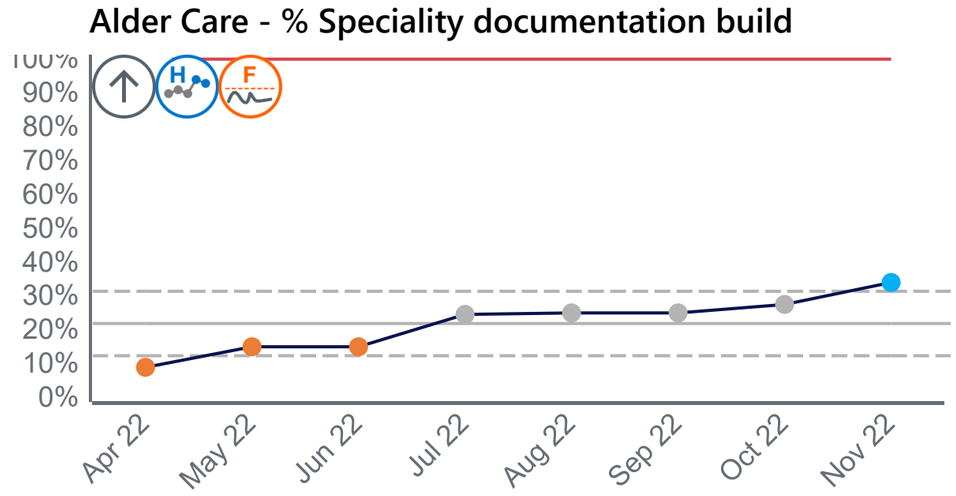
1) Continue build and review during "Patient Journeys"

2) Monitor progress on EPMA build

3) Decision on new theatre system

4) Review BAU request for impact on AlderCare programme

Alder Care - % Speciality documentation build



Technical Analysis:

18 of 58 specialties with changes required to their documents have now been actioned. Orthopaedic documents in the process of being reviewed with the service, with over 80 documents processed. Formal sign off processes continue (4%).

Actions:

1) Complete outstanding design requirements (94% complete)

2) Continue build (31%) and sign off process (4%)

Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• Referral platform for Developmental Paediatrics, ASD and ADHD now live, supporting electronic referrals and improved visibility and tracking of pathways • Was not brought rate has continued to reduce for the third consecutive month • Zero over 52 week wait for developmental paediatrics

Areas of Concern

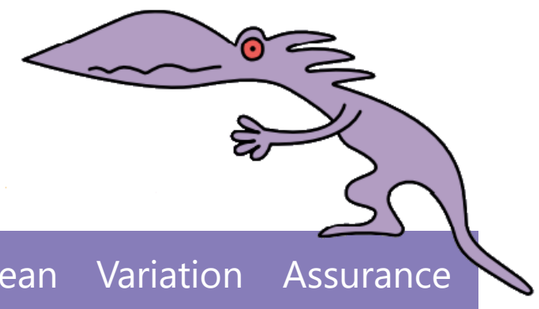
• ASD and ADHD waiting times remain higher than planned due to increases in demand • Initial Health Assessments for children who are new into care are not being carried out within 20 working days • Clinic letters turnaround time remains below 95%

Forward Look (with actions)

• New approach to supporting colleagues in Education to refer to ASD pathway is being rolled out during Q4 which includes training, support and provides more early help to children and families • Focus on PDR completion rates during last 4 months of year • IHA improvement plan supporting increase in compliance with target • Continued negotiation with commissioner colleagues at place to secure funding to support CAMHS, ASD and ADHD capacity

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	November 2022	28	15	19.65		
Number of Incidents rated No Harm and Near Miss	November 2022	80	80	75.25		
Use of physical restrictive intervention (MH Tier 4)	November 2022	2		11.07		



Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	November 2022	4	6	3.15		
Number of PALS contacts	November 2022	55	45	43.25		

Divisional Performance Summary - Community & Mental Health

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	November 2022	47	25	54.11		P
% Was Not Brought Rate (All OP: New and FU)	November 2022	13	10	14.45		F
% of Clinical Letters completed within 10 Days	October 2022	64	95	57.99		F
CYP1 - Number of visitors to the site	October 2022	1562		1,293.38		
CYP1 - Number of Referrals Processed by RPA	November 2022	183		86.47	H	
CYP1 - Number of Referrals Accepted Processed by RPA	November 2022	74		33.95	H	

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	November 2022	0	0	2.25		?
RTT Open Pathway: % Waiting within 18 Weeks	November 2022	49	92	55.36	L	F
% Recovery for OP New & OPPROC Activity Volume	November 2022	112	104	134.36		?
% OPFU Activity Volume	November 2022	129	85	132.50		F
CAMHS: Number of Patients waiting >52weeks	November 2022	10	0	4.45	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	November 2022	54	92	64.09	L	F
CAMHS: Paired Outcome Scores	July 2022	35	40	32.19		?
CAMHS: Crisis / Duty Call Activity	November 2022	772		665.50		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	November 2022	94	95	56.43		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	November 2022	100	95	71.67		?
ASD: % Incomplete Pathways within 52wks	November 2022	75	90	73.88		?
ASD: % Referral to triage within 12 weeks	November 2022	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	November 2022	73	90	81.97		?
ADHD: % Referral to triage within 12 weeks	November 2022	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	October 2022	18	100	9.14		F
IHA: % complete within 20 days of referral to Alder Hey	October 2022	78	100	26.97	H	F

Divisional Performance Summary - Community & Mental Health

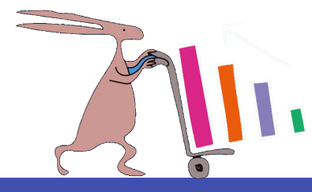
Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	November 2022	14	10	12.54	H	F
Short Term Sickness	November 2022	3	2	1.65		?
Long Term Sickness	November 2022	5	3	3.87		?
Mandatory Training	November 2022	95	90	94.78		P
% PDRs completed since April	November 2022	50	90	54.11	L	F
Medical Appraisal	November 2022	87	100	57.61		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	November 2022	11	0	5.78		?

Integrated Performance Report | December 2022



Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• Sustained compliance with 60 minutes antibiotics standard across the wards • Sustained OP/DC/EL recovery across the Division despite workforce challenges • Sustained compliance with all Childrens Cancer Standards • Radiology and Neurophysiology 100% compliance with 6 weeks

Areas of Concern

• Access to Care (EL/NEL), poor patient experience and delays for treatment • Compliance with Clinical Letters completion • Access to Diagnostic Sleep and Gastroscopy • PDR Compliance rates • Sickness Absence/Availability

Forward Look (with actions)

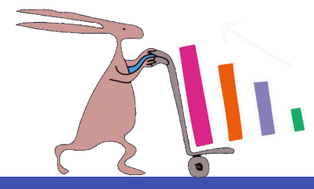
• ED@ Best and Enhanced Winter response, extension of ED footprint and GP offer • Targeted discussion with clinicians re compliance with standards • Recovery plans ongoing for elective access and diagnostics

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	November 2022	31	15	20.50		
Number of Incidents rated No Harm and Near Miss	November 2022	209	140	149.10	H	
Sepsis % Patients receiving antibiotic within 60 mins for ED	October 2022	91	90	84.55		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	November 2022	100	90	90.98		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	November 2022	6	6	4.75		
Number of PALS contacts	November 2022	57	45	42.65		
F&F ED - % Recommend the Trust	November 2022	59	95	68.63		F



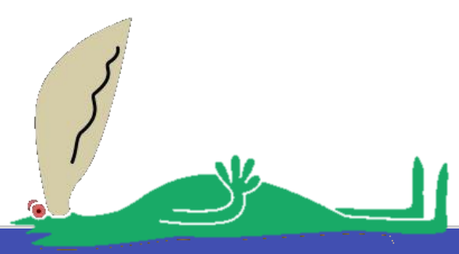
Divisional Performance Summary - Medicine

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	November 2022	65	95	76.88		?
Number of Super Stranded Patients (21 days)	November 2022	32	20	27.50		?
% Virtual Outpatients (national standard 25%)	November 2022	26	25	37.23	L	P
% Was Not Brought Rate (All OP: New and FU)	November 2022	8	10	8.98		?
% of Clinical Letters completed within 10 Days	October 2022	57	95	56.77		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	November 2022	111	104	113.03		?
Number of RTT Patients waiting >52weeks	November 2022	20	0	14.40		?
Diagnostics: % Completed Within 6 Weeks of referral	November 2022	73	99	65.18		F
RTT Open Pathway: % Waiting within 18 Weeks	November 2022	56	92	69.20	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	November 2022	100	100	99.37	H	?
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	November 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	November 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	November 2022	100	100	92.11	H	?
Cancer: Faster Diagnosis within 28 days	November 2022	100	75	93.43	H	P
% Recovery for OP New & OPPROC Activity Volume	November 2022	143	104	101.42	H	?
% OPFU Activity Volume	November 2022	103	85	112.27		F



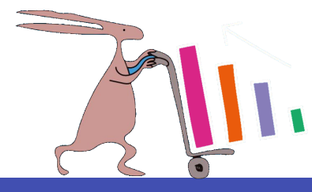
Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	November 2022	14	10	12.72	H	F
Short Term Sickness	November 2022	3	2	2.31		?
Long Term Sickness	November 2022	4	3	4.52		F
Mandatory Training	November 2022	91	90	91.26		?
% PDRs completed since April	November 2022	46	90	46.34	L	F
Medical Appraisal	November 2022	85	100	60.42		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	November 2022	2	0	-1.54		?



Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• Overperformance in OPNew & Proc at 117% in line with recovery plans • Maintained 100% PALS within 5 days • WNB below trust average at 7.8% due to embedded AI tool & targeted specialty actions • No. of patients >52wks continued downwards trajectory due to focused specialty action plans. Number of teams on track for <40wks end of Dec • Improvement in Urodynamics driving Diagnostic compliance at 60%

Areas of Concern

• ERF remains <104% - recovery plans remain a challenge due to theatre staffing pressures & ward capacity • Cancelled Operations remain above target with particular challenge around emergency admissions & medical outliers • Significant increase in NEL activity in particular for Cardiac Surgery & Orthopaedics impacting elective recovery • OPFU increased in Nov, driven by significant volume of overdue Follow Up

Forward Look (with actions)

• Implement higher capacity threshold for starting theatres to reduce cancelled ops • Focused analysis on cancelled op to include training for admin teams • Change in planning to facilitate more complex patients on ward 4A • Ensure scope patients are dated within 6 weeks via new PTL and process • Continue to focus on specialty specific recovery plans in line with trust initiatives around capacity & flow to improve ERF performance

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	November 2022	52	40	48.05		
Number of Incidents rated No Harm and Near Miss	November 2022	164	150	158.95		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	November 2022	100	90	83.67		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	November 2022	10	6	4.95		
Number of PALS contacts	November 2022	39	45	40.25		

Divisional Performance Summary - Surgery

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Cancelled Operations (on day of admission for a non-clinical reason)	November 2022	32	20	21.05		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	November 2022	11	0	7.15		?
Number of Super Stranded Patients (21 days)	November 2022	14	30	9.90	H	F
% Virtual Outpatients (national standard 25%)	November 2022	16	25	17.18	L	F
% Was Not Brought Rate (All OP: New and FU)	November 2022	8	10	8.62		?
% of Clinical Letters completed within 10 Days	October 2022	67	95	57.92		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	November 2022	93	104	89.98		?
Number of RTT Patients waiting >52weeks	November 2022	340	0	270.85		F
Diagnostics: % Completed Within 6 Weeks of referral	November 2022	59	99	35.69		F
RTT Open Pathway: % Waiting within 18 Weeks	November 2022	55	92	61.45	L	F
% Recovery for OP New & OPPROC Activity Volume	November 2022	108	104	98.62		?
% OPFU Activity Volume	November 2022	98	85	100.32		?

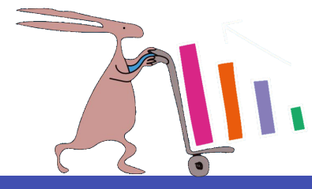
Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	November 2022	13	10	12.19	H	F
Short Term Sickness	November 2022	3	2	2.35		?
Long Term Sickness	November 2022	3	3	3.83	L	?
Mandatory Training	November 2022	91	90	91.66		?
% PDRs completed since April	November 2022	46	90	42.23	H	F
Medical Appraisal	November 2022	88	100	65.82	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	November 2022	-3	0	-3.71		?



Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

Corporate Services Collaborative met on 8th December and all key metrics reviewed. Discussion took place to finalise the problem statement for the finance A3 which was an outstanding action from the last meeting. The general position across the services remains stable but with some movement between the 'top five' hotspots for workforce and finance. The group also reviewed its policies due for renewal and a number of actions were taken to ensure compliance.

Areas of Concern

Overall financial position is just under £1m forecast overspend, of which £0.5m is Energy, £0.4m Catering and £02m HR offset by Finance. Staff Turnover reached 15% for November; analysis of exit interview themes is being undertaken.

Forward Look (with actions)

The Collaborative plans to develop an overall problem statement – or for preference an 'improvement statement' that will focus on key priority areas for the coming year.
A regular service/department level report to be part of the dataset in order to address the 'hotspots' at source.

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	November 2022	15	10	14.48		F
Sickness Absence (Total)	November 2022	7	5	6.66		?
Short Term Sickness	November 2022	2	2	1.56		?
Long Term Sickness	November 2022	5	3	5.10		F
Mandatory Training	November 2022	94	90	92.22	H	P
% PDRs completed since April	November 2022	48	90	51.36	L	F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	November 2022	-12	0	-10.68		?

000050

Safe Staffing & Patient Quality Indicator Report
August 2022

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Compl nts
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good		
Burns Unit	93%	-	97%	0%	1939	84	23.08	7.91	-1.21	-9.21%	0.20	20.00%	0.92	5.38%	0.00	0.00%	37.52	6.95%	0.00	0.00%	1	18	0	4	8	100%	0	0
HDU	66%	39%	67%	52%	7409	287	25.82	31.06	18.99	11.30%	-6.45	-106.09%	1.00	0.72%	0.00	0.00%	223.91	5.18%	9.00	5.17%	11	63	1	2	4	100%	1	2
ICU	71%	97%	71%	77%	14571	381	38.24	31.06	11.85	15.87%	3.05	38.17%	1.53	2.38%	0.00	0.00%	189.24	9.50%	0.00	0.00%	14	100	0	1	1	100%	0	0
Ward 1cC	90%	90%	89%	59%	7277	478	15.22	15.22	-3.35	-5.83%	-0.20	-3.75%	0.00	0.00%	0.00	0.00%	92.25	4.65%	13.00	7.58%	3	21	0	2	14	92.86%	1	0
Ward 1cN	83%	-	101%	-	2922	197	14.83	14.83	-1.93	-6.76%	1.43	58.85%	0.00	0.00%	0.00	0.00%	60.08	7.11%	0.00	0.00%	2	13	0	3	9	100%	0	0
Ward 3A	83%	65%	89%	76%	7025	659	10.66	11.00	-1.38	-2.92%	2.37	14.83%	0.00	0.00%	1.00	8.24%	79.19	5.21%	132.41	35.70%	2	22	1	8	52	98.08%	1	0
Ward 3B	80%	74%	69%	-	4047	311	13.01	13.01	-1.71	-4.90%	-1.85	-31.52%	0.00	0.00%	0.00	0.00%	124.59	9.69%	46.80	30.68%	0	19	0	17	19	100%	1	0
Ward 3C	91%	65%	81%	84%	6716	691	9.72	8.60	-4.14	-9.00%	5.15	47.20%	0.00	0.00%	0.00	0.00%	150.79	9.07%	33.52	25.58%	9	36	0	1	19	100%	0	0
Ward 4A	86%	73%	87%	93%	8489	748	11.35	11.00	-0.49	-0.75%	-0.23	-2.70%	0.00	0.00%	0.61	13.33%	163.20	7.85%	0.00	0.00%	9	35	0	3	69	97.10%	1	0
Ward 4B	73%	73%	62%	81%	7432	533	13.94	10.30	-1.33	-4.87%	1.06	2.69%	1.00	2.35%	1.00	3.07%	131.39	9.91%	207.40	20.18%	4	45	1	10	13	100%	0	0
Ward 4C	80%	94%	79%	103%	6636	691	9.60	11.30	-4.42	-11.28%	0.50	4.38%	2.00	3.59%	0.00	0.00%	99.97	5.85%	44.64	13.20%	18	57	2	9	40	95%	1	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

Staffing fill rates for wards 3B and 3C have improved slightly during day shifts, however night fill rate for RNs remains below 80% on 3B, 4B and 4C due to continued higher levels of sickness. A continued focus with Ward managers, HR, Matrons and Heads of Nursing to ensure we are supporting staff and managing cases in line with policy timeframes, occupational health referrals are in place and welfare meetings conducted.

Ward 4C has increased medication incidents, with a total of 18 recorded during August. As on outcome, a risk & governance board has been installed on the ward to display any lessons learnt. Detail of each medication incident was discussed in the Doctor's monthly meeting to plan changes in practice to make workplace safer for everyone.

Surgery

Wards 3A and 4A had continued low fill rate for HCAs. The wards prioritise HCA cover for patients requiring a 1:1 as per the risk assessment. Sickness for HCAs on 3A remains high at 35.7% and there was minimal uptake for additional shifts.

Critical Care

HDU had a low fill rate of Registered Nurses due to vacancies and sickness. 10 x band 5 posts have been recruited to and further recruitment is underway.

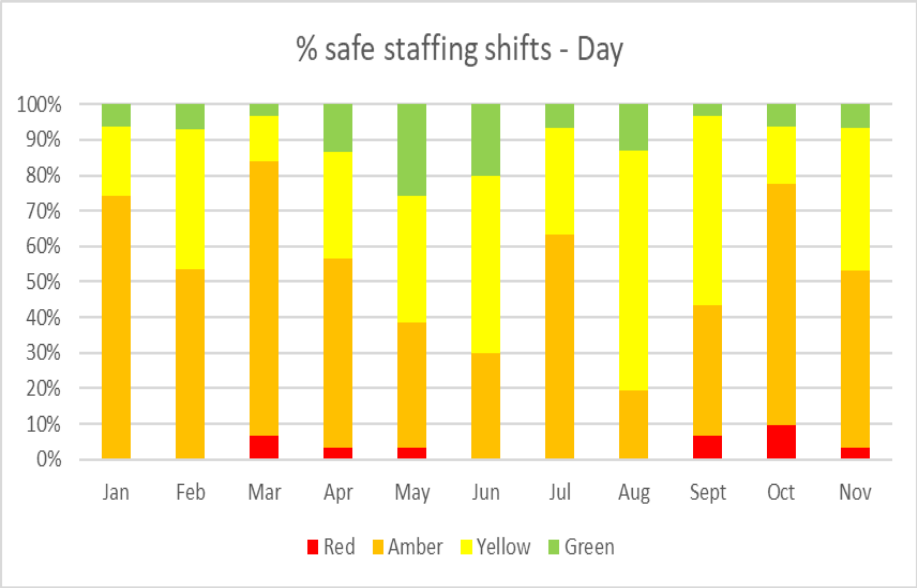
Summary

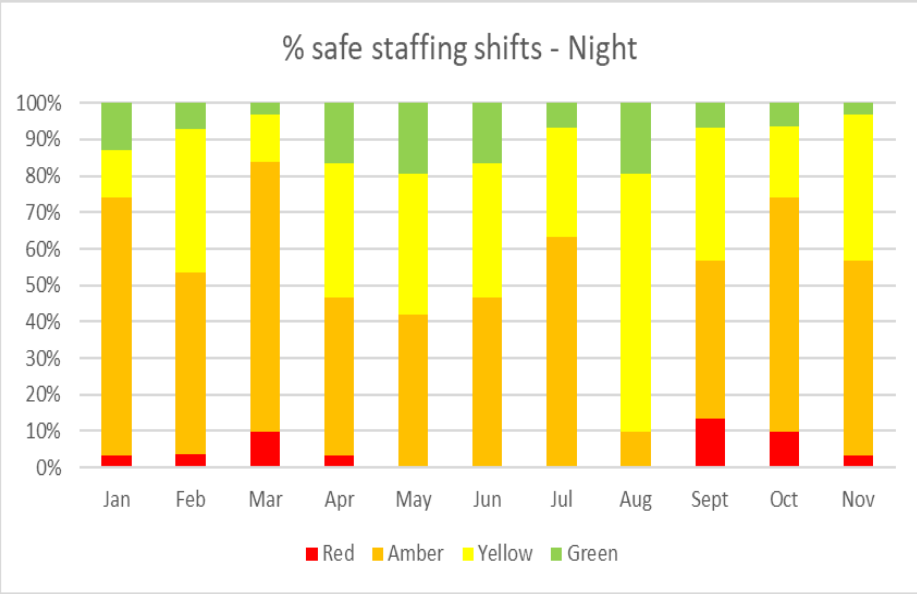
CHPPD compare equally and well with other paediatric hospitals and trusts with Oncology favouring comparably with other trusts.

Friends and Family test showed all wards scored over 90% with 7 wards scoring 100%.

There has been a reduction in red and amber days during November, with mainly yellow staffing day and nights.

During this period reported, staff moves on NHSP were not recorded on eRoster. From December this will be recorded and reflected in the numbers.





Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 15th December 2022

Paper Title:	Finance Report – Month 8 2022/23
Report of:	Director of Finance
Paper Prepared by:	Deputy Director of Finance

Purpose of Paper:	Decision ☐ Assurance ☒ Information ☐ Regulation ☐
Summary / supporting information:	To provide the Committee with an update on the month 8 financial position for 2022/23
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:	Not Applicable

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Alder Hey Children's NHS Foundation Trust

Finance Report

As at
Month 8
November 2022/23

Date of issue: 7th December 2022

Rachel Lea
Deputy Director of Finance

Alder Hey Children's NHS
NHS Foundation Trust

Executive Summary

Key Metrics	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Income £000 (Exclude ERF)	29,320	30,903	1,582	234,558	239,825	5,267
Pay Expenditure £000	(18,149)	(19,224)	(1,075)	(145,493)	(146,418)	(926)
Non Pay Expenditure £000	(10,919)	(11,490)	(571)	(93,144)	(97,479)	(4,335)
Expenditure £000	(29,068)	(30,714)	(1,646)	(238,637)	(243,897)	(5,260)
Trading Position £000	252	189	(63)	(4,079)	(4,072)	7
ERF Income £000	770	837	67	4,655	4,655	()
ERF Expenditure £000	0	0	0	0	0	0
Revised Trading Position £000	1,022	1,026	3	576	583	7
WTE	4,029	4,003	26	4,029	4,003	26
Cash £000		84,226			84,226	
CAPEX FCT £000	1,423	1,294	129	5,349	5,930	(581)

The Trust has achieved an in-month trading surplus of £1.0m in November which is in line with the planned financial position. Year to date (M1-8) the Trust is reporting a surplus of £0.6m again in line with plan, which was profiled to move into a surplus in the second half of the financial year to reach the required £4.6m surplus by the end of March.

The main drivers for the improved year-to-date position include CIP delivery, benefit from additional interest payment, recovery of additional income within the community division and other non recurrent benefits such as rates rebate. Pay pressures continue within the Medicine division associated with HCA 1-2-1 spend as well as continued waiting list initiative spend within the Surgery division. This is in addition to continued non pay pressures associated with Clinical Supplies and Drug costs

The Trust continues to formally report to NHSEI a forecast in line with the financial plan of a £4.6m surplus subject to financial risks including non-delivery of CIP remaining for the year, increasing inflationary costs and other potential cost pressures associated with winter.

The Trust is now forecasting to meet its in year CIP challenge of £17.3m subject to the delivery of schemes still in progress. Progress has also been made with regards to the recurrent CIP target of £12.5m with a further £0.6m identified in month and opportunities of £2.1m identified thus taking the total recurrent identified to £8m reducing the recurrent gap to £4.5m once opportunities have been transacted (£7.2m in M7). Any residual gap still not mitigated by the end of the financial year will be carried forward into 23/24 if not identified.

The value of activity in November was below the 104% target level (measured against the 19/20 activity baseline). In-month we achieved 99.5% and year-to-date the Trust is now at 97.7%. Note that these performance %s are inclusive of the outpatient follow-up adjustment.

Focus remains on the C & M ICB position as a whole and reporting requirements have increased.

Included in the year-to-date position are several areas to highlight:

- **Income £5.3m favourable variance to plan (including interest received)**
  - £3.6m favourable to plan for Cost and Volume drugs predominantly Cystic Fibrosis which is offset by additional expenditure.
  - £0.5m Isle of Man contracted income for a high cost Hemodialysis patient
  - £0.4m additional income from Health Education England
  - £0.7m additional income from Southport and Ormskirk Hospitals Trust for Dentistry Services transferred to Alder Hey

- **Pay £1.0m adverse variance to plan**
  - £0.4m pressure within the Medicine division for cost of sickness cover within HCA 1-2-1 care
  - £1.3m pressure within the Surgery division associated with waiting list initiative spend
  - Above is offset by vacancy slippage in other divisions

- **Non-Pay £3.3m adverse variance to plan**
  - £4.6m drug costs with 72% relating to pass through drugs and offset by income, but the remainder in drugs paid for as a block where activity has increased. Further investigation with the pharmacy team is underway with support from Clinicians.
  - £1.4m clinical supplies and other pressures offset by slippage in other areas and depreciation benefit £1.7m

- **Capital spend of £5.9m year to date.** Of this £5.0m is Capital Departmental Expenditure Limit (CDEL) spend which is £1.3m ahead of plan but will be in line with the forecasted position by the end of the year.

- **CIP achievement in month of £2.3m against a plan of £1.7m.** Therefore £0.5m above the required target for November.

- **Cash at the end of November was £84.2m**

- **Better Payment Practice Code achievement in month of 86% against the target of 95%.** A project is underway with action plan to improve the BPPC, and this is being monitored weekly by the senior finance team. The actions will result in a deterioration as older invoices are cleared but this will improve overall once complete.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday, 15th December 2022

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

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

December 2022

1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.
As of Month 3 in Quarter 3 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Highlights

- Old Histopathology works complete
- Team Prevent, H&S Team and Medical Records Team relocated
- Medical Record files moved off site into new storage facility
- Project Delivery
    - New Development structure proposed
    - Delivery policies to be proposed
    - Strategy being developed

3. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Cost Pressure due to market inflation, availability of labour and / or materials. SPV contract support	Letter of Comfort / Intent agreed with RABD and issued to MSC to secure early orders and design element, mitigating inflation risks. Target savings agreed with MSC to mitigate any future increase and maintain budget. Weekly liaison meetings held, deadlines raised in Trust/SPV liaison meetings, escalated within SPV team.
Sunflower House / Catkin	Quality issues Fire Compliance; Sprinklers	Holding back from Completion due to quality issues. Agreement made with GT and Trust to address concerns. Works planned to start on the 12th December 2022, with a planned completion of 8th February 2023. Reviewing sprinkler provision to car park with MSFR in terms of fire protection. Options being considered.
Temporary Modular Office (Alder Centre)	Programme delay	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works. Building Control visited

		site on the 8th December 2022 and are returning on the 14th December 2022 to inspect works. Anticipating approval will be provided within the next 3 to 4 weeks. Fire and water compliance anticipated w/c 19th December 2022.
Main Park Reinstatement	Vacation of Catkin, linked to Alder Centre Temporary Modular project.	Working up solutions to mitigate delay, minimise impact. Looking at park programme to make back time. Programme workshops held with Park Contractor to condense programme and complete within required timescales.

4. Programme Delivery Timetable

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

Table 1.	**21/22**				**22/23**			
Scheme	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Neonatal and Urgent Care Development Contractor Selection								
Neonatal and Urgent Care Enabling – Car Park								
Neonatal and Urgent Care Enabling – Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (Dec 2024)								
Sunflower House / Catkin Construction								
Catkin Occupation								
Sunflower House Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Police Station)								
Police Station Design								
Police Station Construction								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 1-100%) **COMPLETE**								

Main Park Reinstatement (Phase 2/3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Medical Photography / Orthotics **COMPLETE**								
H&S Move **COMPLETE**								
Team Prevent Move **COMPLETE**								
Medical Records Move **COMPLETE**								
Innovation Park 2 **COMPLETE**								
Fracture / Derm								
EDYS								
Surgical Day case								

5. Project updates

Neonatal and Urgent Care Development

Current status	Risks/issues	Actions
Phase 1 of the enabling works to create a temporary ED car park have completed. Phase 2 of the enabling works complete; service investigations. Phase 3 Blue light road diversion LOI and JCT issued to commence, started on site with site set up. Works started 5th December 2022. MSC engaged, LOC / LOI issued to commence contractor design element and place early orders. Phase 4 Service diversions provisional start date March 2023 Main build provisional start date April 2023, completion Dec 2024 Finalising contract documents and award.	Substantial cost increases due to market inflation, availability of labour and / or materials Project Co engagement extending the programme and increasing costs.	Letter of Comfort / Intent agreed with RABD and issued to MCS to secure early orders and design element, mitigating predicted inflation risks. Target savings agreed with MSC to mitigate any future increase and maintain budget. Continue working with Project Co to mitigate impact. Updated team at AH/SPV liaison meeting. Escalated within SPV.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Accepted takeover of Catkin element, Crisis team occupied and fully operational, clinics live within building. Agreed take over for Police station element, works inspected and accepted by Merseyside Police. Planning the signature of the lease and their occupation.	Quality issues being experienced on site. Fire Compliance; Sprinklers	Holding back from Completion due to quality issues. Agreement made with Contractor and Trust to address concerns. Works planned to start on the 12th December 2022, with a planned completion of 8th February 2023. Reviewing sprinkler provision to car park with MSFR in terms of fire

		protection. Options being considered.

Modular Office Buildings

Current status	Risks/issues	Actions
Larger unit by Alder Centre being provided by LOR; construction completed, furniture installed, commissioned ready for occupation. Smaller unit in Police Station car park being provided by Portakabin. Project on hold due to police station lease not in a position to sign; for takeover of the former police station.	Programme delay, alder centre modular Programme delay, police station modular	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works. Building Control visited site on the 8th December 2022 and are returning on the 14th December 2022 to inspect works. Anticipating approval will be provided within the next 3 to 4 weeks. Fire and water compliance anticipated w/c 19th December 2022. Programme delay due to delay in lease agreement for former Police station. Moves held and alternative accommodation agreed with users. Lease being fast tracked.

Police Station

Current status	Risks/issues	Actions/next steps
Lease documents with lawyers for checking ready for signature. RIBA Stage 3 complete, layouts agreed with Stakeholders and progressing to project sign off and contractor award.	Lease agreement.	Working closely with MP to progress lease.

Park reinstatement

Current status	Risks/issues	Actions
Phase 1 of the park is now operational. Grassed area re-seeded and grass recovering. High cuts and tidying being performed. Standing water being experienced, although improving. MUGA works commenced, frame being installed, liaising with LCC for lighting connection. Trim trail commenced, equipment on site ready for installation, first piece in position. Landscaping completed for Phase 2 with number of paths started. Play equipment being delivered to site in New Year in preparation for installation. Phase 3 started in sections in anticipation for Catkin demolition and main park works. Working with LCC and LPA on park lighting, Sub Station 5 and existing play equipment. Community engagement days held with park tours and presentations for local community. Programme being worked up for completion of the park, linking in with other key projects that release the land to enable park works to proceed. Aiming for an early hand back in Summer 2023, prior to backstop date of Nov 2023.	MUGA lighting Standing water being experienced Campus moves delay park	MUGA lighting utility connection being provided by LCC, working closely to ensure this is provided in time. Soil samples taken and results prove correct soil has been installed, although may have been over compacted. Ponding improving but not confident the issue is resolved. Further design reviews being held to understand issue. Propose rectification as next phase is constructed. Any issues to feed into next phases to ensure problems do not reoccur. Programme reviews held weekly to keep on top of all interdependent projects, with mitigations put in place, to ensure programme is kept on track. Current concern over Alder Centre Modular and potential delays, working through options to mitigate and limit delay impact. Programme workshops held with Park Contractor to condense programme and complete within required timescales.

NEW Mini Master Plan for Eaton Rd frontage

Current status-	Risks/issues	Actions
Revised, smaller proposal being drawn up, workshop being held to look at improving the Eaton Road frontage to wrap into the new park. Proposals being drawn up, with costings to follow for approval.	None	None

Innovation Park 2

Current status	Risks/Issues	Actions/next steps
Complete, commissioned and in occupation.	None	None

Fracture and Dermatology

Current status	Risks/Issues	Actions/next steps
Funding agreed, feasibility study and engagement starting.	None	None

Surgical Day Case

Current status	Risks/Issues	Actions/next steps
Funding agreed, feasibility study and engagement starting.	None	None

EDYS

Current status	Risks/Issues	Actions/next steps
Funding agreed, feasibility study and engagement starting.	None	None

Communications

Current status-	Risks / issues	Actions/next steps

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

6. Trust Board of Directors

The Board of Directors is requested to receive and acknowledge the update provided as of 15th December 2022.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 15th December 2022

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

Purpose of Paper:	Decision ☐ Assurance ☑ Information ☐ Regulation ☑
Summary / supporting information:	Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. NHS Patient Safety Strategy. NHS Improvement. July 2019. Never Events List (revised February 2021).
Action/Decision Required:	To note ☑ To approve ☑
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ☑ **The best people** doing their best work ☑ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☑
Resource Implications:	None identified

1. Purpose

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

2. Background

Serious Incidents (SIs) are adverse events where the consequences to patients, families, staff, or the organisation are so significant or the potential for learning so great, that a heightened level of response is justified.

The National Serious Incident Framework (NHS England 2015) describes the circumstances in which such a response is required and the processes and procedures to be followed, ensuring SIs are correctly identified, investigated and importantly, learning embedded to prevent the likelihood of the same or similar incidents happening again.

In line with National SI Framework, the Trust is required to report SIs to the Strategic Executive Information System (StEIS) and share investigation reports with commissioners. SIs that does not meet the StEIS criteria are discussed at the 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 Quality Boards, Clinical Quality Steering Group (CQSG), Safety and Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

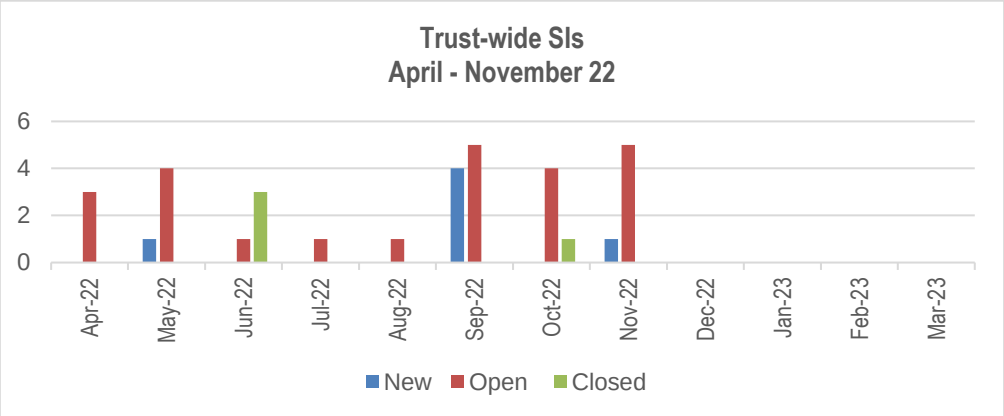
3. Local context

3.1 Never Events

The Trust declared **1** Never Event during the reporting period (1st – 30th November 2022).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status November 2022



3.2.1 Declared Serious Incidents

The Trust declared **1** StEIS reportable incident (Never Event – wrong side biopsy) during the reporting timeframe (1st – 30th November 2022).

3.2.2 Open Serious Incidents

5 SIs were open during the reporting period as outlined in table 1.
0 SI investigations were completed in this reporting period (1st – 30th November 2022).

Table 1 Open SIs September 2022

StEIS reference	Date reported	Division	Incident	Summary
2022/19971	14/09/2022	Surgery	Never Event – retained foreign object post procedure.	Refer to appendix 1 for detail
2022/20586	06/09/2022	Medicine	Staff exposure to highly contagious organism (*non-clinical).	
2022/20661	17/08/2022 (reported to StEIS 28/09/2022)	Surgery	Category 3 pressure ulcer under plaster cast.	
2022/20851	16/09/2022	Surgery	Patient death following discharge.	
2022/23391	10/08/2022 (reported to StEIS 02/11/2022)	Research	Never Event – wrong side biopsy.	

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 30th November 2022):

- **3** SI action plans remained open, of which:
  - **2** SI action plans are overdue their expected date of completion
  - **1** SI action plan is within the expected deadline
- **2** SI action plans sent to commissioners for closure
- **4** SI action plans were confirmed closed by commissioners

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

3.3 Internal level 2 RCA Investigations

The Trust declared **one** internal level 2 RCA investigations during the reporting timeframe (1st – 30th November 2022).

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 Duty of Candour response (1 final duty of candour response) was required and completed within expected timeframes during the reporting period (1st – 30th November 2022).

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 CQSG, 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.

The main themes identified from the closed SI action plans were:

- Lack of automated systems
- Lack of monitoring processes
- Communication barriers
- Education and training
- Lack of pathways

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

0 SI investigations were completed in the reporting timeframe (1st – 30th November 2022).

5. Next steps

- Review of open SIs with overdue action plans is being prioritised by divisions.

- Continued engagement and support are offered by the corporate governance team to aid SI action plan completion.

6. Recommendations

The Trust Board is asked to:

- Consider the content of the report
- Recognise the number of SI action plans that were completed in the reporting period
- Note the number of open and overdue SI action plans by division that require review
- Agree the level of assurance provided

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2022/ 19971	Never Event – retained foreign object post procedure.	Failure to follow the AfPP standard and NatSSIPs guidance for checking instrument tray prior to completion of a surgical procedure which led to a dental mouthguard being left in situ, being removed in the recovery room Anaesthetic screen not completed on EPR, resulting in incomplete information	Discuss with HR, Theatre Manager, Theatre Matron and Surgical Director. Failure to follow AfPP standards should be investigated in line with the Trust disciplinary policy/ NHSE Just culture. **November 2022:** Final report completed and sent to commissioners 01/12/2022. Final duty of candour completed. To be closed in December's reporting period.
2022/ 20586	Staff exposure to highly contagious organism (*non-clinical).	A HG3 organism can occur at any time in any patient Importance of checking clinical details before processing specimens. Adhering to the SOP Staff need to understand that a Class II cabinet at CL2 is not the same as Class I at CL3. Theatre team need to consider seeking specialist IPC advice if a patient has an uncommon infection. Documentation of the incident needed to be clearer and succinct	Culture plates moved into the CL3 room incubator, and the discard jar (used to aliquot etc) placed in autoclave tin in CL3 room for autoclaving prior to disposal. All further specimens were dealt with in CL3. All staff were informed of the situation. Staff at the local and national reference laboratory were consulted. Exposure assessment flowchart and exposure list issued by the reference laboratory was implemented. High risk staff were identified and given prophylactic antibiotics for 21days, and baseline bloods were tested. All low-risk staff were identified, list collated and information sheets given to all staff. Local Heath protection team were informed. **November 2022:** Panel held. Report drafted. On track to be

			submitted within the expected timeframe.
2022/ 20661	Category 3 pressure ulcer under plaster cast.	Standard practice was followed. No lapses in care identified.	Dressing applied to protect fragile skin integrity. Window cast applied for regular skin/ wound review. Wound has completely healed. **November 2022:** Draft report for approval in division.
2022/ 20851	Patient death following discharge.	Tabletop review 27/09/2022: Panel concluded that further detail and discussion with the family in relation to medication history, discharge plan and discharge documentation is required as part of the investigation process	Rapid Review undertaken by the surgical Division on the 20/09/2022. Case now subject to Coroner's inquest. **November 2022:** Second and final panel held. Draft report being written.
2022/ 23391	Never Event – wrong side biopsy.	Consent form did not stipulate body side to be operated on. Research trial protocol was not followed Handover from clinical fellow to surgeon not documented. No direct handover from research team to surgery team Site marking was carried out by the surgeon whilst the patient was on SALS. Unknown if the parents were involved in this site marking. Delay in reporting incident Lack of clarity and ownership for	**January 2022**: Trial company informed of wrong side biopsy: Trial monitor agreed biopsy could be used, with no requirement for further operation, deviation from protocol recorded on trial record and advised that an internal investigation into the error to be carried out by the Trust Timely investigation not undertaken due to delay in reporting of incident Commissioners/CQC informed: Never Event confirmed Requests for theatre slots now state body side and site Copy of the Muscle Biopsy alert form completed by research team/PI and biopsy request sent to Pathway Coordinator (PCO) surgical secretaries. Research nurse now involved in theatre huddle and handover to confirm the body side and site.

		undertaking review of case	PCO to ensure side and site is recorded on Amborder. If it not received in the request from the surgeon, it should be clarified with them before booking. Ward staff reminded to cross reference surgical site with consent form in line with WHO checklist. Theatre staff reminded to check site and side on consent form as part of sign in process. Rapid review to be shared with all teams involved to ensure learning is disseminated. Cross division incidents need a clear escalation/review pathway. **November 2022:** RCA panel held 24/11/2022.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Extension date agreed by commissioners
2019/23494	24/10/2019	25/10/2019	Medicine	Outstanding laboratory test results identified	All actions completed. Closed by commissioners 04/11/2022.	30/04/2020		N/A Closed by commissioners 4/11/2022
2021/1919	03/01/2021	15/01/2021	Medicine	Transfer from Bangor. Treated according to advice, patient suffered raised intracranial pressure requiring shunt	All actions completed. Closed by commissioners 04/11/2022.	30/04/2022		N/A Closed by commissioners 4/11/2022
2021/12203	27/05/2021	10/06/2021	Medicine	Deteriorating patient requiring transfer to HDU	All actions completed. Completed action plan Sent to commissioners 29/11/2022.	01/06/2022		N/A
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	2 actions outstanding. Action plan due for completion 30/11/2022.	30/06/2022	30/11/2022	Escalated to Divisional leads Weekly meeting with action owner in place
2021/25961	15/12/2021	21/12/2021	Medicine	Patient relapsed during receipt of active	All actions completed. Completed action plan sent to	31/07/2022		N/A

				leukaemia treatment	commissioners 29/11/2022.			
2021/17974	16/07/2021	01/09/2021	Medicine	Preparing child's case for discussion at national forum. Identified that care provided for eradication is outside of usual clinical pathway	3 actions outstanding. Action plan due for completion 31/01/2023.	31/08/2022	31/01/2023	01/11/2022
2021/12387	14/06/2021	14/06/2021	Community & Mental Health	Patient suicide whilst under care of CAMHS	7 actions outstanding. Action plan completion date TBC.	31/10/2022		Closed by commissioners 25/11/2022 but action plan remains open internally.
2022/2634	02/02/2022	04/02/2022	Medicine	Missed opportunity to diagnosis a patient.	All actions completed. Completed action plan sent to commissioners 29/11/2022.	31/12/2022		

Appendix 3

Learning from SIs		
StEIS reference	**Theme**	**Actions**
2019/23494 Outstanding laboratory test results identified.	Lack of an automated system	Funding application submitted to Cheshire & Merseyside Pathology Network for 'NPEx' system to allow for requests and results to be electronically sent and received in the Meditech system.
	Lack of monitoring processes	Frequent monitoring and recording of outstanding and unreported results system now in place Laboratory Medicine Performance Dashboard launched
	Communication with external referral laboratories	Introduction of regular communication pathways with external referral laboratories established ensuring tests, supporting clinical and interpretative information offered to Alder Hey clinicians is up to date, appropriate, and presented correctly in the Meditech EPR system.
SI 2019/1919 – Transfer from Bangor. Treated according to advice, patient suffered raised intracranial pressure requiring shunt.	Lack of pathways	The absence of an agreed paediatric specific clinical pathway across the North-West/North Wales for Idiopathic Intracranial Hypertension contributed to the delays experienced in this patient's management – Processes are now in place.
	Education and training	Knowledge gaps were identified resulting in an education/training programme to support clinical staff to recognise and manage cases of paediatric Idiopathic Intracranial Hypertension. This should initially be undertaken at Alder Hey with consideration how to disseminate this across the North- West and North Wales region.
	Communication	Communication breakdowns in relation to the recording of the telephone advice and the patient's clinical management – guidelines have now been put in place to mitigate risk of reoccurrence.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 15th December 2022

Paper Title:	**Quarter 2 2022/23 Complaints, PALS and Compliments report**
Executive Lead:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing

Purpose of Paper:	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q2 2022/23, a thematic analysis of the top reasons for complaints and PALS, action taken because of concerns raised, and achievements in Q2 2022/23.
Summary and/or supporting information:	40 formal complaints received in Q2 with 2 subsequently withdrawn therefore 38 in total (two out of time); this is a decrease compared to Q1 (46). The main complaint theme continues to be in relation to treatment and procedure with a total of 16 complaints (42%) received consistent with the previous quarter. The main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 8 of 16 complaints in this category (50%) and 21% of the overall 38 complaints received. This is consistent with the previous quarter 97% compliance with the 3 working day acknowledgement standard was achieved in Q2. Compliance with the 25 working day response time was 65% in July, 82% in August and 65% in September (average 71%) demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern. 4 second stage complaints were received in Q2 2022/23 There was one new referral to the Parliamentary & Health Service Ombudsman during this period in the Surgical division (received August 2022) There were 448 informal PALS concerns raised in Q2 2022/23; this is consistent with Q1. The main themes continue to relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff There has been a sustained improvement in responding to and resolving informal PALS concerns within 5 working days with an

	average of 82% compliance. This has a direct positive impact on families who raise a concern. PALS themes relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.
Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution and not having staff appropriately trained to locally resolve issues in their ward / department / service
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Delivery of outstanding care** **The best people doing their best work** Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	Trust Board are asked to note and approve the content of this report

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.

The aim of the report is to provide assurance that the Trust is responding to the concerns raised by children, young people, and their families in line with Trust procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO); identifying and analysing themes that the Trust needs to address to make service improvements; and to highlight action taken.

This report provides an overview of formal complaints and informal PALS concerns received and completed between July to September 2022 (Q2).

2. Formal Complaints

2.1 Number of formal complaints received Q2 2022/23

40 formal complaints were received in Q2 of which 2 were subsequently withdrawn (1 from Surgery; 1 from Community) resulting in a total of 38. 2 of these complaints are Out of Time complaints. This is a slight decrease compared to the previous quarter (Q1 2022/23) where 47 formal complaints were received of which 1 was subsequently withdrawn resulting in a total of 46.

Figure 1 shows a comparison of this quarter and the previous quarter (does not include withdrawn complaints); Figure 2 shows the breakdown of complaints received by Divisional services in Q2; Figure 3 shows the complaints received by month (does not include withdrawn complaints) over a rolling 12 month period. Of note a high number of formal complaints was received in August (23) however tis was balanced by a very low number in September (4); the number received aggregated across the two months is consistent with the previous number of complaints received.

Figure 1: Number of formal complaints in Q2 2022/23 compared to previous quarter

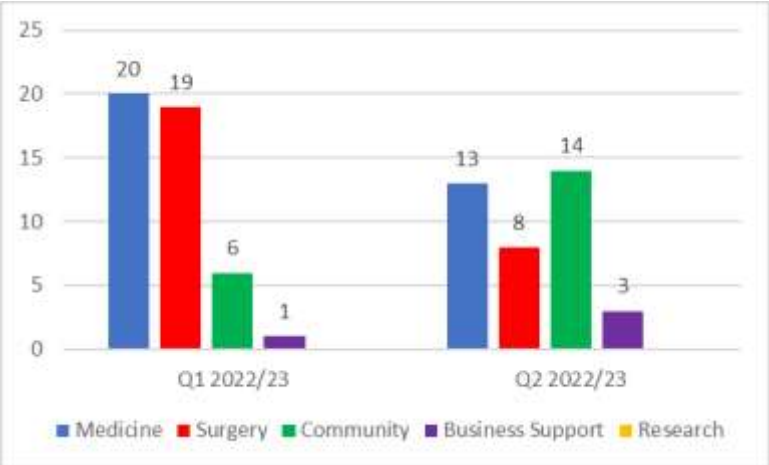


Figure 2: Number of formal complaints by Divisional services Q2 2022/23

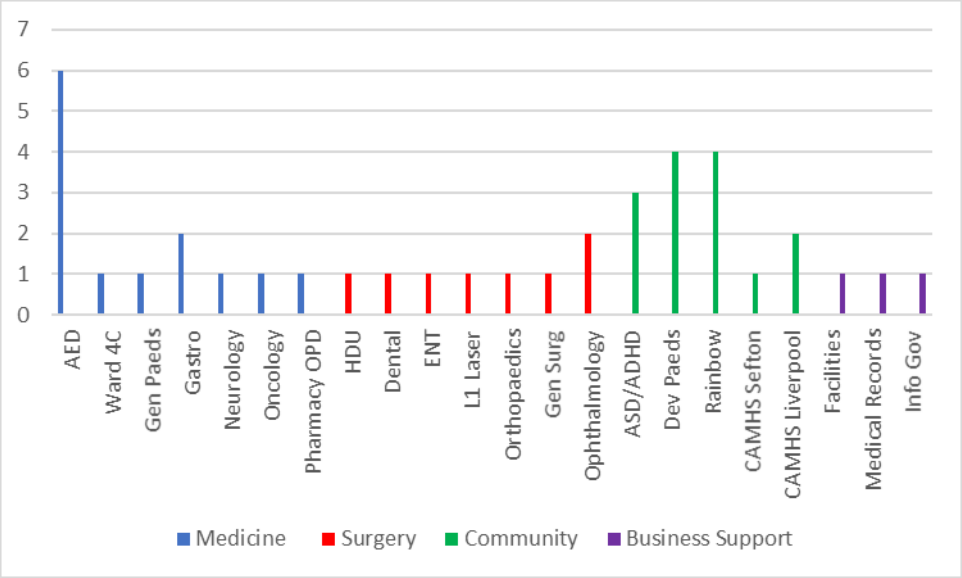
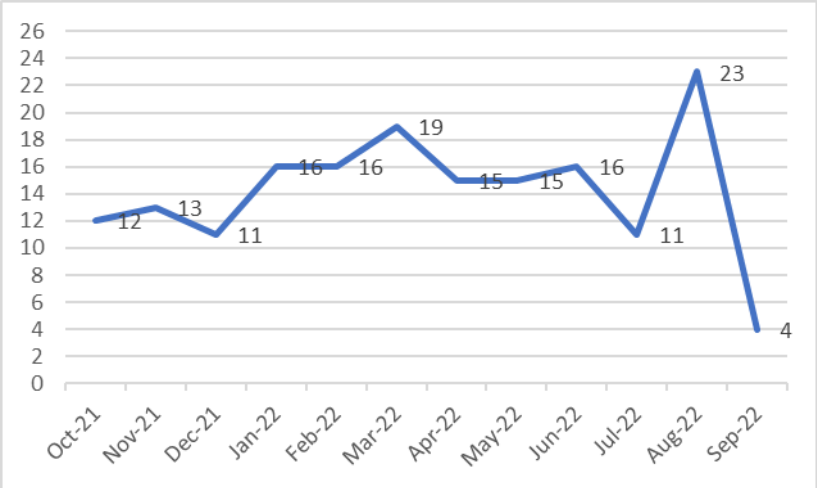


Figure 3: Number of formal complaints rolling from March 2021

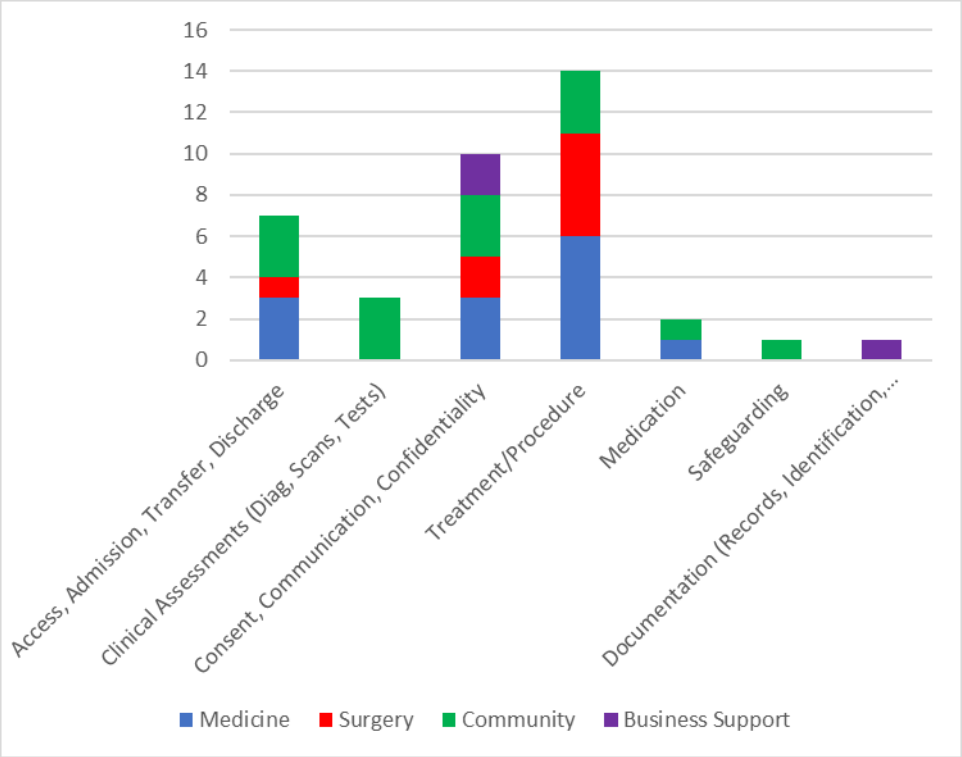


2.2 Complaints received by category Q2 2022/23

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

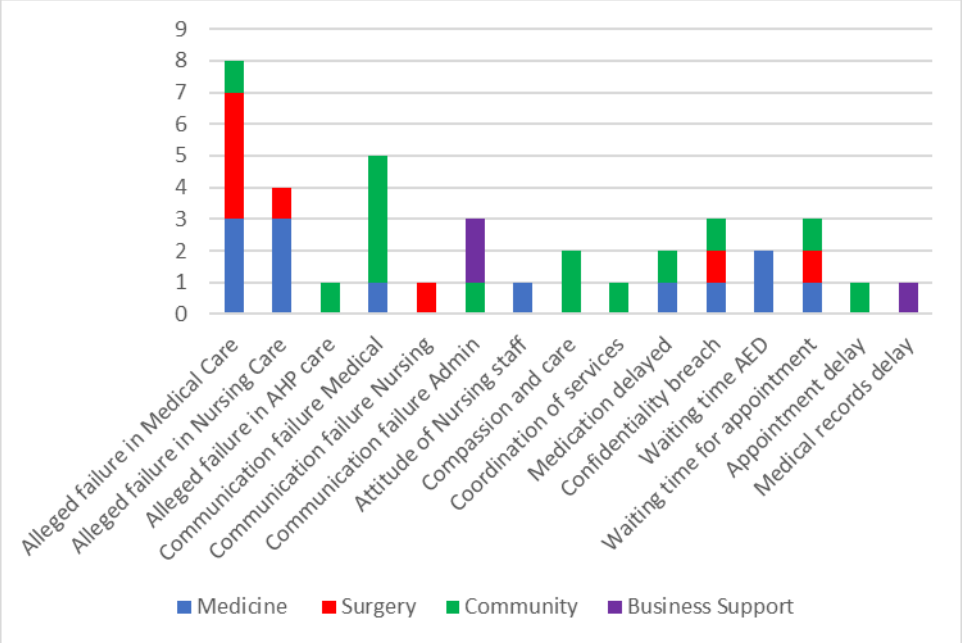
Figure 4 demonstrates that the main theme in this quarter continues to be in relation to treatment and procedure with a total of 16 complaints (42%) in Q2.

Figure 4: Primary categories of complaints Q2 2022/23



Sub-category identification provides further detail regarding the primary issues raised by families. Figure 5 demonstrates the main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 8 of 16 complaints in this category and 21% of the overall 38 complaints received.

Figure 5: Subcategories of complaints Q2 2022/23



2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

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

2.3.2 Compliance with 3-day acknowledgement Q2 2022/23

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

In Q2, 97% (39 of 40) of the formal complaints received were acknowledged within 3 working days, with 31 being acknowledged on the same day demonstrating consistently high standard. The complaint which was not acknowledged in time was due to a matter requiring clarification. Figure 6 and Table 1 shows performance with this KPI over a rolling 12 months which demonstrates the journey of improvement

Figure 6: Percentage of complaints acknowledged within 3 working says over a rolling 12 month period

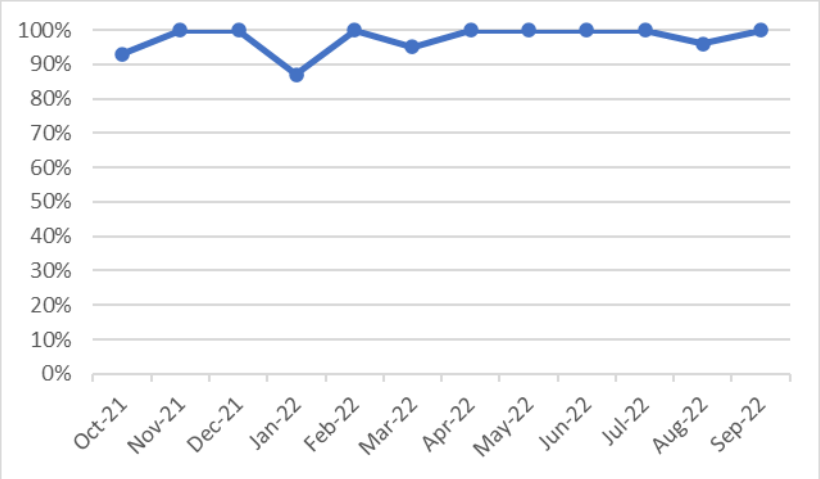


Table 1: Compliance with 3-day acknowledgement for a rolling 12 months (includes withdrawn complaints)				
Reporting period		**Total complaints received**	**Total number acknowledged within 3 working days**	**% number acknowledged within 3 working days**
Q3 21/22	Oct	14	13	93%
	Nov	14	14	100%
	Dec	11	11	100%
Q4 21/22	Jan	16	15	87%
	Feb	19	19	100%
	March	20	19	95%
Q2 22/23	Apr	15	15	100%
	May	15	15	100%
	June	17	17	100%
Q2 22/23	July	12	12	100%
	Aug	24	23	96%
	Sept	4	4	100%

2.3.3 Complaints responded to and closed in Q2 2022/23

A total of 43 complaints were responded to and closed in Q2 (not inclusive of complaints closed due to withdrawn) of which 27 were received during Q2 and 16 were received in Q1.

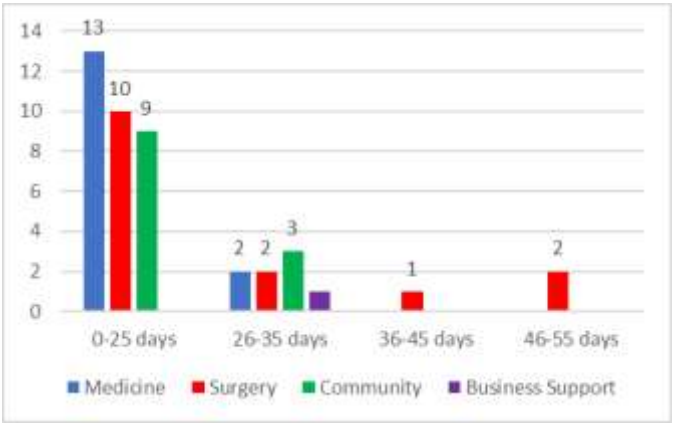
2.3.4 Compliance with 25-day response

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

Of the 43 complaints responded to in Q2, 32 were responded to within 25-days as demonstrated in Figure 7 which is a sustained improvement with this KPI.

Of the 11 complaints that remain open and under investigation (all received within Q2), 5 were within the 25 day timeframe at 1st October 2022 and 6 were overdue.

Figure 7: Compliance with 25-day response – complaints responded to in Q2



Improving the time to respond to families in a timely manner is a continued Trust and Divisional priority. The journey of improvement within Divisions in the past 6 months, can be identified by the sustained shift to the left in the response times illustrated in Table 2 below. The longest time to respond to a complaint in Q2 was 49 working days. Medicine Division achieved 86% compliance (13 of 15); Surgery Division achieving 66% compliance (10 of 15), and Community achieving 75% compliance (9 of 12). Business Support did not meet the timeframe on the 1 completed response therefore 0% compliance.

Table 2: Compliance with 25-day response for a rolling 12 months

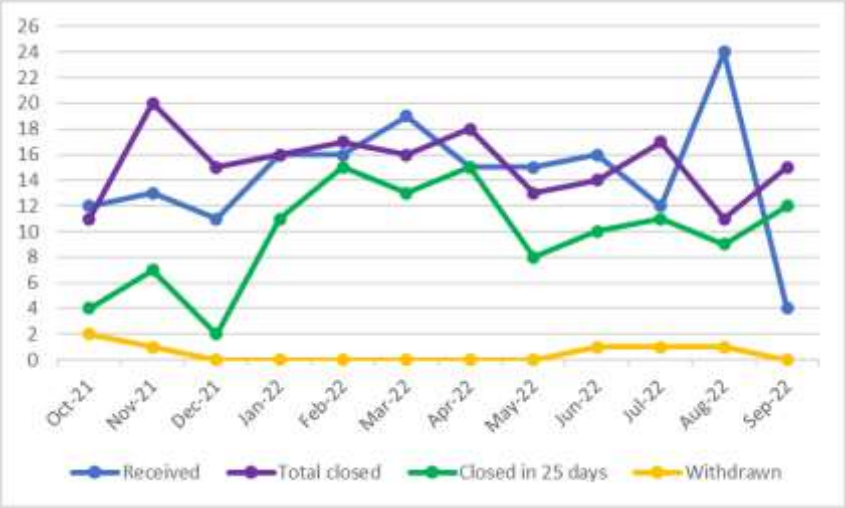
Number of complaints responded to in 2021/22 by Quarter by Division (does not include withdrawn)			Days								
			0-25	26-35	36-45	46-55	56-65	66-75	76-85	86-95	96 -121
Q3 21/22	Medicine	15	3	8	3						1
	Surgery	13	9	3	1						
	Community	7	4	3							
	Business Support	1	1								
Q4 21/22	Medicine	10	9	1							
	Surgery	10	9	1							
	Community	11	11								
	Business Support	1	1								
Q1 22/23	Medicine	18	15	3							
	Surgery	18	11	4	3						
	Community	8	6	2							
	Business Support	1	1								
Q2 22/23	Medicine	15	13	2							
	Surgery	15	10	2	1	2					
	Community	12	9	3							
	Business Support	1		1							

As complaints are often not received and responded to within the same month or quarter of the year, Figure 8 shows the number of complaints received in month, the total number closed

in month and the number responded to within 25-days. The graph also shows the number of complaints withdrawn.

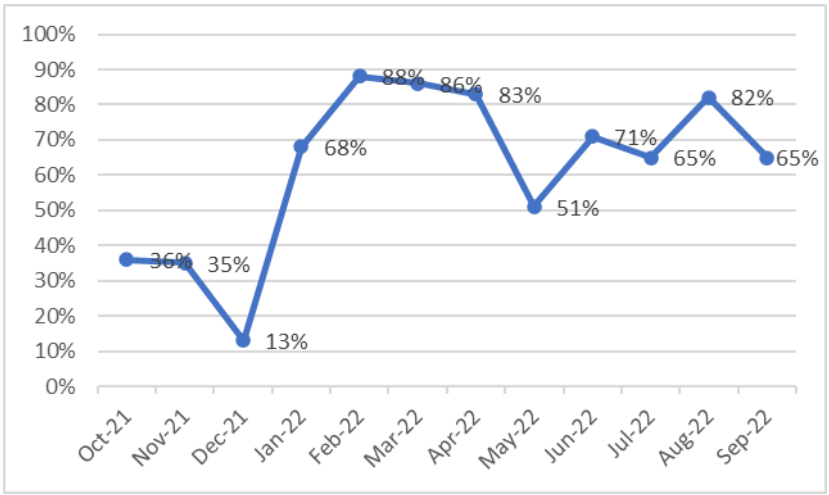
Figure 9 shows the percentage compliance with the KPI by month for a rolling 12 months, overall demonstrating the continued journey of improvement. In Q2 compliance was an average of 71%.

Figure 8: Comparison of complaint number with 25-day response for a rolling 12 months



NB: Withdrawn complaints are not included in the 'received', 'total closed', or 'closed in 25 days' figures and only depicted in the 'withdrawn' figure

Figure 9: Percentage of complaints closed within 25-day response rolling 12 months



2.3.5 Number of open and closed formal complaints by month

Table 4 shows that as at 1st October 2022, there have been 87 formal complaints opened in 2022/23 of which 3 were subsequently withdrawn resulting in 84 new complaints in 2022/23. 88 have been closed and there are 11 open first stage investigations. 9 closed complaints have been reopened at second stage. Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 4: Formal Complaints received 2022/23 40													Cumulative to date
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received (includes withdrawn)	15	15	17	12	24	4							**87**
Withdrawn and closed	0	0	1	1	1	0							**3**
New complaints (adjusted from withdrawn)	15	15	16	11	23	4							**84**
Open (first stage)	3	2	19	10	7	11							
Investigated, responded to and closed	18	13	14	17	11	15							**88**
Re-opened (Second stage)	1	1	3	*(1)	2	2							**9**

**Initially reopened in June; paused and reopened in September. Not included in overall number to avoid double counting*

2.3.6 National complaint reporting: Review of the frequency of the KO41a secondary care complaints collection and publication

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.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.

In July 2022, NHS Digital advised that considering the organisational restructure taking place across the NHS in 2022-23 and other factors affecting the KO41a return, they are currently reviewing the collection and publication cycle for the 2022-23 year. Primarily, they are looking to move to a single, annual collection and publication. They will be engaging with users to fully understand the impact of any suggested changes and users will be notified of changes as soon as possible after the review has been completed.

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 Q2 10 (23%) of complaints were not upheld; 8 (19%) were partially upheld, and 25 (58%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 10 shows the outcome of complaints closed in Q2 by Division; Figure 11 shows the outcomes for the trust overall on a rolling quarterly basis. This demonstrates that the majority of complaints investigated and responded to are consistently fully or partially upheld.

Figure 10: Outcome of 43 complaints closed in Q2 2022/23

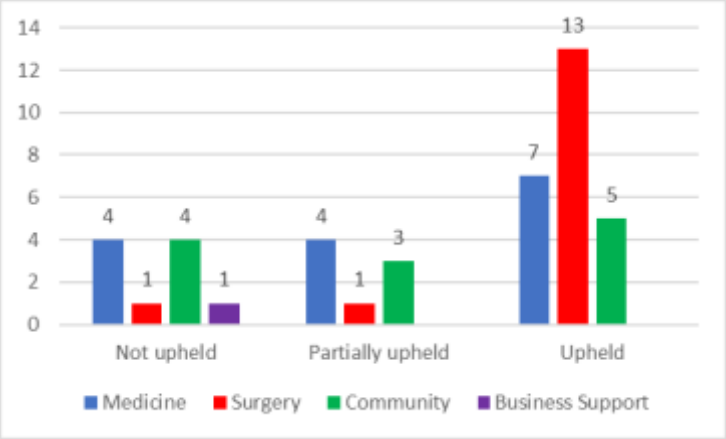
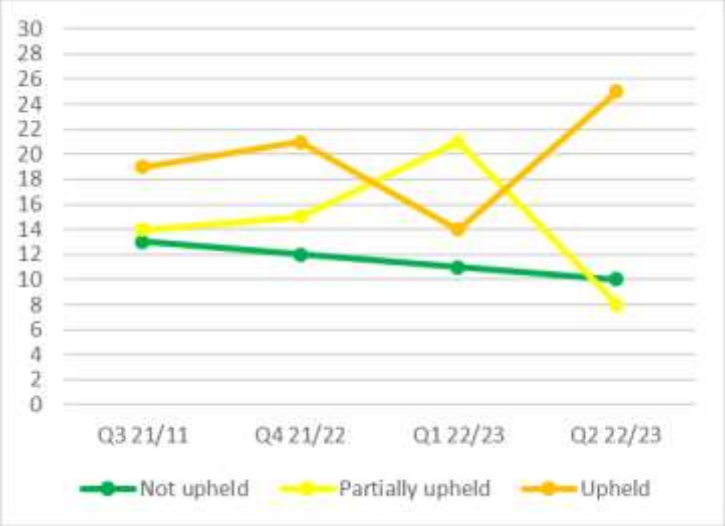


Figure 11: Outcome of complaints closed by rolling quarter



2.4.2 Second stage complaints

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

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

In Q2, 4 families informed us that they were not satisfied with the outcome of their initial complaint response; all were received in Q2. One each relate Division of Surgery, Medicine, Community and Mental Health, and to Business Support. A second stage complaint re-opened in June 2022 was paused until September 2022 in agreement with the family to annual leave and clinical commitments.

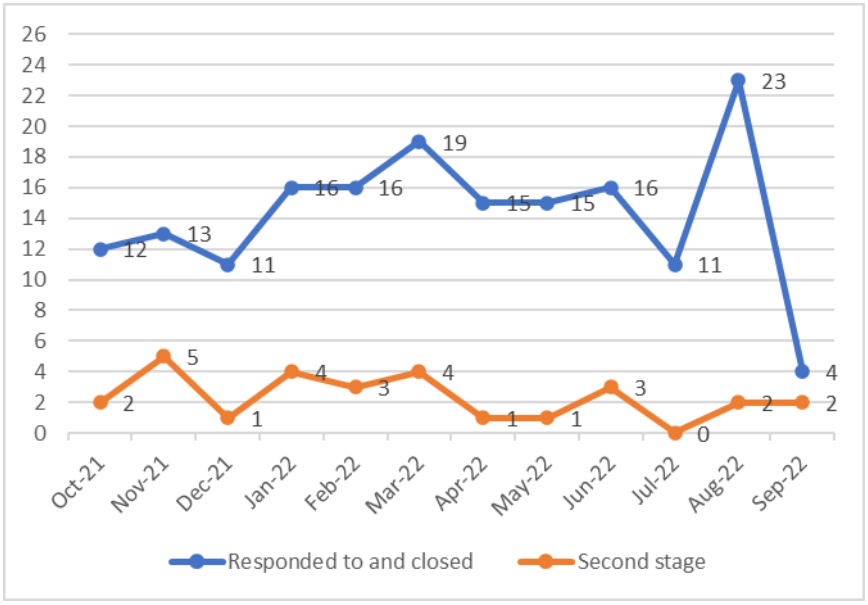
Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response.

100% (4) were acknowledged within 3 working days. All remain open at time of reporting.

This is an overall high level of satisfaction with the quality and content of the initial complaint response, however there is a need to continue to monitor and review the reasons why families remain dissatisfied to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter. However, Figure 12 shows the comparison of monthly initial complaints and monthly second stage complaints received for a rolling 12 months

Figure 12: Comparison of initial formal complaints responses with complaints re-opened at second stage for a rolling 12 months



2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There was one new referral to the Parliamentary & Health Service Ombudsman during this reporting period (received August 2022) and the PHSO have advised the Trust of their

intention to investigate this complaint relating to the Division of Surgery. There are no other open PHSO 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. A clear breakdown of all actions is included 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) each month to ensure Trust wide learning.

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

Medical Division:

Concern: Availability of appropriate medical devices
Action: The Emergency Department to stock a wide variety of fracture boot sizes.

Concern: Poor experience and planning for an appointment
Action: Liaise with the Learning Disability team to ensure the family can access appropriate support for future appointments.

Lessons learned:

- When a new complaint is received, it is important to clarify with the family, the preferred process for managing the complaint
- To ensure the reason for making a referral to the safeguarding team is clearly communicated to families
- Delays in appointments cause anxiety and worry. Increasing clinical symptoms should be taken into consideration whilst on the waiting list
- Information Governance issues raised by patients and families should be investigated immediately and they should be contacted with assurance the issue has been resolved
- Referrals should be checked before being sent from Alder Hey to ensure they contain the correct patient information
- Ward staff to contact the Learning Disability team at the earliest opportunity to support a child with ASD on the ward

Surgical Division:

Concern: Parent did not receive clear information regarding isolating and visiting when patient tested positive for Covid 19
Action: A patient/parent information leaflet will be produced by IPC team which will provide families with all practical information in relation to isolating with their child if they test positive for COVID 19.

Concern: There were a number of communication failures (covid isolating, visiting) and poor experiences of poor patient experience (no toys, cleanliness of room, availability of nappies) Parent was not provided with contact details for PALS

Action: The Ward Manager shared the families experience at a Ward Meeting. Ward now has visible details about how to access the PALS service.

Concern: Medication error

Action: Undertake unannounced observations and audits during the medication round, sharing the findings for learning.

Lessons learned:

- Test results must be delivered to families in a caring and compassionate manner
- Families should be directed to specialist support services
- Parents should be fully informed of the details of any diagnosis and their understanding should be clarified
- Communication and direction from Alder Hey to District General Hospitals needs to be clear
- The importance of explaining waiting time to parents and the process for escalating concerns
- If indicated, the Neurosurgical team will aim to arrange ophthalmology input while patients are an inpatient, if this is possible
- Need to improve communication between referring clinicians and the Radiology team.
- The team will be more vigilant in checking patient labels are correct before issuing prescriptions
- The importance of learning from clinical incidents

Community and Mental Health:

Concern: Delay in repeat prescription

Action: For some medications there can be health implications when there is a break in administering medication; it is therefore important to seek clinical advice before putting a hold on a prescription request. Where we are unable to meet the agreed timeframe for issuing prescriptions, it is important the parent/carer is notified of this and the reason for the delay and a plan agreed together. Ensure that this complaint is shared with the Developmental Paediatric Prescription team to ensure these lessons are imbedded.

Lessons learned:

- All relevant colleagues should be aware of recent change in the safeguarding guidance that discussions should be held with parents more openly
- Young people approaching transition age need to have clear plans in place for care up to, during and post discharge from paediatric services
- For patients with a Learning Disability and/or additional needs, more consideration is needed in regard to transition and the impact this will have on the young person and their family/carers
- In order to manage expectations, accurate waiting times need to be communicated to parents/carers

2.7 Healthwatch

Healthwatch Liverpool and Healthwatch Sefton are key members of the Patient Experience Group 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. No issues have been raised in Q2.

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q2 2022/23

There were 448 informal concerns received during Q2, consistent with the previous quarter (437)

Figure 13: Number of PALS concerns by rolling 12 months

Figure 14 shows a comparitive breakdown of informal PALS concerns by Division for this quarter and last quarter. Figure 15 shows the highest number of informal concerns raised by services in the Divisions; this enables Divisions to identify areas that potentially need additional support or deep dive.

Figure 14: comparative number of informal PALS concerns by Division Q4 2021/22 and Q2 2022/23

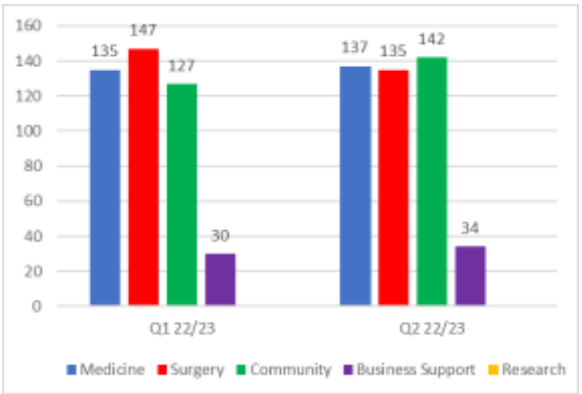
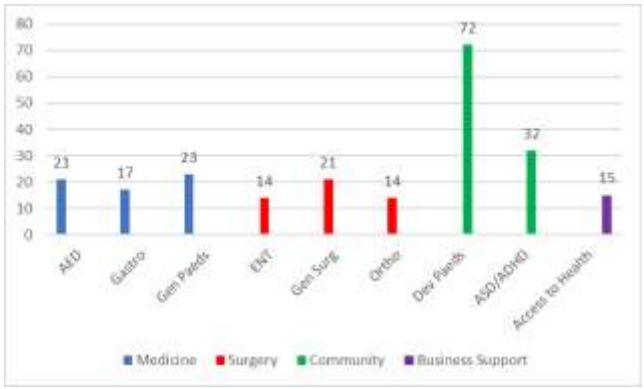


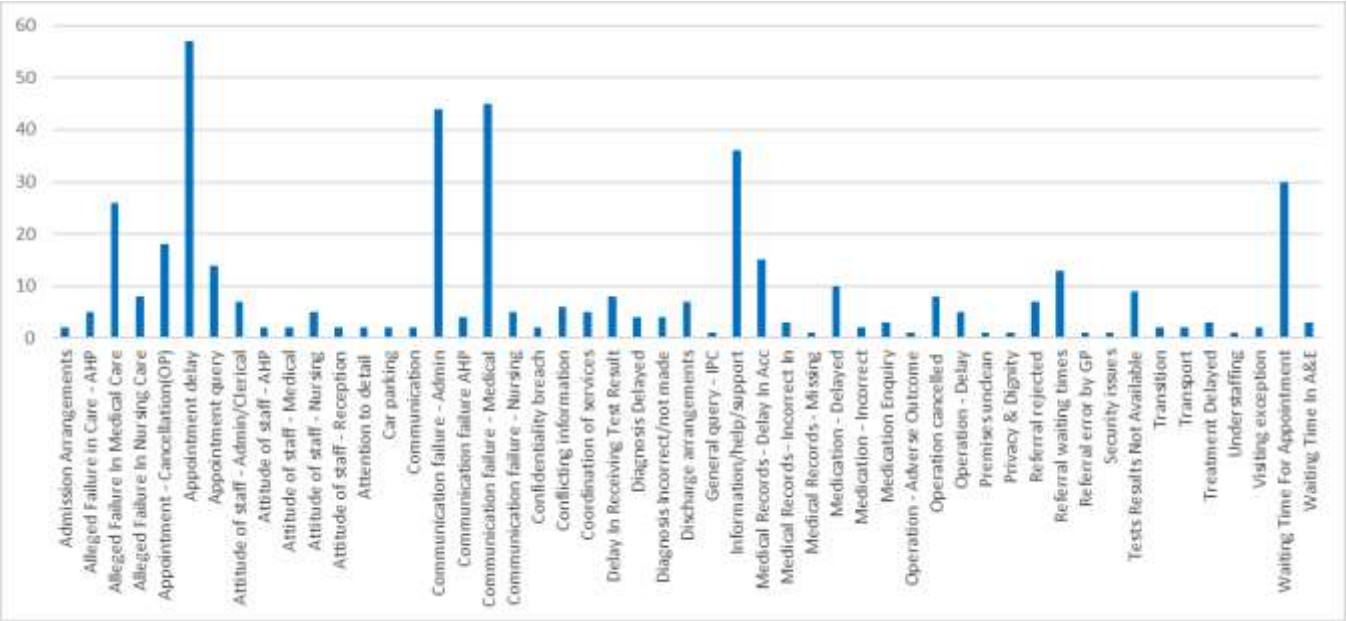
Figure 15: Services by Division with highest number of informal PALS concerns raised



3.2 Informal PALS concerns received by category Q2 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 Q2 relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff as shown in Figure 16. The category of Information / Help / Support, has been reviewed and removed from August 2022 to provide greater clarity of issues.

Figure 16: Category of informal PALS concerns Q2 2022/23



The number per category is consistent with the previous quarter.

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

The timeframe to resolve PALS concerns is 5 working days. There has been sustained progress with this KPI throughout Q2 as demonstrated in Figure 17 which shows compliance between 80% to 88% (mean 85% for Q2). The graph in Figure 18 shows the comparison of number opened, closed and closed within 5 days

Figure 17: Percentage compliance with the 5-day PALS response rolling 12 months

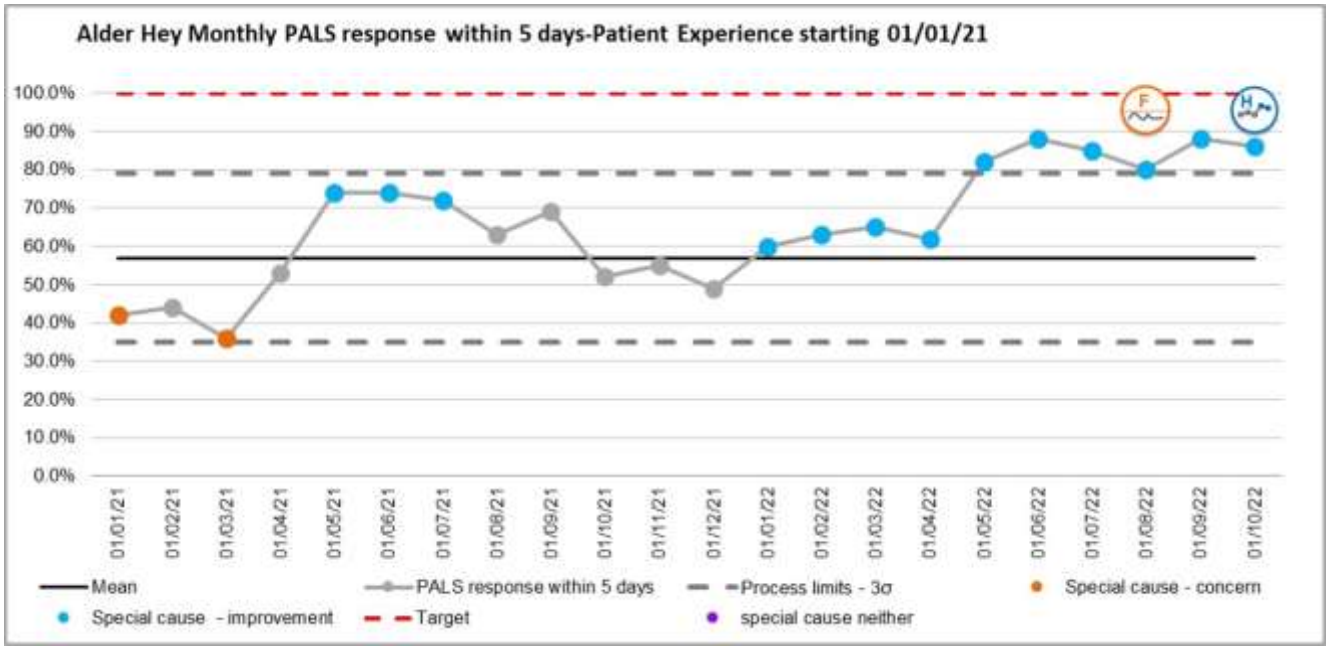


Figure 18: Comparison of PALS number with 5-day response 2022/23

Of particular recognition is the achievement of 98% compliance throughout Q2 by the Surgical Division and 95% compliance by the Medical Division as demonstrated in Figure 19 and Table 5. The whole team, including nursing, medical, operational, risk and governance, complaints and PALS, and Patient Experience, have worked together collaboratively to ensure patients and families have received a timely and supportive resolution to their concerns, and understand that the most important factor in the management of PALS concerns is to assist our families and resolve their concerns. Timely management also enables earlier identification of actions, lessons learned and potential improvements to benefit all of our patients and families.

Figure 18: Percentage compliance by Division 2022/23

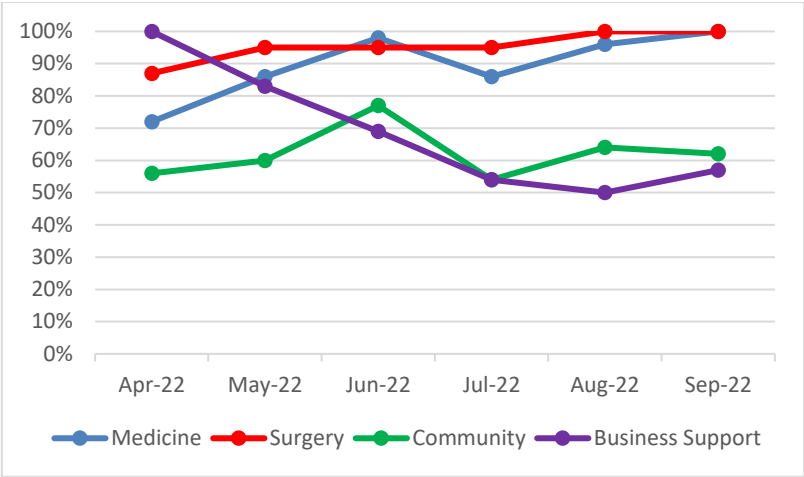


Table 5: Compliance with 5-day response to PALS concerns in Q2			
PALS	**Received Q2 2022/23**	**Closed within 5-day response**	**Ongoing and within 5-day response**
Medicine	137	134 of 141 (95%)	6 of 6 (100%)
Surgery	135	132 of 134 (98%)	4 of 4 (100%)
Community	142	85 of 143 (59%)	13 of 19 (68%)
Business Support	34	16 of 31 (52%)	0 of 7 (0%)
Total	**448**	**367 of 449 (82%)**	**23 of 36 (64%)**

A new PALS process outlining clear roles and responsibilities was agreed in April 2022 and is included in the revised Complaints and Concerns Policy. Divisions have also implemented local monitoring of both formal complaints and informal PALS concerns with weekly review by the PALS & Complaints Officers and Risk & Governance Leads and weekly escalation to the appropriate Associate Chief Nurse as required. These strategies are having a positive impact on compliance and timely resolution for families

3.4 Historic PALS

In May 2022, it was identified that there were a significant number of historic PALS concerns pre-dating this year / and or over 100 days; the Director of Nursing raised the issue with the Divisions and 177 historic PALS concerns were reviewed and closed as shown in Table 6. These concerns date back to 2019.

Table 6: Historic PALS closed		
Medicine	Number closed	57
	Range days to close	164-845 days
Surgery	Number closed	119
	Range days to close	154-851 days
Community	Number closed	0
	Range days to close	NA
Business Support	Number closed	1
	Range days to close	202 days

In October 2022, it was identified that historic PALS pre-dating 2019 remained open, and Business Support concerns remained open; the Director of Nursing has raised the issue with the Divisions and Business Support managers directly to review and close. 385 historic PALS concerns dating back to 2014 require review and closing as shown in Table 7.

Table 7: Historic PALS open											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	Date not known	Total
Medicine	1		13	106	60					10	**190**
Surgery			3	20	35						**58**
Community											**0**
Business Support	1	6	14	26	32	16	15	17	10		**137**

There is a high degree of confidence that such legacy issues could not happen again as there is robust oversight and scrutiny of PALS management at both Divisional and Corporate level.

4. Compliments in Q2

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful, impactful and valuable feedback, and demonstrating that a child, young person or their family feel compelled to voice and share this with us by taking precious time to share what has been good about their experience and the impact that care and treatment has had on their lives. This feedback also provides important balance with concerns raised.

There is currently limited information recorded in the central Ulysses system regarding compliments although it must be noted that the Community Division continue to input the majority of compliments as shown in Figure 19 below. It is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit. Examples of compliments can be found in Appendix 1.

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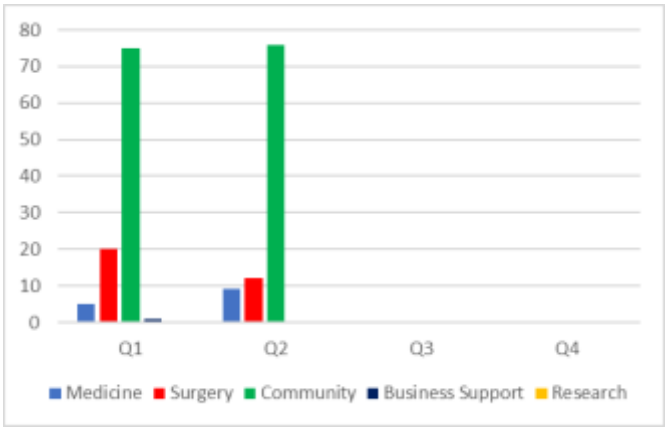
Figure 19: Compliments recorded in Ulysses in Q2



5. Conclusion

This report provides assurance to Trust Board of the continuing improvements in responding to the concerns raised by children, young people, and their families. Continued progress has been made during Q2 in regards to responding to the concerns of families in a timely manner and achieving key performance indicators.

There has been sustained improvement across KPI's, including 97% compliance with acknowledging formal complaints within 3 working days, 71% of formal complaints responded to within 25 working days, and 82% of informal PALS concerns resolved within 5 working days. This has a direct positive impact on families who raise a concern.

An issue was identified regarding historic PALS concerns however this has been addressed in the main from 2019 and remaining PALS that remain open on the system are being reviews and closed. The identification of this issue provides assurance of the increased scrutiny and enquiry deployed.

Appendix 1: Examples of compliments Q2 2022/23

Medicine Division

AED: *" My daughter came today at 7.50am and was in for a few hours, I would just like to say the doctor, and the nursing staff was unbelievably good with her. Was outstanding how well they looked after her, I really hope this message reaches them to say thank you, also the play nurse and the sensory toy boxes are a life saver and made the visit so much more easier as my daughter was very unwell. Thank you"*

EEG: Child underwent a repeat Video Telemetry using a different methodology of electrode application. Both the patient and family sent a compliment around how better the experience was second time round due to the new way of applying the electrodes

Speech & Language Therapy: Mother came to PALS office today as she wanted to say how amazing her son's speech and language clinician had been. Mother said her service has been *'amazing'* and that both her son and Mother have received *'life changing support'.* She wants to thank the staff member and said that her hard work has *'opened up her son's world.'* Mother was very appreciative and could not thank the clinician enough.

MRI: Thank you card received*: "Thank you for going above and beyond to make our daughter feel safe and for helping put us at ease during her scan - we are forever grateful"*

Surgery Division

Audiology team: ***"****I would like to pass on my compliments to the Audiology Team, firstly thanks for identifying a suitable appointment. My son attended appointment with minimal waiting. The Audiologist and Nurse Specialist were friendly and welcoming, they introduced themselves and engaged with my son throughout, fully explaining the procedures and the reassuring outcome to us both. Useful information was given on improving listening skills and this was followed up with an information leaflet".*

Theatre and Urology teams: Family expressed their thanks and appreciation for the wonderful care their son received from the doctors and all the theatre staff while their son was in surgery.

Surgery team: Summary compliment from a family via e-mail:

"I thought I'd give you all an update on my son who started pre school. I'm thankful and grateful, that my son has the opportunity to do all these things, and that is all down to you guys. We cannot thank you enough for all the care and support he has received to date. It's been life changing. I will for ever be thankful. He pushed through today to the front on the que at nursery and walked in, not even turning to say bye to me. Another milestone my son has smashed!!!!"

Community Division

Community Speech & Language: The mother of a child known to the Community SLT team sent an e-mail to the Speech and Language Therapist with an audio recording attached from their son thanking the therapist for the speech therapy sessions he has received. The audio recording said: *"Thank you for finding my voice Rebecca and I guess I make you laugh. Bye".* The mother also sent her appreciation for the efforts given to help their son's speech so he can communicate his thoughts and ideas with them

CAMHS – Liverpool: 11 year old patient has written staff member a poem to thank her for her hard work and kindness:

"To Kat
Thank you so much for being here from start to finish,
The one thing about your heart was that it had kindness in it,
Thank you for making me smile your one of the nicest people I've met in a while.
Now we say goodbyes and hugs but remember you will always be a shining star wherever you are."

Eating Disorder Service (EDYS): Email received from parent with an update on how brilliant previous service user is doing:

"Hi there, I'm wondering if this could please be passed to Nadia – also all the other amazing people who helped X in her recovery.

I just wanted to let you know that almost a year after being discharged from the service, X is doing so, so well. She manages her own food - with me discreetly keeping an eye on it! - and is very fit and very healthy. I've attached some pictures of X from her recent prom - she looked stunning and, most importantly, felt beautiful. We've recently returned from a week in Rome where X ate all the pasta and cheese and cakes she could manage!

I want to say the biggest thank you for not only saving our daughter's life but setting her free from such a debilitating illness and giving her the promise of an amazing future.

X is a confident, happy girl with so much self-belief and inner strength. She is now considering studying sports psychology at university after her A levels in two years, and I'm certain this is in no small part thanks to the fantastic care she received at EDYS. She understands how destructive an eating disorder can be and how crucial nutrition and self-care are.

Nadia, we will never forget you, and will forever be grateful for your expertise, kindness and robustness. You are a very special doctor."

Complex Discharge Team: Team lead from Complex Discharge team has been supporting a family who were discharged earlier in the year to move into more suitable accommodation to meet the complex health needs of the young person. With the support in place and regular contact with local services - the family have been rehoused and the mother sent an email to thank

"Thank-you for your help to get a family home for us with housing, we would like to inform you we have now move into a 3 bedroom bungalow in x about 20 mins away from we're we live before. The bungalow has everything we need for X and his sister, we (move) on the 26 July 2022. I would like to thank you again for all your help."

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 15th December 2022

Paper Title:	**Highlight report – People Plan**
Report of:	**Chief People Officer**
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	None
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.1, 2.2, 2.3

1. Introduction

The purpose of this paper is to provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during November 2022.

2. People Metrics

Staff availability and turnover continue to be two areas of particular focus in respect of the people metrics.

Turnover has increased Trust wide in-month and ongoing analysis has been undertaken to identify and plan appropriate action with the areas with highest turnover. Quarterly reports on Turnover are provided to People and Wellbeing Committee and a task and finish group (a subgroup of the Attraction and Retention group), has been established to review Trust wide actions/support required.

Sickness absence remains above target with an increase in in-month position of over 6%, remaining higher than the Trust target of 5%. This has also required additional analysis to identify areas of concern with appropriate support measures and/or interventions put in place.

PDR's for senior colleagues has remained static at 85% completion, and work is underway to ensure all staff receive their PDR by the end of March '23.

Are We Well Led?
People Section: HR Metrics

Trustwide
Workforce Headcount: 4,171

	KPI	Target	Sept 22	Oct 22	Nov 22
Absence	Sickness Absence (in month %)	5%	5.53%	5.90%	6.40%
	Short Term Sickness Absence (in month %)	2%	1.95%	2.72%	2.75%
	Long Term Sickness Absence (in month %)	3%	3.58%	3.17%	3.65%
	Return to Work Completion (in month %)	100%	66.16%	66.36%	75.13%
Turnover	Staff Turnover (rolling 12m %)	10%	14.09%	14.56%	14.82%
	Leavers (Headcount)	-	28	51	40
	Time to Hire (pre-employment checks)	30 days	37	39	40
Diversity	Proportion of BAME Staff in Workforce (in month%)	-	9.85%	10.22%	10.40%
Pay Accuracy & Spend	Pay Accuracy (%)	99.5%	99.36%	99.37%	99.33%
	Value of Overpayments (£)	-	£13,650.82	£39,316.53	£45,240.05
	Temporary Spend (£'000s)	-	£1,439.53	£1,319.68	£1,509.98
Training & Appraisal	Mandatory Training (in month)	90%	92.52%	92.38%	92.22%
	PDR band 7+ (from 01/04/2022)	90% (by end of July 22)	81.12%	84.65%	85.14%
	PDR all AFC (from 01/08/2022)	90% (by end of March 23)	38.37%	45.35%	49.37%
	Medical Appraisal (from 01/04/2022)	90% (by end of March 23)	81.53%	83.82%	87.04%

3. Staff Survey

The annual Staff Survey closed on 25th November 2022 with a response rate of 54%. It is anticipated that initial feedback will be received by the Trust 9th December 2022.

4. Industrial Action

As a result of the recent ballots, RCN will call their members to take strike action at Alderhey on 15th and 20th December 2022. Services that are 24hrs service will commence strike action at the beginning of the day shift until the start of the night shift, for those services not 24 hours, strikes will last from 8am to 8pm. There may be future dates to be announced by the RCN in the new year, with the possibility of discontinuous industrial action up to May 2023.

UNISON did not meet the threshold for strike action at the Trust. The Chartered Society of Physiotherapists ballot closes on 12th December 2023 and the BMA have suggested they will ballot junior Drs in January 2023.

The Trust has in place the Tactical/Gold command structure, headed up by the Chief Operating Officer/Chief Nurse. These twice weekly meetings will increase in frequency to daily meetings week commencing 12th December. Manger Q&A and All staff Q& A sessions have taken place and SALS support continues to be offered to all staff.

The first meeting with the local strike committee has taken place, and initial discussions have been productive. Regular meetings will also be scheduled with the local strike committee as derogations are agreed.

5. Financial Wellbeing

We have started to look at what we might be able to do, practically, to best support those colleagues who will feel the pressure of the cost-of-living crisis most acutely. This will include:

- Fixed pay date: we will now be paid on the 27th of each month, helping colleagues to manage finances more effectively. This will start from November.
- Rapid access to Citizens Advice Bureau advice/support/guidance, available through SALS
- 25% discount for staff in Alder Hey Charity Shops; all you need to do is show your Alder Hey staff pass
- Buy a 'Blue Light Card' for £5 and claim the full cost back through the Trust's expenses system. A Blue Light Card gives access to significant discounts across a range of retailers, including supermarkets

We are developing an online hub which will have details of support available, as well as special offers, discounts, and what support is available from Trade Unions. It will also include details of how to apply for an interest free loan to support the purchase of a Merseytravel season ticket (bus/train).

'Pay it Forward' scheme has now launched. 'Pay it Forward' will enable those staff who are in the fortunate position to do so to pay for an extra hot drink or meal when purchasing their own. This fund can then be accessed by other staff who need it

through a discreet voucher scheme, administered by SALS, Trade Unions and the Chaplaincy.

Other ideas are in development, such as exploring a salary advance scheme designed to avoid staff accessing payday loan companies. The Board will be kept updated with any future developments.

Sharon Owen
Deputy Chief People Officer
December 2022

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 15th December 2022

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

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

Board Assurance Framework 2022/23

1. Purpose

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

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

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

2. Review of the BAF

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

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

3. Overview at 7th December 2022

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

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

Report generated by Ulysses

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

4. Summary of BAF – at 7th December 2022

The diagram below shows that all risks remained static in-month with the exception of Workforce Equality, Diversity and Inclusion which has increased in score along with Digital Strategic Development & Delivery and Failure to fully realise the Trust's Vision for the Park.

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

5. Summary of November updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ)***
  Risk reviewed; no change to score in month. Evidence and actions updated. Vision 2030 development progressing well and ongoing until March 2023.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ)***
  Risk reviewed; no change to score in month. Controls actions and evidence updated. Significant ongoing engagement in the developing ICS at multiple levels.

- ***Risk of partnership failures due to robustness of partnership governance (DJ)***
  Risk reviewed; no change to score in month. Evidence, controls and actions updated.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions reviewed and updated; risk score increased from 12 to 15. Progress made with networks, EDI steering group and annual workplan agreed. EDI lead to commence in post in Jan 2023

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  The majority of historical defects are now resolved. There has been some notable recent success in getting the gas combined heating & power unit into action, and remedial works to the chillers (now on course for completion in January 2023) with the temporary ones on the top level of the car park being removed mid-December. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. 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. A commercial discussion is open in relation to the number of service failure points accrued.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB)***
  Number of patients waiting >52wks has reduced over the last two months has reduced and is now at 360. Two-thirds are in Dental and the specialty with biggest challenge to achieve zero 78ww is Spinal Surgery. Actions remain in place for all specialties. Diagnostic waiting times for 6wk national standard are improving in line with trajectory for compliance by March 2023. ED waiting times remain challenged due to exceptional high levels of demand.

- ***Inability to deliver safe and high-quality services (NA)***
  This risk has been reviewed and was updated last month. Work continues to mitigate the gaps in controls and is monitored through SQAC.

- ***Financial Environment (JG)***
  Added a gap in control regarding increasing inflation pressures and detailed action plan on controls being taken. No change to risk score in month.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Updated prior to December Board. Risk score increased to 3x4 (previously 3x3).

- ***Digital Strategic Development and Delivery (KW)***
  BAF likelihood score increased due to two issues including scare specialist resource capacity v demand from multiple programmes and organisational capacity for change in 2023 with multiple major programmes and priorities in train.

- ***Workforce Sustainability and Development (MS)***
  Risk is escalated and discussed at board, PAWC and through divisional management as staff availability continues to pose considerable risk. Industrial action now confirmed for some staff and this is managed through tactical command.

- ***Employee Wellbeing (MS)***
  Risk reviewed and actions updated. No change to risk rating.

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL)***
  Risk reviewed Dec 22 – no change.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of all actions taken place and remains the same. Deep dive of risk undertaken at SQAC and RABD committees. Presentation uploaded.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000107

BAF Risk 1.1 — Inability to deliver safe and high-quality services (3x3=9)

Strategic Aim — Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.2
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	2.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.2 & 2.1 & 1.4
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	4.2
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 & 2.1
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2100	Risk of inability to provide safe staffing levels	2.1
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	2.1
2632	Patients are waiting a long time without clear communication which is leading to increased Pals & Complaints and negative Friends and Family Feedback.	
2631	Difficulty in maintaining Emergency department skilled workforce in Nursing to provide safe effective care.	1.2

000108

BAF Risk

1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (3x5=15)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2233	Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies	1.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 2.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal.	1.1 & 2.1

000109

BAF Risk

1.3 Failure to address ongoing building defects with Project Co. (4x3=12)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

1.4 Access to Children and Young People's Mental Health (3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 1.2

000110

BAF Risk

2.1 Workforce Sustainability & Capability

(3x5=15)

Strategic Aim

The best people doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.2
2517	“Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes”, caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 1.2
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	1.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2
2719	Risk the Paediatric Neurology Service becomes unstainable due to vacancies within the Consultant team resulting in collapse of the acute Neurology service and business continuity interruptions in Epilepsy and NORCESS	1.2
2631	Difficulty in maintaining Emergency department skilled workforce in Nursing to provide safe effective care.	1.1
2741	The ability to maintain OFSTED ratio's as a result of staff availability/turnover Health and Safety concerns operating the nursery in its current position in the centre of a building development	

000111

BAF Risk 2.2 Employee Wellbeing (3x3=9)

Strategic Aim: **The best people** doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.1

BAF Risk 2.3 Workforce Equality, Diversity & Inclusion (3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000112

BAF Risk

3.1 Failure to fully realise the Trust's vision for the Park (3x4=12)

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.2 Failure to deliver 'Our Plan' objectives to develop a healthier future for CYP through leadership of 'Starting Well' and CYP systems partnerships (4x3=12)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.4 Financial Environment (4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000113

BAF Risk

3.5 ICS: New Integrated Care System NHS legislation/system architecture; risk of inability to control future in system complexity and evolving statutory environment (4x4=16)

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.6 Risk of partnership failures due to robustness of partnership governance (3x3=9)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2733	Inability to deliver agreed programme outputs of functional dashboards accessible to stakeholders across the ICB.	

000114

BAF Risk

4.1 Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for CYP
(3x3=9)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
2694	Delayed growth plan (strategy KPISs)	

BAF Risk

4.2 Digital Strategic Development and Delivery

(4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	1.1

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2229, 2441, 2463, 2516, 2517, 2327, 2332, 2383, 2597, 2627, 2100, 2450, 2654, 2196, 2632, 2631		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I).	Annual QIA assurance report
Risk registers including the corporate register are actively reviewed, risks are managed and inform Board assurance.	Risk assessments etc. and associated risks monitored via the Risk Management Forum. Trust Board informed vis Audit & Risk Committee minutes.
The Quality & Safety sections of the Corporate Report are reviewed and managed through SQAC and reported up to Trust Board	Safety & Quality Assurance Committee, Trust Board and Risk Management Forum.
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing learning Trust wide.	Patient safety meeting actions monitored through CQSG, learning bulletin produced and learning from RCA's shared at the meeting
Programme of quality assurance rounds is in place at service level which provides assurance against a range of local and national metrics.	Reports and minutes from Safety & Quality Assurance Committee. Thematic analysis across the QAR meeting monitored through SQAC
Ward to Board processes are linked to NHSI Oversight Framework	Ward accreditation reports shared with SQAC, quality rounds outcomes report shared following each round. Programme of clinical audit supports the Trust dashboard in terms of safety and quality of care.
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Safety & Quality Assurance Committee, Divisional Quality Board minutes.
The Trust has a Patient Experience Group that reports against the workplan based on feedback from Children, Young People and their families, and will include representation from a wide range of stakeholders including children & young people.	Minutes of Patient Experience Group and associated workplan and dashboards monitoring a range of patient experience measures.
Oversight of progress with RCA actions and implementation plans is monitored through CQSG	Monitoring reports will be available from each review meeting
The STAT education and training program is in place in theatre to improve safety awareness and culture	monitoring of the AfPP action plan and STAT program outcomes monitored through the Surgery Divisional Board
Patient Safety Strategy board is in place with oversight of implementation of the trust strategy and progress against associated workstreams	Minutes of meetings and progress reports available and shared monthly with SQAC

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2023	The sepsis leads have presented an updated position and action plan to SQAC giving increased levels of assurance. This will continue to be monitored through the reporting on the IPR and quarterly reports to SQAC
2. Each divisional governance lead will be responsible for ensuring this process is reviewed and progress made within the divisional structures	31/03/2023	There is a need for improved oversight and scrutiny through the divisional governance structures regarding NICE assessment and implementation. This will be supported by the medical director and will ensure clear progress of compliance.
3. There will be a review of the audit role, function and staffing model	03/11/2022	There will be a review of the trust clinical audit process, role and function including a review of the staffing.

Executive Leads Assessment

November 2022 - Nathan Askew
The risk has been reviewed and updated based on the deep dive presented to SQAC last month. Gaps in control have been updated to reflect the current position.

September 2022 - Nathan Askew
this risk has been reviewed and appropriate assurance continues in place. Gaps in assurance are progressing and actions are on track

Board Assurance Framework 2022-23

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2233, 2383, 2597, 2463, 2517, 1902, 2501, 2501		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Rising urgent care demand has increased the wait for clinical assessment and reduced the number of patients treated within 4 hours. A loss of capacity during COVID-19 has made access to planned care extremely challenging.

Existing Control Measures	Assurance Evidence (attach on system)
Controls for waiting time in the Emergency Department (ED): - Winter Plan with additional staffing and bed capacity - ED Escalation & Surge Procedure - Additional shifts to increase staffing levels to deal with higher demand - Trust-wide support to ED, including new in-reach services (physiotherapy, Gen Paeds & CAMHS)	- Daily reports to NHS England - Daily performance summary - Monthly performance report to Operational Delivery Group - Performance reports to RABD Board Sub-Committee - Bed occupancy is good
Controls for referral-to-treatment times for planned care: - Weekly oversight and management of waiting times by specialty - Weekly oversight and management of long wait patients - Use of electronic system, Pathway Manager, to track patient pathways - Additional capacity in challenged specialties - Access to follow-up is prioritised using clinical urgent signified by tolerance for delay	- Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee - Use of electronic patient pathway forms to signify follow-up clinical urgency and time-frame
Controls for access to care in Community Paediatrics: - Use of external partner to increase capacity and reduce waiting times for ASD assessments - Investment in additional workforce for Speech & Language service in Sefton - Weekly oversight and management of long wait patients	- Significant decrease in waiting times for Sefton SALT - Corporate report and Divisional Dashboards - Performance reports to RABD Board Sub-Committee
Controls for access to care in Specialist Mental Health Services: - Investment in additional workforce in Specialist Mental Health Services - Extension of crisis service to 7 days - Weekly oversight and management of long wait patients	- Monthly performance report to Operational Delivery Group - Corporate report and Divisional Dashboards
Use of Challenged Area Action Boards for collective improvement in waiting times	Challenge boards live for ED, Radiology and community paediatrics
Transformation programme: - SAFER - Best in Acute Care - Best in Outpatient Care - Best in Mental Health care	- Monthly oversight of project delivery at Programme Board - Bi-monthly transformation project update to SQAC
Performance management system with strong joint working between Divisional management and Executives	- Bi-monthly Divisional Performance Review meetings with Executives - Weekly 'Executive Comm Cell' meeting held - SDG forum to address challenged areas and approve cases for investment where access to care is challenged.
Urgent clinic appointment service established for patients who are clinically urgent and where a face-to-face appointment is essential	New outpatient schedule in situ
Digital outpatient channel established - 'Attend Anywhere'	Weekly tracking of training compliance and number of patients consulted via a digital appointment
Urgent operating lists	
Weekly access to care meeting to review waiting times	Minutes
Winter & COVID-19 Plan, including staffing plan	
Additional weekend working in outpatients and theatres to increase capacity	
Safe waiting list management programme to ensure no child experiences harm whilst on a waiting list for treatment	
Clinical review of long waiting patients, and harm review SOP for patients who were not tracked optimally	

Gaps in Controls / Assurance

1. Reduce to zero the number of C&YP waiting over 52 weeks for treatment to clear the long-wait backlog for planned care
2. In urgent and emergency care, improve to 95% the number of patients treated within 4 hours and a time to clinical assessment of 60 minutes
3. Patients with an urgent referral to the eating disorder service to be seen within 7 days and routine referrals within 4 weeks

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

Urgent Care Improvement Group overseeing several improvement workstreams: PLACE - GP streaming relocation to OPD - complete FUNDING - business case submitted for approval to increase nursing and decision makers - Complete SUPPORT - external company engaged to support GP stream - complete; funding for 22/23 requested via CCG - pending WORKFORCE - subject to funding workforce required including out of hours - pending CAPACITY & DEMAND - review of demand and capacity by stream - pending EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	31/01/2023	Actions remain in progress, with exec oversight through the ED@Best programme
The following actions are being undertaken to improve the RTT performance: Expand the criteria of patients who can be booked onto a weekend list - ongoing External dentist given priority weekend lists - complete Recruit new honorary contract dentist - complete, mid-Sept 2022 Additional weekend capacity has been granted in May - complete Additional weekend capacity to be identified in June Increase number of complex patients planned per list - ongoing Allocate a Consultant Anesthetist on all dental lists - ongoing Consideration of temporary job plan changes to increase capacity - meeting scheduled w/c 23rd May Trial use of VR for older patients to avoid GA and increase productivity - started	02/01/2023	Updated action owners.

Executive Leads Assessment

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

December 2022 - Andrew Mccoll
Number of patients waiting >52wks has reduced over the last two months has reduced and is now at 360. Two-thirds are in Dental and the specialty with biggest challenge to achieve zero 78ww is Spinal Surgery. Actions remain in place for all specialties.

Diagnostic waiting times for 6wk national standard are improving in line with trajectory for compliance by March 2023.

ED waiting times remain challenged due to exceptional high levels of demand

November 2022 - Adam Bateman
The number of C&YP waiting over 52 weeks for treatment in consultant-led pathways has reduced to 376 patients, from 435 in September. Paediatric Dentistry as had the most notable improvement. Elective recovery was strong in October at 107% for elective and 120% for outpatient new activity. Looking forward, the reduction in additional WLI activity, due to the rate card, and the threat of industrial action makes sustaining high levels of elective recovery unlikely.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Building and infrastructure defects that could affect quality and provision of services		
Related CQC Themes: Safe		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Adam Bateman	Type: External, Resource And Business Development Committee	Current IxL: 4x3	Target IxL: 2x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

Building defects that remain unresolved by Project Co could impact on patient services, reputation and financial sustainability

Existing Control Measures	Assurance Evidence (attach on system)
Detailed action plan agreed by both parties in place which reduces the risk of failure and identifies operational mitigations. Review of the action plan takes place monthly to ensure all remains on track.	
Where applicable a team from the service provider, is on standby to address any issues that may arise in a highly responsive way and mitigate operational impact.	
Regular oversight of issues by Trust committee (RABD)	Monthly report to RABD on progress of remedial works
Trust Board aware of the ongoing status and issues.	Monthly report to Board on mitigation and remedial works

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

December 2022 - Graeme Dixon
The majority of historical defects are now resolved. There has been some notable recent success in getting the gas combined heating & power unit into action, and remedial works to the chillers (now on course for completion in January 2023) with the temporary ones on the top level of the car park being removed mid-December. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. 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. A commercial discussion is open in relation to the number of service failure points accrued.

November 2022 - Adam Bateman
The majority of historical defects are now resolved. There has been some notable recent success in getting the combined heath & power pump into action, and remedial works to the chillers (no on course for completion in January 2023). Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving.

Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur.

A commercial discussion is open in relation to the number of service failure points accrued.

October 2022 - Graeme Dixon
The weekly meetings between senior management reps from Estates & Project Co reps are ongoing with a view to closing out the remaining defects although the majority have now been resolved. All new defects or issues should be logged on the helpdesk so stakeholders are aware of the issues and progress to date. The two remaining historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues where discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving and will be pushed on this for regular updates.

Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. Senior managers from the Trust are still in discussions with Project Co reps regarding current issues and associated commercial aspects although these are mainly newly identified issues rather than historic defects. Chillers are due for completion in January 2023 and the temporary ones will be removed in November once RAMS have been approved.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Full validation of community mental health waiting list to remove data quality errors and identify any areas of risk. This will support future capacity and demand planning.	31/12/2022	Discussion with leads additional hours to be provided to validate waiting list
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	01/02/2023	Date extended due to supplier issues
Actions from mental health workforce plan to be delivered which includes: -Improving workforce availability rate to >90% -Task & Finish group with aim to increase headcount of external staff through marketing of services and the organisation and enhancing job roles and adverts -Delivery of staff wellbeing schemes -Staff retention to be improved through review of job plans and education/training opportunities	28/04/2023	Job description task and finish group arranged regarding job roles/descriptions. Continue to meet with Cheshire & Merseyside group (workforce survey)

Executive Leads Assessment

December 2022 - Lisa Cooper
Review of all actions taken place and remains the same. Deep dive of risk undertaken at SQAC and RABD committees. Presentation uploaded

November 2022 - Lisa Cooper
Review of all actions undertaken with Clinical Leads and updates included. Summary investment case added to documentation

October 2022 - Lisa Cooper
review of all actions taken place and updates included.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2383, 2100, 2597, 2516, 2528, 2517, 2535, 2624, 2450, 2196, 2312, 2719, 2741		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to PAWC
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivered and reporting linked to competencies on ESR	-Monthly reporting to the Board via the Corporate Report -Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
HR Workforce Policies	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to PAWC and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to PAWC and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Plan Implementation	People Strategy report monthly to Board
International Nurse Recruitment	78 international nurses recruited since 2019
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to PAWC OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to PAWC
Recruitment and Apprenticeship strategy currently in development	progress to be reported to BAME task force and People and Wellbeing Committee
Employment checks and quality assurance that staff in post have the right skills, qualifications, and right to work in the post in which they are employed	Staff employment checks all on personnel files

Gaps in Controls / Assurance

1. Not meeting compliance target in relation to some mandatory training topics
2. Sickness Absence levels higher than target.
3. Lack of workforce planning across the organisation
4. Talent and succession planning
5. Lack of a robust Trust wide Recruitment Strategy
6. Lack of inclusive practices to increase diversity across the organisation
7. COVID related sickness impacting upon service delivery
8. Increasing turnover rates
9. Industrial action planned

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	31/12/2022	Detailed review of turnover in progress
To identify and target hotspot areas with high turnover rates	31/12/2022	Detailed analysis on Turnover in progress
3. Development of a methodology to roll-out across the organisation.	31/12/2022	Establishment project on target and turnover task and finish group in place

Board Assurance Framework 2022-23

5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	01/03/2023	Attraction and Retention Project identified as key project for 22/23

Executive Leads Assessment
November 2022 - Sharon Owen Risk is escalated and discussed at board, PAWC and through divisional management as staff availability continues to pose considerable risk. Industrial action now confirmed for some staff and this is managed through tactical command.
October 2022 - Sharon Owen Risk reviewed - no in month change to risk score. Actions are on track. The focus of availability remains sickness and turnover.
September 2022 - Melissa Swindell No change to risk score in month. All actions remain on track

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

Failure to effectively support employee health and wellbeing and address mental ill health which can impact upon the delivery of care and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs, HWB diagnostic
Action Plans for Staff Survey	Monitored through PAWC (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
People Pulse results to People and Wellbeing Committee quarterly	PAWC reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Staff surveys analysed and followed up (shows improvement)	2021 Staff Survey Report - main report, divisional reports and team level reports
Celebration and Recognition Group relaunched after being on hold during the peak of the pandemic	Celebration and Recognition Meetings established; reports to HWB Steering Group
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Staff advice and Liaison Service (SALS) - staff support service	Referral data, key themes and outcomes reported to PAWC as part of the People Paper
Counselling and Psychological support - Alder Centre	
Trust Briefs - keeping staff informed	
Spiritual Care Support	
Clinical Health Psychology service support for staff (including ICU)	
Resilience hub now live offering additional psychoeducational support to all staff in the region and taking self-referrals from frontline staff since 12th April	
Ongoing monitoring of wellbeing activities and resources via monthly Health & Wellbeing Steering Group	Minutes presented to PAWC
Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work	Implementation plan in place and progress assessed against 9 WBGuardian principles outlined in national guidance document. Action plan monitored via bi-monthly Wellbeing Guardian Meeting and reported to PAWC monthly
Health and Wellbeing Conversations launched	HWB Conversations now embedded as part of the PDR process supported by training and support from SALS, OD and Wellbeing Coaches where needed. Key metric currently is %PDR completed but value of HWB conversations also assessed via Quarterly People Pulse
Ground TRUTH session at execs (monthly) to feedback outcomes of team debriefings, surveys and targeted listening events, agree actions and communicate to the organisation via briefings and Ground Truth bulletin	Minutes of exec meetings
NICE Mental Wellbeing at Work Guideline issued and baseline assessment complemented	Baseline assessment
Regular Schwartz Rounds in place and Team Time in development in high pressure areas (e.g. ED and ICU)	
Network of SALS Pals recruited to support wellbeing across the organisation	

Gaps in Controls / Assurance

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way

3. Rising demand for SALS support and permanent resource not yet in place to ensure sustainability of provision for staff
4. Increase in self-reported rates of burnout and work-related stress as assessed via 2021 Staff Survey and consistent with national picture for NHS staff
5. Lack of private space to support staff and wellbeing activities
6. Likely psychological impacts on staff in the event of industrial action

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	09/01/2023	SALS booth agreed and ordered to provide additional private space for staff accessing SALS. No further update regarding container spaces.
Staff support plan to be developed to help to respond to and mitigate psycho-social impacts of industrial action on nurses and other staff who may be impacted	20/12/2022	Plan developed and agreed at Industrial Action Planning Group. I will be joining Gold command during active strike period (15th and 20th Dec) to consider staff support needs during active phase.
Business case in development and now awaiting opportunity to present at appropriate forum whilst SALS also seeking external funding sources and opportunities for income generation to assist with current cost pressures.	19/12/2022	Business case circulated to Divisional managers. To be discussed at IRG on 13th Dec
Mental Health training for line managers ("Strengthening Others") being developed by SALS/OD to be rolled out to all leaders and managers as a module of Strong Foundations and as stand-alone training available to all via recorded presentation and monthly drop ins run by SALS	31/01/2023	Date amended
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	17/01/2023	Date updated

Executive Leads Assessment

November 2022 - Jo Potier
Risk reviewed and actions updated. No change to risk rating

October 2022 - Joanne Potier De La
Risk reviewed and actions updated. No change to risk rating

September 2022 - Jo Potier
Risk reviewed and actions updated. No change to risk rating.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 3x5	Target IxL: 4x1	Trend: INCREASED

Assurance Committee: People & Wellbeing Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
PAWC Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	-Bi-monthly reporting to Board via PAWC on diversity and inclusion issues -Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through PAWC
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through PAWC
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
Actions taken in response to the WRES	-Monthly recruitment reports provided by HR to divisions. -Workforce Race Equality Standards. - Bi-monthly report to PAWC.
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
Actions taken in response to WDES	- Monthly recruitment reports provided by HR to divisions. - Workforce Disability Equality Standards. - Bi-monthly report to PAWC.
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
EDI Steering Group now established - Chaired by NED	Minutes reported into PAWC

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Staff Network Chairs to be advertised during August / September	31/12/2022	networks to be advertised nov 22
EDI lead now appointed and will commence 3rd Jan 2023	03/01/2023	EDI lead to commence on 3rd Jan 2023

Executive Leads Assessment

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

November 2022 - Melissa Swindell
risk reviewed, action updated

October 2022 - Melissa Swindell
actions updated. risks reviewed

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: David Powell	Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: INCREASED

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Design and Access Statement (included in planning application)	Compliance reporting from Park Project Team
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision.
Weekly Programme Check.	The Project Team run a weekly programme check.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
Programme and plan (agreed with LCC and LPA) to return the park back by November 2023.	Updates on progress through Campus report .

Gaps in Controls / Assurance

1. Planning approvals for modular buildings to allow demo of Catkin and continuation of park works.
2. Successful handover of IP2 to allow temporary car park to be closed and continuation of park works.
3. Successful realisation of the moves plan.
4. Agreement to MUGA location and planning approval from LPA.
5. Funding availability and potential market inflation.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Create a plan to fix drainage from Phase 1/Agree plan for Phase 2/3	06/01/2023	Initial survey received. Awaiting final survey.
Set up Joint Planning meeting with community	31/12/2022	Awaiting LCC public meeting before organising

Executive Leads Assessment

December 2022 - David Powell
Updated prior to December Board. Risk score increased to 3x4 (previously 3x3).

November 2022 - David Powell
Prior to November Board

October 2022 - David Powell
Prior to October Board

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

	27.1.22 - Presentation of Beyond programme to HCP Programme Board. ICS CEO in attendance. Programme progress accepted. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached Nov 22 - Presentation to ICB Chair (Children's Champion) at St Helens Town Hall; supported to cement further the CYP governance at ICB level - proposal under development Dec 22 - Beyond presented to Alder Hey Trust Board
Coordinated system-wide action planning for predicted RSV surge	NW & C&M Surge Plans
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system objectives and trust ambitions	-Trust Board Strategy / 2030 Vision session scheduled Jan 22 - Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed. - Sept 22 - Trust Board approved strategy overview / baseline paper - agreed next steps to begin wider engagement (see attached evidence)

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	Action updated as above 4/11/22
6.Develop Operational and Business Model to support International and Private Patients	31/03/2023	Incorporated into developing 2030 Vision. Strategy development timetable through to March 23.
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	31/03/2023	Incorporated within 2030 Vision. Strategy development timetable until March 23 - workforce analysis underway

Executive Leads Assessment

December 2022 - Dani Jones
Risk reviewed; no change to score in month. Evidence and actions updated. Vision 2030 development progressing well and ongoing until March 23.

November 2022 - Dani Jones
Risk reviewed; no change to score in month. Actions, evidence and controls updated. Key progress includes agreement of baseline strategy overview paper at Trust Board Nov 22.

October 2022 - Dani Jones
Risk reviewed; controls, actions and evidence reviewed. No change to score in month

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Strong Foundations	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2637		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/12/2022	Work underway with each division/department to understand movement in key areas (Activity/Finance/WTE) from 19/20 to 21/22, recognizing the changing financial framework. This will then inform the forward look for LTFM.
2. Five Year capital plan	31/12/2022	Future years CDEL not yet confirmed. Internal capital planning for 23/24 and 24/25 underway to assess the requirements and prioritise the essential schemes. Discussion also underway with the Chairty re support for capital schemes in future years.
1. Monitor closely impact of inflation increases 2. Ensure procurement processes followed to obtain value for money 3. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2023	Gap in control and actions added

Executive Leads Assessment

December 2022 - Rachel Lea
Added a gap in control regarding increasing inflation pressures and detailed action plan on controls being taken.
No change to risk score in month

November 2022 - Rachel Lea
BAF risk reviewed, and score remains at 16 due to the uncertainty of the financial landscape going into 23/24 and beyond. Planning is underway both internally and across C&M for 23/24 and will feed into the ongoing financial risk.

October 2022 - Rachel Lea
Risk reviewed and actions updated with latest progress. Risk score remains at 16 due to current uncertainty in future years. Work is underway as detailed in the actions.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Membership of CMAST & LDMHC Provider Collaboratives - to ensure CYP voice high on agenda	CMAST - Governance paper and TOR for Committee in Common approach presented to Trust Board in September 22 and approved. Letter confirming Alder Hey support to LDMHC Provider Collaborative MOU (Aug 21) CEO engagement in 1st of 3 CMAST Provider Collaborative workshops (Oct 21) Due to Omicron wave, CMAST collaborative has focused on Hospital Cell / recovery and mutual aid approach during Dec/Jan
Specialist Trust Alliance membership of C&M ICS (HCP) Board - to ensure Specialist Trusts have a voice to influence	Specialist Trust Alliance has amalgamated into CMAST membership; therefore this control is superseded by CMAST and can be closed.
C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22 Update to Trust Board July 22 Update to Council of Governors Sept 22 Update to Trust Board Sept 22 Update to Trust Board Nov 22
C&M CEO Provider Collaborative - Membership - sustain collaborative working arrangements with C&M-wide colleagues to shape system and ensure influence	
C&M ICS Finance Committee - play an integral role and ensure fair share of funding for CYP services	TOR & System Finance Principles in development (to be attached once finalised)
Maintain effective existing relationships with key system leaders and regulators	Regular connection established with Chair ICB and ICB CYP Exec Lead - quarterly meetings set up with Chair (agenda from initial meeting attached) and ICB CYP Exec lead member of Beyond Board from December
Lead Provider and partnership arrangements; development of new models of care	ICS Board Development session in Dec focused in on LDMHC Provider Collaborative plans
Impact assessment re: delegation of specialist services into ICS guidance (national, regional, ICS level) to enable understanding of risks/opportunities and influence for CYP	Children's Hospital Alliance proposals (under development) C&M CMAST Provider Collaborative proposals (under development) Joint letter of response to Specialist Commissioners from Alder Hey and Manchester Children's in August 22 Deputy CEO represents Alder Hey at the C&M Specialist Delegation group Likely delegation will not take place until April 24 - though work will continue through DoF, DoS and partners inc. CHA and NWPPB to shape the direction for CYP specialist services
Monitoring and influencing the direction of SpecCom delegation into ICSs	Joint letter to SpecCom from NW - AH & RMCH outlining the need to work at a NW footprint Nov 22 - Development of joint NW SpecCom delegation plan with Alder Hey and RMCH - outline shared position discussed at NWPPB Nov 22 - to be jointly developed further during Dec/Jan

Board Assurance Framework 2022-23

Gaps in Controls / Assurance		
Uncertainty over future commissioning intentions (see BAF 3.4 re finance, and also new guidance re delegation of Specialist Commissioned services into ICSs)		
Actions required to reduce risk to target rating	**Timescale**	**Latest Progress on Actions**
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2023	Continuous monitoring, influencing and relationship building ongoing ICS-wide - contributing to the C&M HCP strategy, building the Beyond programme, Alder Hey representation at all possible C&M groups.
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/03/2023	As above entry 7.9.22
Executive Leads Assessment		
December 2022 - Dani Jones Risk reviewed; no change to score in month. Controls actions and evidence updated. Significant ongoing engagement in the developing ICS at multiple levels.		
November 2022 - Dani Jones Risk reviewed; no change to score but good progress in month - particularly the influence of ICB Chair in developing greater voice and governance within ICB architecture. Leading this development through Beyond, with partners.		
October 2022 - Dani Jones Risk reviewed; no change to score in month. Development of CMAST governance and trust board approval noted.		

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 3.6	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Risk of partnership failures due to robustness of partnership governance		
Related CQC Themes: No Themes Identified		Link to Corporate risk/s: 2733		
Exec Lead: Dani Jones	Type: External,	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	Control embedded.
Escalation process for risks and issues pertaining to ODNs and Joint Services	North West Paediatric Partnership Board is the escalation route for all - example papers attached. Control embedded.
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement). PQAR Framework now tested with LNP to positive effect. Development of the process and framework underway, supported by Jacqui Rooney, in line with evolving CQC quality statements approach. NorCESS joint management team have agreed to pilot PQAR for the North West - to be scheduled in Q4.
Identification of 'pilot' partner for Partnership Quality Assurance Round - Liverpool Neonatal Partnership	PQAR Pilot scheduled with LNP for October 22 with Non-Exec representatives from both partner Trusts. Pilot of Partnership Quality Assurance Round approach agreed with LWH MD. Liverpool Neonatal Partnership and presented PQAR to LNP Board in June 22 - agreed next action to identify NED rep from both Trusts to do a full PQAR with LNP (under identification/scheduling) PQAR completed with NEDs from both Alder Hey and LWH 14th October. Positive process, plus some learning to shape PQAR pack for future sessions. Draft minutes attached (one amendment pending - ABR was not in attendance) will update once final minutes agreed. Action plan and next steps within.
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - Sept 22 Quarterly Board paper - June 22
Twice-annual ODN oversight report to RABD	May 22 Report attached Nov 22 report attached.
MIAA Audit - Partnership Governance	Audit underway; all documents shared with MIAA. TOR attached

Gaps in Controls / Assurance

Sign up from further partners to engage in PQAR - in development (dependent on both parties subscribing)
Completion of MIAA Audit / identification of key recommendations to follow

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
MIAA Audit scheduled for Q2 2022	29/12/2022	Audit ongoing; all docs submitted, awaiting draft findings from MIAA

Executive Leads Assessment

December 2022 - Dani Jones
Risk reviewed; no change to score in month. Evidence, controls and actions updated.

November 2022 - Dani Jones
Risk reviewed; good progress in month - PQAR pilot tested fully with LNP to positive effect. Some learning and next stage development underway, and action plan in situ and monitored through Quality team.

October 2022 - Dani Jones
Risk reviewed; no change to score in month. Actions and controls updated.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation	Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.		
Related CQC Themes: Well Led		Link to Corporate risk/s: 2694		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

Existing Control Measures	Assurance Evidence (attach on system)
R&I: RABD review of commercial issues per Corporate governance manuals, oversight of Innovation Ltd Corporate governance manual and oversight of deal diligence (commercial and reputational) . Trust Board oversight of shareholding and equity investments and intellectual property.	Reports to RABD / Trust Board and associated minutes
R: Establishment of Research Management Board	Research Management Board papers.
I: Innovation Committee and RABD Committee	Committee oversight of Innovation strategy with NED expertise
I: Clear Management Structure and accountability within Innovation Division	ESR Divisional Hierarchies
R&I: Plans for joint research & innovation clinical leadership	Job Description and Hierarchy
R: Clinical trials Covid recovery plan operational.	Trust Board papers
R: Research Division monthly focus on research at the Research Management Board to support strategy delivery.	Research Management Board papers
I: Legal Partner now in contract to advise on partnership structure and intellectual property	Letter of engagement
R&I: Trust Policies and online declaration portal (gifts & hospitality, sponsorship etc.)	Trust Policies and digital audit trail to audit committee
R&I: Formal Press Releases and external communications facilitated through communications department	Communications Strategy and Brand Guide
R&I: Industry Partner and AI Data governance. To adopt Trust DPIA's/DSA's and IG Steering Group standard process and approvals	Policy and SOPs
New Commercial partnerships SOP approved at IC and RABD OCT/NOV 22	
Innovation risk register expanded and included in Risk Management Group (RMG)	

Gaps in Controls / Assurance

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

Executive Leads Assessment

December 2022 - Claire Liddy
no change - risk reviewed Dec 22

November 2022 - Claire Liddy
review Nov 22 - no significant change. actions updated

October 2022 - Claire Liddy
no change Oct - full risk deep dive due to being presented to the Trust risk group in November which will be updated in BAF risk including refreshed controls and separation of clinical/quality research trials risk from strategic and commercial issues.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2327		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x4	Target IxL: 4x1	Trend: INCREASED

Assurance Committee: Resource And Business Development Committee

Risk Description

Failure to deliver a Digital Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare, failure to provide high quality, resilient digital and Information Technology services to staff.

Existing Control Measures	Assurance Evidence (attach on system)
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy Update Sept: ISD Excellence in Informatics Level 1 accreditation achieved
Formal change control processes in place	Exec agreed change process for IT and Clinical System Changes
Executive level CIO in place	Commenced in post April 2019
Quarterly update to Trust Board on digital developments, Monthly update to RABD	Board agendas, reports and minutes
Digital Oversight Collaborative in place & fully resourced - Chaired by Medical Director	Digital Oversight Collaborative tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs recruited. Divisional IT Leads in place.
NHSE & NHS Digital external oversight of programme	NHSD tracking of Programme through attendance at Programme Board and bi-monthly assurance reports.
Digital Strategy approved by Board July 2019, mobilisation in place to new governance and implementation arrangements	Digital Futures Strategy
Disaster Recovery approach agreed and progressed	Disaster recovery plans in place
Monthly digital performance SMT meeting in place	ToRs, performance reports (standard agenda items) KPIs developed
Capital investment plan for IT including operational IT, cyber, IT resilience	Capital Plan
iDigital Service Model in Place	iDigital Service Model and Partnership Board Governance

Gaps in Controls / Assurance

Cyber security investment for additional controls approved - dashboards and specialist resource in place
Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs
Issues securing experienced resources in some services
Anticipated delays with major programme delivery

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of Alder Care Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023
Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	03/01/2023	Recruitment continues. Some specialist areas with scarce skills are proving difficult to recruit to given demand and capacity issues. Similar issue is being felt regionally and nationally. Partner with external organisations, ISD networks and other organisations re approach.
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development
1. Proposed change freeze of all digital programmes from April particularly in the context of preparation for Aldercare go live 2. Review of all other programmes with implementation to be achieved before April	28/02/2023	Change freeze proposal in development, review of programmes to be initiated

Executive Leads Assessment

December 2022 - Kate Warriner
BAF reviewed. BAF likelihood score increased due to two issues including scare specialist resource capacity v demand from multiple programmes and organisational capacity for change in 2023 with multiple major programmes and priorities in train.

November 2022 - Kate Warriner
BAF reviewed, score remains static.

Aldercare programme progressing with revised plans, good progress with patient journeys in October. Governance process underway for additional

national support for programme. Programme risks include functionality, build, data migration and competing demands for other programmes managed through programme board and Digital Oversight Collaborative. Good progress with digital and data strategy mobilisation.
October 2022 - Kate Warriner BAF reviewed, score remains static. Aldercare programme re-baseline set, progress with programme plan and resources, national support and strategic relationship with supplier. Programme risks include functionality and build managed through programme board. Good progress with digital and data strategy with initiation planning and mobilisation of new models of care and data programmes.
September 2022 - Kate Warriner BAF reviewed, score remains static. Progress against a number of key actions notably recruitment into a number of key positions and completion of Aldercare programme review indicating revised go live date in 2023.
August 2022 - Kate Warriner BAF Risk reviewed. Current scores remain in place. Aldercare programme review has confirmed a re-set of the go live date to 2023, time window to be confirmed. National support requested for additional programme resources. Mobilisation and programme initiation plans for Digital and Data Futures are in development.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Monday 24th October 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	John Grinnell	Deputy CEO/CFO	
	John Kelly	Non-Executive Director	
	Rachel Lea	Deputy Director of Finance	(RL)
	Claire Liddy	Managing Director of Innovation	
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Mark Carmichael	ACOO Medicine	
	Jenny Dalzell	Project Manager	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Cath Kilcoyne	Deputy Director of Business Development	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Alex Pitman	Green Plan, Project Manager	

The Chair welcomed John Kelly, NED at his first meeting as a member of RABD.

22/23/121 **Apologies:**

Adam Bateman	Chief Operating Officer	(AB)
Mark Flannagan	Director of Communications	(MF)
Dani Jones	Director of Strategy and Partnerships	(DJ)
Melissa Swindell	Director of HR & OD	(MS)

22/23/122 **Minutes from the meeting held on 26th September 2022**
Subject to item 22/23/106 Proposed Debt Right Off including a de minimis level of £500, RABD approved the above minutes.

22/23/123 **Matters Arising and Action log**
Intranet, Business Development and Debt Write Off updates would be presented at the November RABD, all other actions had been included on the agenda.

22/23/124 **Declarations of Interest**
There were no declarations of interest.

22/23/125 **Finance Report**
Month 6 Financial Position
M6: An in-month trading deficit of £0.2m in September which is in line with plan. Year to date the Trust is reporting a deficit of £1.5m again in line with the deficit plan which is profiled to deliver a surplus position from month 7.

Year-to-date position continue to be associated with CIP non-delivery from earlier months of the year, continued pay and non-pay cost pressures including Junior Doctor pressures, clinical supplies and drugs, offset in part with slippage in investments and vacancies.

Activity remains low, target is at 104% across the Trust 93.1% has been reached this month however this was impacted by the additional bank holiday.

The Trust continues to formally report a forecast in line with financial plans at month 6 to NHSEI which is a £4.6m surplus subject to financial risks. There remains a risk gap of £2m in order to achieve the control total which will require concerted effort to control costs and identify mitigations during the second half of the financial year.

RABD discussed the challenges with meeting the current CIP for the year and the impact this would have on 23/24 if it was not delivered.

JK said it would helpful to see what was recurrent within CIP and the in-year benefit going forward. CS noted this was included in the CIP slides and would also include in the Finance report going forward.
Action: CS

CL asked for details on the bridging CIP items to close the recurrent gap. RL advised this piece of work was ongoing and will look into bringing a high level piece back in due course.

SA asked for clarity on the activity threshold noting the shortfall appears as if it's from surgery and asked what could be put in place to support the division. CS noted the division are looking at productivity and how this can be increased. RL agreed further detail would be presented at the November RABD. JG noted Surgery had presented a detailed action plan at the last Executive Committee on 20/10/22.
Action: RL

Resolved:
RABD received and noted the M6 Finance report.

22/23/126 Capital and Cash Update

Capital
RL gave an overview of the 3 current bids: the Alder care bid (£2m) and Eating Disorders Day Case Facility (£2.8m) have been approved, MOU's to follow. A decision is awaited on; Paediatric Elective Hub (£5m).

KW noted the acceptance letter for the Aldercare bid has been received and the team are working on a response.

Cash
A new five-year cashflow model is being developed to move towards increased visibility of cashflow forecasts**.**

Resolved:
RABD noted the current position in relation to Capital and Cash.

22/23/127 CIP and 2023 risks

CIP was achieved in full for the third consecutive month. The target is to remain focussed on plans for 22/23 with delivery reported to future SDG meetings and also strategic execs under the programme of work.

CL asked if it would be possible to understand the benefits realised or opportunity form capital investment over recent years. This will be a piece of work undertaken and reported back to RABD in due course.

Resolved:
RABD received and noted the CIP update.

22/23/128 Capital & service development programme for NICU, PAU, Urgent Care and Fracture services

The paper sets out the proposals for the Neonatal Intensive Care Unit (NICU), PAU / Urgent Care Facility and Fracture expansion and seeks approval to continue with the strategic direction of all these schemes noting the inflation risk and pressures that have arisen since the last update.

Updates were provided to the committee on the latest costs and proposed budget for the revised fracture and PAU scheme including the mitigation plans for the increased costs due to inflation and other design changes.

MC went through the plans in detail noting the conclusion to develop a 16 bedded PAU for a combined assessment unit. This is based on 85% occupancy and a new pathway for general paediatrics in terms of direct referral from Primary Care and other healthcare professionals in the community. Plans also include the inclusion of GP services within the ED department. MC noted in terms of fracture services there would be no building extension required.

RL referred to the RABD action to be presented at the December meeting on business opportunities following completion of the building. A number of risks were highlighted to RABD as outlined in the paper which will be included in the update at the next meeting.

The Chair asked for confirmation that the Alder Hey Chair is aware of the current position, RL confirmed this. The Chair asked that himself, Shalni Arora and John Kelly have an overview of any contracts before execution. RL agreed that this would take place.

KW asked to note future implications on capital schemes if some of the risks materialised. CL also highlighted revenue consequences and implications. A discussion was held around future strategies for Alder Hey in terms of the current financial situation and how AH will develop in the future. RABD agreed that this would be picked up at the Alder Hey Trust Board Thursday 27th October 2022.

SA noted the joint work with Liverpool Women's and whether all financial benefits have been included within the benefit realisation piece.

Resolved:
Supported in principle the revised proposed budget envelope and mitigation strategies for any inflation risk that cannot be reduced. Noting that this would be discussed further at the TB the Committee were supportive of the proposal.

22/23/129 AlderC@re Programme

KW highlighted from the report:

- Revisions to the implementation programme continues.
- An update was received on the successful patient journeys across the Trust. A number of staff nominated themselves to be Alderc@re Champions
- A room to be used as a "simulation hub" has been identified on the Mezzanine. This will be a physical location for engaging with the AlderC@re system and programme team and will be the main location for the next set of

patient journeys. The room will be set up to mimic clinical environments with reception area, clinic area, and ward area.
- Details on the gateway process were noted.
- Main areas of risk was also noted.
- Going forward regular meetings with senior managers from Alder Hey and Meditech are to be arranged.
- Confirmed support from Meditech in America, supported with the patient journeys.

JK queried the difference in risk from starting the programme in June or August. KW advised the preference would be June however it is difficult to know at this stage if the programme would be ready to go live hence the fall back to August.

Resolved:
RABD noted the continued challenges around Alderc@re and the go live date to be moved to 2023. RABD will receive further monthly updates.

22/23/130 Digital Future report

KW highlighted:
- Update on ICS and Liverpool Place Digital Strategies
- Formal closure of Digital Futures and launch of Digital and Data Futures 2022
- Launch of the new Integrated Performance Report
- Good Operational performance
- The integrated service across Alder Hey and Liverpool Heart and Chest has been recognised nationally through the Health Tech News (HTN) Awards, winning the Partnership Category. Alder Hey were also 'highly commended' within the HTN Awards for the development and delivery of the 'Online Symptom Checker' which has received thousands of visits from our Children, Young People and Families.
- Good progress has been made against the access to health back log.

Resolved:
RABD received and noted the Digital Future report.

22/23/131 Innovation and Commercial Activity

CL presented the above report for quarter 2 highlighting:

- An overview of the Innovation financial dashboard
  A number of grants had not been met in the original timescales set and going forward grants will be given a 2 year timeframe.
  A table showing grants and donations received over the last years was presented to RABD.
- Commercial Agreements
  Whilst there was nothing for approval today CL noted there are a number of agreements in the developmental stages. A two to three year timescale is given from the beginning stages of the product to revenue.
- Business Development
  Successful grants include: one through Children's Hospital Alliance for Virtual Wards.
  CL provided details on 2 bids that the team are working through.

  The Chair asked if it was likely the transparent mask project would still receive the demand originally thought. CL noted that there was still demand for

transparent masks in clinical areas. There is also scope globally. A further option being looked into is for them to be re-useable.

A discussion was held on a financial reforecast. SA suggested that was put on hold until the start of the new financial year. It was agreed this would be further discussed outside of the meeting.

Resolved:
RABD received and noted the content of this report for quarter 2 22/23

22/23/132 Month 6 Integrated Performance Report
KW introduced the new IPR. RABD had received the full Board version this month going forward RABD will receive the condensed version. The Chair thanked the teams for the new version noting it was much clearer version.

MC highlighted ED performance was significantly above the mean in Aug and Sept. Business case submitted and approval given for investment in the ED extension to improve flow and reduce overcrowding.

Resolved:
RABD received and noted the M6 Corporate report.

22/23/133 Communications update
Resolved:
RABD received and noted the communications paper.

22/23/134 PFI Report
Resolved:
RABD received and noted the M6 PFI report.

22/23/135 Green Plan
Resolved:
A verbal updated was received noting a strategy would be presented in December.

22/23/136 Board Assurance Framework
Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/137 Any Other Business
No other business was reported.

22/23/138 Review of Meeting
The Chair noted the approval in principal for the Neonatal project and the new version of the Integrated Performance report

For Information: Commercial Governance Standing Operating Procedure Approved at Innovation Committee on 10th October 2022
RABD received the above policy for information.

Date and Time of Next Meeting: Tuesday 29th November 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Tuesday 29th November 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Deputy CEO/CFO	
	John Kelly	Non-Executive Director	
	Rachel Lea	Deputy Director of Finance	(RL)
	Claire Liddy	Managing Director of Innovation	
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:			
	Ian Gilbertson	Associate Director of Digital	
	Rachel Greer	ACC, CAMHS	
	Chloe Lee	ACC Surgery	
	Graeme Montegomery	Business Accountant Surgery	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Cath Kilcoyne	Deputy Director of Business Development	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Mark Flannagan	Director of Communications	(MF)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Alex Pitman	Green Plan, Project Manager	

22/23/139 Apologies:

Nathan Askew	Chief Nursing Officer	(NA)
Mark Carmichael	ACC, Medicine	

22/23/140 Minutes from the meeting held on 24th October 2022

The above minutes were approved as a true and accurate record.

22/23/141 Matters Arising and Action log

All actions had been included on the agenda.

22/23/142 Declarations of Interest

There were no declarations of interest.

22/23/143 Finance Report

Month 7 Financial Position

M7: has achieved an in-month trading surplus of £1.0m in October which is in line with the planned financial position. Year to date (M1-7) the Trust is reporting a deficit of £0.4m again in line with the deficit plan which is profiled to deliver a surplus position from month 7.

CS noted CIP has stayed on track with a £1.1m saving since M6. As requested at the last RABD the report has been updated to include what was recurrent within CIP and the in-year benefit going forward as well as the sit report.

JK asked what processes are in place for AH to manage interest rates/savings. RL gave an overview and noted the Cash Management Policy is due to be presented at the January RABD.

Action: RL/CS

RL presented slides on the exit run rate for 22/23 following the request from Cheshire and Merseyside ICS, noting this is not the final position as based on a number of high level assumptions and without the 23/24 planning guidance. RL went through the annual planning processes with the Divisions being worked through to support this.

The Chair queried the Trust underlying position on page 11 of the Finance report. CS responded to the query and noted the reasons for the movement.

Resolved:
RABD received and noted the M7 Finance report.

22/23/144 Surgery Deep Dive

GM and CL presented the year to date forecast as well as the year end position. A breakdown on outstanding CIP was given, main contributors included: increase on drug cost, outstanding vacancies and sickness. Pharmacy have been supporting the division to analysis drug costs and review all options to reduce spend.

CL responded on the balance around increasing Theatre sessions and the process undertaken for each case.

A slide was shared on actions completed and in progress. The Chair asked to see the financial benefit, controllable and none from the actions agreed.
Action: GM/CL

A discussion was held on the confirmed Royal College of Nursing strike days and the implication this will have on activity.

Resolved:
RABD received and noted the financial position within the Surgery Division.

22/23/145 Debt Write Off

Resolved:
This item was deferred until the December RABD.

22/23/146 Board Assurance Framework Deep Dive: Access to Children and Young People's Mental Health

RG highlighted the increase in patients accessing CAMHS since the pandemic and the issues this brings the division in providing a responsive service. RABD noted actions going forward.

SA asked if the new application had been supportive to patients and the service. RG said it had and further options would be added.

Resolved:
RABD received assurance the CAMHS BAF deep dive noting this would continue to monitored through the BAF.

22/23/147 Capital and Cash Update

Capital
RL gave an overview of the 3 approved bids noting when the funding would be received.

CDEL and the Capital plan remain on track.

Cash
Some mitigation of the significant in year pressures identified on energy costs, have resulted in an improvement in the expected outturn which has flowed through to an improved forecast cashflow.

Resolved:
RABD noted the current position in relation to Capital and Cash.

22/23/148 CIP and 2023 risks
Resolved:
RABD received and noted the CIP update.

22/23/149 Campus update
Resolved:
The above item was deferred to the December RABD.

22/23/150 AlderC@re Programme
IG highlighted from the report:

- Continue to work towards a go live date of August 2023, if possible the earliest the programme would go live is June 2023.
- An update was received on the successful patient journeys across the Trust.
- Details on the gateway process were noted.
- Meditech have confirmed a reduction on cost for the programme next year.

Resolved:
RABD noted the continued challenges around Alderc@re and the go live date to be moved to 2023. RABD will receive further monthly updates.

22/23/151 Business Development
CK went through the report noting it can take up to 2 years building relationships internationally. MS asked where a decision would be made on whether it was ethically appropriate to go into business. CK said the team would check with the government of International Trade and a final decision would be made by RABD.

Resolved:
RABD received and noted the Business Development update.

22/23/152 Operational Delivery Network
DJ presented the Alder Hey biannual assurance report for hosting two North West paediatric Operational Delivery Networks (ODNs), which function of behalf of, and include providers from the wider North-West footprint. In addition, the Trust is joint host of other networks with Manchester Children's Hospital.

Resolved:
RABD received and noted the content of this report noting current risks and issues within hosted ODNs and their mitigations/key actions for resolution.

22/23/153 Month 7 Integrated Performance Report
Resolved:
M7 report was received. AB highlighted the Statistical Process Control graphs included within this and future reports.

22/23/154 Communications update

The new intranet development project continues to progress as planned.

Green Plan
JK noted the proposal to agree a 12 month contract in relation to energy costs and asked if this could be reduced to 6 months. AP confirmed flexible options are being looked into.

Resolved:
RABD received and noted the communications and green paper.

22/23/155 **PFI Report**
Resolved:
RABD received and noted the M7 PFI report.

22/23/156 **Board Assurance Framework**
Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/157 **Intellectual Property Policy**
Resolved:
RABD APPROVED the above policy.

22/23/158 **Capital Project Management and Procedure policy**
Resolved:
The above policy was deferred to the December RABD.

22/23/159 **Safe Staffing Nurse Recruitment**
22/23/160 **OPD Staffing Investment**
22/23/161 **Mental Health Investment**
Resolved:
RABD received details and APPROVED the three business cases above.

22/23/162 **Any Other Business**
No other business was reported.

22/23/163 **Review of Meeting**
The Chair noted good discussions.

Date and Time of Next Meeting: Monday 12th December 2022, 1330, via Teams.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 16th November 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Interim Chief Medical Officer	(Aba)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Jason Taylor	Associate Chief Operating Officer, Clinical Research Division	(JT)
	Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)
In attendance:			
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
	David Reilly	Associate Director of Digital Systems	(DR)
	Will Weston	Medical Services Director	(WW)
	Peter White	Chief Nursing Information Officer	(PW)

22/23129 Apologies:

Christine Hill	Pathology Manager	(CH)
Urmi Das	Divisional Director – Medicine Division	(UD)
John Grinnell	Deputy Chief Executive	(JG)
Adrian Hughes	Deputy Chief Medical Officer	(AH)
Dani Jones	Director of Strategy	(DJ)
Phil O'Connor	Deputy Director of Nursing	(POC)
Benedetta Pettorini	Divisional Director, Surgery Division	(BP)
Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
David Reilly	Associate Director of Digital Systems	(DR)
Jo Revill	Non Executive Director	(JR)
Jackie Rooney	Director of Quality & Governance	(JR)
Paul Sanderson	Interim Chief Pharmacist	(PS)
Sarah Wood	Safety Lead, Surgery Division	(SW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC).

22/23/130 Declarations of Interest

SQAC noted that there were no items to declare.

22/23/131 Minutes of the previous meeting held on 19th October 2022 – Resolved:

Committee members were content to **APPROVE** the notes of the meeting held on 19th October 2022.

22/23/132 Matters Arising and Action Log

KN alluded to the Parity of Esteem workstream and requested clarity on reporting. NA advised that Parity of Esteem workstream would be provided within the summary of the whole programme and that he would have an offline discussion to ensure this is included as appropriate.

Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/133 Patient Safety Strategy Board update

WW provided an overview of Patient Safety Strategy Board update:-

- Currently 13 workstreams, success highlights related to a Safe Month which was launched during November 2022, which included an introductory staff Broadcast, creation of SharePoint site, variety of blogs from senior leads, with a planned big conversation planned later in the month, with 4 stall dates later in the month for opportunities to ask patient safety related questions, and gain feedback from staff, patients and families.
- Governance of the programme had been significantly enhanced.
- Challenges remain similar to the previous month, with milestones for next month identified further work to ensure that focus is data driven with clear metrics for all of the workstreams within the programme.
- The workstreams had been reviewed and reduced from 20 workstreams to 13, as a number of workstreams are completed, combined, or weren't strictly projects.
- Agreement for one overall risk recorded for the programme recorded on Ulysses, which is in place. Clinical risks would continue to be managed on Ulysses whilst other programme risks are recorded and updated on the workplan.
- Documentation had been improved, specifically decision documents, A3 problem solving sheets and equality quality impact assessments. Mechanism had been identified to add new workstreams, with a one in, one out rule.
- Milestones had evidenced improvement, and organogram had reduced given 7 fewer workstreams.

FB thanked WW for update and welcomed reduction of portfolio to enable clear focus on key areas and welcomed communication engagement activity which is extremely positive.

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NA referred to the regional approach to transition from RCA investigation process to PSIRF, colleagues had attended 1 of 4 workshops, no current regional timeframe had been provided as yet, further clarity envisaged over the coming months. New risk management system would link in with all the requirements for changes at national level. FB encouraged Executive team colleagues to sign up for webinar, details of which had been circulated.

AB advised that the Trust is currently in the high 70's for pt safety mandatory training, and that hopefully there is appetite for continued engagement from colleagues SQAC **NOTED** the good progress regarding individual workstreams and welcomed future feedback regarding communication campaign.

Resolved SQAC received and **NOTED** the Patient Safety Strategy Board update

22/23/134 Sensory Friendly Environments Northwest Project – Alder Hey & Contact

LC presented the Sensory Friendly Environment Northwest Project – Alder Hey & Contact

000147. Update, which included the Sensory Friendly Environment Final Report & Evaluation of the project by Edge Hill University, together with webinar slides following Sensory Friendly Environment webinar. LC advised that significant work had been completed to date and had been shared nationally.

- LC continues to Chair the Sensory Internal Delivery Group meetings, LC advised that changes which had been made to date have had a significant positive impact on children and young people.
- LC alluded to the high number of staff within the Trust who have sensory issues, and that work is required to address training and development to support staff with sensory issues.
- Scoping exercise is taking place with regards to a dedicated sensory area within the Steven Gerrard garden.

FB asked how the work would continue post the project. LC advised that training would continue, and the uptake of the pilot had been good with 200 staff trained to date.

MS referred to the Disability and long term conditions network, which is shortly to be launched, MS is currently seeking a Chair for this network, MS queried whether the Disability and long term condition network could work closely with LC and Internal Delivery Group to ensure appropriate discussions are held and ensuring good links and support etc, this suggestion was welcomed by LC.

NA welcomed the excellent work undertaken to date, and referred to the powerful video. NA expressed his thanks to LC for her leadership and thanked staff involved for excellent work. FB echoed NA's comments and thanked LC.

SQAC **NOTED** the desirability of wider engagement to raise awareness across the organisation and beyond.

Resolved: SQAC received and **NOTED** the Sensory Friendly Environments Northwest Project -Alder Hey & Contact

22/23/135 DIPC Exception Report

MH presented the DIPC Exception Report, which provided an overview on UKHSA reportable infections, local targets, actions, vaccination programme and track and trace activity, key issues as follows:-

- There had been 10 reportable infections during October 2022
- There had been a significant increase in HAI GN BSI in 2022-23 compared to the same period last year. There had been 14 cases in the medical division with 3 patients on 3C accounting for 9 of the cases.
- CLABSI review meeting had been undertaken in Oncology on 30th September 2022.
- Flu campaign commenced on 10th October 2022, and to date 1,600 doses had been administered.
- Track & Trace activity – the service continues to support the Trust with tracing of positive COVID cases for staff and patients, cases are reducing.

KB alluded to the increase in gram negative BSI's and referred to the list of UKHSA reportable Infections and queried whether they are gram negative, or whether they are something different, MH confirmed that they are different, KB noted that the target had already been exceeded regarding gram negative BSI's and queried whether focussed work is required to address this increase in cases. MH stated that 14 cases were within the Medicine Division and 3 patients on Ward 3C accounted for 9 of the cases. MH stated that she envisaged that there would be a review undertaken, and that MH and BL had previously discussed this issue. MH advised that she would provide feedback to BL to enable BL to provide an update to SQAC

at December 2022 meeting.

Aba advised that there had been an extremely extensive review of infection prevention indicators and that it is CLABSI's outside of ICU, together with the timeline for reporting, and surgical site infections, and whether this is held in Surgery Division, and whether this starts to come through IPR, AB sought clarity regarding integration which would be welcomed. MH stated that She would ask BL to provide SQAC with an update at December meeting.

NA referred to CLABSI's, and stated that work is currently underway to move to measuring against per 1000 line days. This data had only been collected for a 2-3 month period, this would be moved into IPR, and this would enable benchmarking against other centres.

NA referred to vaccination numbers and stated that 1600 doses equates to just over 40% of staff.

NA advised that a Flu Patient Group Direction (PGD) had been signed off on 16th November 2022 to enable parents of vulnerable children and high risk children i.e., children within Oncology to receive flu vaccine.

AB welcomed the per 1000 bed days. AB requested clarity whether this would include line infections outside of PICU when the Trust moves to this approach. NA agreed to follow up to ascertain.

Resolved: NA to follow up re 1000 bed days, and provide clarity whether this would include line infections outside of PICU

Resolved: SQAC received and **NOTED** the DIPC Exception Report and welcomed an update from BL at December 2022 meeting.

Delivery of Outstanding Care

Safe

22/23/136 **Assurance ED Assurance Monthly Update**

SQAC received and **NOTED** the ED Assurance Monthly update
Resolved: SQAC received and **NOTED** the ED Activity Monthly update.

22/23/137 Safeguarding Annual Report

LC presented the Safeguarding Annual Report, key issues as follows:-

- LC advised that the Safeguarding Annual Report meets all statutory requirements.
- Future plans are to have a Safeguarding Annual Report, and in addition the Children & Young People Forum plan to produce a Safeguarding Annual report video to ensure a child friendly version of the report is available.

NA welcomed the planned approach for future child friendly report and stated that the current report is extremely succinct and clearly identifies areas for improvement. NA commended LC and teams for report. KB echoed NA's comments.

KB queried whether the new Safeguarding team had reviewed the Risk Register, LC confirmed that the team had fully reviewed, and that there were a number of risks that had been added, and are in the process of being added, a detailed workplan had been developed and that the Risk Register would be updated..

KB requested whether any demand stats or themes and trends could be included in future Safeguarding Annual Report, LC confirmed that this would be addressed and included in

future reports.

LC advised that as part of separating the core safeguarding service away from the sexual assault and referral service, there would be a separate report, in addition to a report for children in care, therefore the Board of Directors and SQAC should see three different reports in the future.

FB expressed thanks to LC and Safeguarding Team for comprehensive and succinct Safeguarding Annual Report.

Resolved: SQAC received and **NOTED** the Safeguarding Annual Report and accepted assurance that systems and processes are in place to ensure Alder Hey Children's NHS Foundation Trust fulfils its statutory safeguarding responsibilities.

22/23/138 Quarter 2 Mental Health Attendance

LC presented Quarter 2 Mental Health Attendance report, key issues noted as follows:-

- For the reporting period 01 July 2022 – 30 September 2022, 160 children and young people attended the Trust's Emergency Department which is the same as in Quarter 2 (163 attendances). This is a decrease of 30% compared to Quarter 1 (228 attendances), which is an expected reduction in demand due to the school summer holidays.
- Presentations included Self-harm, suicidal ideation, intentional substance overdose, anxiety and depression, behavioural problems and any other mental health concerns.
- 84% of Children and Young people who attended Trust' ED department with mental health concerns had contact with the Trust's Crisis Care services, which demonstrates crisis care pathways and processes are in place.
- Over the past 12 month period there had been 835 attendances to Alder Hey ED department with mental health presentations.
- For the reporting period 37 (23%) of children and young people were admitted to an acute inpatient ward, which is lower than the previous quarter (25%)
- Of the children and young people seen in the ED with a mental health presentation in Quarter 2, 36% are open to Alder Hey Specialist Mental Health Services.
- For the 160 young people who attended ED in Quarter 2, the average time spent in the department was 275 minutes (4.5 hours), this is an improvement compared to 5 hours in quarter 1.

FB thanked LC for comprehensive update

Resolved: SQAC received and **NOTED** the Quarter 2 Mental Health Attendance report.

22/23/139 Clinical Audit Report Quarter 2 2022-2023 Update

PB presented the Clinical Audit Report Quarter 2 2022-23 update, key issues as follows:-

- 59 audits registered during the reporting period (1st July 2022-30th September 2022), including 13 local audits and 21 national audits. Of those 6 had been completed during Quarter 2:

  - 43 (73%) audits are progressing and on schedule
  - 2 (3%) audits not started in quarter (1 suspended, 1 cancelled)
  - Further 45 audits were completed in Quarter 2 from previous audits registered
  - 8 audits had been delayed or had no progress, which had been addressed with relevant teams to ensure that programme is accelerated

- Emerging audit findings include recommendations to enhance existing clinical guidelines/pathways, development of new guidance, development of specialist teaching provision/training, training plan to be developed and tailored to different areas caring for

patients with sickle cell, biannual sonographer training to be conducted by Tiny Tickers charity, followed by yearly sonographer updates from 2023 and increased partnership working.

- Workshop scheduled for early November 2022 had taken place with Divisions, with good attendance, this would be reported on in Quarter 3 report.

KB welcomed the improved format of the Clinical Audit Report, FB echoed and endorsed KB comments, given the oversight of Clinical Audit, and thanked PB and colleagues for considerable progress.

Resolved: SQAC received and **NOTED** the Clinical Audit Update content and findings, and **NOTED** the progress regarding the annual audit activity and agreed the assurance provided.

22/23/140 Safe Waiting List update

AB presented the Safe Waiting List update

Good progress had been made in implementing actions from RCA
Urology outpatient incidents, with 4 of the 8 actions completed in October 2022, 3 of 8 actions behind plan and 1 of 8 actions overdue. As part of the initial RCA a review of how high risk patients are managed was initiated. An options appraisal for mapping of current waiting list to the new categories of high/medium/low had been approved by Clinical Directors of the Division of Community, Medicine and Surgery. A detailed project plan to be developed in conjunction with Alder Care Programme Board to deliver this change, with achievable timelines to be agreed.

Those outstanding actions relate to fail safe reports in BI as the previous incidents had been human error not making appropriate follow up appointments.

FB alluded to the discussion regarding an incident wihth Urology patinets and queried whether this related only to Urology patients, or whether this could be replicated. AB stated that there is a need for a failsafe process for those patients who have had treatment and are discharged, and if no follow up made that there is a daily check, this is subject to final review.

FB stated that this update is a great example of building on success and widening remit to ensure same benefits elsewhere. AB advised that there is ongoing learning and there is a need to ensure oversight and highlighted the importance of daily data quality checks with the safe waiting list team.

FB thanked AB for comprehensive update and for providing SQAC with assurance.

Resolved: SQAC received and **NOTED** the Safe Waiting List update

Clinical Governance Effectiveness

22/23/141 CQSG Key issues report

SQAC received and **NOTED** the CQSG Key issues report.
Resolved: SQAC received and **NOTED** the CQSG Key issues report

22/23/142 Confidential enquiries/national guidance assurance report

PB presented the Confidential enquiries/national guidance assurance report, key issues as follows:-
National Confidential Enquiries relevant to Alderhey include:

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

- Perinatal Mortality, and Morbidity Confidential Enquiries (MBRRACE-UK)
- National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)

The Trust participated in 3 National Confidential Enquiries and 1 national service improvement programme during the reporting period July 2022 - September 2022 as outlined below:

- NCEPOD Transition from child to adult health services
- Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) MBRRACE-UK
- Suicide in children and young people (CYP) - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- 1 Learning Disability Mortality Review Programme (LeDeR) case was completed to LeDER during Quarter 2.

PB alluded to the high level engagement with those enquiries – NCEPOD with 25 sets of case notes requested which had been shared, of which 12 reviewed to date.

- MBRRACE-UK – 5 deaths reported within neonatal period, MBRRACE is managed through the Liverpool Neonatal Partnership with oversight of MBRRACE.
- Suicide in children and young people (CYP) (NCISH) - 0 cases were recorded in the Trust during Quarter 2 2022/23 therefore, no submissions were made to NCISH.
- A new NCEPOD Confidential Enquiry on Testicular Torsion is currently in development. This has been added to the Trust audit Plan for 2022-2023 and it will be assigned to the reverent Division when it goes live.
- A series of patient and parent carer focus groups are scheduled by NCEPOD for the Juvenile Idiopathic Arthritis NCEPOD study in November 2022. The outputs from these meetings will inform the discussions with the Study Advisory Group and will feed into the design of the study protocol and data collection materials.

KB welcomed the improved format of the report, and queried whether NCEPOD are a subset of the clinical audit programme, or whether they are completely separate, PB confirmed that they are a subset and that the Trust is nationally mandated to report on those separately in terms of confidential enquiry level.

Resolved: SQAC received and **NOTED** the Confidential enquiries/national guidance, SQAC welcomed the new style of reporting, and **NOTED** the contents of the report, SQAC acknowledged high level of participation and welcomed the high level of assurance provided, with the correct level of scrutiny and engagement.

22/23/143 Divisional Governance monitoring update

NA confirmed that a preferred provider of the new risk and incident management system had been identified. The contract award phase had commenced NA would be in a position to provide more information to SQAC next month.

NA advised that the aim is to bring the system in before the end of the financial year, subject to business case, with plans currently on trajectory.

Well Led

22/23/144 Board Assurance Framework

ES presented the Board Assurance Framework; key issues as follows:-

- SQAC **NOTED** the ongoing work taking place to strengthen the Board Assurance Framework report regarding controls. ES referred to recent CQC engagement meeting held on 7th November 2022 which highlighted the importance of capturing all of the improvement work and ensuring this is captured into assurance process to provide SQAC

Deep Dive Risk 1.4 - Access to Children & Young People Mental Health

LC presented Deep Dive on Risk 1.4. – Access to Children & Young People Mental Health, which provided an overview on Key risks, Key actions, Key gaps, current controls in place, details on consequences of not delivering controls, and short and long term mitigations. key issues as follows:-

- There had been a significant increase in demand for Specialist Mental Health Services at Alder Hey following the COVID-19 pandemic which has led to an increasing number of children and young people presenting in mental health crisis including those with complex needs and challenging behaviours. This has increased waiting times and challenges meeting the internal Trust access standard of referral to treatment within 18 weeks
- Key risks relate to Failure to provide a responsive service to meet mental health needs of children & young people living in Liverpool and Sefton, and inability to provide a safe, high quality, effective mental health service due to inadequate capacity and insufficient workforce.
- Key actions are in place to address workforce gaps and activity levels through the A3 process, there is also recruitment to new investment for 2022/23 underway. LC advised that the Trust had received confirmation regarding money for 2022/23, Liverpool agreed in July 2022, Sefton are still yet to agree however the ICB had agreed to underwrite the risk for the organisation regarding commissioning arrangements that are legacy issues from CCG's.
- BAF updated to provide assurance on the controls and actions that are in place.
- Key gaps in current trajectory to meet the Trust internal standard of 92% children and young people waiting within 18 weeks for treatment from Alder Hey mental health services.
- Current controls in place include routine safety check calls in place for routine and urgent breaches for community mental health services. If the presentation of a young person has deteriorated the appointment is upgraded to an urgent appointment, there are groups to support children requiring support.
  - Business case for investment submitted and approved by Cheshire and Merseyside ICB.
  - Weekly performance monitoring in place for operational teams, providing assurance on longest waiting patients
  - Monthly performance contract statements shared and presented with narrative to commissioners
  - Access and waiting time information shared with Executive team through monthly IPR and bi-monthly Divisional Performance Review
  - Weekly allocation process in place to ensure children and young people are allocated to a case manager with the right experience and skill set to meet their presenting needs
  - Continuous recruitment to existing vacancies and new recruitment to 2022/2023 investment posts.
- Consequence of not delivering controls – Inability to deliver safe, high quality mental health services to children and young people, increase in waiting times, lack of internal and external assurance on performance, inability to report on new waiting time standards (currently draft guidance, expected to be formalised in future planning)
- LC updated on those short term and long terms mitigations in place

AB alluded to the recruitment and questioned whether there are staff across C&M, LC advised that there are staff who want to come and work at Alder Hey and want to stay, however, there are challenges regarding variance in banding across C&M, and that C&M workforce colleagues are reviewing the job profiles of the workforce and agreeing collective principles regarding recruitment and retention of staff.

ES queried whether there are any implications of the emerging MHLDC Provider Collaborative in terms of a proposed model. LC advised that there would need to be a BAF risk regarding money, LC suggested that this risk should be aligned within finance risk.

FB referenced the children and young people who had been referred to other services and queried whether options had been explored with regards to managing waiting lists. LC confirmed that the Trust is part of Liverpool and Sefton CAMHS partnership and both areas have very different third sector provision. Through the referral platform all referrals are reviewed and triaged and those referrals not suitable for Alder Hey are directed to one of the third sector providers and the appointment is booked. With close working partnership with providers and the Trust, the funding for these providers is often at risk.

FB advised that it is important to capture the strength of those partnerships as part of the mitigation.

NA referred to BAF updates with regards to risk 1.1 and the gaps in assurance that had not pulled through as part of the update, NA advised that this would be updated again this month.

SQAC received and **NOTED** the Deep Dive Risk 1.4 and the assurance provided.

FB thanked LC for update and acknowledged SQAC assurance with regards to Risk 1.4.

Resolved:SQAC received and **NOTED** the Deep Dive and the assurance that this provided.

22/23/145 Divisional reports by exception/Quality Metrics update

Surgery Division - CC presented an update on key issues follows:-

- Division of Surgery had 100% compliance with regards to PALS and complaints responses.
- Improvement in outpatient attendance for the 4th consecutive month
- Divisional focus on percentage completed clinical letters with improvement noted
- Reduction in patients waiting over 52 weeks, although 52 weeks remains a challenge
- Division of Surgery are close to the 104% performance target set for recovery plan, more patients have been treated compared to 2019/20 pre Covid
- Challenges in Dental, Spine and ENT with 52 week waits for children to be seen, with actions plans in place to address a number of these issues

Division of Medicine – CW provided an update on key issues as follows:

- The Division of Medicine have ongoing challenge regarding ED with regards to a further increase in attendees at ED
- Weekly length of stay meetings commenced in October 2022 with significant focus on each patient, with good clinical involvement.
- Division are reviewing how patients can be repatriated to own local hospital or District General, Division are working with other hospitals on those long stay patients
- Nurse led discharge and pathways focusing on virtual ward, new response and bed management team which will be in place from 28th November 2022
- Number of patients receiving antibiotics within 60 minutes for the last 5 months had been over 90%, with four months at 98% with robust progress in place
- Challenge regarding ED patients receiving antibiotics within 60 minutes, the Division had seen an improvement, 90% in October, with ongoing targeted work taking place to embed and improve further

Division of Community & MH – LC presented an update on key issues as follows:-

- Referrals for Neurodevelopmental Services, ASD & ADHD continue to increase

- The Division had used restrictive intervention with one young person on the mental health tier 4 unit on one occasion during September 2022, 0 in October 2022, this is a significant decrease for this young person with an eating disorder, with much improved position.
- Division received 0 formal complaints during October 2022, PALS continues to remain high at 60. LC had met with parent carer forum to discuss different ways on how to share communications and revieing how the department can use social media, website, QR codes etc. to share information with parent with the aim of reducing PALS and complaints.
- Significant moves are taking place, staff had moved from old catkin 2-3 weeks ago, crisis care team are now based in new Catkin. Ongoing moves planned to move to modular building and Liverpool Mental Health services are due to move on 18th November 2022 to Innovation Park, which would result in increased capacity to see additional patients with 10 additional counselling rooms.

Clinical Research Division

- Division recently had its first face to face meeting with young person's advisory group, regarding informing them of the next reiteration of the Clinical Research facility strategy.
- Challenges - 1 no harm never event in October 2022, An RCA panel is scheduled to take place later this month. Main challenge relates to staff turnover, which exceed 30% for October 2022. This is a dedicated improvement priority for the Division with continued focus on staff well-being and listening to staff,
- The division are taking steps regarding staff progression routes and have created a new post of a clinical research practitioner to broaden the skill mix. Division are reviewing the wider staffing model, following the completion of the organisational review which is underway.

FB thanked all Divisions for update.

Clinical Governance Effectiveness

22/23/146 PALS & Complaints Quarterly Report

PB presented the PALS & Complaints Quarterly Report

- 40 formal complaints received in Quar); this is a decrease compared to Quarter 1 (46)
- The main complaint themes continued to be in relation to treatment and procedure with a total of 16 complaints (42%) received consistent with the previous quarter. The main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 8 of 16 complaints in this category (50%) and 21% of the overall 38 complaints received. This is consistent with the previous quarter
- 97% compliance with the 3 working day acknowledgement standard was achieved in Q2. Compliance with the 25 working day response time was 65% in July, 82% in August and 65% in September (average 71%) demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern. 4 second stage complaints were received in Q2 2022/23
- There was one new referral to the Parliamentary & Health Service Ombudsman during this period in the Surgical division (received August 2022)
- 448 informal PALS concerns raised in Q2 2022/23; this is consistent with Q1. The main themes continue to relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff
- There has been a sustained improvement in responding to and resolving informal PALS concerns within 5 working days with an average of 82% compliance. This has a direct impact on families who raise a concern.
- PALS themes relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff

- Alder Hey continued to work closely working with Healthwatch with positive feedback received from Healthwatch, as the Trust was commended on best practice, regarding the level of learning that the Trust demonstrates and the thematic analysis which is good practice.

SQAC **NOTED** the sustained improvement across KPI's

- Issue had been identified regarding historic PALS concerns however work has reduced this significantly, with on going divisional reviews.

FB welcomed the PALS & Complaints update and the positive feedback provided from Healthwatch.

FB referred to legacy cases and referred to the Business Support Division and requested further detail. PB advised that this related to access to health and facilities. PB confirmed that the divisions have a dedicated PALS and Complaints officer who have responsibility for overseeing corporate business support complaints and PALS. PB had personally contacted all of the managers for the historic and legacy PALS and PALS and Complaints Officers have a robust system in place to monitor all of the business support complaints and PALS.

Resolved: SQAC received and **RATIFIED** the PALS & Complaints Quarterly report
FB thanked PB for comprehensive update.

22/23/147 Patient Experience Report

PB presented the Patient Experience Report, and highlighted the new style of the report which focussed on the voice for children and young people, report is envisaged to be more succinct in the future, key issues as follows:-

- 3 Patient Experience stories had been shared at Patient Experience Group during Quarter 2, with significant learning gleaned from those Patient stories, as a result of families being heard families are keen to engage with the Trust.
- Friends & Family Test (FFT) – The percentage/number of young people recommending Alder Hey during Quarter 2 was 92%, 3.418 very good or good responses out of a total of 3,723.
- Targeted work is taking place regarding ED to support families with any concerns regarding waiting times, ensuring families are kept comfortable whilst in ED and ensuring there is appropriate distraction methods in place for those families requiring distraction.
- PLACE Lite inspection was undertaken in June 22, with a full PLACE inspection which was scheduled for Quarter 3, 6th October 2022, the full report and results are expected to be shared by NHSE in January 2023.
- 15 step challenge had been undertaken
- Patient Experience Team are enrolled onto the Brilliant Basics Programme and have implemented the Brilliant Basics methodology in order to improve services, with positive impact evident.
- Focus on volunteer update, young volunteers commenced in Quarter 3, with roles established in Palliative Care and volunteer to career work programme is working well.

AB referred to medicine FFT scores and referred to the positive rise in scores during August 2022 in ED, and that this did not appear to correlate with the overall divisional score which did not appear. AB advised on the importance of understanding when scores may not be as high within some services in medicine, AB requested insight. AB referred to the response rate being low overall and queried how colleagues could collectively support the Patient Experience Team to improve responses and alluded to the potential opportunity -My Alder Hey work being undertaken on the portal to develop QR codes to obtain further feedback is captured, and whether any wrap around support in terms of innovation.
PB advised that QR codes had recently been introduced. PB advised that those areas of

Focus would be detailed in future reports.
000156

CW referred to the FFT feedback scores during August 2022 and stated that there were low responses, and as a result it only took a couple of responses that were not positive which would reduce %. CW advised that during the previous month the Division had focus to increase responses

CW **NOTED** AB comments and would feedback as appropriate.

Resolved: AB to receive medicine insight and ensuring connectivity regarding My Alder Hey work with the Patient Experience Teams.
KB welcomed seeing the young volunteers across the Trust, and commenced the 3 volunteers who now have a career path in the NHS was welcomed. KB commended the improved Patient Experience Report and Aggregate Analysis report which are extremely succinct.
FF thanked PB for Patient Experience update.

22/23/148 Aggregate Analysis Report

PB presented the Aggregate Analysis Report, key issues as follows:-

- Total of 1950 incidents were reported in Q2 2022/23, with high level of reporting, low level of harm.
- 83.1% of all incidents resulted in no harm (near miss and no harm), 16.3% minor harm, and 0.41% of all incidents moderate harm. No severe or catastrophic harm incidents were reported in Q2 2022/23.
- Duty of Candour (CQC Regulation 20) – 100% compliant with initial verbal & written notification for Q2 2022/23.
- 5 moderate incidents reported in Quarter 2, 4 of which were in the Surgery Division and 1 within the Medicine Division. Of those 4 moderate and near misses, 4 had been StEIS,
- 0 Serious Incidents were reported.
- Top 5 Cause Groups in Q2 2022/23 were: Medication, none of the medication incidents were moderation or above, Documentation, Access, Admission, Transfer, Discharge, Medical Devices / Equipment and Treatment / Procedure.
- Claims & Inquests – 6 claims and 0 inquests reported for Q2 2022/23. The top theme related to inappropriate treatment / treatment failure or delay in treatment.
- Actions taken regarding key themes

FB stated that the themes are clearly seen and reinforces the ongoing work of the patient safety Programme and referred to the overlaps with other reports reviewed at SQAC, with assurance regarding responsiveness clear.
FB thanked PB for Aggregate Analysis update.

22/23/149 Any other business

None.

22/23/150 Review the key assurances and highlight to report to the Board

Positive updates were received regarding:

- Patient Safety Strategy Board update was received. SQAC welcomed the reduction in workstreams/themes. SQAC noted the clarity in the reporting and the changes and improvements in governance.
- Sensory Project final report received, SQAC welcomed this important piece of work, and noted the desirability of wider engagement to raise awareness across the organisation and beyond.
- Safeguarding Annual Report received
- Quarter 2 Mental Health Attendance report received

- Clinical Audit Update received. SQAC noted the clarity of the report and the improved oversight of Clinical Audit activity.
- Safe Waiting List update received with useful discussion held regarding management of follow up patients
- Confidential enquiries/national guidance assurance report received, with good assurance provided
- Divisional Governance Monitoring verbal update received on the new Governance system
- CQSG Key issues report received
- Divisional updates received. SQAC noted the challenges across the organisation, given the continued staffing pressures across all divisions, levels of ED attendance and the pressures regarding mental health services. Assurance was provided through the discussions that all options are being fully considered to manage these pressures across the organisation, including pro-active discharge management to manage bed pressures.
- PALS and Complaints Quarterly Report received with good assurance provided.
- Patient Experience Report received with good assurance provided across the organisation.
- Aggregate Analysis Report received with good assurance provided.

21/22/151 Date and Time of Next meeting

FB thanked all for attendance

Next meeting to be held on 14th December 2022 at 9.30 am

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on 31st October 2022 Via Microsoft Teams

Present:	Dame Jo Williams	Trust Chair (Chair)	(DJW)
	Nathan Askew	Chief Nursing Officer	(NA)
	Fiona Beveridge	Non-Executive Director	(FB)
	Mark Flannagan	Director of Communications & Marketing	(MF)
	John Grinnell	Deputy Chief Executive	(JG)
	Claire Liddy	Managing Director of Innovation	(CL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MSW)
	Jason Taylor	Acting Associate COO – Research	(JT)
	Ian Quinlan	Non-Executive Director	(IQ)
Guest:	John Kelly	Non-Executive Director	
In attendance:			
	Pauline Brown	Director of Nursing	(PB)
	Carolyn Cowperthwaite	Acting Associate Chief Nurse – Surgery	(CC)
	Sharon Owen	Deputy Chief People Officer	(SO)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
	Jacqui Pointon	Associate Chief Nurse	(JP)
	Jo Potier	Associate Director of Organisational Development	(JP)
	Clare Shelley	Associate Director of Operational Finance	(CS)
	Kerry Turner	Freedom to Speak Up Guardian	(KT)
	Cath Wardell	Associate Chief Nurse – Medicine	(CW)
	Julie Worthington	Staff Side Rep	(JW)
	Tracey Jordan	Executive Assistant (Minutes)	(TJ)
Apologies:	Kathryn Allsopp	Head of Operational HR	(KA)
	Adam Bateman	Chief Operating Officer	(AB)
	Rachel Greer	ACOO – Community & Mental Health	(RG)
	Mark Carmichael	Associate COO – Medicine	(MC)
	Katherine Birch	Director of the Alder Hey Academy	(KB)
	Maisie StJohn	Service Manager	(MSt)
	Jeanette Chamberlain	Staff Advice & Liaison Service Manager	(JC)
	Chloe Lee	Associate COO – Surgery	(CL)
	Adrian Hughes	Deputy Medical Director	(AH)
	Gill Foden	HR Manager	(GF)
	Alfie Bass	Acting Chief Medical Officer	(AB)
	John Chester	Director of Research & Innovation	(JC)
	Urmi Das	Director, Division of Medicine	(UD)
	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)

22/23/080 **Declarations of Interest**
No declarations were declared.

Introductions
John Kelly was observing today's meeting.

22/23/081 **Minutes of the previous meeting held on 3rd August 2022**
The minutes of the last meeting were approved as an accurate record.

22/23/082 **Matters Arising and Action Log**
Action log was updated accordingly.

Industrial Action Update
MSW announced that formal notification had been received from Unison following the RCN ballot indicating the intention for strike action. Junior Doctors ballot was scheduled for January 2023.

JG assured the Committee that Executives and Senior Operational Teams were working in preparation ahead of winter plans to identify any potential impact to service provisions, associated risks have been added to the risk register.

Next steps: Contingency piece of work will be conducted. AB and Team are currently working in preparation ahead of winter plans.

22/23/083 **Monitor Progress against the People Plan - People Metrics**

Medicine Division:

- Sickness absence for the division was above target with some slight improvement during the last three months including September.
- Return to work remains a challenge and teams continue to push through.
- Turnover figures remain above trust target. The Senior Leadership Team are reviewing pathways for all employees and new starters to help reduce movement. Data from exit interviews to be utilised more effectively to help staff with their work life balance and to remain in their job roles. Potential link to lower paid staff and current cost of living crisis to be analysed. SO confirmed that a Task & Finish Group has been established to look at these pieces of work.
- Long Term Sickness continues to be managed with particular focus on the 3 top reasons for absence and assurance was provided with action plans in place.

PDRs continues to be closely monitored particularly in areas with low reporting rates. Assurance was provided that PDRs remain an area of priority for the division recognising the link with sickness absence, staff retention and staff feeling valued.

Next steps: Teams continue to monitor data and drive improvements across the division via divisional road map 2022/23.

Action: Provide breakdown of turnover and bring to the next Committee for assurance.

Community & Mental Health Division:

- Staff survey completion rate was reported at above 50%

- Sickness absence was above target but has decreased month on month over past three months.
- PDRs remain above trust average, slight drop in September's data.
- Mandatory training is above Trust average for the division.
- Time to Hire is within trust target with the process running smoothly.
- BAME diversity figures remain stable in line with the previous months report which continues to show improvements with a slight increase on a month-by-month basis.
- Return to Work Completion is reporting at 89% and teams continue to work with areas across the division to help support and improve.
- Overall turnover remains high and above trust target, slight decrease to September's data with a total of 8 leavers. A process of engaging with staff who are thinking of leaving is in place.

Next steps: Exit interviews continue to be encouraged throughout the division. Deep dive in CAMHS is being conducted in relation of turnover as part of the brilliant basics programme.

The Chair talked about the need to be proactive in talent spotting and succession planning which is critical in enabling staff to remain with us and develop their careers internally.

JK stated that it would be helpful understand how we fair against the national position in terms of retention. MSW advised that we don't regularly receive national data on turnover, but informal intelligence indicates a higher turnover is being experienced across the country, and the lack of pay progression across bands 8a-8d is having an impact.

Surgical Division:

- Sickness absence was reported at 5.06% for both long- & short-term sickness.
- Mandatory Training is above trust targe at 92.4% and training sessions continue to progress forward to maintain compliance.
- PDRs remain a priority to meet the deadline by end of March 2023 for all staff and ensure they are being delivered in a meaningful way
- Completion of the Staff Survey is proving a challenge but remains a focus by encouraging staff to complete as a priority.
- Time to Hire figures remains a challenging area. Support is being provided from HR to improve.
- Return to Work Admin remains a challenge and teams are working to ensure appropriate plans are in place moving forward including identifying time for ward managers to complete these in a timely manner.

Action: MSW asked for practical steps, in terms of capacity, to be reviewed to ensure that the responsibility of completing these are shared amongst those in other management positions.

- Turnover was reported at 12.48% which is above trust target. Managers continue to meet with staff for better understanding around reasons for leaving. A focus on wellbeing conversations in 1:1s were now in place to try and identify issues that may prompt staff to leave the Trust.

Surgery division has developed new strategies of identifying achievements for staff by creating recognition which consists of:

- "Star of the week" for PDR completion
- "Weekly Newsletter" distributed monthly for summarising success work achieved.
- Away-Days with Operational Managers and Senior Nurse Managers aiming to focus on wellbeing and leadership.

MF referred to his visit to Northumbria Healthcare NHS FT and undertook to provide some shared learning with MSW offline regarding increasing compliance. **Action for MF**

Research Division:

- Sickness absence remains below Trust target.
- Turnover remains a challenge with 16 leavers over the last 12 months which is the highest across the Trust. Work is ongoing to address this, but data does indicate that staff are leaving due to higher pay external to the NHS.
- PDRs continue to be encouraged in a timely manner across the division.
- Mandatory Training is above trust target.

Research Division continues to conduct one to one meeting with staff and ensuring exit interviews are taking place within the timeframe.
Workforce is working in line with brilliant basics programme and holds monthly divisional briefing meetings led by Senior Leaders. Research has introduced a quarterly staff survey to allow issues to be identified and actioned as necessary.

Innovation:
Staff turnover was currently sitting above target. CL advised that a deep dive had been conducted in relation to leavers which identified staff are leaving due to promotions outside of the NHS for a higher rate of pay. Three themes that the division had been addressing during the past 12 months included recruitment and retention, giving staff a voice and a focus on psychological safety

CL advised there is a new procedure in place which provides staff opportunities for recognition which consists of a range of options around show casting supported by HR in relation to tailored talent management plan and currently being piloted to allow accelerated progression.

Alder Hey has designed a New Clinical Fellowship Programme which is the first in the UK working with Health Education England of developing a new approach to staff for temperature checking and building together for staff engagement and development.

There are action plans in place around wellness and environment in relation to refurbishing around safety which has been designed to indefinity on how we as a trust give a sense of keeping our staff at Alder Hey.

The Chair commented advising the importance of PDR completion for our staff by keeping this as a high priority moving forward.

ES highlighted that the Corporate Services data had been omitted from the pack. Assurance was provided that the workforce metrics had been discussed in detail at the

Corporate Services Collaborative and that an update would to be provided at the next Committee meeting.

Resolved:
The Committee received and noted the update on the content of Divisional HR metrics.

22/23/084 **Progress against the Internal Communications Plan**

Committee received the Internal Communications Plan report and noted progress to date.

Intranet Development
MF referred to the new intranet which was set to launch in January 2023 which remained on schedule. Initial plans would be shared with key stakeholders in December to finalise the design in preparation for January's go live date as part of the testing process.

MF highlighted the three principles of the new intranet which form the basis of the new look and feel intranet.

Resolved: Committee noted the progress against the intranet development plans.

Celebration & Recognition
No report received – update to December meeting. **Action.**

22/23/085 **Project Review**

The Committee received the Programme Assurance Report. NP provided an overview on the current position:

NP confirmed 2 programmes that have been completed:

- Workforce Planning – overall rated green. Milestone to be agreed and completed by the end of the financial year.
- Great Place to Work – small improvements needed around housekeeping and documentation which is being actioned.

NP noted to the Committee, Kathryn Allsopp, HR Manager has provided excellent support to the project.

JG suggested having more refined data in relation to Alder Hey being a great place to work specifically relating to staff who have moved location and how they will transition back into the working environment pre-covid. More of a focus needed around what being flexible means for our staff by collating the correct data. MSW commented advising that high standard of accommodation was the first phase of this work agreed this needs to form part of the next steps.

Resolved: Committee noted the progress of the Programme and agreed an initial focus is needed around flexibility.

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22/23/086 **Staff Survey Action Plan – Progress**

JP presented the staff survey action plan around progress update highlighting main key points by exception:

- Data within the packed had slightly increased up to 42% which compares favourably to the national average of 30%. Divisions working hard to encourage higher responses.
- Community has rated above average.
- Facilities Department and various Wards are performing well this year to date.
- Staff groups have reported as the lowest within Clinical Services due to nursing staff; possibly reflective of not having enough l time to complete due to hospital pressures and access to IT equipment.

The Chair thanked the teams who have done well in completing the survey and encouraged this to continue across the services.

Resolved: Committee noted the progress update on the staff survey and teams are encouraged to continue to complete with the aim to keep the data percentage rising.

22/23/087 **Volunteering**

VS provided a verbal overview on the current position within the volunteer's service noting:

An increase in 15% of BAME volunteers being recruited. This was achieved by visiting the community groups, other healthcare groups to share awareness for our own learning and continues to work closely with GOSH and Blackburne House.

Next steps: Service aims to give volunteers a voice and empower them to visit the community to share their lived experience which proves successful.

There is a trust funded programme relating to career opportunities and the service was able to recruit 13 people which had a positive outcome.

Action: To provide data on the newly funded programme at the next Committee.

Palliative Care Project update was shared to the Committee which is a successful part of volunteers visiting the ward areas to interact with patients aiming to support parents and staff. This proved very successful and had a positive outcome.

On Friday 28th October 2022 the trust conducted a "In Step Challenge" which saw young volunteers join the Quality Round Team (volunteers aged between 8 to 11 years old). This is a pilot scheme currently being undertaken. Six young volunteers recently met with staff, patients and their families which provided positive feedback. VS advised this is something the trust had taken part in pre-covid and aims to reinstate going forward. PB commented on the positive impact and feedback received from the young volunteers on the Quality Assurance Round which had been a great success.

Action SO very much welcomed this process and undertook to link with VS in terms of potentially identifying and growing our future workforce from this cohort.

Next Steps: Next round of our young volunteers will join the trust again at Christmas and February 2023 half term. Pictures will be taken and displayed across the trust. There are currently 151 volunteers signed up and a further 144 in application process.

Resolved: Committee noted progress made to the Volunteering service.

22/23/088 **Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES)**

The Committee received the WRES and the WDES reports for information, both of which had been presented to October's Trust Board Meeting where progress had been noted.

MSW informed the Committee that the Trust's new EDI Lead was due to commence in post in January 2023 which would be a shared role in partnership with Clatterbridge.

Good progress was reported in terms of the race equality metrics but, disappointingly slower progress in terms of our disability metrics. JP and colleagues from SALs have undertaken some listening events with our staff with disabilities which highlighted expectations needed from the organisation which was beneficial.

MSW confirmed to the Committee the new EDI Steering Group will pick up the action plans relating to both WRES/WDES reports with the aim to produce meaningful actions on the workforce disability measures. MSW noted, the Team met in July 2022 and future meeting dates are now secured.

FB requested further assurances in terms of trend identification for to a minimum of 3 years data to be reported for NED oversight. MSW advised the current reports follows the format of the report the trust is required to publish but the data can be further explored. **Action.**

MS advised both WRES/WDES reports following PAWC & Board will be published on the Trust internet.

The Chair asked about monthly faith celebrations and whether these were still part of the Trust communications plan. MF undertook to clarify this. **Action**

Resolved: The Committee received and noted the WRES and WDES reports noting progress and actions going forward.

22/23/089 **BAF Deep Dive**

- **Risk 2.1 Workforce Sustainability & Development**

A deep dive into the strategic risk relating to workforce sustainability and development was undertaken. SO informed the Committee that the risk was currently scored at 3x4=12 (moderate & likely) with a target risk score of 6.

Particular attention was drawn to the gaps in controls including mandatory training compliance, workforce planning which is not consistent across the organisation, talent succession planning and the requirement for a new robust Recruitment Strategy.

SO went on to talk about several further actions that have been identified to further mitigate the risk and address the current gaps including:

- Development of the 2030 Trust People Plan will be aligned to the national people plan.
- HR have rolled out a new sickness absence training programme plan which requires some additional support and development with Managers. New cohort now trained and will continue to roll out training sessions.
- Designated HR, SALs and Occupational Health to closely monitor sickness absence with additional scrutiny relating to return to work which will remain a focus.
- Workforce Planning - an establishment control project is in place to support the overall workforce plans.
- Recruitment, Attraction & Retention project continues to move forward and remains a focus for 2022/23 plans
- The establishment of a Task & Finish Group to review turnover rates to analyse the data. A detailed will be brought to review to the next Committee.

FM referred to the reports received earlier in the meeting relating to EDI performance and raised concern that this risk did not capture challenges in relation to EDI specifically relating to gaps in the workforce and suggested to conduct a piece of work to look at EDI maturity and include this data going forward. SO provided assurance that the Recruitment & Retention Group were focusing on these pieces of work.
ES echoed FBs observations and stressed the need to be explicit in linking such gaps, this would be undertaken for future reporting.

Action: Team to include the EDI performance within the data pack for oversight. ES/MSW/SO to meet to discuss further.

JG reflected on the appropriateness of the scoring of this risk given its profile & national landscape. He felt that the mitigations were very internally focussed but part of a bigger external challenge (pay, industrial action, retention etc.). he went on to suggest that perhaps the more fragile workforce areas be highlighted in the report along with detailed actions.

Action: To review BAF risk 2.1 in light of this discussion relating to the 2030 People Plan for clear overview re level of risk on the future workforce and better align to national plan.

Resolved:
The Committee received the Board Assurance Framework Deep Dive Risk 2.1 'Workforce Sustainability & Development'

22/23/090 **Board Assurance Framework**

The Committee received the Board Assurance Framework detailing September updates noting a piece of work to be undertaken to ensure enhanced linkages and better cohesion of all risks sitting within the remit of the Committee (2.1, 2.2 and 2.3)

Resolved:
The Committee received and noted the latest position of the Board Assurance

Framework.

22/23/091 **Ratify HR / Health & Safety Policies**

- **Allied Health Professional Return to Practice Policy and Equality Analysis**

  Allied Health Professional (AHP) Return to Practice Policy was introduced to the Committee. An overview had been submitted to the Committee detailing that this was a new Trust Policy, developed as part of the AHP Workforce Project which sets out the procedure for supporting AHPs no longer registered with the Health and Care Professions Council to return to practice.

  Resolved:
  Committee approved the Allied Health Professional Return to Practice Policy and Equality Analysis

- **Professional Registration & Revalidation Policy**
  It was noted that this Policy had been omitted from the pack and would be presented at the December meeting for approval.

- **Fire Safety Procedure & Hospital Evacuation Plan**

  ES introduced the updated Fire Safety Procedure & Hospital Evacuation Plan which had been subject to Executive approval outside of PAWC
  She advised that correspondence had been received from Merseyside Fire & Rescue Service on the 17th October 2022 raising concerns over the fire protection of the ground floor car park within the new Catkin/Sunflower development, specifically regarding the recommendation of the installation of sprinkler protection. The Trust Fire Authorised Engineer has independently assessed the building and noted that this is complaint with current Fire Regulations.

  Resolved:
  Committee approved the Fire Safety Procedure & Hospital Evacuation Plan.

22/23/092 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on 22nd September 2022.

22/23/093 **Wellbeing Steering Group**

JP advised that the Steering Group had not met since the last PAWC.

22/23/094 **Any Other Business**

No other items of business were raised.

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22/23/095 **Review of Meeting – Chair's Report to Board**

- Workforce and sustainability remain a crucial focus particularly recruitment and retention and ensuring we have a clear understanding of what sits behind the data.
- Colleagues were asked to reflect on how we better coordinate workforce metrics.
- Key learning points for the trust from discussions.
- Good progress on staff survey.
- Volunteering – great work noted
- The People Plan was discussed and developing well.
- Good development in relation to EDI Steering Group

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments.

Date and Time of Next meeting
Wednesday 7th December 2022 at 2pm via MS Teams.

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 10th October 2022**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance:	Mr. M. Flannagan	Director of Communications	(MF)
	Mr. S. Hosny	Innovation Consultant	(SH)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Ms. R. Lea	Deputy Director of Finance	(RL)
	Dr. F Marston	Innovation Consultant	(FM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
Observing:	Mr. J. Kelly	Non-Executive Director	(JK)
Apologies:	Mr. A. Bass	Acting Chief Medical Officer	(AB)
	Prof. I. Buchan	Associate Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics	(IB)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Mr. D. Powell	Director of Development	(DP)
Item 22/23/36	Mr. C. Beaver	Head of Marketing and Communications Operations	(CB)
Item 22/23/39	Ms. W. Blumenow	Senior Specialist Speech and Language Therapist	(WB)

22/23/31 Introductions and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. It was reported that Fiona Marston has stepped down as a Non-Executive Director for the next six months whilst involved in the Trust's Innovation Consultancy Project and will be recorded as 'in attendance' at Innovation Committee meetings until the project ceases. The Committee was advised that John Kelly is a new member of the Innovation Committee.

22/23/32 Declarations of Interest

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Fiona Marston declared her association with the Liverpool School of Tropical Medicine.

Alder Hey Children's NHS Foundation Trust

22/23/33 Minutes from the Meeting held on the 8th August 2022
Resolved:
The minutes from the meeting that took place on the 8th of August 2022 were agreed as an accurate record of the meeting.

22/23/34 Matters Arising and Action Log

Action 21/22/53.1: *Draft Innovation Strategy (Discuss the alignment of the Digital Strategy with the Innovation Strategy)* – It was confirmed that this action has been completed. **ACTION CLOSED**

Action 22/23/06.1: *Q3 Performance Report (Present the Alder Hey Anywhere Digital Platform to the North West Clinical Prediction Group in order to gain advice on deriving models from data and validating them, etc.)* – It was confirmed that a discussion has taken place between Claire Liddy and Iain Buchan, and this action has been superseded by the report on the agenda relating to Alder Hey Anywhere Business Development Plan and proposals. **ACTION CLOSED**

Action 21/22/26.1: *Commercial Partnerships (Further clarity to be included in the report on the materiality level and decision-making process which defines whether an agreement will be submitted to the Innovation Committee or RABD, for approval)* – This item has been included on the agenda. **ACTION CLOSED**

Action 22/23/21.1: *2030 Innovation Strategy: 'Todays Child, Tomorrow's Healthier Adult' (Circulate the pitch deck to Committee members and share the strategy presentation externally with relevant people)* – It was confirmed that this action has been addressed. **ACTION CLOSED**

Action 22/23/22.1: *2022/23 Operational Plan Update the 2022/23 (Operational plan to include the comments made by Committee members on monitoring, benefits realisation, next year's deliverables and include a paragraph on the next steps for 2023/23)* – It was confirmed that this action has been completed. **ACTION CLOSED**

Action 22/23/23.1: *Innovation Performance Report, Q2 (1. Greater detail to be included in future financial outturn updates; YTD figures, variances, breakdown of income lines, cost categories. 2. Include a phased budget with a revised forecast to include a financial update on revenue for transparent masks. 3. Share the revised forecast with Committee members ahead of October's meeting)* – It was confirmed that this action has been completed. **ACTION CLOSED**

Action 22/23/23.2: *Innovation Performance Report, Q2 (Include grant funding figures in internal metrics to provide further detail)* – Grant funding figures have been included in internal metrics and incorporated in October's report. **ACTION CLOSED**

Action 22/23/23.3: *Innovation Performance Report, Q2 (1. Additional risk to be included in the next iteration of the performance report regarding the financial sustainability of the Innovation Centre. 2. Review the operational risks during October's meeting)* – This item has been included on October's agenda. **ACTION CLOSED**

Action 22/23/24.1: *Alder Hey Anywhere Digital Platform – Status and Update (Compile a*

business development proposal for further development of the product; to include information on clinical safety, clinical and operational asks, a specific brand and communications plan (including a market assessment of competitors and the national landscape), and product positioning. Submit the proposal to the Innovation Committee during October's meeting) **–** An interim business development plan has been included on October's agenda. **ACTION TO REMAIN OPEN**

Action 22/23/24.2: *Alder Hey Anywhere Digital Platform – Status and Update (Live data collection and measurement to be compiled on the clinical and operational uses of the product as part of future partnerships)* – **ACTION TO REMAIN OPEN**

Action 22/23/24.3: *Alder Hey Anywhere Digital Platform – Status and Update (Brilliant use case to be included in the business development case to demonstrate the effectiveness and efficacy of the product, along with metrics for measuring benefits realisation)* – **ACTION TO REMAIN OPEN**

Action 22/23/24.4: *Alder Hey Anywhere Digital Platform – Status and Update (Submit a brand and communications positioning paper to the Innovation Committee during October's meeting; to include previous lessons learnt from a brand and comms perspective)* – An interim marketing and communications plan has been included on the agenda. **ACTION TO REMAIN OPEN**

22/23/35 Innovation Performance Report, Q2

The Committee received an update on performance for Q2 2022/23. A number of slides were shared which proved information on the following areas:

- *Operational Scorecard* – In quarter metrics and status against in quarter deliverables.
- *Divisional performance* – People Plan and HR metrics, risks and finance.
- *Strategy deployment detail*;
  - Culture: Pipeline and project examples.
  - Impact: Programme delivery.
  - Growth: Grants funding, industry investment and benefits.
  - Business development: Branding, reputation and partnerships.

The Committee was advised that divisional risks have been reviewed in detail and nine new risks have been incorporated on the operational risk register which reflect the new Innovation Strategy. It was reported that the biggest risks for the Innovation Division relate to the Growth Strategy.

A divisional deep dive has been scheduled to take place at the Risk Management Forum (RFM) on the 25.10.22, of which, the outcome will be submitted during December's Innovation Committee meeting. It was pointed out that new risks will filter through to the Board Assurance Framework (BAF) and operational risks will be a standing agenda item for the Committee going forward.

22/23/35.1 Action: ES

The Committee was asked as to whether the dashboard reflects the expected level of detail. Following discussion a number of points were made:

- Amend the description relating to grant funding to reflect grant income, net cost and the organisation's liability going forward. Include detail on the risk of unfunded posts once the grant ceases.
- Include detail on actuals in order to provide greater depth and clarity on achieved/unachieved targets. Incorporate information on real prospects to give a sense of what the potential is for the rest of the year/future years, for example, partnerships/late stage projects that the Trust is looking to commercialise. In terms of measuring performance, use a model that provides projected accruals versus actual accruals and submit this information on a monthly basis.

As a result of feedback it was agreed to enhance the financial dashboard taking into the account the points made by Committee members. The chair offered her support on this matter, if required.

22/23/35.2 Action: EK

The Chair acknowledged that the Committee is asking for the financials to be presented via a different lens and thanked the team for the hard work that has taken place to produce the information.

The Committee was provided with an update on the Children's Hospital Alliance Was Not Brought (WNB) programme. The key findings of the project were shared along with the benefits and lessons learnt, from an Alder Hey viewpoint. It was reported that the project is ready for productization and commercialisation. A discussion took place around the direction of the WNB AI Predictor from an NHS/external market perspective, and it was agreed to review the commercial business case that work is currently taking place on and produce a plan/decision making process that will support the Trust in achieving a conclusion on its intentions for the WNB AI Predictor. Fiona Marston offered to support this work.

22/23/35.3 Action: CL/EH/FM

Resolved:
The Innovation Committee received and noted the quarterly performance update for July 2022 to September 2022.

22/23/36 Market Communications Plan Update

The Committee received the Market Communications Plan for information purposes. Attention was drawn to specific elements of the report which provided an overview of the approach to support two linked aims (*brand positioning of the Trust/drive business to Alder Hey Innovation)*, key audiences, messages, and channels, tactical activity plans, online platforms, capacity and capability.

Feedback and challenge was provided relating to; the lack of focus in the plan in terms of marketing substance for the spin off and monetising of commercial products, and investment for additional resources. Following discussion it was agreed to submit a next steps report to identify the organisation's lead products, advise on the process for selling lead products, the positioning of innovation, potential customers, with a tactical plan to underpin this area of work.

22/23/36.1 Action: MF/CB

The Chair referred to the comments made regarding investment for additional resources and advised that this will be addressed as part of a piece of work that is being conducted by Fiona Marston.

Resolved:
The Innovation Committee received and noted the Market Communications Plan update.

22/23/37 We Are Nova Update

The Committee received an update on the Nova and Acorn partnership as at the 10.10.22 and was advised of the actions that have been completed, including the additional actions initiated by the Trust to exit the master Acorn agreement. A report will be submitted to the Audit and Risk Committee, laying out the options for the two active companies. Innovation Committee Members and Chair will be invited to attend the Audit and Risk Committee meeting to discuss this item.

22/23/37.1 Action: CL
22/23/37.2 Action: ES

22/23/38 Alder Hey Anywhere Business Development Plan – Progress Update

The Committee was provided with an interim status update following the strategic overview report that was submitted to the Committee in August 2022. An outline of the initial market appraisal was included in the report and a number of slides were shared that provided information on the following areas:

- Deliverables; deployment and adoption.
- Product vision.
- Ambitions.
- Requirements for partner.
- Benefits realisation.

Emma Hughes responded to a number of questions that were raised in respect to the cost of deployment for version 1, the approach for the deployment of the plan for the initial phase of the portal, the offer to patients in terms of the portal platform, and the business cases required to progress Alder Hey Anywhere internally and commercially. Following discussion the Chair requested a monthly report in order to update the Committee on the progress of the business cases and deployment.

Resolved:
The Innovation Committee received and noted the interim status update and the initial market appraisal.

22/23/39 Bluetree Group Licence Update

The Committee received a status update of the BrillianSee transparent mask product and license and were asked to support the following two recommendations:

- Continue to monitor the performance of the license deal for a further six months before further escalation is considered.

- Complete an analysis of sales forecast and submit a report early in 2023.

Following a discussion on the impact of Bluetree's non-performance of aspects of the licence and their sales strategy and pipeline going forward, it was agreed to;

- Submit a paper to the Committee in February 2023 to provide a review of the situation to enable an informed decision to be made about the next steps and agree proposed recommendations. Include Bluetree's Sales Strategy and Pipeline in the report.

22/23/39.1 **Action: WB**

- Establish a task and finish group to prepare recommendations in the event an alternative route has to be sought if Bluetree's performance fails to improve by April 2023. Group to include John Kelly, Fiona Marson and Ian Quinlan.

22/23/39.2 **Action: CL**

Resolved:
The Innovation Committee noted the Bluetree Group licence update and agreed to support the recommendations in the report.

22/23/40 Commercial and Partnership Agreements Report, Q2.

The Committee received the Commercial and Partnership Agreements report for Q2. It was felt that the report is much clearer and informative and once the Standard Operating Procedure has been approved it will provide an overview of requirements for future reports.

Resolved:
The Innovation Committee received the Q2 update and noted the content of the Commercial Partnership Agreement schedule.

22/23/41 Innovation Commercial Partnerships Standard Operating Procedure (SOP)

The Committee was advised that the purpose of the report is to provide the Innovation Committee (IC) and the Resources and Business Development Committee (RABD) with the detail of the Alder Hey Innovation Centre's commercial partnership governance process including the due diligence and legal procedures for all innovation led corporate or academic co-creation, commercial partnerships, and the creation of new commercial companies. An overview of the report was provided and it was pointed out that the SOP will provide the relevant transparency and rigour to give the Trust assurance regarding innovation commercial activity, and will be updated/iterated on a regular basis in line with research and innovation governance, Trust strategies and policies. The Chair asked Committee members for their feedback on the document.

Claire Liddy drew attention to the importance of having a governance procedure in place for the interim period until additional processes are recommended, based on a piece of consultancy work that is to be undertaken. Following discussion, the Innovation Committee approved the Commercial Partnership and Governance SOP, acknowledging that it is subject to change over the next six months.

The Chair agreed to liaise with Shereef Hosny to discuss a process for reporting against the flow diagram on page six of the SOP.

22/23/41.1 Action: SA/SH

Resolved:
The Innovation Committee approved the Commercial Partnership and Governance SOP

22/23/42 Board Assurance Framework (BAF) Update

The Innovation Committee received the BAF report for August 2022. The following points were highlighted:

- It was reported that a lot of work has taken place in order to update the Innovation Division's operational risk register.
- BAF risk 4.1 *(failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People)* is under review with a focus on controls.
- Risks relating to research and innovation are to be reviewed to ensure they are fit for purpose going forward.
- It was confirmed that an extensively updated version of the BAF will be submitted to the Committee in December.

Resolved:
The Innovation Committee received and noted the contents of the BAF report for August 2022.

21/22/43 Any Other Business

There was none to discuss.

21/22/44 Review of Meeting

The Chair felt that the meeting was very productive and thanked everyone for their contributions. Thanks were also offered to the team for the time and effort that went into preparing the reports. The Chair pointed out that as a result of discussion a number of gaps were identified which may hinder progress against the strategy.

Following an invite to provide feedback on the outcome of the meeting, John Kelly pointed out that the meeting was positive, but also highlighted the gaps in some of the thinking around commercialisation which generated a discussion on this area of work.

Date and Time of the Next Meeting: Monday 12th December, 10:30am-1:30pm, via Teams