Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 23rd February 2023, commencing at 9:00am

Lecture Theatre 4, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**22/23/274**	**9:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/275**	**9:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/276**	**9:02 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **26th January 2023.**	**D**	Read enclosure
4.	**22/23/277**	**9:04 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/278**	**9:05 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update and External Partnerships							
6	**22/23/279**	**9:15 (10 mins)**	**Liverpool Clinical Services Review - Update.**	L. Shepherd	To receive an update.	**N**	Verbal
7.	**22/23/280**	**9:25 (10 mins)**	**Vision 2030 Strategy Update.**	J. Grinnell	To receive an update on the work that is taking place on the Vision 2030 Strategy.	**A**	Read report
Operational Issues							
8.	**22/23/281**	**9:35 (60 mins)**	• **Integrated Performance Report for M10.** • **Finance Report for M10, 2022/23 and Planning Headlines.**	Exec Leads/ Divisional Leads R. Lea	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M10 position and planning headlines.	**A** **A**	Read report Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			• **Digital, Data and Information Technology Update.**	K. Warriner	To receive an update on the current position.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
Brilliant Basics Patient Story (10:35-10:50)							
9.	**22/23/282**	**10:50 (10 mins)**	**Brilliant Basics Update.**	N. Askew	To provide an update on the current position.	**A**	Read report
Operational Issues							
10.	**22/23/283**	**11:00 (10 mins)**	**Springfield Park Update.**	J. Grinnell/ D. Powell	To receive an update.	**A**	Read report
11.	**22/23/284**	**11:10 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 21.2.23.** - **Approved minutes from the meeting held on the 23.1.23.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 23.1.23.	**A**	Read enclosure
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
12.	**22/23/285**	**11:15 (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
13.	**22/23/286**	**11:20 (5 mins)**	**PALS and Complaints Report, Q3.**	N. Askew	To receive the PALS and Complaints report for Q3.	**A**	Read report
14.	**22/23/287**	**11:25 (5 mins)**	**Mortality Report, Q3.**	A. Bass	To receive the Mortality Report for Q3.	**A**	Read report
15.	**22/23/288**	**11:30 (10 mins)**	**Gender Identity Development Service Update.**	L. Cooper	To receive an update on the current position.	**N**	Read report

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
16.	**22/23/289**	**11:40 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 22.2.23.** - **Approved minutes from the meeting held on the 18.1.23.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 18.1.23.	**A**	Read enclosure
Game Changing Research and Innovation							
17.	**22/23/290**	**11:45 (10 mins)**	**Update on Research.**	J. Chester	To receive an update on progress.	**A**	Presentation
18.	**22/23/291**	**11:55 (5 mins)**	**Innovation Committee:** - **Chair's verbal update from the meeting held on the 6.2.23.** - **Approved minutes from the meeting held on the 12.12.22.**	S. Arora	To escalate any key risks, receive updates and note the approved minutes from the 12.12.22.	**A**	Read enclosure
The Best People Doing Their Best Work							
19.	**22/23/292**	**12:00 (10 mins)**	**People Plan.**	S. Owen	To receive an update on the current position.	**A**	Read report
Strong Foundations (Board Assurance)							
20.	**22/23/293**	**12:10 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
Items for information							
21.	**22/23/294**	**12:15 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
22.	**22/23/295**	**12:19 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Lunch (12:20-12:50pm)							
Date and Time of Next Meeting: Thursday 30th March 2023, 9:00am, Meeting Room 2 and 3, Liverpool Innovation Park.							

REGISTER OF TRUST SEAL
The Trust seal was used in February 2023 392: Settlement between Laing O'Rourke and Alder Hey Children's NHS FT

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M10, 2022/23	R. Lea

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 26th January 2023 at 9:00am**
Lecture Theatre 4, Institute in the Park

Present:	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	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)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Dr. U. Das	Director of Medicine	(UD)
`	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mr. I. Gilbertson	Assis. Chief Digital and Information Officer	(IG)
	Ms. R. Greer	Associate COO	(RG)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Patient Story	Ms. K. O'Hagan	Advanced Nurse Practitioner	(KO)
Item 22/23/246	Mr. A. Pitman	Project Director	(AP)
Item 22/23/247	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Item 22/23/247	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Item 22/23/249	Ms. S. Calderwood	General Manager for Urgent Care	(SC)
Item 22/23/249	Dr. B. Mehta	Director of Urgent Care	(BM)
Item 22/23/249	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Item 22/23/249	Dr. J. Potier	Assoc. Director of Organisational Development	(JP)
Item 22/23/249	Dr. M. Rotheram	Consultant in Paediatric Emergency Medicine/ Joint Specialty Clinical Director	(MR)
Apologies	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Mr. D. Powell	Development Director	(DP)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
	Dame Jo Williams	Chair/Non-Executive Director	(DJW)

Patient Story

The Vice Chair welcomed Advanced Nurse Practitioner, Kate O'Hagan, who had been invited to January's Trust Board to share a story on behalf of a parent whose son was admitted to the Trust via ED. This story dates back to an earlier period of time but highlights the positive actions that were taken to change practice as a result of a poor experience.

The story is about a mother's experience when her four year old child was admitted to Ward 4C for stabilisation of diabetes. The patient had been transported with his mother and twin two year old siblings on the back of a lorry from Iraq. The family had been separated from dad and didn't speak English. The Trust provided accommodation for mum who understandably would not leave her four year old son on the ward to take the twins to McDonald House at night. On numerous occasions mum advised that her children were hungry and she did not have enough money to feed them. As the family were new to the UK, mum asked staff to take her to the supermarket, which they were unable to do. Ultimately, mum shared the single patient meal amongst her three children. It was reported that once Kate O'Hagan became familiar with the situation it was escalated to a duty manager who took steps to ensure that the children and mum were fed.

Kate O'Hagan drew attention to the work that she has been conducting on health inequalities and advised that poverty in childhood has a direct impact on a child's health. A number of slides were shared that provided the following information:

- Environmental factors that affect the life expectancy of a child.
- Life expectancy: North and South divide.
- Infant mortality: Infant mortality rate is an important marker of the overall health of a society.
- Infant mortality rate by index of multiple deprivation.
- Food insecurity: 12% of families in England experience food insecurity each month in 2020/21 and 18% of families in the North West experience food insecurity each month.
- An overview of the changes that have been made following the negative experience of the family in this story.

Louise Shepherd thanked Kate O'Hagan for the work that has taken place and queried as to whether there is anything further that can be done in terms of addressing food insecurity for families in the care of the Trust. It was confirmed that there are lots of ideas in the pipeline and discussions taking place to address the impact of this issue; co-ordinating ideas to ask the Trust for support, Sophie's Legacy, gaining the views of clinical teams with regard to health and wellbeing hubs for patients and their families, etc. Work is also taking place in association with the Citizens Advice Bureau but it was pointed out that resources are required to drive this area of work forward.

The Board was advised of the survey that the Trust has conducted which highlighted that the cost of food was one of the main concerns for parents whilst their child was at Alder Hey, especially if it was due to an emergency admission. It was suggested that the Trust should promote the Healthy Start benefit that is available for people who have just had a child and are struggling or immigrants coming into the UK. Mark Flannagan advised of the imminent launch of the Trust's new website and felt that it would be beneficial to include information on the website for signposting purposes.

Louise Shepherd asked about the progress of the family whose plight was highlighted in the story. The Board was advised that the patient is now involved in boxing training, attends clinic on a regular basis, is talking about the management of his condition and has integrated into the community he is living in.

The Vice Chair thanked Kate O'Hagan for sharing the patient story with the Board and providing an overview of the work that is taking place to support families.

22/23/239 Welcome and Apologies

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

22/23/240 Declarations of Interest

There were none to declare.

22/23/241 Minutes of the previous meetings held on Thursday 15th December 2022

Resolved:

The minutes from the meeting held on the 15th of December were agreed as an accurate record of the meeting.

22/23/2242 Matters Arising and Action Log

Matter Arising

There were none raised.

Action Log

All actions are on track.

22/23/243 Chair's and CEO's Update

Liverpool Clinical Services Review – It was confirmed that Alder Hey has received the final report following an independent review of clinical services in Liverpool. The Integrated Care Board (ICB) will formally receive the report today therefore discussions relating to the document will be discussed in the private session of the Trust's Board meeting.

Gender Identity Development Service (GIDS) – The Board was advised that the Director of Community and Mental Health Services, Lisa Cooper, is leading on the Northern Hub (Manchester/Liverpool) in partnership with colleagues in the South. A formal Programme Board has been established and work is taking place to agree a programme of work. Attention was drawn to the challenges being experienced in terms of reaching a decision on the specification for the service. It was reported that the public consultation closed in December 2022 and NHSE are presently working through the 6000 responses received.

An outline proposal for a clinical pathway/model has been submitted by the Trust and is being discussed by commissioners in the Southern Hub and colleagues in the North. The Board was advised that Leeds Teaching Hospitals NHS Trust has agreed to become a partner therefore the Trust will link in with staff based in the Gender Identity Development Service in Leeds.

Assurance was offered to the Board that the Trust will not move forward with developments until clarification on the gateways has been received. A formal update will be provided in February and further information on the gateways will be provided in March 2023.

22/23/243.1 Action: LC

Resolved:

The Board noted the CEO's update.

22/23/244 Strategy Update (Vision 2030)

The Board was provided with an overview of the strategy development progress and outcomes following a Board development session on the 16.1.22 which focused on futures, engagement and governance.

Attention was drawn to the following key items that came about as a result of the session;

- It was reported that the engagement phase has commenced in order to create awareness, understanding and build belief in the 2030 vision. This initial engagement has allowed the Trust to refine the narrative of the strategy.
- An engagement session took place with the Trust's Charity on the 25.1.23, and the first clinical session with the Division of Surgery is scheduled for the 26.1.23.
- It was confirmed that the formal Engagement Plan will be submitted to the Board in February.

22/23/244.1 Action: JG/MF

Development of Futures – A programme of work is in the process of being developed using the methodology discussed at January's Board strategy session. There is also a focus on the development of an economic case that will underpin decision making in support of the emerging direction of travel. A full detailed proposal and economic case will be presented to RABD in February and to the Board in due course.

People Plan – The Chief People Officer, Melissa Swindell, will be leading the development of the Trust's People Plan, utilising the intelligence insights gained through the strategy development. A detailed proposal will be presented to the People and Wellbeing Committee in March 2023 and the Board in due course.

New Governance Arrangements - It was reported that the creation of a new governance structure will provide the foundations upon which the 2030 strategy will be delivered.

Resolved:
The Board noted the progress that has been made to date in the development of the engagement approach, the 'Futures' blueprint and the governance principles.

22/23/245 Growing Great Partnerships

Key System Developments:

The Board was provided with an update and assurance of progress and risk management against the Trust's strategic objective of growing great partnerships. The update, as detailed in the report, focussed on;

- Children's Hospital Alliance.
- CYP Specialist Services and delegation to ICS's.
- NW Paediatric Networks.
- Health and Care Partnership (C&M HCP)
- CYP in the Integrated Care System (C&M ICS); including "Beyond" ICS CYP Programme and Elective Recovery.
- Liverpool Place: Contain Outbreak Management Fund (COMF) - Liverpool
- Sefton Place.
- Knowsley Place.
- Alder Hey Partnership Governance Audit *(prepared by Mersey Internal Audit Agency, MIAA)*

John Kelly raised a question about the effect the reach of the hospital's programme is having on the Trust's planning, for example, looking to support CYP, families/carers and staff as appropriate through the cost-of-living crisis.

It was pointed out that the Children's Hospital Alliance has placed emphasis on addressing the cost-of-living crisis, including supporting the implementation of 'Sophie's

Legacy', which is aligned with the NHSE Food Review. There is no funding model to support this area of work but it was felt that lots can be done in terms of a discretionary effort to join things up. It is also about driving the prevention agenda to avoid/reduce admissions into hospital and attendance at ED.

Strategic Partnership with LWH

The Board was advised that the Trust and LWH are keen to develop a stronger partnership in terms of wider issues and have agreed to form clinical partnerships. It has also been agreed to work in partnership on research with an initial meeting taking place on the 30.1.23.

22/23/246 Green Strategy Update

The Board received the updated version of the Green Strategy for approval. It was reported that the Trust has committed to reaching net zero carbon emissions and has made good progress towards this in 2022, with significant financial savings being made. The next steps are to broaden involvement via the creation of engagement groups, including CYP and staff members, look towards making energy efficiency investments in the main building and expand the work with the ICB and the wider system.

It was confirmed that a business case is to be presented to the Investment Review Group (IRG) in March to provide details on the next steps and the 2023/24 Implementation Plan.

Alex Pitman responded to a query regarding the Trust's target and a discussion took place about the importance of engaging via the lens of the child. He reported that there were investments, grants and the opportunity of LED lighting that would help reduce carbon omissions.

Garth Dallas drew attention to the progress that the Trust has made and thanked the team who have enabled the organisation to achieve this position. It was reported that the Green team will continue to develop the Green Strategy and is linking in with the work that is taking place in the City.

Resolved:
The Board noted the Green Strategy update.

22/23/247 Integrated Performance Report, M9

The Board received the Integrated Performance Report (IPR) for Month 9. An update was provided on the following areas of the IPR:

- Outstanding Safety - *Safe;*
  - There is a continued focus on category 2 pressure ulcers even though there has already been a decrease in the numbers reported.
  - Staff are reporting more accurate data relating to deteriorating patients but work continues to reduce the overall number of inpatients unexpectedly admitted to critical care.
  - Sepsis compliance is challenged due to sickness absence in the team.
  - *Nursing Workforce:* There were no red shifts in December.

- *Outstanding Safety - Caring;*

- It was reported that 100% of formal complaints were acknowledged within 3 working days and 87% were responded to within the 25 working day timeframe.

- Recovery and Access – *Effective*
  - *Emergency Department (ED):* During November and December there has been record demand, with attendances sometimes exceeding 300 per day. The has affected performance in terms of achieving the national target for treating patients in ED within 4 hours.
  - *Cancelled Operations:* There are some areas that aren't making progress with rescheduling cancelled operations as emergencies are taking precedence.
  - *Was Not Brought Target:* Improvements are being made to reduce the high rates of non-attendance.

- Recovery and Access – *Responsiveness*
  - *Recover for Day Case and Elective Activity Volume:* It was reported that 98% of patients received treatment in December 2022.

- Well Led – *Great Place to Work (People)*
  - *PDRs:* It was reported that only 47% of PDR's have been completed Trust wide but there is still an opportunity for staff to have their PDR ahead of the March deadline. This matter has been escalated to the Divisions so that it can be addressed.
  - *Sickness Absence:* Sickness absence has reduced slightly from 7.7% in December to 6.5% currently.
  - *Staff Turnover*: December 2022 was the highest month of the year in terms of staff turnover. Work is taking place on this issue and there is a detailed focus on staff retention by the People and Wellbeing Committee (PAWC). Attention was drawn to the Radiology Open Day that is taking place on the 28.1.23 to encourage recruitment.

- Well Led – *Financial Sustainability* (*Finance)*
  - For M9, the Trust is reporting a surplus of £1m which is in line with the plan.
  - There has been a continued improvement in-month of recurrent CIP achievement which is now at 70% of the identified target. Work is ongoing with the Divisions and there is to be a focus on the organisation's transformation programmes and recurrent efficiency
  - The Trust is forecast to achieve a £4.6m control total surplus with the potential to improve further subject to ongoing discussions, but it was pointed out that 2023/24 will bring challenges.

- Well Led – *Risk Management*
  There was nothing to raise in addition to what was in the IPR.

- Well Led – Safe Digital System – *Digital*
  There was nothing to raise in addition to what was in the IPR.

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 M8. The following points were raised:

Community and Mental Health
There was nothing to raise in addition to what was in the IPR.

Medicine

It was reported that there are challenges in Neurology due to consultant staffing issues. A meeting has taken place with the teams to look at the nursing infrastructure to try and offer support, and assistance is being sought from a general paediatric colleague.

Surgery

A discussion took place around the concerns relating to the Division's sickness rates and staff turnover figures. It was reported that the Division is planning to recruit against its sickness rate which is at 10% at the present time, of which, a paper is due to be submitted to the Executive team. There has also been a focus on retention with a deep dive having been completed and actions planned in key areas.

A number of suggestions were made in terms of finding solutions to address the issue of recruitment/sickness; look at supportive roles, deploy alternative staff members, apprenticeships, etc. It was pointed out that there is a lot more work to do and discussions to take place to address these areas of work. Louise Shepherd drew attention to the importance of the Board supporting and wrapping around this issue.

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

Resolved:
The Board received and noted the content of the IPR for Month 10.

Finance Report for M9, 2022/23 and Forward Look.

The Board received an update on the 2022/23 financial position and a forward look. A number of slides were shared which provided information on the following areas:

- 22/23 position;
  - Achieved financial targets at the end of Q3 with a £6.1m surplus in line with the plan.
  - Forecast to achieve £6.1m surplus against a plan of £4.6m.
  - Focus on ICB system position.
- Cost Improvement Programme;
  - Forecast to achieve full £17.3m in year target.
  - Recurrent forecast to achieve £8m against a £12.5m target.
  - Shortfall will be carried forward to 2023/24 which is an increasing risk. Transformation CIP schemes are required.
- Capital;
  - Scrutiny C&M on FCT capital spend (Alder Hey remains on plan).
  - Secured capital funding of £10m in Q3 (Alder Care £2m, Eating Disorder Day Case £2.8m and Paediatric Elective Hub £5m).
- Forward Look;
  - 2023/24 planning headlines.
  - Guidance on national objectives and targets for 2023/24.
  - Key financial headlines.
  - What it means for Alder Hey.
  - Opportunities and risks for Alder Hey.
  - Operational planning timetable for 2023/24.
  - Alder Hey's planning approach for 2023/24.

John Kelly raised a question about the 4% C&M efficiency factor which includes a 1% convergence and queried as to whether the Trust is able to submit a plan on how this efficiency can be achieved rather than waiting to be instructed on how to do it.

It was confirmed that the efficiency target is a national one and any system found spending in excess will need to apply additional efficiencies to achieve the target. In terms of the Trust submitting its own plan, it was reported that early discussions are taking place and work has commenced following the review of clinical services in Liverpool.

Transformation Programme Governance Report

The Board received an update on the Transformation Programme for Q3 and was provided with assurance around the adherence to the programme management standards. The report also detailed the approach to managing the transition to the 2023/24 Change Programme. It was confirmed that there are no risks for escalation following the completion of the assurance assessment.

Kerry Byrne pointed out that all of the current projects have an overall delivery rating of amber and queried the reason for the delay in delivery. It was reported that the projects set at amber aren't due to reach their full benefits until the end of the 2023.

John Kelly drew attention to the implementation of the Alder Care Programme and the level of scrutiny on this area of work; he queried the programme going live in August and suggested if possible, an alternative date should be agreed. The Board was advised that the programme is discussed on a regular basis at RABD and the Alder Care Programme Board. It was also confirmed that the Alder Care Programme has completed the first Gateway stage. In terms of a live date, this is yet to be set but a report is to be submitted to the Executive Team in order to discuss this matter.

Resolved:
The Board noted the Q3 Transformation Governance report.

Infection, Prevention and Control (IPC) Update

The Board received an update on IPC across the Trust from the Director of IPC, Bea Larru. It was reported that a significant number of patients on Ward 1C have been colonized with Carbapenem-Resistant Enterobacteriaceae (CRA). A number of slides were shared to which provided information on the following areas relating to the CRA outbreak:

- The timeline of the CRE outbreak in Ward 1C (April 2022 - December 2022). It was confirmed that the last positive test was on the 13.12.22.
- The reduction action plan for Ward 1C.
- The measures that were implemented to test patients, manage outside influences and control the outbreak.
- Alder Hey's baseline assessment based on the criterion used in the code of practice on the prevention and control of infections and related guidance (*Health and Social Care Act 2008*).

Reference was made to the review of the baseline assessment that is due to take place in June 2023 and it was queried as to whether a programme of work has been implemented to address this ahead of the deadline. It was reported that the Trust has made a decision to work toward the guidance in order to meet the criteria. The Board was advised that there are a number of challenges in terms of the IPC team delivering

this work but it was confirmed that there is to be a review of the team to look at how IPC fits into all of the systems across the Trust.

Resolved:
The Board noted the update on infection, prevention and control across the Trust.

22/23/248 Industrial Action Update

The Board was provided with an overview of the industrial action that is being taken by the Royal College of Nursing (RCN) on the 15th and 20th of December 2022. It was reported that the Trust has developed a good partnership approach to the Local Strike Committee and was able to secure all 22 derogation requests to maintain patient safety.

In the lead up to the industrial action a variety of support was offered to staff members by the Trust, as detailed in the report. On the day all clinical areas had senior nursing presence, the Executive team visited the picket line and staff on strike were provided with hot drinks and a morning breakfast, as well as receiving support from local businesses and the general public. It was reported that staff found Executive visibility positive on the day and fed back about how supported they had felt in making their personal choice.

Nurse Staffing Position

The Board was advised that most wards are close to establishment, and in some cases over established, with the exception of HDU and Ward 4B. It was confirmed that plans are in place to address these two areas.

It was reported that the poor perception of nurse staffing levels is driven by unavailability and short-term sickness on a backdrop of 14% unavailability gap across the organisation. This will reduce to 10% once supernumerary staff are included in the figures. Work is taking place to make information available at ward level to ensure that staff are aware of the actions that the Trust is taking to address staffing issues.

Louise Shepherd highlighted the importance of continuing to engage with staff especially in light of the challenges that will be experienced when members of the RCN and the unions that support the Ambulance Service come together for the first time in February. In terms of nurse staffing levels, it is imperative that the Trust is sighted on the risks.

Resolved:
The Board noted the industrial action update and the nurse staffing position.

22/23/249 'ED at its Best' Project Update

The Board was provided with an update on the 'ED at its Best' project. It was reported that compassion has been the frame for this project; listening, understanding, empathising and taking intelligent action. A number of slides were shared that provided information on the following areas:

- *The problem* – ED has faced significant challenges over many years, exacerbated by the Covid-19 pandemic which resulted in an increase in demand and attendances across all acuities.
- *The vision* – To improve ED's service delivery model to manage the increase in patient demand, safely and effectively.
- *The objectives* - To improve patient and staff experience.

- *The How* – Diagnose and initiate, develop, implement, sustain and review.
- Improvements; communications, organisational development, operational, IT/Digital, learning, education, development and Brilliant Basics.
- Achievements to date;
  - Urgent Treatment Centre and new ways of working.
  - Team working, approach and culture.
  - Positive feedback from staff.
  - ED ranked as the number one department in the Trust to return to by students.
  - Improved communication.
  - Improved mandatory training compliance (now over 90%).
- Next steps and opportunity to build on learning.

The Board was advised that the new Urgent Treatment Centre will help with front door attendances this winter but it was pointed out that there is a lot of learning to be gained from the project that will help the Trust address winter pressures in 2023. From a continuous improvement perspective, it is felt that it is really important to get the basics right in regard to listening, leadership and investing support in the leadership team as this model will be a blueprint for 2030 in terms of how the Trust will work.

Louise Shepherd thanked the team for the wonderful way in which they have addressed the challenges in ED and felt that the key to this has been the listening element of the project. To understand the depth of what has been achieved and to take this learning and share it elsewhere is remarkable.

The team responded to questions raised about the purpose of the Friends and Family Test in ED, and the plans for the Urgent Treatment Centre in terms of offering patients an alternative model.

Melissa Swindell advised the Board that there are five to six teams across the Trust who are interested in adopting this Change Programme therefore discussions are taking place to look at how this could be resourced.

On behalf of the Board, the Vice Chair thanked the team for providing an update on the 'ED at its Best' project and the work that has taken place.

Resolved:
The Board noted the update on the 'ED at its Best' project.

22/23/250 Alder Hey in the Park Campus Development Update.

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

- *Neonatal and Urgent Care Development* – It was confirmed that Phase 1 and 2 of the enabling works have been completed, with roadworks due to commence. The Board was advised that the provisional start date for the main build is April 2023 with a completion date of December 2024.

  The Trust is continuing to work with the PFI provider, Project Co, with regard to the release that is required to enable the organisation to sign up to the arrangement. An update on this matter will be submitted to RABD and the Board in February.

- *Sunflower House Construction* – Following a quality issue, the first phase of the work to the finish of the building has been completed and the issue relating to a sprinkler provision in the car park is being addressed.
- *Modular Office Building* – The programme has been delayed due to compliance issues with water, fire and building control. It was confirmed that mitigations have been implemented and a move is expected to take place on the 30.1.23.
- *Park Reinstatement* – It was confirmed that the MUGA works are complete in terms of structure and the Trust is liaising with Liverpool City Council regarding lighting connection.

Resolved
The Board received and noted the Campus Development update provided on the 26.1.23.

22/23/251 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 12.12.22 were submitted to the Board for information and assurance purposes. During January's meeting the Committee focussed on the Campus and organisation's finances.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 12.12.22.

22/23/252 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 1.12.22 to the 31.12.22. The following points were highlighted:

- The Trust declared zero Never Events during the reporting period.
- There has been a real focus on closing down current investigations before the organisation transitions over to the new system.
- Action plans are either on track or have been closed.
- It was confirmed that the RCA relating to the Never Event reported in November (Ref: 2022/23391) will be submitted to the commissioners on the 31.1.23.

Resolved:
The Board received the Serious Incident report for the period from the 1.12.22 to the 31.12.22.

22/23/253 Nurse Staffing Update

Refer to agenda item 22/23/248.

22/23/254 Proposal to Obtain Veteran Covenant Healthcare Alliance Accreditation.

The Board received a paper outlining a proposal for Alder Hey Children's NHS Foundation Trust to enter into an assessment to be awarded Veteran Aware status as part of Veteran Covenant Healthcare Alliance (VCHA).

Background information was shared with the Board along with the VCHA assessment process, and attention was drawn to the following points:

- A veteran may have served one day of service and may have ceased to work for the armed forces.
- Children and families of service personnel may suffer detriment due to the requirement of service life to move to various parts of the country, and internationally, which can have a negative impact on their health and wellbeing needs.
- The armed forces covenant gained royal assent in December 2021 and was enacted in November 2022. The covenant is a promise from the nation to those who serve or have served and their families to be treated fairly.

A query was raised as to whether there are any differentials in CYP in veteran families. It was reported that accessing mental health services is one of the biggest challenges, but in the event Alder Hey is awarded 'Veteran Aware' status a child from a veteran family won't have to wait to be seen and will move onto the waiting list at the same point they were at previously.

Following discussion it was felt that this is a fantastic opportunity for the Trust to demonstrate its commitment to providing equity of care to its armed forces community, including patients and staff.

Resolved:
The Trust Board agreed to:

- Support the application to begin the process of accreditation.
- Approve the governance structure outlined in the report.
- Approve the signing of the covenant.

22/23/255 Safeguarding Children and Adults at Risk Annual Report, 2021/22

The Board received the Safeguarding Children and Adults at Risk Annual Report for 2021/22 and was provided with an overview of the Trust's safeguarding governance arrangements and a retrospective view of the work that was completed by the Safeguarding Team within Safeguarding and Statutory Services from the 1.4.21 to the 31.3.22.

It was reported that a new Named Nurse for Safeguarding has been appointed, and work continues to train and develop the Trust's workforce to recognise and respond to abuse to safeguard CYP and adults at risk, who are in the Trust's care. In terms of moving forward, the organisation is looking to include data in future reports and provide a version of the report for CYP.

Resolved:
The Board received and approved the Safeguarding Children and Adults at Risk Annual Report for 2021/22.

22/23/256 Children in Care Annual Report, 2021/2022
Resolved:
The Board received and approved the Children in Care Annual Report for 2021/22.

22/23/257 Organ Donation Report, 2021/22

The Board received the Organ Donation Report for 2021/22 which highlighted the recommendations required to reset this area of work. It was reported that the Organ and Tissue Donation Committee meetings are now re-established following the pandemic. There is a focus on meeting national trajectories, ensuring deceased organ donation national policies, guidelines and best practice are implemented and followed

consistently within the Trust. The organisation is also looking to champion and promote organ donation at Alder Hey and ensure staff are adequately trained.

Resolved:
The Board received and noted the Organ Donation Report for 2021/22

22/23/258 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 14.12.22 were submitted to the Board for information and assurance purposes. During January's meeting the Committee received an overview of the significant changes to process and culture that will be required due to the implementation of the Patient Safety Incident Response Framework (PSIRF) which will replace the SI Framework in 2023/24. A presentation was submitted to the Committee to advise on how this project will be taken forward. A discussion also took place on risk appetite and tolerances for clinical safety and effectiveness risks.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 14.12.22.

22/23/259 People Plan Update

The Board was provided with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during December 2022. The following points were highlighted:

- The Trust is continuing to review financial wellbeing and the impact of this on staff in light of the ongoing economic climate.
- It was reported that the 'Pay it Forward' scheme has been 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 via a discreet voucher scheme, administered by SALS, Trade Unions and the Chaplaincy.
- Work is ongoing to find more ways in which practical support can be offered to the workforce. It was confirmed that the feedback received from staff is really positive.

Resolved:
The Board noted the People Plan update.

22/23/260 People and Wellbeing Committee (PAWC)

The approved minutes from the meeting held on the 7.12.22 were submitted to the Board for information and assurance purposes. During January's meeting the Committee focussed on the staff survey, sickness absence, PDRs and received Divisional metric updates and assurance that the Trust's intranet is on track. A deep dive also took place into risks on the Board Assurance Framework (BAF).

It was queried as to whether the spike in short-term sickness absence is due to a change. The Board was advised that some members of staff are suffering from RSV at the present time and others are unwell from short term ailments. With regard to long-term sickness absence it was confirmed that numbers are low.

Resolved:

The Board noted the update and the approved minutes from the meeting held on the 7.12.22.

22/23/261 Board Assurance Framework Report (BAF)

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

- There has been a real focus on strategic risks and deep dives across a range of the Assurance Committees which will continue on a cyclical basis.
- Risk appetite and tolerance has been discussed at Assurance Committee level.
- The Innovation Committee will cease in February 2023 therefore the risks on the BAF will be reviewed via a new Research and Innovation lens.
- A deep dive into BAF risk 1.4 *(Access to Children & Young People's Mental Health)* will take place in March during the Risk Management Forum.

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

22/23/262 Audit and Risk Committee (ARC)

The approved minutes from the meeting held on the 10.11.22 were submitted to the Board for information and assurance purposes. Attention was drawn to a piece of work that all Trusts were mandated to undertake in the form of a detailed financial sustainability assessment with the outcome reported to the Centre, including any actions required where weaknesses were identified. MIAA was also mandated to undertake an independent review of the supporting information of 12 key questions. Two minor recommendations only were raised by MIAA which management confirmed have been actioned.

22/23/263 Any Other Business

Sefton Council has awarded Alder Hey and a number of other trusts the Freedom of the Borough in light of the hard work, sacrifice and dedication shown by medical staff during the COVID-19 pandemic. This award is the highest ceremonial honour Sefton Council can bestow and stands as a permanent record of the Borough's endless appreciation and debt of gratitude to the trusts and their staff. To mark this prestigious honour a special ceremony will take place at Bootle Town Hall on Thursday the 26th of January 2023. On behalf of the Board, Louise Shepherd thanked Sefton Council for awarding Alder Hey the 'Freedom of the Borough' which the Trust is honoured to receive.

22/23/264 Review of the Meeting

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

Date and Time of Next Meeting: Thursday the 23rd of February 2023 at 9:00am, Lecture Theatre 4, Institute in the Park, Alder Hey.

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 February 2023							
26.1.23	22/23/244.1	Strategy Update (Vision 2030)	Submit the formal Engagement Plan for the Vision 2030 Strategy during February's meeting.	J. Grinnell/ M. Flannagan	23.2.23	On-track Feb-23	**17.2.23** - An update on the Vision 2030: Engagement Plan will be provided during February's Board meeting.
Actions for March 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	Mar-23	
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	Mar-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **ACTION TO REMAIN OPEN**
26.1.23	22/23/243.1	Chair/CEO's Update	*GIDS* - Provide an update on the gateways for the Gender identify Development Service	L. Cooper	30.3.23	On track Mar-23	
Actions for April 2023							
27.10.22	22/23/176.1	Research and Innovation Committee Terms of Reference	*Alignment to RABD ToR* - RABD ToR to be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.	R. Lea	26.1.23	Feb-23	19.1.23 - This item has been deferred to February's Trust Board. ACTION TO REMAIN OPEN
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							
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	Closed	**15.12.22** - A discussion has taken place with the CEO of LWH regarding this matter. The Trust is awaiting feedback from LWH. **20.2.23** - This has been agreed in principle and will be taken forward by Nathan Askew on behalf of the Trust in association with LWH. **ACTION CLOSED**
26.1.23	22/23/243.1	Chair/CEO's Update	*GIDS* - Submit a formal report to the Board in Feburary to provide an update on the Gender identify Development Serivce.	L. Cooper	23.2.23	Closed	16.2.23 - This item has been included on Feburary's Board agenda. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Alder Hey Vision 2030**
Report of:	John Grinnell – Deputy CEO/CFO Dani Jones – Director of Strategy and Partnership
Paper Prepared by:	Natalie Palin, Dani Jones and John Grinnell

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	Supporting information provided as packs for the 6 Board Strategy sessions undertaken since April 2022.
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:	To be described in subsequent documents.

1. Introduction – summary of key risks and issues

This document provides an overview to trust board around the continued progress that has been made since we last reported in January 2023, in the development of the 2030 Strategy.

This report provides an overview of the economic case methodology, and status updates regarding **Engagement**, **Governance** and development of our **Strategic Initiatives**. The report also provides some high-level details of the progress to date in the assignment of Executive Leads to Strategic Initiatives.

2. Background and current state

Our big vision is a 'Happier, Healthier, and fairer futures where every child & young person achieves their full potential'.

The important next steps that we are outlining in the 2030 strategy development, in this paper relate to: -

- Further engagement with our stakeholders,
- Further Development of our 'Strategic Imperatives',
- Development of our People Plan and,

Vision 2030: Engagement

The aim of the engagement phase is to create awareness, understanding and build belief in the 2030 vision (Qtr. 1 23/24).

During Jan-Feb 23, we have progressed with the first two stages of our plan, On-Boarding Senior Leaders and CYPF engagement. To date the following activities have been completed: -

- 70% of the Senior Leaders on Boarding Sessions have been completed. This provided an opportunity to both secure further feedback and prepare leaders to there continued role from March around their own team's engagement.

- Engagement with CYPF has started and will continue through Feb 2023. This a targeted engagement against the CYP segments and has initially taken the form of collection of surveys and Video-Vox pops (capturing what Healthier, Happier and Fairer means to them). The outputs from the videos, will provide content to support wider staff engagement and will be used in the development of the final strategy.

- Colleague focus testing – of draft messages and materials (this has occurred with colleagues from estates, corporate services, ED and community services). This focus testing is designed to ensure that the messaging and language resonates with colleagues across Alder Hey.

The feedback, from these initial engagement activities has been extremely positive. The focus around the needs of CYP&F has particularly resonated with colleagues. They recognised the stories, challenges, and impact – each group posed differing questions to our Exec Leads, around funding, wider system, partner support and challenges that we will need to collectively overcome.

Ensuring we are able crisply articulate the benefits to our colleagues, has also led to separating the 'People areas of our Strategy' into a specific Strategic Objective.

Development of Our Strategic Objectives

During Feb 2023, we have continued to refine and develop – our Strategic Objectives, and alignment of strategic initiatives (previously described as tiles). Whilst we are still refining the naming conventions the 5 Strategic areas that will become our strategic objectives, broadly fit under: -

- Outstanding care and Experience,
- Incredible place to work,
- Revolutionising care,
- Pioneering Breakthroughs,
- Collaborating for CYP.

Work has progressed to align current trust programmes that are multi-year or strategically important against the 2030 Plan and this will be finalized during March 23. Executives Leads are being assigned SRO responsibilities against Strategic objectives and initiatives. The interconnected approach to the entire strategy will be detailed through the dependency plan and will be a key approach to how we achieve success.

Development of the Economic Case

A set of scenarios are being developed to test the economic/financial strategy which will support the vision. This is being tested through RABD in Feb/March and will subsequently form part of the new Strategic Board agenda in May and will be aligned to this years planning round and be supported by a new Long Term Financial Model.

Futures

As reported to the Board there is now a weekly programme team, supported by Strasys, working up the Futures proposal. It is proposed that the new Futures workstream will be presented at the May Strategy Board

People Plan

The Chief People Officer remains on track to present the refreshed People Plan to our March People Committee and Trust Board.

Governance Arrangements

As agreed in principle by the Board the start of the new financial year will see a dedicated Strategic Trust Board that will oversee the launch of the 2030 vision and oversee delivery of our strategic objectives. This will include the strategic transformation programme, phased delivery and proposed new outcomes.

The Director of Corporate Affairs/Director of Strategy are developing the terms of reference for this Board and ensuring aligned governance through our committee and executive functions, alongside setting out an initial workplan.

3. Conclusion

This paper ensures that the Trust Board, is sighted on the continued progress that is being made in the development of the 2030 Strategy and supporting strategies and governance arrangements.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

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

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

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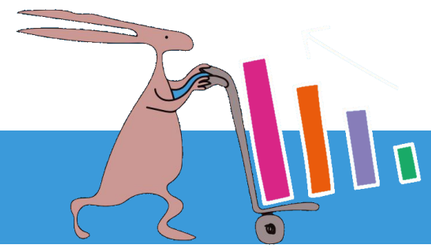
NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: February 2023



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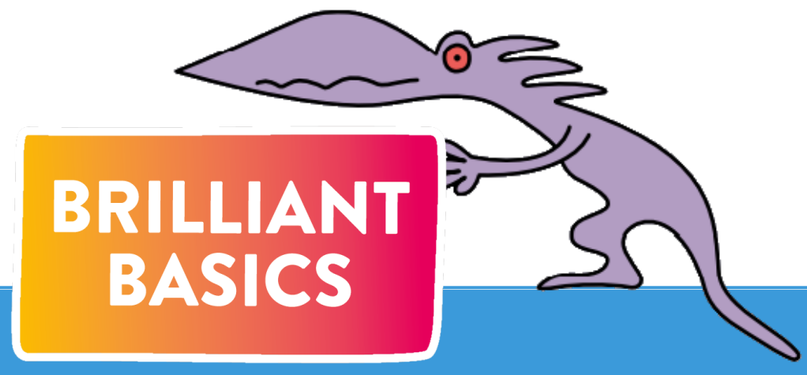


Icon Definitions

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

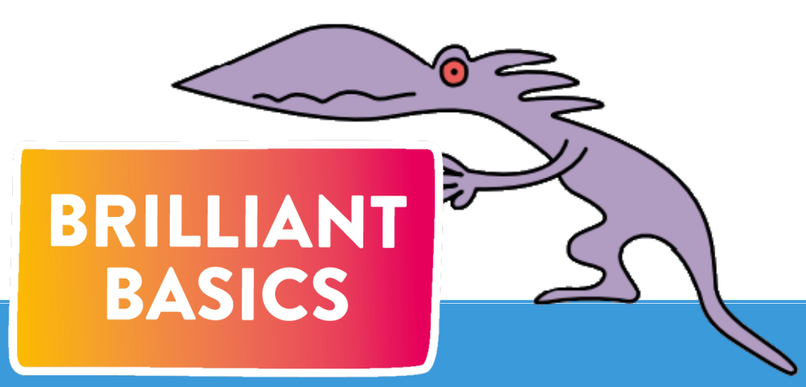
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		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	Recovery for Outpatient New & Procedures are inconsistently achieving target with an improving trend	Medical Appraisals 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			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:

- 12.2% of our metrics are consistently achieving target
- 61.3% of our metrics are inconsistently achieving target
- We are not achieving the target for 26.5% of our metrics but experiencing improvement in 4 of these metrics.

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



Integrated Performance Report | February 2023

Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe

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

Highlights:

• No serious incidents of Never Events in January • No Category 3 or Category 4 pressure ulcers, and a transparent culture of reporting and managing Category 2 pressure ulcers preventing further tissue deterioration • Administration of antibiotics within 1 hour for sepsis over 90% for both inpatients and children presenting in ED

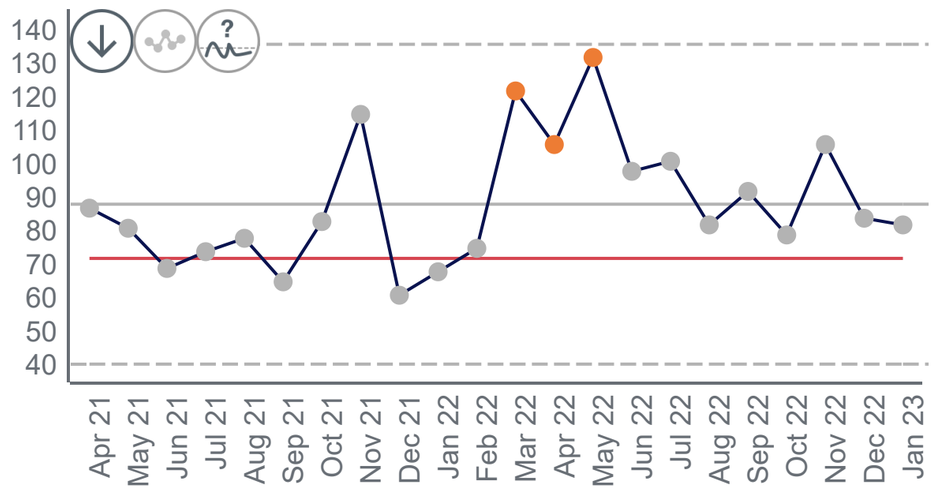
Areas of Concern:

• Increased number of physical restrictive intervention within Tier 4 Mental Health however this signals a high level of reporting. The Community and Mental Health Division is fully engaged with a CQUIN to support quality impovement in the use of restrictive practice

Forward Look (with actions)

• The Trust is currently working with Commissioners to agree CQUINS for 2023/24 and is planning to engage in the CQUIN to reduce the need for restrictive practice in children and young people's inpatient settings

Number of Incidents rated Minor Harm and above



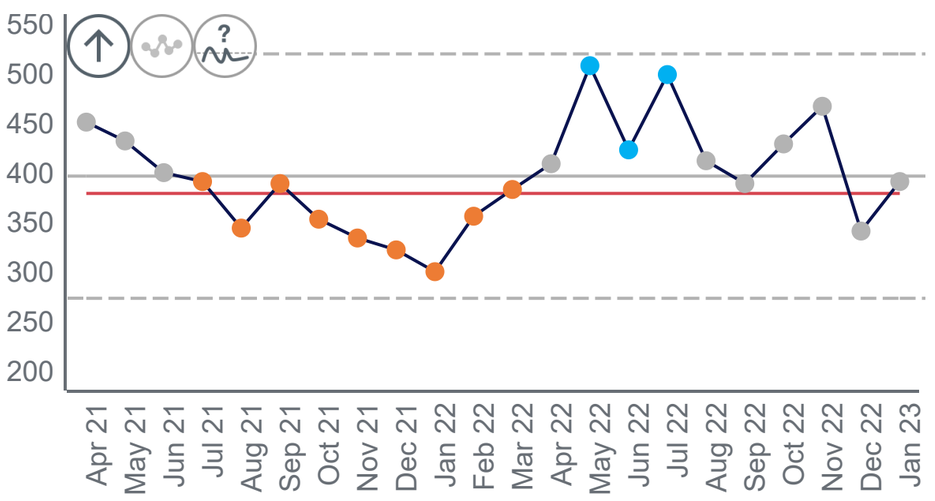
Technical Analysis:

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 85 incidents in Jan, 84 were minor harm and 1 moderate/major harm.

Actions:

Continue to encourage incident reporting. Divisions and services aim to investigate and close incidents within 10 working days ; taking appropriate action and feeding back to the reporter to close the loop

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. In January this returned above target, but shows common cause variation.

Actions:

Continue to encourage wide multi-disciplinary attendance at the weekly Patient Safety Meeting to share learning from incidents

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	January 2023	82	88	72		
Number of Incidents rated No Harm and Near Miss	January 2023	392	398	380		
Number of Serious Incidents (Steis reported)	January 2023	0	1	0		
Number of Never Events	January 2023	0	0	0		
Sepsis % Patients receiving antibiotic within 60 mins for ED	January 2023	93	85	90		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	January 2023	95	89	90		
Number of Medication Errors resulting in harm (minor harm and above)	January 2023	7	4	4		
Pressure Ulcers G2-4	January 2023	6	4	5		
Use of physical restrictive intervention	January 2023	32	15			
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	January 2023	22	23	30		
Hospital Acquired Organisms - MRSA (BSI)	January 2023	0	0	0		
Hospital Acquired Organisms - (C.Difficile)	January 2023	0	0	0		
Hospital Acquired Organisms - MSSA	January 2023	1	1	0		

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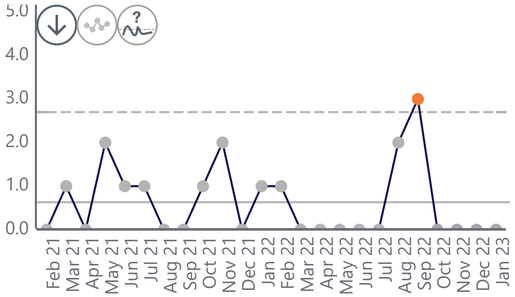
Integrated Performance Report | February 2023

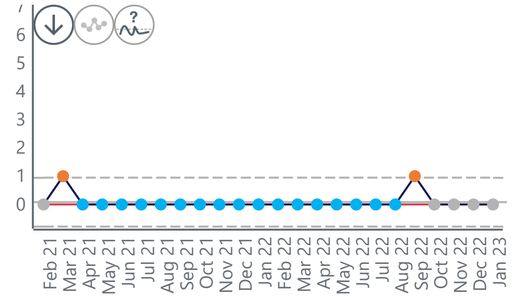
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

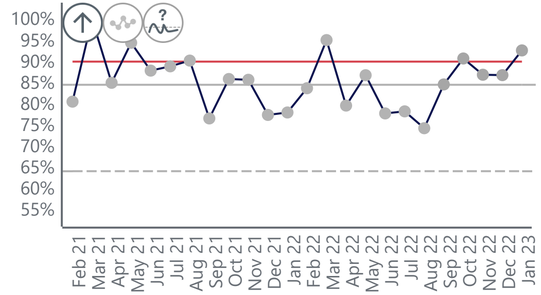
Number of Serious Incidents (Steis reported)



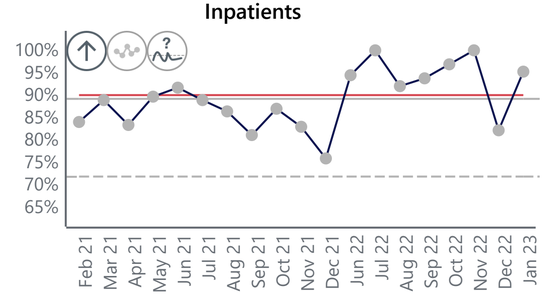
Number of Never Events



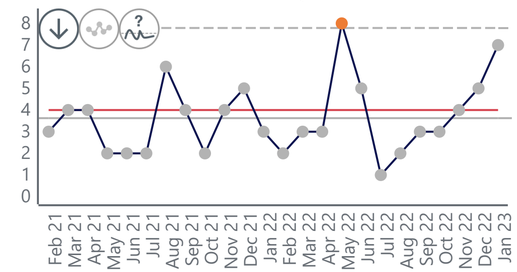
Sepsis % Patients receiving antibiotic within 60 mins for ED



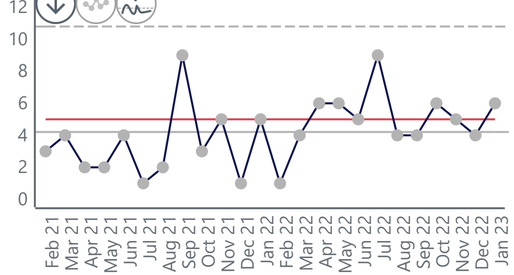
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



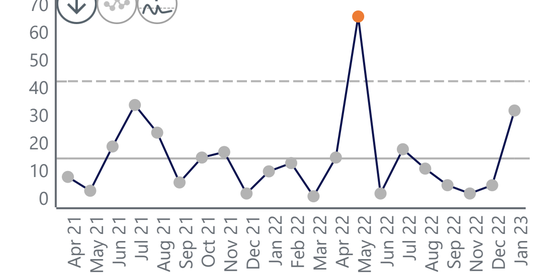
Number of Medication Errors resulting in harm (minor harm and above)



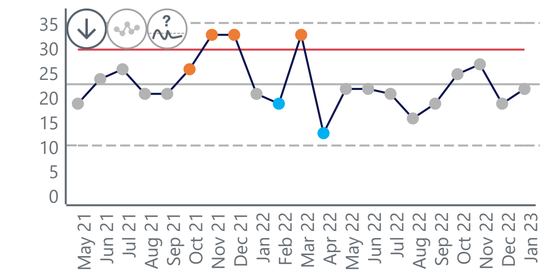
Pressure Ulcers G2-4



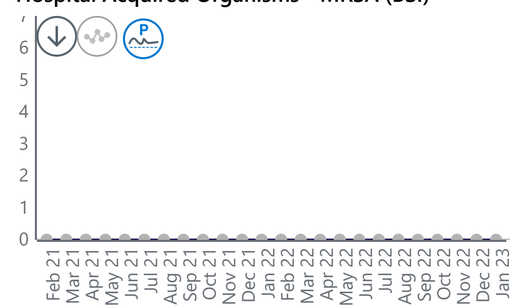
Use of physical restrictive intervention



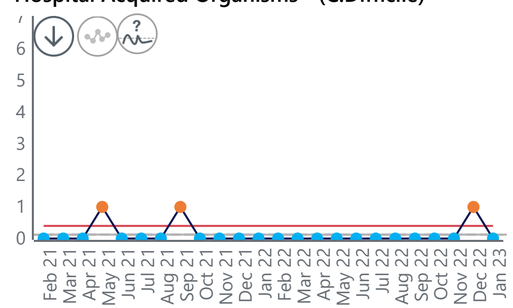
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



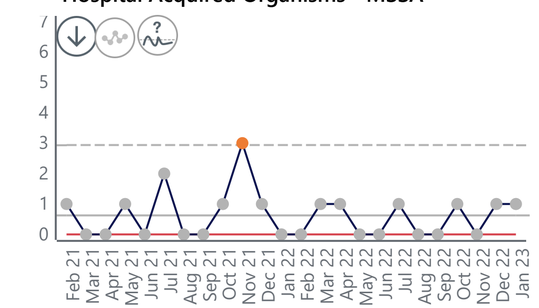
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Outstanding Safety - Caring

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

Highlights:

• Divisions feedback to the Patient Experience and Engagement Group to share highlights, best practice and learning from our children, young people and families • Patient Experience team have worked with the Brilliant Basics team and enhanced the way they report on FFT • Sustained improvement in responding to PALS concerns within 5 working days

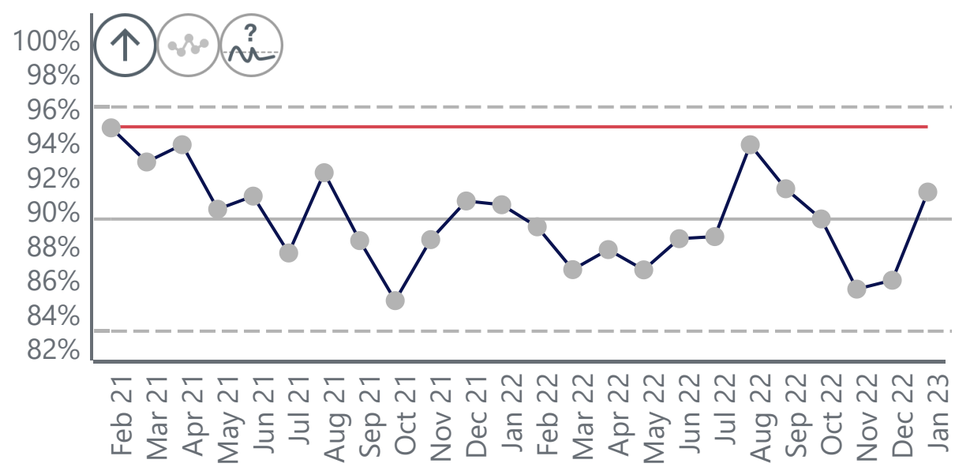
Areas of Concern:

• FFT score in ED below 90% however there has been a marked increase in comparison to the previous month

Forward Look (with actions)

• The Play Team are supporting teaching throughout the Trust to enhance practice and promote the power of play. The Play Team are also offering practice placements to Level 3-5 child care students to raise awareness of the importance of play in hospital and to make a positive impact on future recruitment and workforce development

F&F Test - % Recommend the Trust



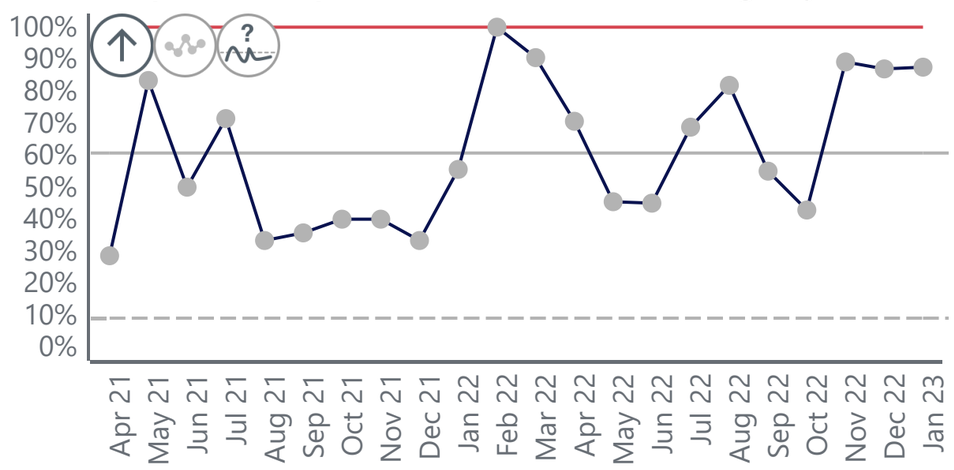
Technical Analysis:

Consistently falling short of the target – ED is at 81.4% with no department exceeding the 95% target. Jan figure of 91% is higher than previous two months, but the data continues to demonstrate normal cause variation.

Actions:

Ward Manager and Matron ward rounds to directly address any issues or concerns and to improve the patient and family experience

% Complaints Responded to within 25 working days



Technical Analysis:

January response rate of 50% within 25 working day target is a significant change from Nov and Dec (both >85%). This is technically common cause variation, but with mean at 59% against a 100% target, significant improvement work is required.

Actions:

Divisional governance teams meet weekly to review and track progress of all complaints

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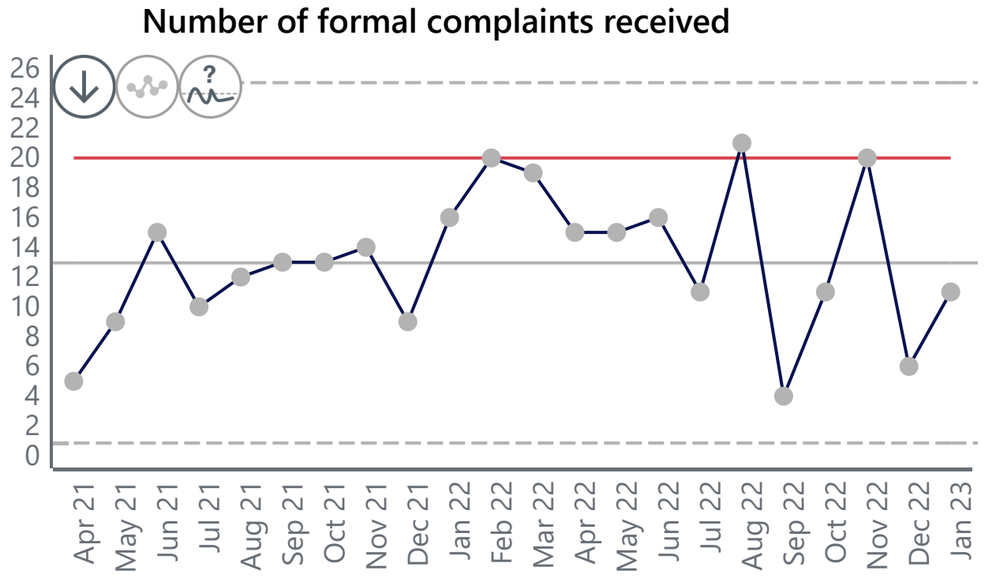
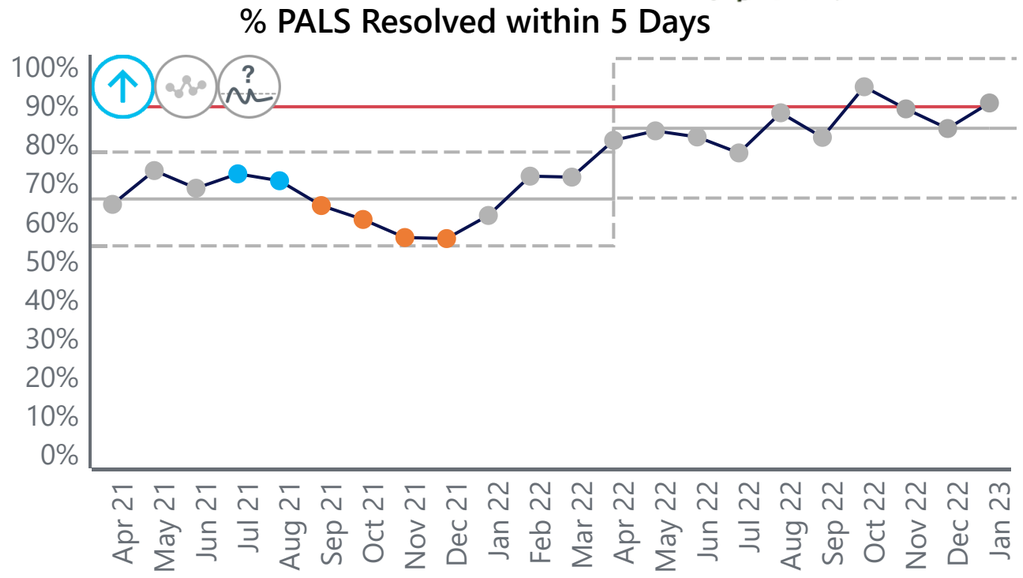
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	January 2023	91	95	90		
% Complaints Responded to within 25 working days	January 2023	88	100	61		
Number of formal complaints received	January 2023	11	20	13		
% PALS Resolved within 5 Days	January 2023	91	90	75		
Number of PALS contacts	January 2023	161	150	135		
F&F ED - % Recommend the Trust	January 2023	81	95	69		

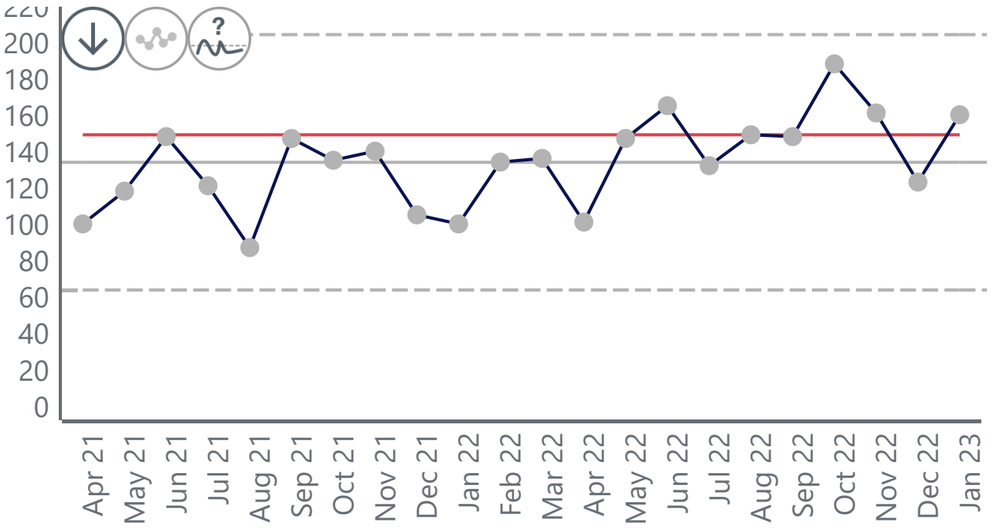
Number of formal complaints received



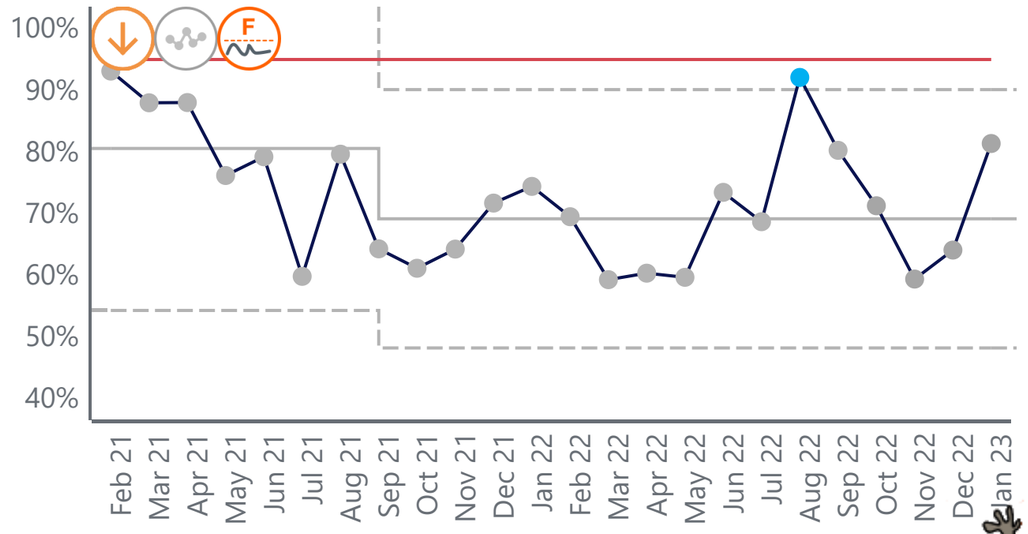
% PALS Resolved within 5 Days

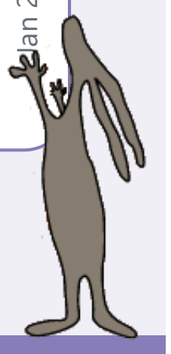


Number of PALS contacts



F&F ED - % Recommend the Trust





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Alder Hey Children's NHS Foundation Trust

Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• ED performance up to 76%, noting reduced number of attendances and actions in place • 780 patients seen through Urgent Treatment pathways (inc Hub 2 and GPs etc) • Triage time returned to 11 minutes (<15min standard) • Only 15 patients >12hrs Time in Dept (138 in Dec) •Backlog of clinic letters >30days reduced to 322 (from 525 in Nov and 2034 in Aug) • 8% WNB rate is best month in reporting period

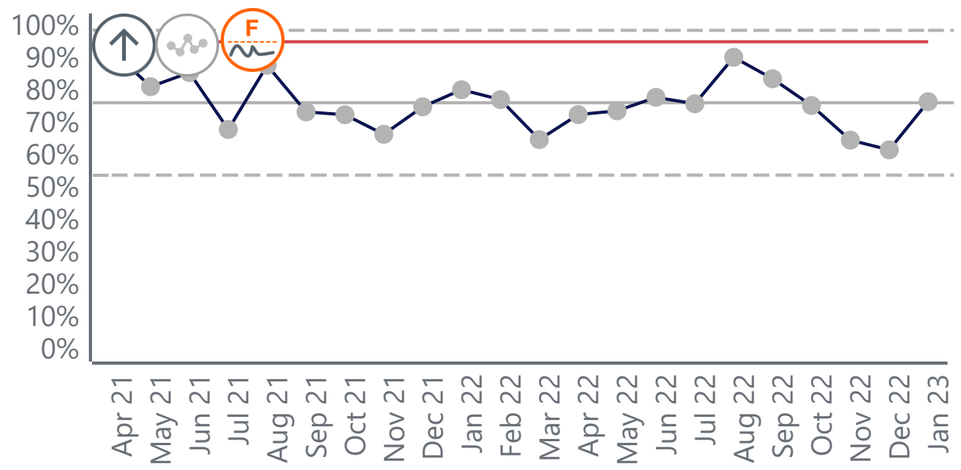
Areas of Concern:

• Pressure remains on ED performance • Long stay patients remains above target, with 42 in Jan • Cancelled patients not re-booked within 28 days, with additional challenges due to provision of mutual aid

Forward Look (with actions)

• New Urgent Treatment Centre opened on 30 Jan. Ensure CYP are streamed to most appropriate setting, with continuous training to implement this effectively • New huddles to support discharge planning and increase Virtual Ward occupancy • Clear backlog of letters >30 days • Maintain actions driving down WNB to show sustained improvement over time

ED: % treated within 4 Hours



Technical Analysis:

January performance of 76% is higher than the last two months, although demand has reduced with fewer attendances in Jan (5176) compared to Nov (6610) & Dec (7420). Although technically within the range of normal variation, a number of significant actions have been implemented, including UTC, which are expected to improve performance in future months

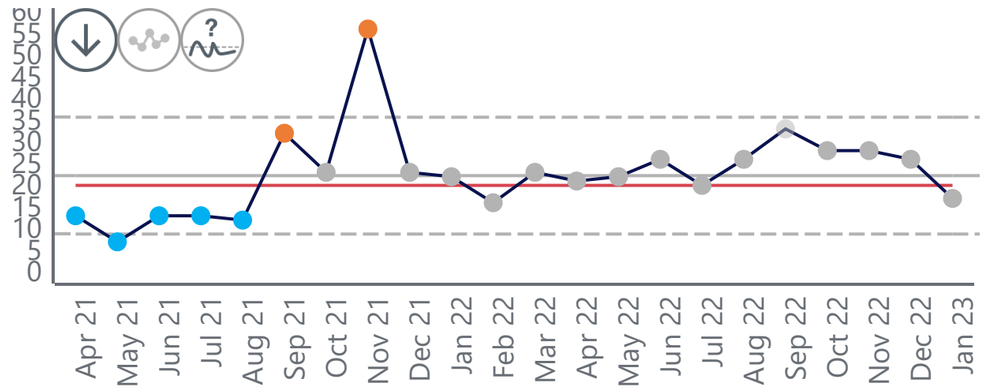
Actions:

New Urgent Treatment Centre opened on 30 Jan. Ensure CYP are streamed to most appropriate setting, with continuous training to implement this effectively

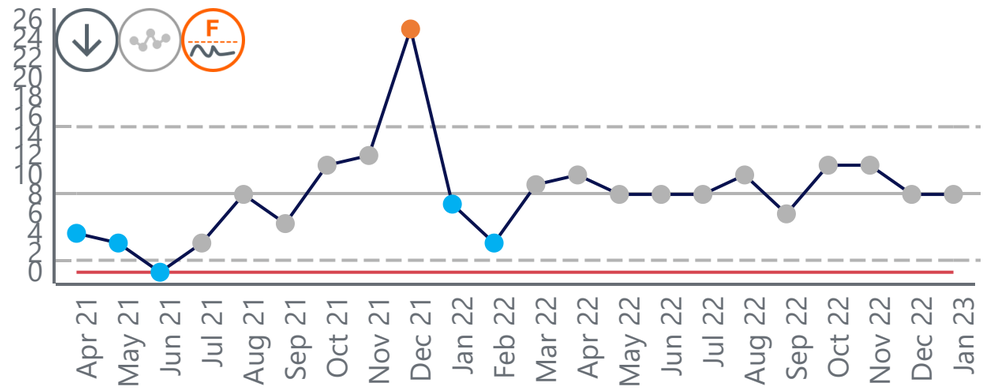
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	January 2023	76	95	76.17		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	January 2023	17	20	22.73		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	January 2023	8	0	8.09		F
Number of Super Stranded Patients (21 days)	January 2023	43	30	37.91		?
% Virtual Outpatients (national standard 25%)	January 2023	25	25	29.37		?
% Was Not Brought Rate (All OP: New and FU)	January 2023	8	10	9.79		?
% of Clinical Letters completed within 10 Days	January 2023	72	95	59.01		F

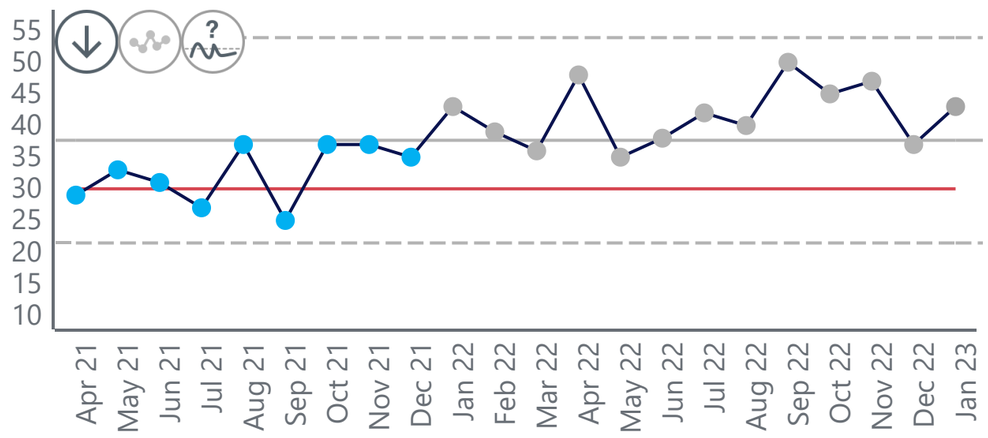
Number of Cancelled Operations (on day of admission for a non-clinical reason)



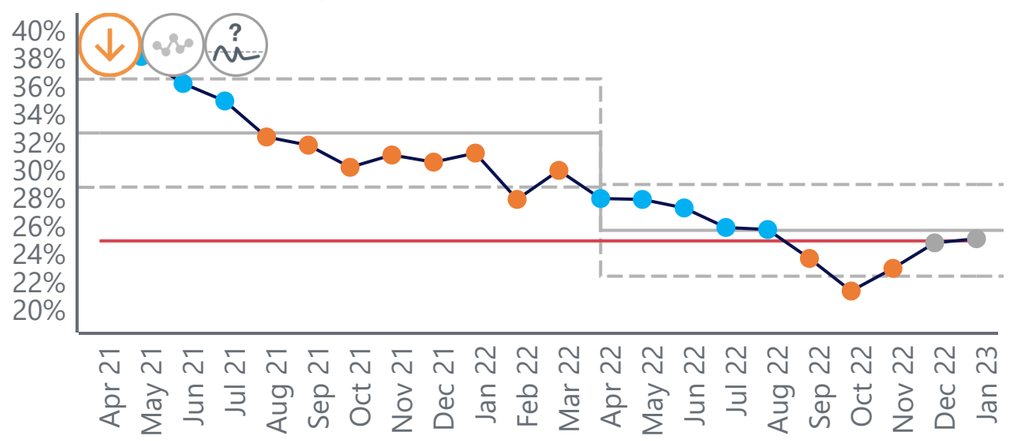
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



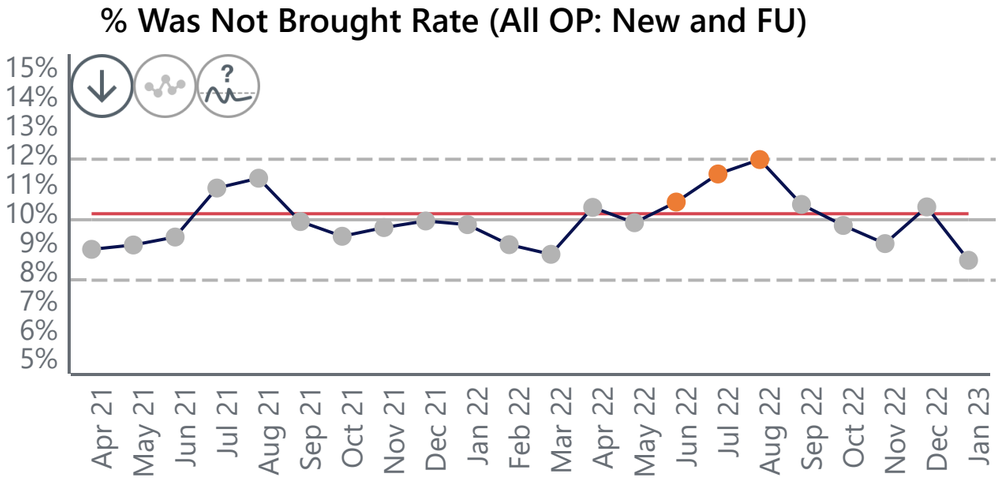
Number of Super Stranded Patients (21 days)



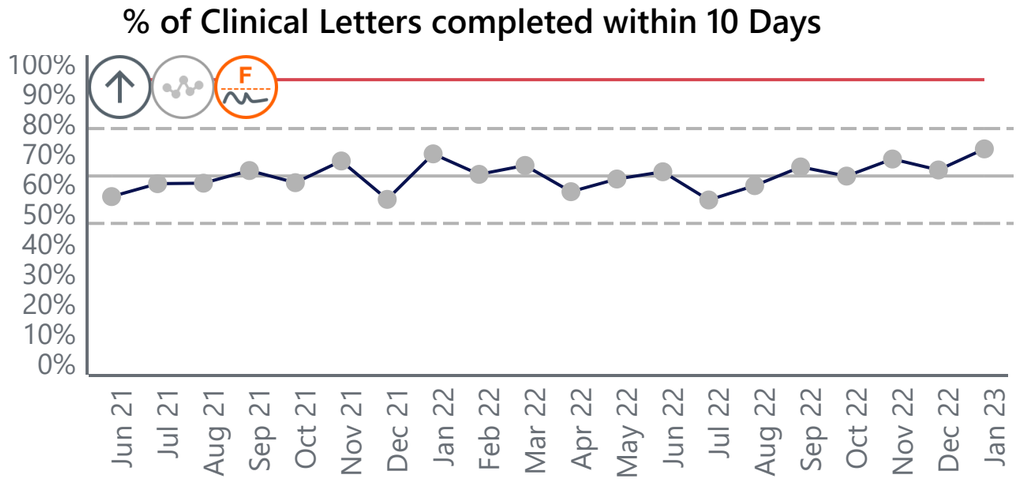
% Virtual Outpatients (national standard 25%)



% 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:

• Sustained improvement in Diagnostic access with >70% within 6 weeks, including commencement of Home Sleep Studies in January • Strong OP performance with high levels of recovery for New patients (6mths >104% target) and reductions in FU (7mths below average) • 100% compliance with cancer access standards • Dental Insourcing model commenced in Jan

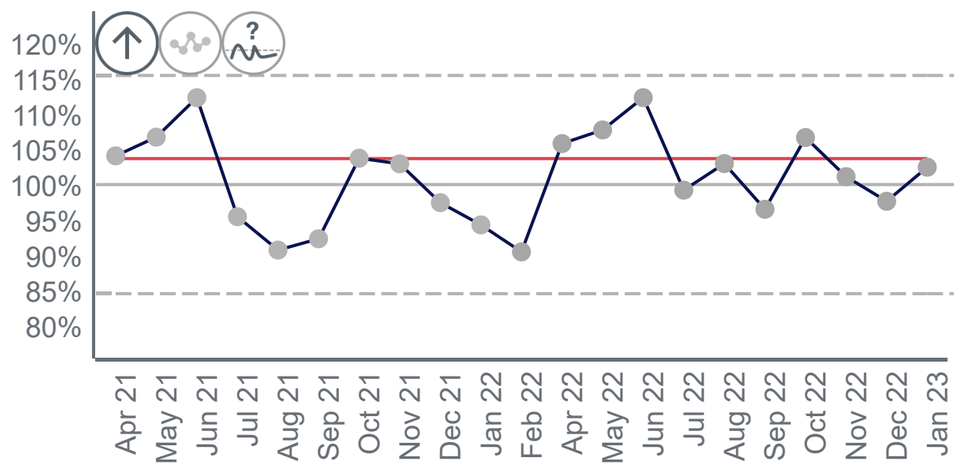
Areas of Concern:

• More patients are waiting >52wks, with pressures caused by Industrial Actions, provision of Mutual Aid to RMCH, and service level capacity issues in ENT (emerging as a challenged specialty) • Recovery for IP & DC activity marginally below 104% target, but performance in stable

Forward Look (with actions)

• Priority focus on the longest waits to ensure zero >78wks by end of March (in line with national standards) • Provision of Mutual Aid to RMCH • Ensure safe care delivered during any further Industrial Action • Optimise benefits from Home Sleep and Dental Insourcing

% Recovery for DC & Elec Activity Volume



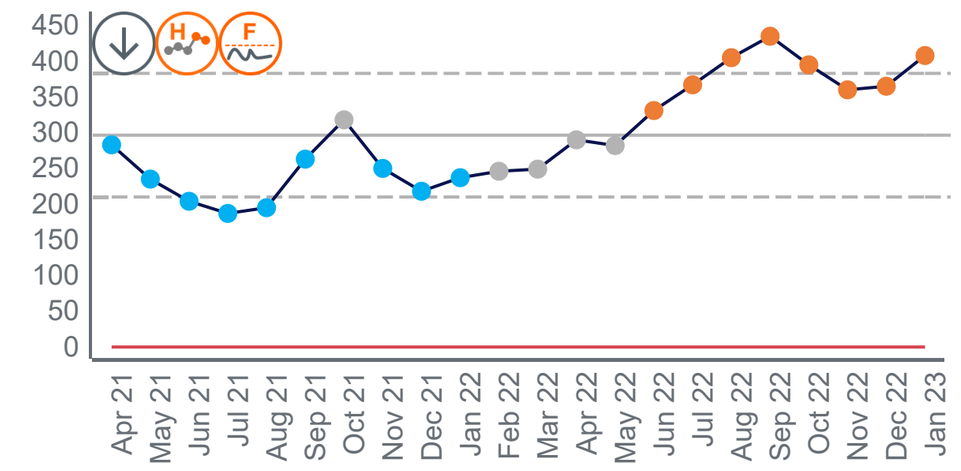
Technical Analysis:

Jan performance of 103% by volume is slightly below the target. It is significantly higher than Jan 22 (95%) although that month was impacted by Omicron Covid variant. Monthly variation continues to demonstrate common cause variation. Further actions will be required to achieve step change required for 23/24 recovery targets.

Actions:

Implement additional sessions with new rate of pay for additional work. Continue re-allocation of under used theatre lists. Theatre productivity work ongoing, with focus on touch-time.

Number of RTT Patients waiting >52weeks



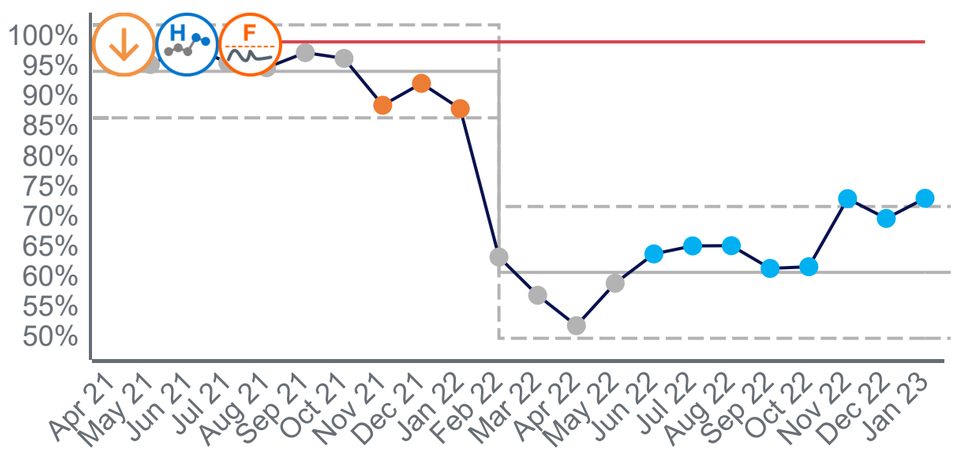
Technical Analysis:

In Jan there were 408 RTT patients >52wks, in part due to impact of Industrial Action and provision of Mutual Aid. This includes 10 RTT patients >78wks. Dentistry has 240 pts>52wks, 59% of the Trust total. ENT has now emerged as a challenged specialty with 102pts >52wks 25% of Trust total.

Actions:

Focus on ensuring no patients >78wks by end of March. Provision of Mutual Aid to RMCH. Produce bespoke recovery plan for ENT (both short term and medium actions). Drive OP waits to <40wks.

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

Special Cause variation has been observed which demonstrates the success of the improvement actions taken in Radiology and Urodynamics to reduce waiting times. However, 73% in Jan remains below national standard of 99%, and further actions are being taken in Sleep and Scopes to drive continued improvement

Actions:

Realise benefits of Home Sleep studies and ensure optimise capacity with total of 16 patients per week (8 IP, 8 Home). Focus on Scope capacity with implementation of standard lists (based on complexity).

Recovery & Access -Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	January 2023	103	104	101.41		?
Number of RTT Patients waiting >52weeks	January 2023	408	0	296.50	H	F
Diagnostics: % Completed Within 6 Weeks of referral	January 2023	73	99	63.63	H	F
RTT Open Pathway: % Waiting within 18 Weeks	January 2023	56	92	62.26	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	January 2023	100	100	99.42		P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	January 2023	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	January 2023	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	January 2023	100	100	92.86	H	?
Cancer: Faster Diagnosis within 28 days	January 2023	100	75	93.77	H	P
% Recovery for OP New & OPPROC Activity Volume	January 2023	111	104	102.22	H	?
% OPFU Activity Volume	January 2023	100	85	106.21		F
Waiting List Size	January 2023	23,859		19,312.09	H	?

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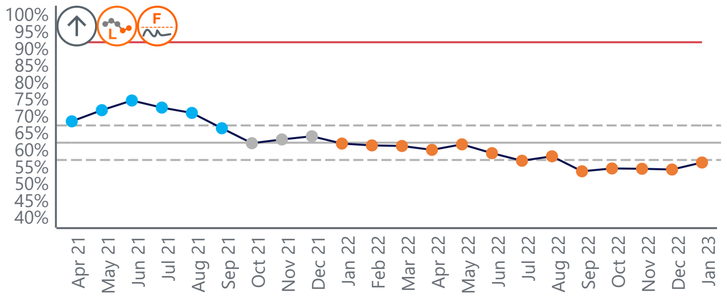
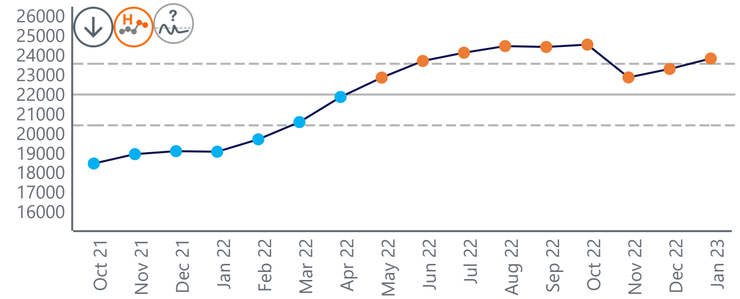
Recovery & Access -Responsive - Watch Metrics

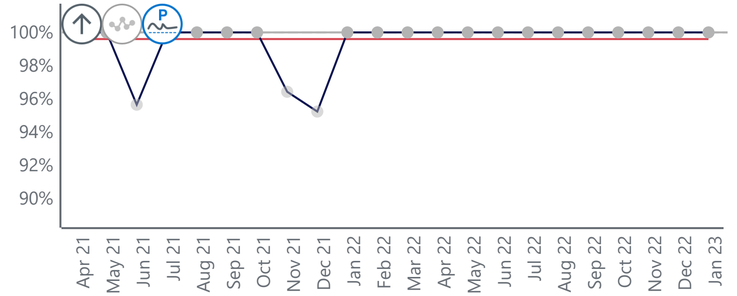
RTT Open Pathway: % Waiting within 18 Weeks



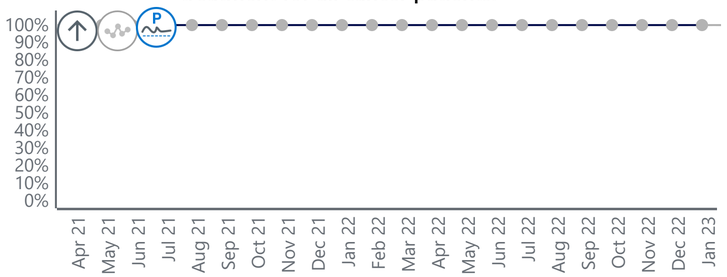
Waiting List Size



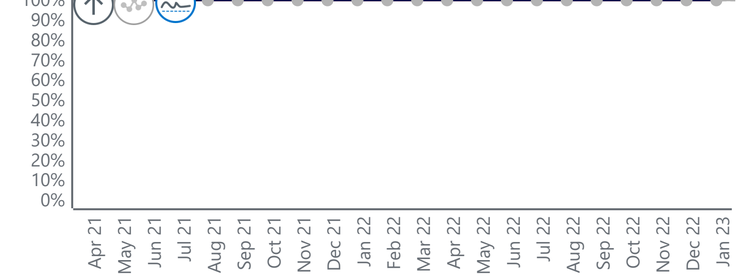
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



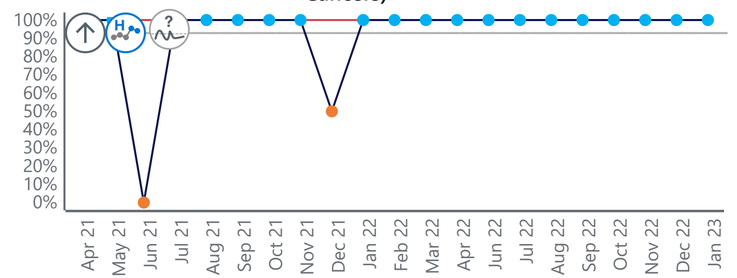
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



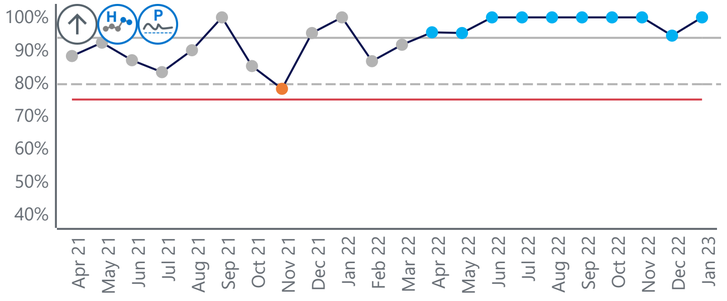
All Cancers: 31 day wait until subsequent treatments



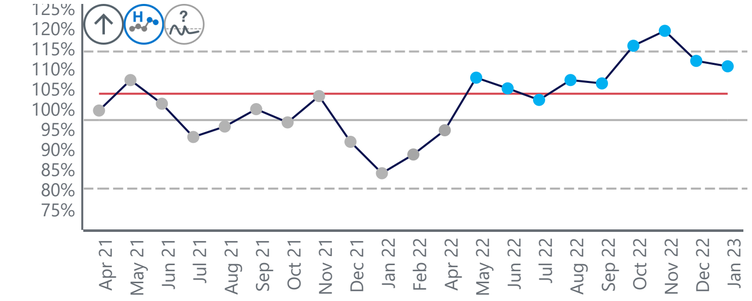
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



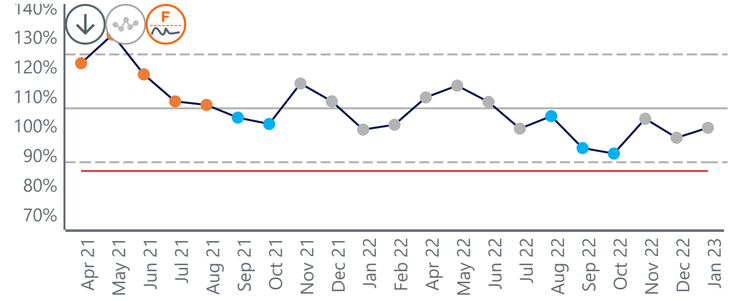
Cancer: Faster Diagnosis within 28 days



% 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 compliance remains above target • Sickness absence reduced in month for the first time since September 22, though remains above the 5% target. This is in encouraging though not yet statistically significant.

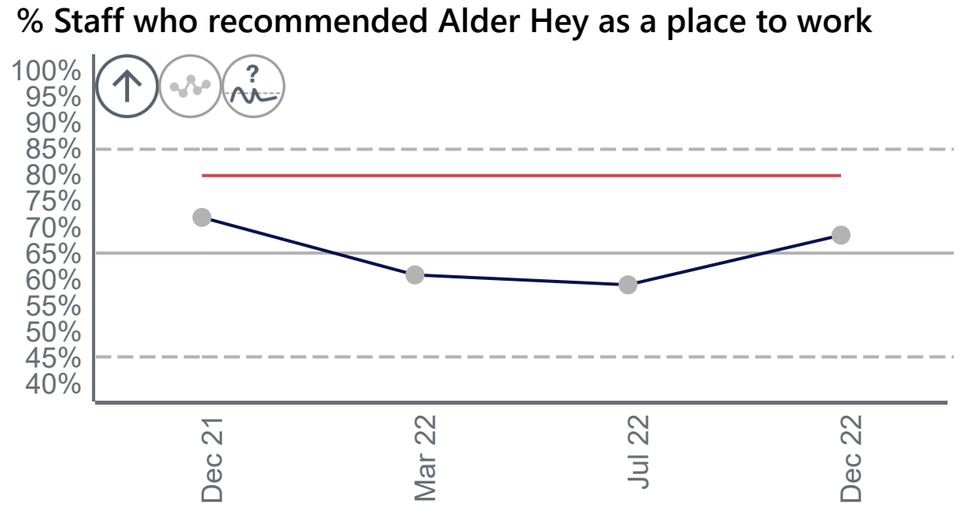
Areas of Concern:

• Staff availability remains an area of concern, particularly sickness absence & retention • PDRs are a concern in this context, as it is through these discussions, we review performance, objectives and review development need and career aspirations. These discussions can provide a clear indicator if we foresee retention issues. Though below target, the completion % did jump up in month.

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. PAWC will continue to receive detailed analysis and oversight of this. • Preparing staff survey data to information action planning conversations. Opportunity to celebrate improvement and positive consistency, and develop plans to address areas of concern (important link to turnover)

% Staff who recommended Alder Hey as a place to work



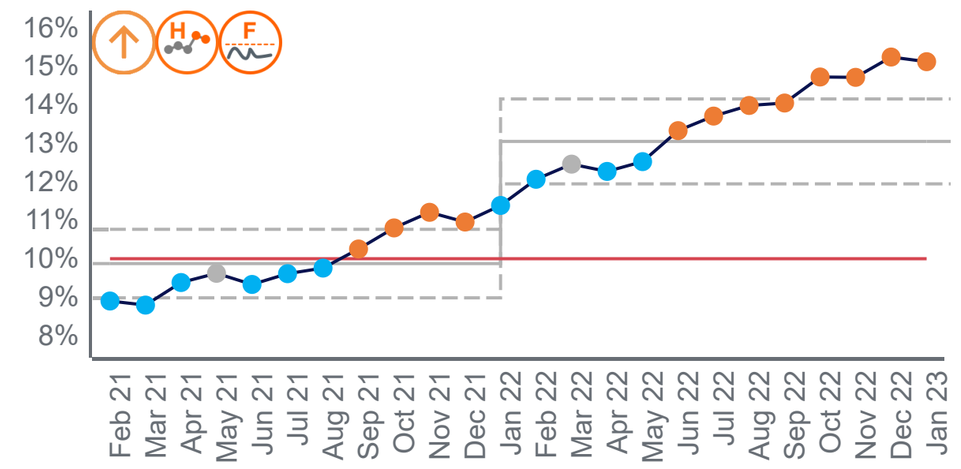
Technical Analysis:

Dec 22 performance of 69% is from national staff survey and therefore is considered a more reliable indicator than previous data points. Given current frequency of the data it is not possible to observe statistical trends, however is it noted that Dec 22 (69%) is lower than Dec 21 (72%) and lower than 80% target.

Actions:

The Staff Survey with a response rate of 54% confirmed that 69% of those staff would recommend Alder Hey as a place to work. Division and department level packs are being generated to support action planning. (Staff Survey Information remains currently under embargo outside of the organisation)

Staff Turnover



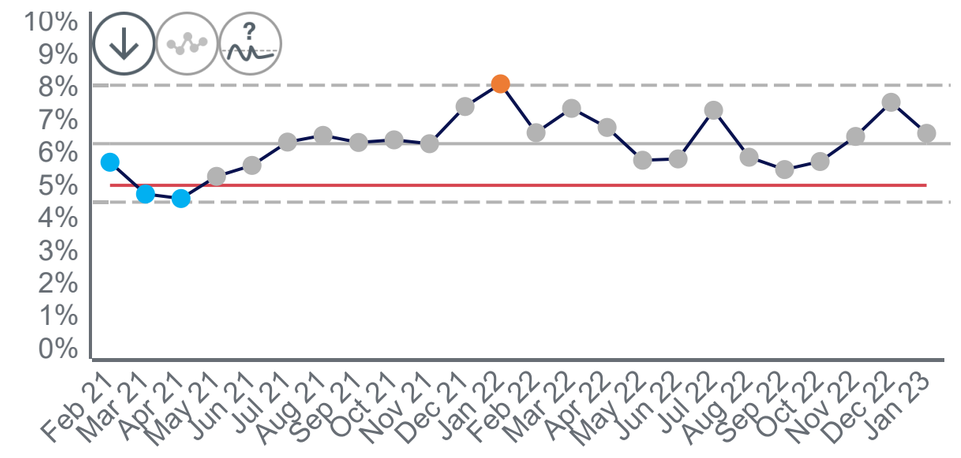
Technical Analysis:

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

Actions:

Staff turnover is a concerning trend which continues to be monitored closely and reviewed by divisional boards and PAWC. Sustainable interventions are being considered and presented through the Trust Attraction and Retention long term plan. Task and finish group established to address immediate actions & support long term plans.

Sickness Absence (Total)



Technical Analysis:

Total absence in Jan is 6.0%, lower than Dec (7.7%), but above the 5% target. This comprises STS at 2.3% and LTS at 4.2%. This is still demonstrating common cause variation, and further actions are required to drive 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. Detailed analysis to be presented to PAWC.

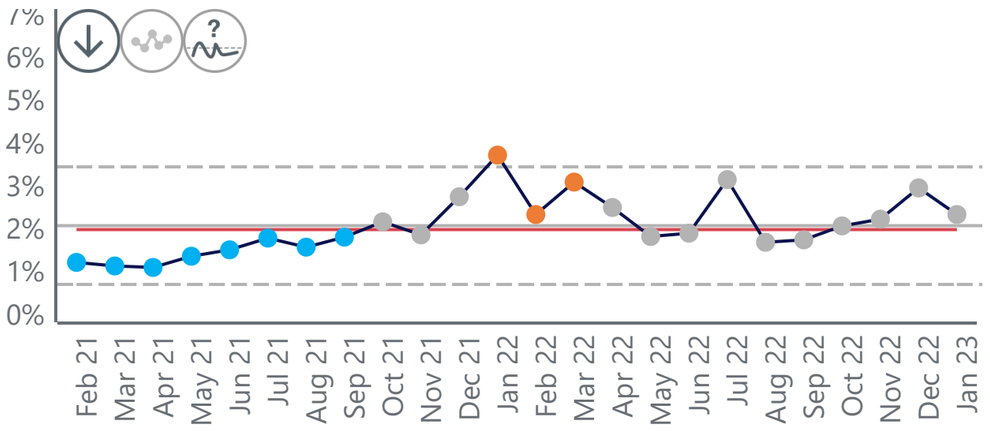
Integrated Performance Report | February 2023

Alder Hey Children's NHS Foundation Trust

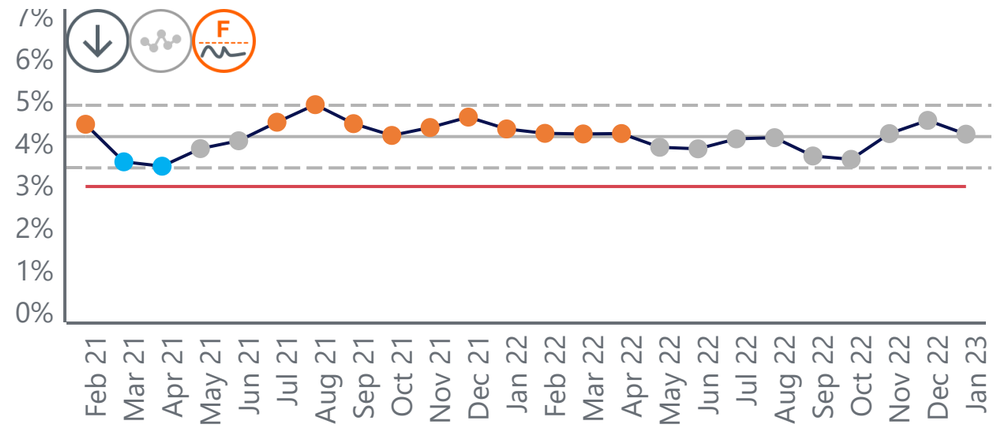
Well Led - Great Place to Work - People - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Staff who recommended Alder Hey as a place to work	December 2022	69	80	65.18		?
Staff Turnover	January 2023	15	10	13.18	H	F
Sickness Absence (Total)	January 2023	7	5	6.27		?
Short Term Sickness	January 2023	2	2	2.09		?
Long Term Sickness	January 2023	4	3	4.18		F
Mandatory Training	January 2023	92	90	92.20		P
% PDRs completed since April	January 2023	57	90	45.73		F
Medical Appraisal	January 2023	86	100	62.01	H	F

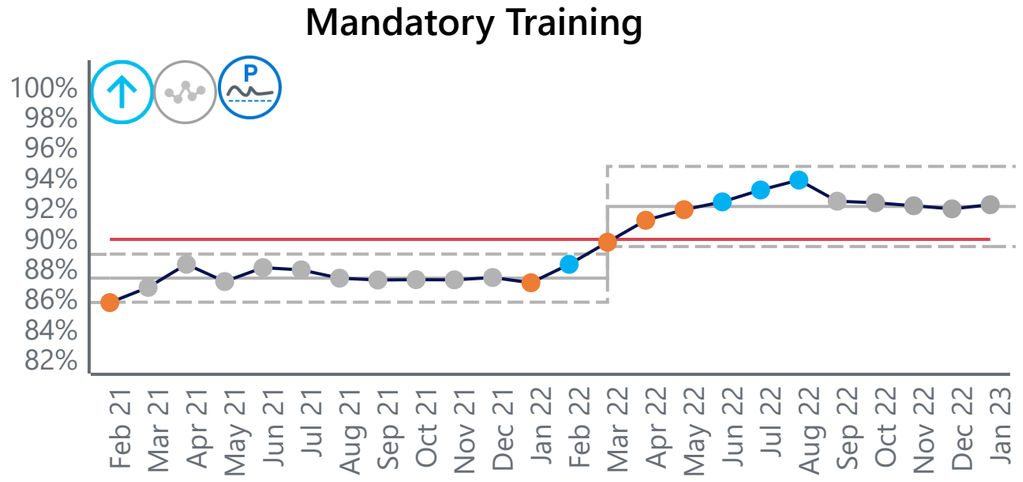
Short Term Sickness



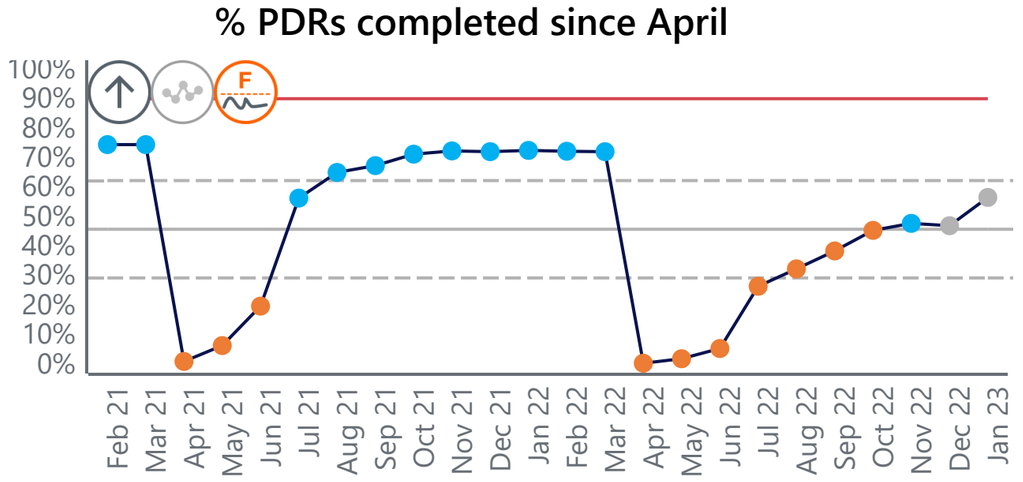
Long Term Sickness



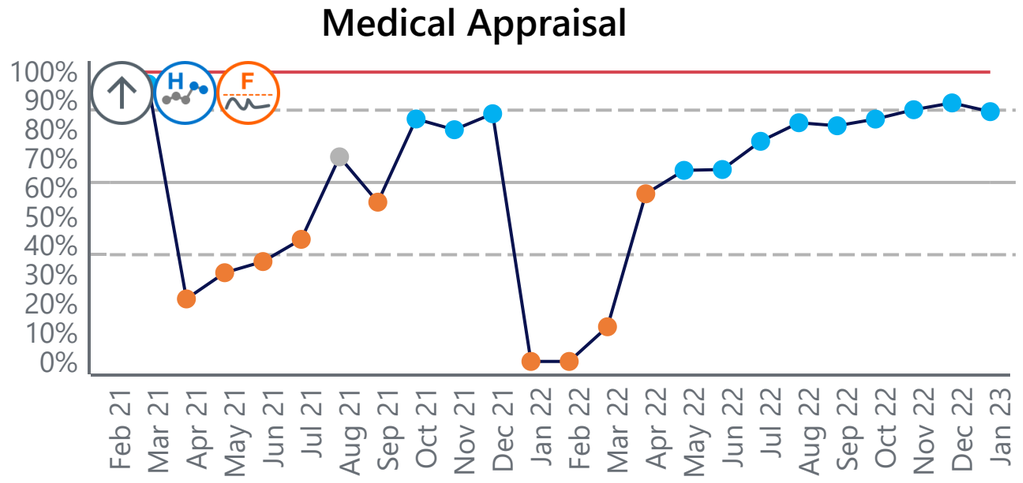
Mandatory Training



% PDRs completed since April



Medical Appraisal



Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Highlights:

• For January (M10), the Trust is reporting a surplus of £1.5m which is £0.5m ahead of the planned position. The year to date position is £3.2m surplus again £0.5m ahead of plan. The Trust is forecast to achieve an outturn position of £6.1m as approved last month however is also seeking to increase by a further £1m to £7.1m through further non recurrent improvement. Forecasting to achieve £17.3m in year Cost Improvement Plan target. A continued improvement in the month of recurrent CIP achievement now at 63% of the identified target after opportunities have been transacted. Cash has remained high in line with the plan as capital spend increases in future months.

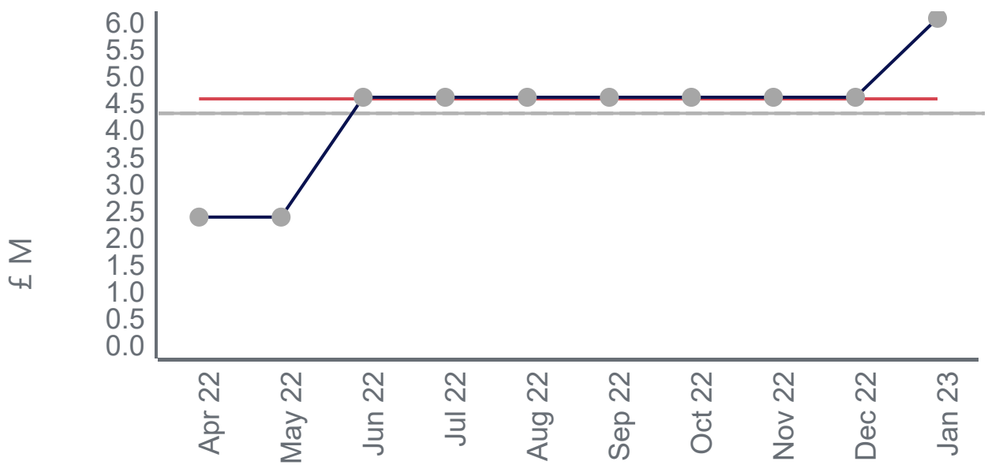
Areas of Concern:

• A 44% gap remains in recurrent CIP identified with no transformational schemes in the plan. Challenges remain as we head into 23/24 financial year including inflationary pressures within energy, drugs, non pay and an increase in temporary/premium pay despite activity below 19/20 levels. Not achieving the 104% ERF threshold.

Forward Look (with actions)

• Continued cost control to ensure achievement of the revised forecast by end of the financial year. Urgent focus required on recurrent efficiency. Further divisional finance panel meetings scheduled. Triangulation of costs/activity/workforce through the hospital optimisation project and will inform the 23/24 annual planning process.

Revenue Position (Year End Forecast)



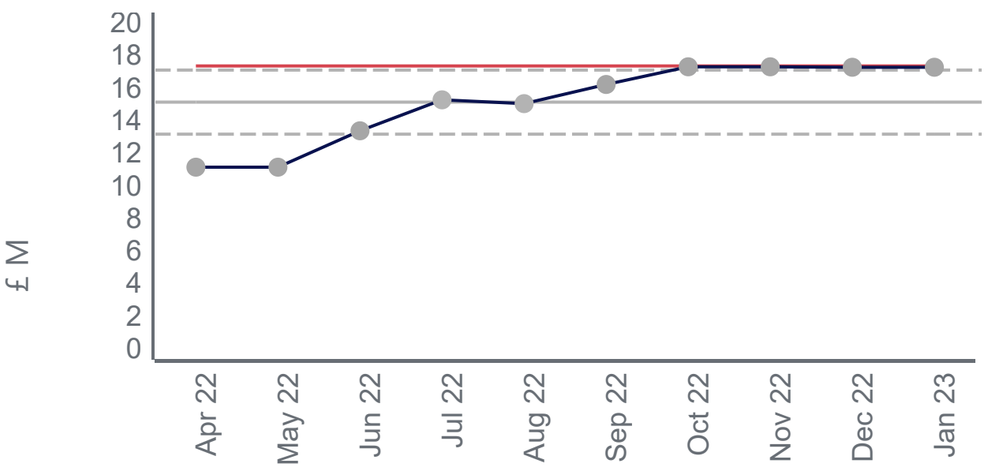
Technical Analysis:

Forecast to achieve £6.1m surplus with potential to improve further subject to ongoing discussions

Actions:

Continue to monitor inflationary pressures risk and mitigations and ensure robust cost control

CIP Position In Year (Year End Forecast)



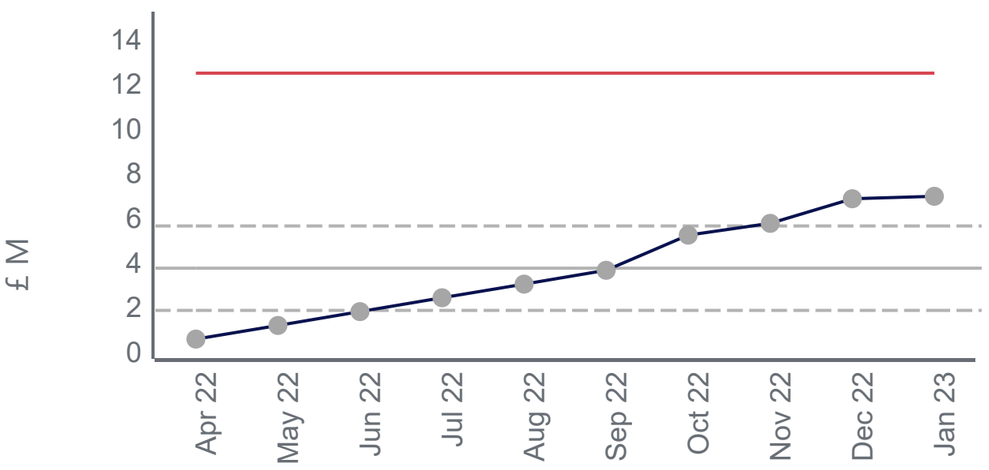
Technical Analysis:

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:

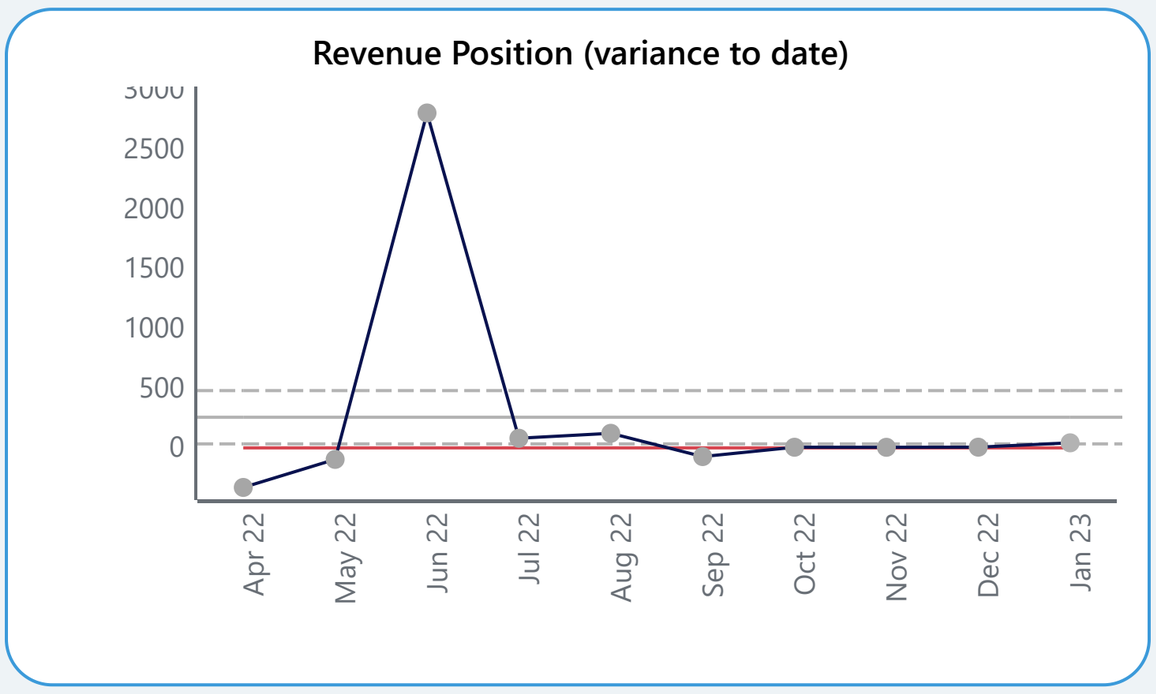
Current forecasts now in line to achieve £7.8m subject to schemes will in progress

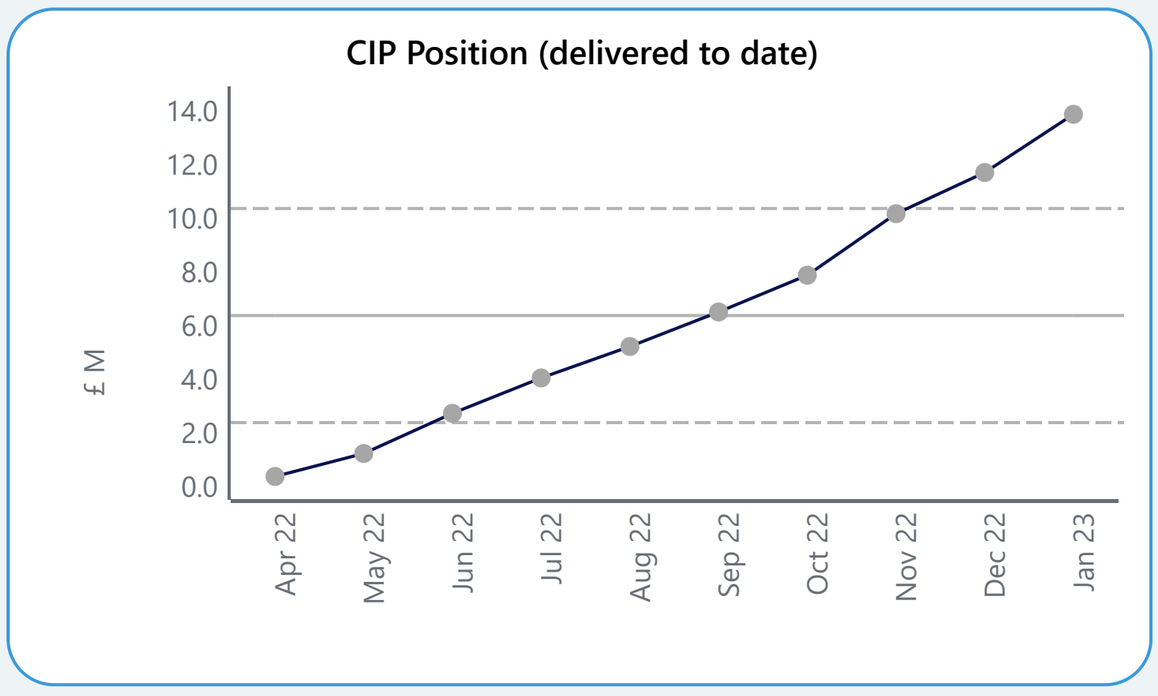
Actions:

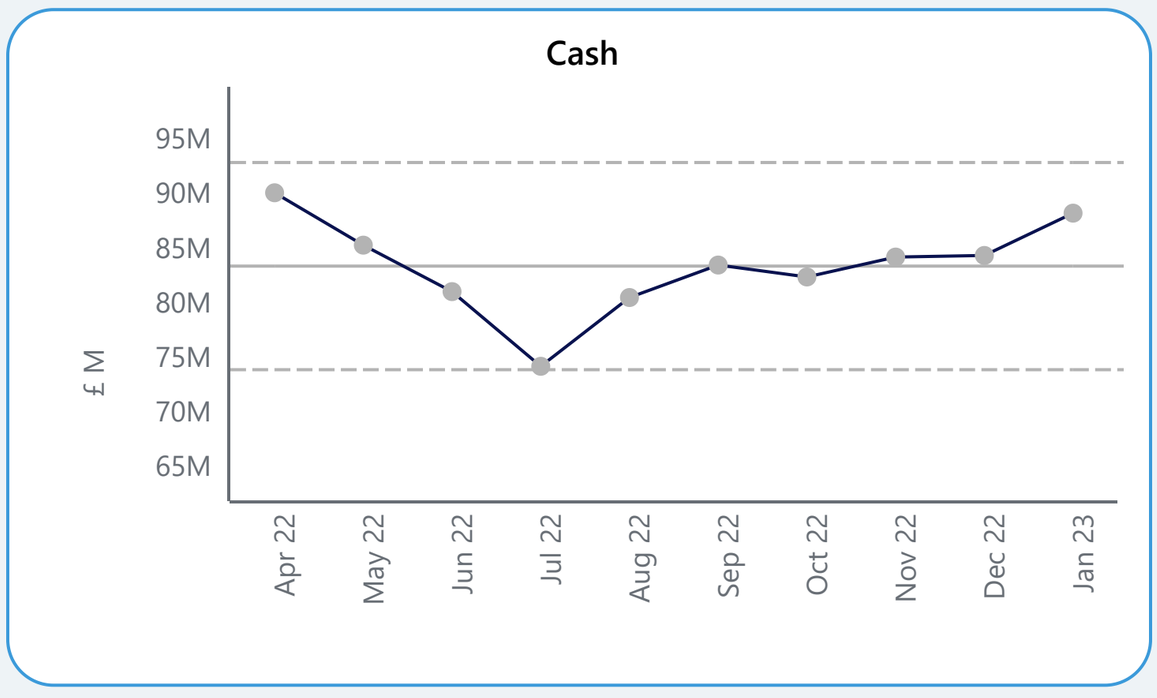
Support required with exec leads and transformation to identify the large scale opportunities either through existing programmes/projects or if not likely to deliver and for new schemes to be agreed & supported.

Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	January 2023	6	5		
CIP Position In Year (Year End Forecast)	January 2023	17	17		
CIP Position Recurrent/Full Year Effect	January 2023	7	13		
Revenue Position (variance to date)	January 2023	42	0		
CIP Position (delivered to date)	January 2023	14			
Cash	January 2023	88,246,000			







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

• Risk Management Forum met 9th January • Division of Medicine deep dive of high moderate risks undertaken • All risks reported to RMF continue to be closely scrutinised • Improving picture of decreasing number of high risks being reported via risk register due to mitigations in place • All Corporate high risks (score 12+) reviewed via corporate services collaborative • Monthly risk register validation meetings continue with corporate oversight • Corporate Service Collaborative report developed and shared at Risk management forum

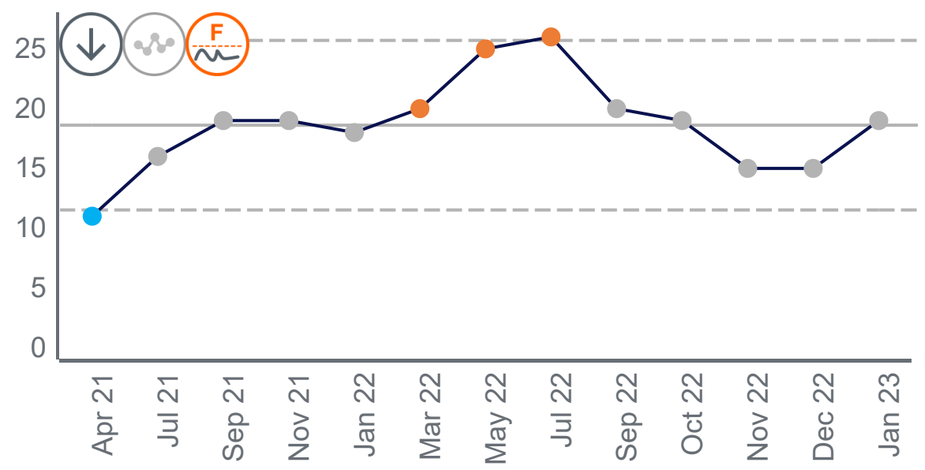
Areas of Concern:

• None at present

Forward Look (with actions)

• Ongoing cleanse and update of risk registers continues focused work with service leads/divisions with oversight from corporate governance team • Individual risk management training being offered as requested/required • Refresh of risk management training with staff once procurement of new risk management system implemented • Rolling programme of deep dive presentations delivered at Risk management forum • Implementation plan for new risk and incident management system now brought forward to GO LIVE date April 2023 • Ongoing cleanse and update of risk registers continues

Number of High Risks (scored 15 and above)



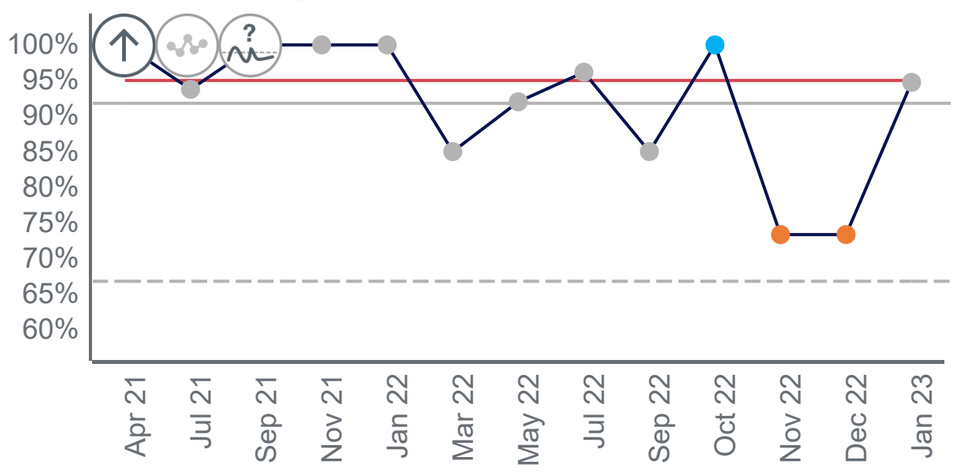
Technical Analysis:

There are a total of 19 high risks in January, this demonstrates common cause variation.

Actions:

As of end Jan 23 there are 19 high risks (risks scored 15+) this figure excludes BAF and network risks

% of High Risks within review date



Technical Analysis:

In Jan 23, 18/19 High Risks were within review date. Although this demonstrates natural variation this is a positive outcome given the previous 2 months demonstrated special cause variation of a declining trend.

Actions:

At the end of Jan 23, 94.7% of all high risks are within review date with 1 risk overdue. This has been escalated via the relevant division. This data will be continuing to be collected monthly with oversight and assurance of mitigation provided at Risk Management Forum

Well Led - Safe Digital Systems - Digital

SRO : Kate Warriner, Chief Digital and Information Officer

Highlights:

• Intranet beta version available, ask of all staff to access/provide feedback • 1st Project Board took place for the new Risk and Incident Management system, working to develop deployment plans for Apr 23 • Working with 4/5 specialties to become early adopters of AlderHey Anywhere once system development is complete • PowerBI training sessions being developed for staff in preparation for the delivery of a new Analytics Insight Portal • Enabling technical works across multiple new locations on the Trust Campus • 3rd cycle of AlderCare patient journeys with users completed • NHSE Funding confirmed for AlderCare and clinical safety hazard workshops completed as part of safety assurance

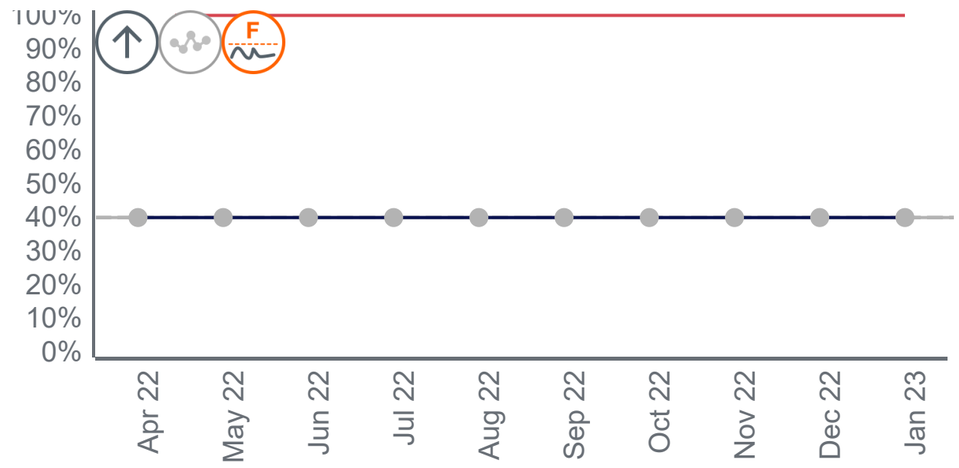
Areas of Concern:

• ISLA Care contract due for renewal in March, lodged as Cost Pressure for a year extension, whist longer term strategy is explored • Completion of AlderCare build to time and quality still contains risks especially for EPMA

Forward Look (with actions)

• Relaunch of automated Pharmacy solutions in February • Official launch of Trust new intranet site • Design and build of electronic consent forms for Medicine • Continue to deliver Analytics training for users of Power BI • Finalise Business Dashboard for CAMHS • AlderCare go live planning including the proposed go live timing

Alder Care - Divisional Critical Criteria



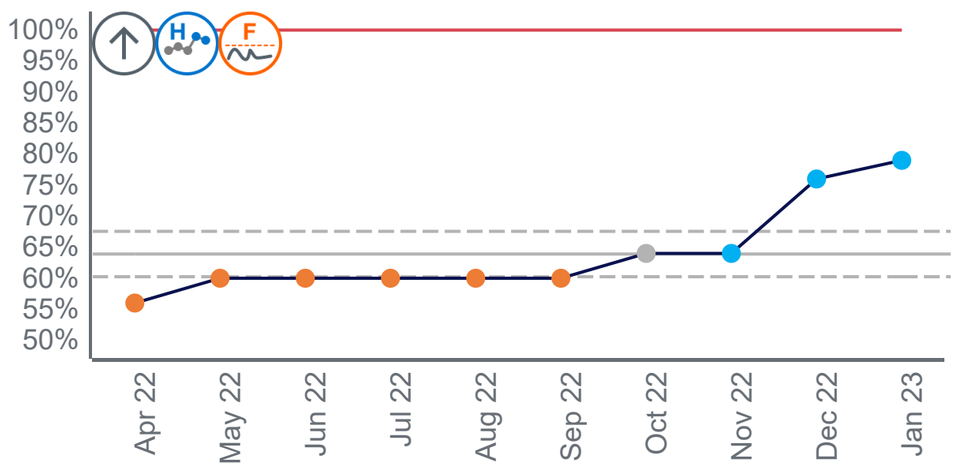
Technical Analysis:

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 reviewed in December but further review ongoing in January / February before final sign off.

Actions:

1. Ongoing development for remaining items. 2. Two critical criteria in progress and expected completion in the next month. 3. Review high risk items for theatres, notifications and specialty documentation 4. Clinical Safety Workshop with Chief Medical Officer, Chief Nurse and Divisional Directors.

Alder Care - % System Build Completion



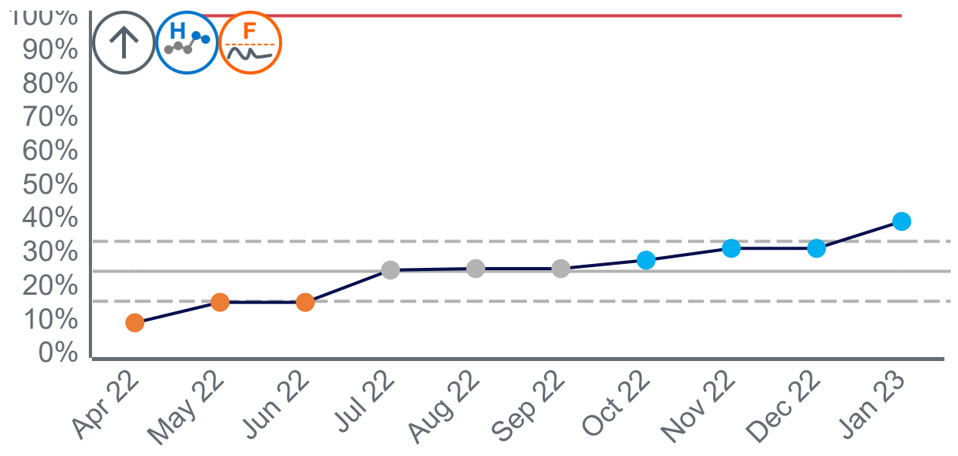
Technical Analysis:

This metric monitors build across all workstreams. Further validation of build continued through cycle 3 of "Patient Journeys" with clinical and operational teams. Output of the patient journeys being collated and will inform further build requirements for go live, and items for post go live optimisation.

Actions:

1. Continue build.
2. Review output of all patient journeys so far. Monitor progress on EPMA build (19%).

Alder Care - % Speciality documentation build



Technical Analysis:

21 of 58 specialty documents have now been completed, with 3 others close to completion. Formal sign off processes continue (11%).

Actions:

Continue build (39%) and sign off process (11%).

Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• Improvement in letters signed within 10 days of clinic • Continued zero patients waiting over 52 weeks in Community Paediatrics and therapy services • Sensory programme continues with positive feedback from families

Areas of Concern

• Increase in children and young people waiting over 52 weeks in Community Mental Health Services • Increase in short term sickness

Forward Look (with actions)

• Increase in capacity available in Community Mental Health Services following recruitment to additional posts, anticipated reduction in waiting times from February/March 2023 • Sickness reviews with line managers and HR to identify additional actions to support reduction in sickness absence rates • PDR rate focussed improvements to ensure achieve 90% by 31 March 2023

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	January 2023	11	15	18.73		
Number of Incidents rated No Harm and Near Miss	January 2023	55	80	73.27		
Use of physical restrictive intervention (MH Tier 4)	January 2023	0		10.56		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	January 2023	4	6	3.05		
Number of PALS contacts	January 2023	57	45	43.59		

Divisional Performance Summary - Community & Mental Health

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	January 2023	47	25	53.67	L	P
% Was Not Brought Rate (All OP: New and FU)	January 2023	11	10	14.35		F
% of Clinical Letters completed within 10 Days	January 2023	71	95	58.90		F
CYP1 - Number of visitors to the site	January 2023	2156		1,405.25		?
CYP1 - Number of Referrals	January 2023	228		94.33	H	?
CYP1 - Number of Referrals Accepted	January 2023	87		37.57	H	?

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	January 2023	0	0	2.05		?
RTT Open Pathway: % Waiting within 18 Weeks	January 2023	51	92	54.91	L	F
% Recovery for OP New & OPPROC Activity Volume	January 2023	163	104	132.93		?
% OPFU Activity Volume	January 2023	139	85	130.67		?
CAMHS: Number of Patients waiting >52weeks	January 2023	34	0	6.36	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	January 2023	59	92	63.58	L	F
CAMHS: Paired Outcome Scores	November 2022	19	40	29.25		?
CAMHS: Crisis / Duty Call Activity	January 2023	890		670.73		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	January 2023	80	95	69.35		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	January 2023	100	95	76.67		?
ASD: % Incomplete Pathways within 52wks	January 2023	65	90	73.01		?
ASD: % Referral to triage within 12 weeks	January 2023	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	January 2023	71	90	80.80		?
ADHD: % Referral to triage within 12 weeks	January 2023	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	January 2023	5	100	9.18		F
IHA: % complete within 20 days of referral to Alder Hey	January 2023	25	100	27.67		F

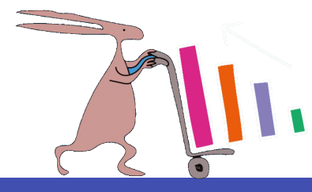
Divisional Performance Summary - Community & Mental Health

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	January 2023	16	10	12.92	H	F
Short Term Sickness	January 2023	3	2	1.75	H	?
Long Term Sickness	January 2023	5	3	4.01		?
Mandatory Training	January 2023	95	90	94.73		P
% PDRs completed since April	January 2023	59	90	51.79	H	F
Medical Appraisal	January 2023	81	100	56.06	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	January 2023	17	0	6.12		?



Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• Recovered Sepsis above 90% in ED and wards in month • Maintained Children's Cancer Performance • Improved F&F in ED – recommending trust • Sustained recovery >104% OP/DC/EL

Areas of Concern

• Diagnostics recovery (Sleep & Gastro) – revised recovery trajectory due to equipment delays and workforce issues to summer 2023; impact of mutual aid to RMCH under review • PDR Compliance: now 61% with >90% dated before 31/3 • 52-week breaches – impact of continued IA and Neurology workforce risks • Letters over 30 days – unsigned • ED compliance met national improvement target (76%) in month

Forward Look (with actions)

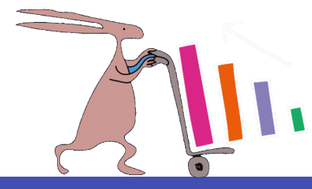
• Agreed trajectories for Diagnostics and ED recovery to achieve 95% in 23/24 • Business planning ambition to achieve RTT within 26 weeks 23/24 • New PDR approach launching April 2023 • New UTC opened end of January – continued focus on UC transformation • Review of letters process with clinicians in difficulty • Mutual Aid/ Exec support for Neurology

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	January 2023	29	15	20.68		
Number of Incidents rated No Harm and Near Miss	January 2023	189	140	150.36		
Sepsis % Patients receiving antibiotic within 60 mins for ED	January 2023	93	90	85.33		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	January 2023	94	90	90.98		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	January 2023	4	6	4.64		
Number of PALS contacts	January 2023	43	45	42.68		
F&F ED - % Recommend the Trust	January 2023	81	95	69.11		F



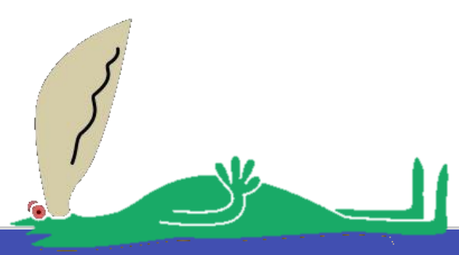
Divisional Performance Summary - Medicine

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	January 2023	76	95	76.17		?
Number of Super Stranded Patients (21 days)	January 2023	26	20	27.09		?
% Virtual Outpatients (national standard 25%)	January 2023	28	25	36.41	L	P
% Was Not Brought Rate (All OP: New and FU)	January 2023	8	10	9.01		?
% of Clinical Letters completed within 10 Days	January 2023	65	95	57.54		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	January 2023	105	104	112.04		?
Number of RTT Patients waiting >52weeks	January 2023	18	0	14.86	H	?
Diagnostics: % Completed Within 6 Weeks of referral	January 2023	72	99	66.22		F
RTT Open Pathway: % Waiting within 18 Weeks	January 2023	59	92	68.12	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	January 2023	100	100	99.42	H	?
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	January 2023	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	January 2023	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	January 2023	100	100	92.86	H	?
Cancer: Faster Diagnosis within 28 days	January 2023	100	75	93.77	H	P
% Recovery for OP New & OPPROC Activity Volume	January 2023	127	104	104.96		?
% OPFU Activity Volume	January 2023	98	85	110.79	L	F



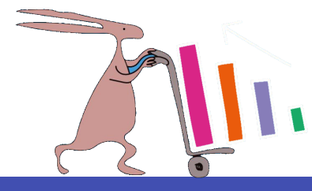
Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	January 2023	14	10	12.92	H	F
Short Term Sickness	January 2023	2	2	2.40		?
Long Term Sickness	January 2023	4	3	4.58		F
Mandatory Training	January 2023	92	90	91.33		?
% PDRs completed since April	January 2023	46	90	43.89		F
Medical Appraisal	January 2023	83	100	59.66	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	January 2023	2	0	-1.64		?



Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• 0 never events for the 4th consecutive month • 100% inpatients received antibiotic for Sepsis 60 mins • Reduction in on the day cxd. Operations for non-clinical reason due to targeted project • WNB rate continues to be below trust target • 101% achieved for elective recovery and 98% OPNEW/PROC (activity volume) • Significant turnaround in Diagnostic performance at 90% • continued 100% PALS & formal complaints response

Areas of Concern

• % of clinical letters completed within 10 days remains below target • No. of patients waiting over 52 weeks increased in line with trajectory, further impacted by workforce constraints in key areas of ENT & Dental • Sickness although decreased in month is above trust target with LTS cases at 4% • PDRs remain below target but current position is 75% with booked dates before end of March

Forward Look (with actions)

• Focus by DD and ACOO on achieving unsigned letters target 0 over 30 days by end of Feb & 0 over 10 days by end of March • Review all super stranded patients for Jan in weekly improvement group • Targeted work remains in ENT & Dental with associated workforce plans • Continue to review PDR performance against given booked dates

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	January 2023	42	40	47.73		
Number of Incidents rated No Harm and Near Miss	January 2023	136	150	157.41		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	January 2023	100	90	85.78		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	January 2023	1	6	4.68		
Number of PALS contacts	January 2023	56	45	40.95		

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)	January 2023	15	20	20.73		
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	January 2023	8	0	7.18		
Number of Super Stranded Patients (21 days)	January 2023	17	30	10.77	H	F
% Virtual Outpatients (national standard 25%)	January 2023	19	25	17.37		F
% Was Not Brought Rate (All OP: New and FU)	January 2023	8	10	8.63		
% of Clinical Letters completed within 10 Days	January 2023	77	95	60.06	H	F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	January 2023	101	104	90.74		
Number of RTT Patients waiting >52weeks	January 2023	390	0	279.59	H	F
Diagnostics: % Completed Within 6 Weeks of referral	January 2023	90	99	42.94	H	F
RTT Open Pathway: % Waiting within 18 Weeks	January 2023	56	92	60.88	L	F
% Recovery for OP New & OPPROC Activity Volume	January 2023	98	104	98.48		
% OPFU Activity Volume	January 2023	95	85	99.97	L	

Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	January 2023	13	10	12.41	H	F
Short Term Sickness	January 2023	3	2	2.40		?
Long Term Sickness	January 2023	4	3	3.79		?
Mandatory Training	January 2023	90	90	91.43		?
% PDRs completed since April	January 2023	53	90	40.50		F
Medical Appraisal	January 2023	92	100	65.45	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	January 2023	-2	0	-3.86		?

Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

• The Corporate Services Collaborative met on 24th January • Continued focus on risk management, workforce metrics and financial position • Mandatory training for Corporate Services was above the 90% target for the months Oct-Dec 2022 • Turnover – leavers continue to be on the downward trajectory (down to 6 from a high of 17 in Oct).

Areas of Concern

• Sickness absence increased month on month since October 2022. December position 6.72% • Managers have been asked to ensure plans were in place for PDR discussions • Focus on the financial position continues to be a priority working with business development to maximise opportunities and all areas to monitor non-pay spend closely.

Forward Look (with actions)

• The Collaborative will undertaken a deep dive on staff wellbeing to triangulate turnover data with occupational health and other emerging themes.

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	January 2023	16	10	14.54	H	F
Sickness Absence (Total)	January 2023	7	5	6.63		?
Short Term Sickness	January 2023	2	2	1.67		?
Long Term Sickness	January 2023	5	3	4.97		F
Mandatory Training	January 2023	94	90	92.53	H	P
% PDRs completed since April	January 2023	75	90	50.23		F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	January 2023	3	0	-10.04		?

Safe Staffing & Patient Quality Indicator Report
October 2022 CHPPD National Benchmark

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at Midnight	CHPPD Rate		RN - 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	Pals	Complaints
Burns Unit	92%	-	100%	-	1892	**119**	15.90	12.04	0.30	1.84%	-0.20	-20.00%	0.00	0.00%	0.00	0.00%	53.44	10.36%	0.00	0.00%	4	22	0	4	5	100%	0	0
HDU	64%	115%	65%	104%	7241	**267**	27.12	27.30	-8.34	-11.02%	-2.72	-50.97%	0.92	1.42%	0.00	0.00%	189.35	9.17%	0.00	0.00%	5	68	0	2	5	100%	1	0
ICU	67%	92%	66%	58%	13891	**401**	34.64	27.30	-14.75	-9.19%	0.83	19.90%	1.77	1.23%	0.00	0.00%	171.98	3.82%	0.00	0.00%	11	131	1	2	1	100%	1	1
Ward 1cC	84%	75%	83%	46%	6699	**495**	13.53	13.53	3.59	6.14%	0.12	2.31%	1.77	2.83%	0.00	0.00%	121.93	6.23%	1.00	0.59%	2	27	0	3	7	100%	1	0
Ward 1cN	79%	0%	95%	-	2765	**218**	12.68	12.68	-8.22	-23.36%	-0.53	-100.00%	1.61	5.90%	0.00	0.00%	85.20	9.95%	0.00	0.00%	5	18	2	6	1	100%	0	2
Ward 3A	83%	93%	86%	80%	7205	**781**	9.23	9.46	2.79	5.78%	-4.00	-25.03%	1.00	2.00%	0.00	0.00%	134.89	8.43%	7.05	1.91%	2	25	0	8	27	96.30%	2	0
Ward 3B	73%	86%	70%	-	3919	**375**	10.45	10.45	-3.71	-10.62%	-1.85	-31.52%	0.92	2.18%	0.00	0.00%	142.63	10.83%	36.52	23.94%	0	19	4	23	11	100%	4	0
Ward 3C	85%	91%	75%	68%	6385	**839**	7.61	7.69	0.19	0.34%	4.15	38.04%	0.00	0.00%	0.00	0.00%	198.30	10.96%	0.92	0.70%	10	53	1	4	16	100%	0	1
Ward 4A	83%	65%	84%	52%	8031	**829**	9.69	9.46	1.80	2.71%	-0.72	-12.67%	1.00	1.46%	0.31	5.97%	218.22	10.18%	13.49	8.24%	6	43	0	3	42	95.24%	1	0
Ward 4B	60%	77%	63%	75%	7087	**637**	11.13	8.59	2.12	4.86%	0.08	0.20%	0.00	0.00%	0.00	0.00%	226.83	16.61%	217.93	22.24%	8	55	4	14	5	100%	3	0
Ward 4C	82%	93%	76%	103%	6520	**847**	7.70	11.56	-5.25	-10.89%	-0.50	-4.38%	1.00	1.84%	0.00	0.00%	150.91	8.73%	21.79	6.44%	16	74	6	16	27	100%	0	0

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

Medicine

There continues to be high levels of sickness on all wards in medicine. A constant focus with ward managers and matrons which has significantly reduced sickness levels in January. Ward 4B have started HR drop-in sessions w/c 13th February and ward 3B started a workstream in September to focus and support staff wellbeing and retention.

Ward 3B nursing vacancy is over by 10% due to covering maternity leave.

Ward 3C is showing significant gaps in HCA, due to being uplifted from a band 2 to a 3. This has been highlighted to finance to remove from budget line as it is incorrectly showing as a vacancy.

Ward 4C medication incidents have increased in October and are the highest reporting ward for the month, 12 of the 16 were reported as no harms, and themes recorded where prescribing, administration, and storage. There has been an increased culture of reporting medication incidents on the ward which is positive and is being actively encouraged.

Surgery

HCA sickness has improved on ward 3A this month, which has also increased the fill rate to over 80% for both day and night shifts. However, there is still a high requirement for 1:1s on both 3A and 4A which has required NHSP cover.

Critical Care

Following a successful recruitment day, several new nurses commenced in critical care in October but will be supernumerary for 4 months (till January 2023) and not included in numbers.

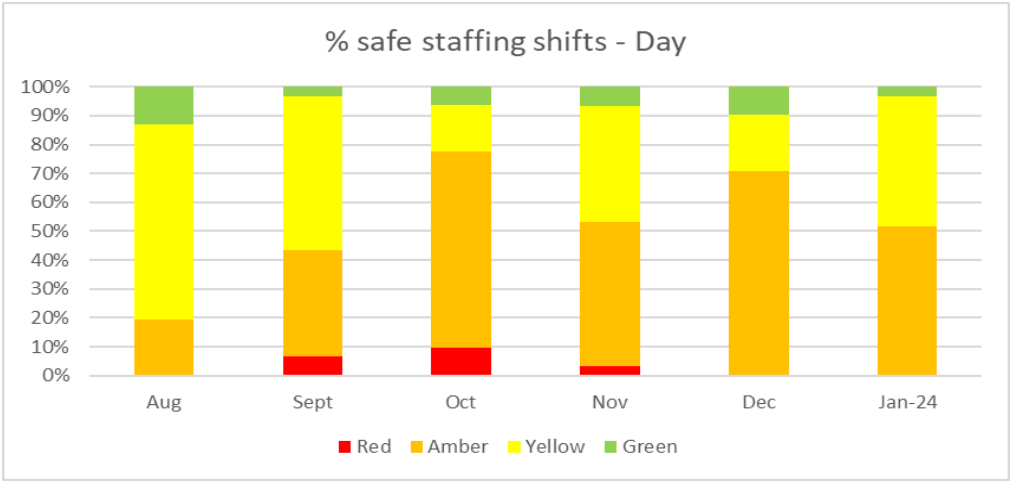
Summary

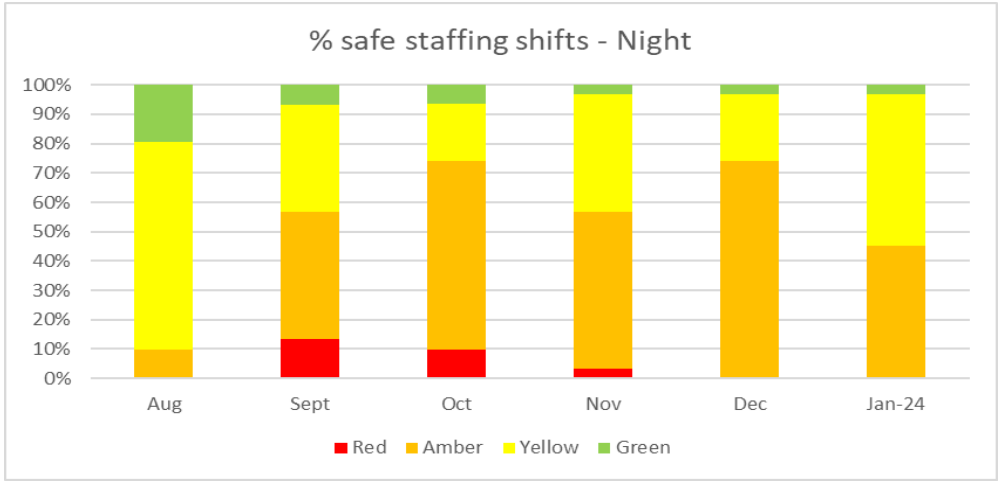
CHPPD compares equally and well with other paediatric hospitals and trusts, apart from ward 4C. To note, 4C were over established however a number of staff had just commenced in role and were supernumerary thus not included in the overall staffing numbers explaining the lower CHPPD rate.

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

Summary of January staffing

There has been a a reduction in orange days and increase in yellow days and night. 0 red days where recordered throughout December and January indicating a improvement in staffing levels.





Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	Digital, Data and Information Technology Update
Report of:	Kate Warriner, Chief Digital and Information Officer
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer; Ian Gilbertson, Deputy Chief Digital and Information Officer

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

The purpose of this report is to provide the Board of Directors with an update on progress against the Digital and Data Futures Strategy. It reports on the overall service, key areas of transformation and operational performance.

Key headlines include:

- Introduction of National 'What Good Looks Like – Digital Maturity Assessment
- NHS Digital merges with NHS England
- AlderC@re Update
- Good progress with Digital and Data Futures
- Good Operational performance

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

2. National and Regional Digital Update

2.1 What Good Looks Like - Digital Maturity Assessment (WGGL DMA)

In August 2021 NHS England published the WGLL Framework, which sets out a clear group of expectations for local systems and organisations with regards to good digital practice across health and care. Since the publication of the framework NHS England have partnered with McKinsey to develop a mechanism that will formally assess Trusts against the success measures within the framework.

The assessment aims to helps Trusts gain a clearer view of their digital capabilities against WGLL through a single repository of information. This will enable the tracking of the development of digital capabilities year-to-year.

The assessment was launched early in February 2023 and all Trusts are expected to complete the online assessment by March 2023. Following the completion of the survey, each Trust will be allocated a 'peer' to help initially validate each others assessments. Following this, the Frontline Digitisation Team with hold workshops to further validate and walk through the results with each organisations. It is hoped by the end of April 2023 the results will be made available and can be viewed across a number of different tiers, including local, regional and national.

2.2 NHS Digital merges with NHS England

NHS Digital has merged with NHS England. This means that NHS England has assumed responsibility for all activities previously undertaken by NHS Digital. This includes running the vital national IT systems which support health and social care, and the collection, analysis, publication and dissemination of data generated by health and social care services to improve outcomes.

The systems and services, functions, processes and structures of NHS Digital and Health Education England will continue to operate as normal, and contracts will automatically transfer to NHS England, with terms and conditions unchanged.

3. Digital and Data Futures Progress

3.1 Digital and Data Futures 2022

The new ‘Digital and Data Futures’ strategy has been formally launched, which details the deliverables planned over the next 3 years.

Digital and Data Futures is based around 4 core themes:

- Digital Children, Young People and Families – New Models of Care
- Outstanding Records and Safe Systems
- Healthier Populations through digital, data and analytics
- Technical roadmap and Operational Service Excellence

Each Programme has its own set of deliverables and established or developing governance. Progress on the Digital and Data Futures strategy will be reported through the Digital Oversight Collaborative and Resource and Business Development Committee.

3.2 Digital Children, Young People and Families – New Models of Care

The ‘New Models of Care’ Programme Board is now meeting on a monthly basis to receive updates from the individual workstreams. It will continue to monitor progress, risk, delivery and benefits realisation.

Stakeholder engagement for the AlderHeyAnywhere platform continues and the team are now working to identify 4 or 5 services to act as early adopters once the platform is ready to be deployed. This platform will provide Children, Young People and their Families with a single point of access to all of the Trusts virtual services and information about their appointments and care. There is further technical development to be completed prior to this point and this is scheduled to complete in April.

ISLA Care is operational in 21 specialities across the trust, which has enabled remote monitoring of wound surveillance and reduced the need for patients to come back into hospital. Feedback from both patients and clinical teams has been really positive.

The new ‘Community Paediatrics Referral Platform’ is now live for professionals to refer to Developmental Paediatrics, ADHD Pathway, and the ASD Pathway. The webpage will act as a digital front door for clinical professionals to complete digital referral forms and questionnaires that are currently completed on paper forms. It also allows parents/carers to track the progress of the referrals more easily. It aims to provide time saving benefits, improved data quality and auditability, improved communication and improved patient experience.

The replacement of the Trusts Intranet is progressing well with the Beta version now available. The project team are now asking staff around the Trust to participate in testing the solution and providing feedback, prior to the final version being signed off and released before the end of February 2023. Work is ongoing concurrently to refresh the Trusts external website which will be deployed following the release of the intranet, ensuring the branding is in line with the Trusts 2030 strategy.

3.3 Outstanding Records and Safe Systems

The Trust launched its paperless consent initiative in November, which has been well received by the clinical teams. The system remains well utilised throughout Alder Hey with over 7000 procedures completed through the new platform.

Following a successful tender process, the Business Case was successfully approved in December to procure a new Risk and Incident Management system for the Trust, replacing their current platform. The governance will now be reviewed and geared up around a ensuring a successful deployment by April 2023.

3.3.1 AlderC@re

The programme has now completed the first Gateway stage. The criteria were reviewed at the Programme Board on the 13th of December 2022 and it was confirmed that the twenty-two points were successfully met, enabling the Programme to progress towards Gateway 2.

Following on from the launch of Patient Journeys October 2022, three cycles of system walkthroughs have been delivered covering sixteen pathways, including a first full walk through of electronic prescribing. A version of the test system will be released to users to allow wider access to review and assess the system build. The simulation hub on the mezzanine is being fitted out to resemble clinical areas. Launch of the test system and simulation hub is planned for February 2023.

Funding from the NHS England Frontline Digitisation programme was confirmed in January and draw down processes are in progress. A revised internal business case for the programme has also been approved.

A proposed go live schedule is being developed, with a deep dive into planning in February, including operational input into activity planning and staff availability. It is expected that a go live date will be confirmed in March 2023.

3.4 Healthier Populations through Digital, Data and Analytics

The service has been working collaboratively with Operational, Performance and Finance colleagues to support the delivery of the annual operational plan. The Analytics team have also delivered a new report for the People Committee in line with the new Integrated Performance Report and a dashboard to help with Winter planning.

In preparation for the launch of a new Analytics Portal, a number of Power BI training sessions have been scheduled, including fortnightly drop-in sessions to support the organisation with their self-service needs. Development of a new web-based Insights Portal begins in February 2023. The Data Engineering Team continue to support the AlderC@re Programme and are working through the transition to the new platform.

Clinical Coding are continuing to stay on top of their uncoded position whilst meeting with 8 specialities on validations. They are also involved in the Coding and Capture Sprint work, investigating possible coding changes to better reflect the activity at Alder Hey.

3.5 Technical roadmap and Operational Service Excellence

Key operational targets continue to be delivered and improved upon. 96% of incidents and requests are resolved within target, reducing average response and fix times and improving customer satisfaction.

This report provides performance to the end of January 2023. Key highlights include:

Ticket resolutions continue to consistently meet our 95% Service Level Agreement target.

Over 80% of tickets fixed within 1 day consistently over the last 5 months.

January has been a busy month with the highest volume of tickets resolved over the last 12 months.

4. Summary and Recommendations

In summary, progress with digital and data developments and delivery at Alder Hey remain positive although as reported there have been challenges with the Aldercare programme throughout 2022.

Alder Hey have actively supported the development of the Cheshire and Merseyside ICS and Liverpool Place Strategies which will be formally launched shortly.

Performance of operational key performance indicators are good and customer service satisfaction feedback is high. The refresh of the digital and data strategy continues to progress well and will be officially launched in August.

Digital staff and service development and engagement has been a key area of development and success, which has been evidenced through the service being successfully awarded with Level 3 Excellence in Informatics.

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	Brilliant Basics - Delivery Plan 2023-2024
Report of:	Nathan Askew, Chief Nursing Officer and AHP/HCP Lead
Paper Prepared by:	Natalie Palin, Associate Director of Transformation Jennie Williams, Head of Quality Hub

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	N/A resource requirements for 2023/24 are within the existing budget provision.

1. Introduction

The purpose of this paper is to outline the Brilliant Basics 2023-24 delivery plan.

2. Background

Brilliant Basics is our vehicle for improvement and supports our journey towards **'outstanding.'** Building on the long history in Alder Hey to continuously improve and enhance outcomes for children and young people.

Over the last 12 months we have made significant progress on the ambitious plan that was set out. Highlights include further embedding Children, Young Peoples, and families voice into our approach, through the expansion of the Youth Engagement Team. We have also exceeded our target of 12 teams formally coached and achieved 16 teams. Working in a BB way has also been adopted through the introduction of Daily Safety Meetings, delivery of the Patient Safety Programme and Performance Review Meetings (Divisionally / Corporately).

The next phase of the delivery plan has been informed through stakeholder engagement, learning in practice and benchmarking against peers. Working in a Brilliant Basics way will also form a key basis for how we work in the delivery of the 2030 Strategy.

3. Conclusion

The delivery plan details the approach for 2023-24; learning from the previous year and stakeholder engagement have informed the plan, and the Executive team remain committed to embed BB (Brilliant Basics) as 'how we work in Alder Hey.'

In accordance with working in a continuous improvement manner, we will continue to incorporate learning into the programme.

4. Recommendations

To note the Brilliant Basics Delivery Plan for 23-24, and for reporting to continue quarterly basis to Trust Board.

Alder Hey Children's NHS Foundation Trust

Brilliant Basics - Delivery Plan 2023-2024

'Small Changes, Big Improvements, Healthier Futures.'

Contents

Appendices

Executive Sponsor (SRO):	Nathan Askew
Operational Lead	Andy McColl
Quality Improvement Lead	Jennie Williams / Natalie Palin
Workstream sponsors:	John Grinnell (*Leading Improvement),* Melissa Swindell (*Learning for Improvement*), Adam Bateman (*Delivering Improvement*)
Authors	Jennie Williams / Natalie Palin

Listen Focus Be informed Empower Challenge Data driven Adapt Vision

1. Introduction

1.1 Purpose of Brilliant Basics

The purpose of this paper is to outline the delivery approach and priorities for Brilliant Basics (BB) in 2023/24; and to provide assurance to the board around the systems of control that support the achievement of the BB vision: 'Small Changes, Big improvements, Healthier futures.'

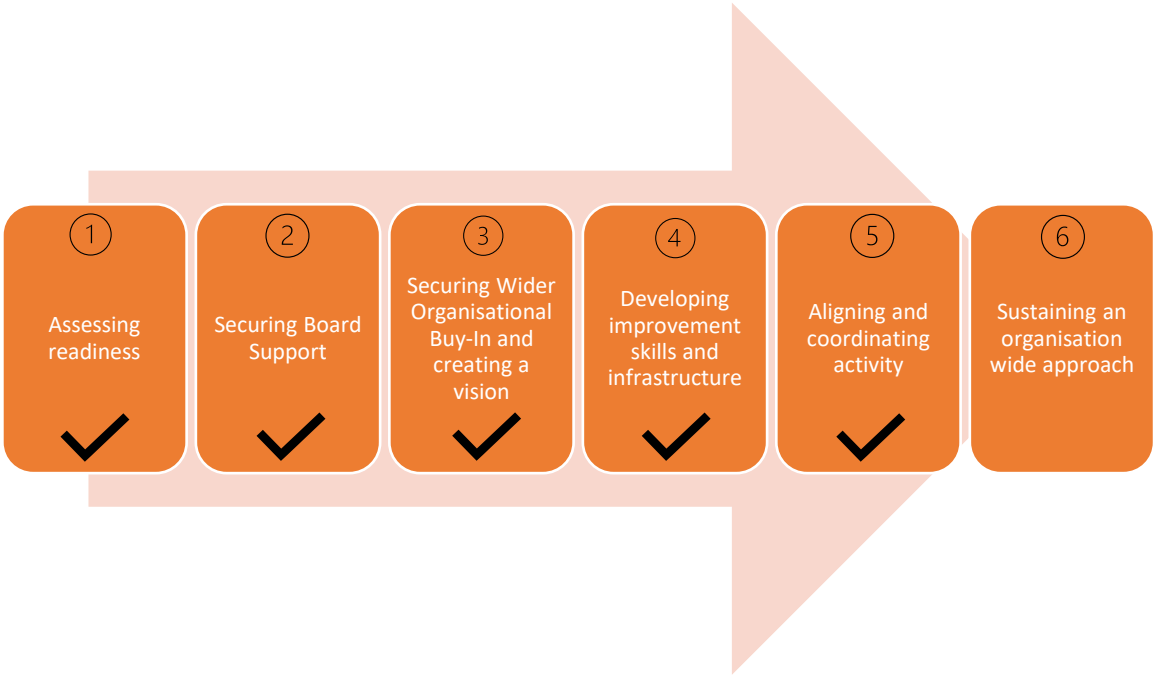
- **What**: BB our approach to improving quality, safety, and effectiveness
- **Why**: BB a standard approach to increase the effectiveness of the organisation
- **How:** Brilliant Basics tools and behaviours for 'how we do things'

Brilliant Basics is not an initiative, it is our vehicle for improvement, it's a way of working '*how we do things at Alder Hey*'.

1.2 Context

There has been a national drive for NHS Trusts to develop a 'lean' culture of continuous improvement; moving away from ad hoc sporadic projects into a more streamlined board to ward approach to quality and performance, centred around trusts strategy and national priorities. As part of the NHS national planning guidance new requirements signal a shift towards a more systematic approach[1].

It is recognised that developing an organisational approach to improvement is a journey that can take several years. Alder Hey's journey to date can be found in appendix one. The key steps in that journey are outlined in the diagram below.[2] We have made good progress, the next phases are to make this even better, to go further to embed BB into the DNA of Alder Hey.



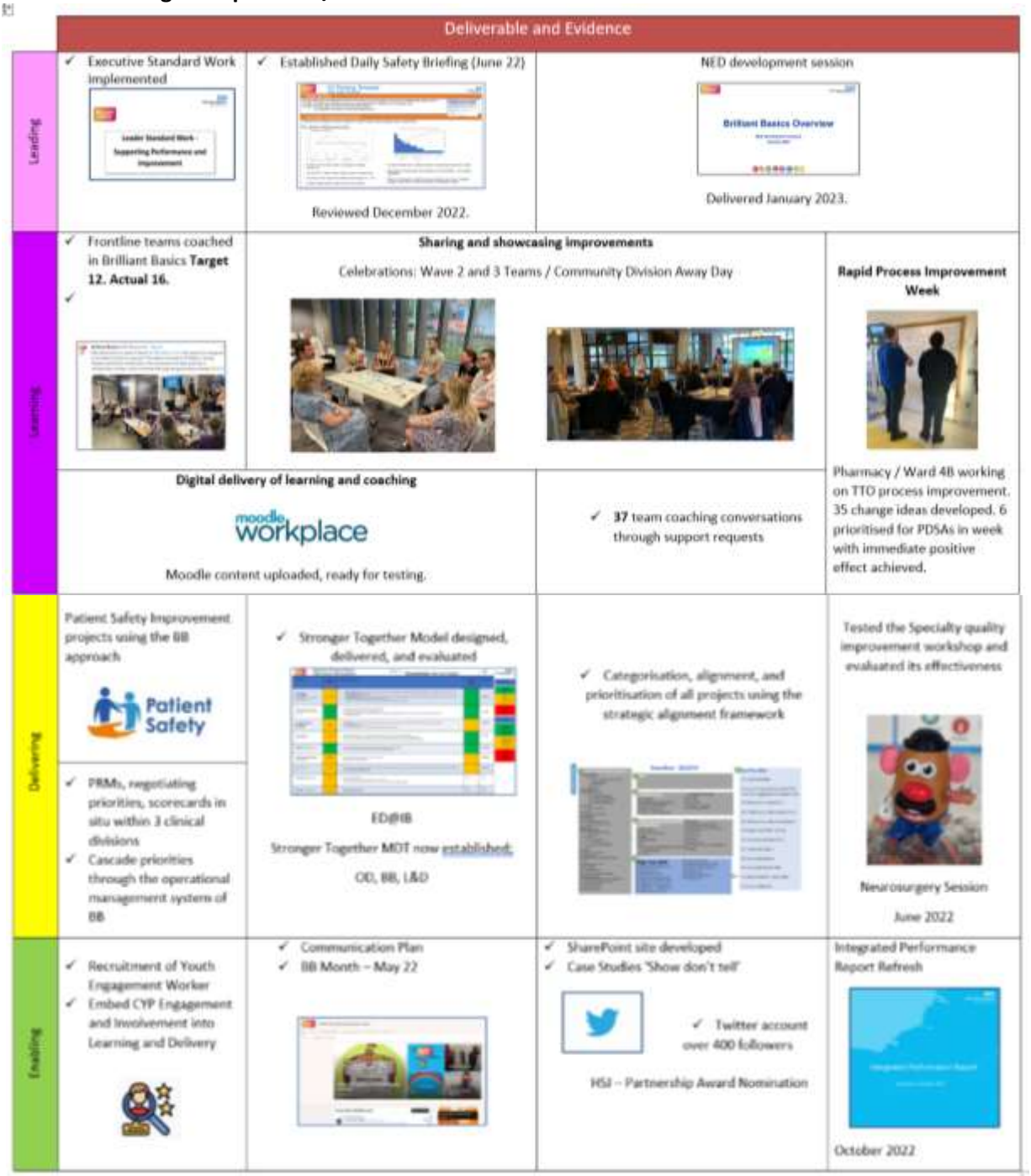
[1] NHS Planning Guidance 2023/2024
[2] The improvement journey - The Health Foundation

2. Current State

The original Brilliant Basics plan was approved by Trust Board in 2020.

- 2021 saw the establishment of the Quality Hub and upskilling in the methodology.
- The 2022/2023 plan was developed with a high level of ambition; to make a bigger and bolder step change in the implementation of Brilliant Basics. Table One below outlines the progress against that plan, and evidence of achievement.

2.1 Table 1: Progress update 22/23 and Achievements



2.2 2022/2023 Plan Assessment

Appendix 2, (2022/23) Plan Assessment, provides an overview of the assessment of the achievement of the current year 'Delivery Objectives'. The assessment of progress was based on review of evidence and was undertaken with workstream leads and the Brilliant Basics Friday Forum members in January 2023 (*There is a full audit trail of decisions made*).

- To date 73% of objectives have been completed
- A further 4 - objectives are scheduled to be completed by March 23, which would take the overall completion to 90%
- One objective did not meet the evidence threshold and will be carried forward into 23/24.

The SRO has been accountable during 2022/23 for all decisions regarding milestone completion and change control.

3. Future State

3.1 Brilliant Basics – 23/24 Delivery Plan

In accordance with continuous improvement, we have developed the 2023/24 priorities and approach, taking into consideration the original approved plan, stakeholder feedback and learning to date.

- ✓ We will continue to build on our unique approach to involvement of Children, Young People and Families.

- ✓ The 2023/2024 plan is focused on maturity, sustainability and ensuring the effectiveness and impact is accurately captured using numerous metrics.

Table two outlines the objectives, key outcomes, and measures for 23/24.
Table 2: Brilliant Basics – 23/24 Delivery Plan

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

A more detailed descriptor of the deliverables is contained in appendix three.

3.2 Measures

Table two lists the measures that are intended to be used to support assessment of the impact and outcomes of implementing Brilliant Basics. It will also measure how mature the continuous improvement system is.

- The driver measure is % of staff who feeling able to make improvements in their work. This is captured annually through the Staff Survey and this measure allows an assessment of the culture change, desired through using Brilliant Basics as 'the way we work' at Alder Hey.
- The watch measures as detailed in table 2, are specifically designed to be a mixed methodology of subjective and objective measures to capture breadth and depth of the approach.

The continued monitoring of the measures remains the responsibility of the BBFF and the SRO is accountable for achievement.

3.3 Communication Plan

A communication plan supporting delivery of BB is in development and will be presented for approval at Strategic Executives meeting in March 2023.

4. Resources

4.1 Resources

Resources for the core team is already in place and there is no requirement for further investment for 2023/2024.

5. Conclusion

5.1 Conclusion

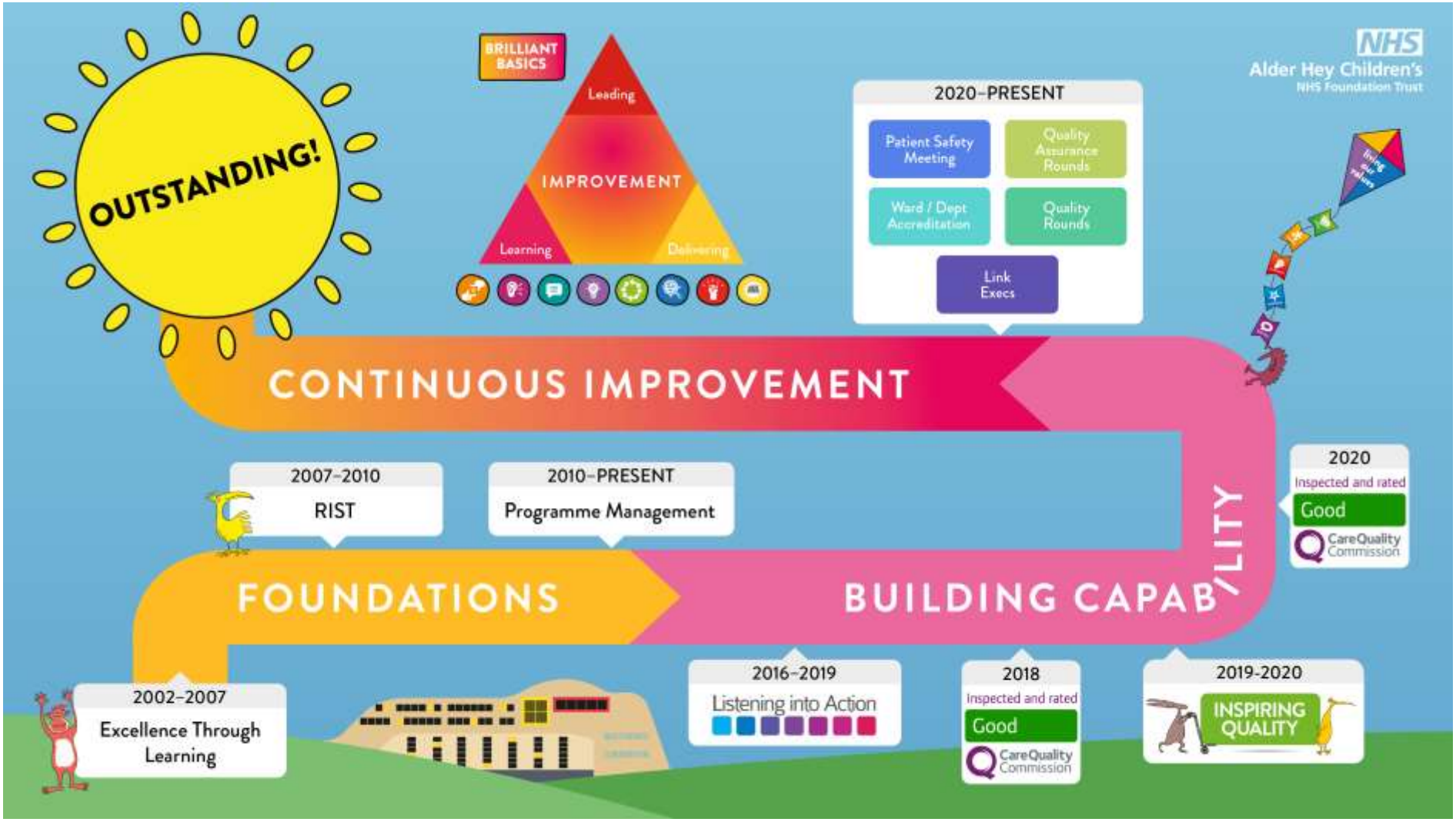
In conclusion, the delivery plan outlines progress to date and the approach for 2023/2024 to build on the maturity and sustainability of Brilliant Basics.

The learning from 2022/2023, along with stakeholder engagement, has informed the plan, and the Executive team remain committed to embed BB as 'how we work in Alder Hey'.

In accordance with working in a continuous improvement manner, we will continue to incorporate learning into the programme and maintain an agile approach to delivery.

Alder Hey Children's NHS Foundation Trust

Appendix One: Alder Hey Improvement Journey



Listen Focus Be informed Empower Challenge Data driven Adapt Vision

Appendix Two: 2022/2023 Plan Assessment.

Workstream	Leading for Improvement	Learning for Improvement	Delivering improvement
Workstream aim	'Brilliant Basics' routines and leadership behaviours are role modelled and cascaded through the organisation structure.	An integrated learning and development programme to build capacity and capability for Brilliant Basics routines and behaviours across the organisation	Deliver the strategic objectives at every level in the trust utilising the Brilliant Basics routines and behaviours.
Key workstream deliverables/ purpose	1. Executive standard work implemented	1. Design, develop and manage use of online Training approach including a self-directed Brilliant Basics handbook*	1. Integrated OD approach into Brilliant Basics improvement approach, to support cultural changes to be sustained
	2. Executive coaching – 1:1 for personal development and Exec BB coaching (leadership behaviours) *	2. Provisions of frontline ongoing coaching and training programme to support the roll out of huddles to all front line and connect with OMS	2. Categorisation, alignment, and Prioritisation of all projects (including safety priorities) using the strategic alignment framework – reported via the Improvement Board / Healthier Futures Board
	3. NED development session delivered	3. Provision of ongoing managers coaching and training programme (note proposed model for community and MH)	4. Cascade priorities through the operational management system of BB (PRMs, negotiating priorities, scorecards – annual refresh) and using standard work.
	4. Development and ongoing governance, oversight and assurance of Brilliant Basics programme	4. Brilliant Basics Improvement Huddles to all coached teams	6. Operational transformation programme (Step change/time limited projects) benefits delivered*
	5. "Go, Look, Listen" / Exec Link role implemented	5. Cascading and sharing and showcasing improvements – inc celebration events	7. Tested the Specialty quality improvement workshop and evaluated its effectiveness
	6. Daily Safety Briefings (Executive led) implemented	6.Deliver and sustain the integrated improvement model where Stronger foundations and BB align*	
	7. Cascade of leadership behaviours and standard work from Execs to other senior leaders*		
	8. Develop an integrated improvement model to incorporate 'high performing teams' with Brilliant Basics/Organisation Development		

Alder Hey Children's NHS Foundation Trust

Appendix Three: 2023/2024 Plan Deliverables.

Exec Lead (SRO): Nathan Askew QI Lead: Natalie Palin Operational Lead: Jennie Williams Organisational Development lead: Jo Potier	**Brilliant Basics** "Small Changes, Big Improvements, Healthier Futures"		
Workstream	**Leading for Improvement**	**Learning for Improvement**	**Delivering improvement**
Exec sponsor	**John Grinnell**	**Melissa Swindell**	**Adam Bateman**
Workstream Lead	Nat Palin	Jennie Williams	Nat Palin / Jennie Williams
SMEs	Jo Potier, Erica Saunders	QH Team	QH Team, DMO Leads, Andy McColl
Workstream aim	'Brilliant Basics' routines and leadership behaviours are role modelled at all levels and cascaded through the organisation.	An integrated learning and development programme to build capacity and capability for Brilliant Basics tools, routines and behaviours across the organisation	Deliver the strategic objectives at every level in the trust utilising the Brilliant Basics routines and behaviours.
Workstream Metrics	Objectives for achieving key deliverables are on target and completed on time	Objectives for achieving key deliverables are on target and completed on time	Objectives for achieving key deliverables are on target and completed on time
Key workstream deliverables	1. Executive standard work review and refresh utilising A3 thinking.	1. Online learning and coaching tested, evaluated and embedded.	1. Brilliant Basics to become 'part of the DNA' of Alder Heys mechanisms and processes to support the cultural change required.
	2. Further Board development plan scoped and implemented.	2. Agile learning and coaching using BB tools, routines and behaviours to support strategy deployment.	2. CYP&F involvement in all strategically important and BB frontline improvement work 2.a. Rights of the Child Approach Implemented in clinical areas
	3. Leadership behaviours maturity assessment of Board colleagues and their direct reports.	3. Leadership behaviours integrated into all learning and coaching opportunities that support the delivery of an integrated improvement model.	3. Alignment of strategic priorities and breakthrough objectives through the operational management system of BB to ensure board to ward cascade and return of reporting.
	4. Develop and coach leadership behaviours and leader standard work with Divisional leaders.	4. Learning and coaching for 20 teams through face to face or online route.	4. Develop the maturity of Divisional routines to manage performance and improvement
		5. Further development of SharePoint site to support cross team and organisational learning.	5. Facilitate Patient Safety Strategy Board to ensure BB tools, routines and behaviours are utilised.
		6. Health inequalities knowledge integral to all methods of delivery of learning.	

ENDS

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Subject/Title:	Springfield Park Update
Report of:	Deputy Chief Executive
Paper Prepared by:	Associate Development Director, Jim O'Brien Director of Marketing and Communications, Mark Flannagan
Background papers:	N/A
Purpose of Paper:	The purpose of this report is to provide an update on Springfield Park
Action/Decision required:	The Board is asked to note the content of the report.
Link to: ➢ **Trust's Strategic Objectives:**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact:	N/A

Springfield Park – Update Report

February 2023

1. Introduction

The purpose of this report is to keep the Trust Board informed of progress, risks, and actions concerning Springfield Park.

2. Overview on Progress

2.1. Phase 1

Phase 1 of the park was handed over to Liverpool City Council (LCC) and opened to the public in July 2021. Under the agreement it will be managed up to April 2023 by Alder Hey. Whilst phase 1 is fully operational the area has experienced some areas of poor grass growth and water pooling. Therefore, the grassed areas were turned over, fertilised and re-seeded in June 2022 and the grass is recovering. Other work is being performed to maintain quality and visual appearance, including another fertilisation to be carried out in April 2023.

2.2. Phases 2 and 3

Landscaping has been completed for sections of Phase 2 and Phase 3. Handover of both phases to Liverpool City Council will take place in November 2023. Under the agreement these will be managed up to November 2025 by Alder Hey. Key updates includes:

- The temporary car park is now down to approximately 40 spaces and due to close in March 2023.
- Play equipment is being delivered to the site over the next month in preparation for installation in the new play area in May.
- Work has started on the new Sports England reserve pitch areas and on several footpaths across the park. Reserve football pitches will be complete by the end of Summer 2023, with usage dependent on grass growth which has a timeline of three to six months.
- The agreed, revised programme of works for our Campus includes the retention of the old Histopathology building as a site office for the Neonatal building works until November 2024. LCC has agreed to grant a licence for an extension period to allow this and we are ensuring in the meantime that this has no functional impact on the park itself.

3. Recent Community Engagement

We held two Community Drop-In Days on 5th and 19th November 2022, at which we were able to engage face to face about our plans for the Alder Hey Health Campus and the return of Springfield Park to Liverpool City Council.

We issued feedback forms and 14 were completed. Among the comments were:

- *Improved communications as to date this has been poor.*
- *Fantastic event-wonderful ideas for the park to come alive again.*
- *Amazing campus and park plans look very promising.*
- *Be open to discuss - great partnership possible with FOSP.*
- *Information needs to be sent to wider community.*

- *Issue with lighting in park - too dark.*
- *Would like to hear more about the park itself including safety and security in the park - worried about standard of park.*
- *Would like to hear more about the new buildings/playgrounds as they open on social media, opportunities to use the park and facilities and access for younger groups.*
- *Always good to talk so need as much info as possible about everything.*

4. Issues of local concern

A subsequent public meeting (held on 14th December 2022, organised by Councillor Harry Doyle at which John Grinnell and Jim O'Brien spoke), as well as other direct and indirect contact from members of the community highlighted a number of items of concern where additional assurances were sought, including;

4.1. Multi Use Games Area (MUGA)

Planning approval was awarded in September 2022 and works commenced in October 2022. Works are complete in terms of structure, with final tarmac to be laid with line marking commencing week of 27th February 2023. A safety inspection is booked in for week commencing 27th February 2023. We are, however, awaiting connection of the lighting to the MUGA by LCC. We have asked if LCC wish to open the MUGA without lighting. We await a response.

4.2. Phase 1 Drainage

Whilst phase 1 of the park has been handed back, areas of drainage remain a concern and are being investigated. Soil samples have been taken and although the soil is of the correct specification, the soil may have become compacted during installation. We have committed to rectifying any issues as part of our handover to LCC.

4.3. Lighting in the Park

It was clear from the community events, the public meeting and subsequent contact the importance to the community of the provision of lighting in the park. We are working with LCC and the Liverpool Planning Authority (LPA) to achieve a solution that discharges planning requirements and meets the needs of LCC in terms of ongoing maintenance. As soon as we have a clearer position, we will update the Trust Board and share this more widely with the community.

4.4. Swales

Swales are drainage features for the park and the North East Plot. They will be banked, planted areas, like other areas in the park, with drainage behind.

The community pointed out, as per the Land Exchange Agreement, that the swales should be on Trust owned land and maintained by the Trust. However, a subsequent amendment in March 2019 was made that allows the swales to be in the park if they meet ecological and functional usage. The revised conditions include that: the swales have a sustainable technical function, they are managed and maintained by the Trust or its agent, they are leased back to the Trust at a peppercorn rent, and Alder Hey passes no third-party liability to Liverpool City Council.

If the management and/or maintenance of the swales is compromised in any way Alder Hey is legally obliged to correct this and provide this function.

4.5. *The Existing Play Area*

The Friends of Springfield Park (FoSP) requested that, in addition to the new play park that is being created, the existing park be left in situ. LCC have stated that due to maintenance issues they are unable to retain the current play area and that Alder Hey must remove the old play area to discharge planning conditions. We have agreed to relocate the disability swing that the FoSP raised funds for into the new play area.

4.6. Sub-station

There is a sub-station in the park that is required to be demolished as part of the planning application. FoSP had requested it be retained as a community facility. Having discussed with LCC/LPA it has been made clear that we must demolish the sub-station to discharge planning requirements. We remain committed to working with the community to seek suitable facilities in the future.

5. Engagement Plan

Having listened to the community we are launching a refreshed engagement plan. This plan will be centred around key issues in the park and campus development. Core channels to communicate information in relation to this and other news will be:

5.1. Website Updates

The Springfield Park section of the Alder Hey website will be maintained with up-to-date information published as we receive it. The relevant page of the website has been updated recently to better reflect the need for a positive, proactive approach. We will continue to use this to highlight latest news including about key features e.g., playground, MUGA. Link here: www.alderhey.nhs.uk/healthier-future/springfield-park.

5.2. Social Media Updates

New information will be communicated as it happens on social media (mainly on Twitter) and we will also seek to respond directly, as appropriate, to questions raised on social media.

5.3. *Community Newsletters*

The next issue will be published on the Springfield Park section of our website, issued via social media, and sent to an email database of local community groups. Further newsletters will continue to be delivered by post to local postcodes. The plan is additionally for Royal Mail to distribute the newsletter during week commencing 20th March, *however, we will be checking with LCC if this newsletter will breach Purdah which commences 23rd March 2023 and, if so, adjust content and/or timing accordingly.*

Subsequent issues are planned for delivery in June, September, and December – we are agreeing dates with Royal Mail now.

5.4. Community Drop-In Days

Following those held in November 2022 we will hold further Drop-In days and will be seeking to link these against key delivery events in the park. The next Drop-In day is 18th March. The proposed timetable for the rest of 2023 is: first Sunday in July, November 2023 and then February 2024.

5.5. Ongoing Engagement

Alder hey are committed to being an active partner in ensuring the park is finished to a high standard and handed back to LCC per the Land Exchange Agreement and that we can continue to support LCC and the local community to ensure the park is well maintained and continues to evolve. We would welcome discussions with FoSP/Local community Groups and LCC to determine how we can best offer any support.

6. Decisions Awaited

6.1. LCC to provide a connection date for lighting to the MUGA and subsequent date for it be open to the public.

6.2. Agreement to be reached on a lighting scheme to meet Planning requirements and any ongoing maintenance requirements.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 23rd January 2023 at 14:00, 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 – Joined from 195 onwards	
	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:	Nathan Askew	Chief Nursing Officer	(NA)
	Ian Gilbertson	Assistant Chief Digital and Information Officer	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Andy McColl	Associate Chief Operational Officer, Performance	
	Clare Shelley	Associate Director Operational Finance	(CS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Mark Flannagan	Director of Communications	(MF)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Graeme Dixon	PFI Manager	
	Alex Pitman	Green Plan, Project Manager	

22/23/180 Apologies:

Mark Carmichael	ACC, Medicine	
Kate Warriner	Chief Digital and Information Officer	(KW)
Cath Kilcoyne	Deputy Director of Business Development	

22/23/181 Minutes from the meeting held on 12th December 2022
The above minutes were approved as a true and accurate record.

22/23/182 Matters Arising and Action log
Cash Management Policy
EK provided a verbal update noting the policy would be presented at the February RABD. JK asked for the policy to include references to how long investments will be made for with consideration to holder investments for longer.

All other actions had been included on the agenda.

22/23/183 Declarations of Interest
There were no declarations of interest.

22/23/184 Finance Report
Month 9 Financial Position
M9: The Trust has achieved an in-month trading surplus of £1.0m in December which is in line with the planned financial position. Year to date (M1-9) the Trust is reporting a surplus of £1.6m 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.

Cheshire & Merseyside Integrated Care System has seen a deterioration in overall financial position over the last month with a number of Trusts unlikely to meet their control total by the end of the financial year. As such, all Trusts have been asked to

confirm ability to improve their forecasted outturn position to manage the overall C & M position. RL will be presenting on this later in the agenda.

JK queried the Interest budget noting a budget had been included M8 and not in M9. RL advised that mapping of interest hadn't been correct in previous month but this has now been corrected in M9.

Resolved:
RABD received and noted the M9 Finance report.

22/23/185 23/24 Annual Plan

RL introduced the item noting the update is following on from the planning guidance update received last month.

AMc went through the operational plan referring to a slide included in the pack to support Divisions with priorities. AMc also noted the work being completed with Alder Hey's 2030 vision and longterm strategy. It was noted the strategy was draft.

CL went through the funding assumptions. AMc presented the internal plans noting a further update would be presented at the February RABD before submitting final plans in March 2023.

Resolved:

RABD noted progress to date on the 23/24 Annual plan a further update would be presented at the February RABD.

Cheshire and Merseyside System
In order to ensure the C&M system hits the control total for 22/23, providers have been asked to review financial positions and include any additional benefit in the forecast. Alder Hey have been asked to improve by £1.5m initially with a potential for a further ask and incentive to be agreed.

JK queried if Alder Hey are meeting the financial budgets on a monthly basis. RL advised that AH stays within budget.

Resolved:
RABD supported the proposal to improve the forecast above the control total.

22/23/186 CIP
Resolved:
Update was received within the finance paper.

22/23/187 Cash
Resolved:
Update was received within the finance paper.

22/23/188 Campus update
JO'B highlighted the following points from the campus update:

Neonatal and Urgent Care: final contracts to be approved on 20th February 2023.
Temporary modular office accommodation:

Temporary Modular Office (Alder Centre): JO'B gave a detailed update on a number of moves taking place over the next few weeks.

Main Park Reinstatement: Current main risks were highlighted.

Capital Management Proposal
Approved.
Resolved:
RABD received the monthly update in relation to the Campus.

RABD approved the Capital Management Policy.

22/23/189 **Aldercare**
IG highlighted from the report:
- Aldercare programme had passed through the first gateway completed in December 2022, the second gateway will be completed in February 2023.
- The patient journey cycles have been continuing with positive feedback.
- Updates had previously been received been received on bring the Aldercare Programme launch date early, a workshop was being held next week to finalise a date.
  JK asked for details on why they had not been able to confirm an earlier date and asked for a further update at the February RABD.
  Action: IG

Resolved:
RABD received the monthly update on Aldercare.

22/23/190 **BAF Deep Dive: Financial Environment**
Current BAF rating is at 16. RL went through key gaps and actions.

Resolved:
RABD received an update for the risks associated with the Financial Environment.

22/23/191 **Interim Innovation Financial Strategy Review**
CL introduced this item noting the Innovation strategy was approved by Trust Board May 2022, at the time RABD asked for annual/bi annual updates on progress. CL gave an overview of the last 6 months, highlighted Key Performance Indicators and one of the purposes is for Innovation to be financially sustainable by 2027.

CL went through a number of lessons learnt in relation to timescales of the beginning and an end of project, progress with grants and that there is currently no funding for a sales/development team. It was noted that lessons learnt will be used in business plans going forward.

Resolved:
RABD received and noted progress to date on the Innovation Strategy.

22/23/192 **Innovation Commercial & Partnership Monitoring report**
CL presented the first version of the quarterly report highlighting the commercial agreement that progressed.

Going forward CL went through the monitoring process for commercial agreements.

Resolved:
RABD received IC&P Monitoring report.

22/23/193 **Month 9 Integrated Performance Report**

AB highlighted:
45% rise in emergency department attendances related to respiratory infections, this led to a deterioration in the timeliness of care to 62% of children being treated within four hours. A number of interventions were initiated which included additional GP support on site, mobilizing the acute respiratory infection hubs, extending the ED floor space, creating a new green stream, occupying some space previously used by radiology, and then lastly, updating the symptom checker on the Alder Hey website.

It was noted that attendance rates to ED have dropped in January 2023.

AB went through challenges faced with cancelled operations noting the process is under review. The two main areas in high demand are sleep studies and gastroscopy. At the end of January sleep studies at home will be launched.

Resolved:
M9 IPR report was received.

22/23/194 **Green Plan Strategy**

AP presented the updated version of the strategy. The main change includes further details on the ICB energy.

A discussion was held on the plans being developed to making it as easy as possible for staff to follow the strategy.

AB noted it would be useful for RABD to be able to follow the progress on reducing carbon emissions and bringing green investments through the capital programme.

AP went through a number of difficulties measuring carbon footprint however new ways were being reviewed.

Resolved:
RABD received and noted progress against the Green Plan Strategy.

22/23/195 **Energy update:**

Energy Procurement Strategy
Current contract will end at the end of March 2023. The proposal today was to receive approval to move forward with a flexible contract. RABD APPROVED this.

Renewable Electricity Procurement Strategy
AP went through the benefit of moving to non-REGO electricity.

Resolved:
RABD Approved proposals to move forward with an energy flexible contract and a non-REGO Electricity.

22/23/196 **Communications Paper**

Resolved:
RABD received and noted the Communications paper.

22/23/197 **PFI – Building report**

Corroded Pipework is on-going looking at improving the quality of water to stop further corrosion of the pipes.

Completed an Audit with Merseyside Fire and Rescue. 7 actions received were completed within a week. MF&R have asked to use Alder Hey as an example going forward.

Resolved:
RABD received the monthly update on PFI.

22/23/179 **Board Assurance Framework**
ES highlighted:
Innovation Committee is due to close at the end of the month, Research and Innovation Committee will start in March.

Risk appetite action is due to be presented at RABD in February.

Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/182 **Any Other Business**
No further business was discussed.

22/23/183 **Review of Meeting**
The Chair noted good discussions.

Date and Time of Next Meeting: Tuesday 21st February 2023, 1330, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st January 2023
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

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

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidents that are considered as serious incidents following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st – 31st January 2023.

2. Background

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

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

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

Outcomes and oversight of SIs are considered at Divisional Assurance Boards, 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.

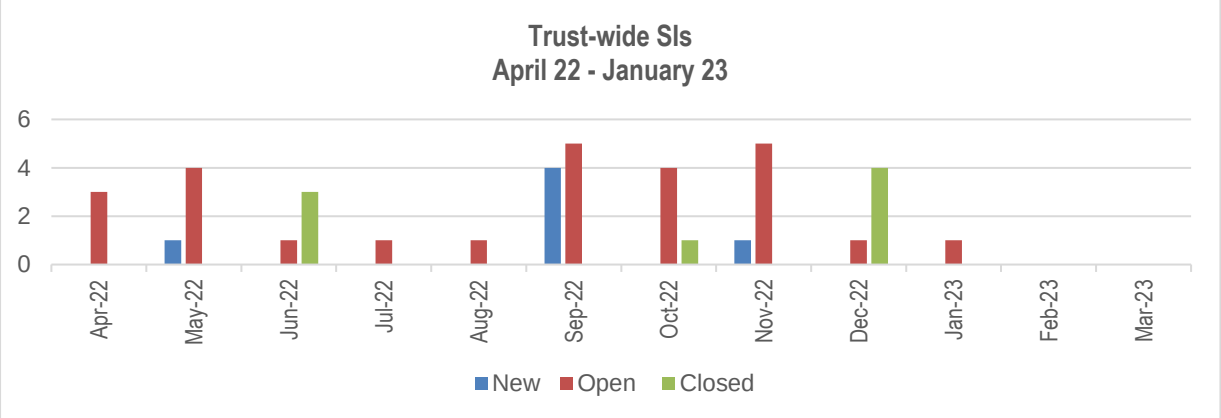
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status January 2023



3.2.1 Declared Serious Incidents

The Trust declared **0** StEIS reportable incidents during the reporting time frame (1st – 31st January 2023).

3.2.2 Open Serious Incidents

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

Table 1 Open SIs January 2023

StEIS reference	Date reported	Division	Incident	Summary
2022/23391	10 Aug 22 (reported to StEIS (2 Nov 2022)	Research	Never Event – wrong side biopsy.	Refer to appendix 1

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 31st January 2023) of the **5** action plans:

- **2** SI action plans are within their expected date of completion
- **3** SI action plans were completed and closed

Full details of the SI action plan position can be found at appendix 2. **Note**: Following the move from CCG to ICS, commissioners will no longer oversee the completion of SI action plans, however this will continue to be monitored internally.

3.3 Internal level 2 RCA Investigations

The Trust declared **zero** internal level 2 RCA investigations during the reporting period (1st – 31st January 2023).

3.4 Duty of Candour

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

3 final Duty of Candour responses were required during the reporting period (1st – 31st January 2023). All responses were completed within the expected deadlines.

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 completed SI action plan were:

- Insufficient evidence of informed consent
- Lack of clinical oversight
- Failure to follow systems & process

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

5. Recommendations

The Trust Board is asked to receive and consider the content of the report.

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2022/ 23391	Never Event – wrong side biopsy.	**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. 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. 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 undertaking review of case.	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. PCO to ensure side and site is recorded on Amborder. If not received in request from 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. Report findings to be shared with all teams involved to ensure learning is disseminated. Cross division incidents need a clear escalation/review pathway. **January 2023:** Final statement received 27/01/2023. Extension granted to 03/02/2023.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Extension date agreed by commissioners	Number of extensions
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	8 All actions completed.	30/06/2022	12/02/2023	30/11/2022	3
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	13 All actions completed.	31/08/2022	31/01/2023	01/11/2022	0
2022/19971	14/09/2022	16/09/2022	Surgery	Never Event – retained foreign object post procedure.	6 2 actions outstanding.	31/01/2023	28/02/2023	N/A	1
2022/20661	17/08/2022	28/09/2022	Surgery	Category 3 pressure ulcer under plaster cast.	2 1 action outstanding.	31/01/2023	28/02/2023	N/A	1
2022/20851	18/09/2022	29/09/2022	Surgery	Patient death after discharge.	8 All actions completed.	31/01/2023			0

Appendix 3

Learning from SIs		
StEIS reference	**Theme**	**Learning and Actions**
2021/17974 Preparing child's case for discussion at national forum. Identified that care provided for eradication is outside of the usual clinical pathway.	Insufficient evidence of informed consent	No evidence in notes to confirm if the conversation relating to consent was fully and comprehensively documented. National consent forms now exist for anti-cancer therapy.
	Lack of clinical oversight	Unclear from patient notes who was leading on the treatment decisions in relation to the patient's treatment. Now routine practice to confirm the following questions via the Clinical Development Evaluation Group (CDEG) submission form: a. What would constitute a successful outcome using the proposed device or treatment? b. What factors would result in treatment being stopped or a device not being used?
	Failure to follow systems & process	At the commencement of the patient's treatment, the British Journal of Haematology (2012) had published guidelines for the diagnosis and treatment of Factor 8 and Factor 9 inhibitors in congenital haemophilia that referenced rituximab as a 'second line' approach. 2012 guidelines were not referenced in the CDEG submission of August 2014. At the time the patient commenced on novel immunomodulatory treatment, there was no National Paediatric Haemophilia MDT. No evidence from either CDEG submission or the patient notes that the Alder Hey Haemophilia Team sought advice or support from other paediatric haemophilia treatment centres throughout the patient's treatment. It is now routine practice and included on the CDEG submission form.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Quarter 3 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 Q3 2022/23, a thematic analysis of the top reasons for complaints and PALS, action taken because of concerns raised, and achievements in Q3 2022/23
Summary and/or supporting information:	37 formal complaints received in Q3 with 1 subsequently withdrawn therefore 36 in total; comparative to Q3 (40). The main complaint theme continues to be in relation to treatment and procedure (inclusive of medication and nutrition) with a total of 21 complaints (58%) 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 13 of 21 complaints in this category (58%) and 36% of the overall 36 complaints received. This is consistent with the previous quarter 92% compliance with the 3 working day acknowledgement standard was achieved in Q3. Compliance with the 25 working day response time was 66% (27% in October, 83% in November and 87% in December) demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern. Three second stage complaints were received in Q3 2022/23 The Parliamentary & Health Service Ombudsman concluded an investigation in December 2022 following a referral received in August 2022; the PHSO did not uphold the complaint. No new referrals to the PHSO this quarter There were 499 informal PALS concerns raised in Q3 2022/23; this is consistent with Q2. The main themes to relate to appointment delays, cancellations, waiting times and queries, and also communication issues including conflicting information There has been a sustained improvement in responding to and resolving informal PALS concerns within 5 working days with an increased average of 90% compliance. This has a direct positive impact on families who raise a concern
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 October to December 2022 (Q3).

2. Formal Complaints

2.1 Number of formal complaints received Q3 2022/23

37 formal complaints were received in Q3 of which 1 was subsequently withdrawn (from Surgery) resulting in a total of 36. This is a slight decrease compared to the previous quarter (Q3 2022/23) where 40 formal complaints were received of which 2 were subsequently withdrawn resulting in a total of 38.

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 Q3; 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 November (20) however this was balanced by a very low number in December (5); the number received aggregated across the two months is consistent with the previous number of complaints received and also mirrors the pattern in the previous quarter.

Figure 1: Number of formal complaints in Q3 2022/23 compared to previous quarter

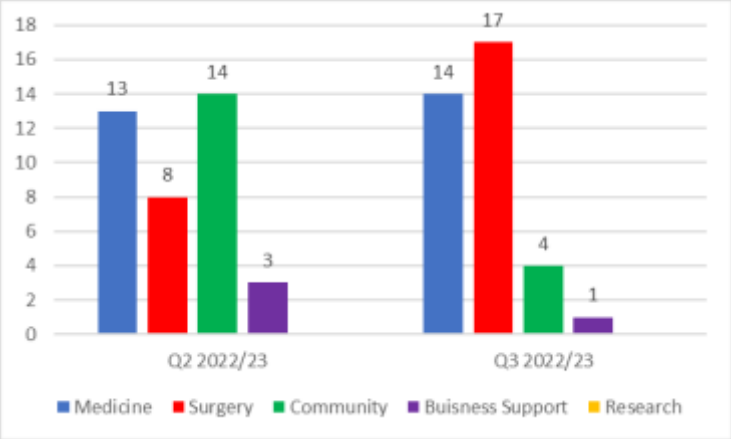


Figure 2: Number of formal complaints by Divisional services Q3 2022/23

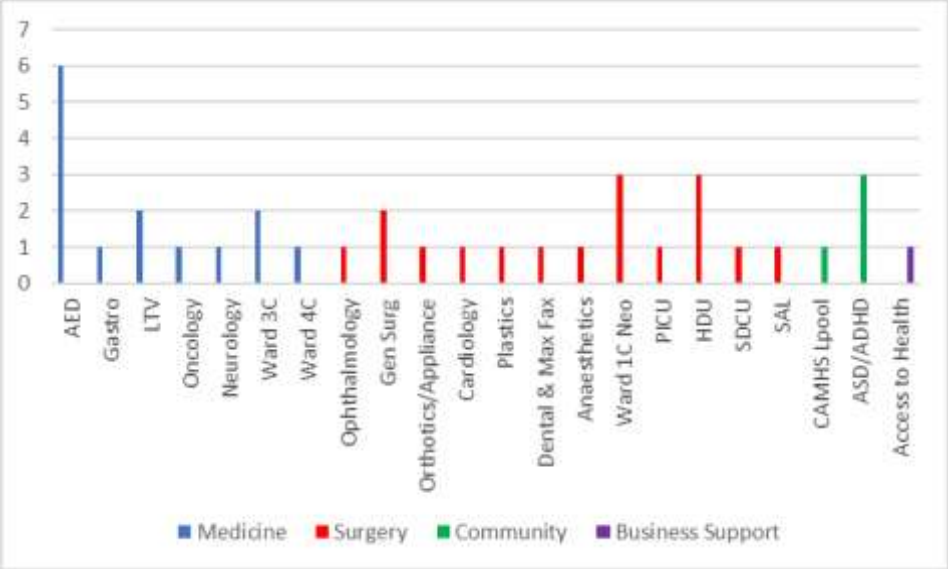


Figure 3: Number of formal complaints rolling from Nov 2021

2.2 Complaints received by category Q3 2022/23

The main theme (primary category) in this quarter continues to be in relation to treatment and procedure (including medication and nutritional issues) with a total of 21 complaints (58%) in Q3 as shown in Figure 4. Figure 5 demonstrates the main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 13 of 21 complaints in this category (62%) and 36% of the overall 36 complaints received.

Figure 4: Primary categories of complaints Q3 2022/23

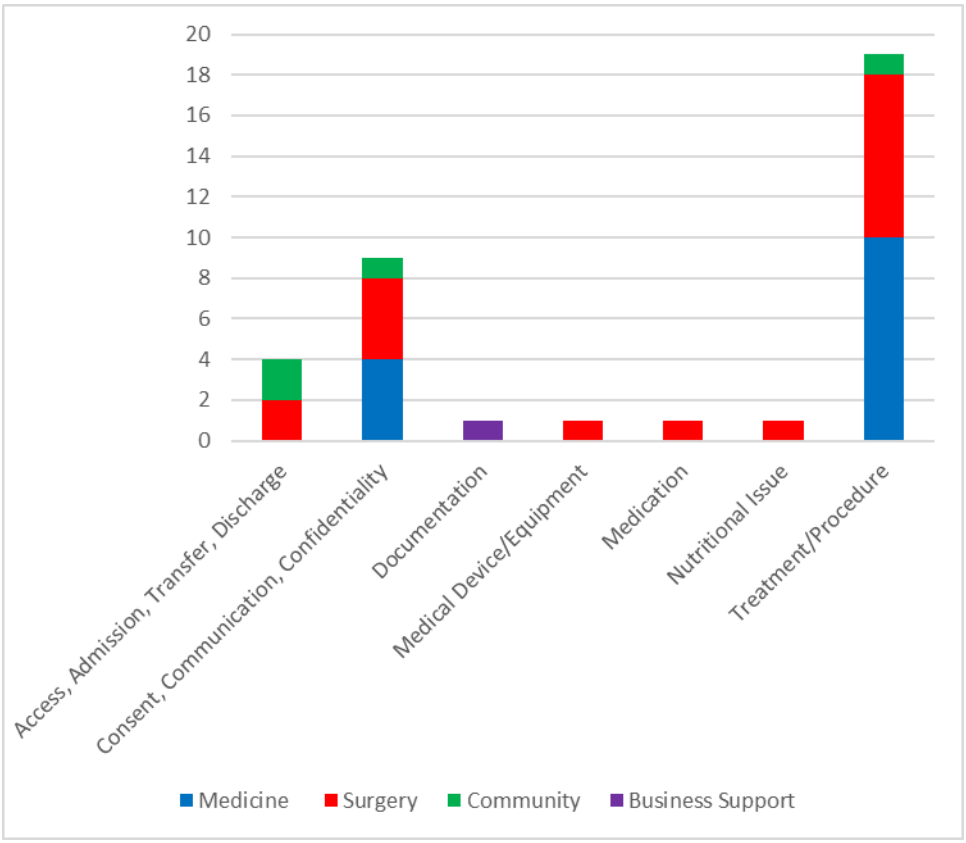
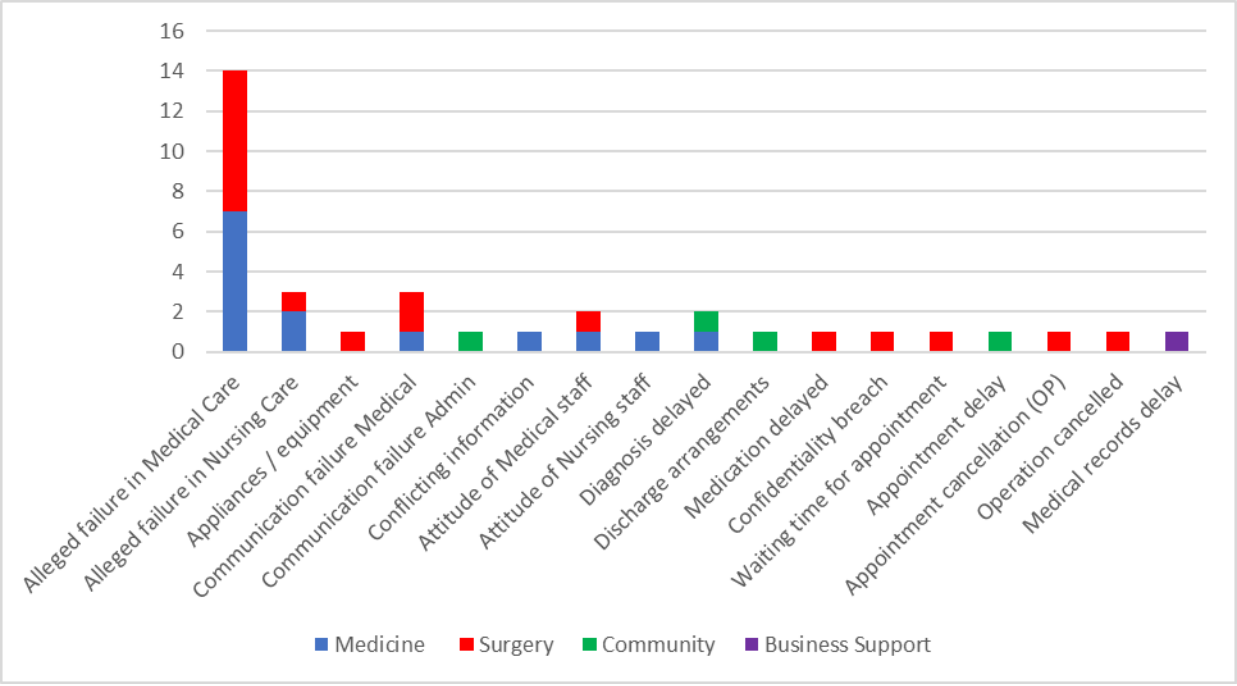


Figure 5: Subcategories of complaints Q3 2022/23



2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 Compliance with 3-day acknowledgement Q3 2022/23

In Q3, 92% (34 of 37) of the formal complaints received were acknowledged within 3 working days, with 32 being acknowledged on the same day demonstrating consistently high standard.

The 3 complaints which were not acknowledged within 3 working days were due to administrative errors and were acknowledged between 4-6 days. Table 1 shows performance with this KPI over a rolling 12 months which demonstrates the continued strive for 100% compliance.

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

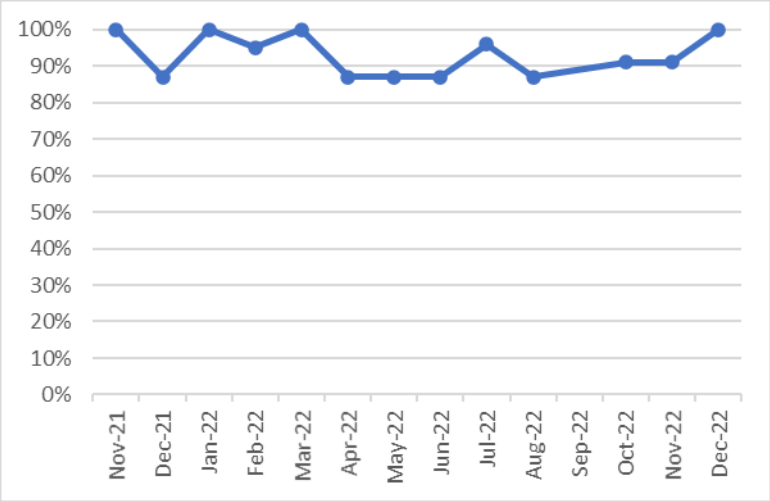


Table 1: Compliance with 3-day acknowledgement for a rolling 12 months for initial complaints (includes withdrawn complaints)

Reporting period		Total complaints received	Total number acknowledged within 3 working days	% number acknowledged within 3 working days
Q4 21/22	Jan	16	15	87%
	Feb	19	19	100%
	March	20	19	95%
Q1 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%
Q3 22/23	Oct	11	10	91%
	Nov	21	19	91%
	Dec	5	5	100%

2.3.2 Complaints responded to and closed in Q3 2022/23

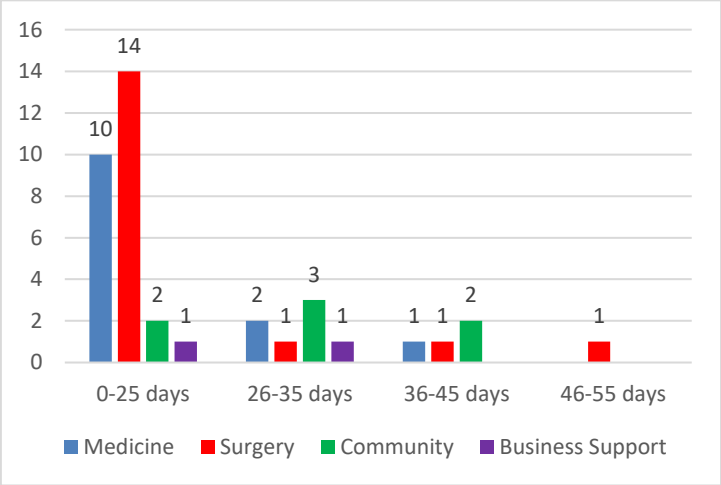
A total of 39 complaints were responded to and closed in Q3 (not inclusive of complaints closed due to withdrawn) of which 28 were received during Q3 and 11 were received in Q2.

2.3.3 Compliance with 25-day response

Of the 39 complaints responded to in Q3, 27 (69%) were responded to within 25-days as demonstrated in Figure 7 which is a sustained improvement with this KPI.

Of the 8 complaints that remain open and under investigation (all received within Q3), 6 were within the 25 day timeframe at 1st January 2023 and 2 were overdue.

Figure 7: Compliance with 25-day response – complaints responded to in Q3



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 12 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 Q3 was 48 working days. Medicine Division achieved 77% compliance (10 of 13); Surgery Division achieving 82% compliance (14 of 17); Community achieving 29% compliance (2 of 7); and Business Support achieving 50% compliance (1 of 2).

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

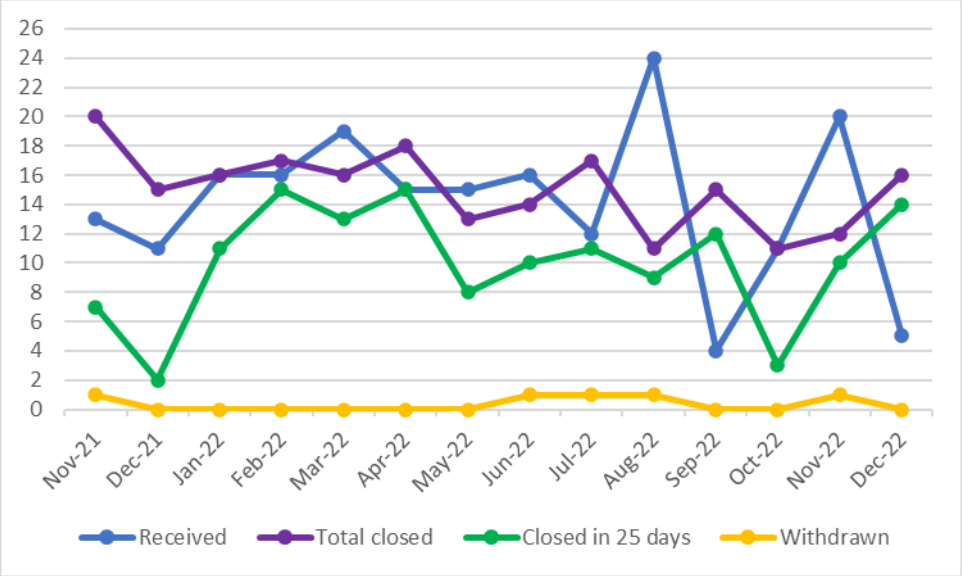
Number of complaints responded to in 2022/23 by Quarter by Division (does not include withdrawn)			Days								
			0-25	26-35	36-45	46-55	56-65	66-75	76-85	86-95	96 -121
Q4 21/22	Medicine	10	9	1							
	Surgery	10	9	1							
	Community	11	11								
	Business Support	1	1								
Q1 22/23	Medicine	18	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							
Q3	**Medicine**	**13**	10	2	1						
22/	**Surgery**	**17**	14	1	1	1					
23	**Community**	**7**	2	3	2						
	Business Support	**2**	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 Q3 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

2.3.4 Number of open and closed formal complaints by month

Table 4 shows that as at 1st January 2023 there have been 124 formal complaints opened in 2022/23 of which 4 were subsequently withdrawn resulting in 120 new complaints in 2022/23. 120 have been closed and there are 8 open first stage investigations. 12 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	11	21	5				**124**
Withdrawn and closed	0	0	1	1	1	0	0	1	0				**4**
New complaints (adjusted from withdrawn)	15	15	16	11	23	4	11	20	5				**120**
Open (first stage)	3	2	19	10	7	11	14	21	8				
Investigated, responded to and closed	18	13	14	17	11	15	11	12	16				**127**
Re-opened (Second stage)	1	1	3	*(1)	2	2	3	0	0				**12**

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

2.3.5 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.

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

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q3 9 (23%) of complaints were not upheld; 11 (28%) were partially upheld, and 19 (49%) 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 Q3 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; year to date 76% of formal complaints are fully or partially upheld (40 partially upheld; 58 upheld).

Figure 10: Outcome of 43 complaints closed in Q3 2022/23

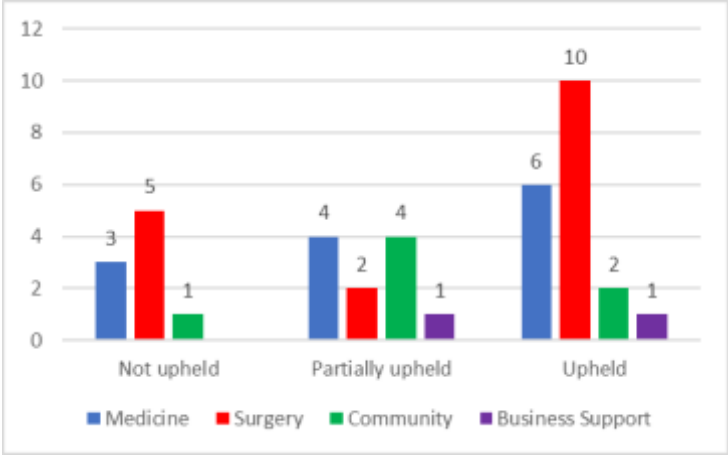
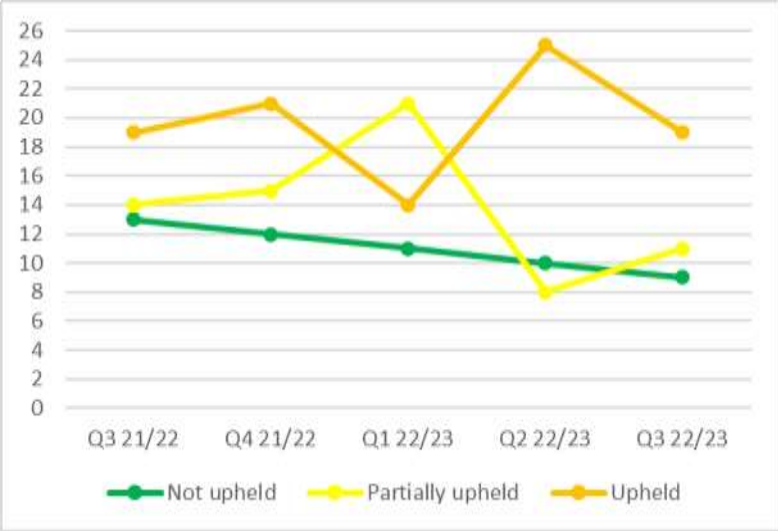


Figure 11: Outcome of complaints closed by rolling quarter



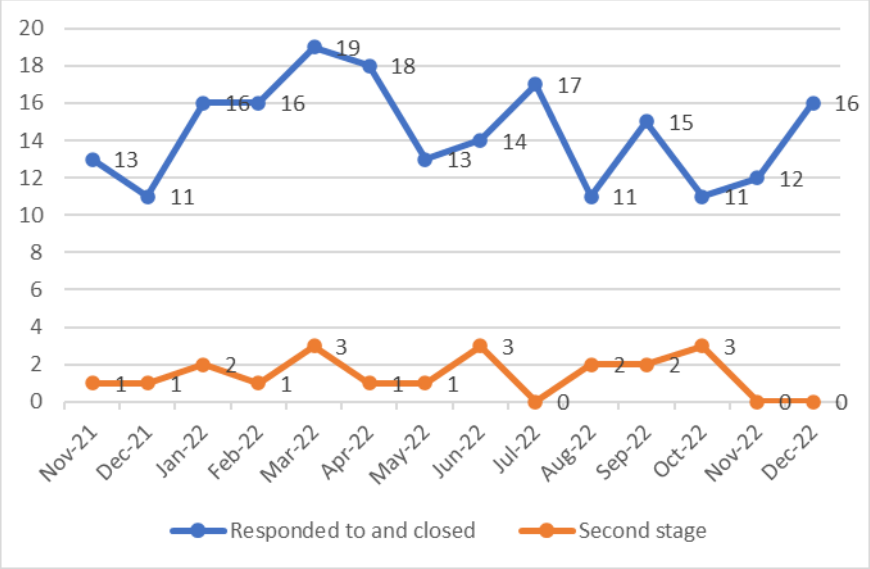
2.4.2 Second stage complaints

In Q3, 3 families informed us that they were not satisfied with the outcome of their initial complaint response; all 3 initial complaints were received in Q2. One each relate to the Divisions of Surgery, Medicine, and Community and Mental Health.

Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response. 100% (3) were acknowledged within 3 working days and all (100%) were closed within 25 working days.

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter however year to date 9% of complaint responses have resulted in a second stage complaint (12 of 127 responses). 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)

The Parliamentary & Health Service Ombudsman concluded an investigation in December 2022 following a referral received in August 2022 relating to a complaint in the Division of Surgery; the PHSO did not uphold the complaint. There have been no new referrals to the PHSO this quarter and 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:	Not all nursing staff are compliant when administering TPN
Lesson learned:	Need for better training in relation to TPN
Action:	Improved training for nursing staff on Ward 3C
Concern:	Parent feels there is a lack of communication between staff and parental concerns not listened to
Lesson learned:	Need for improved communication between nursing staff and parents
Action:	Improved communication between the teams on Ward 3C Improve documentation Shared up to date PPE guidance with the ward team and communicate the importance of PPE compliance
Concern:	Patient's care plan was not up to date on the hospital system
Lesson learned:	The importance of understanding the background history and being aware of any care plans for patients with complex medical needs
Action:	Seizure plan to be reviewed SOP developed and implemented
Concern:	Patient's ASD / sensory needs were not considered during the admission
Lesson learned:	Ward staff to contact the LD team at the earliest opportunity to support a child with ASD on the ward
Action:	Lessons learnt shared at daily staffing huddle and displayed for staff on ward Governance board

Surgical Division:

Concern:	Patient did not receive newborn checks whist an inpatient
Lesson learned:	Importance of communication, documentation and completion of screening
Action:	Staff made aware of importance of completing documentation during the discharge process Improve communication to the team through educational updates: 'focus of the week' and 'My Paeds App' Medics have a daily teaching session to incorporate the completion of NIPE (Newborn and Infant Physical Examination) in a timely manner and process of discharge / transfer
Concern:	Expressed breast milk had two different patient labels on resulting in a patient being given another patient's breast milk
Lesson learned:	**H**ighlights the importance of the two person bedside verification check
Action:	Importance and essential compliance with the Bedside verification check disseminated to all members of the team as focus of the week w/c 21/11/22

	Breast Milk Policy is under review; to ensure clarity of process to minimise the risk of incorrect milk being given
Concern:	A bag containing personal belongings went missing, possibly when patient was transferring from one cubicle to another
Lesson learned:	Extra vigilance required during transfer / discharge process
Action:	Any belongings left in cubicles to be placed in a labelled bag and stored in the ward managers office, while arrangements made with the family.
Concern:	Patient had an MRI scan with a medication patch in situ
Lesson learned:	Ensure all patches are removed from patient prior to MRI
Action:	The MRI Checklist now includes a section for staff to complete to ensure that all patches are removed prior to a scan taking place

Community and Mental Health Division:

Concern:	Failure of CAMHS to process referral for ASD assessment
Lessons learned:	Adequate time needs to be taken to ensure the patient receives all treatments and are referred successfully into other services required,
Action:	Ensure greater transparency and regular to ensure parents/carers know where their child or young person is on a waiting list
Concern:	ADHD and ASD waiting times, discharge from Developmental Paediatrics and wording of discharge letter
Lesson learned:	Ensure correct contact details for the child or young person are noted at the start of every appointment so correspondence is received
Action:	Parent or guardian telephone conversations should always be recorded on the PAS system Further communication maybe required to Patient and Parent Forums to ensure the understanding of the separation of community service (ADHD, ASD and Developmental Paediatrics) is understood
Concern:	ADHD referral, assessment delays and lack of communication
Lessons learned:	It is important to keep parents up to date with where they are up to on the pathway.
Action:	Need to ensure clear communication with parents around the pathway and how processes could be delayed due to completion of screening tools If time frames are given to parents/carers and our service is unable to adhere to this time frame, contact needs to be made with parent/carer to inform them.
Concern:	Delay in receiving medical records as requested
Lessons learned:	Where there is a reason why an Access to Health Request cannot be completed on time or for any reason cannot be fulfilled, this needs to be communicated to the requester as soon as possible
Action:	Processes in Access to Health under review to expedite requests

2.7 Healthwatch

Healthwatch Liverpool and Healthwatch Sefton feedback any issues or concerns raised by children, young people and families to the Patient Experience lead. Numbers are small and concerns are usually anonymous; there is a process to triangulate any concerns with concerns received by the Trust both by theme and if the complainant shares their name the Trust is able to respond either directly to the individual or through Healthwatch.

Healthwatch received one feedback contact for Alder Hey in Q3 regarding arrangements for a covid booster

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q3 2022/23

There were 499 informal concerns received during Q3, significantly higher than the previous quarter (448)

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 Q2 2022/23 and Q3 2022/23

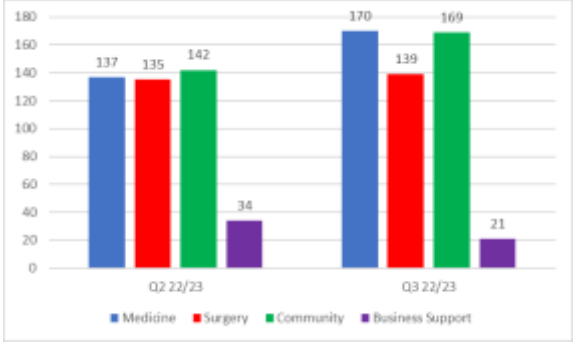
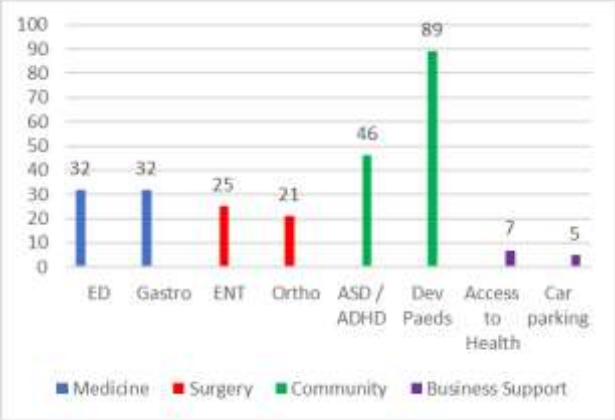


Figure 15: Services by Division with highest number of informal PALS concerns raised



3.2 Informal PALS concerns received by category Q3 2022/23

The main issues raised within Q3 relate to appointment delays and waiting times for appointments, and perceived communication failure as shown in Figures 16 and 17.

Figure 16: Categories of informal PALS concerns Q3 2022/23

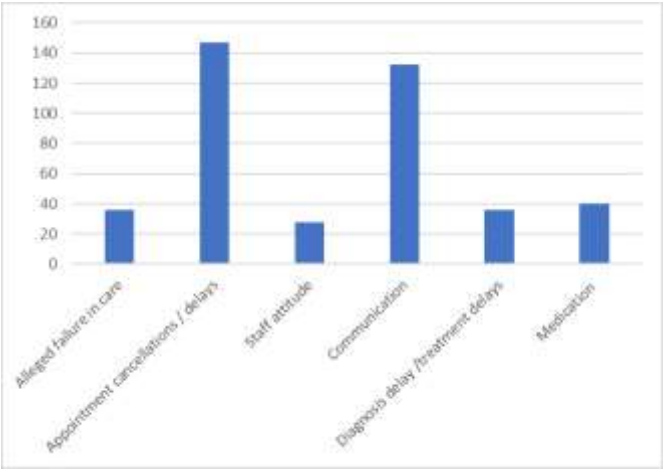
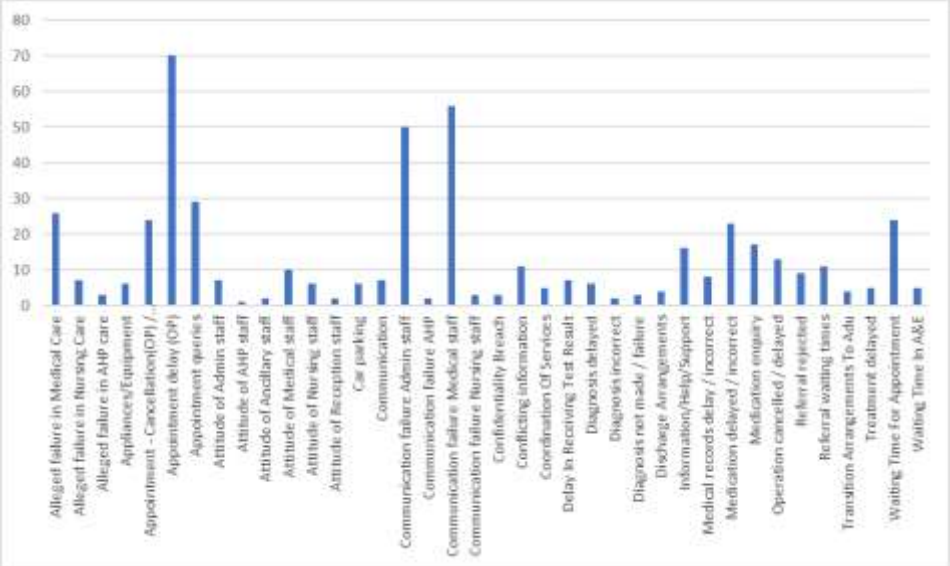


Figure 17: Sub-categories of informal PALS concerns Q3 2022/23



The number per category is consistent with the previous quarter and year to date.

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

There has been sustained progress with this KPI throughout Q3 as demonstrated in Figure 18 which shows compliance between 88% to 92% (mean 90% for Q3). The graph in Figure 19 shows the comparison of number opened, closed and closed within 5 days; please note that a concern may be generated in a different month to that in which it is resolved

Figure 18: Percentage compliance with the 5-day PALS response rolling 12 months

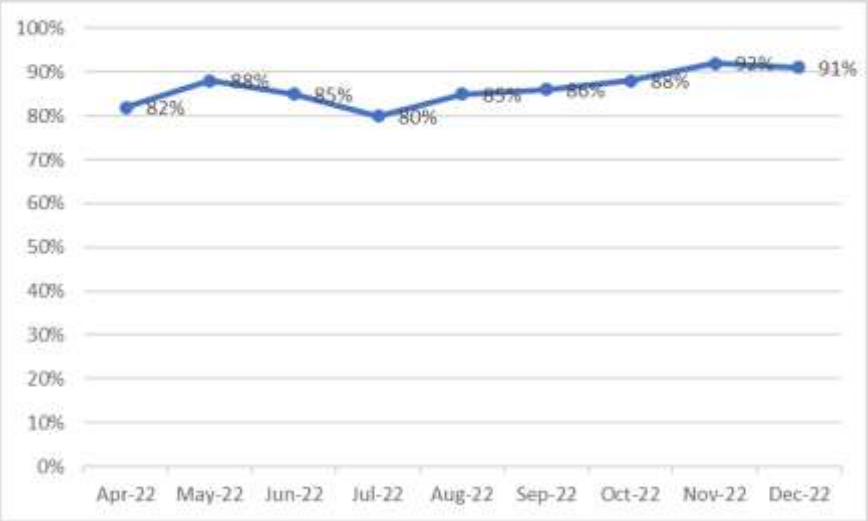


Figure 19: Comparison of PALS number with 5-day response 2022/23

Of particular recognition is the achievement of 99% compliance throughout Q3 by the Surgical Division and 97% compliance by the Medical Division as demonstrated in Figure 20 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 20: Percentage compliance by Division 2022/23

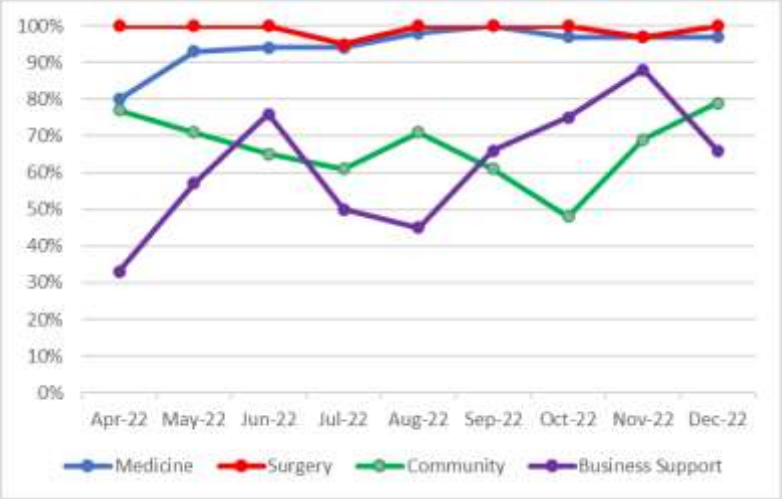


Table 5: Compliance with 5-day response to PALS concerns in Q3			
PALS	**Received Q3 2022/23**	**Closed within 5-day response**	**Ongoing and within 5-day response**
Medicine	170	161 of 166 (97%)	3 of 4 (75%)
Surgery	139	137 of 138 (99%)	1 of 1 (100%)
Community	169	100 of 158 (63%)	0 of 11 (0%)
Business Support	21	15 of 19 (79%)	1 of 2 (50%)
Total	**499**	**413 of 481 (86%)**	**5 of 18 (28%)**

3.4 Actions and learning from PALS

Theme: Incorrect demographic details post adoption
Action: New Standard Operating Procedure devised and implemented

Theme: Incidents relating to appointment errors
Action: Having identified this theme, resulting in a poor patient experience and a wasted appointment slot, the Community and Mental Health Division have set out the '5 Rights of Appointments' where all staff involved in appointments check to ensure:

- The right patient
- The right clinic location
- The right date and time
- The right type of appointment (face to face; Attend Anywhere; telephone)
- The right clinician

A 15 point action plan was developed with 15 actions covering training, creation of 'how to' guides and amendments to Meditech and Medisec systems (action plan attached). Updates on progress are being reported through the Divisional Integrated Governance Committee

3.4 Historic PALS

In May 2022, it was identified that there were a significant number of historic PALS concerns pre-dating 2022 calendar 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 dating back to 2019.

In October 2022, it was identified that historic PALS pre-dating 2019 remained open, and the Director of Nursing raised the issue with the Divisions and Business Support managers directly to review and close.

In January 2023, 992 historic PALS dating back to 2012 were identified in the Ulysses system; it is unclear why these concerns did not pull through into the previous reports in May 2022 and October 2022 (52 of the 992 had pulled through in May 2022). Following closure of all historic concerns, the Ulysses system will be rechecked to assure that there are no legacy issues in the system and that these do not transfer into the new risk management system. The open historic concerns have been stratified in Tables 6 to 8 and actioned as follows:

Table 6: 651 Clinical Business Unit (CBU) historic PALS open from 2012-2016

	2012	2013	2014	2015	2016	Total
Business Support	1	2	1	6	12	**22**
Clinical Support Unit	4	8	5	26	7	**50**
Critical Care / Cardiac Unit	5	-	-	-	-	**5**
Integrated Community Services	6	12	7	46	109	**180**
Medical Specialities	12	7	4	16	65	**104**
Neuro, Head & Neck	5	-	-	-	-	**5**
Neurosciences, Musculoskeletal, Surgery	3	11	9	39	134	**196**
Surgery, Cardiac, Anaesthesia, Critical Care	1	1	6	21	24	**53**
TOPAS	12	-	-	-	-	**12**
CBU not assigned	1	3	1	5	14	**24**
Total						**651**

The main themes were appointment delays and waiting times, perceived communication failure, alleged failure in care, and staff attitudes. All concerns are being closed

Table 7: 294 Divisional historic PALS open 2016 to June 2022

	2016	2017	2018	2019	2020	2021	2022	Total
Medicine	9	106	60	-	-	-	-	175
Surgery	-	-	-	-	-	-	-	0
Community		1	2	2	-	-	-	5
Business Support	3	28	32	20	14	11	7	115
Total								**295**

The Divisions have worked hard to close historic PALS previously identified and the Division of Surgery and the Division of Community and Mental Health have closed all, or almost all,

dating back to 2016; the Division of Medicine have closed all historic concerns since 2019 and are now addressing concerns from 2016-2018. The PALS & Complaints Officers are working with managers in Business Support to review and close all historic concerns and will provide greater support and oversight to Business Support going forward in line with the agreed process.

Table 8: 46 Divisional historic PALS open with no date and / or no Division documented					
	No date	**2016**	**2017**	**2018**	**Total**
Medicine	11				11
Surgery	10				10
Community & MH	3				3
Business Support	1				1
No Division	5	2	8	6	21
Total					**46**

The Divisions will review and close. Staff have been reminded of the importance of accurate data management however it is believed these concerns are more than two years old due to the increased scrutiny of PALS concerns within the last two years. Themes are same as outlined in section 3.4.2

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.

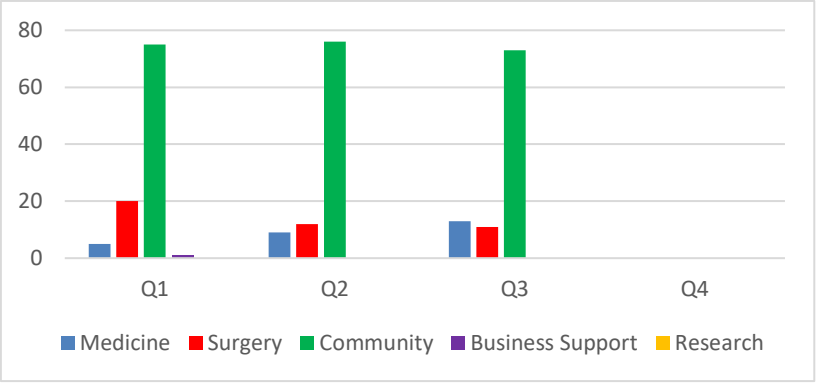
4. Compliments in Q3

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 21 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.

.

Figure 19: Compliments recorded in Ulysses in Q3



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 Q3 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 92% compliance with acknowledging formal complaints within 3 working days, 66% of formal complaints responded to within 25 working days, and 90% of informal PALS concerns resolved within 5 working days. This has a direct positive impact on families who raise a concern.

Appendix 1: Examples of compliments Q3 2022/23

Medical Division

AED: *"I rarely take the time to write anything like this, but this morning at around 00:10 A.M I attended Alder Hey hospital with my son who was having difficulty breathing. The receptionist, triage nurse and student nurse were amazing. Especially one Anna Webster who was the triage nurse who reviewed my son. Anna was beyond exceptional when dealing with my son's case and I feel this feedback needs to make it's way back to her. While the ordeal was very stressful, Anna was reassuring, attentive, caring and positive about the situation. She explained the situation thoroughly and in terms that I could understand while still engaging with (child's name) who was very upset at the situation. Following our initial triage consultation, we were transferred to another waiting room to await treatment. Around an hour went by when Anna came through and noticed we had not yet been seen and she immediately followed up with the treatment required even though I imagine this was not her job to do so. Once medicine had been administered Anna again went above and beyond bringing a leaflet explaining what had happened and provided further reassurance. In a culture where everyone is so quick to criticise the NHS there are people such as Anna who are going above and beyond and this is very often not recognised."*

AED: *"We had a rather frightening medical emergency late last night with my daughter. I would like to say the team/staff/gps were outstanding throughout. we are grateful for everything"*

Medical Day Case: *"I just wanted to express how amazing Kayleigh was on the medical day ward. She was empathetic, patient and so supportive and understanding. She is an absolute asset to the team. She has such a friendly yet professional approach and it's so obvious she absolutely loves her job. Thank you for making such a stressful day that little bit easier. Can't thank Kayleigh enough really. Your kindness made a huge difference to my daughter today when she was so anxious. She really liked you and we both hope you are there when we have to attend in the future"*

Ward 3B: Both parents thanking Dr Hayden for his care, compassion and his excellence in the care and expertise he is providing to their son throughout his treatment.

Surgery Division

Ward 3A: *"I would like to thank all the amazing staff on 3A they were incredible with there care compassion for my daughter. The students our outstanding. Angels on earth"*

Ward 4A: Mother explained that Alder Hey has changed her son's life and has given her son his confidence back. Mother would like to thank Ward 4A and every member of staff that she has come into contact with along the way and during their stay. Mother had a negative experience at another hospital however Alder Hey has been the opposite. Mother made special mention of the volunteers on the doors, concierge staff, radiology staff, ward staff, domestic staff and catering staff. Mother could not thank enough for going above and beyond in helping her son

Surgical Day Case Ward: *"I would just like to highlight the care my son received. My son attended yesterday 24/10/22 for dental day surgery. I would like to praise the outstanding care my son received by all involved with his surgery. My son is non verbal and has Autism and SLD the attention to his needs and triggers and the thought given to make him as comfortable and as happy as possible was heartwarming to a very anxious mum. Particularly would like to thank Colette on day surgery who took time to understand (child's name) needs and was considerate of these her documentation was invaluable for his care moving forward. (Child's name) Anaesthetist was outstanding and thoughtful beyond words from the moment of meeting (child's name) to actually entering theatre . I felt like (child's name) was recognised and seen for all his needs, consideration even when talking at a low voice, moving chairs quietly and reducing lighting all made a huge difference. Finally in recovery Sister (really sorry didn't catch her name) was so helpful and kind ensuring we had a quiet space for (child's name) as soon as one became available and reassuring me post surgery. I cannot thank you all enough, you truly are angels with NHS badges"*

Ophthalmology: Note to Sue Ophthalmology thanking her for her kindness, skill and companionate care, with true appreciation

Community and Mental Health

Community Physiotherapy & Occupational Therapy: "My daughter has bone problems. She has been supported well by the physio team in Sandfield Park. She has 10 consultants and lots of medical input. On 9th sept she underwent an MPFL reconstruction on her right knee despite me being warned it could have a high chance of failure. I can't rate the care she received highly enough from all the physio team. It is the most joined up service of all the services (child's name) has used. The team have gone over and above to meet her physio needs seeing her daily in school and even came out to the house extra early at 8am to support us both in the acute phase. The team must have had earache from my constant calls and stresses but they were consistently patient and supportive. They even got some CPM machine in school for her and are now happily dancing the cha cha slide which is (child's name) new physio routine. Please tell them all I am forever grateful for their input. They are all amazing and deserve recognition."

Eating Disorder Service: *"The EDYS team are amazing and I'm really appreciative of all the help they are giving to my child. She has been treated with the utmost respect and dedication and we have been looked after as a family also. Thank you"*

ICCNT: "*Thank you so much for all your help with my son. You made transition from hospital to home a lot easier for us. We will never forget it."*

Complex Discharge Team: *"The best Occupational Therapist I have ever dealt with. A woman who loves her job and puts the patient as a priority. @Alderhey you can be proud of such an employee."*

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Mortality Report (Q3), 2022/23**
Report of:	**Chief Medical Officer**
Paper Prepared by:	Julie Grice, Consultant in Paediatric Emergency Medicine and HRMG/Mortality Lead.

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

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

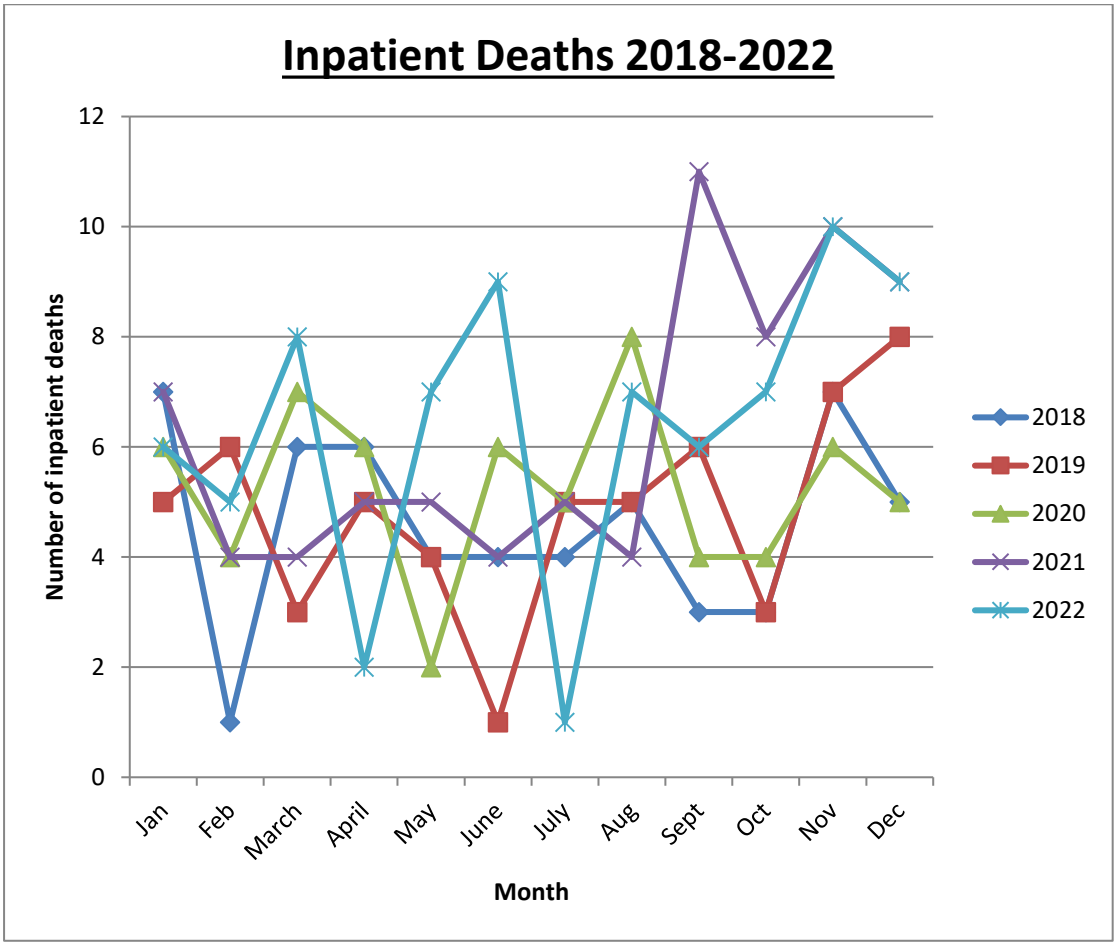
The report is split into two sections. Section one is a review of the Hospital Mortality Review Group (HMRG) including the number and types of death at Alder Hey during the calendar year to date and how the HMRG is meeting its aims.

Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

Inpatients Deaths 2018 -2022

Month	2018	2019	2020	2021	2022
Jan	7	5	6	7	6
Feb	1	6	4	4	5
March	6	3	7	4	8
April	6	5	6	5	2
May	4	4	2	5	7
June	4	1	6	4	9
July	4	5	5	5	1
Aug	5	5	8	4	7
Sept	3	6	4	11	6
Oct	3	3	4	8	7
Nov	7	7	6	10	10
Dec	5	8	5	9	9
Total	55	58	63	76	77



Looking at the 5-year figures, there was an increase in total case numbers in 2021 However, significantly in 2021, there were changes in the way that the data was recorded because of the national child death mortality process. The children /YP that died in ED, were not included in the figures prior to this, as these cases had minimal clinical input due to being in such a precarious state that unfortunately nothing could be done. These cases already had rapid external reviews, discussed in ED M and M's and went down the coronial process so there did not seem much learning that could be achieved by reviewing them in HMRG. However, these are now all reviewed at HMRG.
The mortality figures remain high later in the year due to the number of viruses that have been more virulent post COVID lockdowns. This has caused the record high attendances to the Emergency department and then sadly some deaths. In addition, to the increase in viral infections there has been an increase in Group A infections with some unfortunately causing sepsis and deaths nationally.

The mortality process in the Trust continues to evolve because of issues identified by HMRG members and bereaved families, plus external changes:

1) One of the most significant changes is the introduction of the Medical Examiner (ME) process in the Trust in April 2023. There are several reasons for the ME legislation – 'enabling families to have a voice', improving accuracy of death certificates and ensuring every death is reviewed.

   The main challenge for AHCH introducing the ME process is ensuring that it doesn't slow down the current process and impact negatively on the families. The plan currently is for AHCH to be covered by the medical examiner team at LUHFT. The Trust is supporting this by appointing an AHCH ME to support the LUHFT team. The appointment has just been made and the process is being implemented.

2) Another change over the next 6-12 months is the introduction of the new PSIRF framework and how this will work with the internal mortality process and the coronial system. It will take time to transition to this new system.

3) The way that learning is shared across the organization is currently changing and should be far more effective and in a timelier manner.

Current Performance of HMRG

Summary of 2022 Deaths

Number of deaths (Jan. 2022 – Dec. 2022)	77
Number of deaths reviewed	43
Departmental/Service Group mortality reviews within 2 months (standard)	57/58 (98%)
HMRG Primary Reviews within 4 months (standard)	39/45 (87%)
HMRG Primary Reviews within 6 months	36/47 (97%)

The percentage of cases being reviewed within the 4-month target is consistent due to the group increasing meeting frequency and duration when the need has arisen.

The HMRG consists of members with a considerable variety of expertise so ensuring that the case is reviewed as comprehensively as possible. This includes NWTS (the regional paediatric transfer team), LWH (neonatology

expertise), psychology, Snowdrop (bereavement) team aiming for as robust process as is possible.

Most cases are very complex for a variety of reasons and often require multiple discussions so entailing a considerable amount of time, but this is vital to ensure that the correct conclusions and learning is achieved. The meetings are once a month and held on TEAMS enabling more people to attend including the DGH clinicians involved if they wish.

Outcomes of the HMRG process 2022

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2 month timescale	HMRG Reviews within 4 month timescale	HMRG Reviews within 6 month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
							Internal	External		
Jan	6	6	5	5	6	2				2
Feb	5	4	5	4	4					1
Mar	8	8	8	7	8	2			1	2
April	2	2	2	2	2	1				2
May	7	7	7	6	7	3			1	2
June	9	9	9	8	9					2
July	1	1	1	1						
Aug	7	6	7	6		1				
Sept	6		6							
Oct	7		7							
Nov	10									
Dec	9									

Potentially Avoidable Deaths

There has been 1 potentially avoidable death in this reporting period although the case concerned involved a haematology patient who died over 18 months ago. The case was discussed within 4 months initially but was finally discussed last month with all the relevant reviews. There was a considerable amount of learning from this very difficult haematological case both from AHCH and the District general hospital involved. As a result, there have been considerable changes in practice in AHCH to prevent a reoccurrence. There has been

widespread education on clotting products, changes in the way that the haematology and oncology consultants work and clearer handovers of these very complex patients.

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 43 cases, so far reviewed in 2022, 11 (26%) were identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend / issues in patients with learning disabilities which can occur at any age not just over 4. A deep dive will be completed in the next report reviewing the year's data to ensure that there are no concerning trends.

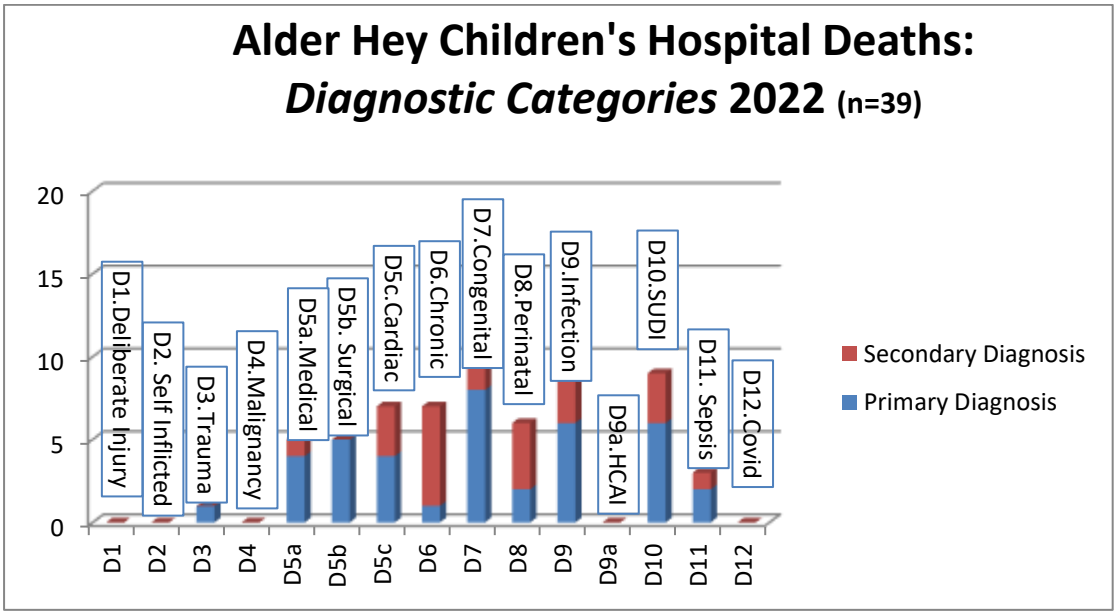
Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide. The Snowdrop team will be involved in the discussion about the introduction of the ME process to minimise the impact on the families.

External Benchmarking

In the last 6 months, AHCH has engaged with Birmingham Children's hospital with the opinion that it was the Trust with the closest workload and demographics to us. It has enabled us to compare figures and trends and to work together to improve our processes and learn from each other.

Primary Diagnostic Categories



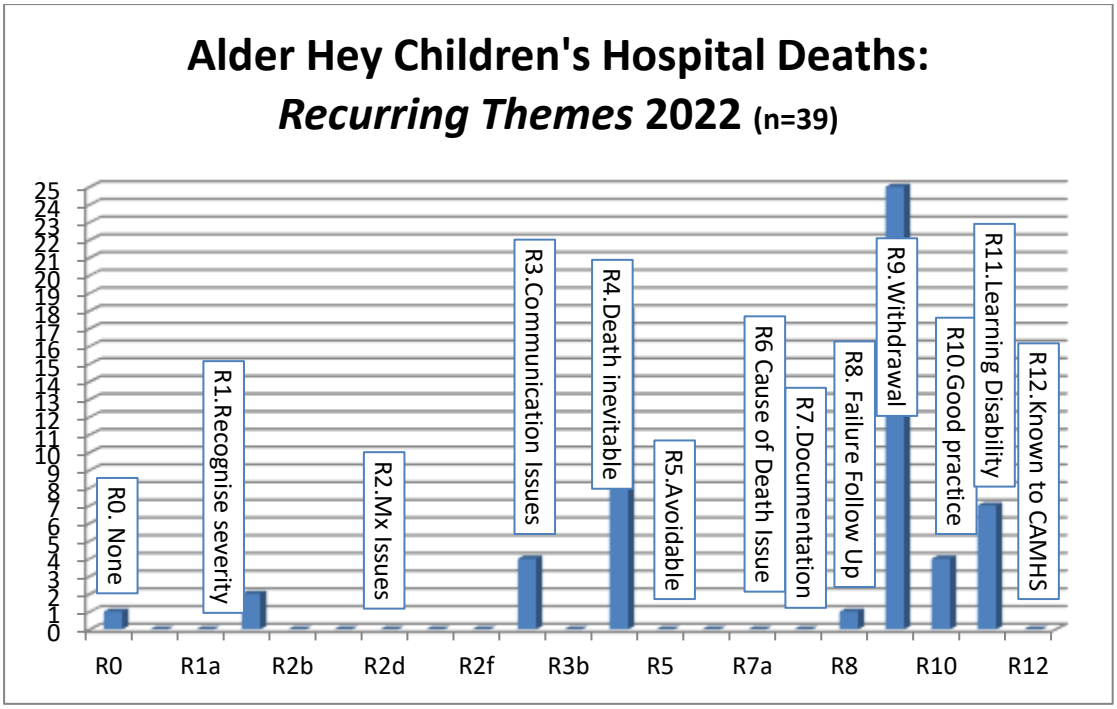
Diagnostic/Disease Categories

D1. Deliberately inflicted injury, abuse or neglect
D2. Suicide or deliberate self-inflicted harm
D3. Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4. Malignancy
D5. Acute Medical or Surgical condition – subcategories:
D5a. Medical D5b. Surgical D5c. Cardiac
D6. Chronic medical condition
D7. Chromosomal, genetic and congenital anomalies
D8. Perinatal / Neonatal event
D9. Infection (proven or clinical) – subcategory:
D9a. Healthcare-associated infection (home or away)
D10. Sudden unexplained, unexpected death / SUDI / SUDC – *excludes SUDE (D5)*
D11. Sepsis (proven or clinical)

The difference in the number of cases reviewed and only 39 coded is because more information was required to finalise coding. The cases reviewed so far in 2022 show that the highest diagnostic code is 'children with underlying congenital conditions' (23 %), these are often the most complex with several issues on going and are the most vulnerable patients. Next, is sudden unexplained, unexpected death', with 15% of the cases being coded with this. This is the initial coding and when the case is reviewed with more information there is a high possibility that a more specific diagnosis will be allocated. Also

with 15 % is infection which corresponds to all the viral and bacterial cases which is separate from sepsis of which there were no cases in this period .

Recurrent Themes



Recurring Themes

R0. No RT

R1. Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review

R2. Possible management issues – subcategories:
- R2a. External
- R2b. Delay in Transfer
- R2c. in Alder Hey
- R2d. Delay in supporting services or accessing supporting service
- R2e. Difference of opinion re: Rx – Patients & families
- R2f. Difference of opinion re: Rx – Clinical teams

R3. Communication issues – subcategories:
- R3a. Patients & families
- R3b. Clinical teams

R4. Death inevitable before admission

R5. Potentially avoidable death – subcategories:
- R5a. Alder Hey
- R5b. Medical
- R5c. External

R6. Cause(s) of death issue – subcategories:
- R6a. Incomplete or inaccurate Death Certificate
- R6b. Should have had a post-mortem
- R6c. Not agreed
- R6d. Failure to discuss with the Coroner

R7. Documentation – subcategories:
- R7a. Recording
- R7b. Filing

R8. Failure of follow-up

R9. Withdrawal / Limitation of care

R10. Example of Good Practice

R11. Learning disability

R12. Known to CAMHS

The main recurrent code for 2022 was withdrawal of care (64 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child / young person suffers unnecessarily when all treatment options are explored but are not suitable.

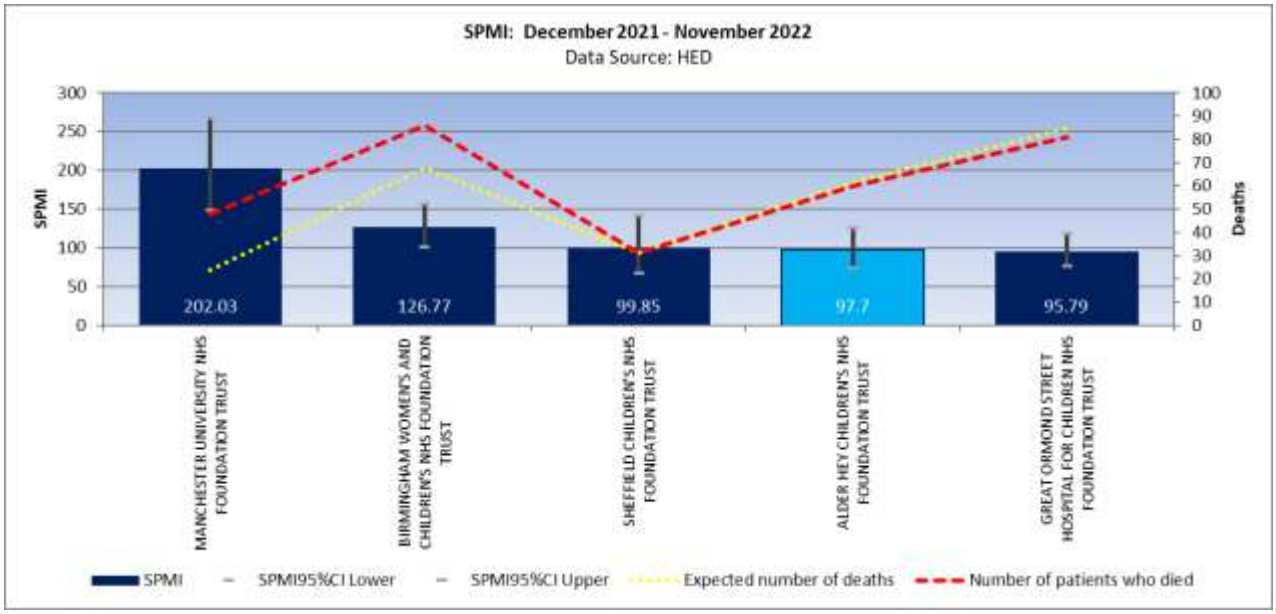
Death was concluded to be inevitable in 46%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.
It is interesting to note that the group recorded 10% of the cases as good practice the members tend to be very reserved at allocating this as they believe the standard of care, we aim to achieve is extremely high. Therefore, to achieve 'good practice 'is when the team concerned has clearly gone way 'beyond the normal'.

Section 2: Quarter 3 Mortality Report: October 2022 – December 2022

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

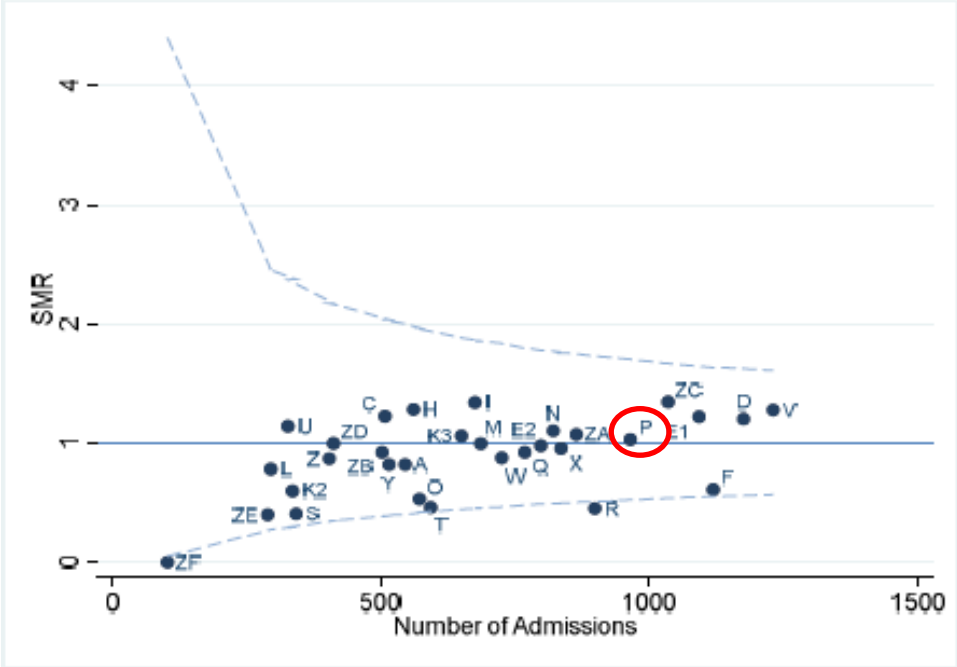
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. This is for the most recent available period covering December 2021 to November 2022.



The chart shows that Alder Hey according to the SPMI figures has no concerns. This would fit with the elective and day case workload increasing again post COVID. During COVID, the workload that AHCH undertook had to be prioritised. This resulted in the higher risk, more urgent admissions and less of the 'cold case /lower risk workload. In comparison to Birmingham (the best Trust to compare AHCH with similar caseload and demographics) we are performing very well.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other Children's Trusts. In the most recent PICANet report (2019 Annual Report of the Paediatric Intensive Care Audit Network January 2016-December 2018), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
The chart below is taken from PICANet's most recent report and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.

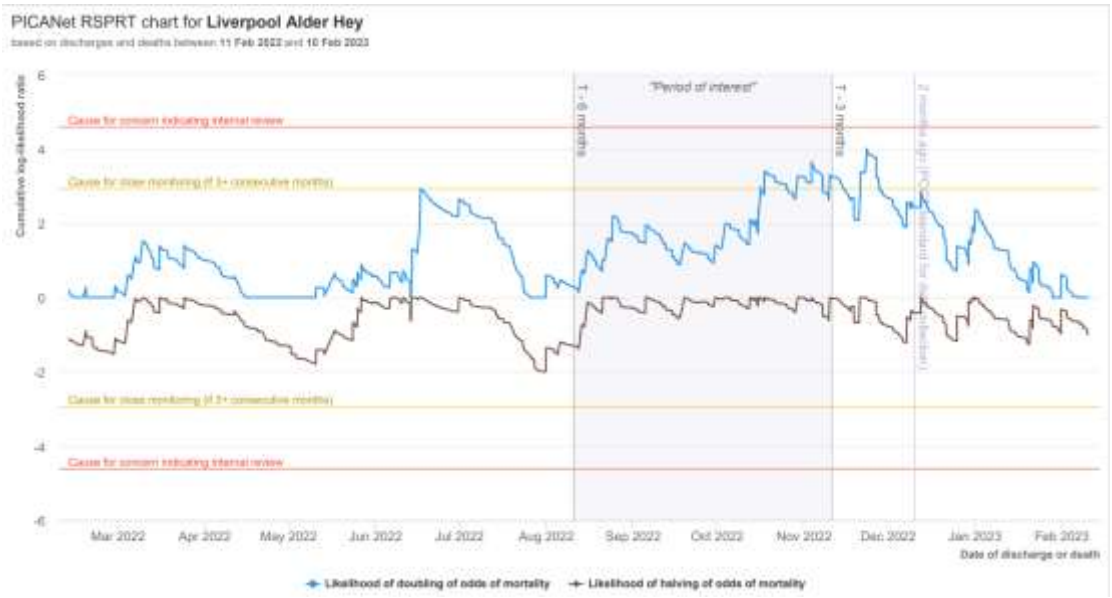


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'. Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.

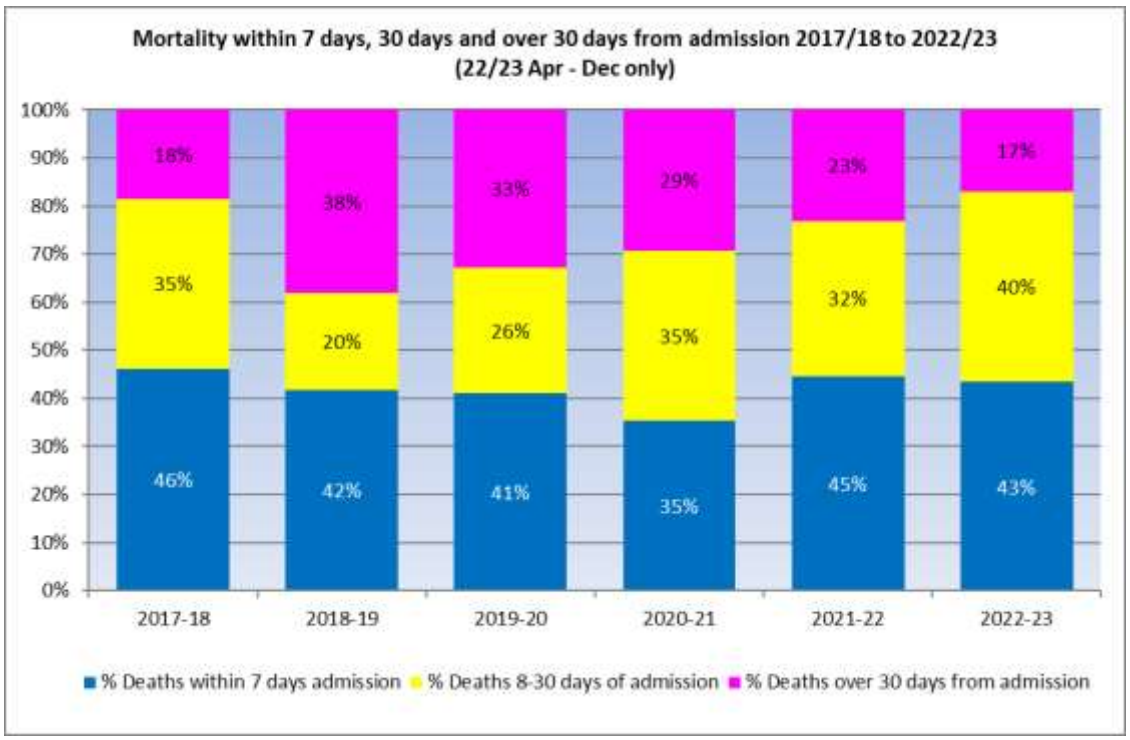


The graph demonstrates that there are no concerning features currently relating to the PICU data.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April 2022 – Dec 2022) 43% occurred within 7 days of admission, 40% occurred within 8-30 days from admission, and 17% deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, and the 4-month target is running at an acceptable level in view of the workload and the complexity of the cases.
There are no concerning trends that have been identified for patient deaths and the issues that have been raised by staff or families there is work underway to try and resolve them. It is very positive that we have appointed to the post of medical examiner and now can work towards an effective process working with our current mortality process.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 9**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Gender Identity Development Service North Programme Update**
Report of:	**Lisa Cooper, Director of Community and Mental Health (Alder Hey), SRO North Programme** **Dr Neelo Aslam, Consultant Psychiatrist (Manchester Children's), Clinical Lead North Programme**
Paper Prepared by:	**Emily Gardner, Programme Director, North Programme**

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

1. Report Purpose

The purpose of this report is to advise Trust Board of the governance and North hub programme arrangements, agreed with NHS England and in place regarding the proposed Gender Identity Development Service. It should be noted that Alder Hey Children's NHS Foundation Trust and Manchester Children's Hospital have not at this stage taken responsibility for the provision of a Gender Identity Development Service for children and young people.

2. Background

The current Gender Identity Development Service is commissioned by NHS England and provided by Tavistock and Portman NHS Foundation Trust. The service is for children and young people who experience difficulties in the development of their gender identity.

In 2020, NHS England commissioned Dr Hilary Cass to review gender identity services for children and young people. The Cass Review was commissioned because of several factors including significant increased demand; long waiting times and a lack of evidence to support clinical decision making. In February 2022, Dr Cass released an interim report Here, which highlighted the following:

- A rapid increase in the number of children requiring support and the complex case-mix means that the current clinical model, with a single national provider, is not sustainable in the longer term.
- There has not been routine and consistent data collection, which means it is not possible to accurately track the outcomes and pathways that children and young people take through the service.
- There is lack of consensus and open discussion about the nature of gender dysphoria and therefore about the appropriate clinical response.
- Due to the specialist service evolving rapidly and organically in response to demand, the clinical approach and overall service design had not been subjected to the normal quality controls that are typically applied when new or innovative treatments are introduced.

In July 2022, Dr Cass in a letter to NHS England Here recommended that the new regional centres for Gender Identity Development should be provided by experienced providers of tertiary paediatric care, with strong links to mental health services to ensure a focus on child health and development. They should have established academic and education functions to ensure that ongoing research and training is embedded within the service delivery model.

NHS England approached Alder Hey Children's NHS Foundation Trust and Great Ormond Street Hospital for Children to develop and lead "early adopter" hubs for the North and South regions respectively.

In addition, to the development of "early adopter" regional hubs, NHS England issued for public consultation, an interim service specification for the service Here . The public consultation of the interim specification has recently concluded and an external organization has been commissioned by NHS England to review the responses which number over 5000. When this analysis is concluded, the findings will be published

nationally along with an updated service specification. The final service specification will be released following the publication of the final report from the Cass Review, which is expected by the end of 2023.

2. North Programme - Gender Identity Development Service

Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital, part of Manchester University NHS Foundation Trust, have agreed to jointly begin work to develop a potential North Hub for the Gender Identity Development Service. Leeds Children's Hospital, part of Leeds Teaching Hospitals NHS Foundation Trust, also form part of the North Hub, as the existing providers of endocrinology services for children and young people under the care of the current Gender Identity Development Service.

The Gender Identity Development Service North programme team are working together, along with other clinicians in both organisations to develop a proposal for a North Hub to operate as a single service. In addition, the North programme team are working collaboratively with the South programme team to ensure a consistent and cohesive approach to the programme and proposed service.

The North programme has developed overarching programme tools including a governance structure, programme plan, and a risk register which have been endorsed at the North Regional Delivery Programme Board. In addition, the North Regional Delivery Programme Board reports to the National Gender Identity Development programme which is led by NHS England.

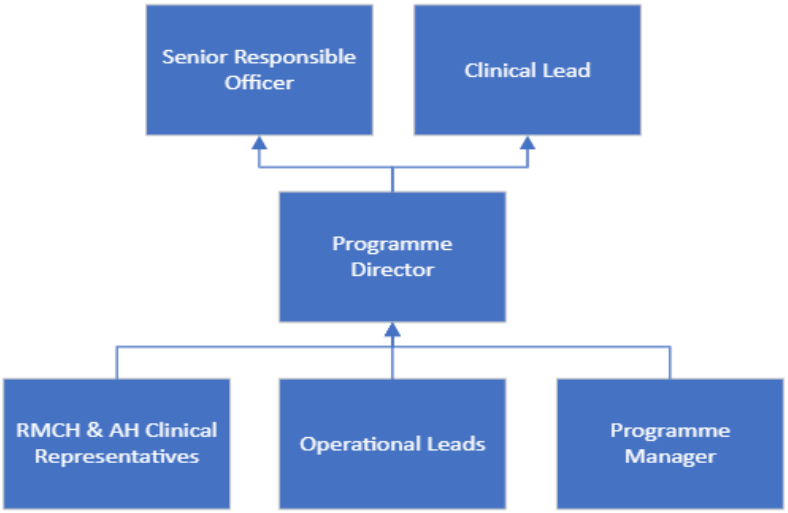
2.1 Programme Team

A programme team has been established which includes joint senior leadership from Alder Hey and Royal Manchester Children's Hospital. The core current programme team is shown in the table below:

Programme Role	Organisation
Senior Responsible Officer	Alder Hey Children's NHS Foundation Trust
Clinical Lead	Royal Manchester Children's Hospital
Programme Director	Hosted by Alder Hey Children's NHS Foundation Trust
Programme Manager	Royal Manchester Children's Hospital
Operational Leads	Alder Hey Children's NHS Foundation Trust & Royal Manchester Children's Hospital
Clinical leads	Alder Hey Children's NHS Foundation Trust & Royal Manchester Children's Hospital & Leeds Children's Hospital (Endocrinology)
Communications Lead	Alder Hey Children's NHS Foundation Trust agreed to lead across North on behalf of both Trusts

NHS England has provided non-recurrent funding (£450k) to support the programme team on an interim basis. This resource is split between both Trust's to support with backfill support for the programme team. The Programme Director is the only full-time post within the programme team. The programme team structure is shown below **(Figure 1)**:

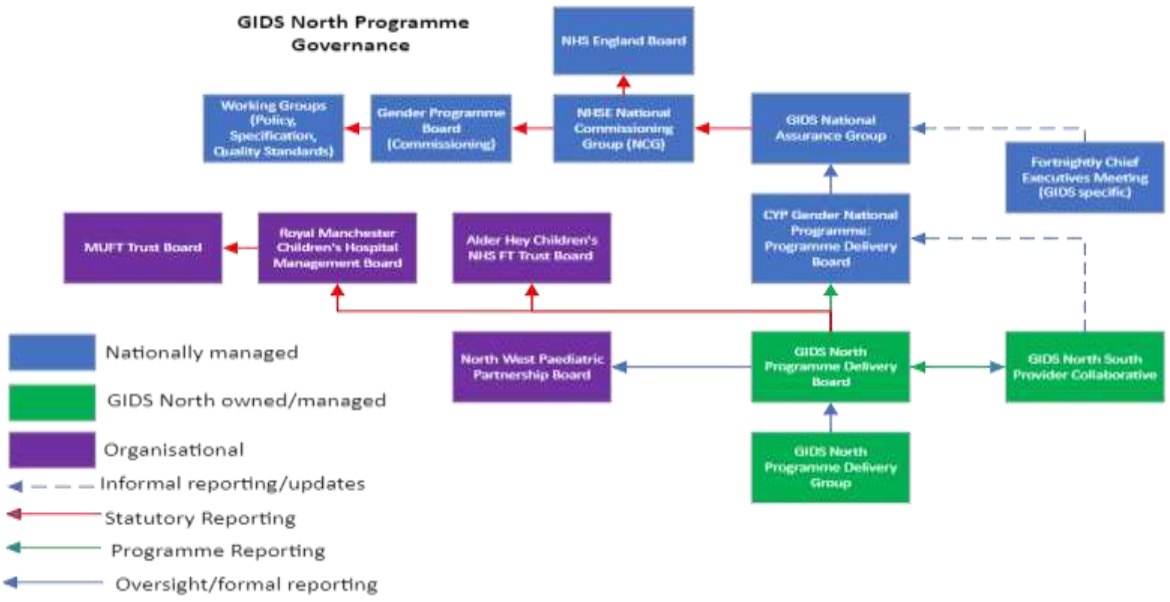
Figure 1: North Programme Team Structure (February 2023)



2.2 Programme Governance including risk management

The programme governance structure is shown in the diagram below **(Figure 2)** and shows a clear reporting line into NHS England's national programme and subsequent statutory governance within NHS England. The North Programme governance will be regularly reviewed and may require enhancing as the service develops.

Figure 2: North Programme Governance Structure (February 2023)



The North Programme Delivery Board is co-chaired by the Chief Executive Officers of Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital and meets monthly.

Key outputs developed by the North programme team will be tabled by the board, with the working expectation that outputs are socialised across relevant departments/colleagues in both organisations and where appropriate with the South Hub. Where a formal decision is required, that has the potential to affect either or both Trusts then the decision-making ability will remain with the individual Trust Boards. A copy of the current terms of reference for the North Programme Delivery Board are provided in **Appendix 1**.

A detailed programme risk register is in place which is reviewed regularly by the North programme team and at the North Programme Delivery Board. The risks within the programme relate solely to the management of the programme and outputs associated with the programme.

Whilst there is a risk register in place within the North programme, both Alder Hey Children's NHS Foundation Trust and Manchester Children's Hospital have included a risk related to reputation within in each organisation's corporate risk register. This risk relates solely to reputational risk to both Trusts in relation to the potential adoption of a service that supports children and young people with gender incongruence or gender dysphoria. There is public awareness that both Alder Hey Children's NHS Foundation Trust and Manchester Children's Hospital have agreed to potentially establish a service. The current mitigated score for this risk is 16 (4 x 4).

2.3 Current progress

The North programme was established in December 2022 and has focused on the following priority areas: development of a clinical model and pathway; workforce planning; governance arrangements with NHS England; liaison with NHS England regarding current waiting lists; input into national meetings including national programme board, service specification review, meetings with Dr Cass and team.

Whilst work is progressing regarding a single clinical model and pathway, this remains dependent on current evidence/research, the publication of the final national service specification and the Cass review publishing their final report. Workforce planning is also subject to TUPE arrangements if applicable.

The programme team has also focused on further strengthening the established relationship between Alder Hey Children's NHS Foundation Trust and Royal Manchester Children's Hospital and developing relationships with paediatric endocrinology colleagues at Leeds Children's Hospital and the South Gender Identity Development Hub.

Work with the South Hub is progressing positively, and shared ownership is in place relating to a recruitment strategy and electronic patient record system.

It should be noted that the proposed North regional hub for Gender Identity Development Service will not take clinical responsibility for children and young people

until key gateways agreed with NHS England have been achieved. Until the required gateways are fully achieved responsibility for the service will remain with NHS England and Tavistock & Portman NHS Foundation Trust.

3. Conclusion

The Trust Boards are asked to note the contents of this report and the establishment of a Gender Identity Development Service North programme and agreed NHS England governance arrangements relating to this work. It is proposed that the North programme provides regular reports to both Trust Boards, including progress in achieving the required gateways prior to agreement to provide the service.

Appendix 1

Terms of Reference: Gender Identity Development North Programme Board

Gender Identity Development North Hub
North Programme Delivery Board Terms of Reference

Introduction

The Gender Identity Development Service (GIDS) is for children and young people, and their families, who experience difficulties in the development of their gender identity.

NHS England has established a single programme of work, nationally coordinated and supported by the national specialised commissioning team, through joint working and collaboration with the early adopter providers, Tavistock and Portman NHS Foundation Trust, and NHSE regional teams. The immediate focus is on supporting the transition from the current state to early adopter providers, moving to issues of wider regional rollout over time from 2023/2024.

Alder Hey Children's NHS Foundation Trust and Manchester University NHS Foundation Trust have agreed to, jointly, become one of the early adopters, and herein establish a GIDS North Programme Delivery Board.

GIDS North Programme Delivery Board

The GIDS North Programme Delivery Board will provide direction and oversight of the programme as they relate to the regional mobilisation and interfaces to the national Programme Delivery Board. It will ensure that key deliverables for the programme are achieved for the region, aligning both to the national programme and local organisational context. It will ensure clear plans, objectives, reporting and exception management processes are in place.

The GIDS North Programme Delivery Board will report to the NHS England National Programme Delivery Board, as well as the North West Paediatric Partnership Board. The board will also receive updates and escalations from the GIDS North Programme Delivery Group.

Duties

The GIDS North Programme Delivery Board will:

- Provide strategic direction to the work programme, providing advice and support to the regional leads of the core workstreams as required, and will ensure that the

right capabilities and capacity to manage and successfully deliver the work programme are in place
- Have an important inward-facing role in that members will ensure that the outputs of the GIDS North Programme Delivery Board are reported into the organisations that they represent, and that the constituent organisations are aligned with the GIDS North Programme Delivery Board's work so that there is consistency of approach
- Act as the central point of coordination for the various elements of work across the core work streams
- Ensure that appropriate programme structures and reporting arrangements are in place for the GIDS North Programme Delivery Board to monitor progress within each core workstream, including ownership of a central risk register and issues log
- Agree progress and status reports to the groups to which it reports, including exceptional reports

Chair of meeting and secretariat

The meeting will be jointly chaired by Chief Executives of Alder Hey Children's NHS Foundation Trust and Manchester University NHS Foundation Trust or a delegated deputy. The Chairs will alternate the responsibility where possible dependent on availability.

The secretariat role will be delivered by North Programme Director.

Quorum

The quorum of the Group is 40% of members are present, and must include two directors from each of Alder Hey Children's NHS Foundation Trust and Manchester University NHS Foundation Trust in addition to the air

Decision-making and reporting

The GIDS North Programme Delivery Board does not have delegated powers. It reports into NHS England GIDS National Programme Delivery Board providing status updates, risk escalation and will provide formal advice to the national programme.

Where key decisions are required by Alder Hey Children's NHS Foundation Trust and Manchester University NHS Foundation Trust, on matters relating to strategy, clinical design, workforce planning or financial management the GIDS North Programme Delivery Board shall make recommendations to the relevant Directors of both Trusts. Such Directors may then make final decisions in line with Trust schemes of delegation.

Structure and format

The GIDS North Programme Delivery Board will meet monthly for the duration of the programme.

It is envisaged that most meetings will be held remotely.

The GIDS North Programme Delivery Group will provide updates and escalations to the board. Other informal meetings or working groups may be held in between formal meetings; these should report back to the GIDS North Programme Delivery Board.

All members will be expected to attend all meetings or to provide their apologies or nominate a deputy in advance should they be unable to attend.

Actions and key issues arising from the meetings shall be formally recorded and agreed by the GIDS North Programme Delivery Board.

These terms of reference will be reviewed on a quarterly basis, the next review will be due in March 2023.

Membership

- Chief Executive Officer, Royal Manchester Children's Hospital, Manchester University NHS Foundation Trust
- Chief Executive Officer, Alder Hey Children's NHS Foundation Trust
- Medical Director, Royal Manchester Children's Hospital, Manchester University NHS Foundation Trust
- Chief Medical Officer, Alder Hey Children's NHS Foundation Trust
- GIDS North Senior Responsible Officer
- GIDS North Clinical Lead
- GIDS North Programme Director
- GIDS North Programme Manager
- Lead Nurse for GIDS, Leeds Children's Hospital, The Leeds Teaching Hospitals NHS FT

Invitations to the Programme Board may be extended to include additional executive leads from across both organisations, particularly where individuals are engaged with the GIDS programme as workstream leads and/or engaged with the national programme. This may also include a wider team, including clinicians, project managers and operational managers, which should be agreed in advance of the meeting with the Chair.

NB: In relation to HR and Communications, the North Programme Delivery Board's membership will be a single lead nominated by one of either Alder Hey Children's NHS Foundation Trust or Manchester University NHS Foundation Trust such nominated lead will liaise directly with their counterpart between meetings to ensure a joint approach.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	22nd February 2023 – Summary 18th January 2023– Approved Minutes
Report of:	Fiona Beveridge, Non Executive Director
Paper Prepared by:	Fiona Beveridge

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 22nd February 2023, along with the approved minutes from the 18th January 2023 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

The Safety Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

2. Agenda items received, discussed / approved at the meeting

- Patient Safety Strategy Board update was received and SQAC **NOTED** the update on the rollout of Inphase, which is imminent, and the continued orientation towards PSIRF.
- SQAC received a Parity of Esteem update, SQAC acknowledged the ongoing Parity of Esteem journey and welcomed updates on how this evolves in the future.
- SQAC received an update on ED@its Best, with good discussion held regarding next steps, sustainability, innovation, and collaboration. SQAC received an update on the continued focus on improvement and some initial positive impact from the new UTC.
- SQAC received NICE guidance update, and noted the improvements made with regards to reporting, with further refinement still required, SQAC noted an improved position.
- SQAC received a Proposal for a Trust Wide Clinical Effectiveness and Outcomes Group, SQAC supported and approved the report and welcomed the proposal, ensuring alignment to SQAC and other committees as appropriate, and ensuring that the Terms of Reference are appropriately updated to reflect and align.
- SQAC discussed the future of Divisional reports presented to SQAC. NA welcomed comments from colleagues, with ongoing discussions required over the next 2-month period. Divisions welcomed a Divisional reporting template to be presented at SQAC, to enable SQAC to receive assurance and to receive updates on challenges and issues relevant to Safety and Quality across the Divisions.

3. Key risks / matters of concern to escalate to the Board (include mitigations)

None

4. Positive highlights of note

5. Issues for other committees

None.

6. Recommendations

The Board is asked to note the Committee's regular report.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 18th January 2023
Via Microsoft Teams

Present:	Kerry Byrne	Non-Executive Director - Chair	(KB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Chief Medical Officer	(Aba)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Deputy Chief Executive	(JG)
	Jo Revill	Non Executive Director	(JRe)
	Jackie Rooney	Associate Director of Nursing Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)

In attendance:

	Julie Creevy	Executive Assistant (Minutes)	(JCre)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jill Preece	Governance Manager	(JP)
22/23/175 &182	Will Weston	Medical Services Director	(WW)
22/23/182	Chris Talbot	Consultant Orthopaedic Surgeon, Patient Safety Specialist	(CT)
22/23/176	Bea Larru	Director Infection Prevention Control	(BL)
22/23/179	David Porter	Consultant Infection & Immunology, Infectious Diseases, Sepsis Lead	(DP)
22/23/179	Kim Hewittson	Sepsis Nurse Specialist	(KH)
22/23/179	Julie Grice	AED Consultant, HMRG/Mortality Lead	(JGr)
	M Hamer	Director of Allied Health Professionals	(MH)

22/23/171 Apologies:

Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
John Chester	Research Division	(JC)
Christine Hill	Pathology Manager	(CH)
Dani Jones	Director of Strategy	(DJ)
Phil O'Connor	Deputy Director of Nursing	(POC)
Paul Sanderson	Interim Chief Pharmacist	(PS)
Peter White	Chief Nursing Information Officer	(PW)
Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)
Sarah Wood	Safety Lead, Surgery Division	(SW)

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

22/23/172 Declarations of Interest

SQAC noted that there were no items to declare.

22/23/173 Minutes of the previous meeting held on 14th December 2022 – Resolved:

Committee members were content to **APPROVE** the notes of the meeting held on 14th December 2022.

22/23/174 Matters Arising and Action Log

Divisional Governance Monitoring Update – Clinical Governance External Review Action Plan was received and **NOTED**.

Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/175 Patient Safety Strategy Board update

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

- Patient Safety Strategy Board had been applying careful scrutiny to workstreams, 7,8 12, 15 and 17.
- Significant success in month regarding further development of the Communication Plan and the commissioning of patient safety artwork.
- Chris Turner, external presenter had presented on the connection between civility and patient safety at a session held on 17.01.2023, with 150 delegates in attendance.
- Discussion had taken place at the last Patient Safety Strategy meeting regarding a potential new workstream regarding unacknowledged Meditech notices, with approximately 700,000 unacknowledged notices, which poses several risks to the organisation and to patients. There is a recommended remedial plan, with the intention to formally incorporate this into the next Patient Safety Strategy Board at its next meeting.
- Patient Safety Strategy Board continue to enhance governance documentation by reviewing all decision documents and further improvement in the identification of and management of risks.

SQAC **NOTED** good progress made in month

Aba advised that the Trust had recently advertised for a Medical Examiner, with two applications received, interviews are scheduled to take place on 2nd February 2023; this is a joint interview with the Head of the Medical Examiner department at LUFT. ABa advised that the appointment process is on trajectory to have a Medical Examiner for Alder Hey by 1st April 2023.

Aba advised that in addition to the deteriorating patients workstream a project had commenced looking at wider issues of hospital at night and hospital optimisation which may include the reporting of the deteriorating patients' programme.

KB welcomed the positive news regarding the Medical Examiner Interview process.

KB queried whether there would be a gap in assurance, in terms of the deteriorating patients workstream being in this programme and potentially another programme. ABa advised that the first meeting had taken place on 6th January 2023, with four workstreams established, 1 of which was the deteriorating patient workstream. ABa stated that he would value an offline discussion regarding alignment of reporting mechanisms for clarity, as to whether the workstream should report to Patient Safety Strategy Board or to SQAC.

Resolved: Offline discussion to be held with ABA, FB and appropriate colleagues

JG informed SQAC that as the trust transition to the new 2030 strategy there will be a requirement to review the current projects, and how these transition into the new strategy.

JG requested NP to include an appropriate section detailing this within Trust Board report at January 2023 meeting.

NA stated that under the National Patient Safety Strategy the Trust will be required to evidence and report against deteriorating patients workstream from a governance and assurance point of view through our Patient Safety Strategy Board.

NP recommended to SQAC that this should be kept as it is until there is clarity and certainty regarding the new approaches, and in the short term the team continue to report to SQAC and to Patient Safety Strategy Board, until colleagues are in agreement with changes, rather than accelerating any changes.

JRe welcomed the overall progress made on the Patient Safety Strategy Programme. JRe questioned if there are any challenges with the project management resource within the programme. WW advised that the team had advertised internally and externally on a number of occasions and colleagues are extremely grateful for the temporary support provided in the short term from the DMO. The post is currently out to advert, but the funding is only temporary for a 12 month period, which has limited the number of applicants.

KB referred to the 700,000 unacknowledged notices and queried how this issue had been brought to the attention of the Patient Safety Strategy Board. ABa advised that this was highlighted when a patient came to harm due to a missed result. ABa provided SQAC with a detailed overview of the challenges with the current system and process.

ABa informed SQAC that there has been a clear plan for managing the current number of results that had been agreed by the executive team with legal advice and support. Moving forward the solution will be delivered in EXPANSE, and will be supported through training, education and a robust SOP.

KB expressed concern that this appears to have been an accepted problem and queried whether there were any other similar issues. KB queried whether a sample of Meditech users had been consulted with to identify any other issues ahead of moving to EXPANSE.
ABa stated that there is a group that reviews this.

AB advised that the issues had been reviewed by EXPANSE.

Resolved: AB would definitively seek assurance offline that issues had been fully reviewed, and that they are being addressed within EXPANSE.
AB would address legacy uncomplete actions and ascertain whether there is an appropriate action plan to address.

JRe sought clarity as to whether colleagues are trawling back through the unacknowledged notices in each area. ABa stated that various samples had been reviewed and validated however, colleagues could not review all 700,000 unacknowledged notices. ABa advised that the organisation had consulted with the legal team as to what would be a representative sample; this piece of work is almost complete.

JRe sought clarity whether SQAC would be updated should any further issues emerge in the process. ABa stated that this would be the process.

KB referred to Parity of Esteem update and queried whether an update would be provided at the next SQAC meeting, WW confirmed that a comprehensive Parity of Esteem update would be provided at February 2023 meeting.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy Board Update

Safe

22/23/176 DIPC Exception Report

SQAC received and **NOTED** the DIPC Exception Report.

KB queried whether the report could be corrected as the first table within the report did not accurately reflect the current position with regards to Hospital acquired infections, RSV, covid and VRE as they are currently coloured green but should be red. BL confirmed that the table within the DIPC report required amending, and that this would be amended and recirculated to committee members following the SQAC meeting.

Resolved DIPC Report to be amended and reissued to SQAC

SQAC received and **NOTED** the DIPC Exception Report

22/23/177 Assurance Emergency Department Activity Monthly Update

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

22/23/178 Safeguarding & Statutory Services Assurance Group Briefing

Resolved: SQAC received and **NOTED** the Safeguarding & Statutory Services Assurance Group briefing.

22/23/179 Sepsis Update

DP, JC & KH were welcomed to SQAC.

DP presented the Sepsis Update

- DP advised on the need to formalise Sepsis nurse cross cover arrangements during periods of unexpected absence which the team are working on.
- SQAC received a detailed summary on sepsis compliance for in patients and ED as detailed in the pack.
- In response to the increase nationally in presentations of Group A Strep NHSE had advised on a reduction in threshold prescribing antibiotics to children. This has increased the number of presentations which are being treated as sepsis in the ED.
- There had been some slippage with regards to Sepsis mandatory training. DP requested any support to increase emphasis on the importance of mandatory training. A discussion had been held within the Division of Medicine to address the issue.
- A clear plan and priorities for the next 6 months was presented.
- Sepsis dashboard - a meeting had been held with the Data Team and the Sepsis Team are currently awaiting any update with regards to potential solution.

NA expressed his thanks to the team for the cross cover arrangements. NA advised that the divisional teams had been requested to address the poor compliance with sepsis training however, this had seen little improvement. NA confirmed he would discuss training compliance at PAWC later that same day.

KB asked which the appropriate clinical forum was to review the mandatory training compliance.

NA advised that the correct forum was PAWC for oversight and operationally through the divisional governance processes to ensure assurance across the organisation. This is discussed through Education Governance, however further visibility is required.

KB stated the importance of receiving high level assurance regarding individual mandatory training levels.

Resolved: NA would raise at PAWC, in terms of how this is reporting into the Board of Directors.

JG asked for some additional detail on the issues relating to developing the Sepsis dashboard.

DP advised that the Sepsis Team had not been able to follow this up further with the Data Team due to lack of capacity within the Sepsis Team. However, the issues related to the useability of the dashboard, and if the ED data could also be included.
DR agreed to feedback to IT colleagues in order for an offline discussion to be held with IT and the Sepsis Teams.

KB commented that, whilst it may be difficult for the Sepsis Team to find the time, development of the dashboard would reduce the manual intervention required by the Sepsis Team and reduce the time spent in the future.

Resolved: KB welcomed a quarterly update on Sepsis Dashboard progress.

Resolved: DR to liaise with IT colleagues to enable offline discussion and support to be provided to Sepsis teams to enable improvements with regards to Sepsis Dashboard.

Resolved: SQAC received and **NOTED** the Sepsis update.

Clinical Governance Effectiveness

22/23/180 Ockenden Report

PB presented the Quarterly Update Ockenden Report.

PB advised that there are no specific items to escalate to SQAC with regards to the Ockenden Action Plan, which is extremely well monitored including through the Liverpool Neonatal Partnership (LNP) Board. Each of the actions has a LNP component, with a number of actions only applicable to LNP, and not to Alder Hey site.

PB advised that the Kirkup Report was published in October 2022 relating to maternity and neonatal care in East Kent. The majority of actions are high level, and responsibility for delivery of actions sits with NHSE/I, HEI's, Government, Royal College etc. The report details four main components regarding the monitoring of performance, standards of clinical behaviour, teamworking and organisation behaviour, care, and compassion.

KB acknowledged the significant work undertaken, and stated that the action plan is extremely detailed. KB alluded to those areas where extensions had been made to the original deadlines given the timescales were arbitrary and set extremely early. KB had fully reviewed those extensions and none extended beyond this financial year, with no concerns expressed.

KB referred to action plans in general, and queried whether the updates provided are specifically, just from the action owners or whether any are peer or independently reviewed to ensure a level of certainty that actions signed off as complete are complete.

PB stated that updates for this action plan had all been from action owners, and that routinely PB requests supporting evidence to substantiate.

KB stated that further consideration would be required regarding suitable approach/process to independently verify. PB advised that the action plan is reported through Clinical Quality

Review meeting (CQRM), which is ICB led. CQRM are content with our approach.

JRe referred to LNP and stated that she was assuming that there is sharing of plans across LNP and alluded to a sense of our plans affected by partners. PB stated that LWH have a wider action plan, as every recommendation from Ockenden was applicable to them, however not all actions are applicable to Alder Hey. Those actions within the Ockenden Action Plan had been agreed thorough LNP, with agreement and oversight across both Alder Hey and LWH.

Resolved: SQAC received and **NOTED** the Ockenden Action Plan
Resolved: SQAC approved planned approach to Kirkup.

22/23/181 CQSG Key issues report

PB provided the CQSG Key Issues Report, key issues as follows:-

- Divisional reports had been received detailing top three issues and concerns.
- Good progress had been made with regards to SIRIs, all RCAs had been responded to and investigations undertaken and completed within appropriate timescales.
- CQSG noted the increase in referrals for SEND health assessments.
- CQUIN progress report received.
- Within the divisional report from Community & MH Division raised two incidents in the mortuary; those incidents are being investigated both internally and externally.
- Good progress from the divisions regarding a number of assurance metrics such as PALS, complaints, patient information leaflets, closing down incidents with colleagues fully aware of historic/legacy issues in preparation for the new risk management system.

KB referred to SEND, and sought clarity whether this was shared with SQAC for awareness only or was action required. PB confirmed this this had been shared for SQAC awareness only.
LC clarified that the SEND Team issues related to health and education care plans for children and young people. LC advised that Alder Hey are maintaining all of the timescales regarding health advice.

Resolved: SQAC received and **NOTED** the CQSG Key Issues Report from meeting held on 10th January 2023

22/23/182 Overview of PSIRF

WW & CT presented an overview of the Patient Safety Strategy & PSIRF
SQAC received a detailed presentation in relation to this item, a copy of which was provided in the meeting pack.

KB acknowledged that this is a big change for the organisation, and will take time and focus to deliver.

KB alluded to the current prescribed serious incidents process, and of PSIRF moving towards a more judgement and empowerment based approach, and questioned how assurance will be provided to Trust Board, and whether education for Board members would be provided at the correct time.

NA advised that the Trust would continue to measure improvements, against the plan, which would be an iterative process, and that relevant training and updates would be provided as the programme of implementation evolves.

NA expressed thanks to WW, CT and JR for ongoing support, and welcomed a further update in future for further clarity.

KB requested WW and team to confirm an appropriate timescale to report back to SQAC in the future to ensure this is included on SQAC workplan.
Resolved: SQAC received and **NOTED** the Overview of PSIRF and welcomed a further update in due course.

22/23/183 Children in Care Annual Report

LC presented the Children in Care Annual Report, key issues as follows:-
Children in Care Annual Report had been approved at the Safeguarding Strategy Assurance Group. LC referred to the newly formed Safeguarding leadership team who are managing this report, with the aim of a children & young person's version to be included in the future on the Trust's website.

KB welcomed the Children in Care Report.
KB sought clarity regarding timing of future reports as the reports related to the year ended 31 March 2022. LC advised that both reports for year ended 31 March 2023 aim to be presented to June 2023 or July 2023 SQAC meeting, (dependent on data).

Resolved: SQAC received and **NOTED** the Children in Care Annual Report, and welcomed an update at June 2023 meeting.

Well Led

22/23/184 Board Assurance Framework

SQAC received and **NOTED** the Board Assurance Framework.
ES advised that the BAF is well socialised in many forums across the organisation, alignment had taken place.

ES referred to Board oversight of Sepsis, and advised that it is included in the BAF report given the previous gap in assurance, and questioned how long the Committee consider this, based on the improvements presented by DP. ES advised that NA and ABa to consider this.

ES highlighted Risk 1.4, given the Divisional Director of Mental Health's decision to include this new risk over the last couple of months. There is a proposed deep dive on this risk and other clusters in the Risk Management Forum - potentially March 2023. ES & LC are due to discuss this further.

KB thanked ES for update and advised that she had reviewed the BAF and has no concerns.
Resolved: SQAC received and **NOTED** the Board Assurance Framework.

22/23/185 Risk Profiling/Tolerances – Clinical Risks

ES provided a presentation regarding the Risk Appetite Statement & Risk Profiling/Tolerances – Clinical Risks update.

Discussions had been held at Trust Board and the Board had agreed a formal risk appetite statement and suggested risk tolerances for clinical safety and clinical effectiveness. ES stated that she wanted to try to determine within the different assurance committees what the various members feel would be acceptance tolerance levels for those risks addressed at various assurance committees. ES advised that it would be helpful to the Board of Directors to obtain a view from SQAC regarding how this may be framed in terms of risk appetite and tolerances of clinical risks moving forward.

KB queried whether SQAC supported the Board proposal where setting tolerance for clinical risk, or whether this should this be reviewed.

KB described the current challenge which related to consistency of scoring and target risk setting across a large number of risks with many risk owners. The risk appetite score sets a very high level of the Boards view on risk, i.e., for clinical safety risk this is very low, and it is important for Trust Board to signal this. Tolerances are the scores that the Board are indicating that if your risk is below this, that the Board are content that this risk can be closed and if the risk is above it then the Board require action to be taken to reduce the risk. Setting tolerances removes any inconsistency, ensuring everyone who has a clinical safety risk would be working to the same target score e.g.,1-3 and everyone who has a clinical effectiveness risk would be working to 4-6.

ES advised that the presentation is being shared with PAWC & RABD to review, and feedback would be provided to the Board to enable the risk tolerances to be agreed.
KB sought clarity whether colleagues wanted to review the detail contained in the presentation further and feedback.

NA stated that the organisation had experienced issues regarding safety and, as a result, the tolerance appears to have been narrowest very low. For example, a risk may have a catastrophic impact (5) and be unlikely (1) with a score of 5 and under the proposed tolerances this risk would be unable to be closed, but also unable to be mitigated further. NA referred to risks on the risk register with no target completion, with tighter assurance/regarding rejecting risks with no targets required. ES advised that it is important to address this going forward.

KB welcomed further discussion with NA or SQAC colleagues to address complexities. KB stated that she is happy to co-ordinate offline discussion regarding the complexities raised.

LC welcomed review of the slides and advised that this would be discussed within the Community & MH Division to review the impact on their risk register. LC welcomed the process, and highlighted the importance of ensuring the risk is located within the right category.

LC advised that the divisional governance group would review and oversee their risks, JR stated that she was happy to support divisions as appropriate.

UD advised that there is a robust system in place within the Medicine Division who regularly meet and review risks scored 10 and above, and assess what the category should be, whilst reviewing mitigations. This system has worked extremely well over the last 3 months.
JRe alluded to the issue regarding movement, and at what point may tolerances change and queried what would this look like, and how it would be described.
KB advised that the review of tolerance should be an annual process at Board but that, the assurance committees should be the guardians of the tolerances for their relevant risks, and if these are wrong, it should be highlighted to the Board.

Resolved: KB, ES & JR to meet offline to address issues raised, following that discussion, a meeting would be held with KB, UD, LC & NA, within the next few weeks followed by any further discussion if needed regarding update on complexities and realities within the system.

22/23/186 Divisional reports by exception/Quality Metrics update

KB referred to Medicine and Surgery both reporting a reduction in 21 day stay which is positive news.

Surgery Division – CC provided an update on key issues as follows:-

- Division of Surgery had maintained 0 Never Events
- 100% compliant for PALS, Division had a reduction in PALS in December 2022
- Significant improvement with regards to waits for diagnostics

- Cancelled operations on the day is above target, however there are patients booked within 28 days which has improved, Division are continuing to review this further to reduce any negative impact on families
- There is an improvement plan in place regarding cancelled operations, with continued focus on theatre recovery with additional sessions planned.

KB welcomed the positive improvements regarding Length of Stay Group.

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

- Division are working with Governance Lead and Director of Governance with regards to NICE Guidelines. The Division have 1 baseline assessment pending within Oncology, UD is hopeful that this would be addressed, and actions plans are in place for all other Guidelines.
- Challenges regarding diagnostics, due to delay in receiving home sleep kits, with delays experienced due to industrial action, expected progress at the end of January 2023.
- Division continue on elective recovery which is exceeding 104%

KB welcomed the positive update on NICE Guidance and the innovate approach to the Sepsis training to improve mandatory training compliance.

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

- No Children & Young People waiting over 52 weeks, in developmental paediatrics or therapies, with further work to do in MH Services as the number had increased.
- Division continue to sustain delivery of virtual appointments. The Division are undertaking a review of this given the Division are a significant high user of virtual appointments. LC is keen to undertake a sense check on virtual appointments, with a good discussion held at Divisional Performance Review.
- Division continue to achieve eating disorder services targets.
- Division continue to remain compliant with mandatory training compliance
- Continued increased demand for ASD and ADHD pathways with the highest number of children referred during November 2022, with increasing referrals.
- Deep dive - Division are changing the approach regarding community clinical measurement clinic was not brought rate. WNB rates are currently high, and Division are undertaking an additional piece of work to address.
- Colleagues within the Division are moving out of the old Catkin Building on 23.1.23 to the new modular building.

KB welcomed the review of the virtual appointments versus those face to face.

NA queried whether there is a requirement to review this section of the agenda regarding the assurance it provides for the committee. CC welcomed this approach in order to ensure a standard approach from each of the Divisions.

Resolved: Offline discussion to take place with SQAC NEDs and NA, to enable feedback to be provided thereafter to Divisional Directors.
KB thanked all Divisions for update.

Responsive

22/23/187 Child Abduction Policy

SQAC received and **RATIFIED** the Child Abduction Policy

22/23/188 Any other business

000146

22/23/189 Review the key assurances and highlight to report to the Board

Positive updates were received regarding:

- Patient Safety Strategy Board update was received, SQAC **NOTED** the positive position.
- Assurance Emergency Department Activity monthly update received
- Divisional updates were received, which SQAC **NOTED**
- SQAC Ratified the Child Abduction Policy
- Sepsis update
- Ockenden update received
- PSIRF update
- Discussion regarding risk appetite and tolerances

21/22/190 Date and Time of Next meeting

KB thanked all for attendance

Next meeting to be held on 22nd February 2023 at 9.30 am

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday the 12th of December 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)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance:	Prof. I. Buchan	Assoc. Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics	(IB)
	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)
	Dr. F Marston	Innovation Consultant	(FM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
Observing:	Ms. F. Ashcroft	CEO of the Charity	(FA)
Item 22/23/49	Ms. K. Davies	DETECT Study Team	(KD)
Item 22/23/49	Mr. O. Olajide	DETECT Study Team	(OO)
Item 22/23/49	Dr. G. Sefton	DETECT Study Team	(GS)
Item 22/23/50	Ms. S. Johnson	Innovation Consultant	(SJ)
Item 22/23/51	Ms. K Morgan	Innovation Programme Manager	(KM)
Item 22/23/51	Dr. L. Crabtree	Beyond Programme Director	(LC)
Item 22/23/52	Ms. A. Davies	Senior Programme Manager	(AD)
Item 22/23/54	Mr. C. Beaver	Head of Marketing and Communications Operations	(CB)
Apologies:	Mr. A. Bass	Chief Medical Officer	(AB)
	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)
	Ms. R. Lea	Deputy Director of Finance	(RL)
	Mr. D. Powell	Director of Development	(DP)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)

22/23/45 Apologies

The Chair noted the apologies that were received.

22/23/46 Declarations of Interest

There were none to declare.

22/23/47 Minutes of the previous Meeting

The minutes from the meeting held on the 10.10.22 were agreed as an accurate record of the meeting, pending the following amendment:

- *Minute 22/23/31*: Remove the last sentence of the paragraph as it was confirmed that Non-Executive Director, John Kelly, is an official member of the Innovation Committee.

22/23/48 Matter Arising and Action Log

Matters Arising

The Committee was informed of the Trust's success in being awarded three HETT awards during a ceremony in November. The awards were presented for the work conducted by the Innovation Team in collaboration with a number of teams across the Trust and John Moores University; 1. Digital Innovation in Mental Health award for the development and deployment of the CYP As One Platform. 2. Digital Service for CYP of the Year Award for the CYP As One Platform. 3. The Unexpected Innovator of the Year accolade went to a clinical innovator, Wendy Blumenow, who felt it was an honour to be recognised individually.

Action Log

Action 22/23/37.1: *We Are Nova Update* (*Report on the two live spinout companies - Submit a report to the Audit and Risk Committee that will close the loop on the KPMG recommendations related to the Acorn Partnership and also lay out the future options for the two active companies. It was also agreed to circulate the report, once complete, to members of the Innovation Committee)* – This item has been included on the agenda. **ACTION TO REMAIN OPEN**

Action 22/23/41.1: *Innovation Commercial Partnerships Standard Operating Procedure (Liaise with Shereef Hosny to discuss a process for reporting against the flow diagram on page six of the Standing Operating Procedure)* – This meeting was postponed and is in the process of being rescheduled. **ACTION TO REMAIN OPEN**

22/23/249 Impact Story: DETECT Research Findings and the use of Data Science.

The Committee received a presentation on a study that took place, Dynamic Electronic Tracking and Escalation to reduce Critical care Transfers (DETECT), that was using smart technology to improve real time situation awareness about children who are deteriorating in the hope that that the Trust would be able to change the trajectory of a patient's deterioration and avoid an unplanned transfer to ICU/HDU. A number of slides were shared that provided further detail on the

study, its outcomes, benefits and opportunities in terms of implications to go beyond Alder Hey.

A response was provided to questions that were raised relating to the plans for continuous updating with cumulative data, consideration for the use of a number of different models when there are changing circumstances, and whether thought has been given in terms of taking early warning risk scores and adapting observation according to the trajectories of the risk of the patient and the prevailing circumstances of the hospital setting.

Claire Liddy thanked everyone involved in the study which was conducted in collaboration and pointed out how the use of big data can be used to benefit patients. A discussion took place around the next steps for the study and the grant funding available to take this opportunity forward.

Resolved
The Committee received a presentation on the DETECT research findings and the use of data science.

22/23/50 Draft Engagement and New Pipeline Plan

The Committee received the draft Engagement and New Pipeline Plan and was advised of the work that is being created to increase the quality of the Pipeline in terms of internal engagement, which will be reported on in due course.

Louise Shepherd drew attention to the refresh of the Trust's strategy (2030 Vision) and pointed out that reflection is taking place to look at how innovation can be sited at the heart of everything that is done at Alder Hey. It was agreed that engagement needs to take place with clinicians but there is also a strategic element that needs to be addressed too. It was confirmed that discussions will take place during December's Exec strategy session regarding this matter and a report will be submitted to the Trust Board accordingly.

Resolved:
The Committee noted the update on the draft Engagement and New Pipeline Plan.

22/23/51 Cheshire and Merseyside (C&M) Integrated Care System (ICS)/NHS England Innovation partnership activities

Establishing the Automation Solutions Centre of Excellence.

The Committee received an overview of the growth and business development of the Robotic Process Automation (RPA) Programme to a Centre of Excellence Service that offers fee for service innovation and automation solutions to other Trusts. A number of slides were shared that provided information on;

- Achievements.
- Benefits of working with the ICS.
- The work that is taking place to promote the Centre of Excellence.

Due to the success of the Trust's RPA Programme, and being the most advanced Trust in the Cheshire and Mersey (C&M) region it was able to secure grant funding to establish Alder Hey as the Centre of Excellence for the C&M region. It was reported that there is a lot of positive work taking place across the Trust but the

Centre is going to commence to work with other organisations which will provide a fee for service revenue. It was felt that this is a great opportunity for the Trust as there are only two other Centres of Excellence across England.

Further detail was provided on the role of the Trust, the involvement of the ICS, and the grant funding for this venture. A discussion also took place on the pricing model, the rate card in terms of the fee for service for solutions provided by the Trust, the prioritisation of projects/partners, and the next steps from an internal/external perspective. As a result of this conversation it was agreed to;

- Circulate the business case for the pricing model/running of the service once the additional activity has been included and the document has been finalised.

22/23/51.1 **Action: KM**

Ian Buchan raised two questions appertaining to automation targets and the NLP project. Following discussion it was agreed to discuss this area of work outside of the meeting.

22/23/51.2 **Action: CL/IB**

Children and Young People (*CYP) As One Platform and ICS C&M Beyond CYP Programme*

The Innovation Committee received a report that provided information about the partnering activities with the C&M system and the business development of the CYP As One Mental Health Platform. A presentation was shared with the Committee that provided information on the following areas:

- Context of the start that children have across C&M in terms of the real disparity in the outcomes of CYP.
- The CYP Transformation Programme and its key objectives.
- The increase in emotional wellbeing and mental health rates of CYP in C&M, and the national picture of children's emotional wellbeing and mental health.
- Innovation solutions scoping of the As One Mental Health Platform;
  - Background.
  - Why?
  - Impact.
  - Interest and feedback.
  - Streamlining and provision needs.
  - The three common needs across C&M.
  - Recommended next steps.

Claire Liddy responded to a couple of questions that were raised with regard to funding the next phase of the CYP As One Platform, and whether discussions have taken place in terms of moving beyond process measures to look at outcomes, taking into account the requirement to break new ground between population and individual level intervention in mental health.

The Committee was advised of the associated research and evaluation work that is taking place in collaboration to measure the impacts of healthcare inequalities using the data generated from the platform. Following discussion, it was agreed to share the initial evaluation report once authorisation has been received from

the Trust's research partner and it was confirmed that the larger ongoing piece of work will be available at a later date in 2023.

22/23/51.3 Action: CL

Resolved:
The Innovation Committee noted the update on the C&M ICS/NHS England innovation partnership activities.

22/23/52 Children's Hospital Alliance – Innovation Programme

The Committee received an update on the Children's Health Alliance Innovation Programme that has been developed over the last twelve months. A number of slides were shared with the Committee that provided information on the following areas:

- An overview of the Children's Health Alliance (CHA).
- CHA strategic objectives.
- CHA workstreams.
- Success and progress in terms of the work that has taken place to address inequalities via innovation.
- What's next?
- Update of the Children's Hospital Alliance Was Not Brought (WNB) Innovation Programme including the interventions, learnings and benefits to date.

Committee members were asked to share their views on the Innovation Centre's next steps with the Children's Health Alliance in terms of taking on a potential national role to drive the innovation programme forward or whether a more peripheral role would be appropriate. Feedback and challenge was provided relating to; the importance of having a clear set of goals and priorities to enable constructive comments and decisions to be made, whilst ensuring that future priorities align with the Trust's overall Vision 2030 Strategy. Attention was also drawn to the importance of reflecting upon what an operating model could look like whilst being clear on how the Trust services priority areas.

Resolved:
The Innovation Committee noted the update on the CHA's innovation programme.

22/23/53 Commercial Partnerships Monitoring Report.

The Committee was provided with an update on commercial activities as at the end of November 2022, and feedback was requested on the new format of the report. Following discussion, it was agreed that the Committee would provide their reflections during February's meeting following drill down into the report to ensure it is committee friendly.

22/23/53.1 Action: All

22/23/54 Innovation Strategy Marketing and Communications Plan Update

The Committee was advised that work is ongoing with an external company to develop a marketing activity plan for the Trust and to look at the next steps for strategic brand positioning, etc. It was confirmed that a number of ideas have been proposed that require further development prior to submission to the Committee. Internal meetings are also continuing to discuss innovations in the

pipeline that will form part of the work that is taking place with the external company.

Resolved:
The Innovation Committee noted the update on the Innovation Strategy Marketing and Communications Plan.

22/23/55 Acorn Partnership Next Steps Discussion

The Committee was advised of the importance of making a decision on the next steps for the two remaining active companies of the partnership that are presently in a formal pause position with the Trust. In order to review the situation and make a judgement on the overall position it was agreed that a subgroup of the Committee will meet in January 2023 to make a decision and formalise the Trust's plans to address the situation. The group will consist of CL/JG/SA/ES/IQ/ JC/MF.

Resolved:
The Innovation Committee noted the next steps discussion relating to the Acorn Partnership.

22/23/56 Grant Achievement Update
Resolved:
The Committee received and noted the summary of the income generated via grants.

22/23/57 Inward Investment

Charity Grant KPI Interim Report
Resolved:
The Innovation Committee received and noted the content of the Charity's interim report for 2022/23.

Update on the National Children's Innovation Centre SOC Development

The Committee was informed of the work that has been taking place on infrastructure grants that has led to Trust being sponsored to write a strategic outline case to expand Alder Hey Innovation. The Trust is also in the process of creating an effective bid proposal that is linked in with an ask that has been submitted to the department of Levelling Up.

A question was raised around dedicated resources in the event the Trust is successful with both bids. Following discussion, it was agreed to submit the draft documents to provide further detail on the ask/requirements and focus of the bids.

22/23/57.1 Action: CL

Research and Grant Update.

The Committee was provided with an update on a two stage bid that was submitted in November 2022. If successful, confirmation will be received in February 2022 in terms of progressing to the second stage. The second stage of the bid will have to be submitted by May 2023.

Attention was also drawn to a multi academic research partnership that is being developed in order to address child health and wellbeing, which the Trust will be a part of. It was agreed to provide an update on this area of work as it progresses.

22/23/57.2 **Action: JC**

22/23/58 **Research and Innovation Committee Planning Update**

The Committee received the draft governance structure for the newly formed Research and Innovation Committee. The inaugural meeting will take place in April 2023, and from there on the Committee will meet on a quarterly basis. Further detail was also provided on the remit of the various boards and groups in the committee structure.

It was reported that a meeting is taking place on the 15.12.22 to discuss the Terms of Reference for Sub-committees, membership, and frequency of meetings in terms of the overall fit with the Research and Innovation Committee. A number of concerns were raised about the possible duplication of attendance, repeated meetings and staff having to attend additional meetings due to the amount of layers in the governance structure. It was confirmed that all feedback will be noted and addressed accordingly.

Following discussion, it was agreed to share the outcome of the meeting in order to outline the details of the conversation and the agreed actions.

22/23/58.1 **Action: JC**

22/23/59 **Board Assurance Framework Report**

Resolved:

The Innovation Committee received and noted the contents of the BAF report for October 2022. It was agreed to defer the update on the deep dive into BAF risk 4.1 that took place during the Risk Management Forum, until the next meeting.

22/23/59.1 **Action: ES**

22/23/60 **Any Other Business**

There was none to discuss.

22/23/61 **Review of the meeting**

The Chair felt that the meeting was very informative in terms of the updates received on current projects and programmes and thanked everyone for their contributions to discussion during the meeting. The Chair also thanked the team for the time and effort that went into preparing the reports.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 23rd February 2023

Paper Title:	**Highlight report – People Plan**
Report of:	**Chief People Officer**
Paper Prepared by:	Melissa Swindell, 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 January 2022.

2. People Metrics

The detailed people metrics can be found within the Integrated Performance Report (IPR), however it is worth noting in this report that:

- Sickness absence has reduced in month for the first time since September 2022 to 6%, which is still 1% over Trust target but a positive downward move
- Turnover remains high at 15%, with a focused review of turnover and retention initiatives underway which will be captured in the Trust long term plans on attraction and retention
- A focused effort from the whole Trust on PDR's has seen an increase in compliance to 91% for staff in bands 7 and above, and 69% for all staff. Divisions have been tasked with ensuring all staff received their PDR before the end of March, and it is encouraging to see that 83% of colleagues now have either a completed or planned date for their PDR before the end of March 2023. Divisions have provided assurance that they will meet this target by the deadline

3. Staff Survey

Team based Staff Survey information packs have now been distributed across the Trust to support divisional and team 'big conversations' and focused action plans. The Trust wide action plan will be submitted to the People and Wellbeing Committee in March 2023.

4. Industrial Action

The RCN have announced further strike for 1st and 2nd March 2023. This will be a 48 hour strike with no wide ranging derogations in place (according to the RCN official website). The Trust will be working closely with nursing colleagues to put plans in place to ensure all children and young people who need our services during those days are kept safe.

The BMA Junior Doctor ballot closes on the 20th February 2023. Should there be a mandate for strike action, there is likely to be a 72 hour strike in March 2023.

The BMA have opened a consultative ballot for industrial action for all consultants, to gain information about whether consultants are willing to engage in strike action. This closes 27th February 2023.

The Trust continues to work closely with all staffside colleagues, as well as providing frequent Trust wide communications and updated FAQ's. Gold/tactical command structure is in place as well as ongoing staff support through the Trust SALS Service.

5. Partnership Agreement

The Trust has agreed a new Partnership Agreement with Trade Union colleagues, which outlines how we will work together in effective partnership and confirms the facility time that will be supported for Trade Union stewards and Health & Safety representatives. This will be presented to the People and Wellbeing Committee in March 2023.

Melissa Swindell
Chief People Officer
February 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 23rd February 2023

Paper Title:	**Board Assurance Framework 2022/23 (January)**
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.

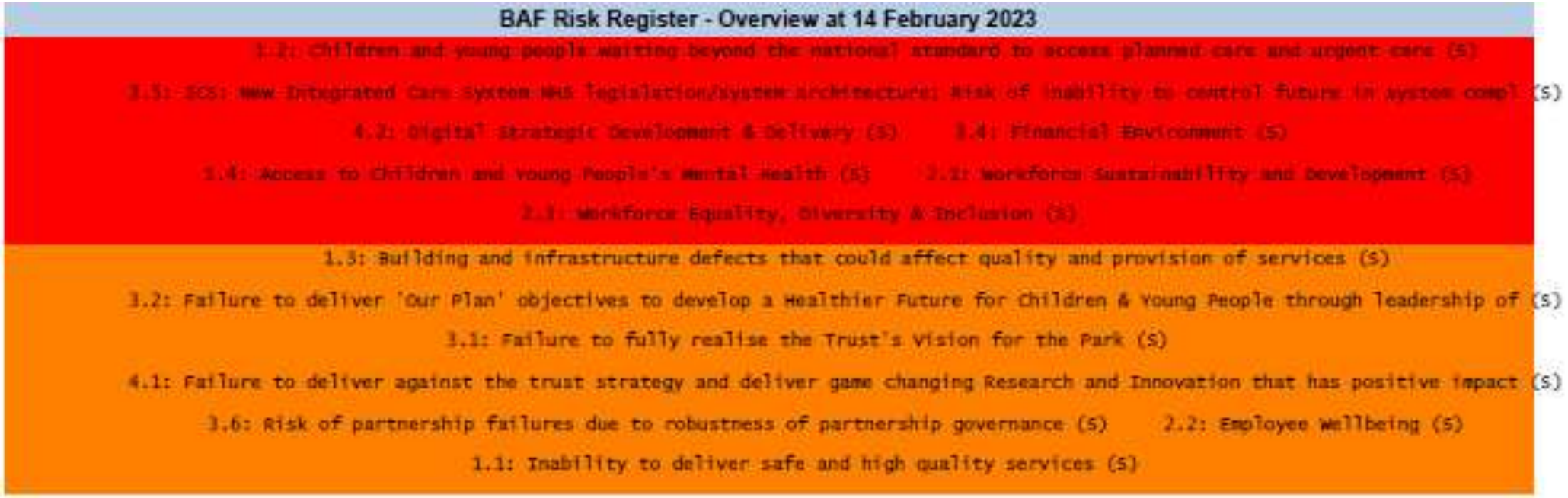
2. Review of the BAF

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 the 14th February 2023

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



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

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

4. Summary of BAF – at 14th February 2023

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

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

5. Summary of January 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, actions and controls reviewed and updated.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ)***
  Risk reviewed; no change to score in month. ICS arrangements still developing and delegations unclear. AH involved at all levels. Actions, evidence and controls reviewed and updated.

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

- ***Workforce Equality, Diversity & Inclusion (MS)***
  actions updated and risks reviewed. no change to risk rating.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  The SPV board members have agreed to provide a report on the corroded pipework and the associated cold water temperatures. GD has chased (1/2/23) with the SPV general manager and was informed they are being reviewed. GD continues to meet weekly with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding. The chiller works continue and we await a date for the removal of the temporary ones. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review. The next liaison committee is set for the 16th March.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB)***
  For Urgent Care enhanced streaming is now in place with Hub 2 and opening new Urgent Treatment Centre from 30 Jan. Access for scheduled care remains challenged with Industrial Action and providing Mutual Aid (to RMCH) slowing the rate of improvement.

- ***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 and Patient Safety Board.

- ***Financial Environment (JG)***
  Risk reviewed, actions and controls updated. No change in risk score due to current uncertainty on the 23/24 financial plan and longer term position.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Decommission of (old) Catkin is now complete and the site is being handed over to Beech (demolition contractor) this week. A programme has been issued from the contractor, detailing a timeline for demolition of Catkin and Sub 5, and construction of swales, which will enable the ongoing remediation of land (known as phase 3 of the park) as per the agreement with LCC.

- ***Digital Strategic Development and Delivery (KW)***
  Risk reviewed, score remains static. Work continues regarding timing of key programmes deployments in 2023.

- ***Workforce Sustainability and Development (MS)***
  risk reviewed, actions on track. remains high at 15

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

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL)***
  Reviewed FEB 23. Strategic investment action updated including timetable to March 23. Risk score no change.

- ***Access to Children and Young People's Mental Health (LC)***
  Risk reviewed: Job description review this is progressing well and on course for target date. ROMs app progressing well but some delays so date extended to end February 2023. All controls remain the same and in place for this month.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000163

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

Strategic Aim: Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.2 & 1.4
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	1.2
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 , 2.1 & 1.4
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2100	Risk of inability to provide safe staffing levels	2.1
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.2
2755	There would be a risk to the delivery of high quality services for Children and Young People. Due to Lack of sustainable workforce plans and associated investment (Surgery)	2.1
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	2.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	2.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	2.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	2.1
2295	Current Occupational Therapy service for complex 0-2 children in Liverpool community is non recurrent funding, funding from CCG is due to finish on 31/3/23.	3.4
2360	Sefton Young People referred for urgent or routine treatment are likely to exceed locally set targets (2 weeks for urgents and 18 week referral to treatment target for routine).	

000164

BAF Risk

1.2

Children and young people waiting beyond the national standard to access planned care and urgent care
(4x5=20)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal.	1.1 & 2.1
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.1
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	1.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.1

000165

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
2643	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.1 & 1.4
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

000166

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
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2
2741	The ability to maintain OFSTED ratio's as a result of staff availability/turnover Health and Safety concerns operating the nursery in its current position in the centre of a building development	
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	1.1
2755	There would be risk of delivery of high quality services for Children and Young People. Due to lack of sustainable workforce plans and associated investment (Surgery)	1.1
2684	the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants.	1.1
2767	There is a risk that the Safeguarding Team will be unable to provide a service for children/young people and/or staff in the hospital	1.1
1524	Delayed initiation and review of ADHD medication (due to lack of capacity within the service)	1.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	1.1

000167

BAF Risk

2.2 Employee Wellbeing

(3x3=9)

Strategic Aim

Related Corporate Risk(s)

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

BAF Risk

2.3 Workforce Equality, Diversity & Inclusion

(3x5=15)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000168

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
2754	The Surgical division currently does not have a sustainable financial plan and is currently forecasting a year end deficit position.	
2295	Current Occupational Therapy service for complex 0-2 children in Liverpool community is non recurrent funding, funding from CCG is due to finish on 31/3/23.	1.1

000169

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.	

000170

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, 2383, 2597, 2100, 2654, 2332, 2632, 2450, 2463, 2627, 2516, 2327, 2517, 2196, 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
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	28/02/2023	Review ongoing
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2023	The sepsis leads have presented an updated position and action plan to SQAC giving increased levels of assurance. This will continue to be monitored through the reporting on the IPR and quarterly reports to SQAC

Executive Leads Assessment

February 2023 - Pauline Brown
This risk has been reviewed and was updated last month. Work continues to mitigate the gaps in controls and is monitored through SQAC and Patient Safety Board.

December 2022 - Nathan Askew
This risk has been updated based on feedback from SQAC and now should be aligned. Controls remain in place and progress has continued in relation to gaps in control, notably in increasing compliance with ABx administration

Board Assurance Framework 2022-23

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
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

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, 1902, 2501, 2501, 2463, 2517		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

There remains a backlog of patients waiting for planned care, particularly in a small number of specialties with particular challenges related to their recovery of capacity and/or high demand. In addition, unprecedented demand for urgent care has increased the wait for clinical assessment and reduced the percentage of patients treated within 4 hours. These factors combine to create a risk that waiting times for elective and urgent care will exceed national standards, with potential detriment to experience and outcomes for Children, Young People and their families

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

Gaps in Controls / Assurance

1. Reduce to zero the number of C&YP waiting over 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

Board Assurance Framework 2022-23

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 STREAMING - Hub 2, increase GP presence (x4 per day) and open Urgent Treatment Centre (from 30 Jan) - complete EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	31/03/2023	Streaming improvements include Hub 2 and opening Urgent Treatment Centre from 30 Jan
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	28/02/2023	Clinical activity commenced as planned on 28th January. Trajcetory to be updated with increased activity

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.

February 2023 - Andrew Mccoll
For Urgent Care enhanced streaming is now in place with Hub 2 and opening new Urgent Treatment Centre from 30 Jan.

Access for scheduled care remains challenged with Industrial Action and providing Mutual Aid (to RMCH) slowing the rate of improvement

January 2023 - Adam Bateman
Over 1,800 C&YP were treated in December 2022 relative to December 2019. This level of demand is unprecedented and the proportion of patients treated within 4 hrs decreased. In response we mobilised acute respiratory infection clinics in collaboration with primary care. We opened an additional ED are for low acuity patients, and updated the symptom checker to include advice for families on Strep A (with c. 70,000 views in December).

In elective care we faced the headwinds of industrial action which reduced the number of patients we treated, and less additional activity is being undertaken as we negotiate the levels of pay for medical staff undertaking additional duties. The number of long wait patients is now plateaued, rather than reducing. Recovery (as measured by the number of patients treated) for outpatients was strong at 112%, with elective care reduced to 98%.

In order to support the elective recovery programme we have changed the rate of pay for additional work (although the effect of this on uptake is unclear as yet) and invested in agency staff in theatres.

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

February 2023 - Graeme Dixon
The SPV board members have agreed to provide a report on the corroded pipework and the associated cold water temperatures. GD has chased (1/2/23) with the SPV general manager and was informed they are being reviewed. GD continues to meet weekly with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding. The chiller works continue and we await a date for the removal of the temporary ones. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement and details of the proposal have been received and shared with relevant stakeholders for review. The next liaison committee is set for the 16th March.

January 2023 - Graeme Dixon
Weekly meetings with the SPV, LOR & Mitie continue to discuss historical and newly identified risks, although 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 now being removed mid-January to ensure resilience over the festive period. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipe work 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. P Co/Mitie are seeking a standstill agreement and details of the proposal are awaited.

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.

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
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	28/02/2023	Meeting held with airelogic and Alder Hey staff to review current position of the ROMS app. Next steps agreed with all stakeholders to progress this and move to a wider testing phase. Further meeting again on 14th February and enquiry underway re provisional go live date
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

February 2023 - Lisa Cooper
Risk reviewed and update below:

Job description review this is progressing well and on course for target date

ROMs app progressing well but some delays so date extended to end February 2023.

All controls remain the same and in place for this month.

January 2023 - Lisa Cooper
Risk reviewed and action relating to waiting lists and validation completed

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

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, 2528, 2535, 2450, 2516, 2517, 2196, 2312, 2741, 2624, 2719		
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	28/02/2023	as above
3. Development of a methodology to roll-out across the organisation.	30/04/2023	Project plan on track
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

Board Assurance Framework 2022-23

Executive Leads Assessment
February 2023 - Melissa Swindell risk reviewed, actions on track. remains high at 15
January 2023 - Sharon Owen Risk reviewed and action remain on track - risk score remains high
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.

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	
Drop in support sessions offered to ED staff during high pressure times to help to manage rising levels of moral distress and burnout	
Staff support plan for all staff to manage social and emotional impacts of strike action. Plan reviewed and communicated as part of tactical command and developed in consultation with nursing community and local strike committee	

Gaps in Controls / Assurance

Board Assurance Framework 2022-23

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	28/02/2023	SALS booth ordered. Awaiting delivery. No further update re staff container space. Will seek update at next HWB Steering group.
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.	28/02/2023	Discussion with finance confirming that business case to be considered as part of annual planning process to be concluded end March 2023. Meeting arranged to set budget with finance and to review any non-recurrent monies available to add additional temporary capacity into SALS in the short term
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	28/02/2023	Debrief guide still in draft form. To be further developed and finalised by end Feb. Guide to be aligned with guidance also developed by Emergency Preparedness and Response lead via a meeting with him in January.

Executive Leads Assessment

January 2023 - Jo Potier
Risk reviewed and actions updated to reflect December activity. No change to risk rating.

December 2022 - Jo Potier
Risk reviewed and new controls added to reflect increased support to staff during industrial action and increased support to ED during additional significant pressures. Actions reviewed and updated. No change to risk rating.

November 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: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
	31/03/2023	task and finish group have met once to discuss

Executive Leads Assessment

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

February 2023 - Melissa Swindell
actions updated and risks reviewed. no change to risk rating

January 2023 - Melissa Swindell
Actions closed and risk 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: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Create a plan to fix drainage from Phase 1/Agree plan for Phase 2/3	28/02/2023	Awaiting Laboratory results on soil samples
Set up Joint Planning meeting with community	31/03/2023	Team appointing a community liaison officer.

Executive Leads Assessment

February 2023 - Richie Harkness
Decommission of (old) Catkin is now complete and the site is being handed over to Beech (demolition contractor) this week. A programme has been issued from the contractor, detailing a timeline for demolition of Catkin and Sub 5, and construction of swales, which will enable the ongoing remediation of land (known as phase 3 of the park) as per the agreement with LCC.

January 2023 - David Powell
End of Year Review

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

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)
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly). Partnership update & refresh of North West Paediatric Partnership Board schedule and arrangements undertaken Feb 22 Sept 22 - NWPPB Chairs Report to Trust Board attached
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019 2030 Vision development underway with Trust Board - will succeed Our Plan once approved in early 23/24
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Implementation of the 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH confirmed.	Inaugural HC&F meeting held 24.1.23 - pack attached
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities.
C&M "Beyond" Children's Transformation Programme - AH host and lead for C&M	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed. 27.1.22 - Presentation of Beyond programme to HCP Programme Board. ICS CEO in attendance. Programme progress accepted. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached Nov 22 - Presentation to ICB Chair (Children's Champion) at St Helens Town Hall; supported to cement further the CYP governance at ICB level - proposal under development Dec 22 - Beyond presented to Alder Hey Trust Board
2030 Vision: Alder Hey strategy refresh - Q4 21/22 - alignment with system	-Trust Board Strategy / 2030 Vision session scheduled Jan 22

objectives and trust ambitions	- Refreshed Draft 2030 Vision (to be attached following Jan Board session) - Final 2030 Vision & objectives to Trust Board for sign off Feb 22 - Trust Board Strategy session Feb 22 confirmed direction for 2030 vision, CYP @ heart and 5 core integrated strategic objectives - aligned with system priorities e.g. Health inequalities and prevention - Pop Health plan developed in conjunction with Strasys to inform 2030 vision - working group established. Initial Exec session 21st April, Trust Board session 28th April - Completed Sessions underscehduling with NEDs, Governors and Working Group during May - May 22 Informal Governors Vision 2030 / Strasys session completed (attached) - May 22 Trust Board Strategy Session Vision 2030 / Strasys & futures strategies completed - June 22 Trust Board strategy session / Vision 2030 strasys session completed. - Sept 22 - Trust Board approved strategy overview / baseline paper - agreed next steps to begin wider engagement (see attached evidence) - Jan 23 - 2030 Vision update paper to Trust Board, and Trust Board Strategy session (update & Futures) - Jan 23 - Council of Governors strategy session (full overview) - Jan & Feb 23 - Divisional Strategy 'tester' sessions - Surgery, MH & Community, Medicine - all completed to date. Excellent feedback, iterating.
Growing Great Partnerships - Quarterly Trust Board assurance report	- June 22 - Sept 22 - Jan 23

Gaps in Controls / Assurance

1. Inability to recruit to highly specialist roles due to skill shortages nationally.
2. Full completion of 2030 Vision and delivery plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	Action updated as above 4/11/22
6.Develop Operational and Business Model to support International and Private Patients	30/06/2023	Incorporated into Futures 2030 development plans
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/06/2023	Incorporated into 2030 People Plan developments

Executive Leads Assessment

February 2023 - Dani Jones
Risk reviewed, no change to score in month. Evidence, actions and controls reviewed and updated.

January 2023 - Dani Jones
Risk reviewed; no change to score in month. Key progress in Vision 2030 development and C&M CYP / Beyond. Controls, actions and evidence reviewed.

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.

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 SDG for the relevant transformation schemes
RABD deep dive into any areas or departments that are off track with regards to performance and high financial risk area	RABD Agendas, Reports & Minutes
Financial Review Panel Meetings	Any area/division that is off plan is expected to attend a financial review panel meeting with DDOF with action plan detailing mitigation to bring back into budget.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/03/2023	This work is now included as part of the optimisation work underway and originally expected Dec but due to issues outside of our control, now expected February. Annual planning and budget setting is due to be complete end of January and this will include a full bridge and detail of WTE/Activity and £ to inform the overall trust plan.
2. Five Year capital plan	31/03/2023	Awaiting confirmation of CDEL for 23/24 and 24/25 following release of national planning guidance. Capital planning underway as part of Trust 23/24 annual planning process. Capital management group to be held early feb to review requests against expected CDEL and to present to TB in Feb.
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

February 2023 - Rachel Lea
Risk reviewed, actions and controls updated. No change in risk score due to current uncertainty on the 23/24 financial plan and longer term position.

January 2023 - Rachel Lea
Risk reviewed. Updated action plans and control measures to reflect current position following release of the national planning guidance and expected completion dates.

Board Assurance Framework 2022-23

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
Beyond - C&M CYP Transformation Programme hosted at Alder Hey	ICS Programme Highlight Report Further evidence attached to BAF 3.2 Confirmation of funding for Y2 of programme received April 22 Beyond Impact Assessment submitted to ICS Feb 23
Uncertainty over System Finance planning, commissioning intentions and response to H2 (described in BAF 3.4)	See BAF 3.4 (financial environment)
Trust Board & Council of Governors - tracking of system / legislative developments, continued engagement and action planning	Presentations to Trust Board & CoG - updated July, Sept, Nov, Dec ICS Board development session complete Update to Trust Board April 22 Update to Council of Governors June 22 Update to Trust Board June 22 Update to Trust Board July 22 Update to Council of Governors Sept 22 Update to Trust Board Sept 22 Update to Trust Board Nov 22 Jan 23 Growing Great Partnerships Trust Board report incorporated HCP and ICS update
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 Future delegation of Specialist Commissioned services into ICSs - shadow arrangements under definition		
Actions required to reduce risk to target rating	**Timescale**	**Latest Progress on Actions**
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/08/2023	As previous
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/08/2023	Delegation of SpecCom services to ICS's delayed nationally. 23/24 shadow running year - arrangements in NW as yet unclear. AH represented at NW SpecCom development group through DCEO. Continued work with RMCH to shape NWPPB supporting role and through CHA to assess impact of delegation on range of specialist services.
Executive Leads Assessment		
February 2023 - Dani Jones Risk reviewed; no change to score in month. ICS arrangements still developing and delegations unclear. AH involved at all levels. Actions, evidence and controls reviewed and updated.		
January 2023 - Dani Jones Risk reviewed; no change to score in month. Developing proposal for ICB CYP Board - TBC. Controls and actions reviewed.		
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.		

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 Quarterly Board paper - Jan 23
Twice-annual ODN oversight report to RABD	May 22 Report attached Nov 22 report attached.
MIAA Audit - Partnership Governance	Audit complete - MIAA returned verdict of significant assurance. To be presented to January Audit Committee. Final report attached

Gaps in Controls / Assurance

Sign up from further partners to engage in PQAR - in development (dependent on both parties subscribing)

Executive Leads Assessment

February 2023 - Dani Jones
Risk reviewed. No change to score in month. Evidence updated, controls and actions reviewed.

January 2023 - Dani Jones
Risk reviewed; no change to score in month - but this will move based on signfiicant assurance in MIAA audit and subsequent recommendations/actions. Evidence, controls and actions updated

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

February 2023 - Claire Liddy
Reviewed FEB 23. Strategic investment action updated including timetable to March 23. Risk score no change.

January 2023 - Claire Liddy
review Jan 23. no change to risk score but note the new corporate risk of financial sustainability

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

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: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
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	03/04/2023	Recruitment of perm positions to senior management team complete. Recruitment and retention plans in progress
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

February 2023 - Kate Warriner
Risk reviewed, score remains static. Work continues regarding timing of key programmes deployments in 2023.

January 2023 - Kate Warriner
BAF reviewed. Score remains appropriate. Progress with recruitment of permanent positions within iDigital Senior Management Team. Recruitment and retention focus in place. Work ongoing regarding timing of key programmes in 2023.

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.