Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 24th November 2022, commencing at 9:00am

Lecture Theatre 4, Institute in the Park, Alder Hey

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Staff Story (9:00-9:15)							
1.	**22/23/193**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/194**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/195**	**9:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **27th of October 2022.**	**D**	Read enclosures
4.	**22/23/196**	**9:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/197**	**9:25 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**22/23/198**	**9:35 (70 mins)**	• **Integrated Performance Report for M7.** • **Finance Report – Month 7 2022/23** • **Potential Industrial Action.** • **IPC Update.** • **Staff Flu Vaccination Programme – Update.**	Exec Leads/ Divisional Leads J. Grinnell S. Owen/ A Bateman B. Larru N. Askew	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current position. To receive an update on the current position. To receive an update. To provide an update on the current position.	**A** **A** **N** **A** **A**	Read report Read report Verbal Presentation Presentation
Strategic Update							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	**22/23/199**	**10:45 (15 mins)**	**'Beyond' C&M CYP Programme – Update.**	D. Jones/ L. Crabtree	To receive an update on the current position.	**N**	Read report/ Presentation
8.	**22/23/200**	**11:00 (10 mins)**	**ICS Update.**	D. Jones	To receive an update on the development of ICSs.	**N**	Presentation
9.	**22/23/201**	**11:10 (5 mins)**	**Liverpool Clinical Services Review.**	L. Shepherd	To receive an update.	**I**	Verbal
10.	**22/23/202**	**11:15 (10 mins)**	**Alder Hey in the Park Campus Development Update; including:** • **Springfield Park update.**	D. Powell	To provide an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
11.	**22/23/203**	**11:25 (15 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
12.	**22/23/204**	**11:40 (10 mins)**	**Mortality Report, Q2.**	A. Bass	To receive the Mortality Report for Q2.	**A**	Read report
Game Changing Research and Innovation							
13.	**22/23/205**	**11:50 (10 mins)**	**University Partnership Arrangements.**	L. Shepherd/ J. Chester	For information.	**N**	Verbal
The Best People Doing Their Best Work							
14.	**22/23/206**	**12:00 (15 mins)**	**People Plan; including:** • **Staff Survey Update.** • **Equality, Diversity and Inclusion Steering Group - Annual Workplan.**	S. Owen S. Owen G. Dallas	To receive an update on the current position. To receive an update on the current position. To receive the EDISG Annual Workplan.	**A** **A** **N**	Read report Presentation Read enclosure
Lunch (12:15pm-12:35pm)							

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
Strong Foundations (Board Assurance)							
15.	**22/23/207**	**12:35 (5 mins)**	**Board Assurance Framework Report.**	J. Grinnell	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
16.	**22/23/208**	**12:40 (10 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 10.11.22.** - **Approved minutes from the meeting held on the 15.9.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 16.11.22.** - **Approved minutes from the meeting held on the 19.10.22**	K. Byrne F. Beveridge	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes
Items for information							
17.	**22/23/209**	**12:50 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
18.	**22/23/210**	**12:54 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 15th December 2022, 9:00am -12:55pm, Lecture Theatre 4, Institute in the Park, Alder Hey							

Alder Hey Children's NHS Foundation Trust

REGISTER OF TRUST SEAL
The Trust Seal was used in October
390: Ainsdale Centre for Health and Wellbeing – Hill Dickinson (Leeds)

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

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 27th October 2022 at 9:45am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Staff Story	Dr. F. Mehta	Consultant Paediatrician	(FM)
Item 22/23/172	Mr. A. Garbett	Assoc. Director of Data and Analytics	(AG)
Item 22/23/172	Ms. N. Palin	Assoc Director of Transformation	(NP)
Item 22/23/179	Mrs. K. Turner	Freedom to Speak Up Guardian	(KT)
Item 22/23/179	Ms. G. Foden	HR Manager	(GF)
Apologies	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. D. Powell	Development Director	(DP)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)

Staff Story

The Chair welcomed Consultant Paediatrician, Fulya Mehta, who had been invited to October's Trust Board to provide an update on her new role as the National Clinical Diabetes Lead for children and young adults.

A number of slides were presented to the Board which provided an overview of some of Fulya's experiences and career highlights whilst working at Alder Hey. The Board was also advised of the work that the Paediatric Diabetes team has conducted to become a positive national outlier for outcomes which has enabled the team to contribute to national work.

Attention was drawn to the challenges that the Paediatric Diabetes team has experienced in terms of recovery, connection, and workforce. It was pointed out that virtual appointments work well for some families but not all therefore work is taking place to ensure a balance for patients. The team is also looking to have a hybrid working model going forward. Fulya referred to the

issues being experienced by the service in terms of the middle grade rota and the stability in the management team, which is a problem when managers move on, and intelligence is lost.

Fulya provided an overview of her new national role and advised that the NHS Diabetes Programme and the Children and Young People's (CYP) Transformation Programme have established a new joint programme of work to support further focus on improving care and outcomes for children and young adults with diabetes. The scope covers children and young adults (CYA) with all types of diabetes up to age 25, and aligns to the NHS Long Term Plan priority to move to a 0-25 years' service model, with a focus on four key areas;

- Reducing health inequalities and variation in outcomes for children and young adults with diabetes, including more equitable access to treatment technology.
- Reducing current variation between paediatric departments.
- Improving care for those transitioning from paediatric to adult care, addressing the poorer outcomes for children and young adults with diabetes at transition age.
- Improving care and outcomes for children and young adults with Type 2 diabetes.

The Director of Medicine, Urmi Das, reported that the Paediatric Diabetes team are doing a magnificent job. They have opened clinics in the community, arranged for patients to have access to insulin pumps and given talks at prevention meetings.

The Chair thanked Fulya for sharing her story with the Board and reiterated how proud the Board is of her success in being appointed to this national role.

22/23/167 Welcome and Apologies

The Chair welcomed everyone to the meeting and noted the apologies received. Congratulations were offered to Mr. Alfie Bass on his successful appointment as the Trust's new Chief Medical Officer, and also to the Trust's Chief Digital and Information Officer, Kate Warriner, whose team were one of the finalists of the 2022 Health Tech Awards in the 'digitising patient services' category. The team received the 'Highly Commended' accolade for designing an online symptom checker to support children and families.

22/23/168 Declarations of Interest

There were none to declare.

22/23/169 Minutes of the previous meetings held on Thursday 29th September 2022
Resolved:
The minutes from the meeting held on the 29th of September were agreed as an accurate record of the meeting, pending the following amendments;

- Page 9, item 22/23/143, second and third sentence: To read '*The Board was advised that there was one avoidable death in this reporting period. There has been a considerable amount of learning from this case and how these particular cases were escalated'.*
- Page 10, item 22/23/147, third sentence: To read *'Following a successful bid from the Contain Management Outbreak Funding (COMF), funding of nearly £1m has been received for the grass roots public health work'.*

22/23/170 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 22/23/82.1: *Corporate Report (Medicine - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance)* – A further update will be provided in November. **ACTION TO REMAIN OPEN**

Action 22/23/134.1: *Integrated Performance Report, M4 (Follow up the concerns regarding the new interpreter service with the Integrated Care Board (ICB)* – The Trust has raised concerns about the new interpreter service via the ICB and as a result a monthly contract monitoring is in place. The non-fill time frame has been increased from three hours to twenty-four so that cases when an interpreter is not available can be highlighted ahead of the scheduled appointment.
ACTION CLOSED

Action 22/23/137.1: *Planned community events for Springfield Park (Follow up on the arrangements for the public meeting)* – It was confirmed that Liverpool City Council is arranging the public meeting to take place at the end of November 2022.
ACTION CLOSED

22/23/171 Chair's and CEO's Update

The Chair provided an update on the combined North West (NW) System Leaders and Chairs meeting that took place on the 25.10.22. It was reported that the NW Regional Director, Richard Barker, advised of the focus on waiting lists in the adult acute sector and staff retention, with the Centre interested in the work that trusts are conducting to retain staff. The Board was informed that further messages will filter down from the Centre now that the new Secretary of State is in office.

The Board was informed that the Liverpool Clinical Services Review is underway with a focus on two workstreams; urgent care and the issues relating to the Liverpool Women's Hospital. It was confirmed during a meeting on the 26.10.22 that a report will be available for circulation in the next two weeks.

John Grinnell advised of the recent visit to Alder Hey by the Chair of the ICB, Raj Jain. During the visit, Raj Jain reported that consideration is being given in terms of where CYP fit in the new governance structure for Integrated Care Partnerships (ICPs) and the ICB.

From an external perspective there is a lot of focus on access to care, with a number of requests having been received for mutual aid across the NW. Discussions are also taking place to look at how elective recovery can be improved across Cheshire and Merseyside (C&M), of which, it was reported that Alder Hey is well placed to support work across C&M. Nationally there is a focus on recovery and finances. The Board was informed that the Children's Hospital Alliance (CHA) is looking to advocate for CYP as it is felt that it is critical to have a national voice in terms of the plans for 2023/24.

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

22/23/172 Integrated Performance Report Overview

The Board was provided with an overview of the Integrated Performance Report (IPR), which has been produced in the new format. It was reported that the IPR has been developed using the Brilliant Basics approach and includes a significant amount of stakeholder input from across the Trust. Attention was drawn to the key changes to

the IPR and it was pointed out that the report is structured around the CQC Domains and aligns to the 5 Priorities in the 2022/23 Annual Plan. A number of slides were presented to the Board to provide an orientation on the navigation of the report.

The Chair felt that great progress has been made and acknowledged the contributions of Alex Garbett and Andy McColl in producing the IPR. The Chair asked Alex Garbett to attend the informal governors meeting on the 16.11.22 to share his presentation on navigating the new report, ahead of the governors receiving the IPR in December.

22/23/172.1 Action: AG

Kerry Byrne felt that it would be beneficial to incorporate illustrations into the report to provide examples of the different outcomes.

Resolved:
The Board noted the content of the IPR Overview Report and supported the use of the new IPR.

Integrated Performance Report for M6 and Q2 stocktake

The Board was provided with a summary of the performance metrics incorporated in the IPR, with attention being drawn to aspects of performance that aren't achieving target, including ED performance and overall sickness metrics. Access and staff turnover metrics are not achieving target and have a declining trend.

Performance metrics achieving target and making improvements relate to infection control, cancer, mandatory training, and the overall financial position.

An update was provided on the following areas of the IPR:

- *Outstanding Safety - Safe;*
  - Infection Prevention Control metrics are compliant.
  - There has been an improvement in the 60-minute target for the management of sepsis on in-patient wards as a result of the improvement work that is being conducted.
  - There were four incidents in August/September that were StEIS reportable. It was confirmed that all statutory regulations were met, and investigations have commenced. In terms of a forward look, work is taking place to ensure the timely investigation and conclusions of the four new RCA investigations within sixty working days.
- *Outstanding Safety - Caring;*
  - There has been a sustained improvement in responding to informal PALS concerns within five working days in Q2, but it was pointed out that some of the Business Support services who receive PALS concerns are not responding in a timely manner. Targeted work is in place to assist these services to address concerns and the Patient Experience Group is looking at how it can obtain more feedback from CYP and families.
- *Recovery and Access – Effective;*
  - ED performance against the four-hour target remains challenged. The Board was advised of the stream that is to be implemented from December for low acuity patients which it is felt will create a step change in terms of ED performance.
  - The completion of clinic letters is significantly below the 95% target. It was confirmed that the Divisions are focussing on this issue in order to reduce the backlog/longest times.

- Virtual outpatient appointments have reduced below the target in part due to reducing outpatient follow-up appointments in place of face-to-face appointments for new patients. An in-depth analysis of this matter will be conducted by the Divisions.
- It was reported that five specialities are piloting the AI Was Not Brought predictor tool. An evaluation will take place following completion of the pilot.

- *Recovery and Access – Responsiveness;*
  - Compliance with national cancer standards throughout Q2 is at 100%.
  - Recovery, as measured in volume, was reduced to 97% in September with the additional bank holiday for the State Funeral reducing activity by 4%. It was pointed out that recovery remains strong when measured by the number of patients treated (over 104%) but applying the value in terms of specialities reduces the overall figure for recovery (99.2%).
  - The number of patients waiting over 52 weeks for treatment has increased due to access challenges in Paediatric Dental. From a regional perspective, NHS England has asked the Trust to provide mutual aid to the Royal Manchester Children's Hospital (RMCH) to help reduce the number of patients waiting 52 weeks for treatment.
  - It was reported that Diagnostics had an improved performance of 70% during this reporting period and are looking to achieve 99% by March 2023.

Kerry Byrne queried as to whether there is a conflict between the recovery funding being based on the financial value of treatment performed versus the number of treatments performed and asked as to how assurance can be provided that clinicians are taking the right decisions for CYP rather than for financial reasons.

The Board was advised that the Trust is trying to balance volume and value but in order to achieve 104% recovery organisations have to attain 107% performance which is a difficult target to accomplish. It is felt that the solution to address the issue is to increase activity therefore a plan has been tailored based on speciality, target, and value but decisions have to be made about further investment to ensure the Trust has the resources to progress this plan.

John Grinnell (JG) felt that it would be beneficial to illustrate the design/process of the system that manages clinical need and recovery in order to provide assurance to the Board. Attention was also drawn to the increase in the Trust's waiting list and the importance of demonstrating Alder Hey's productivity. In terms of a NW solution to address waiting lists JG felt that a collaborative approach should be taken.

Fiona Beveridge queried as to whether the Trust is continuing to improve the waiting list and safe waiting list management. It was confirmed that improvement work is taking place on follow ups/follow up waiting list and a recommendation has been made about changing the way in which the Trust categorises clinical risk.

- *Great Place to Work – Well Led/People;*
  - The Trust's turnover remains high with an in-month position of 14%. This figure is lower than the national position but is a real concern. There is an increased focus on turnover and retention initiatives, and the organisation is looking to compile data that will provide an understanding at departmental level as to why staff are leaving. Work is also taking place to acquire feedback from staff via a more rounded listening approach with the outcome to be submitted to the Executive Team.
- *Well Led - Financial Sustainability (M6);*
  - The Trust is reporting a deficit of £0.2m which is in line with plan.

- It was reported that there is a challenging year end £4.6m control total surplus with only 30% of CIP identified as recurrent, and £9m to be identified and delivered in the remaining six months. In year, a £1m gap remains to achieve the CIP target in full assuming schemes in progress deliver as planned.
- From a forecast perspective, mitigations are being implemented to address the challenges on cost control and there is an element of ERF funding expected in Q3/Q4 that has not been included in the Trust's forecast due to the uncertainty on clawback.

- *Well Led - Risk Management*;
  - There are two new metrics under review at the present time; number of high risks scored at 15 and above and percentage of high risks within review date.
- *Well Led – Safe Digital Systems;*
  - The Trust continues to make progress with the revised go live plans for AlderC@re.
  - Progress is being assessed via patient journey demonstrations during October.
  - It has been confirmed that the AlderC@re simulation suite will be located on the mezzanine floor in the Atrium of Alder Hey.
  - It was reported that there are still a number of risks to the project which are being managed via the Programme Board.

Divisional Performance

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

Community and Mental Health

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

Medicine

- It was reported that NICE guideline training is available to clinicians and staff.
- Radiology achieved 100% performance in this reporting period, but diagnostics are still experiencing challenges.
- Two new Haematology Consultants have been appointed who advised that they wished to work at Alder Hey because of the outstanding care that patients receive at the Trust.

Surgery

- It was reported that governance has improved within the Division.

Research

- Following a discussion on the reporting of metrics for the Research Division it was agreed to look at the possibility of having a quarterly update to make the information more meaningful.

22/23/172.2 Action: JC/KW

Corporate

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

Kerry Byrne asked for additional information to be included in the summary page of the IPR on key projects and how the Trust is addressing them.

22/23/172.3 Action: JG

The Chair felt that the new IPR is providing material for a richer conversation, transforming the way the Board looks at information and highlights some of the key issues that require focus.

Resolved:
The Board received and noted the content of the new IPR for Month 6.

Transformation Programme Governance Report

The Board was offered assurance around the adherence to the programme management standards; for programmes designated as strategically important as part of the 2022/23 Operational Plan.

It was reported that 86% of the programmes have been rated as green for the adherence to the governance standards and all programmes are currently rated as amber for delivery assurance. There is to be a review of milestones during Q3 to ensure clarity between a deadline/milestone and to provide further assurance around delivery achievability. It was confirmed that there are no risks for escalation following the completion of the assurance assessment.

Resolved:
The Board received and noted the content of the Transformation Programme Governance Report

Digital, Data and Information Technology update

The Board received an update on progress against the Digital and Data Futures Strategy in terms of the overall service, key areas of transformation and operational performance. The following points were highlighted:

- There are two Digital Strategies out for consultation *(Integrated Care System and Liverpool Place)* that Alder Hey have actively contributed to.
- A new Chief Digital Officer, John Lewellyn, has been appointed to sit on the C&M ICB.
- Digital staff, service development and engagement have been key areas of development and success, which has been evidenced through the service being successfully awarded the Level 3 accreditation for Excellence in Informatics as part of the Skills Development Network professional framework. This is the highest level that can be attained and Alder Hey is only the second organisation to receive this award in the NW.
- There are a number of new programmes in the development stage as a result of the Digital and Data Futures Strategy.
- Digital Dewi Jones went live in September with height, weight, allergies, and observations all being regularly updated on Meditech. Electronic prescribing is safely being used and the bedside medication verification processes followed. Feedback from the team has been really positive and they are keen to continue on their digital journey.

Resolved:
The Board received the Digital, Data and Information Technology update and noted the progress.

New NHS England Operating Framework

The Board was advised that NHS England (NHSE) published a new Operating Framework on the 12.10.22 which sets out how the NHS will operate in the new structure that was created by the 2022 Health and Care Act.

The new operating framework sets out the roles that NHS England, ICSs and providers will play in the new structure. It describes a way of working together and shows how accountabilities and responsibilities will work.

Resolved:
The Board noted the update on the publication of the new NHSE Operating Framework.

22/23/173 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:

- *New Catkin Centre* - It was reported that staff have commenced to move into the new Catkin Centre as of the 27.10.22.
- *Sunflower House* – The Trust is continuing to work with the contractor to address the issues relating to the finishes in the building.
- *Liverpool Innovation Park (Phase 2)* – Staff are scheduled to move into Liverpool Innovation Park in November 2022.
- *Community Events* – Community sessions are scheduled to take place on the 5.11.22 and the 19.11.22 to discuss a variety of subjects and receive feedback. Contact has been made with Liverpool City Council to request their attendance.

Resolved
The Board received and noted the Campus Development update provided on the 27.10.22.

22/23/174 Serious Incident 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 1st of September to the 30th of September 2022. The following points were highlighted:

- The Trust declared one Never Event and four StEIS reportable incidents that met the SI criteria during the reporting timeframe. All incidents have been reported to commissioners.
- The Board was advised of the issues that have been experienced in respect to a longstanding RCA (Incident ID: 2021/24660). It was confirmed that a final review of the RCA report is to be conducted on the 1.11.22.

Safe Staffing and Patient Quality Indicator Report

The following key points were raised:

- It was reported that Care Hours per Patient Day (CHPPD) are mostly equal to or above the national average for wards and departments, with the exception of ICU and HDU. It was pointed out that it is unusual to have a

dedicated HDU for paediatrics and therefore national benchmarking is difficult. It was confirmed that overall critical care is in line with expectations, given the high levels of ECMO patients.

- There has been a significant increase in red and amber staffing ratings in September. To address this the Trust has approved the winter incentive temporary staffing rates which will be live from the 31.10.22.

Resolved:
The Board received the Serious Incident report for the period from the 1.9.22-30.9.22 and the Safe Staffing and Patient Quality Indicator Report.

22/23/175 Safeguarding our Children, Young People and Families Against Failings in Care

The Board was advised that following the BBC panorama investigation in October 2022, into the abuse of patients in the care of another NHS trust, the Executive Team considered it prudent to seek assurance that safeguards are in place to prevent a similar situation occurring at Alder Hey.

The Trust conducted a review which confirmed that there are robust systems and processes in place to safeguard CYP and families whilst in Alder Hey's care. It was reported that there are areas for improvement that will be captured in an action plan.

It was noted that in contrast to adult services most of Alder Hey's patients who receive care in the acute setting have a resident parent/carer to advocate on their behalf which provides an additional level of assurance in protecting them against failings in care. It was confirmed that the Tier 4 unit is compliant with requirements to advocate for and safeguard CYP during their admission.

The Chair felt that recruiting staff who have values that align to the NHS and care of CYP is fundamental and felt assured that the Trust has systems and processes in place to safeguard CYP in the care of the Trust.

Resolved:
The Board received and noted the content of the report on Safeguarding our Children, Young People and Families Against Failings in Care.

22/23/176 Research and Innovation Committee (R&I) - Terms of Reference (ToR).

The Board received the ToR for the R&I Committee for approval purposes. An overview of the organisation's long-term goal to re-establish the R&I Committee was provided along with the contents of the document. The following feedback was offered by Board members;

- *Membership* – Rachel Lea pointed out that the R&I Committee will be making financial decisions that would previously have been addressed at RABD therefore it was queried as to whether the membership should be expanded to ensure appropriate financial oversight.
- *Alignment to RABD TOR* – Rachel Lea asked that the TOR for RABD be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.

22/23/176.1 Action: RL

- Nathan Askew requested that further clarity on the structure, role, and purpose of the Advisory and Management Board be provided in the R&I ToR.

22/23/176.2 Action: JC

Resolved:
The Board approved the ToR for the R&I Committee, but it was pointed out that it is the responsibility of the R&I Committee to ratify the ToR for the Sub-Committees/working groups that report to the R&I Committee.

22/23/177 Sefton Place Partnership Agreement

This Board was updated on the development of the Sefton 'Place' collaborative arrangements and received a copy of the Sefton Place Collaboration Agreement. It was reported that Alder Hey have long been a committed partner in Sefton, providing a significant range of services in the patch and has subscribed to previous iterations of collaborative agreements.

The 'Place' collaboration agreement has been iterated to take account of the new system architecture, in line with the implementation of Integrated Care Systems, and represents arrangements for Sefton as a 'Place' building on the existing integrated governance structures already in situ in Sefton.

Attention was drawn to the benefits of working collaboratively in Sefton and if was recommended that the Trust sign up as a partner to the Sefton Place Collaboration Agreement.

Lisa Cooper drew attention to some of the text in the agreement that requires amending; the word 'hospital' needs to be removed throughout the agreement to reflect the Trust's correct name, and it was also pointed out that not all mental health services are delivered by Mersey Care.

Resolved:
The Board agreed to sign up as a partner to the Sefton Place Collaboration Agreement.

22/23/178 Workforce Disability Equality Standard (WDES) Report

The Board received the WDES report for 2022 which is due to be published on the Trust's website on the 31.10.22. It was reported that the Trust has seen an improvement in two of the nine metrics. However, of the other metrics, five have seen a decline in performance, as highlighted in the report. It was pointed out that there is a lot of work to do to ensure staff with a disability have a better experience at Alder Hey. Active engagement of disabled staff has commenced with a series of listening events held in 2021/22, and the launch of the new disability staff network in the autumn of 2022 aims to work with staff and acknowledge their feedback in order to create and embed positive change. The action plan to address this area of work will be overseen by the Equality, Diversity and Inclusion Steering Group (EDISG).

The Chair of the EDISG highlighted the importance of ensuring that the Trust continues to have a focus on people and a culture where it engages with staff so that reasonable adjustments can be implemented to assist staff to do their job. It was reported that the author of the WRES has offered assistance to Alder Hey in terms of sharing their organisation's best practice with the Trust.

Workforce Race Equality Standard (WRES) Report

The Board received the WRES report for 2022 which is due to be published on the Trust's website on the 31.10.22. It was reported that there has been an improvement in seven of the nine metrics, as highlighted in the report.

The Chair referred to the WDES report and acknowledged that the Trust has a number of challenges that it needs to address. Attention was drawn to the importance of prioritising this work in terms of taking it forward/supporting the EDISG so that the Trust doesn't lose momentum and continues to build on the good work that has taken place.

Resolved:
The Board received and noted the 2022 WDES/WRES Report.

22/23/179 Freedom to Speak Up (FTSU) Update

The Board received a summary of the activities of the FTSU team in Q1/Q2 and an outline of the actions planned for the coming six to twelve-month period. The following points were raised:

- It was reported that there were 8 cases for Q1 and 18 cases for Q2 that were submitted to the NGO for Q4 of 2021/22. Of these cases, there were 6 closed in Q1 and 3 closed in Q2. It was noted that 8 of those cases remaining open are part of a collective concern, but all have approached the Freedom to Speak Up Guardian (FTSUG) independently of each other. Of the total cases raised in Q1/Q2, 4 were done so anonymously.
- The Board was advised that feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again.
- An overview of a recent lessons learnt case study was shared with the Board with attention drawn to the model and activities that were taken to reach a successful outcome. In terms of next steps, it has been agreed to;
    - Adopt the new national Speaking Up policy which has recently been approved by the People and Wellbeing Committee.
    - Develop a toolkit, within which clarity and expectation is detailed, as well as tools and techniques.
    - Produce a monitoring product to enable quarterly and annual activity.
- It was reported that a 'brainstorming session' took place to evaluate the sustainability and capacity of the FTSU service. As a result of this, it was felt that a Deputy FTSUG position was required, in recognition of the limitations placed on the FTSU Champions due to the NGO recommendations and the increase in activity. This role will also provide additional resilience to the team and reduce key person risk on the FTSUG. The Board was asked to review the current time provided to the FTSUG and consider as to whether this time could be increased. Following discussion, it was agreed to review this matter and compile a plan for moving forward.

22/23/179.1 Action: ES/KB/KT

- The Board was advised that take up of the 'Speak Up, Listen Up, Follow-up' training by staff remains low and it was queried as to whether consideration would be given to mandating the Speak Up module so that assurance can be provided about staff awareness of FTSU. Mark Flannagan advised of the launch of the Trust's new intranet and suggested using this as a route to promote FTSU.

Nathan Askew felt that there is benefit for staff in being able to raise issues via a number of different routes and thanked Kerry Turner for her service to enable this to happen. The Chair also thanked Kerry Turner for her leadership and valuable work.

Resolved:
The Board received and noted Freedom to Speak Up (FTSU) Quarterly Progress

22/23/180 Freedom to Speak Up (FTSU) Self-Review Tool for NHS Trusts and Foundation Trusts – Half year Update Report

The Board received the FTSU Board Self-Review Tool half year update in order to reflect on the organisation's current position and the improvement needed to meet the expectations of NHS England, NHS Improvement, and the National Guardian's Office. It was reported that there are few actions outstanding and that the Trust is comparable with the best organisations.

The Non-Executive Directors (NEDs) of the Board felt that it would be beneficial to have a 360-degree appraisal that can be shared with partners to seek feedback on NED performance.

Resolved:
The Board received and noted the Freedom to Speak Up (FTSU) Self-Review Tool for NHS Trusts and Foundation Trusts – Half year Update Report

22/23/181 Financial Update, M6

- The Trust reported an in-month trading deficit of £0.2m with a YTD deficit of £1.5m which is in line with the deficit plan profiled to deliver a surplus position from month 7. The Trust has achieved an in-month CIP of £1.2m against a plan of £1.2m, and cash at the end of September 2022 is £83.5m.
- It was reported that an external bid has been submitted for Central PDC funding towards the Paediatric Elective Hub scheme. Additional bids have also been submitted for AlderC@re and an Eating Disorders Day-case unit. Decisions on these allocations are pending.

Resolved:
The Board noted the financial update for Month 6.

22/23/182 Board Assurance Framework Report

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

- The Board was advised that all risks on the BAF have been scrutinised in month by the respective Assurance Committees.
- It was reported that the Safety and Quality Assurance Committee (SQAC) received assurance via a deep dive into BAF Risk 1.1 *(Inability to deliver safe and high-quality services),* and a deep dive was conducted during September's Risk Management Forum (RMF) into BAF Risk 4.1 (*Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People)* which was well received.
- A request was made for the risk rating of BAF Risk 1.2 (*Children and young people waiting beyond the national standard to access planned care and urgent care)* to be reviewed owing to the large number of factors that is making access to planned care and urgent care very challenging.

22/23/182.1 Action: AB/RABD/SQAC

- Attention was drawn to the wording 'static' in the monthly trend on page 4 of the BAF and it was queried as to whether this element of the report could be presented in a more dynamic way. It was pointed out that the risks in the BAF are strategic and as a result of this there is a tendency for them to remain static. Erica Saunders agreed to look into this matter.

22/23/182.2 Action: ES

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

22/23/183 Board Assurance Committees

RABD – The approved minutes from the meeting held on the 26.9.22 were submitted to the Board for information and assurance purposes. During the meeting on the 24.10.22 there was a focus on the challenges being experienced around activity in the Division of Surgery and the delivery of CIP which the Committee is monitoring closely.

SQAC – The approved minutes from the meeting held on the 20.9.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 19.10.22 the Committee received the Ockenden Action Plan which provided assurance. A positive discussion took place on sepsis.

Innovation Committee – The approved minutes from the meeting held on the 8.8.22 were submitted to the Board for information purposes. It was reported that progress is being made on the Innovation Strategy and the commercialisation of activities.

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

22/23/184 Any Other Business

There was none to discuss.

22/23/185 Review of the Meeting

The Chair felt that robust discussions had taken place on the metrics in the IPR and thanked everyone for the work that has been conducted to produce the reports for October's Board.

Board members were asked as to whether the Board had demonstrated the Trust's values and put CYP at the centre of discussion during the meeting. It was felt that CYP were at the centre of the Board's discussions, but it was pointed out that there is more to be done. It was suggested that a black member of staff be invited to present to the Board during 'Black History Month'.

22/23/185.1 Action: KMC

Date and Time of Next Meeting: Thursday the 24th November 2022 at 9:00am

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 November 2022							
30.6.22	22/23/82.1	Corporate Report	*Medicine* - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance.	U. Das	28.7.22	Nov-22	**28.7.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during September's Trust Board. **29.9.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during October's Trust Board. **27.10.22** - A further update will be provided in November. **ACTION TO REMAIN OPEN**
27.10.22	22/23/172.2	Integrated Performance Report Overview	Following a discussion on the reporting of metrics for the Research Division it was agreed to look at the possibility of having a quarterly update to make the information more meaningful.	J. Chester/ K. Warriner	24.11.22	Nov-22	
27.10.22	22/23/172.3	Integrated Performance Report Overview	Additional information to be included in the summary page of the IPR on key projects and how the Trust is addressing them.	J. Grinnell/ K. Warriner	24.11.22	Nov-22	
Actions for December 2022							
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	On track Dec-22	
27.10.22	22/23/182.1	Board Assurance Framework Report	SQAC and RABD to review the risk rating of BAF Risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care*) owing to the large number of factors that is making access to planned care and urgent care very challenging.	A. Bateman	15.12.22	On track Dec-22	
27.10.22	22/23/182.2	Board Assurance Framework Report	Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way.	E. Saunders	15.12.22	On track Dec-22	
Actions for January 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	On track Jan-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							

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

Alder Hey Children's NHS
NHS Foundation Trust

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
28.7.22	22/23/111.1	Equality, Diversity and Inclusion Steering Group (EDISG) Update	Submit a workplan in October for the EDISG along with a highlight report following future meetings.	M. Swindell/ G. Dallas	27.10.22	Closed	**20.10.22** - The EDISG workplan will be submitted to the Board in November 2022. **18.11.22** - This EDISG workplan has been included on November's agenda. **ACTION CLOSED**
29.9.22	22/23/134.1	Integrated Performance Report, M4	Listening Session' to be arranged to enable a specific patient story to be shared with Board members.	L. Cooper/ K. McKeown	Nov-22	Closed	**18.11.22** - a 'Listening Session' has been arranged for the 15.12.22 following December's Trust Board. **ACTION CLOSED**
29.9.22	22/23/134.2	Integrated Performance Report, M4	Follow up the concerns regarding the new interpreter service with the ICB.	N. Askew	27.10.22	Closed	**27.10.22** - The Trust has raised concerns about the new interpreter service via the ICB and as a result a monthly contract monitoring is in place. The non-fill time frame has been increased from three hours to twenty-four so that cases when an interpreter is not available can be highlighted ahead of the scheduled appointment. **ACTION CLOSED**
29.9.22	22/23/137.1	Alder Hey in the Park Campus Development Update	*Planned community events for Springfield Park* - Follow up on the arrangements for the public meeting.	J. Grinnell	27.10.22	Closed	**27.10.22** - It was confirmed that Liverpool City Council is arranging the public meeting to take place at the end of November 2022. **ACTION CLOSED**
27.10.22	22/23/172.1	Integrated Performance Report Overview	Alex Garbett to attend the informal governors meeting on the 16.11.22 to share his presentation on navigating the new report, ahead of the governors receiving the IPR in December.	K. McKeown	16.11.22	Closed	**18.11.22** - This action has been completed. **ACTION CLOSED**
27.10.22	22/23/176.2	Research and Innovation Committee Terms of Reference	Further clarity on the structure, role and purpose of the Advisory and Management Board to be provided in the R&I ToR .	J. Chester	24.11.22	Closed	**18.11.22** - This action is in the process of being addressed. **ACTION CLOSED**

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NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: November 2022

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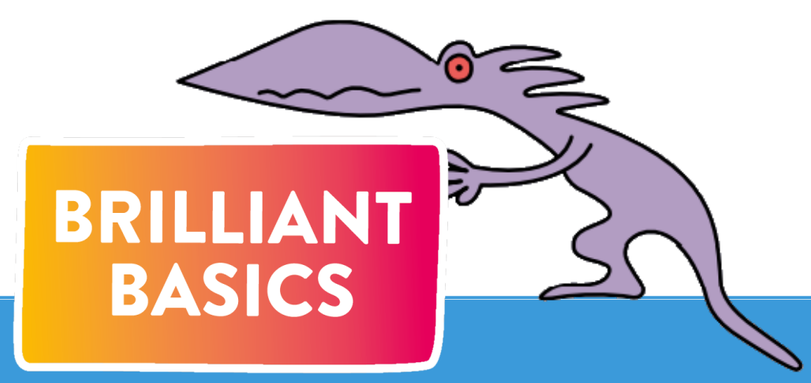


Icon Definitions

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

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

XmR chart

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

Process limits

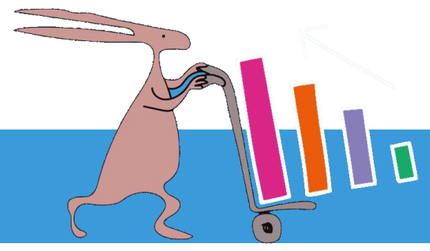
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

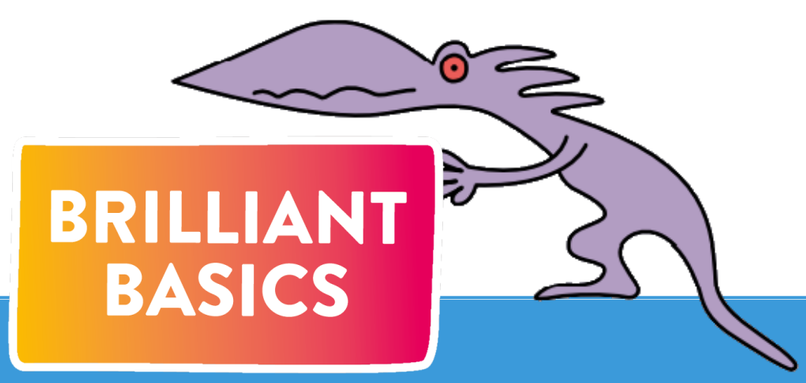
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Infection Control metrics demonstrate performance is consistently achieving target with an improving trend		PDR, PALS Complaint Management, Outpatient Activity Volume and Recurrent CIP metrics are not achieving targets but demonstrating improvement
	Common Cause	Cancer, Mandatory Training 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 Diagnostics are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern		Virtual Adoption metrics within Outpatients inconsistently achieving target with a declining trend	Access & Staff Turnover metrics are not achieving targets with a declining trend

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

- 16.6% of our metrics are consistently achieving target
- 54.9% of our metrics are inconsistently achieving target
- 28.5% of our metrics are not achieving target, 4 metrics are demonstrating special cause improvement

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



Integrated Performance Report | November 2022

Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe

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

Highlights:

• No major or serious harm incidents reported • Culture of high reporting associated with low or no harm • No hospital acquired MRSA, MSSA or C.Diff infections reported • Patients receiving antibiotics within 60 minutes for management of sepsis in in-patient wards is above target and if sustained will indicate an underlying improvement

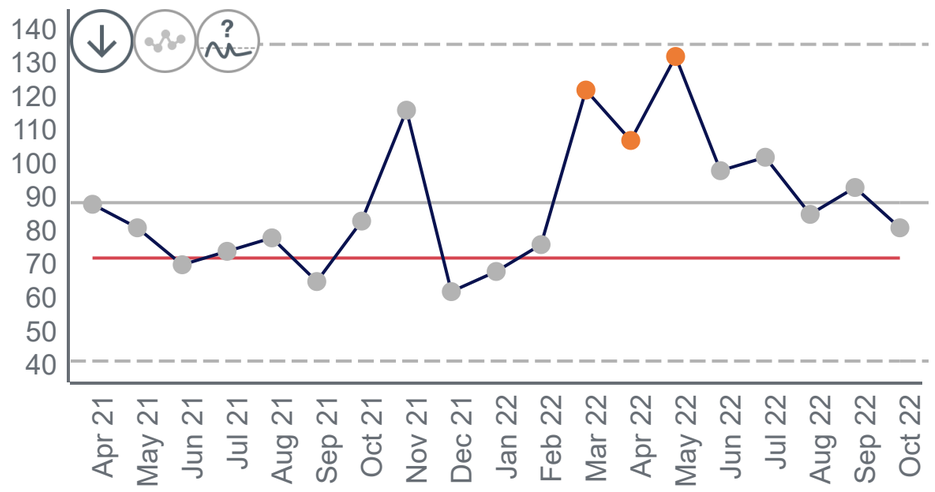
Areas of Concern:

• Increased number of unplanned admissions to PICU; to be investigated as part of the Deteriorating Patient workstream

Forward Look (with actions)

• Working group in place to implement the new Patient Safety Incident Response Framework (PSIRF) as part of the Trust Patient Safety Strategy

Number of Incidents rated Minor Harm and above



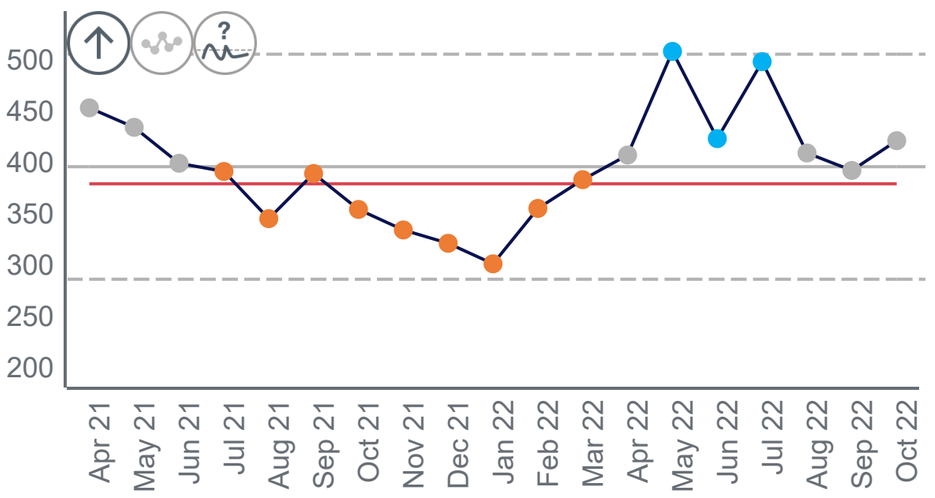
Technical Analysis:

Number of Harms per month have stabilised after a peak in Mar-May. This is common cause variation and does not indicate a step change or underlying improvement. Of the 83 incidents in October, 82 were minor harm and 1 moderate harm

Actions:

Continue to encourage a culture of reporting and learning from incidents. Specific workstreams established via Patient Safety Board; continue to progress actions

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

A high number of Near Miss and No Harm incidents reflects an open reporting culture. This has been above the target for 7 consecutive months, but shows common cause variation and therefore is still inconsistently passing the target.

Actions:

Continue to encourage a culture of reporting and learning from incidents

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	October 2022	81	88	72		?
Number of Incidents rated No Harm and Near Miss	October 2022	422	397	380		?
Number of Serious Incidents (Steis reported)	October 2022	0	1	0		?
Number of Never Events	October 2022	0	0	0		?
Sepsis % Patients receiving antibiotic within 60 mins for ED	October 2022	91	84	90		?
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	October 2022	97	87	90		?
Number of Medication Errors resulting in harm (minor harm and above)	October 2022	5	4	4		?
Pressure Ulcers G2-4	October 2022	7	4	5		?
Use of physical restrictive intervention (MH Tier 4)	October 2022	0	14			?
Number of Unplanned Admissions to Critical Care (HDU/PICU)	October 2022	84	70	30		F
Hospital Acquired Organisms - MRSA (BSI)	October 2022	0	0	0		P
Hospital Acquired Organisms - (C.Difficile)	October 2022	0	0	0	L	P
Hospital Acquired Organisms - MSSA	October 2022	0	1	0		?

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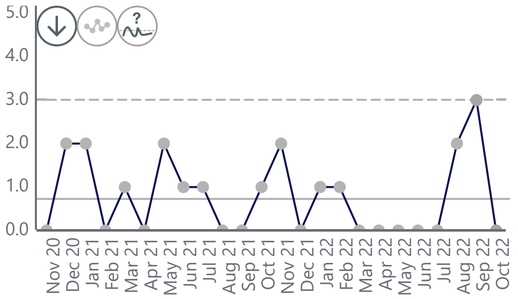
Integrated Performance Report | November 2022

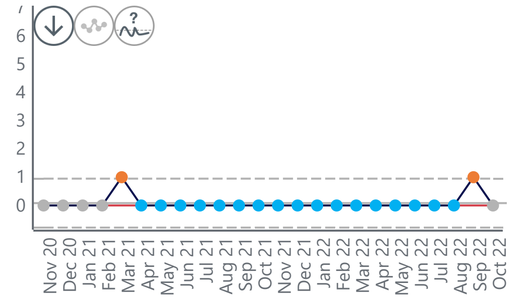
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

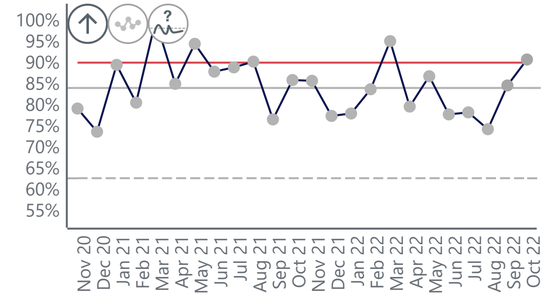
Number of Serious Incidents (Steis reported)



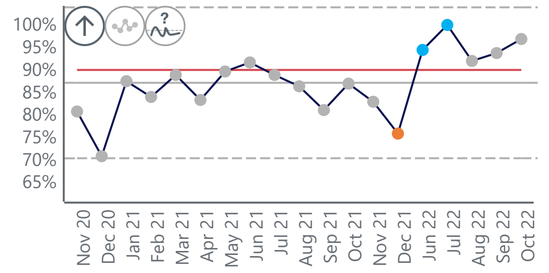
Number of Never Events



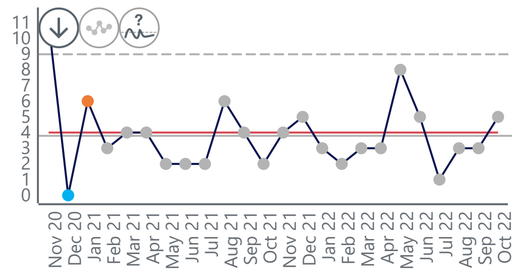
Sepsis % Patients receiving antibiotic within 60 mins for ED



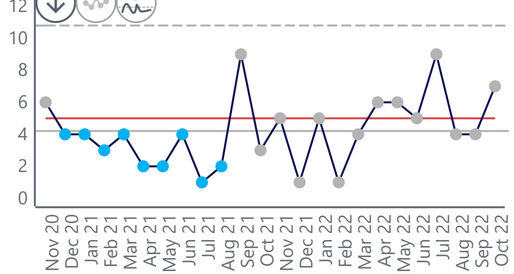
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



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

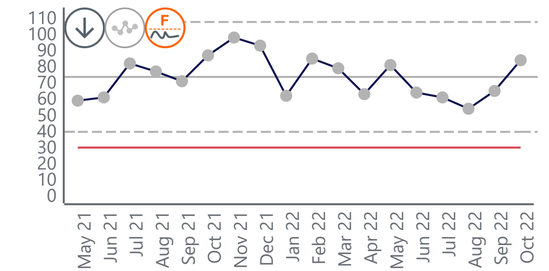


Pressure Ulcers G2-4

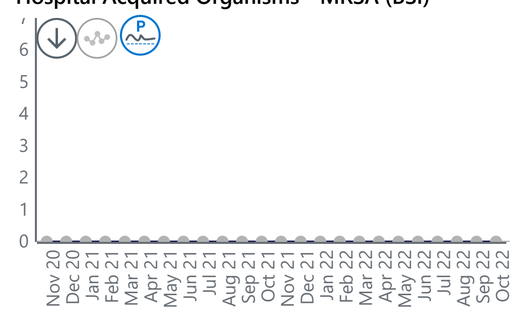


Use of physical restrictive intervention (MH Tier 4)

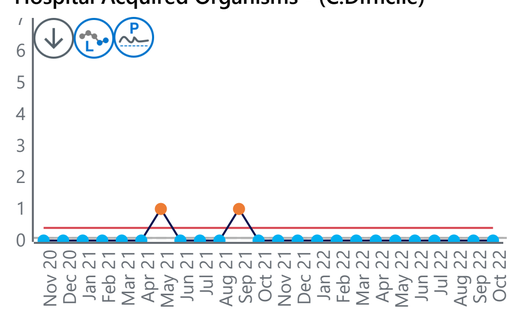
Number of Unplanned Admissions to Critical Care (HDU/PICU)



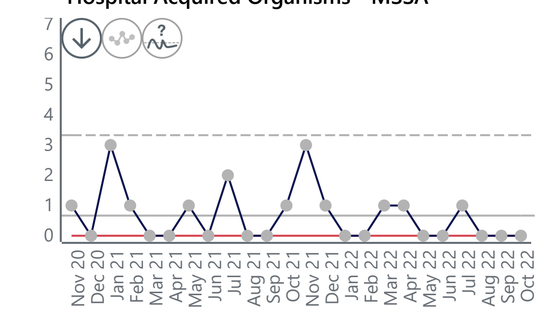
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Outstanding Safety - Caring

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

Highlights:

• 90% of families who completed the Friends and Family Test would recommend Alder Hey • Sustained improvement in Surgical and Medical Divisions in resolving PALS concerns within 5 working days; 100% in Surgery and 96% in Medicine

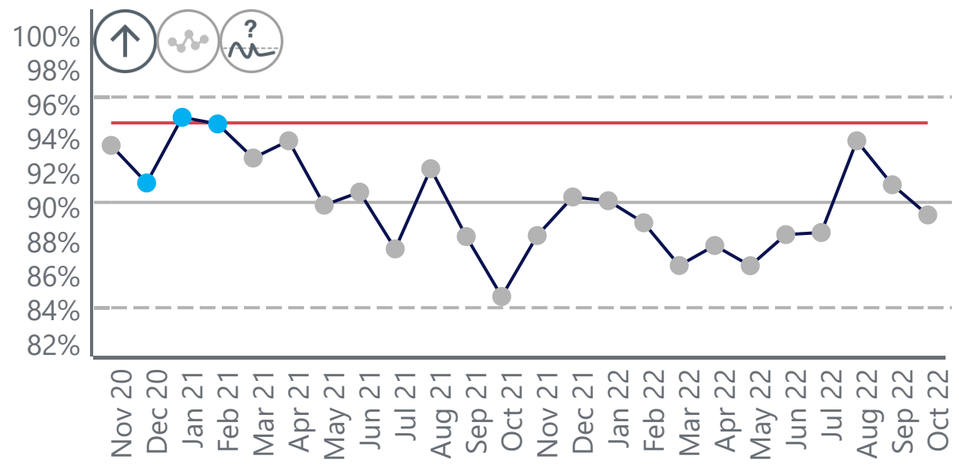
Areas of Concern:

• The Friends and Family Test completed by patients and families being cared for in the Emergency Department is 71%. The Division of Medicine are leading on the "Best in ED" workstream to identify and implement improvements

Forward Look (with actions)

• Divisions to continue to respond to PALS and complaints in line with Trust policy to ensure a timely resolution for families

F&F Test - % Recommend the Trust



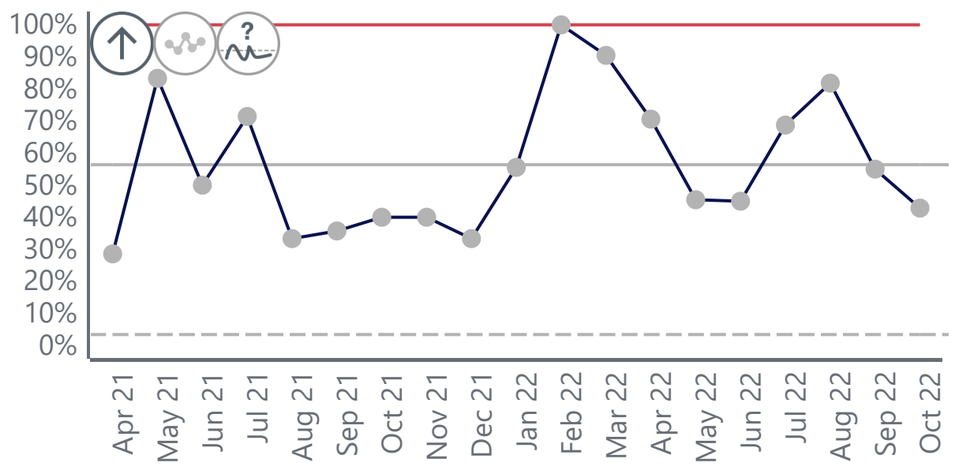
Technical Analysis:

Consistently falling short of the target – ED is at 71.3% and with only Inpatients and Mental Health exceeding the 95% target. Currently demonstrating normal cause variation, noting the recent peak of 94% in Aug-22 is within normal range.

Actions:

Best In ED workstream addressing feedback regarding waiting times and availability of toys and distraction

% Complaints Responded to within 25 working days



Technical Analysis:

With an average of 56%, almost half of all complaints are not responded to within the 25 working day target. Although the volumes are low (meaning each breach represents a high percentage) improvement work is required.

Actions:

Divisions continue to monitor and strive to resolve within 25 days; extensions can be applied for in line with the Complaints policy

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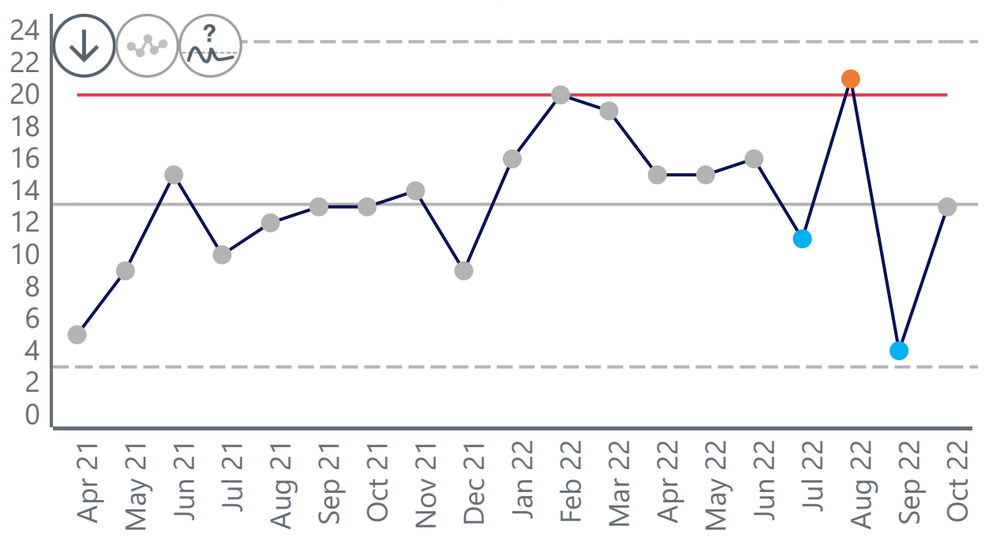
Alder Hey Children's NHS Foundation Trust

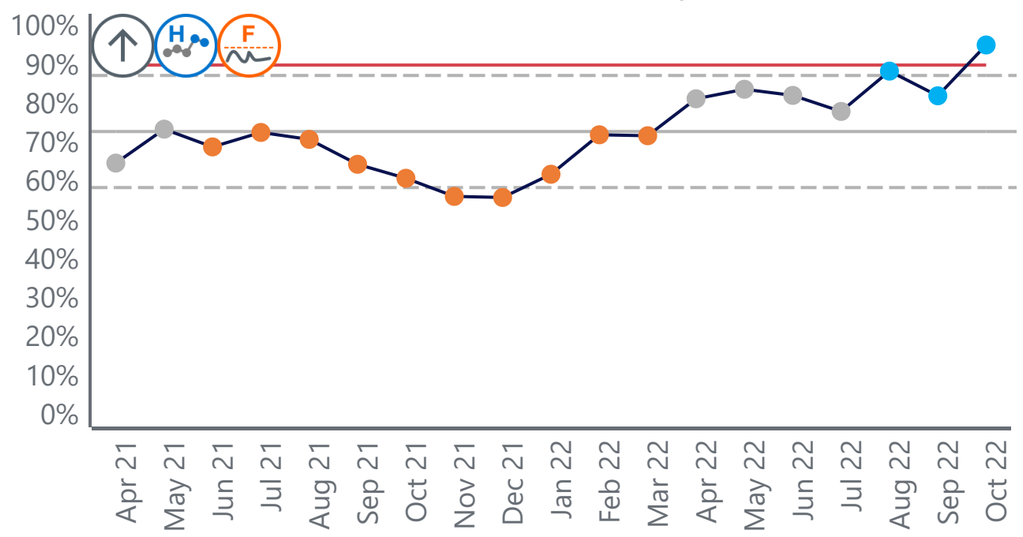
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	October 2022	90	95	90		?
% Complaints Responded to within 25 working days	October 2022	43	100	56		?
Number of formal complaints received	October 2022	13	20	13		?
% PALS Resolved within 5 Days	October 2022	95	90	73	H	F
Number of PALS contacts	October 2022	184	150	132		?
F&F ED - % Recommend the Trust	October 2022	71	95	69		F

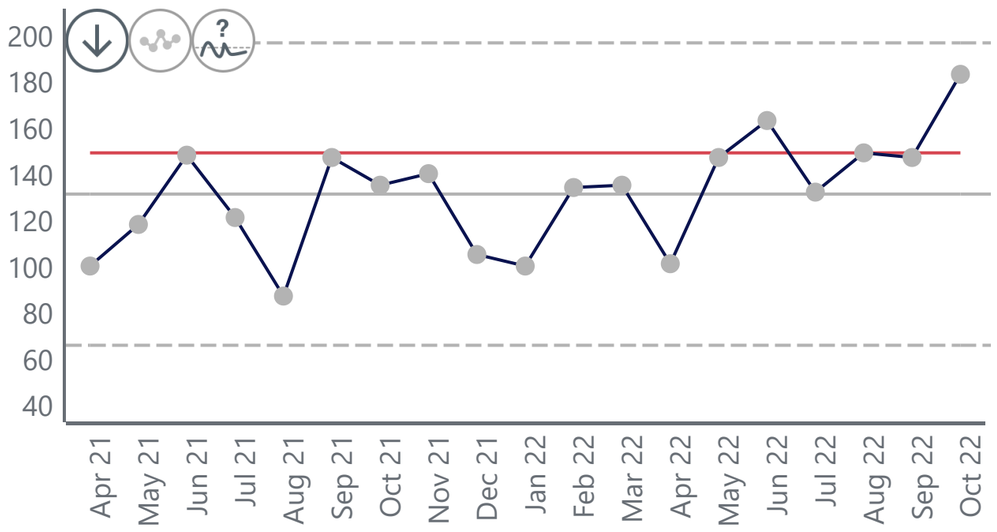
Number of formal complaints received



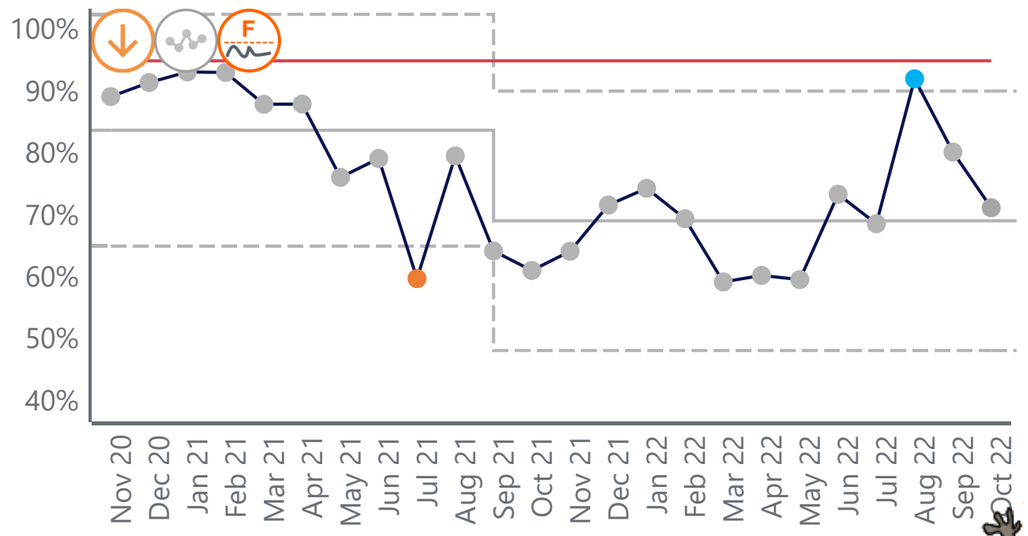
% PALS Resolved within 5 Days

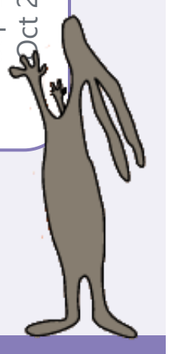


Number of PALS contacts



F&F ED - % Recommend the Trust





Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• WNB rate <10% in Oct, whilst too soon to show statistical significance this does correlate with interventions using AI tool in 5 specialties to support "higher risk" patients to attend appointments • Although ED 4hr performance remains challenged, median triage time was 13min so we continue to achieve the 15min national standard

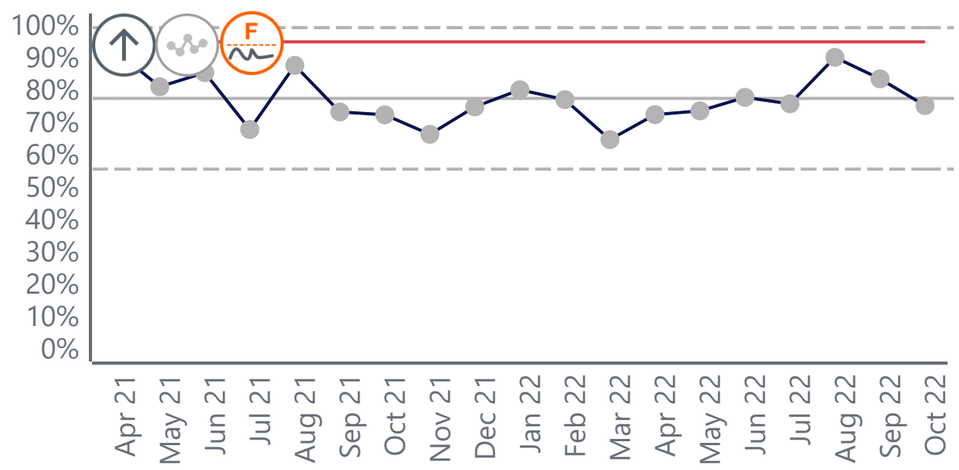
Areas of Concern:

• ED Performance against 4hr target (75%) and 12hr Time in Dept (19pts in Oct) remains challenged • % Virtual OP fallen again, in part due to reducing OPFU and prioritising F2F OPNew; revised mean still >25% national standard • 45 long stay patients with adverse impact on bed capacity • Clinical Letters backlog is reducing (Surgery cleared c.2000 letters in last 4 weeks) but still c.600 >4 weeks, 60% in Medicine

Forward Look (with actions)

• Continue ED@Best programme, overseeing actions to improve culture and performance. This includes ED Extension to open in Dec (subject to planning permission) • Continue use of AI tool to deliver sustained reduction in WNB rate and improve equity of access

ED: % treated within 4 Hours



Technical Analysis:

Performance is stable, dipping below the mean in Oct following a peak in Aug related to lower volume of attendances. Further actions are required in improve performance and achieve the national standard

Actions:

Utilise Strasys review to improve flow from ED to other specialties. New rota to increase consultant presence at evenings and weekends with fully established consultant workforce (4 new consultants). Continue to develop the pathways for the low acuity unit anticipated Dec. New huddles and board rounds embedded

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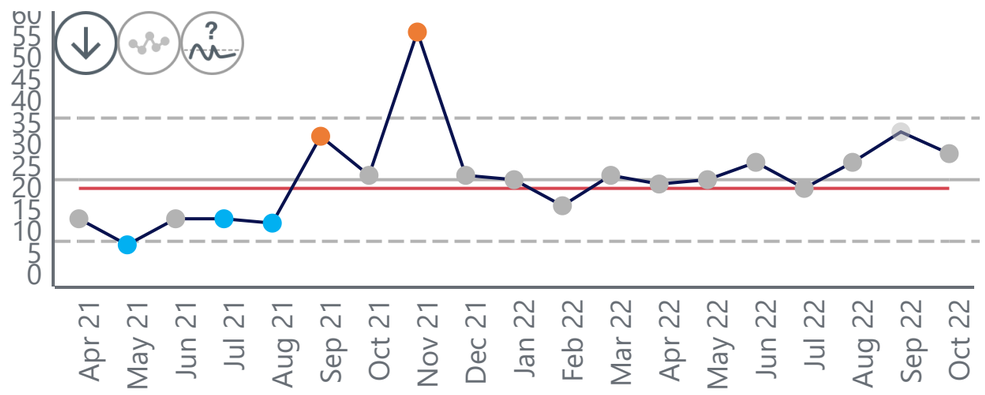
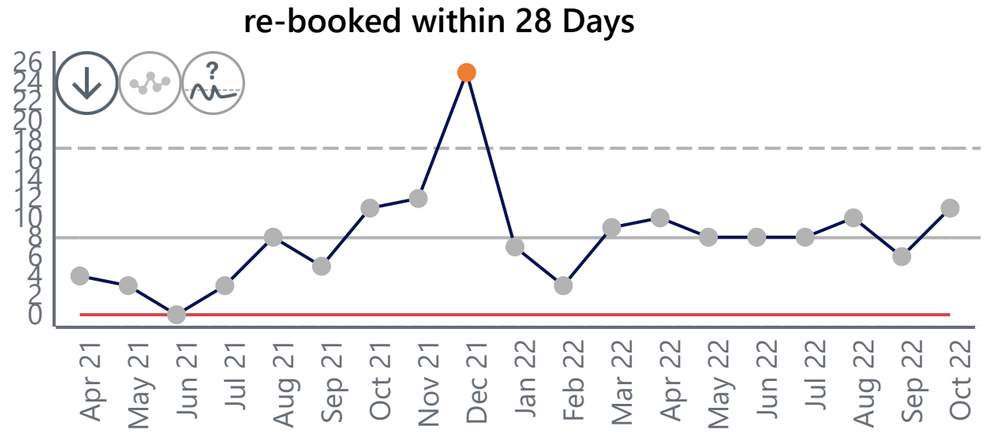
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	October 2022	75	95	77.52		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	October 2022	28	20	22.58		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	October 2022	11	0	7.95		?
Number of Super Stranded Patients (21 days)	October 2022	45	30	36.95		?
% Virtual Outpatients (national standard 25%)	October 2022	21	25	30.16	L	?
% Was Not Brought Rate (All OP: New and FU)	October 2022	9	10	9.87		?
% of Clinical Letters completed within 10 Days	October 2022	63	95	57.52		F

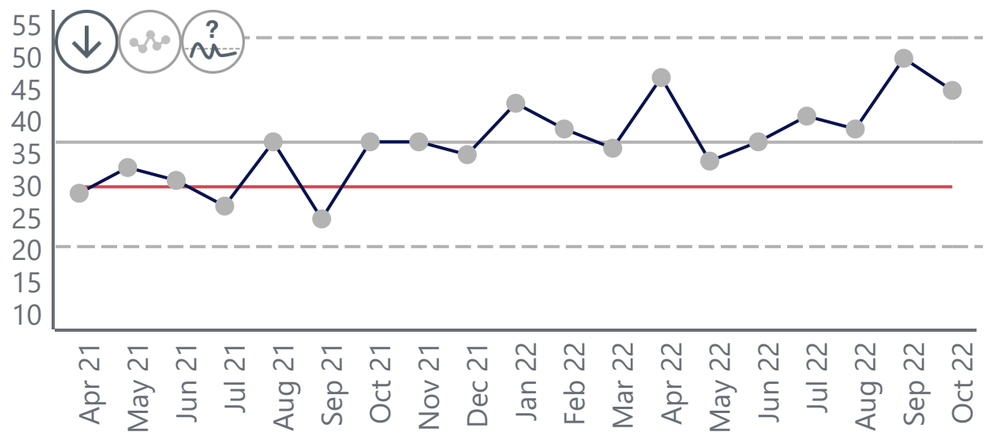
Number of Cancelled Operations (on day of admission for a non-clinical reason)



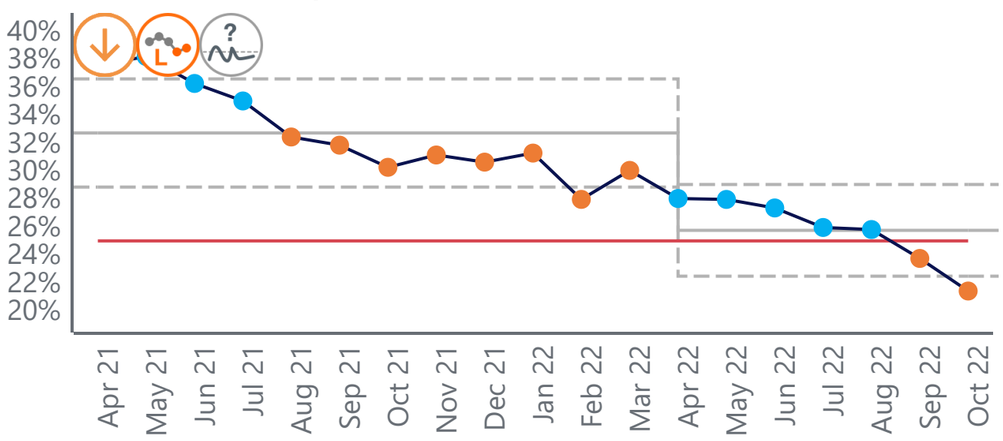
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



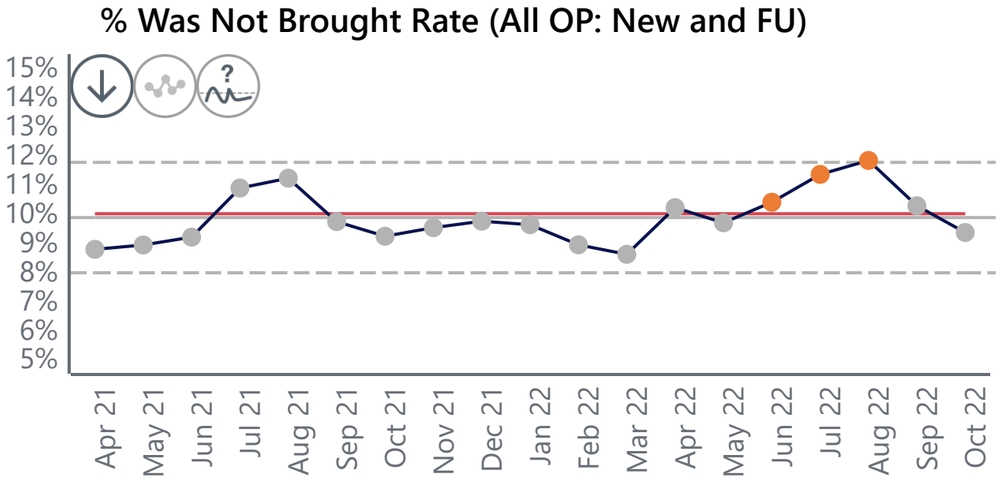
Number of Super Stranded Patients (21 days)



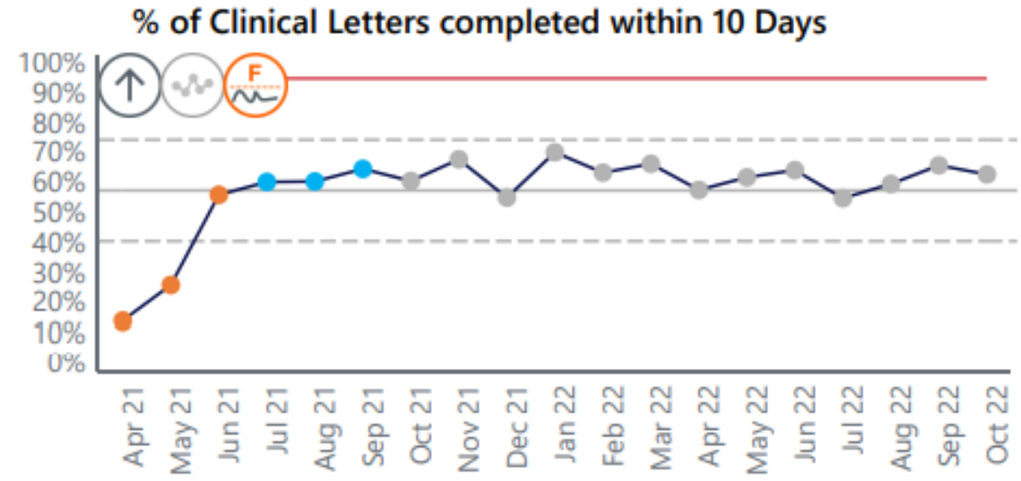
% Virtual Outpatients (national standard 25%)



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



% of Clinical Letters completed within 10 Days



Recovery & Access -Responsive

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• 107% Recovery volume (number of patients treated) in Oct. Oct ERF value was strong at 110% gross (net 103% due to OPFU) • Positive indication that 52ww reducing with consecutive weekly improvement through Oct • Radiology achieved zero 6wk breaches in Oct, significant improvement from 61 >6wks in Apr (subset of the overall Diagnostic waits • Cancer Standards continue 100% compliance • Approval of £5m Elective Hub Bid

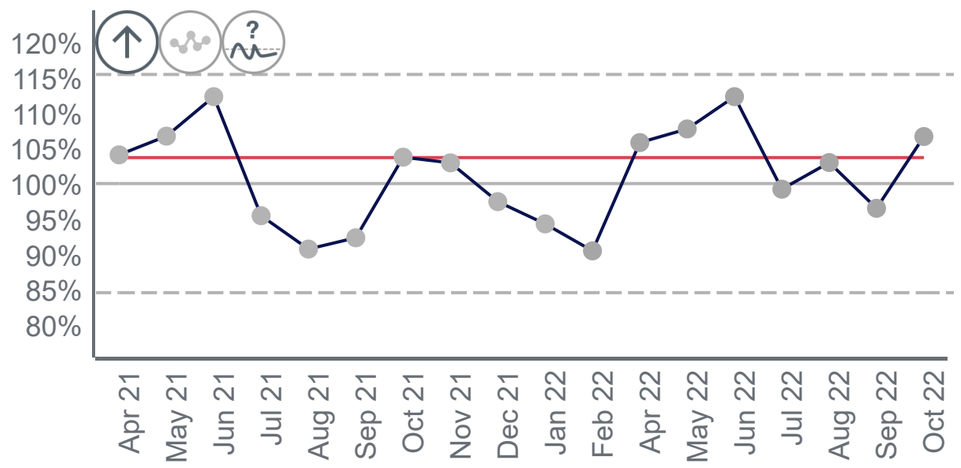
Areas of Concern:

• ERF remains less than 104% target despite high volume of patient activity • Some specialties continue to be challenged with long waits >52ww, including Dental, Spinal, ENT, Gastro, Neurology and have local action plans • RTT Open Pathways within 18 weeks consistently below mean indicating deterioration, due to focus on longest waiting patients and chronological booking as we reduce 52ww

Forward Look (with actions)

• Continue to reduce long waits, with focus on all patients >40 weeks • Dental Insourcing model to increase capacity and reduce waiting times • Diagnostic to further improve with commencing home sleep studies during Nov • Waiting List Size requires target value to be agreed, and demand-capacity work to be completed at specialty level

% Recovery for DC & Elec Activity Volume



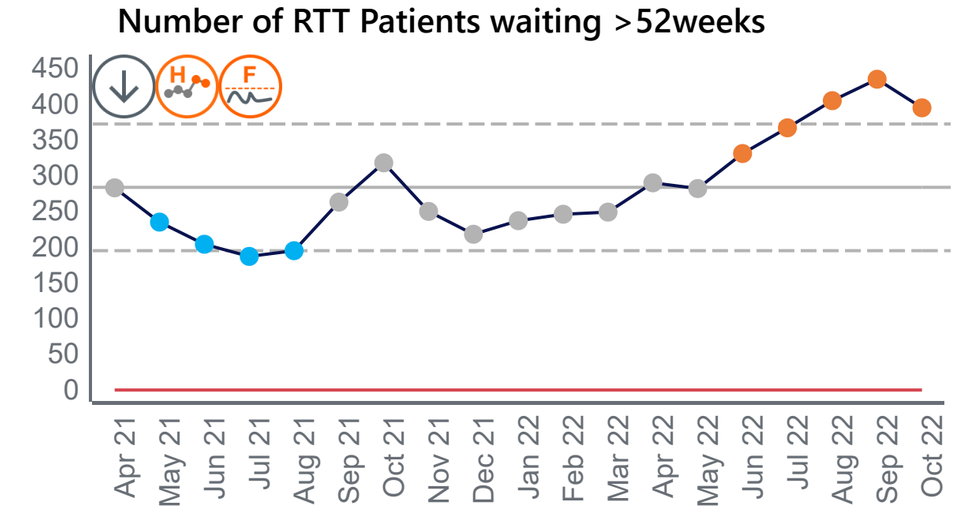
Technical Analysis:

Oct performance of 107% is above the target, and maintains cumulative average since April 22 >104%. However this is common cause variation, and continues but follow a similar seasonal pattern as last year.

Actions:

Priority to optimise activity in high volume specialties, and Divisions working at specialty level to drive improved recovery (eg ENT and Paediatric Surgery)

Number of RTT Patients waiting >52weeks



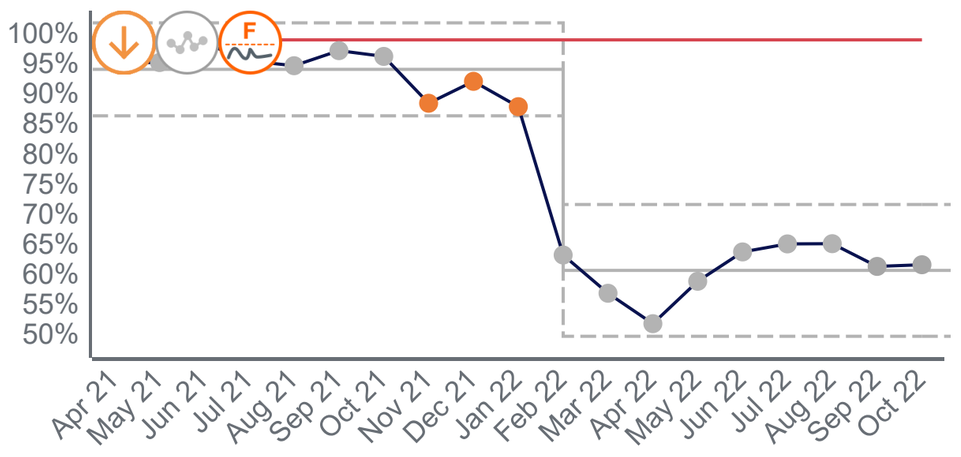
Technical Analysis:

In Oct there were 395 RTT patients >52wks; this includes only 3 RTT patients >78wks. Dentistry has 270pts >52wks, 68% of the Trust total. After 4 months of consecutive increase, the Oct data point only shows normal variation, but the weekly report has shown 4 weeks consecutive improvement through Oct which is a good indicator.

Actions:

Weekly monitoring of all patients >40wks and patient level actions to expedite appointments. Dental Insourcing model to be implemented to increase capacity. Spinal Surgery tracking every patient to manage 78wk waits. Plans in place to increase OPNew appointments in ENT and Paed Surg

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

The Baseline was reset in Feb following Safe Waiting List Management validation and correction of reporting.

Actions:

New Dexa Scanner to be installed and commissioned in Nov. Commence Home Sleep Studies to double capacity following receipt of new equipment in Nov. Maintain compliance with national standards in Radiology

Recovery & Access -Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	October 2022	107	104	101.53		?
Number of RTT Patients waiting >52weeks	October 2022	395	0	283.68	H	F
Diagnostics: % Completed Within 6 Weeks of referral	October 2022	62	99	60.88		F
RTT Open Pathway: % Waiting within 18 Weeks	October 2022	55	92	63.39	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	October 2022	100	100	99.33	H	P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	October 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	October 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	October 2022	100	100	91.67	H	?
Cancer: Faster Diagnosis within 28 days	October 2022	100	75	93.08	H	P
% Recovery for OP New & OPPROC Activity Volume	October 2022	116	104	100.23	H	?
% OPFU Activity Volume	October 2022	91	85	107.33	L	F
Waiting List Size	October 2022	24,570		18,672.89	H	?

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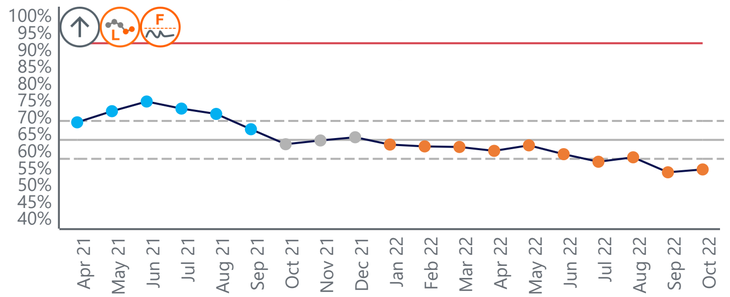
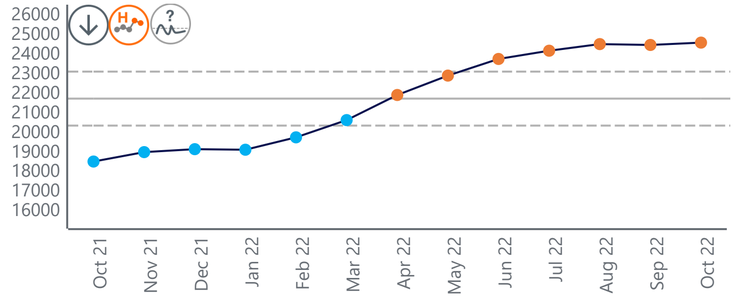
Recovery & Access -Responsive - Watch Metrics

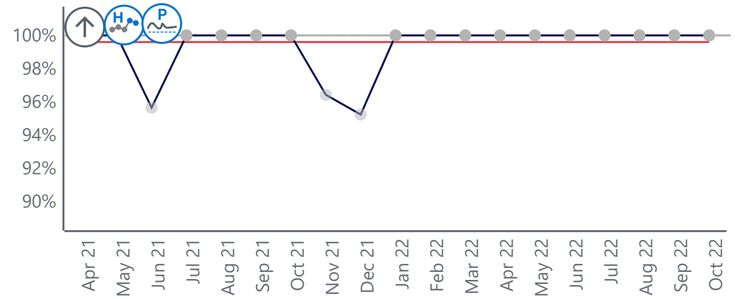
RTT Open Pathway: % Waiting within 18 Weeks



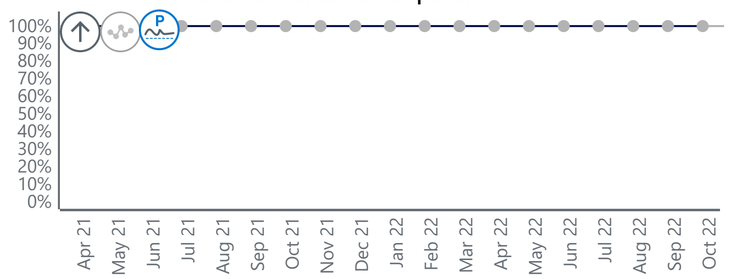
Waiting List Size



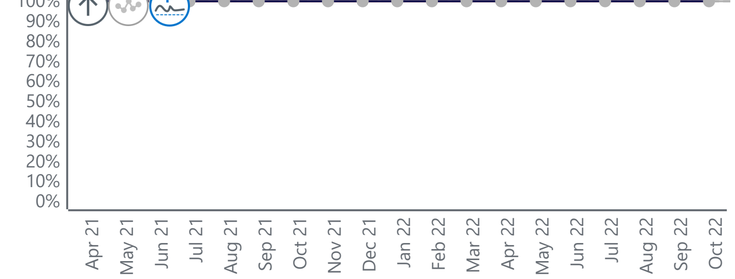
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



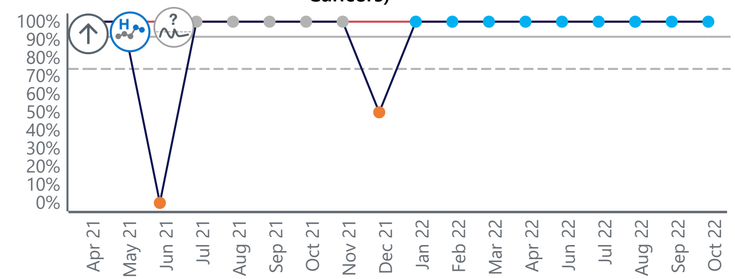
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



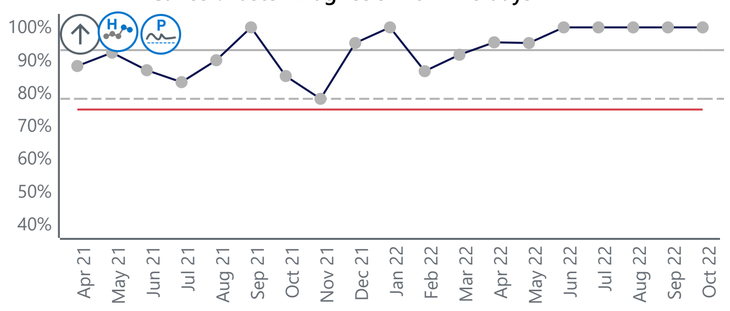
All Cancers: 31 day wait until subsequent treatments



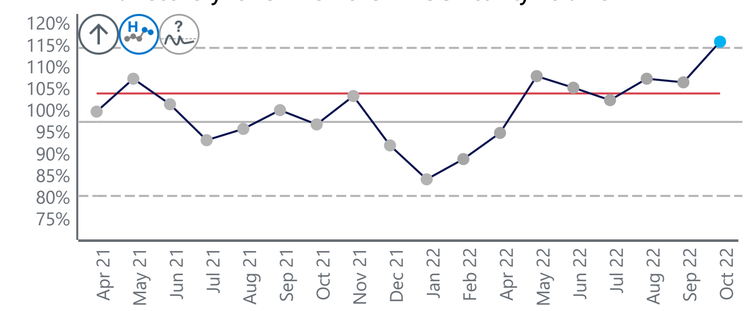
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



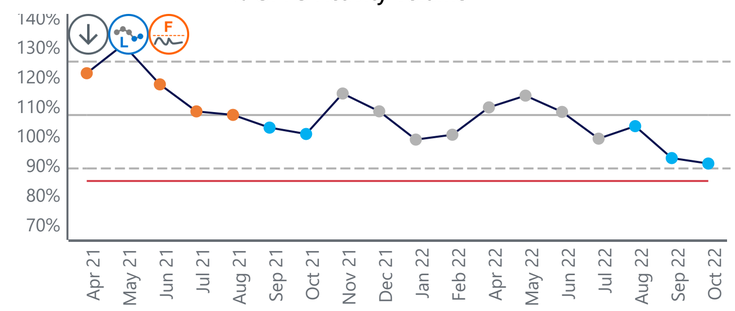
Cancer: Faster Diagnosis within 28 days



% 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 remains above target at 92%. Sickness absence remains above the 5% target, however Oct remains below the mean (5/6 months) which is positive, but is still showing normal cause variation.

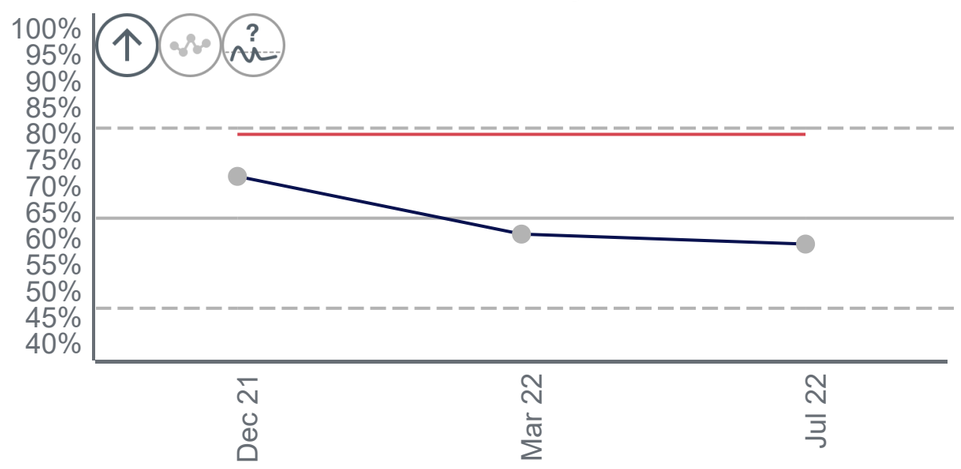
Areas of Concern:

Reflective of the national position, Trust turnover remains high with an in-month position of 14% • PDR's whilst they are steadily increasing across all bands, for those in band 7+, at 81% completion this falls short of the 90%, which should have been achieve by end of July 2022. Q3 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 (currently in development)

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 (currently in development).

% Staff who recommended Alder Hey as a place to work



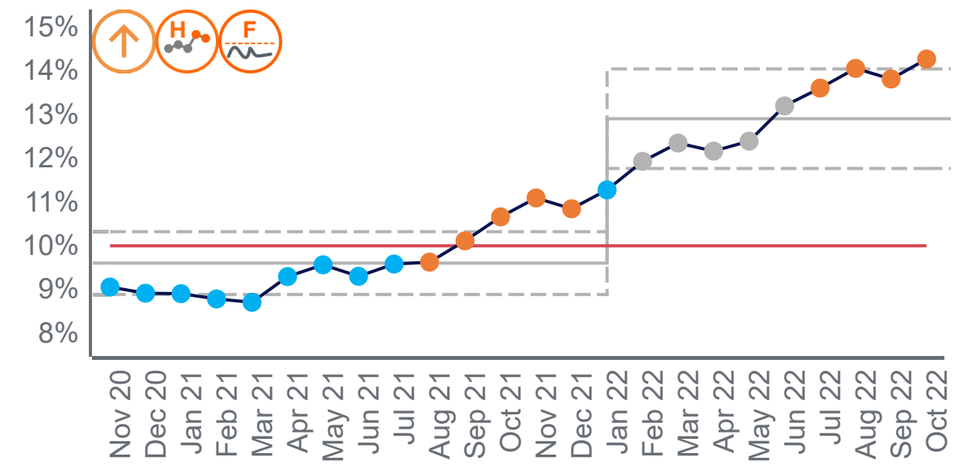
Technical Analysis:

Only 3 data points, so not possible to analyse data given frequency of the survey (quarterly). Most recent data points at 61% and 59% are significantly below the 80% target. The next data point is expected from the full national staff survey, which is currently live.

Actions:

The 2022 National Staff Survey is currently open and closes on 25th Nov, with ongoing communications planned to support/encourage completion. Results will be available early 2023.

Staff Turnover



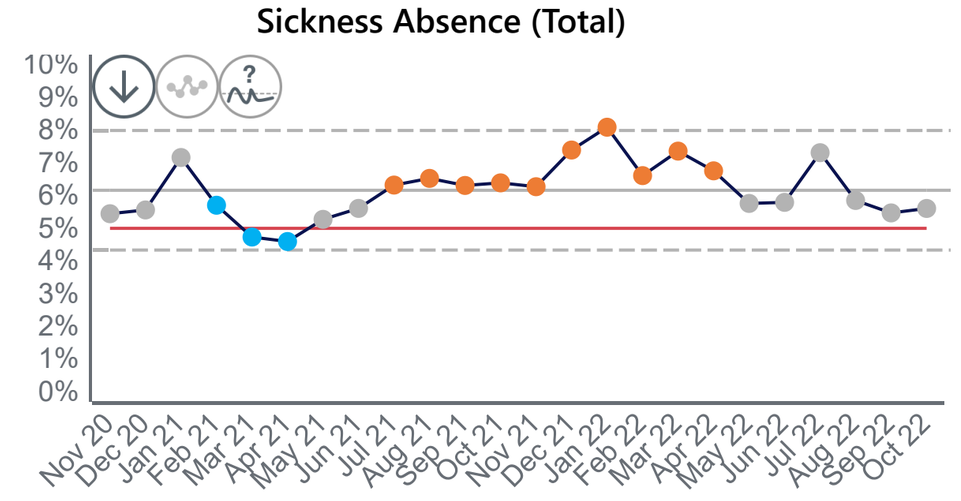
Technical Analysis:

This data raises significant concern due to special cause variation driving a substantial increase in turnover rate, with the mean now reset at 13%. This level of staff turnover, along with current rates of sickness absence (5.7% in Oct) is creating substantial risk for the Trust.

Actions:

Reflective of the national position, staff turnover is a concerning trend which is monitored closely and reviewed by divisional boards and PAWC. Sustainable interventions are being considered and presented through the Trusts Attraction and Retention long term plan (currently in development)

Sickness Absence (Total)



Technical Analysis:

Total absence in Oct is 5.7%, falling short of the 5% target. This comprises STS at 2.4% and LTS at 3.3% (both above target). Oct remains below the mean (5/6 months) which is positive, but is still showing normal cause variation – and further actions are required to demonstrate underlying 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.

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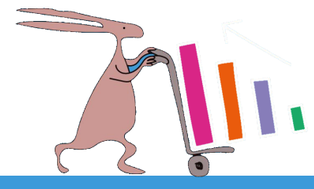
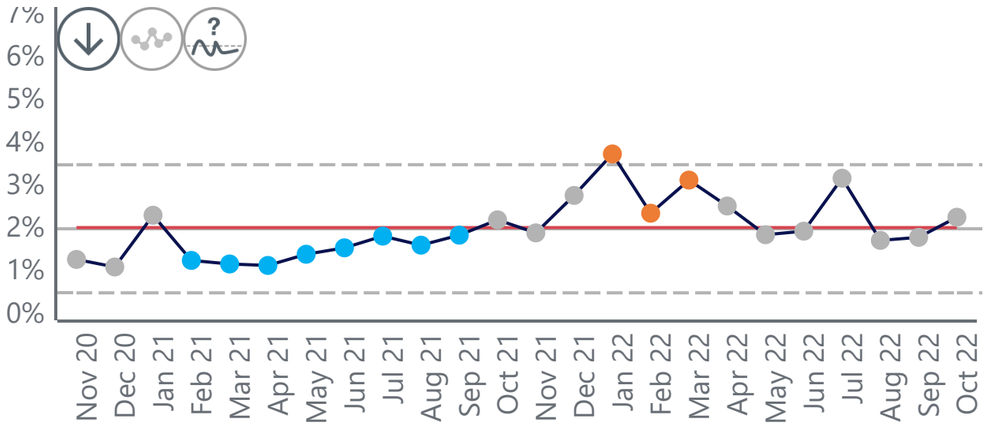


Alder Hey Children's NHS Foundation Trust

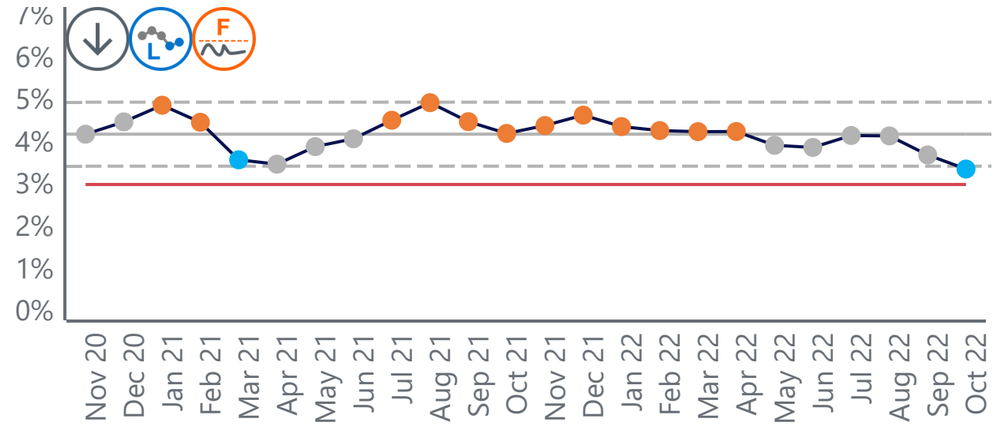
Well Led - Great Place to Work - People - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Staff who recommended Alder Hey as a place to work	July 2022	59	80	64.03		?
Staff Turnover	October 2022	14	10	12.58	H	F
Sickness Absence (Total)	October 2022	6	5	6.16		?
Short Term Sickness	October 2022	2	2	1.97		?
Long Term Sickness	October 2022	3	3	4.19	L	F
Mandatory Training	October 2022	92	90	92.20		P
% PDRs completed since April	October 2022	45	90	48.65	L	F
Medical Appraisal	October 2022	84	100	63.03		F

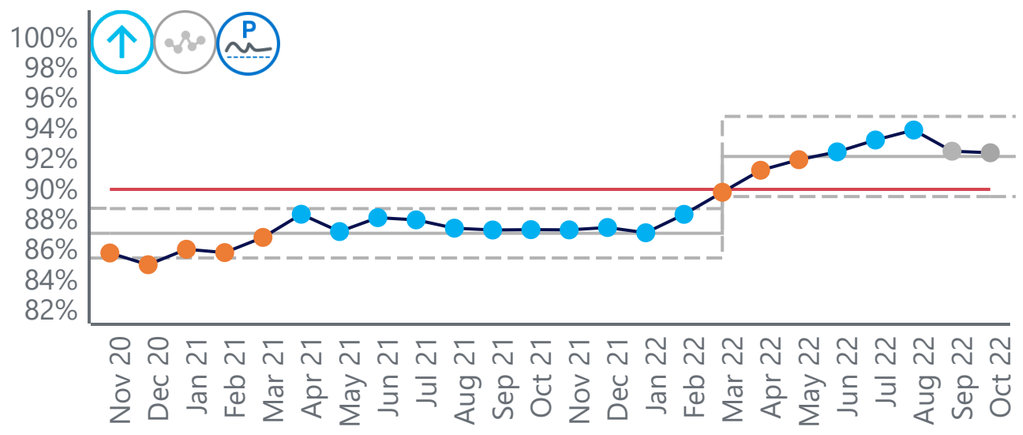
Short Term Sickness



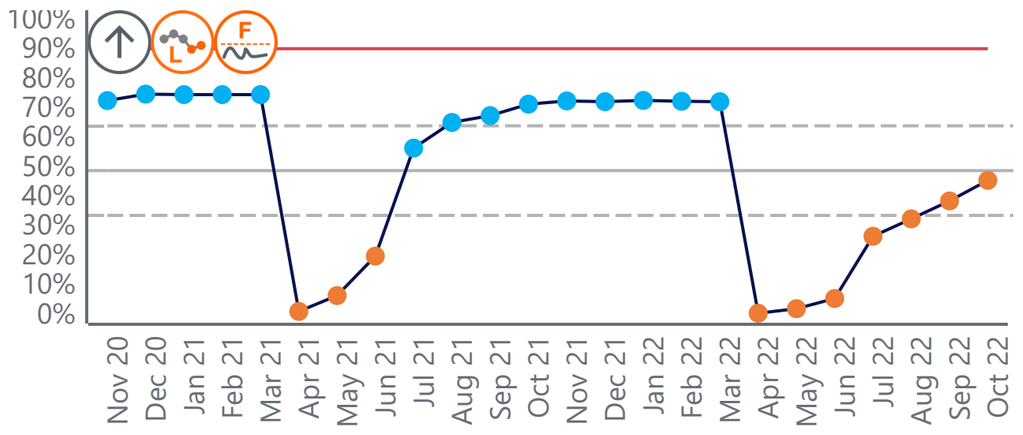
Long Term Sickness



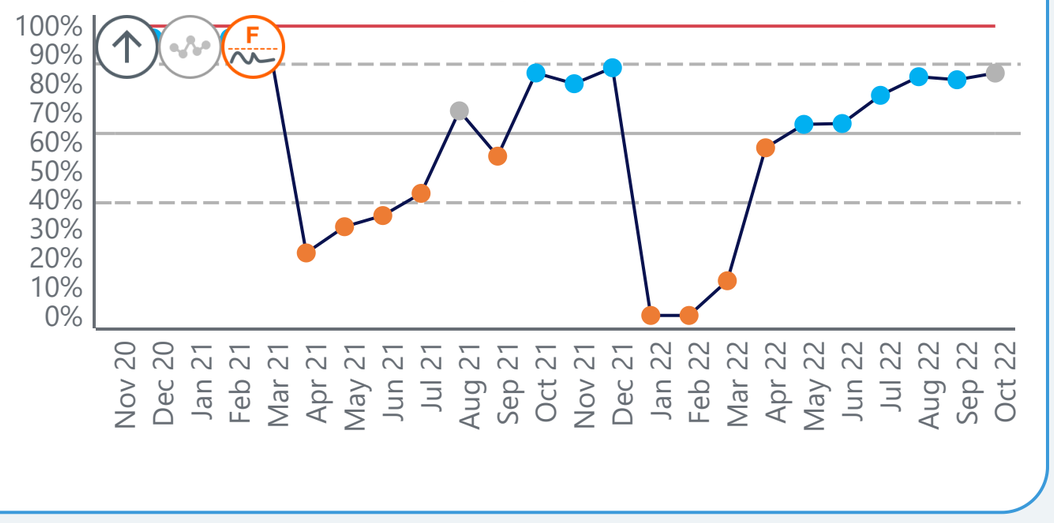
Mandatory Training



% PDRs completed since April



Medical Appraisal



Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Highlights:

• For October (M7), the Trust is reporting a surplus of £1m which is in line plan. The year to date position is a £0.4m deficit in line with the plan approved • The CIP targets have been achieved during Q2 predominantly on a non-recurrent basis which will result in a pressure carried forward into 23/24 • Cash has remained high during Q2 in line with the plan as capital spend increases in future months.

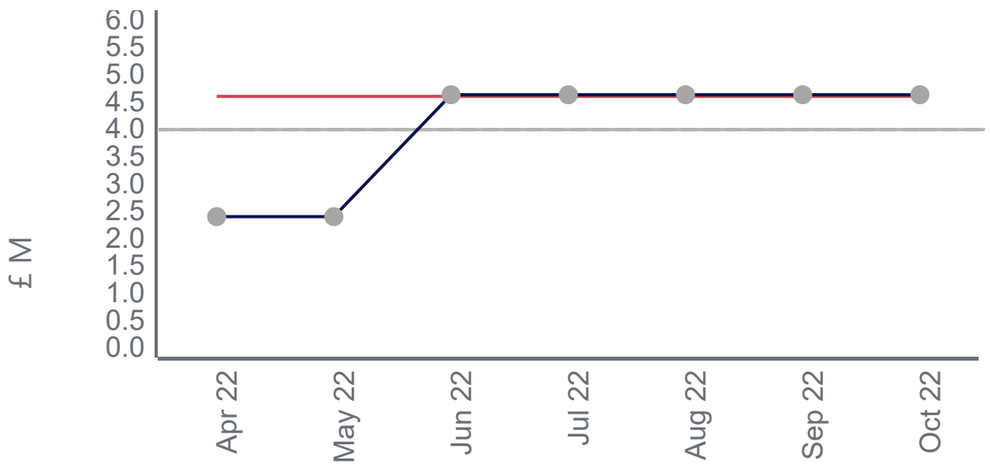
Areas of Concern:

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

Forward Look (with actions)

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

Revenue Position (Year End Forecast)



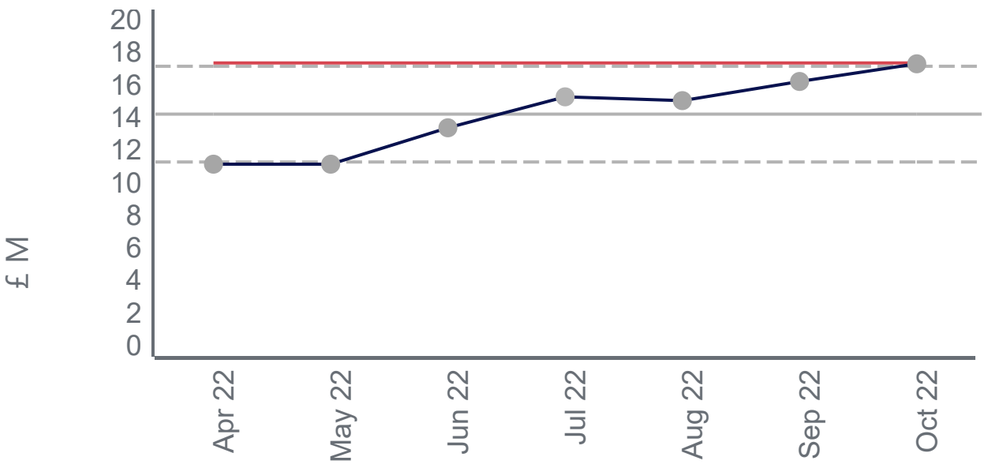
Technical Analysis:

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

Actions:

Continue to monitor inflationary pressures risk and mitigations.

CIP Position In Year (Year End Forecast)



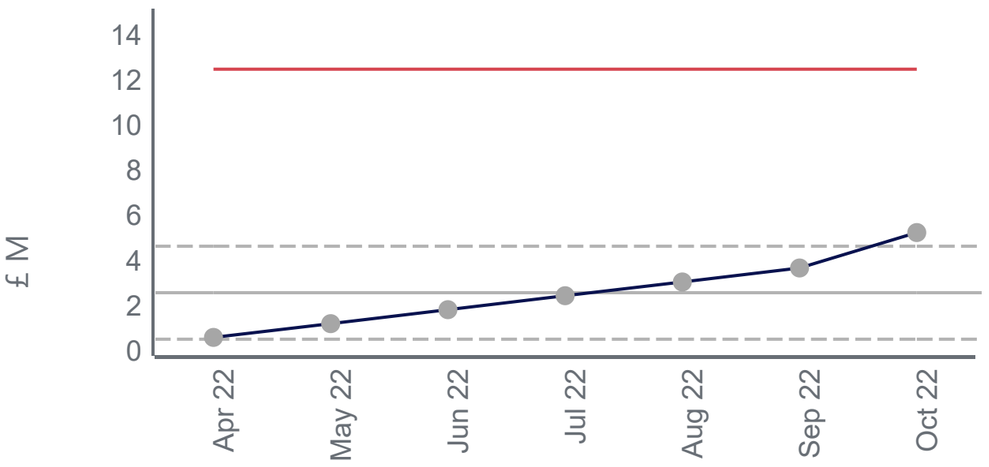
Technical Analysis:

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

Actions:

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

CIP Position Recurrent/Full Year Effect



Technical Analysis:

Slight improvement in month but only 28% CIP identified as recurrent, with £7m left to be identified and delivered in the remaining 5 months.

Actions:

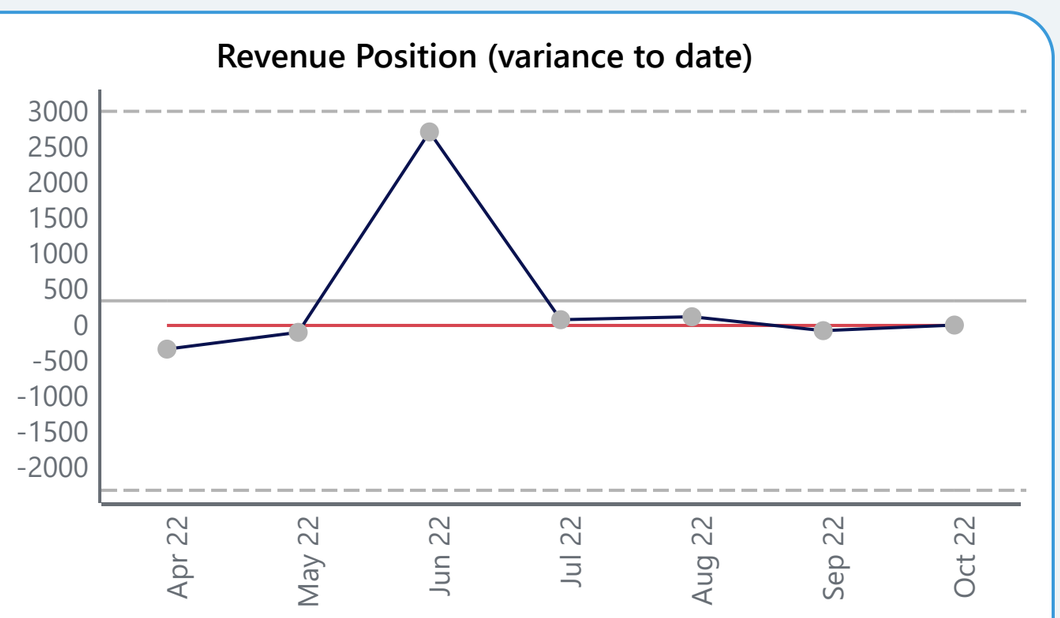
Support required with exec leads and transformation to identify the large scale opportunities either through existing programmes/projects or if not likely to deliver and for new schemes to be agreed and supported. Letter to be sent to Trust in November outlining current position.

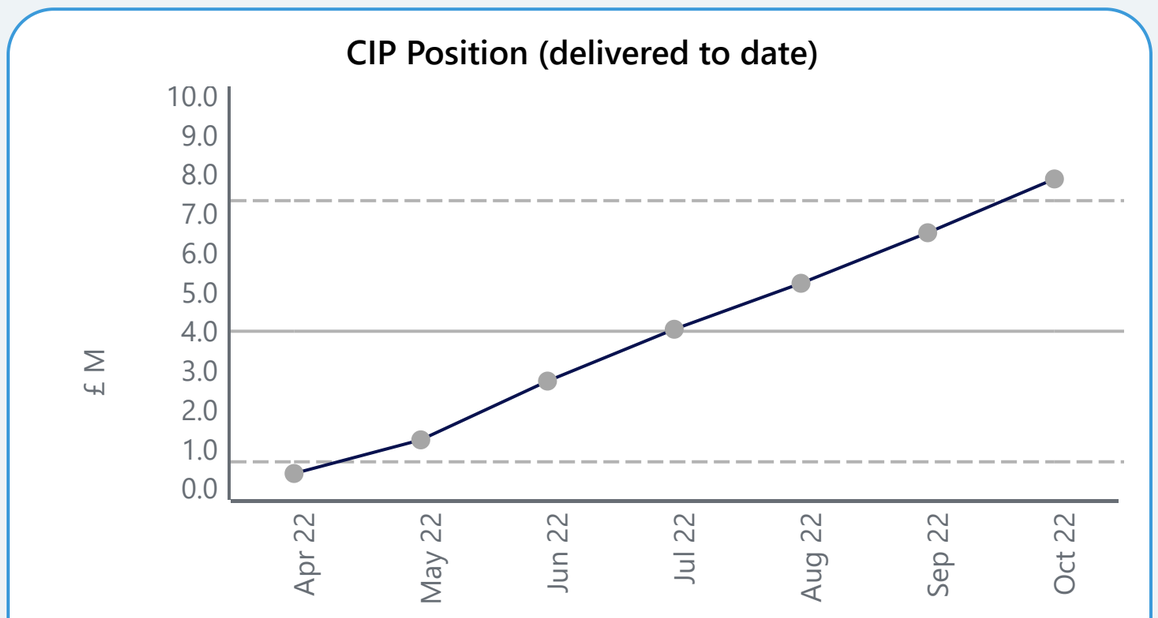
Integrated Performance Report | November 2022

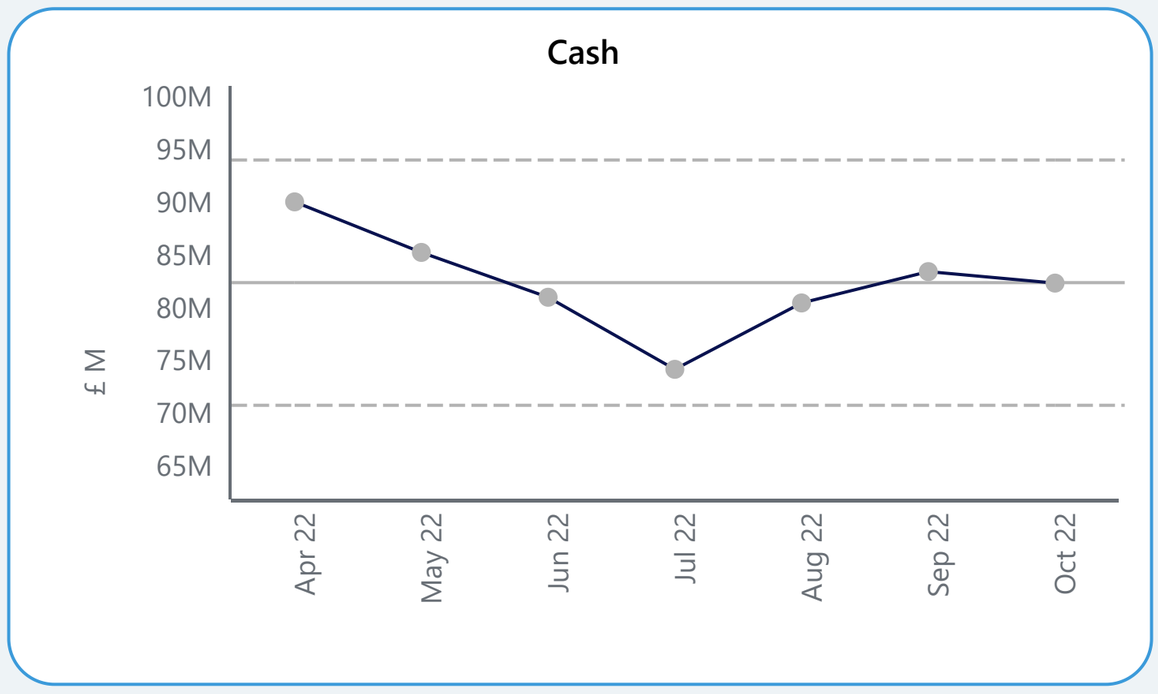
Alder Hey Children's NHS Foundation Trust

Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	October 2022	4.6	4.6		
CIP Position In Year (Year End Forecast)	October 2022	17	17		
CIP Position Recurrent/Full Year Effect	October 2022	5	13		
Revenue Position (variance to date)	October 2022	5	0		
CIP Position (delivered to date)	October 2022	8	8.7		
Cash	October 2022	82,403,000			







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

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

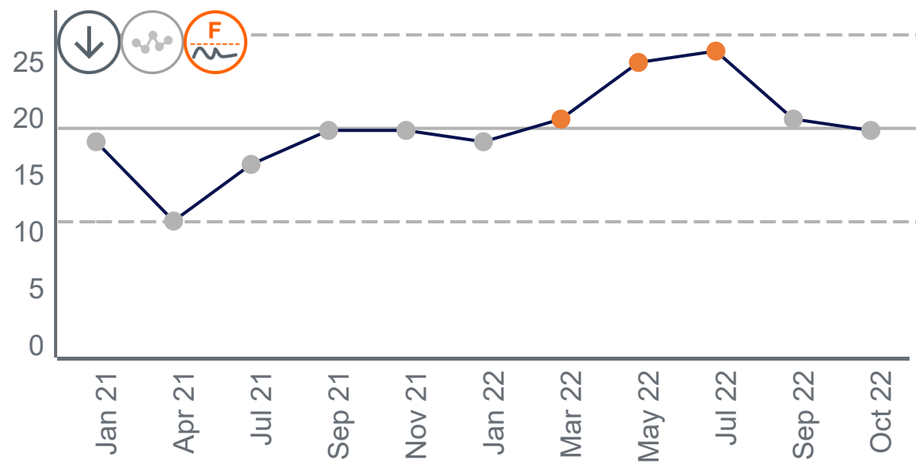
Areas of Concern:

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

Forward Look (with actions)

• Corporate Service collaborative report to be developed and shared at Risk management forum. • 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

Number of High Risks (scored 15 and above)



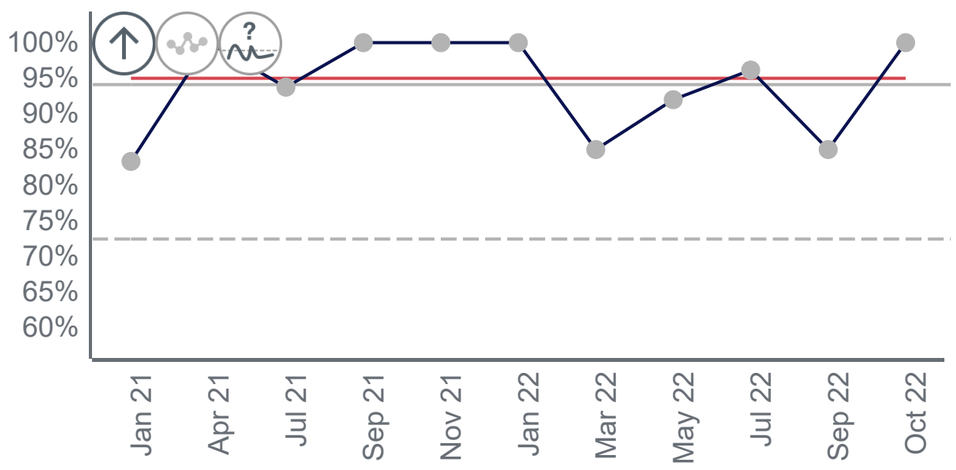
Technical Analysis:

There are a total of 19 High Risks in Oct, which is stable and within the normal variation limits. This data is now being collected on a monthly basis, which will enable more meaningful analysis of trends

Actions:

As of end Oct 22 there are 19 high risks (risks scored 15+) this figure excludes BAF and network risks

% of High Risks within review date



Technical Analysis:

At the end of October, zero risks from 19 were overdue review, meaning 100% are within review date. This is the first time 100% has been achieved since Jan-22

Actions:

At the end of Oct '22 100% of all high risks are within review date. 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:

• New Models of Care Programme Board established, plans in development to deploy AlderHey Anywhere • Paperless E-Consent is live across Surgery • iDigital won an HTN award for Best Partnership and AH were Highly Commended for the ED Symptom Checker • Tender process completed for Risk Management System • New version of IPR live alongside improvements to the Governance and Surgery Dashboards • Successful AlderC@re Patient Journey events held in October, preparation work underway for November Gateway review.

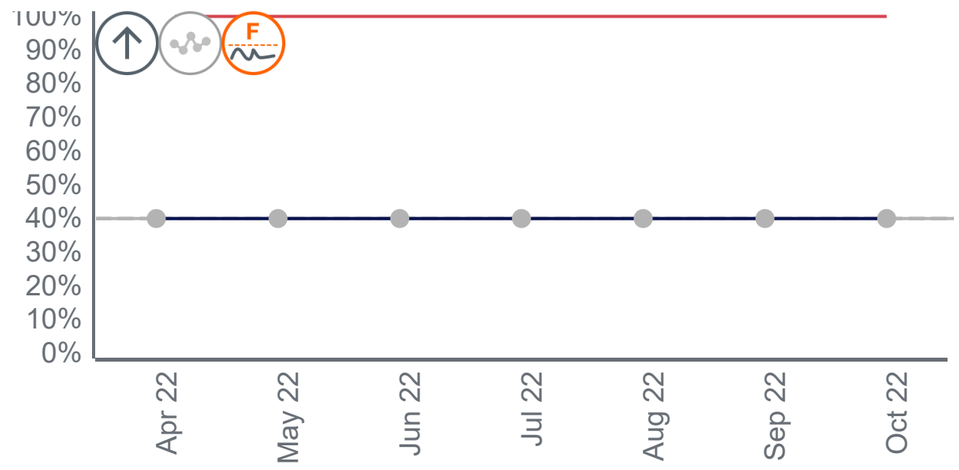
Areas of Concern:

• Work continues with Meditech to review and resolve outstanding priority 1 AlderC@re issues, particularly for electronic prescribing; Meditech have now provided delivery dates for all outstanding items • There are dependencies on the deployment of the proposed new theatre system, with a decision regarding timing pending • Resources continue to be monitored, with a priority for additional prescribing build resource.

Forward Look (with actions)

• Second round of Patient Journeys scheduled November / December • Formal Alderc@re Gateway Review will take place assessing progress, risks and plans for the next phase

Alder Care - Divisional Critical Criteria



Technical Analysis:

6/15 complete. Remainder awaiting system build or key decisions (eg waitlist management). Performance metric is for sign off, percentage increases once each item is signed off. Additional project management resource in place, planning to be completed by end of Nov. Critical criteria are part of gateway review for clinical safety

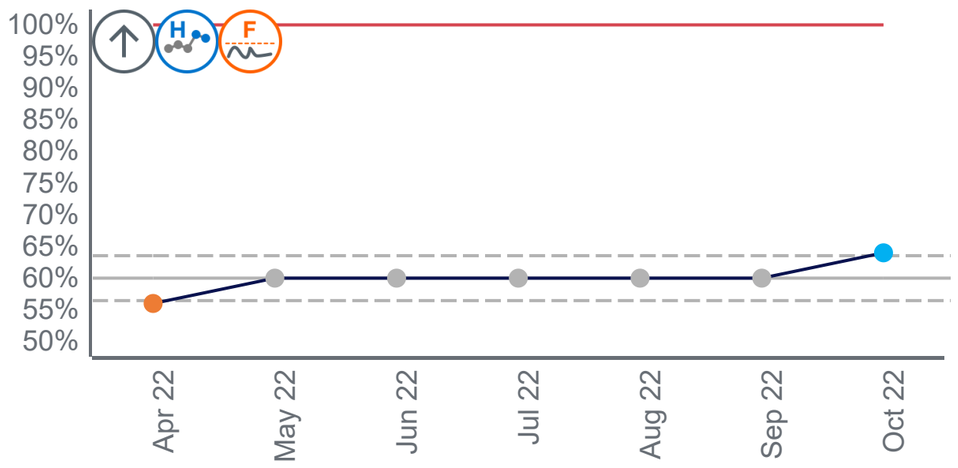
Actions:

1. Ongoing development for remaining items

2. Plan to be reviewed by AlderCare Programme Board as part of the Gateway process in Nov 2022

3. Clinical safety workshops planned for January 2023

Alder Care - % System Build Completion



Technical Analysis:

This metric monitors build across all workstreams. The current status of the build and trajectory has been through a robust validation process via a Programme Review and also as part of the Patient Journeys with clinical team.

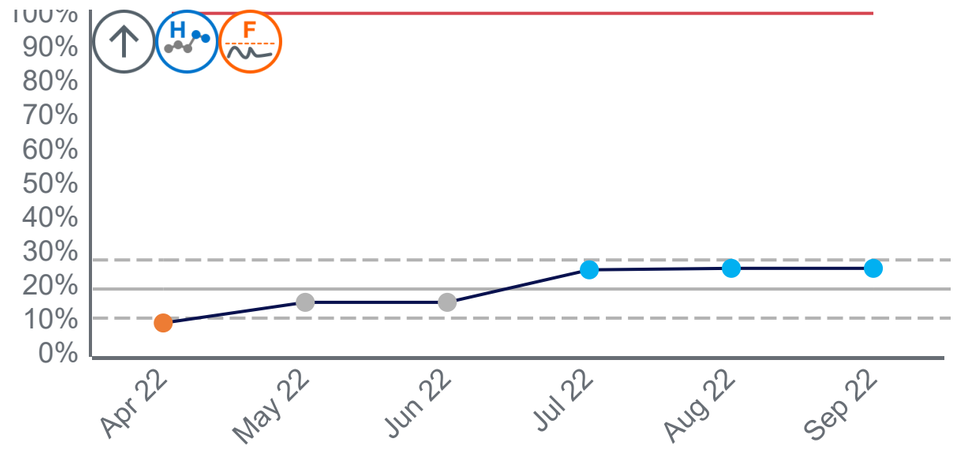
Actions:

1. Progress build following review at Patient Journey sessions

2. Continue theatres build in Expanse subject to decision on new theatre management system

3. Prescribing build starting in November

Alder Care - % Speciality documentation build



Technical Analysis:

16 of 58 specialties with changes required to their documents have now been actioned. The current status of the build and trajectory has been through a robust validation process via a Programme Review. Orthopaedic documents in the process of being amended, with over 80 documents to be reviewed (93% built).

Actions:

1. Continue build, including completion for Orthopaedics

2. Complete remaining requirements gathering (currently 83%)

3. Continue formal sign off process for completed specialties

Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

•Zero complaints received in October • Continued reduction in WNB rates across the Division • Continued improvement in the number of clinic letters completed within 10 days • Mandatory training remains above 90%

Areas of Concern

• Increase in PALS associated with access and communication, specifically related to the Trust interpreting service • Waiting times for CAMHS remain an area of concern

Forward Look (with actions)

•Review of the telephony team supporting community paediatrics, ASD and ADHD to improve timeliness and effectiveness of response. • Recruitment underway in Mental Health services using new 22/23 investment which will increase clinic capacity.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	October 2022	11	15	19.26		
Number of Incidents rated No Harm and Near Miss	October 2022	77	80	74.63		
Use of physical restrictive intervention (MH Tier 4)	October 2022	0		11.71		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	October 2022	0	6	3.11		
Number of PALS contacts	October 2022	60	45	42.58		

Divisional Performance Summary - Community & Mental Health

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	October 2022	48	25	54.48		P
% Was Not Brought Rate (All OP: New and FU)	October 2022	14	10	14.63		F
% of Clinical Letters completed within 10 Days	October 2022	64	95	57.99		F
CYP1 - Number of visitors to the site	October 2022	1562		1,293.38		
CYP1 - Number of Referrals	October 2022	137		81.11		
CYP1 - Number of Referrals Accepted	October 2022	47		31.72		

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	October 2022	5	0	2.37		?
RTT Open Pathway: % Waiting within 18 Weeks	October 2022	48	92	55.70	L	F
% Recovery for OP New & OPPROC Activity Volume	October 2022	99	104	135.60		?
% OPFU Activity Volume	October 2022	101	85	132.68		F
CAMHS: Number of Patients waiting >52weeks	October 2022	8	0	4.16	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	October 2022	53	92	64.60	L	F
CAMHS: Paired Outcome Scores	July 2022	35	40	32.19		?
CAMHS: Crisis / Duty Call Activity	October 2022	714		659.84		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	October 2022	88	95	50.15		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	October 2022	67	95	66.67		?
ASD: % Incomplete Pathways within 52wks	October 2022	71	90	73.78		?
ASD: % Referral to triage within 12 weeks	October 2022	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	October 2022	74	90	83.20		?
ADHD: % Referral to triage within 12 weeks	October 2022	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	October 2022	18	100	9.14		F
IHA: % complete within 20 days of referral to Alder Hey	October 2022	78	100	26.97	H	F

Divisional Performance Summary - Community & Mental Health

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	October 2022	14	10	12.38	H	F
Short Term Sickness	October 2022	2	2	1.59		?
Long Term Sickness	October 2022	4	3	3.82		?
Mandatory Training	October 2022	95	90	94.78		P
% PDRs completed since April	October 2022	47	90	55.43	L	F
Medical Appraisal	October 2022	85	100	58.14		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	October 2022	2	0	5.49		?

Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• Improvement in Sepsis compliance for inpatients and ED. • Sustained recovery position. • Sustained Childrens Cancer standards performance

Areas of Concern

• FFT in ED and ED 4-hour performance. • 52 week waits; daily focus in this area through November. • PDR compliance showing improvement but falling short of trajectory. • % Unsigned letters over 7 weeks, improvement in Paediatrics but below target

Forward Look (with actions)

• New UTC building scheduled for December to reduce ED crowding. • Daily 52-week meetings to review breaches; recovery plans developed. • Care Group PDR Plans in development. • Direct targeting clinicians with overdue letters.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	October 2022	25	15	20.00		
Number of Incidents rated No Harm and Near Miss	October 2022	205	140	146.21	H	
Sepsis % Patients receiving antibiotic within 60 mins for ED	October 2022	91	90	84.33		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	October 2022	100	90	89.67		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	October 2022	7	6	4.74		
Number of PALS contacts	October 2022	59	45	41.84		
F&F ED - % Recommend the Trust	October 2022	71	95	69.29		F

Divisional Performance Summary - Medicine

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	October 2022	75	95	77.52		F
Number of Super Stranded Patients (21 days)	October 2022	29	20	26.89		?
% Virtual Outpatients (national standard 25%)	October 2022	27	25	37.80	L	P
% Was Not Brought Rate (All OP: New and FU)	October 2022	9	10	9.04		?
% of Clinical Letters completed within 10 Days	October 2022	57	95	56.77		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	October 2022	112	104	113.16		?
Number of RTT Patients waiting >52weeks	October 2022	33	0	14.11	H	?
Diagnostics: % Completed Within 6 Weeks of referral	October 2022	65	99	64.28		F
RTT Open Pathway: % Waiting within 18 Weeks	October 2022	55	92	69.87	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	October 2022	100	100	99.33	H	P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	October 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	October 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	October 2022	100	100	91.67	H	?
Cancer: Faster Diagnosis within 28 days	October 2022	100	75	93.08	H	P
% Recovery for OP New & OPPROC Activity Volume	October 2022	147	104	99.11	H	?
% OPFU Activity Volume	October 2022	102	85	112.80		F

Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	October 2022	14	10	12.74	H	F
Short Term Sickness	October 2022	3	2	2.27		?
Long Term Sickness	October 2022	4	3	4.47		F
Mandatory Training	October 2022	91	90	91.30		?
% PDRs completed since April	October 2022	42	90	47.30	L	F
Medical Appraisal	October 2022	82	100	60.85	H	F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	October 2022	-1	0	-1.72		?

Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• Special cause variation PALS complaints remaining at 100% • WNB rate improved for the 4th consecutive month • % clinical letters shows special cause variation of an improving nature as a result of divisional focus • Significant reduction in patients waiting over 52 weeks • % Recovery (volume) close to 104% treating more patients than 19/20 • LTS absence shows significant reduction with special cause variation at 2.8%

Areas of Concern

• ERF remains less than 104% for the division, key challenges; imbalance of high value tariff and 52 week challenges specialties, workforce constraints in theatre to deliver additional sessions • Although improved through October, continue to fail target for number of patients waiting over 52 weeks- key challenges Dental, Spine, ENT • Staff turnover shows special cause variation and continues to fail the target with

Forward Look (with actions)

• Continue to focus on 52 week waits in line with divisional trajectories- key action plans in place for areas of concern with insourcing model planned for Paediatric Dentistry • Complete specialty level capacity & demand models with clear action plans • Support agency in theatre to enable delivery of recovery plan • Deep dive into high turnover areas- theatre already complete. Retention action plans

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	October 2022	44	40	47.95		
Number of Incidents rated No Harm and Near Miss	October 2022	134	150	158.53		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	October 2022	86	90	83.14		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	October 2022	6	6	4.74		
Number of PALS contacts	October 2022	61	45	40.32		

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)	October 2022	28	20	20.47		
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	October 2022	11	0	6.95		
Number of Super Stranded Patients (21 days)	October 2022	16	30	10.00		F
% Virtual Outpatients (national standard 25%)	October 2022	14	25	17.22	L	F
% Was Not Brought Rate (All OP: New and FU)	October 2022	8	10	8.65		
% of Clinical Letters completed within 10 Days	October 2022	67	95	57.92	H	F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	October 2022	102	104	89.84		
Number of RTT Patients waiting >52weeks	October 2022	357	0	267.21	H	F
Diagnostics: % Completed Within 6 Weeks of referral	October 2022	31	99	33.10		F
RTT Open Pathway: % Waiting within 18 Weeks	October 2022	55	92	61.82	L	F
% Recovery for OP New & OPPROC Activity Volume	October 2022	104	104	98.08		
% OPFU Activity Volume	October 2022	82	85	100.42	L	

Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	October 2022	13	10	11.72	H	F
Short Term Sickness	October 2022	2	2	2.30		?
Long Term Sickness	October 2022	3	3	3.88	L	F
Mandatory Training	October 2022	92	90	91.72		?
% PDRs completed since April	October 2022	45	90	43.12	H	F
Medical Appraisal	October 2022	85	100	66.05	H	F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	October 2022	-8	0	-3.72		?

Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

• Collaborative continues to review key workforce and financial metrics plus risk registers with focus on 'hot spot' areas. Agreed approach to mirror Divisional boards as far as practicable to aid consistency.

Areas of Concern

• Lack of engagement to date from some of the corporate areas. This is being addressed ahead of the next meeting on 30th November.

Forward Look (with actions)

• Agreement and completion of the CSC's A3 (problem statement) at the next meeting. Plan to report risk issues via the Risk Management Forum going forward, per a discussion at the Audit and Risk Committee.

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	October 2022	14	10	14.12		F
Sickness Absence (Total)	October 2022	6	5	6.67		?
Short Term Sickness	October 2022	2	2	1.52		?
Long Term Sickness	October 2022	4	3	5.15		F
Mandatory Training	October 2022	94	90	92.01	H	?
% PDRs completed since April	October 2022	48	90	52.54	L	F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	October 2022	-3	0	-10.61		?

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Report of:	Deputy Director of Finance
Paper Prepared by:	Associate Finance Director Operational Finance
Subject/Title:	Finance Report – Month 7 2022/23
Background Papers:	N/A
Purpose of Paper:	To provide the Committee with an update on the month 7 financial position for 2022/23
Action/Decision Required:	It is recommended that the Committee: (i) Note the contents of the report;
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Improving Financial strength
Resource Impact:	N/A

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Alder Hey Children's NHS Foundation Trust

Finance Report

As at
Month 7
October 2022/23

Date of issue: 18th November 2022

Rachel Lea
Deputy Director of Finance

Alder Hey Children's NHS
NHS Foundation Trust

Executive Summary

Key Metrics	In Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
Income £000 (Exclude ERF)	29,320	30,191	871	205,237	208,922	3,685
Pay Expenditure £000	(18,149)	(18,582)	(433)	(127,343)	(127,194)	149
Non Pay Expenditure £000	(10,916)	(11,354)	(438)	(82,225)	(85,989)	(3,764)
Expenditure £000	(29,065)	(29,936)	(871)	(209,569)	(213,183)	(3,615)
Trading Position £000	255	255	()	(4,331)	(4,261)	70
ERF Income £000	772	772	(0)	3,885	3,819	(67)
ERF Expenditure £000	0	0	0	0	0	0
Revised Trading Position £000	1,027	1,027	()	(446)	(442)	4
WTE	3,944	3,869	74	3,944	3,869	74
Cash £000		82,403			82,403	
CAPEX FCT £000	1,400	1,228	172	3,825	4,636	(811)

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

The main drivers for the year-to-date position continue to be associated with CIP non-delivery from earlier months of the year, continued pay and non-pay cost pressures including Junior Doctor pressures, inflation on clinical supplies and drugs, offset in part with non recurrent benefits such as rates rebate, interest received and pay vacancies.

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

The Trust is now forecasting to meet its in year CIP challenge of £17.3m subject to the delivery of schemes still in progress. There is however a risk to the recurrent CIP position given the Trust has a recurrent efficiency target of £12.5m however only £5.3m (42%) has been identified, meaning the remaining £7.2m (58%) will be carried forward into 23/24 if not identified.

The value of activity was positive in October and close to the 104% target level (measured against 19/20 activity baseline). In-month we achieved 103.4% and the year to date the Trust is now 98.6%.

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

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

- **Income £3.6m favourable variance to plan (including interest received)**
  - £3.0m favourable to plan for Cost and Volume drugs predominantly Cystic Fibrosis which is offset by additional expenditure.
  - £0.6m interest received higher than original planned due to increasing interest rates with a full year benefit estimated to reach £1m.
  - ERF – variance reflects Wales under performance when compared to plan. English ERF remains to report breakeven until the national position is known. More information on ERF can be found in section 6 below.

- **Non-Pay £3.3m adverse variance to plan**
  - £4.1m drug costs with 72% relating to pass through drugs and offset by income, but the remainder in drugs paid for as a block where activity has increased. Further investigation with the pharmacy team is underway.
  - £0.8m non-delivery of CIP predominantly from earlier months of the year
  - £1.4m clinical supplies and other pressures offset by slippage in other areas and depreciation benefit £1.5m.

- **Capital spend of £4.6m year to date.** Of this £3.8m is Capital Departmental Expenditure Limit (CDEL) spend which is £0.7m ahead of plan but will be in line with the forecasted position by the end of the year.

- **CIP achievement in month of £1.4m against a plan of £1.7m.** Therefore £0.3m below the required target which has increased from month 7 to strive towards the overall £4.6m surplus Trust position by the end of the year.

- **Cash at the end of October was £82.4m**

- **Better Payment Practice Code achievement in month of 83% against the target of 95%.** A project is underway with action plan to improve the BPPC, and this is being monitored weekly by the senior finance team. The actions will result in a deterioration as older invoices are cleared but this will improve overall once complete.

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beyond
Children and Young People's Transformation Programme

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Beyond Update**
Report of:	**Dani Jones, Executive Lead: Beyond; Director of Strategy and Partnerships: Alder Hey**
Paper Prepared by:	**Dr Elizabeth Crabtree, Programme Director: Beyond**

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Summary / supporting information:	Link to BAF Risk 3.6 – risk of partnership failures due to robustness of partnership governance.
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:	N/A

Cheshire and Merseyside
Health and Care Partnership

1. Introduction – summary of key risks and issues

Alder Hey Children's NHS Foundation Trust is host organisation for Beyond: NHS Cheshire and Merseyside's Children's Transformation Programme. The purpose of this report is to provide the Board of Directors with an update on the Beyond Programme.

The report provides assurance to the Board of both programme delivery, and that the Trust is fulfilling its hosting role robustly and that any associate risks are adequately managed.

2. Background and current state

- **Context**

In 2021, C&M Health Care Partnership formed a children and young people's transformation programme, "Beyond", to support the NHS Long Term Plan commitments. They widened the scope of delivery to ensure a Population Health focus across key priority areas:

Beyond has been formally hosted by Alder Hey NHS Foundation Trust since inception in July 2021. The programme is funded through both NHS Cheshire and Merseyside ICB, and NHSE Children's Transformation Programme.

The programme focus was co-produced across Health, Social Care and Public Health and reflected Place priorities, informed by Place Joint Strategic Needs Assessments. Key to this programme of work was "shift left" to focus on integrated early intervention and prevention that addresses the wider determinates of health and social outcomes. The key objectives of Beyond centre on improving population health and healthcare including safety and quality improvement, tackling health inequalities, enhancing productivity and

value for money and supporting broader social and economic development through multi-agency design and delivery.

The key priorities of the programme are in line with the emerging Core 20+5 for children, with the exception of Oral Health which is currently being scoped for delivery.

- **Case for Change**

Children and Young People represent 27.2% of the population across C&M and they face a difficult start in life with significantly higher levels of deprivation compared to the national average.

C&M has some of the most deprived areas of the country, with more than 33% people living in the 20% most deprived neighbourhoods, significantly higher than the national average (20%). Deprivation is strongly associated with poor health outcomes and people in deprived communities experience poor health and require care from a much younger age. This is demonstrated by the stark health inequalities within C&M and compared to England.

Nationally, life expectancy is falling and falling highest in areas of highest deprivation. There is a difference of 10 years Healthy Life Expectancy (HLE) within C&M. Four Place areas have significantly lower levels of HLE than the England average. Lower HLE outcomes correlate strongly with those areas where greater numbers of children are living in absolute low income families.

Across our region, over 67,000 children under 16 years live in absolute low-income families, and in our most deprived communities this can be circa 20% of all children and young people. Children in 6 of 9 Places are more likely than the England average to receive free school meals – and in the areas of highest deprivation, this is equal or double the England average.

For children across C&M, many have greater levels of difficulties than the England average (data source: CIPHA):

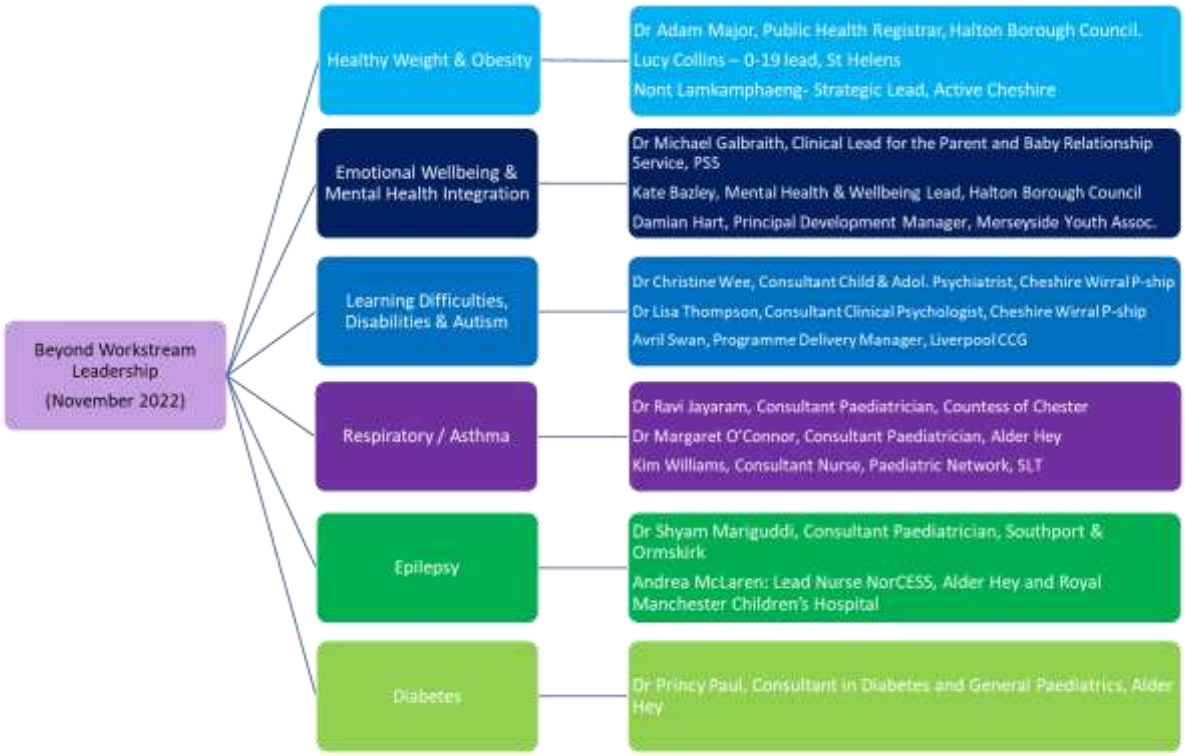
- Children are performing less well in educational readiness / attainment particularly those eligible for free school meals:
- In parts of C&M 70% of school children are classified as overweight or obese
- CYP are experiencing significant mental health difficulties
- Children are less likely to be breastfed at 6 – 8 weeks
- A greater proportion of children are within Local Authority care – some recording double the England average
- Children are more likely to have a hospital admission for asthma

- **Delivery**

The Programme Chair is Kath O'Dwyer, Chief Executive Officer of St Helen's Borough Council, and Louise Shepherd, Chief Executive, Alder Hey Children's NHS Foundation

Trust is the Beyond Senior Responsible Officer. Dani Jones, Director of Strategy, Partnerships and Transformation, is the Executive Lead for the Programme.

The programme works with a range of multi-agency, clinical and organisational leads from across the ICS who provide expert leadership for each of the workstreams.



The programme is supported by a small, strong programme management team including programme manager, project managers and a data scientist.

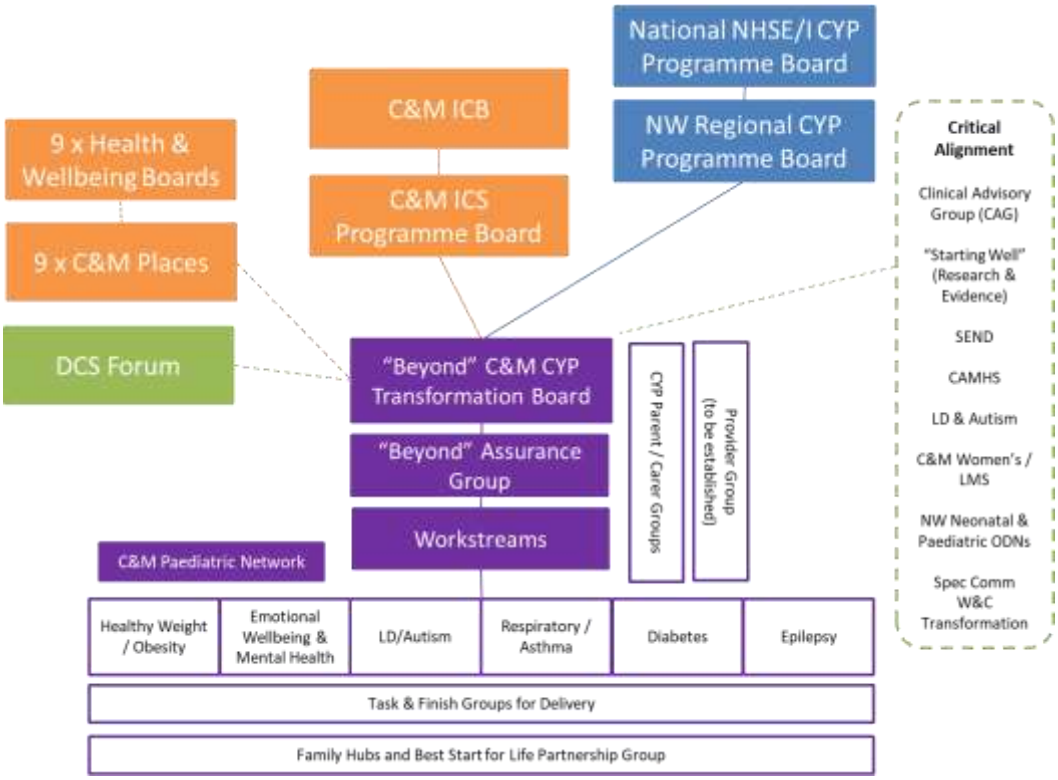
- **Governance**

The Beyond programme has established a strong partnership approach to delivery, with representatives from Place; Voluntary, Community and Social Enterprise Sector (VCSE); Social Care; Public Health; Office for Health Improvement and Disparities (OHID); NHS Providers and commissioners represented at every level of delivery from workstreams to Board. This strong partnership and collaboration has ensured integrated working, and a population health approach to transformational delivery.

There is an effective governance structure in place to provide assurance around delivery both within Alder Hey and across the system into the ICB and NHSE. The Beyond Board meets quarterly, is chaired by a Local Authority CEO (St Helens). The Beyond SRO is Alder Hey's CEO and the Beyond Exec lead (Alder Hey Director of Strategy & Partnerships) are both represented at the Board.

The programme finances are managed within Alder Hey's scheme of delegation and standing financial instructions,

Beyond reports on a bi-monthly basis for assurance to both NHSE via the North-West CYP Programme Board, and the C&M ICB transformation board. We are reporting green for delivery via both routes with no key risks to escalate.



- **Risks**

  All programme risks are monitored via the Programme Team and reported through Board Assurance,

  There are no programme risks for escalation scoring 15 or above.

- **Strategic Influence**

  Beyond has established strong links across the ICP, and at Place. Contact has been made with Place Directors and the Programme Director has presented at 3 Place Partnership boards, with a further 2 scheduled.

  Key projects are being developed across the ICS, with programmes of work being undertaken in all 9 areas. All programmes of work are being evaluated to enable robust analysis of delivery to inform transformational change and inform commissioning decision making.

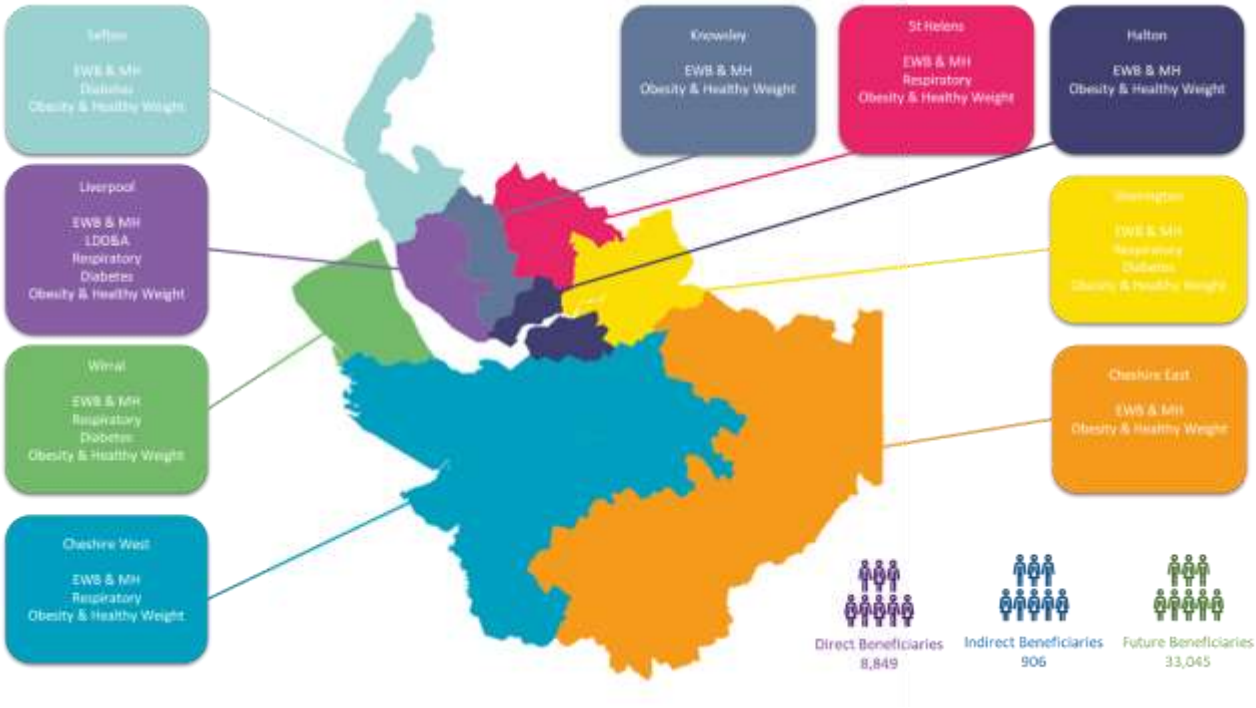
  The programme has coordinated the response to the children and young people's element of the developing ICP strategy to ensure that there remains a focus on the CYP agenda.

Beyond had worked across the ICP with colleagues from Public Health, OHID and Marmot to bid to be part of a Health Equity Collaborative. We have been successful at the first stage of the process and awaiting a partnership conversation to discuss next steps. This is a partnership with Barnados and the Institute of Health Equity to develop:

- Children and Young People's Health Equity Framework
- Children and Young People's Health Equity Dynamic Measurement Tool
- Children and Young People's Health Equity Interventions

- **Programme Reach**

  Initial analysis suggests an existing programme reach of circa 9000 children and families with an expected additional reach of 33,000 children and families within the next year of delivery.



3. Conclusion

Beyond, as a hosted programme, is well-established within the ICP, and is forming effective links across the system to drive transformational change for children and young people across Cheshire and Merseyside.

4. Recommendations

Trust Board are recommended to receive and note the content of this report.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday, 24th November 2022

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

Campus Development report on the Programme for Delivery

November 2022

1. Introduction

The purpose of this report is to keep the Board informed of progress, risks and actions on the key capital projects as they arise.
As of Month 2 in Quarter 3 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Highlights

- Crisis Care live and operational in New Catkin
- Community Paediatric outpatient facility live and operational in New Catkin
- FREASH Cams live and operational in IP2

3. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Cost Pressure due to market inflation, availability of labour and / or materials. SPV contract support	Reduction in costs via value Engineering, redesign, and commercial agreement complete. Additional support through management of other capital funds and charity support secured. Presenting final costs to Board for approval to proceed. Weekly liaison meetings held, deadlines raised in Trust/SPV liaison meetings, escalated within SPV team.
Sunflower House / Catkin	Quality issues	Holding back from Completion due to quality issues. Issues with CLT finish, process agreed with contractor to provide samples for agreement to address issue. Sign off solution taking place 24th November 2022, projected 6 week process to complete if agreed.
Temporary Modular Office (Alder Centre)	Programme delay	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works.
Main Park Reinstatement	Vacation of Catkin, linked to Alder Centre Temporary Modular project.	Working up solutions to mitigate delay, minimise impact. Looking at park

		programme to make back time.

4. Programme Delivery Timetable

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

Table 1.	21/22				22/23			
Scheme	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr.1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Neonatal and Urgent Care Development Contractor Selection								
Neonatal and Urgent Care Enabling – Car Park								
Neonatal and Urgent Care Enabling – Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (Dec 2024)								
Sunflower House / Catkin Construction								
Sunflower House / Catkin Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Police Station)								
Police Station Design								
Police Station Construction								
Relocations								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 2-100%) **COMPLETE**								
Main Park Reinstatement (Phase 3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Medical Photography / Orthotics **COMPLETE**								
Innovation Park 2								
Fracture / Derm								
EDYS								
Surgical Day case								

5. Project updates

Neonatal and Urgent Care Development

Current status	Risks/issues	Actions
Phase 1 of the enabling works to create a temporary ED car park have completed. Phase 2 of the enabling works complete; service investigations. Phase 3 Blue light road diversion LOI issued to commence, started on site with site set up. Works start 5th December 2022. Phase 4 Service diversions provisional start date March 2023 Main build provisional start date April 2023, completion Dec 2024 Agreeing and seeking final approval regarding funding, to allow project to proceed. Finalising contract documents and award.	Substantial cost increases due to market inflation, availability of labour and / or materials Project Co engagement extending the programme and increasing costs.	Reduction in costs via value Engineering, redesign, and commercial agreement complete. Additional support through management of other capital funds and charity support secured. Presenting final costs to Board for approval to proceed. Continue working with Project Co to mitigate impact. Updated team at AH/SPV liaison meeting. Escalated within SPV.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Accepted takeover of Catkin element, Crisis team occupying and fully operational, clinics live within building. Agreed take over for Police station element, works inspected and accepted by Merseyside Police. Planning the signature of the lease and their occupation.	Quality issues being experienced on site.	Holding back from Completion due to quality issues. Issues with CLT finish, process agreed with contractor to provide samples for agreement to address issue. Sign off solution taking place 24th November 2022, projected 6 week process to complete if agreed.

Modular Office Buildings

Current status	Risks/issues	Actions
Larger unit by Alder Centre being provided by LOR; construction completed, furniture installed, commissioned ready for occupation. Smaller unit in Police Station car park being provided by Portakabin. Project on hold due to police station lease not in a position to sign; for takeover of the former police station.	Programme delay, alder centre station modular Programme delay, police station modular	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works. Programme delay due to delay in lease agreement for former Police station. Moves held and alternative accommodation agreed with users. Lease being fast tracked.

Police Station

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

Park reinstatement

Current status	Risks/issues	Actions
Phase 1 of the park is now operational. Grassed area re-seeded and grass recovering. High cuts and tidying being performed. Standing water being experienced. MUGA works commenced liaising with LCC for lighting connection. Trim trail commenced and equipment on site ready for installation.	MUGA lighting Standing water being experienced	MUGA lighting utility connection being provided by LCC, working closely to ensure this is provided in time. Soil samples being taken, installation being tested and design reviews

Landscaping completed for Phase 2 with number of paths started. Play equipment being delivered to site in New Year in preparation for installation. Phase 3 started in sections in anticipation for Catkin demolition and main park works. Working with LCC and LPA on park lighting, Sub Station 5 and existing play equipment. Community engagement days held with park tours and presentations for local community. Programme being worked up for completion of the park, linking in with other key projects that release the land to enable park works to proceed. Aiming for an early hand back in Summer 2023, prior to backstop date of Nov 2023.	Campus moves delay park	booked to asses and understand issue. Propose rectification as next phase is constructed. Any issues to feed into next phases to ensure problems do not reoccur. Programme reviews held weekly to keep on top of all interdependent projects, with mitigations put in place, to ensure programme is kept on track. Current concern over Alder Centre Modular and potential delays, working through options to mitigate and limit delay impact.

NEW Mini Master Plan for Eaton Rd frontage

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

Innovation Park 2

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

Fracture and Dermatology

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

Surgical Day Case

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

EDYS

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

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
Land value presented to Trust. Trust considering options.	Value of option not viable to Trust.	Challenge value through independent, jointly appointed valuer.

Communications

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

6. Trust Board of Directors

The Board of Directors is requested to receive and acknowledge the update provided as of 24th November 2022.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st October 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Director of Nursing 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 October 2022.

2. Background

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

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

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

Outcomes and oversight of SIs are considered at Divisional Quality Boards, Clinical Quality Steering Group (CQSG), Safety and Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

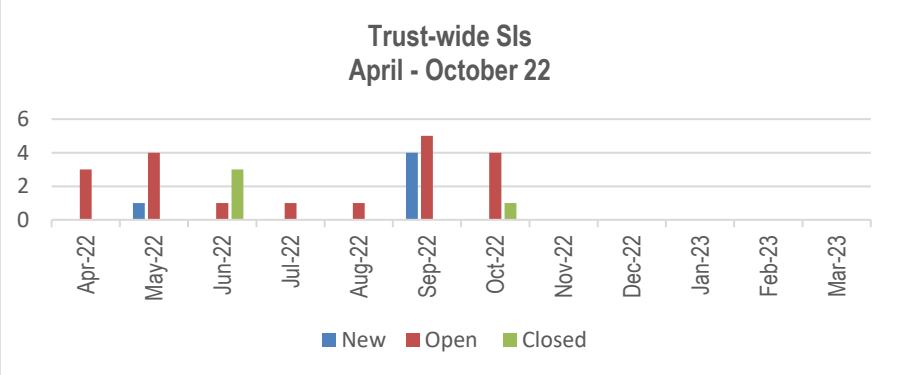
3. Local context

3.1 Never Events

The Trust declared **0** Never Events during the reporting period (1st – 31st October 2022).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status October 2022



3.2.1 Declared Serious Incidents

The Trust declared **0** StEIS reportable incidents during the reporting timeframe (1st – 31st October 2022).

3.2.2 Open Serious Incidents

4 SIs were open during the reporting period as outlined in table 1.
1 SI investigation was completed in this reporting period (1st – 31st October 2022).

Table 1 Open SIs September 2022

StEIS reference	Date reported	Division	Incident	Summary
2021/24660	25/11/2021	Surgery	Near miss reported for potential for learning.	Completed and sent to commissioners.
2022/19971	14/09/2022	Surgery	Never Event – retained foreign object post procedure.	Refer to appendix 1 for detail
2022/20586	06/09/2022	Medicine	Staff exposure to highly contagious organism (*non-clinical).	
2022/20661	17/08/2022 (reported to StEIS 28/09/2022)	Surgery	Category 3 pressure ulcer under plaster cast.	
2022/20851	16/09/2022	Surgery	Patient death following discharge.	

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 31st October 2022):

8 SI action plans remained open, of which:

- **6** SI action plans are overdue their expected date of completion
- **1** SI action plan completion date was extended by commissioners
- **1** SI action plan is within the expected deadline

3 SI action plans were confirmed closed by commissioners during the reporting timeframe (1st – 31st October 2022).

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

3.3 Internal level 2 RCA Investigations

The Trust declared **zero** internal level 2 RCA investigations during the reporting timeframe (1st – 31st October 2022).

3.4 Duty of candour

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

2 Duty of Candour responses (1 initial duty of candour and 1 final duty of candour response) were required and completed within expected timeframes during the reporting period (1st – 31st October 2022).

4. Learning from serious incidents

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

SI action plan completion is monitored internally via CQSG, to ensure barriers to completion are addressed and learning is embedded across the organisation as required.

The emerging themes and associated learning from completed reports in the reporting timeframe include:

- Policy/guidelines - lack of protocol in place
- Communication
- Training/experience
- Availability of equipment

5. Next steps

- Ongoing monitoring of open SIs with overdue actions plans being undertaken by divisions.

- Continued support offered by the corporate governance team to support SI action plan completion.

- Ongoing review of the RCA process to support the timely conclusion of investigations and psychological safety support offered to all staff involved in the current RCA process.

6. Recommendations

The Trust Board is asked to:

- Consider the content of the report
- Note the number of open and overdue SI action plans by division that require review
- Agree the level of assurance provided

Appendix 1

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

2022/ 20661	Category 3 pressure ulcer under plaster cast.	Standard practice was followed. No lapses in care identified.	Dressing applied to protect fragile skin integrity. Window cast applied for regular skin/ wound review. Wound has completely healed. **October 2022:** Panel completed on 04/11/2022. Draft report being reviewed by the panel members.
2022/ 20851	Patient death following discharge.	Tabletop review 27/09/2022: Panel concluded that further detail and discussion with the family in relation to medication history, discharge plan and discharge documentation is required as part of the investigation process	Rapid Review undertaken by the surgical Division on the 20/9/2022. **October 2022:** Panel scheduled 11/11/2022. Note: Case now subject to coroner's inquest

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed
2019/23494	24/10/2019	25/10/2019	Medicine	Outstanding laboratory test results identified	Closed by commissioners 04/11/2022.	30/04/2020	
2020/608	08/01/2020	09/01/2020	Medicine	Misdiagnosis of tumour	Closed by commissioners 14/10/2022.	30/06/2021	
2020/12954	09/07/2020	10/07/2020	Corporate Services	Incorrect settings on port-a-count machine resulting in staff being incorrectly passed on an FFP3 mask	Closed by commissioners 20/10/2022.	20/12/2021	
2021/1919	03/01/2021	15/01/2021	Medicine	Transfer from Bangor. Treated according to advice, patient suffered raised intracranial pressure requiring shunt	All actions completed. Closed by commissioners 04/11/2022.	30/04/2022	

2021/12203	27/05/2021	10/06/2021	Medicine	Deteriorating patient requiring transfer to HDU	All actions completed 03/11/2022.	01/06/2022	
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	2 actions outstanding. Closed by commissioners 04/11/2022.	30/06/2022	
2021/25961	15/12/2021	21/12/2021	Medicine	Patient relapsed during receipt of active leukaemia treatment	All actions completed 03/11/2022.	31/07/2022	
2021/17974	16/07/2021	01/09/2021	Medicine	Preparing child's case for discussion at national forum. Identified that care provided for eradication is outside of usual clinical pathway	13 3 actions outstanding.	31/08/2022	01/11/2022
2022/1581	18/01/2022	24/01/2022	Surgery	Category 4 Pressure Ulcer	Closed by commissioners 28/10/2022.	31/08/2022	
2021/12387	14/06/2021	14/06/2021	Community & Mental Health	Patient suicide whilst under care of CAMHS	All actions completed 11/11/2022.	31/10/2022	

2022/2634	02/02/2022	04/02/2022	Medicine	Missed opportunity to diagnosis a patient.	All actions completed 03/11/2022.	31/12/2022	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Mortality Report (Q2), 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 1 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

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

This is a concise report as it is a shorter period than usual since the last report was written due to August's paper being delayed to September. In August /September the HMRG process was audited by MIAA and awarded the highest rating possible:

High Assurance	There is a strong system of internal control which has been effectively designed to meet the system objectives, and that controls are consistently applied in all areas reviewed.

Key findings of Audit

Overall, the review identified that is a strong system of internal control which has been effectively designed, and Board leadership was evident in respect of scrutiny and oversight of mortality.

The Trust's Hospital Mortality Review Policy is in line with NHS guidance and due for review in late 2022. The Policy is comprehensive with respect to the processes to be followed and includes clear description of the roles, responsibilities, and accountability at all levels.

Robust governance arrangements are in place at both departmental and Trust levels via the Hospital Mortality Review Group (HMRG) which meets monthly (and more frequently when required) with diverse and experienced

representation from across the Trust. MIAA attended the August HMRG meeting, which demonstrated robust, positive, constructive, and supportive discussions of individual cases to capture lessons learned. HMRG reports to the Clinical Quality Steering Group (CQSG) and Safety and Quality Assurance Committee (SQAC) through Quarterly Reports which are also shared with the Board.

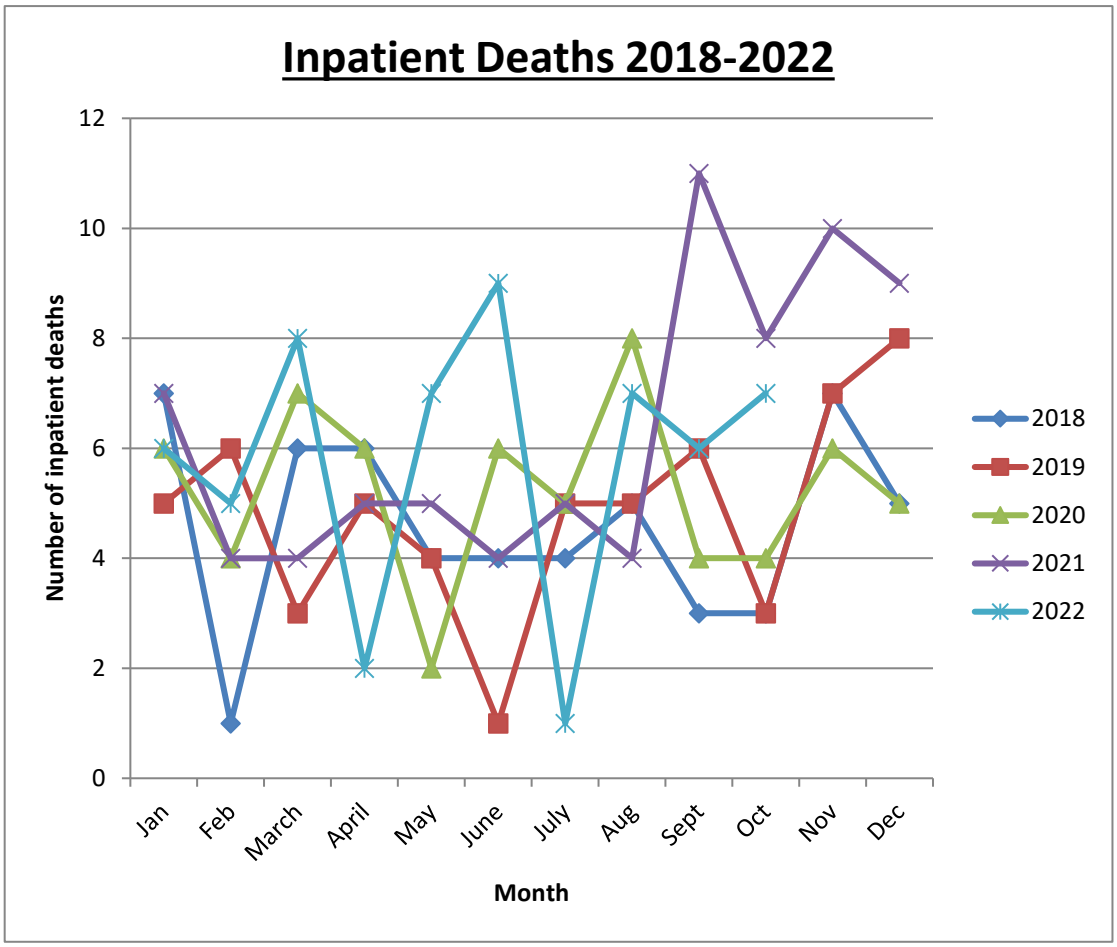
Audit review confirmed that the processes around mortality reviews, reporting and governance are consistent with Trust policy. The HMRG Chair and wider team involved in the mortality process are committed to continuous improvement and are supportive of innovations which optimise the process. For example, PICU have worked with the Innovation Centre to create an app to efficiently capture the information required to complete the departmental review form, and the Trust are now looking at the potential benefits of rolling out the app to other teams.

The Trust has recognised its responsibility to ensure lessons learned are disseminated widely. Starting Summer 2022, a new process has been implemented to provide formal feedback to the divisions from HMRG. Learning days have been introduced from August 2022. It was noted that the Trust has recently led on national guidance around button batteries. Finally, external benchmarking of the mortality review process is in progress with a partner Trust.

The Alder Centre teams provide exceptional support to family, friends and staff affected by the death of a child. Learning is captured informally through discussions and formally through professional reflection and input to 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	
Dec	5	8	5	9	
Total	55	58	63	76	58



Looking at the 5-year figures, there was an increase in total case numbers in 2021 but significantly there had been changes in the way that the data was recorded. In 2022, the figures seem to be returning to more usual levels although there have been increases in all childhood illnesses following COVID lockdowns. The summer months have seen children presenting with illnesses that traditionally we would only see in winter /spring. This corresponds with the 9 deaths in June which is the highest number in the last 5 years. On review of these deaths there were 2 out of hospital cardiac arrests which have a very poor outcome and 4 transfers for assessment however the planned treatment was not ultimately considered to be in their best interest, all were extremely unstable, and they were palliated after full reviews and discussion with the families.

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 will be the introduction of the

Medical Examiner (ME) process which has been delayed to next year 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 and the process is being worked on. To enable this to happen AHCH will need to provide paediatric expertise in the ME process to support the implementation. This would entail one of the AHCH consultants completing the ME course and then joining the LUFT ME team.

2) RCA's as highlighted in the previous report have been problematic to the HMRG process due to a variety of issues impacting on staff involved in addition to the families. These issues have been highlighted and now are being acted upon by the organization to resolve them. In the future investigations will be undertaken using the new PSIRF framework although 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 now be far more effective and in a timelier manner.

Current Performance of HMRG

Summary of 2022 Deaths

Number of deaths (Jan. 2022 – Nov. 2022)	58
Number of deaths reviewed	26
Departmental/Service Group mortality reviews within 2 months (standard)	43/45 (96%)
HMRG Primary Reviews within 4 months (standard)	24/28 (86%)
HMRG Primary Reviews within 6 months	18/19 (95%)

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.

The majority of 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		1				2
May	7	6	6	6		3			1	2
June	9		9							
July	1		1							
Aug	7		7							
Sept	6									
Oct										
Nov										
Dec										

Potentially Avoidable Deaths

There have been no avoidable deaths in this reporting period. However, there is still the outstanding RCA on a traumatic death that was STEIS reported which was highlighted in the previous report.

Learning disabilities

The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 26 cases, so far reviewed in 2022, 9 (35%) 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. This percentage is higher than usual, but it is likely that this is because of the limited numbers of cases reviewed so far but needs careful monitoring and a deep dive will be done as part of the process in the spring.

Family

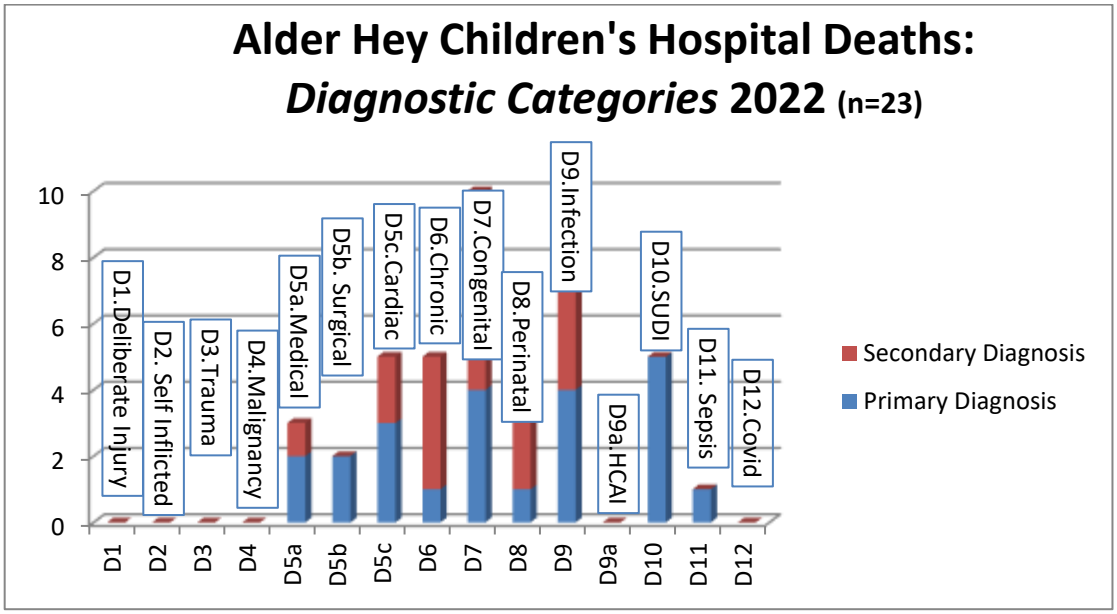
The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide.

The Operational Bereavement group has restarted, and this should help in consistency of the bereavement process across the Trust. 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

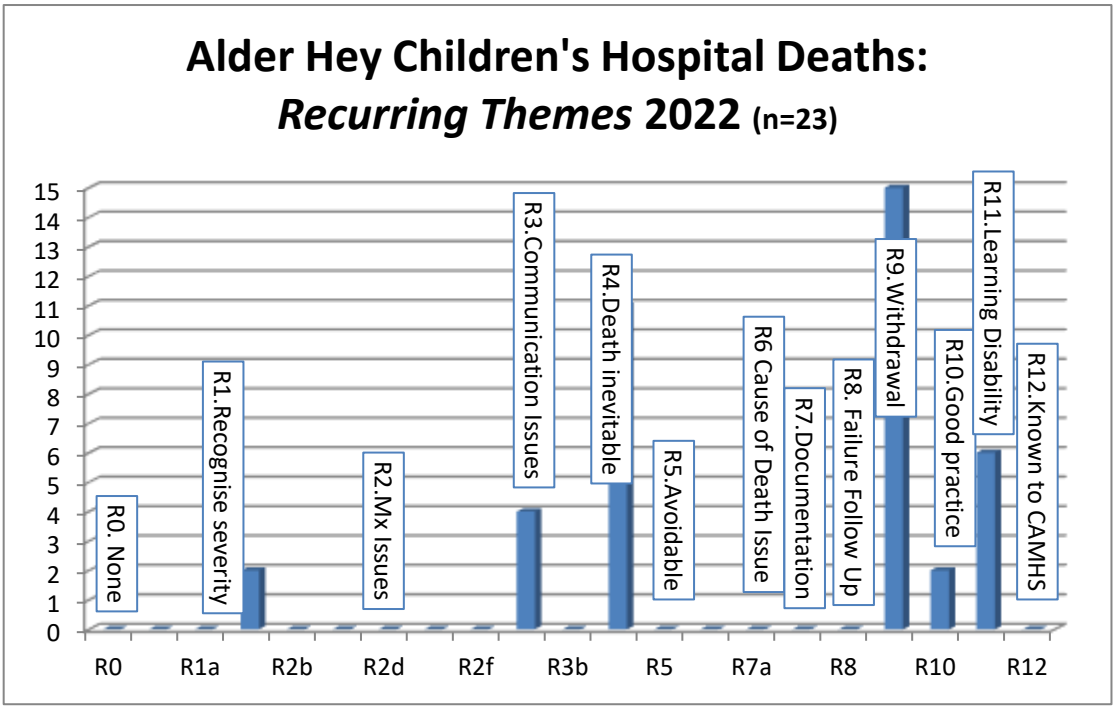


Diagnostic/Disease Categories

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 23 coded is because more information was required to finalise coding. The cases reviewed so far in 2022 show that the highest diagnostic code is 'sudden unexplained, unexpected death', with 22% 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. The next most common diagnostic codes are: 'children with underlying congenital conditions' (17 %), these are often the most complex with several issues on going and infection which is separate from sepsis and to be expected with the very vulnerable patients that we have

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 (65 % 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.

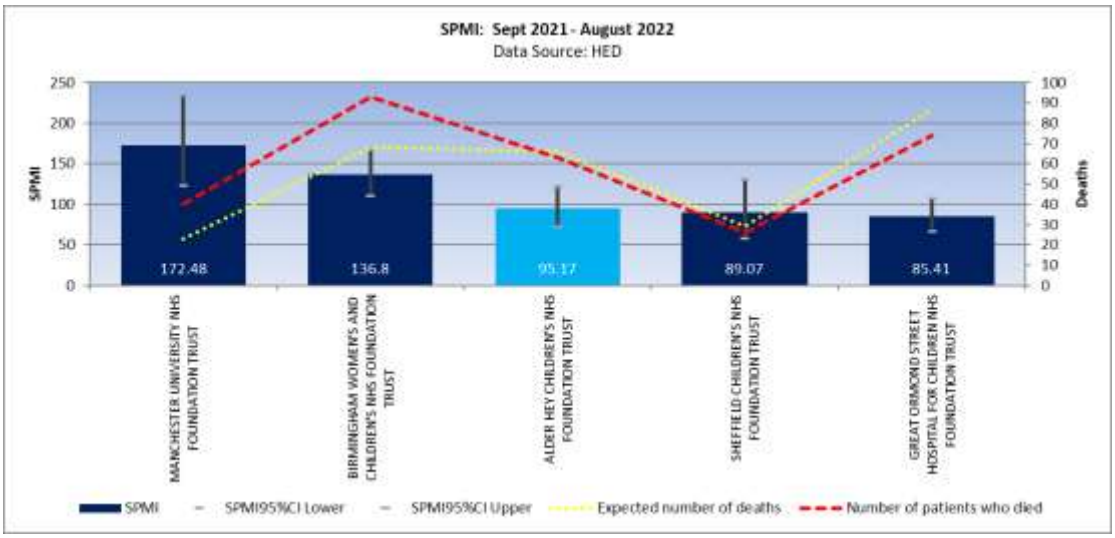
Death was concluded to be inevitable in 48%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.

Section 2: Quarter 2 Mortality Report: July 2022 – September 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 September 2021 to August 2022.



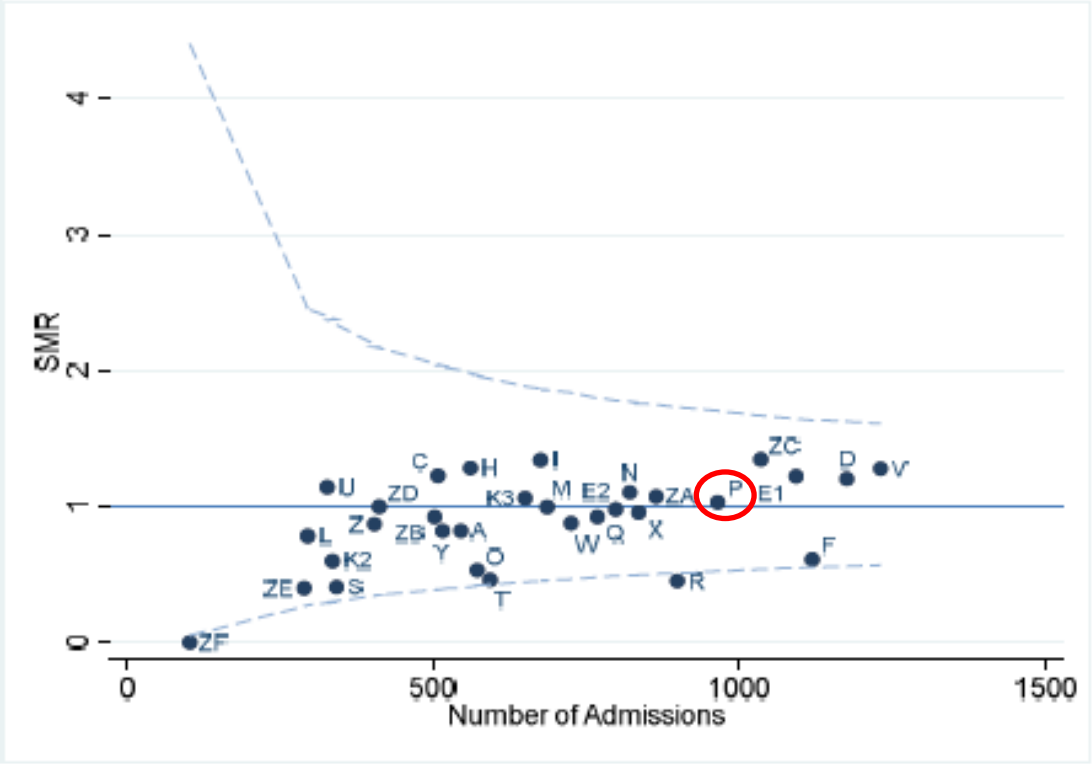
The chart shows that Alder Hey has performance of 63 deaths against 66.2 expected deaths. This shows that the level of mortality is below that expected and is reassuring and indicates that the workload is returning to more normal

patterns after COVID where our admissions decreased, and we had to prioritise the high risk cases.

- **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.

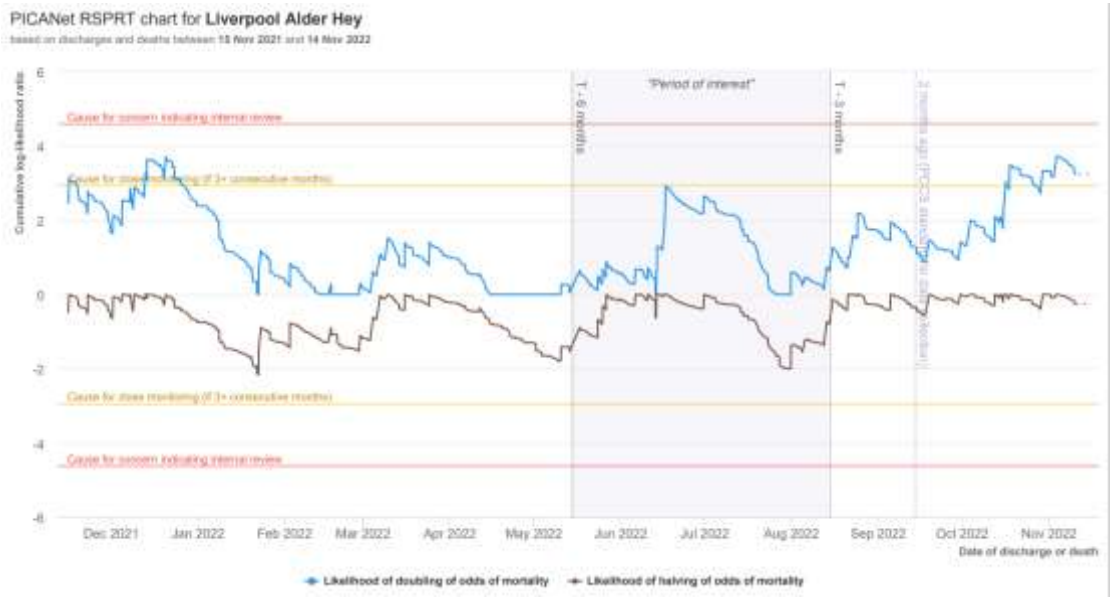
The chart below is taken from PICANet's most recent report and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.



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)



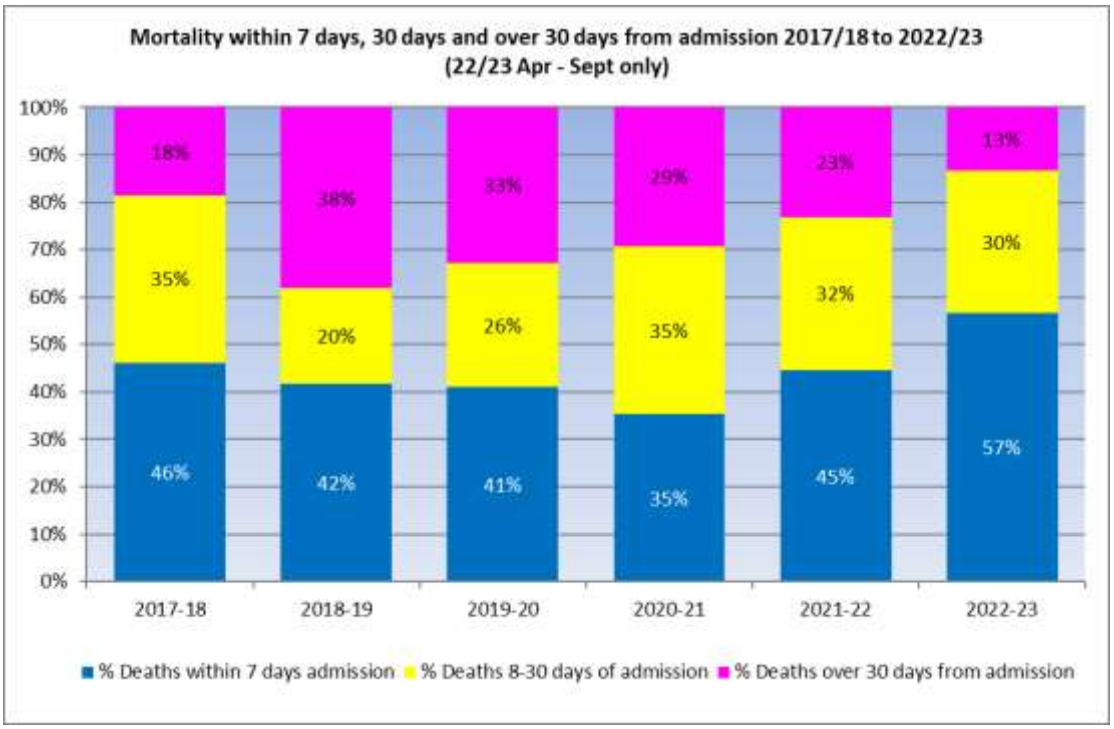
In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can 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.

During the period April – Sept 22 there were 27 deaths in PICU. The mean length of stay was 17 days, the median 5.5 days and the mode ≤ 1 day (13 deaths). This highlights the severity of patients on admission and that in a significant proportion little can be done. The RSPRT (which is corrected by PIM3 for severity) has remained within the 'safe zone' throughout this period and continues to be closely monitored.

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 – Sept 2022) 57% occurred within 7 days of admission, 30% occurred within 8-30 days from admission, and 13% deaths occurred over 30 days from admission. This would correspond with the comments above relating to critical patients being transferred and after assessment being palliated.

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.

The group has raised concerns about RCA's which has been acted upon and is now working to ensure that children are not transferred unnecessarily to AHCH for treatment that is not an option on further assessment.

The MIAA audit showed how hard and effectively the HMRG work to ensure that each death is reviewed, and all possible learning is achieved and shared.

References

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

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

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

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

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

1. Introduction

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

2. People Metrics

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

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

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

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

Are We Well Led?
People Section: HR Metrics

Trustwide
Workforce Headcount: 4,187

	KPI	Target	Aug 22	Sept 22	Oct 22
Absence	Sickness Absence (in month %)	5%	6.13%	5.53%	5.90%
	Short Term Sickness Absence (in month %)	2%	2.18%	1.95%	2.72%
	Long Term Sickness Absence (in month %)	3%	3.95%	3.58%	3.17%
	Return to Work Completion (in month %)	100%	71.66%	66.16%	66.36%
Turnover	Staff Turnover (rolling 12m %)	10%	14.61%	14.09%	14.56%
	Leavers (Headcount)	-	72	28	51
	Time to Hire (pre-employment checks)	30 days	30	37	39
Diversity	Proportion of BAME Staff in Workforce (in month%)	-	9.85%	9.85%	10.22%
Pay Accuracy & Spend	Pay Accuracy (%)	99.5%	99.34%	99.36%	99.37%
	Value of Overpayments (£)	-	£39,809.93	£13,650.82	£39,316.53
	Temporary Spend (£'000s)	-	£1,188.40	£1,439.53	£1,319.68
Training & Appraisal	Mandatory Training (in month)	90%	93.92%	92.52%	92.38%
	PDR band 7+ (from 01/04/2022)	90% (by end of July 22)	77.98%	81.12%	84.65%
	PDR all AFC (from 01/08/2022)	90% (by end of March 23)	32.29%	38.37%	45.35%
	Medical Appraisal (from 01/04/2022)	90% (by end of March 23)	82.57%	81.53%	83.82%

3. Staff Survey

The annual Staff Survey launched on 20th September 2022 and will be open for responses until the 25th of November 2022. Significant changes were made to the Survey last year to align with the People Promise from the 2020/21 national People

Plan which sets out what we can expect from each other and our leaders to make the NHS the best place to work and stay well. Although there have been some minor changes to the survey this year, they have not been significant and so we are able this year to compare our results against the 2021 Survey. Completion rates are monitored on a weekly basis and will be reported to the Board and People and Wellbeing Committee. As of 15th November 2022, the overall response rate was 49%.

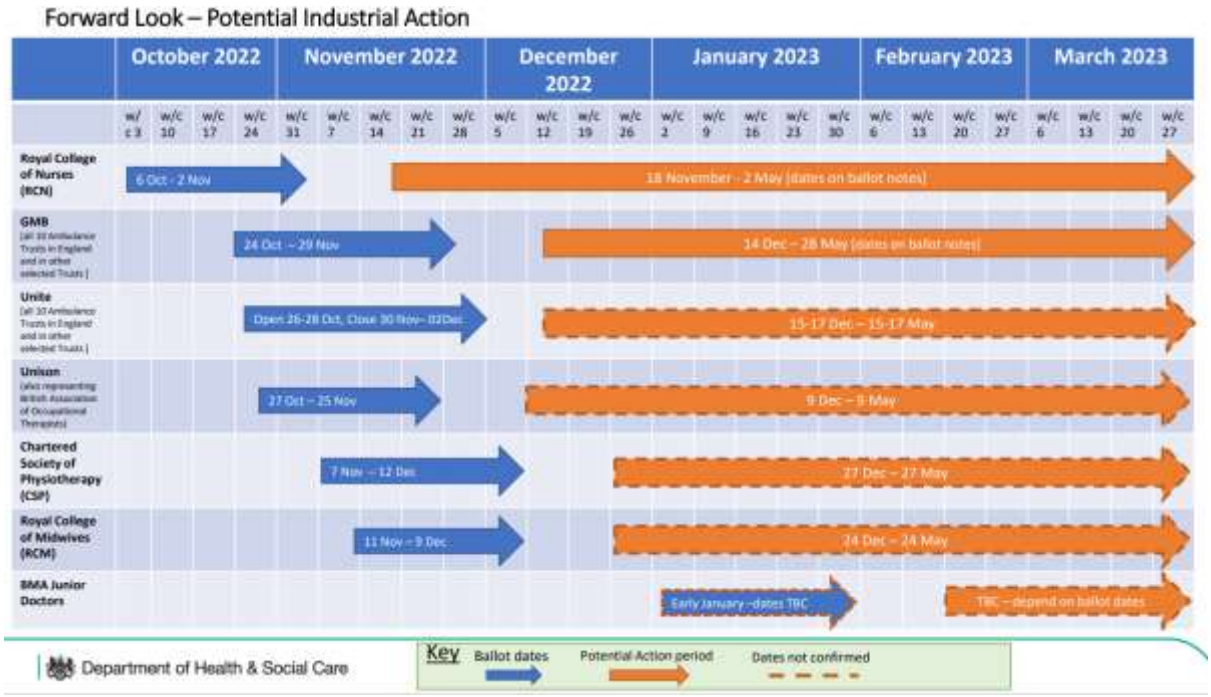
4. Industrial Action

Collectively, the Trade Unions representing NHS Agenda for Change staff and doctors and dentists have expressed their disagreement and lack of support for the recent national pay deals implemented by the government.

Further to the outcome of the RCN ballot, the RCN has announced that nursing staff at the majority of NHS employers across the UK have voted to take strike action over levels of pay and patient safety concerns. Alderhey did meet the threshold with 63% of eligible staff voting, and of those voting 94% voted to take strike action. The Trust has put in place the tactical command structure, headed up by the Chief Operating Officer and discussions have also commenced with staff side colleagues. Discussions with Staff side colleagues focus on how we plan to keep the hospital safe during any planned strike action, in addition working in partnership to acknowledge how difficult a time this will be for many staff thus identifying appropriate communications and support measures.

While RCN has received mandate for action at a number of NHS Employers, they have not yet given formal notice of action taking place (this is a 14day notice period). No dates for strike action have been confirmed at this stage.

Information relating to other Unions time frames for balloting and potential dates of strike action are detailed below.



5. Financial Wellbeing

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

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

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

We will also be launching a scheme in the restaurant called 'Pay it Forward'. 'Pay it Forward' will enable those staff who are in the fortunate position to do so to pay for an extra hot drink or meal when purchasing their own. This fund can then be accessed by other staff who need it through a discreet voucher scheme, administered by SALS, Trade Unions and the Chaplaincy.

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

Sharon Owen
Deputy Chief People Officer
November 2022

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Equality and Diversity Steering Group, Annual Workplan**
Report of:	**Chief People Officer**
Paper Prepared by:	Sharon Owen, Deputy Chief People Officer

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ☐
Summary / supporting information:	The purpose of the Equality Diversity and Inclusion Steering Group (EDISG) is to oversee the Trusts strategic ambitions and specific Equality Diversity and Inclusion (EDI) goals, and to ensure that EDI is at the heart of the Trust's policies and practices as an employer, health care provider and procurer or services. Linked to BAF risk 2.3
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:	TBC

1. Introduction

The purpose of this paper is to provide the Trust Board with a high-level overview of the Annual workplan of the Trust Equality, Diversity, and Inclusion Steering Group for 2023.

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

2. Background and current state

The Trust has relaunched the EDISG, chaired by Non-Executive Director Garth Dallas, with the inaugural meeting taking place on 21st July 2022. The group established an agreed Terms of Reference with an accompanied annual workplan for 2023 and will meet bi-monthly to review progress against the workplan.

The workplan aims to ensure that the Trust meets the General Equality Duties as outlined in the Equality Act 2010, through the submission of specific equality information in a timely manner and monitors progress against the associated actions plans. It also supports the implementation of key workstreams and projects that impact on the Equality agenda, supporting the development of a diverse and inclusive culture at Alder Hey.

3. Recommendations

The EDI Steering group will support and drive the EDI agenda for the Trust. During 2023 and beyond, the group will give particular focus to the following:

3.1 Delivery of the Trust's performance

- To review the Trust's performance in EDI using the EDS2/3, GPG, WDES and WRES, the staff survey and listening initiatives.
- Ensuring there are clear reporting and accountability processes in place throughout Trust departments, divisions on EDI matters such as Task and Finish groups.
- To assess risks associated with EDI and advise the Trust Board.
- To influence external parties such as suppliers and procurement to improve performance around EDI.
- To report the Trust's progress to the Trust Board via the People and Wellbeing Committee

3.2 Inclusive recruitment and progression practices and increased representation

- Identify and recommend positive action initiatives to address systemic inequality and to promote EDI within all policies, to ensure that the Trust is promoting this agenda across all practices.
- The monitoring, on behalf of the Trust Board, of progress against the EDS2/3, WRES, WDES, Gender Pay Gap and general action plan to ensure the Trust progresses towards its aim of inclusivity and equality of opportunities for all staff in relation to recruitment, retention, and progression in the workplace.

3.3 Leadership and culture of inclusion and belonging

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

3.4 Addressing differentials in experience

- To be responsible for focusing on matters of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation, providing a key strategic focus on matters of race, LGBTQI+ and disability and long-term health conditions based on evidence of need within the Trust.
- To ensure all staff actively promote EDI in their work and are confident in the ability to challenge discrimination when it is identified.
- To support the development and empowerment of staff networks and to provide opportunities for representatives to share EDI related issues and concerns to support the Trusts action planning.
- To promote equality of opportunity for all staff and children, young people and families who access services and to ensure all sections of the community have ease of access to the Trust, with care and information that supports their need.
- To promote, recognise and value the diverse nature of communities and staff groups.

4. Conclusion and next steps

The Trust board and the People and Wellbeing Committee will receive regular updates from the EDI Steering Group as to the progress of the Trust's strategic ambitions against the specific Equality Diversity and Inclusion (EDI) objectives.

Sharon Owen
Deputy Chief People Officer
15/11/2022

EQUALITY AND DIVERSITY STEERING GROUP WORKPLAN

Agenda Item	JAN 2023	MAR 2023	MAY 2023	JUL 2023	SEP 2023	NOV 2023	JAN 2024	MAR 2024
Purpose: to oversee the Trusts strategic ambitions and specific Equality Diversity and Inclusion (EDI) goals, and to ensure that EDI is at the heart of the Trusts policies and practices as an employer, health care provider and procurer or services								
Monitor progress against the People Plan	✓	✓	✓	✓	✓	✓	✓	✓
Monitor progress against the Internal Communications Plan	✓	✓	✓	✓	✓	✓	✓	✓
Belonging in the NHS & Looking after our People								
Equality, Diversity & Inclusion Plans - Monitoring Process	✓	✓	✓	✓	✓	✓	✓	✓
Equality Delivery Scheme (EDS)	✓			✓			✓	
Workforce Race Equality Standards (WRES)	✓		✓				✓	
Workforce Disability Equality Standards (WDES)	✓		✓				✓	
Gender Pay Gap	✓	✓					✓	
Staff Survey Results	✓							
Staff Temperature Check		✓			✓			✓
Raising Concerns/FTSU		✓			✓			✓
New Ways of Working & Growing for the Future								
Attraction & Retention Strategy		✓				✓		
Governance								
Review and agree EDISG ToR & Work Plan	✓						✓	
Board Assurance Framework- Monitoring of Risk 2.3 (Workforce Equality, Diversity, and Inclusion)	✓			✓			✓	

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Board Assurance Framework 2022/23 (October)**
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 9th November 2022

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

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

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

4. Summary of BAF – at 9th November 2022

The diagram below shows that all risks remained static in-month with the exception of Workforce Sustainability and Development which has increased in score due to the ongoing impact of staff availability.

Ref, Owner	Risk Title	Board Cttee	Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 NA	**Inability to deliver safe and high-quality services**	SQAC	3x3	2x2	STATIC	STATIC
1.2 AB	**Children and young people waiting beyond the national standard to access planned care and urgent care**	RABD / SQAC	**3x5**	3x3	STATIC	STATIC
1.3 AB	**Building and infrastructure defects that could affect quality and provision of services**	RABD	4x3	2x3	STATIC	STATIC
1.4 LC	**Access to Children and Young People's Mental Health**	RABD / SQAC	**3x5**	3x3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**	PAWC	**3x5**	3x2	STATIC	**INCREASED**
2.2 MS	**Employee Wellbeing**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	PAWC	4x3	3x2	STATIC	
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	RABD	3x3	3x2	STATIC	STATIC
3.2 DJ	**Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships**	RABD	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	RABD	**4x4**	4x3	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	4x3	4x1	STATIC	STATIC

5. Summary of October updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ)***
  Risk reviewed; no change to score in month. Actions, evidence and controls updated. Key progress includes agreement of baseline strategy overview paper at Trust Board Nov 22.

- ***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 but good progress in month - particularly the influence of ICB Chair in developing greater voice and governance within ICB architecture. Leading this development through Beyond, with partners.

- ***Risk of partnership failures due to robustness of partnership governance (DJ)***
  Risk reviewed; good progress in month - PQAR pilot tested fully with LNP to positive effect. Some learning and next stage development underway, and action plan in situ and monitored through Quality team.

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

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  The majority of historical defects are now resolved. There has been some notable recent success in getting the combined heath & power pump into action, and remedial works to the chillers (no on course for completion in January 2023). Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. A commercial discussion is open in relation to the number of service failure points accrued.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB)***
  The number of C&YP waiting over 52 weeks for treatment in consultant-led pathways has reduced to 376 patients, from 435 in September. Paediatric Dentistry as had the most notable improvement. Elective recovery was strong in October at 107% for elective and 120% for outpatient new activity. Looking forward, the reduction in additional WLI activity, due to the rate card, and the threat of industrial action makes sustaining high levels of elective recovery unlikely.

- ***Inability to deliver safe and high-quality services (NA)***
  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.

- ***Financial Environment (JG)***
  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.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Updated prior to November Board.

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed, score remains static. Aldercare programme progressing with revised plans, good progress with patient journeys in October. Governance process underway for additional national support for programme. Programme risks include functionality, build, data migration and competing demands for other programmes managed through programme board and Digital Oversight Collaborative. Good progress with digital and data strategy mobilisation.

- ***Workforce Sustainability and Development (MS)***
  The risk score has increased to a score factor of 15 given the ongoing impact of staff availability. The areas of particular concern are sickness absence, imminent potential for strike action, increased turnover rates and lack of talent and succession planning to retain talent.

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

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL)***
  Review Nov 22 - no significant change. Actions updated.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of all actions undertaken with Clinical Leads and updates included. Summary investment case added to documentation.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000107

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

Strategic Aim — Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2229	Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity.	2.1
2233	Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies	1.2
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
2501	Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments.	1.2 &2.1
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	2.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.2 & 2.1 & 1.4
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	4.2
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	
2312	Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 & 2.1
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	2.1
2589	Inability to safely staff Catkin and Community Clinics	2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2548	Unable to provide the clinical records in the required time scales – breach of GDPR / Court and police timescales	4.2
2100	Risk of inability to provide safe staffing levels	2.1

000108

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2233	Risk of failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies	1.1
2501	Risk of inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 10 pandemic leading to a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments	1.1
2463	Risk that Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals during 2020	1.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 2.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal.	1.1 & 2.1

000109

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

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

000110

BAF Risk

2.1 Workforce Sustainability & Capability

(3x4=12)

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
2312	Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients	1.1
2501	Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments.	1.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 1.2
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2450	The risk is that there will be no laboratory haematology/transfusion service which would lead to suspension of any service requiring blood for transfusion such as cardiac surgery, ED, ICU, oncology, theatres and ECMO	1.1
2589	Inability to safely staff Catkin and Community Clinics	1.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2

000111

BAF Risk 2.2 Employee Wellbeing (3x3=9)

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

Related Corporate Risk(s)

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

BAF Risk 2.3 Workforce Equality, Diversity & Inclusion (4x3=12)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.1 Failure to fully realise the Trust's vision for the Park (3x3=9)

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
2637	The Greener Project may not achieve the predicted £1 million savings target linked to energy	

000113

BAF Risk

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

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000114

BAF Risk

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

Strategic Aim

Related Corporate Risk(s)

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

BAF Risk

4.2 Digital Strategic Development and Delivery

(4x3=12)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2548	Unable to provide the clinical records in the required time scales – breach of GDPR / Court and police timescales	1.1
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	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, 2233, 2441, 2463, 2501, 2516, 2517, 2327, 2332, 2312, 2383, 2589, 2597, 2627, 2548, 2100, 2450, 2196, 2654		
Exec Lead: Nathan Askew	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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

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

Board Assurance Framework 2022-23

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Urgent Care Improvement Group overseeing several improvement workstreams: PLACE - GP streaming relocation to OPD - complete FUNDING - business case submitted for approval to increase nursing and decision makers - Complete SUPPORT - external company engaged to support GP stream - complete; funding for 22/23 requested via CCG - pending WORKFORCE - subject to funding workforce required including out of hours - pending CAPACITY & DEMAND - review of demand and capacity by stream - pending EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	30/09/2022	Go 2 Doc now covering 7 days per week but still working toward 2 x GP/ACP cover 9am-9pm. OPD rooms still being utilised Mon-Fri whilst a longer term solution is sought for a location for streaming services. - update required before 30/5/22 Meeting with executive team Thurs 5/5/22 and ED senior team to discuss challenges in urgent care and create action plan for short and long term improvements. To reconvene in 2 weeks to discuss ideas. - deadline 19/5/22 'ED at it's Best' launched as listening event for ED staff supported by project management team. Reporting findings and recommendations to Urgent Care Improvement Board (UCIB) monthly. 4 new ED consultants appointed at interviews in April 2022. Anticipated start dates of September 2022. Nursing posts to be advertised following approval of business case for investment in 2022/23. Updates to be provided monthly to UCIB. Capacity and demand work ongoing alongside review of triage guidance to ensure all patients suitably streamed at point of attendance - target for completion 24/5/22 Task and finish groups to be arranged with support teams and medical/surgical specialties to improve pathways for patients that avoid inappropriate attendance at ED - target date of 20/5/22 for start PAU pilot scoping underway to test pathways ahead of implementation in 2024/25. Proposal to be put forward to PAU Project group and UCIB in June 2022.
The following actions are being undertaken to improve the RTT performance: Expand the criteria of patients who can be booked onto a weekend list - ongoing External dentist given priority weekend lists - complete Recruit new honorary contract dentist - complete, 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	01/11/2022	As above

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.

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

October 2022 - Andrew Mccoll
At end of Sept the number of patients waiting >52weeks has increased to 435. 295 (68%) are in Paediatric Dentistry. There is increased focus on reducing waiting times below 52 weeks for majority of specialties by December. Action plan for Dental includes Insourcing model to commence in November (subject to contract sign off); Spinal Surgery working to sustain <78 week waits. For urgent care, the "ED at its Best Programme" continues to oversee actions including: Increased low acuity streaming to scheduled GP appointments; Improved staffing resilience; review and relaunch key ED Dept functions (eg Boards Rounds, Huddles, role cards); Utilise Digital solutions to support flow.

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

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

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

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

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

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

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

Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. Senior managers from the Trust are still in discussions with Project Co reps regarding current issues and associated commercial aspects although these are mainly newly identified issues rather than historic defects.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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

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

August 2022 - Lisa Cooper
All actions reviewed and updated

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: 2312, 2383, 2100, 2501, 2597, 2589, 2516, 2528, 2517, 2535, 2624, 2450, 2196		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: INCREASED

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

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	30/11/2022	actions continue to be rolled out and monitored. sickness absence managed at local level with HR Advisers.
To identify and target hotspot areas with high turnover rates	31/10/2022	Detailed turnover reports presented to PAWC
3. Development of a methodology to roll-out across the organisation.	01/12/2022	Establishment control project on target
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people	01/03/2023	Attraction and Retention Project identified as key project for 22/23

plan		

Executive Leads Assessment
October 2022 - Sharon Owen Risk reviewed - no in month change to risk score. Actions are on track. The focus of availability remains sickness and turnover.
September 2022 - Melissa Swindell No change to risk score in month. All actions remain on track
August 2022 - Melissa Swindell Risk reviewed and actions updated. No change to risk score in-month. Focus on sickness and turnover is priority

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
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.	30/11/2022	Business case finalised and sent to Chief People Officer and Finance partner to be presented at next IRG on 15th November
Mental Health training for line managers ("Strengthening Others") being developed by SALS/OD to be rolled out to all leaders and managers as a module of Strong Foundations and as stand-alone training available to all via recorded presentation and monthly drop ins run by SALS	30/11/2022	Updated target date
After Action Review to be coordinated to inform learning from incident. Director of Nursing to ask for member of Governance team to lead the review. Risk management plan in place to ensure member of staff is safe and receiving appropriate interventions.	30/11/2022	No further progress. Will discuss with Chief People Officer in next meeting
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	30/11/2022	Draft Debriefing Guide developed to be presented to Debriefing reference group on 3rd November for comment and approval. Final guide to be completed and shared by end November
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	01/12/2022	SALS in discussion with development team to consider options for bespoke SALS booth which could be placed on the mezzanine and accessed only for staff support. Proposal for additional staff container based space agreed at execs over summer and to be built over the next 3 months. Plan for utilisation of this space yet to be developed and to involve HWB Steering group

Executive Leads Assessment

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

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

August 2022 - Melissa Swindell
Risk and actions reviewed - no change to risk score.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 4x3	Target IxL: 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 and anti-racist work place where all staff feel their contribution as an individual is recognised and valued. Failure to provide equal opportunities for career development and growth.

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

Gaps in Controls / Assurance
Staff Networks still in development stage, requires further support, resource and input.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Staff Network Chairs to be advertised during August / September	31/12/2022	networks to be advertised nov 22

Executive Leads Assessment
0 - Sharon Owen Risk reviewed and actions progressing. Temporary collaborative EDI Lead now in place, progressing actions.
November 2022 - Melissa Swindell risk reviewed, action updated
October 2022 - Melissa Swindell actions updated. risks reviewed

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation.
The impact of Covid-19 is both on physical progress on site and from an inability to engage with community stakeholders however the team continue to pursue works liaising with the appointed contractor.	The Trust is in contact with the City Council to discharge pre-commencement conditions so that once demolition is completed the Phase 1 park reinstatement works can commence in late summer.
The Trust Development team continues to liaise closely with Liverpool City Council and the planning department to discharge pre-commencement conditions	Minutes of park development meeting
The Trust has appointed Capacity Lab for an 18 month period, they are responsible for working with the local community, planning activities in the park, supporting the local community to form an Enterprise/Community Interest Company. Whilst completing this work they will be engaging with Liverpool City council and local councillors. The work has already begun and feedback from the community is positive	Minutes of meetings SLA
Exec Design Group	Minutes of Exec Design Reviews to Campus Steering Group
We are working with a designer and a QS to review the Remediation Strategy which has now been submitted to LCC. This should lead to a reduction in estimated costs, if approved. In addition we are looking at alternative suppliers that meet the LCC specification.	Planning submission and the estimated costs. Estimated costs provided by Landscape Contractor and QS.
Programme and plan agreed with LCC and LPA to return the park back by November 2023.	Works commenced on site and plans established, agreed, costed and signed off as approved.

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Set up Joint Planning meeting with community	31/12/2022	Awaiting LCC public meeting before organising
Establish an Eaton Road Frontage Review to Prepare Delivery Plan	30/11/2022	Review scope agreed.
Create a plan to fix drainage from Phase 1/Agree plan for Phase 2/3	30/11/2022	Organise survey

Executive Leads Assessment

November 2022 - David Powell Prior to November Board
October 2022 - David Powell Prior to October Board
September 2022 - David Powell Prior to September Board

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Partner and stakeholder engagement on Vision 2030 as it is developed, and appropriate circulation/engagement following Board sign off.	30/11/2023	Action updated as above 4/11/22
6.Develop Operational and Business Model to support International and Private Patients	30/12/2022	International / commercial being built into new 2030 Vision strategy refresh - timeline aligned to Dec 22
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	30/12/2022	Workforce analysis core part of Vision 2030 development. Initial analysis undertaken and timeline aligned to Dec 22 (Board agreement to Blueprint scheduled for Oct 22, further shaping with staff, partners and CYP & Families Oct-Dec)

Executive Leads Assessment

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

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

September 2022 - Dani Jones
Risk reviewed; no change to score in date. Actions and controls reviewed and evidence updated.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/12/2022	Work underway with each division/department to understand movement in key areas (Activity/Finance/WTE) from 19/20 to 21/22, recognizing the changing financial framework. This will then inform the forward look for LTFM.
2. Five Year capital plan	31/12/2022	Future years CDEL not yet confirmed. Internal capital planning for 23/24 and 24/25 underway to assess the requirements and prioritise the essential schemes. Discussion also underway with the Chairty re support for capital schemes in future years.

Executive Leads Assessment

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.

September 2022 - Rachel Lea
Risk reviewed and actions updated. Current risk score maintained at 16 to reflect the latest forecast for 22/23 and emerging risks with regards to inflation and other costs pressures.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

Board Assurance Framework 2022-23

Uncertainty over future commissioning intentions (see BAF 3.4 re finance, and also new guidance re delegation of Specialist Commissioned services into ICSs)

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	15/12/2022	Joint letter to SpecCom re delegation of specialist services to ICSs - Alder Hey & RMCH - sent 29th July 22
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/03/2023	As above entry 7.9.22

Executive Leads Assessment

November 2022 - Dani Jones
Risk reviewed; no change to score but good progress in month - particularly the influence of ICB Chair in developing greater voice and governance within ICB architecture. Leading this development through Beyond, with partners.

October 2022 - Dani Jones
Risk reviewed; no change to score in month. Development of CMAST governance and trust board approval noted.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	
Escalation process for risks and issues pertaining to ODNs and Joint Services	
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement). PQAR Framework now tested with LNP to positive effect. Development of the process and framework underway, supported by Jacqui Rooney, in line with evolving CQC quality statements approach. NorCESS joint management team have agreed to pilot PQAR for the North West - to be scheduled in Q4.
Identification of 'pilot' partner for Partnership Quality Assurance Round - Liverpool Neonatal Partnership	PQAR Pilot scheduled with LNP for October 22 with Non-Exec representatives from both partner Trusts. Pilot of Partnership Quality Assurance Round approach agreed with LWH MD. Liverpool Neonatal Partnership and presented PQAR to LNP Board in June 22 - agreed next action to identify NED rep from both Trusts to do a full PQAR with LNP (under identification/scheduling) PQAR completed with NEDs from both Alder Hey and LWH 14th October. Positive process, plus some learning to shape PQAR pack for future sessions. Draft minutes attached (one amendment pending - ABR was not in attendance) will update once final minutes agreed. Action plan and next steps within.
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - Sept 22 Quarterly Board paper - June 22
Twice-annual ODN oversight report to RABD	May 22 Report attached
MIAA Audit - Partnership Governance	Audit initiation meeting scheduled for 5th October 22

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
MIAA Audit scheduled for Q2 2022	29/12/2022	Audit ongoing; evidence gathering stage underway.

Executive Leads Assessment

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

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

September 2022 - Dani Jones
Risk reviewed; no change to score in month. Controls, actions and evidence reviewed.

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

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

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

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

September 2022 - Claire Liddy
no change (SEPT 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: 2548, 2327		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of Alder Care Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023
Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	03/01/2023	New iDigital model under review/evaluation throughout November with positive feedback and performance. Permanent recruitment planned imminently
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development

Executive Leads Assessment

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

Aldercare programme progressing with revised plans, good progress with patient journeys in October. Governance process underway for additional national support for programme. Programme risks include functionality, build, data migration and competing demands for other programmes managed through programme board and Digital Oversight Collaborative.

Good progress with digital and data strategy mobilisation.

October 2022 - Kate Warriner
BAF reviewed, score remains static. Aldercare programme re-baseline set, progress with programme plan and resources, national support and strategic relationship with supplier. Programme risks include functionality and build managed through programme board.

Good progress with digital and data strategy with initiation planning and mobilisation of new models of care and data programmes.

September 2022 - Kate Warriner
BAF reviewed, score remains static. Progress against a number of key actions notably recruitment into a number of key positions and completion of Aldercare programme review indicating revised go live date in 2023.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Kerry Byrne, Committee Chair

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 10th November, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 15th September 2022.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

The Audit & Risk Committee (ARC) 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 shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register and Trust Risk Register Report
- Fire arrangements for new buildings – Catkin Centre and Sunflower House
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Progress against actions identified in the ARC self-assessment
- Waiver activity report

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

The Board is asked to note that Merseyside Fire & Rescue Services (MF&RS) has written to the Trust to express concern at the lack of sprinklers in the car park for (new) Catkin House and Sunflower Centre and recommended that we reconsider this decision. Management have commissioned an independent fire consultant to review the car park safety, the report for which is expected in two weeks and the Sunflower Centre will not be occupied until this issue is resolved. A response will be provided to MF&RS following consideration of the independent report.

4. Positive highlights of note

The Committee noted that the positive outcome of the audit of Morbidity & Mortality (high assurance) which is the highest assurance level available.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 15th September 2022**
Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
In Attendance:	Mr G Baines	Regional Assurance Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mrs R Lea	Deputy Director of Finance	(RL)
	Ms. V. Martin	Anti-Fraud Specialist, MIAA	(VM)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Mr. J. Wilcox	Divisional Accountant	(JW)
Apologies:	Dr. U. Das	Director of Medicine	(UD)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JR)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
Observing:	Mr. J. Kelly	Non-Executive Director	(JK)
Item 22/23/60	Ms. C. Wardell	Assoc. Chief Nurse, Medicine	(CW)
Item 22/23/66	Mr. S. Riley	Clinical Audit and Quality Improvement Manager	(SR)
Item 22/23/68	Mr. J. Gray	Emergency Preparedness, Resilience and Response Manager	(JGray)

22/23/53 Introductions and Apologies

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

22/23/54 Declarations of Interest

There were none to declare.

22/23/55 Minutes from the Meeting held on the 14th of July 2022
Resolved:
The minutes from the meeting that took place on the 14th of July 2022 were agreed as an accurate record of the meeting.

The Chair queried as to whether a date has been agreed for a Board to Board meeting with Project Co to discuss the high risk defects. It was reported that the Trust has requested that a meeting take place in the autumn.

22/23/56 Matters Arising and Action Log

Action 22/23/13.1: *Internal Audit Follow Up Report (Project Management Review - RL to liaise with the Development Team to see if the overdue recommendations can be implemented within the next three months with an update to be provided to the June meeting)* **-** A meeting is to be scheduled with the Development team w/c 19.9.22 to discuss the progress of the overdue recommendations. In the event progress has not been made the team will be invited to attend November's Committee to provide a reason for this. **ACTION TO REMAIN OPEN**

21/22/87.1: *Trust Risk Register Analysis (Conduct a piece of work to confirm that the information being reported in terms of zero/low risks by a number of areas across the Trust is correct. Divisional Leads to provide an update during January's Audit and Risk Committee*) – Work is taking place to look at these areas of risk from a granular departmental level. An update will be provided during November's meeting.
ACTION TO REMAIN OPEN

21/22/87.2: *Trust Risk Register Analysis (Look at a governance reporting structure for the risks of services that sit under the remit of an Executive Lead rather than within a Division)* – An overview of the progress that has been made by the Corporate Services Collaborative was shared with the Committee. It was reported that the collaborative is looking at moderate risks (12+) on a monthly basis in order to conduct deep dives and challenge scores/mitigations, as well as reviewing the top five Corporate Services' risks/finance areas and HR metrics. A dry run of the performance review for Corporate Services has also taken place with the Chief Operating Officer, Adam Bateman. It was agreed that a process is required for presenting future collaborative updates.

22/23/56.1 Action: ES/KB

Action 21/22/89.1: *Update on Risk Management Process within the Division of Surgery (During the next Risk Management Forum discuss the possibility of implementing a set of best practice standards Trust wide in order to have a standard approach for risk management)* – It was confirmed that an update will be provided in January 2023.
ACTION TO REMAIN OPEN

Action 21/22/15.2: *Final Internal Audit Plan for 2021/22 (Conduct a piece of work over the next twelve months, in association with MIAA, to look at what the Internal Audit plan would look like if a different approach was taken by the Trust on key financial controls) –* It was agreed to keep this action open so that it can be reviewed in 2023. A meeting is to take place between KS/RL/JG/KS to discuss this matter further.
ACTION TO REMAIN OPEN

Action 21/22/36.1: *Committee Annual Reports for 2020/21(Include a statement in the Annual Report for each committee highlighting whether (relevant BAF) risks are being well managed, to enable the Audit and Risk Committee to provide assurance to the Board on the overall effectiveness of the Trust's risk management process)* – The Chair is liaising with Jill Preece on this matter. An update will be provided in January 2023.
ACTION TO REMAIN OPEN

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Action 21/22/101.1: *Trust's Nil Net Assets Review (Compile guidance to support the management of the process for nil net assets)* – A report was submitted to the Committee during September's meeting. **ACTION CLOSED**

Action 21/22/113.1: *Local Counter Fraud Progress Report (Submit a report in September 2022 on the outcome of the new Fraud Risk Assessment that all NHS organisations have to conduct in compliance with component three of the Government Functional Standard* – A report was submitted to the Committee during September's meeting. **ACTION CLOSED**

Action 22/23/15.1: *Counter Fraud Annual Report 2021/22 (Provide an update on the work that has taken place to progress the Fraud Champion's role)* – The Trust will need to appoint an interim Counter Fraud Champion (CFC) whilst the original CFC is on secondment. A discussion is going to take place regarding this matter and an update will be provided in November. **ACTION TO REMAIN OPEN**

Action 22/23/19.1: *Clinical Audit Annual Report, 2021/22 (Divisional Clinical Audit Action Plans - Once completed, submit the Divisional Audit Plans to the Committee)* – A small working group is to be established to address Clinical Audit and the wider remit. An update will be provided in January 2023. **ACTION TO REMAIN OPEN**

Action 22/23/24.2: *Audit and Risk Committee Self-Assessment Exercise Ongoing Actions (Number 2 - Discuss as to whether the annual Committee reports should set out the assurance they have received and their impact on the organisation's assurance framework and advise of any matters to be brought to the attention of the Audit and Risk Committee)* – The Chair is liaising with Jill Preece on this matter. An update will be provided in January 2023. **ACTION TO REMAIN OPEN**

Action 22/23/24.3: *Audit and Risk Committee Self-Assessment Exercise (Committee to receive an annual report on Data Protection and Freedom of Information)* – The Data Protection Annual Report and the Freedom of Information Annual Report will be submitted to the Committee in April 2023. Both items are to be included on the Committee's workplan. **ACTION CLOSED**

Action 22/23/32.1: *Minutes from the Previous Meeting (Share the outcome of the advisory work that was conducted by MIAA on the incident relating to the stolen iPads and report on the recommendations via the follow-up process)* – This action has been addressed. **ACTION CLOSED**

Action 22/23/35.2: *Internal Audit Follow Up Report (Provide an update on future plans for addressing Consultant Job Planning actions)* – There are a number of open recommendations that relate to consultant job planning that won't be completed by the revised date. It was confirmed that a meeting is to take place between Internal Audit and Alf Bass and Urmi Das to discuss this issue.
ACTION TO REMAIN OPEN

Action 22/23/38.1: *Third Party Assurance form ELFS – Payroll Service (Summary report be compiled to highlight the areas of the assurance report that appertain to the Trust)* – A report was submitted to the Committee during September's meeting. **ACTION CLOSED**

Action 22/23/49.1: *Trust Risk Management Report (Trend be included in future Trust Risk Management reports to show the progress that is being made with the 25 long standing high moderate risks)* – Further work is required to condense the appendix on high/moderate risks in the Trust Risk Management Report. **ACTION TO REMAIN OPEN**

Action 22/23/51.1: *Any Other Business (Liverpool Health Procurement Proposal – Submit the Liverpool Health Procurement proposal to the Audit and Risk Committee*

during September's meeting, and share the proposal documentation with the Chair and Garth Dallas ahead of September's meeting) – The proposal was shared with the Chair and Garth Dallas and the Committee received the Liverpool Health Procurement Proposal during September's meeting. **ACTION CLOSED**

22/23/57 Board Assurance Framework Policy

The Committee received version six of the Board Assurance Framework Policy for approval. It was felt that commentary should be included in the policy to reflect the delegation of BAF risks to the Trust's Assurance Committees for oversight purposes. It was agreed that the Chair would liaise with Jill Preece to advise of the minor amendments to the policy.

22/23/57.1 Action: KB

Resolved:
The Audit and Risk Committee approved the Board Assurance Framework Policy subject to a number of minor changes.

22/23/58 Board Assurance Framework (BAF) Report
Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 31.8.22.

22/23/59 Risk Management Forum (RFM) Update; including Corporate Risk Register, Trust Risk Management Report and approved minutes from the last meeting of the RMF

The Committee received an overview of the RMF meeting that took place on the 30th of August 2022. The Chair of the RMF advised of the high quality discussions that took place during the meeting and the positive engagement from colleagues across the Divisions/departments. It was felt that the RMF set aside an appropriate amount of time required to address areas of concern; including the BAF, Trust Risk Management Report, Corporate Risk Register (CRR) Report and issues highlighted by the Divisions or raised via service reports.

It was reported that an in depth discussion took place on high risks/corporate risks and the Committee was advised of the recent improvements that have been made in terms of overdue risks being reviewed within timelines, a reduction in risks without actions and validation meetings being used to close down risks where appropriate. There were no deep dives during August's meeting therefore time was set aside to focus on the describing of risks and areas that required additional support.

Attention was drawn to the incorrect annotation on page two of the Chair's RMF report. It was confirmed that risk 2663 (*unachievable CIP savings*) has been included on the CRR rather than the BAF as it is operationally focussed. BAF risk 4.3 relates to the financial environment.

Corporate Risk Register

The Committee was advised that major trauma is the main clinical focus of the CRR in terms of service delivery and it was confirmed that a deep dive will take place during October's RMF with a spotlight on compliance with standards.

There is also an acute problem in access to health records in terms of providing clinical records in the required timescales (*breach of GDPR/Court and police timescales*) caused by an increase in access to health records requests. Mitigations have been implemented and the Trust is in a recovery plan turnaround situation therefore it has been agreed to conduct a deep dive in October to ascertain the level of exposure for this service and to receive an update on the progress of the recovery plan.

Key points to be raised to the Audit and Risk Committee

The Committee was advised that:

- Colleagues and risk owners are well sighted on risks.
- The Associate Director of Nursing and Governance, Jackie Rooney, is working with the Divisions to complete a piece of work collectively on how the Trust drives and articulates risks. It was agreed that risks require a better description and more accurate scoring, which will be the focus for the coming period.
- Risk Management Strategy Policy was approved by the RMF on the 30.8.22 but it was confirmed that there have been some further amendments. Once the document has been updated it will be circulated to Committee members for ratification.

22/23/59.1 **Action: JR**

The Chair felt that the RMF is developing well and provides the Audit and Risk Committee with assurance. The Chair raised a number of questions relating to the BAF and the CRR;

1. It was pointed out that there are a number of risks on the BAF that don't have corporate risks linked to them, and it was queried as to whether this matter needs to be reviewed from a tactical/operational risk perspective. It was agreed to look into this and perhaps put greater challenge to colleagues in terms of scoring operational risks that are associated with BAF risks.

22/23/59.2 **Action: ES**

2. It was queried as to whether a process could be incorporated in the CRR to differentiate between risks that are included for a short period versus the risks that are more challenging and therefore remain on the CRR for a longer period of time.

22/23/59.3 **Action: ES**

3. The Chair referred to the risk that relates to staffing levels (2100) and queried as to whether it's beneficial having this risk on the CRR, taking into account the staff sustainability risk on the BAF and staffing risks that are included on individual team risk registers. It was also pointed out that the way in which the risk is worded it is very unlikely that it will ever be closed down and removed from the CRR. Erica Saunders agreed to liaise with Melissa Swindell to discuss this matter.

22/23/59.4 **Action: ES**

Trust Risk Management Report

The Committee received the Trust Risk Management Report which provided an overview of the data presented at the RMF on the 30.8.22, and the opportunity to scrutinise the effectiveness and oversight of risk management in the Trust. The Chair advised the Committee that the report has been slightly amended in order to draw out concerns and to highlight the clear actions that have been implemented to address them. It was felt that the report was very positive and that there has been quite a significant improvement in terms of the number of risks that are overdue for review and those that don't have a plan.

Resolved:
The Audit and Risk Committee received and noted the RFM update, CRR, Trust Risk Management Report and the approved minutes from the meeting held on the 20.6.22.

22/23/60 Update on the Risk Management Process within the Division of Medicine

A number of slides were shared with the Committee to describe the Division of Medicine's approach to risk management within the Division. The following information was shared:

- Risk management process for new risks ranked at 12 and above.
- Risk management process for new risks ranked below 12.
- Risk matrix.
- Ongoing risks processes.
- Example of a risk proposal form and a Divisional monthly risk report.
- *Priorities*; education of teams, risk management training, monthly education sessions, focus on individual teams who require support, identify teams with low or no risks and monthly Divisional newsletter/report.
- *Plans going forward*; working with Divisional Leads to address risk ranking, overdue actions, wording of risks and making risk business as usual.

A discussion took place about the possibility of having risk on all agendas to ensure that it is discussed at each meeting across the Divisions thus becoming business as usual for all. The Chair asked that Management think about how this could be progressed.

22/23/60.1 JG/ES/JR

John Grinnell suggested using the Brilliant Basics methodology to trial the use of huddle boards in potential areas in the Division of Medicine based on three top risks and a weekly check in. It was pointed out that using this process will make risk a part of everyone's daily activities and also empower staff members to improve things. Cath Wardell felt that this would be beneficial in terms of helping the Division reach a point where risk is addressed and discussed every day.

22/23/60.2 Action: JG/CW

The Chair pointed out that it is really useful for the Committee to hear how each Division implements its risk management process and felt that the work that is taking place in the Division of Medicine signifies a real step change in engagement and culture. The Chair praised the process that is being used by the Division of Medicine for new risks ranked as 12 and above and felt that this should be shared as best practice across the Divisions.

Resolved:
The Audit and Risk Committee received and noted the update on the Risk Management Process within the Division of Medicine

22/23/61 Internal Audit Progress Report

The Internal Audit Progress Report was submitted to the Committee to provide an update on the progress that has been made against the Internal Audit Plan during the period from July to September 2022. The following points were highlighted:

- It was reported that two reviews have been completed with both receiving substantial assurance; Data Security and Protection Toolkit (DSPT) and Consent. DSPT also received an opinion for the ten standards that are set by the National Data Guardian data security standards, of which, eight opinions were substantial and two were moderate in respect to continuity planning and IT protection.
- There are two reviews in the fieldwork stage; Partnership Governance and Data Quality and one draft report has been issued; Mortality and Morbidity. It was confirmed that preparation of the Audit Plan for 2022/23 is on track to be delivered for the January 2023 meeting.

The Chair referred to the DSPT review and queried as to whether the two non-compliant actions are the same as the previous year or whether they are new actions as a result of a change in standards. The Chair also asked as to whether an action plan had been produced for both actions and queried the process for overseeing them. Kath Stott confirmed that action plans would have been implemented but due to the privacy angle of DSPT they would have been tracked in a different way. Kath Stott agreed to look into this matter and provide an update.

22/23/61.1 Action: KS

The Committee received the IT Hardware Asset Management Review Report, including the action plan, following a request to submit the full report during September's Committee meeting. The review was conducted outside of the Internal Audit Plan as a result of a specific request from the organisation following a high profile case in the media in December 2021 relating to stolen iPads. It was reported that the review has highlighted a number of serious gaps in some of the fundamental controls relating to the storage and monitoring of IT assets.

The Chair advised the Committee that MIAA have been asked to follow up the recommendations in the report as part of the internal follow-up process. It was requested that the follow-up of recommendations be conducted by a member involved in the initial review due to the complexity of the matter. The Chair felt that this area of work should be included in the 2023/24 audit plan but in the meantime given the nature of some of the findings, it was agreed to invite the Chief Digital and Information Officer, Kate Warriner, or a member of the IT team to January's Committee meeting to discuss the actions that have been implemented to address the gaps in control.

22/23/61.2 Action: JG

John Kelly highlighted the risk to the organisation if the EPR upgrade is not implemented on the revised date and felt that this topic should be a regular item on the Audit and Risk Committee's agenda. The Committee was advised that a report is to be submitted to the Board on the 29.9.22 to formalise the go live arrangements/revised governance approach but it was felt that further work needs to take place to ascertain an assurance process. Following discussion about a reporting process for the project and visibility/exposure for NEDs in terms of assurance, it was agreed to review the remit of the Audit and Risk Committee and the Resources and Business Development Committee (RABD), taking into account that RABD has been monitoring the progress of this project, to look at a way of enabling the Audit and Risk Committee to receive updates and assurance on the implementation of the upgrade.

22/23/61.3 Action: KB/ES

Resolved:

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

22/23/62 Internal Audit Follow-up Report

The Committee received an update on the latest position regarding the most recent phase of follow-ups and the progress that has been made during the period from July 2022 to September 2022. The following points were highlighted:

- It was reported that there were 24 actions due to be followed-up in the last reporting period, of which, 14 have been implemented or superseded and 10 have been partially implemented with approval requested from the Committee for extensions.

The Committee spent time discussing the history and issues relating to the consultant job planning recommendations/actions that have resulted in a request for an extension. It was pointed out that a number of the actions will have been superseded due to the passage of time, but it was confirmed that a further discussion that includes the Chief Medical Officer, Alfie Bass, and the Director of Medicine, Urmi Das, will have to take place to ascertain this before the actions can be closed.

The Chair advised that the job planning recommendations are long standing ones from four years ago but confirmed that a lot of progress has been made during the last eighteen months. The Chair drew attention to the importance of completing the actions as soon as possible in order to assess the implementation of the L2P system in the current year.

The Committee was informed of the challenges of completing actions when a recommendation is not applicable to the here and now and it was suggested that the likes of these recommendations be superseded with a stretch challenge to enable consultant job plans to be completed and uploaded onto the system. The Chair agreed that a more realistic/pragmatic approach needs to be taken to provide a way forward to help the L2P system become embedded across the Trust. It was reported that the Chief Medical Officer is looking into this area of work.

The Chair pointed out that to receive a request for the extension of ten actions is quite unusual but it was agreed to approve the extensions, as the timeframe requested is not unduly long, with a caveat that a message is shared with the Executive Team to highlight this matter and advise that, going forward, there needs to be a good reason as to why the actions haven't been fully implemented within the original timeframe. It was agreed to raise this issue with the Executive Team and provide a substantive response in terms of agreeing a pragmatic approach for 1. A general principle that requesting an extension should only be as a result of exceptional circumstances. 2. Applying this principle to address the consultant job planning actions that are outstanding. It was also agreed to reinstate the internal process for monitoring recommendations and incorporate this as a regular item on the Executive team meeting agenda.

22/23/62.1 Action: JG
22/23/62.2 Action: ES/RL/KB

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

22/23/63 Review of HFMA Improving NHS Financial Sustainability Review Checklist – Terms of Reference (ToR)

The Committee received the ToR for the 'HFMA Improving NHS Financial Sustainability Review Checklist' and was advised that MIAA will commence the audit of the review in October 2022 with a deadline of the 30.11.22. It was reported that the overall objective of the audit is to 1. Confirm that the Trust's self-assessment has been completed. 2. Check that the self-assessment has been approved by the Trust in line with NHSE guidance. 3. Conduct a deep dive into the organisation's self-assessment for the 12 nationally specified questions.

The Chair queried as to whether there are any plans to share the Trust's self-assessment with the organisation's assurance committees. Following discussion on this matter, it was agreed to submit a presentation to the Audit and Risk Committee on areas of non-compliance, if applicable, alongside MIAA's outcome of the review in January 2022. The Committee was advised that Alder Hey is taking the opportunity to work with local trusts as a result of the audit review to receive and share best practice.

22/23/63.1 Action: RL

Resolved:
The Audit and Risk Committee approved the 'Terms of Reference for the Review of HFMA Improving NHS Financial Sustainability Review Checklist' ToR.

22/23/64 Internal Audit Junior Doctor Proposal

The Committee was asked to approve the use of unallocated days in the Internal Audit Plan to conduct a Trust wide assurance review of the process used for bringing junior doctors into the organisation and to look at the reasons behind the increase in spend in this area during the last twelve months.

A discussion took place around the reasons for wanting to conduct the review, but it was felt that a high level scope is required to provide further information on whether the concerns are financial related, or control related. It was pointed out that in the event it is an internal control/governance concern then it will be appropriate to request that this review be included on the Internal Audit Plan reserve list for approval. It was agreed to compile a high level scope and circulate it to Committee members for approval outside of the meeting.

22/23/64.1 Action: RL

Resolved:
The Audit and Risk Committee noted the request to conduct an assurance review of the process used for bringing junior doctors into the organisation.

22/23/65 Anti-Fraud Progress Report

The Committee received a progress update on the work undertaken during the period from the 1.4.22 to the 7.9.22. The following points were highlighted:

- The Counter Fraud Functional Standard Return (CFFSR) submission was submitted on the 7.6.22. The Trust received a green rating overall, with 12 of the

13 components rated as green and one rated as amber. The amber rating relates to component 1b; the Counter Fraud Champion (CFC) role at the Trust.

It was confirmed that the CFC completed the online training within the reporting period, but it was pointed out that the Trust needs to provide an update on the CFC arrangements going forward as the present CFC is on secondment.

- *Outcome of the new NHS Fraud Risk Assessment* - An update has been provided to the Trust on the initial NHS Fraud Risk Assessment that has been completed. There are 40 risks that have been individually scored and condensed into 7 thematic fraud risk areas for the Trust. The next step will be to process this information via the Trust's risk management score mechanism to see if any of the risks need to be included on the Trust's risk registers. In the event that they do risk descriptors have been provided for each of the thematic areas.
- *National ESR Fraud Awareness e-Learning Module* – Current compliance for staff completion of the module is 96.3%.
- Sixteen local MIAA Fraud Prevention Notices have been issued to the Trust in the reporting period for consideration, including a Notice around cyber enabled mandate fraud which is a high priority for NHSCFA in 2022/23. It was pointed out that there are a lot of actions and recommendations in the Notices therefore an action plan has been compiled to assist clients with completing recommendations. The Committee was advised that AFS will work with the Trust to address the recommendations and an update on progress will be provided in January 2023.
- *Hold to Account* – The Trust submitted four new queries/requests for advice during the reporting period. The AFS provided advice to the Trust in relation to these requests which have been closed from an AFS perspective with no further action advised.
- It was reported that there is one case open on the 'National Case System' which has been submitted to the Crown Prosecution Service for consideration.

The Chair referred to the outcome of the NHS Fraud Risk Assessment and highlighted the importance of risks being addressed on an individual basis rather than being grouped in themes and the scores averaged to ensure that high risks aren't masked by the averaging process and to identify the individual risks that need to be included on the risk register so they can be tracked and reviewed. Erica Saunders agreed to pick this up with the Associate Director of Nursing and Governance, Jackie Rooney.

22/23/65.1 Action: ES

The Chair alluded to the case that has been referred to the CPS and queried as to whether a breakdown in controls had led to the fraud occurring. It was confirmed that there were issues in terms of process not being followed therefore an internal review was conducted by HR to identify the breakdown in controls. The Chair drew attention to the importance of the Committee receiving relevant information on any controls that have been identified as weak or non-compliant. Following discussion, it was agreed to submit the outcome of the internal review and the action plan during January's meeting.

22/23/65.2 Action: VM

Resolved:
The Audit and Risk Committee received and noted the Anti-Fraud Progress Report.

22/23/66 Clinical Audit Annual Work Programme, 2022/23

The Committee received the Clinical Audit Annual Work Programme for 2022/23 for approval purposes. It was reported that the Clinical Audit Programme is developed in line with mandatory requirements for the forthcoming year and is reflective of mandatory national and regional audits, confidential enquiries and Trust-wide priority audits, fulfilling the requirements of the NHS Quality Contract and Trust's Quality Account. The following points were highlighted:

- There is a total of 21 national and 15 local Trust priority audits included in the 2022/23 plan which are aligned to the Divisions/Corporate Services.
- The Committee was provided with an overview of the amendments to appendix 1 of the report;
  - **Ref 5707** (Newborn Spot Screening) – it is being queried as to whether this audit is required in 2023/24.
  - **Ref 1076** (testicular torsion) – It was confirmed that this audit has commenced and is on course to meet the 21.9.22 deadline.
- The Trust's Clinical Audit Plan will develop as part of an iterative process, being updated as new national audits and confidential enquires are published throughout 2022/23.

The Chair advised that the Divisions are in the process of developing their audit plans which will be submitted to the Committee at a later date. In terms of the Clinical Audit Work Programme, it was confirmed that this will be presented to the Committee at the beginning of the financial year going forward.

Resolved:
The Audit and Risk Committee approved the Clinical Audit Work Programme for 2022/23.

22/23/67 Third Party Assurance – ELFS Payroll Service

A number of slides were shared with the Committee that drew attention to the key points of the third party ELFS assurance report that relate to Alder Hey. It was reported that there were a number of exceptions raised in relation to payroll services to which ELFS provided management responses and advised of the actions that will be undertaken to address these matters. It was confirmed that the Trust's Payroll lead will seek assurance re implementation as laid out in the report.

A query was raised about the sustainability of ELFS and whether there are any risks posed to the Trust in the near future. It was agreed to follow this up formally during a scheduled quarterly review meeting and liaise with the Chief People Officer, Melissa Swindell, re this matter.

The Chair asked that the Committee receive this report on an annual basis in a condensed format. It was agreed to include this item on the Committee's work plan.

22/23/67.1 Action: KMC

Resolved:
The Audit and Risk Committee noted the third party ELFS assurance report.

22/23/68 Emergency Preparedness Resilience and Response (EPPR) Annual Assurance Report; including Core Standards Assessment, Cold Weather Plan and Critical Incident Plan.

This Committee received the annual assurance report on the current position of the Trust's EPRR portfolio following a self-assessment which resulted in the organisation rating itself as 'substantially compliant'.

- It was reported that the Trust declared full compliance on 59 of the 64 standards which provides an overall rating of 92% compliance.
- A deep dive took place in addition to the assessment in order to gain additional assurance into a specific area. For 2022 - 2023 the 'deep dive' topic is evacuation and shelter and holds 13 'deep dive standards'. It was confirmed that the deep dive does not contribute to the Trust's overall compliance.
- The Committee was informed of the action plans that are in place to address the standards that the Trust were not fully compliant with.

The Chair queried the date of the last EPRR audit. It was agreed to look into this matter with the view to conducting an audit in 2023/24.

22/23/68.1 Action: KS

The Committee received the Cold Weather Plan and the Critical Incident Plan for ratification purposes following a number of minor updates.

The Chair requested that the following amendments be made to the Critical Incident Plan;

- Section 10 to reflect that the Emergency Planning Group approves the documents and the Audit and Risk Committee ratifies them.
- Section 25 to reflect a change to the terminology used for VIPs to high profile individuals.

Action: JGray

The Chair referred to the Cold Weather Plan and asked as to how the risk registers in Appendix D feed into the Trust wide risk process. It was reported that the Trust has been issued with a standardised 'on the day' template for these types of incident plans and are used to formulate additional risks that the Trust has at that exact moment in time. Following discussion it was felt that this process was appropriate as long as there is a procedure in place for transferring respective risks highlighted on the day onto the risk register as appropriate.

Resolved:
The Audit and Risk Committee agreed to ratify the suite of reports subject to the minor amendments that were highlighted.

22/23/69 CARS Review – Net Nil Value Fixed Assets

The Committee was updated on the actions that were taken to address the issues raised in the 2020/21 external audit report. It was confirmed that no further work was required therefore it was agreed that action 21/22/101.1 could be closed.

Resolved:
The Audit and Risk Committee received and noted the CARS Review – Net Nil Value Fixed Assets update.

22/23/70 Progress against actions from the Audit and Risk Committee Self-Assessment

The Committee received a report on the current status of the progress against actions arising from the 2022 Audit and Risk Committee self-assessment exercise. The Chair asked that MIAA take note of action 5 in the table in Appendix 1 and confirm as to whether the Academy will form part of the audit planning process.

22/23/70.1 Action: KS

It was reported that a similar question has been raised in relation to risk registers for the Academy and international work to ensure there are no gaps. It was confirmed that there is a populated risk register for the Academy and that work is taking place to incorporate risks on the risk register relating to the Trust's international work.

Resolved:
The Audit and Risk Committee noted the progress against the actions to date.

22/23/71 Any Other Business

Resolved:
The Committee received a report that provided an overview of the current waiver processes across Health Procurement Liverpool (HPL) organisations and approved the implementation of a single HPL waiver form, register and process across the alliance.

The Chair queried as to whether a date has been agreed in terms of commencing a review of external audit. It was agreed to look into this matter and provide an update at the next meeting.

22/23/71.1 Action: RL

22/23/72 Meeting Review

It was felt that the Committee had a number of beneficial discussions as a result of a packed agenda. The Chair confirmed that update will be provided to the Board on risk, the outcome of the new NHS Fraud Risk Assessment, the Anti-Bribery memo and EPRR.

Date and Time of the Next Meeting: Thursday 10th November 2022, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th November 2022

Paper Title:	**Safety Quality Assurance Committee**
Report of:	16th November 2022 – Summary 19th October 2022 – Approved Minutes
Paper Prepared by:	Fiona Beveridge

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary / supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 16th November 2022, along with the approved minutes from the 19th October 2022 meeting.
Action/Decision Required:	To note ■ To approve ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Implications:	None

1. Introduction

The 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. SQAC welcomed the reduction in workstreams/themes. SQAC noted the clarity in the reporting and the changes and improvements in governance.
- Sensory Project final report received, SQAC welcomed this important piece of work, and noted the desirability of wider engagement to raise awareness across the organisation and beyond.
- Safeguarding Annual Report received
- Quarter 2 Mental Health Attendance report received
- Clinical Audit Update received. SQAC noted the clarity of the report and the improved oversight of Clinical Audit activity.
- Safe Waiting List update received with useful discussion held regarding management of follow up patients
- Confidential enquiries/national guidance assurance report received, with good assurance provided
- Divisional Governance Monitoring verbal update received on the new Governance system
- CQSG Key issues report received
- Divisional updates received. SQAC noted the challenges across the organisation, given the continued staffing pressures across all divisions, levels of ED attendance and the pressures regarding mental health services. Assurance was provided through the discussions that all options are being fully considered to manage these pressures across the organisation, including pro-active discharge management to manage bed pressures.
- PALS and Complaints Quarterly Report received with good assurance provided.
- Patient Experience Report received with good assurance provided across the organisation.
- Aggregate Analysis Report received with good assurance provided.

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

None.

4. Positive highlights of note

The Sensory Project offers important insight into ways in which patient experience for many of our CYP can be improved, with wide ramifications for Alder Hey, but also for other organisations. The project identified sensory issues facing some staff members as well.

The improved quality of reports, especially in the responsiveness domain and in relation to Clinical Audit, was noted and commended.

5. Issues for other committees

Pressures on staffing, including those arising from grade inflation in other organisations, were noted, along with the risk flowing from delayed funding decisions by some partners in relation to Mental Health provision.

6. Recommendations & proposed next steps

The Board of Directors are asked to note the contents of this report.

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 19th October 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Interim Chief Medical Officer	(Aba)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Deputy Chief Executive	(JG)
	Adrian Hughes	Deputy Chief Medical Officer	(AH)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jo Revill	Non Executive Director	(JR)
	Jackie Rooney	Director of Quality & Governance	(JR)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)
	Sarah Wood		

In attendance:

Kelly Black	Interim Head of Nursing, Division of Surgery	(KB)
Julie Creevy	Executive Assistant (Minutes)	(JC)
Julie Grice	Mortality Lead	(JG)
Kim Hewitson	Sepsis Nurse	(KH)
David Porter	Consultant Infection & Immunology, Infectious Diseases	(DP)
Daniel Hawcutt	Senior Lecturer Paediatric Pharmacology	(DH)
Natalie Palin	Associate Director of Transformation	(NP)
Jill Preece	Governance Manager	(JP)
Paul Sanderson	Interim Chief Pharmacist	(PS)
Will Weston	Medical Services Director	(WW)
Peter White	Chief Nursing Information Officer	(PW)

22/23110 Apologies:

Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
Christine Hill	Pathology Manager	(CH)
Dani Jones	Director of Strategy	(DJ)
Phil O'Connor	Deputy Director of Nursing	(POC)
Benedetta Pettorini	Divisional Director, Surgery Division	(BP)
David Reilly	Associate Director of Digital Systems	(DR)
Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC). FB introduced Jo Revill, recently appointed Non Executive Director to committee members, Veronica Greenwood, Deputy Director of AHP's and Daniel Hawcutt, attending representing Clinical Research Division.

22/23/111 Declarations of Interest

SQAC noted that there were no items to declare.

22/23112 Minutes of the previous meeting held on 21st September 2022 – Resolved:

Committee members were content to **APPROVE** the notes of the meeting held on 21st September 2022.

22/23/113 Matters Arising and Action Log

Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/114 Patient Safety Strategy Board update

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

- Successes related to recruitment of Patient Safety Specialist (Mr Christopher Talbot), and Programme management support had now commenced.
- Patient Safety Board continue to focus on a data driven approach and decisions.
- Team have utilised the data available to commence a piece of work to focus on what matters most to reduce harm to patients. With next steps to triangulate other data sources to enable a better understanding of where to focus efforts.
- A patient safety culture process is due to be established to measure how safe staff feel to raise concerns in the context of patient safety.
- Training, culture, communication and data crosscutting areas of work are developing and gathering momentum to support underlying ethos of the programme. Communications plan had been developed and is set to launch from November 2022.

SQAC **NOTED** the good progress regarding individual workstreams.
SQAC acknowledged the longevity and pace of programmes with some aspects taking time to embed, such as PSIRF.

KB alluded to the DMO slide and stated that it would be beneficial to review this on a monthly basis. WW referred to the 'amber items' and stated that progress is envisaged on these items within the next month.

FB queried whether there were any projects causing concern which required escalation to SQAC. WW referred to the quantity of programme management resource that is currently available, agreed offline discussion to take place with WW and NP.

Resolved: Offline discussion to be held with WW and NP with regards to programme management support.

WW advised that EIA and QIAs are anticipated to progress within the next month, and that consideration is required with regard to the content and requirements, and suggested offline discussion with WW, NA and ABa in this regard.

Resolved: Offline discussion to be held with WW/ABa & NA

KB sought clarity regarding how risks are being captured on Ulysses and queried whether colleagues were populating information on Ulysses with individual risks, or whether colleagues are having summary programme risks. WW confirmed that

each workstream is articulating their individual risks which will then be captured on the system.

KB referred to Parity of Esteem workstream and noted that the slide focussed on restraint and restrictive handling, and stated that her understanding that it was broader than this. KB referred to assessing mental health wellbeing, alongside physical issues, and that this was not included within the update. WW stated that a wider piece of work is required, and that this information is not yet reflected in the progress report, with further work to do in this regard.

JP referred to the methodology regarding the specific patient safety aspect of Parity of Esteem, which is a significant piece of work regarding culture change which is trust wide. JP stated that lots of content isn't directly related to patient safety and that JP had included specific information regarding supportive holding and restrictive practice. JP referred to physical management of violence and aggression as a very specific patient safety element and advised that it is worth changing the title, as the title is currently misleading.

KB welcomed visibility of Parity of Esteem project updates to ensure visibility at SQAC within future updates.

FB stated that there are broader safety issues beyond physical handling and referred to time to treatment and welcomed colleagues to provide thought regarding those initiation documents in different workstreams, with appropriate reconciliation. FB welcomed reconciliation of the Parity of Esteem slide; NA stated that this would be reviewed and addressed with the aim of merging slides to ensure focus on safety elements.

NP expressed concern regarding adding a further workstream given that there are currently 20 workstreams, NP advised that she recognises that some are action points rather than workstreams and highlighted the need to manage key milestones for the next meeting to ensure that colleagues are not trying to do too much too soon. NP welcomed review of key milestones to be included within the update for November 2022 meeting, to aid prioritisation and pace, whilst ensuring realistic timelines.

JG referred to the measures to reduce harm levels and ensuring clarity regarding the breadth of the programme to ensure this is having sufficient impact., JG advised on the need for SQAC to receive assurance regarding impact on harm levels. NA advised that at Patient Safety Strategy Board meeting in October 2022 that the Board reviewed information regarding harm levels. NA referred to opportunities regarding minor harm and the four associated programmes that would account for the highest number of harms. Discussion is planned at November 2022 Patient Safety Strategy Board, to focus on those areas of minor harm that could have a significant impact on the overall harm metric.

Resolved SQAC received and **NOTED** the Patient Safety Strategy Board update and **NOTED** that SQAC would receive slide 2 on a monthly basis.

22/23/115 DIPC Exception Report

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

KB sought clarity on the rationale why SQAC had not received CLABSI data since July 2022. NA advised that he would liaise with BL offline to establish, and would provide offline feedback to KB ahead of Trust Board.

Resolved: NA to liaise with BL and provide prompt feedback to FB and KB as appropriate.
000156

Delivery of Outstanding Care

Safe

22/23/116 **Assurance ED Assurance Monthly Update**

SQAC received and **NOTED** the ED Assurance Monthly update

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

22/23/117 Ockenden Update

PB presented the Ockenden update:-.

- PB referred to the original Ockenden Action Plan which had a number of actions due to be completed. Excellent progress had been made with 40 of the 68 actions completed.
- 16 actions are on trajectory with the original timescale set.
- 12 actions have had an adjustment timescale set and are on trajectory.
- SQAC **NOTED** that there are no specific actions to escalate to SQAC.
- SQAC **NOTED** that there is a report shortly to be published on 19th October 2022 with regards to 'Reading the signals: maternity and neonatal services in East Kent, the report of the independent investigation', and that once the report had been published it would be fully reviewed to establish whether there are any actions or recommendations that were not covered in Ockenden.

FB welcomed an update regarding any future integrated items following the 'Reading the signals: maternity and neonatal Services in East Kent publication and welcomed an update to SQAC at January 2023 meeting.

FB thanked PB for update and acknowledged the good progress made, and the exemplary assurance provided to SQAC.

Resolved: SQAC received and **NOTED** the Ockenden update and **NOTED** the progress made to date, SQAC welcomed update at January 2023 meeting, to include any integrated items following the 'Reading the signals: maternity and neonatal Services publication.

22/23/118 Sepsis Update

DP presented the Sepsis Update; Key issues as follows:-

- DP confirmed that since the previous Sepsis SQAC update at July 2022 meeting, that the majority of areas of focus had been on trajectory. DP stated that there is a detailed review of data now that Sepsis Nurse is in post for inpatients.
- Sepsis Steering Group meetings had resumed
- Clinical Governance – reviews of cases over 60 minute administration are being routinely reviewed

A presentation of the sepsis data for inpatients and ED was given along with explanations of the differences in the clinical environments and workload that may impact on performance.

DP referred to the 60 minute target and highlighted the lack of supporting evidence on the importance of administering IV antibiotics within 60 minutes, with some evidence showing a positive outcome within 3 hours where the child was not critically unwell.

DP referred to the difficulty in recognising the difference between infection and Sepsis as there is caution with some trainees, with sepsis often considered initially then downgraded.

Key issues

- Inaccurate documentation – significant improvements made – however Sepsis is often used when 'infection' is intended.
- Importance that the 60 minute target should not override all other clinical priorities and managing the patient overall.
- DP referred to difficulties regarding the Sepsis Dashboard used for Inpatient an ED data, given that numbers do not always align, with further work required to address alignment on the dashboard.
- Continued focus regarding training figures to improve mandatory training levels going forward.

- Action for the next 3 months included – improving the ED data, focus on training and continuing to develop doccumentaiton in preparation for meditech expanse.

DP welcomed any support from colleagues regarding improving training compliance and addressing Sepsis dashboard issues to correct errors, improve display and explore amalgamating with/direct feed to MDC system which is used to report information into info fox.

FB thanked DP for comprehensive update. FG sought assurance whether SQAC are monitoring the right target, or whether the target should this be reconsidered. DP advised on the importance of interpreting the 60 minute target with some caution for the reasons presented to the committee, but DP welcomed the continuation of the 60 minute target.

JG reiterated the need for clinical assessment and decisions that some children may require a period of observation to prevent unnessecary administration of antibiotics. JG advised on the importance of correct data and correct coding particularly within the ED and there was a continued need to provide training for staff.

NA thanked DP for excellent paper, NA advised on the importance of continuing with the 60 minute target which is a national standard, and emphasised that the Trust should be looking to detail the narrative alongside, to clearly articulate the deviation and reasons why.

NA advised that KH routinely reviews all sepsis cases which had shown a significant improvement in compliance for inpatient wards, NA stated that it would be beneficial to undertake a consistently similar process within ED.

JG advised that the ED data is reviewed however there are challenges in removing patients if incorrectly coded as sepsis.

JR alluded to the 25% of staff who had not received the necessary training and sought clarity whether there was any other means of providing training in order to improve training compliance. DP stated that the training data only referred to online training. DP confirmed that face to face training is provided at induction, aim to provide face to face training for all doctors, with aspiration of resuming face to face training on induction for nurses in the future.

NA advised that it would be helpful for SQAC to receive a quarterly report going forward and following the next two quarter updates the workplan would be reviewed as appropriate.

Resolved: Offline discussion to take place regarding smarter actions, clear actions and ownership and ensuring DP and team have appropriate support in place.

Resolved: NA, DP, CW & KH to undertake offline discussion.

FB thanked DP and KH for comprehensive update

Resolved: SQAC received and **NOTED** the Sepsis Update, SQAC welcomed quarterly Sepsis update. Divisions to review and address Sepsis Compliance within Divisions to improve compliance.

22/23/119 Health Inequalities & Prevention Steering Group report

AH presented the Health Inequalities & Prevention Steering Group report. An overview of the NHSE and Chesshire and Mersyside approach was given.
AH informed the group that an action plan against all 14 areas had been developed and would be included in the next update for oversight of SQAC.

AH advised that there is a clear vision with oversight on all matters, with clear governance arrangements and learning, with impressive thematic information provided at Health Inequalities & Prevention Steering Group meetings.

Health Inequalities Group are clear that this would not be delivered by Steering Group and needed to become part of core business. AH advised that the aim is to embed through a Brilliant Basics approach, ability for all staff to embrace making every contact count.

AH welcomed thoughts regarding appropriate forum for discussion regarding call to arms.

FB sought clarity regarding how outcomes are tracked to ensure all patients are receiving equitable levels of attention, care and treatment with regards to core data and how this is received.

JR stated that it would be helpful to have an offline discussion with AH, and referred to multi partnership working. JR referred to funding opportunities to develop further with different partners.

AH welcomed JR to join oversight group to discuss further.

FB referred to the joint appointment of the Public Health Officer focussing on this area for the City is a new initiative and ensuring that this is delivering the value it could deliver.

Resolved: Offline discussion to take place with AH & JR.

JG stated that he is particularly interested in the action elements 2030 vision, and expressed concern regarding a number of unconnected workstreams, and whether the group could be thoughtful on the action piece. AH concurred with this. AH stated that 6 monthly updates would be provided to SQAC.

Resolved: Offline discussion regarding whether SQAC or Execs require any additional Reports, acknowledging the importance of the strategy discussions.

FB welcomed 6 monthly updates to SQAC, and in the interim offline disscusion to be held with regards to alignment with strategy discussions.

Resolved: SQAC received and **NOTED** the Health Inequalities & Prevention Steering Group Report.

22/23/120 Winter Planning report (Autumn and Winter Emergency Response Plan)

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AB provided SQAC with the comprehensive Winter Planning report, (Autumn and Winter Emergency Response Plan), reported detailed the Enhanced services for winter, capacity and escalation plan, patient flow, staff wellbeing, support and advice, staff vaccination and the Trust escalation framework. Winter Emergency Response Plan has four goals to Provide safe care; keep staff safe, deal effectively with increases and peaks in emergency demand and maintain elective care services.

AB stated that given staffing and bed challenges if the Trust enters extreme pressure, the Trust would have to get into clinical prioritisation, contracting some of the elective programme, with the need to be honest and realistic regarding safe staffing levels and how much capacity could be made available. Real focus on staff recruitment, with confidence that this year there is good capacity on PICU. Open additional 10 general and acute beds this year, Virtual Ward establishment had been approved and the aim for the ED extension being operational at the end of this calendar year. Covid and flu vaccination campaign is established, clear focus in supporting staff through challenges, with new offer regarding costs of living pressures and HR leading on support for staff. AB advised that the plan is constantly being reviewed to strengthen resilience, and that he is currently reviewing how the paediatric capacity within C&M address any extreme pressures to protect the specialised work undertaken at Alder Hey.

JR referred to actions that the local councils had undertaken and queried how much support is being provided by the local council to colleagues, AB confirmed that positive support from external colleagues had been received.

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

Resolved: SQAC received and **NOTED** the Winter Planning report

Clinical Governance Effectiveness

22/23/121 CQSG Key issues report

FB welcomed SQAC feedback regarding the first written CQSG key issues report and requested whether SQAC were content with the level of detail/information contained within the report.

KB stated that it would be useful to follow a format that shared successes and for key escalations it was clear if these were for information or for discussion and action at SQAC. NA confirmed that this would be included in future reports.

FB stated that the report was informative and confirmed that SQAC were content to receive CQSG Key issues report in same format, whilst including the modifications suggested by KB.

SQAC received and **NOTED** CQSG Key issues written report and **NOTED** modification required for future CQSG key issues report.

FB thanked NA for CQSG key issues report update.

22/23/122 Safeguarding our Children, Young People and families against failings in Care

NA presented the Safeguarding our Children, Young People and families against failings in Care report, which had been requested from Executive Team following the BBC panorama investigation (October 2022). Aim of the report is to provide assurance regarding the quality and safety of services, and the methods in place to safeguard children, young people and

families against failings in care.
000160

The review had identified robust systems and processes in place at Alder Hey to safeguard the children, young people and families in our care. SQAC **NOTED** that as with any review there are areas for improvement that had been identified and would be captured into an action plan. Report detailed three key areas for review:-

- Safer recruitment practices including training
- Roll out of improved safeguarding training -training is being reviewed in line with the updated national intercollegiate guidelines and would need to involve a more detailed focus on aspects such as Deprivation of Liberty Safeguards and Trust Board training.
- Language and terminology – to enable a review of language and terminology used by all staff when working with complex and challenging children and young people with acute paediatric settings.

FB welcomed SQAC feedback – KB stated that it is positive that the report had been completed, KB alluded to the 4 specific questions detailed on page 2 of the report with regards to whether the Executive Team colleagues felt sufficiently assured that this is well controlled, or whether there were any gaps, and advised that supporting information/narrative would be helpful. KB alluded to the three key areas for review and referred to recruitment and sought clarity on how they align within the People Strategy, and sought clarity on the monitoring process on a whole.

JP stated that it is not acknowledged within the report the exemplary Leadership provided by Chief Nursing Officer and the Divisional Director for Community & MH and that this should be acknowledged within the report.

NA expressed thanks to LC and colleagues for support.

SQAC **NOTED** that in contrast to adult services, most of the children and young people who receive care in the acute setting have a resident parent or carer to advocate on their behalf, which provides an additional level of assurance in protecting them against failings in care. The Tier 4 unit is compliant with requirements to advocate for and safeguard young people during their admission.

Resolved: SQAC received and **NOTED** the content of the assessment and the actions required for improvement, which would be monitored through SQAC.
FB thanked NA for comprehensive update.

Well Led

22/23/123 Board Assurance Framework

ES presented the Board Assurance Framework; key issues as follows:-
ES advised that she had commenced benchmarking of the Board Assurance Framework with Great Ormond Street Hospital, and that there are a number of similarities to Alder Hey, with various elements of learning, ES stated that she envisaged that her counterparts at Great Ormond Street Hospital would be content to share information if helpful to aid any future learning if appropriate.

Discussion took place regarding scheduling of Deep Dive 1.4 - Access to Children and Young People Mental Health and agreeing an appropriate timescale for SQAC to receive deep dive, LC stated that she was content to provide Deep Dive update to SQAC at November 2022 meeting, ES referred to whether LC was of the opinion that there had been sufficient movement since the risk had been included on the Board Assurance Framework, ES & LC agreed to discuss schedule offline.

Resolved: Offline discussion to be held with ES & LC to agree whether 1.4 would be presented to SQAC at November 2022 meeting.

Deep Dive Risk 1.1. - Inability to Delivery safe and high quality care
NA presented Deep Dive on Risk 1.1. – Inability to Deliver safe and high quality care, key issues as follows:-

SQAC **NOTED** that the key risks and control gaps had been restated and reviewed, with significant work undertaken to review control gaps; control gaps are being addressed through Patient Safety Strategy Board, with the requirement to redefine and rearticulate as appropriate to demonstrate that they are no longer gaps in control.

NA advised that focus is on the new Electronic Governance Incident and Risk Management system, to triangulate data which would further strengthen assurance regarding this risk in the future.

FB stated that there is a clear difference regarding a gap in performance and a gap in control, and that it does not always get separated out as clearly enough within the documentation.
KB stated that all patient safety strategy work that could be included within controls
KB queried whether NICE compliance should be included within control gaps, given that this does not feature in the Board Assurance Framework. NA advised that the new system would help in this regard, NA stated that this could be more focussed.

FB thanked NA for update and acknowledged SQAC assurance with regards to Risk 1.1.

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

22/23/124 Clinical Ethics Committee Plan

ABa provided a verbal update on the Clinical Ethics Committee Plan, key issues as follows:-
ABa stated that AH was leading on this issue, and that the Clinical Ethics Committee Terms of Reference had been updated to reflect how the Clinical Ethics Committee react with the Complex Decision Making Group, the constitution of the Clinical Ethics Committee had been fully reviewed, with the aim to broaden Committee membership, to include university representation, 2 lay members, external professional representation, increasing representation from various religions and to include Divisional representation.
ABa advised that a Clinical Ethics Committee Chair had been identified, who is an external qualified clinical colleague. AB confirmed that the updated Terms of Reference are currently awaiting feedback/comments from Clinical Ethics Committee members, and that following feedback the Terms of Reference would be updated as required.

SQAC **NOTED** that there would be a small associated cost with regards to the appointment of the Clinical Ethics Chair and Vice Chair, and any associated expenses for lay committee members and that a small Business Case would be required.

FB referred to the importance of increasing visibility of Clinical Ethics Committee and welcomed the growth and expansion of committee membership.

ES alluded to any data being shared with external colleagues, and highlighted the importance of ensuring that appropriate safeguards are in place when sharing sensitive information with external colleagues.

Discussion took place regarding training for key individuals within the Clinical Ethics Committee and the need for appropriate budgetary provision to support such training.

FB thanked AB for update.
000162

22/23/125 Divisional reports by exception/Quality Metrics Update

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

- Division of Surgery had 100% compliance with regards to PALS responses, with no formal complaints received in month.
- Division of Surgery had a decrease in Medication errors incidents reported in September 2022.
- Targeted work is taking place within the Division of Surgery to align with the Winter Plan to ensure resilience and winter preparations, with regular checks on staff wellbeing, particularly during challenging periods for staff, with wellbeing walkabouts, and hot debriefs on challenging days.
- Challenges – The Division of Surgery had 1 no harm Never Event in September relating to a retained dental block, there had been immediate lessons learned for the Division, the patient had no harm, panel set for later this month.
- Activity and capacity with regards to inpatients with a slight increase in the number of on the day cancellations for theatre and challenges of rebooking those patients in within 28 days, with 8 breaches during September 2022.

KB referred to the retained dental block and stated that she would be keen to understand whether this was related to a previous dental block incident and sought clarity whether this was similar and welcomed an update on review. NA provided a summary to SQAC on the individual case.

SQAC **NOTED** that NA had discussed this issue with the CQC Inspector who was content with information provided, with no additional questions raised.

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

- The Division of Medicine had 100% compliance with regarding to complaint responses within 25 days.
  A discussion regarding the desire for the divison to increase clinical audit activity occurred.
- Highlight – Diagnostics is achieving 100% compliance within six weeks.
- Improvement with sleep studies as the Division now have the 2 home kits which has increased capacity
- UD acknowledged significant ongoing work within Haematology services, to continue to maintain cancer standards despite the reduction of 2 consultants with Haematology.
- Following feedback from Division of Medicine Senior Leadership Team colleagues have expressed a request to work more 'leaner', given that there are multiple meetings which run late into the evening, this is currently being reviewed to enable support for staff.

FB alluded to the need to align professional requirements for undertaking audits to strategic priorities.

JR stated that she is planning an away day with Governance Leads, Governance Team is currently being planned to enable review of audit and audit process. JR stated that she continues to meet monthly with Divisional Management Governance Leads and Associate Chief Nurses, and the issues raised would be reviewed and addressed.

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

- Referrals for Neurodevelopmental Services, ASD & ADHD continue to increase.
- Division is commencing with a vast recruitment campaign, and the ability to recruit appropriate practitioners.

- Division are undergoing moves which had commenced during week commencing 17th October 2022, with colleagues due to be in place in the new 'Catkin' Centre on 31st October 2022. Awaiting a date for tier 4 unit. Move also includes the relocation of administrative staff into a new temporary modular building of the new couple of weeks.
- Highlight – Sexual Assault & Referral Accreditation is gaining momentum, and the Trust had been accepted as an early adopter pilot site.
- Sensory project had concluded, work would continue within the Trust, with internal Sensory Group chaired by Divisional Director for Community & MH, with a final report envisaged to be presented to SQAC at November 2022 meeting.
- Division had secured funds for an Eating Disorder Day case unit from Integrated Care Board, Day Case Unit would be placed within Alder Park. FB queried whether any additional staffing would be required. LC confirmed that this is being funded for this year, and the Division are currently awaiting funds this year from PLACE.

FB thanked Divisions for update

Clinical Governance Effectiveness

22/23/126 Policy Approval

SQAC received and **RATIFED** the **Document Management Policy.**

Resolved: SQAC received and **RATIFIED** the Document Management Policy – Policy RATIFIED.

22/23/127 Any other business

None.

22/23/128 Review the key assurances and highlight to report to the Board

Positive updates were received regarding:

- Patient Safety Strategy Board update was received
- Assurance provided regarding the Ockenden Action plan
- Sepsis update was received, with informative discussion held.
- Health Inequality & Prevention Steering Group report received, discussion held regarding the need for this work to become action orientated, with ways for colleagues across the organisation to engage with tis agenda. The need to align this workstream to the Strategy 2030 development work was recognised.
- CQSG Key Issues written report received, SQAC approved the CQSG Key issues format forward going.
- Safeguarding our Children, Young People and families against failings in care report received, with valuable discussion held
- Deep dive received regarding Board Assurance Framework Risk 1.1 which provided SQAC with assurance that the risk is being appropriately managed.
- Verbal update was received regarding Clinical Ethics Plan, with ongoing work progressing.
- SQAC received Divisional updates.
- SQAC received and RATIFIED the Document Management Policy

21/22/128 Date and Time of Next meeting

FB thanked all for attendance

Next meeting to be held on 16th November 2022 at 9.30 am