Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Thursday 24th of September 2020, commencing at 9:00am
via Microsoft Teams

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT/STAFF STORY (9:00am-9:15am)							
1.	**20/21/118**	**9:15**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**20/21/119**	**9:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/120**	**9:17**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 8th September 2020.**	**D**	Read minutes
4.	**20/21/121**	**9:19**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read action log
Phase 3 Covid-19 Response							
5.	**20/21/122**	**9:25**	• **Winter Plan 2020/21 and update on the Phase 3 Covid-19 response.** • **Financial Update:** - **2020/21 Financial Plan and Phase 3 Framework.** • **COVID Risk Register.** • **IPC COVID Assurance Framework.**	A Bateman J. Grinnell J. Grinnell J. Grinnell N. Murdock	To update the Board on the work that is taking place to finalise the 2020 Winter Plan. To provide an overview of the 2020/21 Financial Plan and Phase 3 Framework. To discuss the current 5 Key Risks. To provide an update.	**A** **A** **A** **A**	Presentation Presentation Read report Verbal
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
6.	**20/21/123**	**10:00**	**Division of Surgery: Governance and Safety Rates.**	A. Bass	To provide an update on the work that has taken place around safety and governance in the Division of Surgery, following feedback from CQC.	**A**	Presentation
7.	**20/21/124**	**10:10**	**Cumulative Corporate Report Metrics - Top Line Indicators:**	N. Murdock/ P. Brown/ A. Bateman	To receive a weekly metrics/monthly report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report

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			• **Quality** • **Safety** • **Effective/Responsive**				
8.	**20/21/125**	**10:30**	**Serious Incident Report.**	P. Brown	To provide board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	*To follow*
9.	**20/21/126**	**10:45**	**Positon Statement for PALS and Complaints. Q1.**	P. Brown	To receive the position statement for Q1. 2020/21.	**A**	Read report
10.	**20/21/127**	**10:55**	**Infection, Prevention Control Report, Q1.**	N. Murdock	To receive the position statement for Q1, 2020/21.	**A**	Read report
The Best People Doing Their Best Work							
11.	**20/21/128**	**11:05**	**Cumulative Corporate Report Metrics - Top Line Indicator:** • **People.**	M. Swindell	To receive a weekly metrics/monthly report of Trust performance for scrutiny and discussion**,** highlighting any critical issues.	**A**	*(refer to item 7)*
12.	**20/21/129**	**11:15**	**Alder Hey People Plan Update:** • **EDI Task Force Terms of Reference.**	M. Swindell	To provide an update on the People Plan.	**A**	Read report
13.	**20/21/130**	**11:25**	**Freedom to Speak Up.**	K. Turner	To provide an update on the current position.	**A**	Read report
Game Changing Research and Innovation							
14.	**20/21/131**	**11:35**	**Innovation Strategy Update.**	C. Liddy	To provide an update on the work taking place on the Innovation Strategy.	**A**	Presentation
Sustainability through Partnerships							
15.	**20/21/132**	**11:50**	**Charity Update.**	F. Ashcroft	To provide an update.	**N**	Verbal
Lunch (12:00pm-12:30pm)							
Strategic Update							
16.	**20/21//133**	**12:30**	**Alder Hey in the Park Campus Development update.**	D. Powell/ R. Gates	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report

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Strong Foundations (Board Assurance)							
17.	**20/21/134**	**12:40**	**Reducing the Burden - Reset of Board Assurance Committees:** - **Terms of Reference for Assurance Committees.**	E. Saunders	To provide an update on the revised approach for Board Assurance Committees. To ratify the Terms of Reference for the Assurance Committees that report into the Trust Board.	**N** **D**	Verbal Read report
18.	**20/21/135**	**12:50**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 17.9.20.** - **Approved minutes from the meeting held on the 16.6.20.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.9.20.** - **Approved minutes from the 24.6.20 and the 29.7.20.** • **Safety Quality Assurance Committee:** - **Chair's verbal update form the meeting held on the 23.9.20** • **People and Wellbeing Committee:** - **Chair's highlight report from the 14.9.20.** - **Approved minutes from the 2.3.20.** • **Integrated Governance Committee:** - **Approved minutes from the 11.3.20.**	K. Byrne I Quinlan A. Marsland C. Dove K. Byrne	To escalate any key risks, receive verbal updates and note approved minutes.	**A**	Verbal/ Read highlight reports and minutes

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			• **Innovation Committee:** - **Approved minutes from the 11.5.20.**	S. Arora			
19.	**20/21/136**	**13:05**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic operational plan are being proactively managed.	**A**	Read report
Items for information							
20.	**20/21/137**	**13:15**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
21.	**20/21/138**	**13:20**	**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, 29th October, 9:00am-2:00pm, via Microsoft Teams.							

REGISTER OF TRUST SEAL
The Trust Seal was used in September 2020: - Surrender of the Lease for the UOL Building. - Hopkins Architects, Deed of Novation for Phase 2 of the Research and Education Building.

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M5	**John Grinnell**
CQC Action Plan	**Erica Saunders**
Corporate Report	**Executive Leads**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Confirmed Minutes of the meeting held on Tuesday the 8th of September 2020
Via Teams

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Pauline Brown	Acting Chief Nurse	(PB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mrs. C. Dove	Non-Executive Director	(CD)
	Mr. J. Grinnell	Director of Finance/ Deputy Chief Executive	(JG)
	Mrs. A. Marsland	Non-Executive Director	(AM)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Vice Chair	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Director of HR & OD	(MS)
In Attendance:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Ms. L. Cooper	Director of Community Services	(LC)
	Mr. M. Flannagan	Director of Communications	(MF)
	Dr. A. Hughes	Director of Medicine	(AH)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Information Officer	(KW)
Observing:	Mr. S. Hooker	Lead Governor	(SH)
Apologies:	Mr. A. Bass	Director of Surgery	(ABAS)
	Miss. J. Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Dr. N. Murdock	Medical Director	(NM)
Staff Story	Jo Potier	Associate Director of Organisational Development/Consultant Clinical Psychologist	(JP)
Staff Story	Lalith Wijedoru	A&E Consultant	(LW)
Item 20/21/115	Jennie Williams	Improvement Manager	(JW)

20/21/109 Apologies

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

20/21/110 Declarations of Interest

There were no declarations to declare.

20/21/111 Minutes of the Previous Meetings
Resolved:
The minutes from the meetings held on the 7th of July 2020 were agreed as an accurate record of the meeting.

20/21/112 Matters Arising

There were none to discuss.

20/21/113 Robust Response to the 'Black Lives Matter' movement and Improvement Plans for Supporting Black and Minority Ethnic Communities Locally.

The Chair thanked Claire Dove for agreeing to help drive the Trust's response to the 'Black Lives Matter' movement and Improvement Plans for supporting black and minority ethnic communities locally, which has come about as a result of the pandemic.

Claire Dove informed the Board of her intention to share some of her life experiences when she faced racism and to highlight what it means to have such a diverse workforce. Attention was drawn to the recent events in the United States of America that have shocked the world as a result of racial injustice which has brought about a huge reaction on a scale that hasn't been seen before.

It was pointed out that 1 in 10 of the UK workforce are from black and minority ethnic communities (BAME) of which, 47% are on zero contracts. Attention was drawn to the number of BAME workers who have tragically lost their lives as a result of being on the front line, leaving little doubt about the disproportionate effect of COVID-19 on these groups.

The Board was advised that the Covid-19 outbreak is putting a stark lens on the inequalities faced by health workers from BAME backgrounds and despite giving their lives to care for others, are being treated of a lesser value. Claire Dove highlighted the importance of coming together as colleagues to tackle inequalities within the Trust in order to empower the organisation's BAME workforce.

The Board was informed about the blog that Claire Dove had written for the Civil Service which shared a number of her experiences where racism reared its head; one particular story went back to the 1970's when Claire tried to register with an employment agency for work. There were jobs being advertised by the business but Claire was informed that there were no suitable jobs available and that they wouldn't be able to employ her as other members of staff would not be willing to work alongside her. Claire's response to this was to challenge the racism that she faced by setting up an employment agency with two of her friends, ensuring that the best candidates were employed regardless of their race, religion or disability. Claire pointed out that when you are black you not only have to deal with the daily routine of your job but you also have to deal with the mental health issues of inequality.

Claire Dove raised the issue of educational attainment for pupils from BAME backgrounds and highlighted the lack of support for black children throughout the educational system. It was pointed out that Blackburne House was rated as outstanding by OFSTED and reflected a place where pupils feel safe. It was reported that 60% of the cohort at Blackburne House are BAME. Claire reflected upon the ethnic disparities in higher education and as a Fellow of John Moores University advised of her pleasure when seeing a BAME pupil from the local community graduate. Claire Dove pointed out that the NHS employs numerous amounts of people, and asked as to how many black CEO's, Board members, Directors, etc. do you see in these roles?

It was pointed out that the majority of the country relies upon the NHS for healthcare, but what experiences do patients receive? Claire informed the Board of an occasion

when she was racially abused by a patient when accessing an A&E department, but due to being so poorly did not raise this as an issue. On another occasion Claire had to deal with the narrow mindedness of a doctor who suggested that her illness was as a result of her ethnic background.

Claire pointed out that one of Alder Hey's values is 'The Best People Doing Their Best Work' but felt that the Trust needs a clear plan to address equality and diversity and address the stagnant statistics that do little to change behaviours. Claire felt that the Workforce and Organisation Development Committee had not been seen as being as important as other Assurance Committees that feed into the Board, but felt that this may change owing to a refresh of the Committees and having a more high level membership. Claire pointed out that the Trust must plan for the future and not rely upon overseas recruitment, which on the positive side has brought some element of diversity to the organisation.

Claire pointed out that Alder Hey is the leading hospital for children, young people and families but queried as to whether the Trust actually reflects the communities it serves. The Board was advised that action needs to take place to work on unconscious bias, support BAME staff into senior positions and to ensure that BAME staff and children have a voice at meetings and forums. In order to drive this work forward a Task Force Group has been established. The group will agree a plan of action, listen to staff to gain their views, ensure a safer environment for staff and liaise with partners with the view to working collaboratively on this matter.

Claire highlighted the importance of the Trust creating and promoting opportunities, for example, introduce apprenticeships/placements, implement a code of conduct and arrange for strategic partners to sign up to the organisation's policies and establish agreements with colleges so that they inform their students of the opportunities at Alder Hey. It has to encompass all as this is about learning from each other to make the working environment safe.

On behalf of the Board, the Chair thanked Claire Dove for sharing her high impact and powerful personal experiences. The Chair agreed that it is time to translate words into actions as now is the time for change. The Chair drew attention to the leadership that Claire has provided and advised that it is imperative that the Trust supports this area of work to ensure crucial changes take place.

The Board discussed the challenges that have hindered the progress of E&D across the organisation and it was felt that additional resources are required to achieve a positive outcome. It was reported that the Trust is looking to develop a team in partnership with four local specialist trusts, there is a good infrastructure in place along with vocational support, and there is an opportunity to bid for a potential of £50k via the Captain Tom Fund. Work is also taking place to encourage staff members to participate in the Task Force Group.

The Board was informed that the inaugural meeting of the Task Force Group is scheduled for the 1st of October 2020 and future meetings will take place on a monthly basis. Data for measuring progress will be obtained via staff survey statistics and recruitment statistics. It was reported that work has commenced to gain feedback from staff and Claire Dove is offering support and guidance to the organisation.

Anita Marsland thanked Claire for the opportunity to support the Task Force Group.

Kerry Byrne pointed out that human stories are very powerful and help you understand a person's situation rather than reading about it in a report or action plan.

Claire felt that a statement from the Chair and Chief Executive should be shared with staff members to make them aware that black lives matter and to promote the Task Force Group. Communications need to be shared to make staff aware that Alder Hey wants to listen to its staff members and Children and Young People's Forum. Claire advised that the Government has a whole range of events to promote E&D, for example, the 1st of October starts 'Black History Month' and felt that the Trust could do some profiling of black people to ensure that staff have resources to look at.

20/21/113.1 **Action: DJW/LS**

Claire concluded that Board members should not feel guilty about not prioritising this agenda previously but now was the time to move forward positively; she pointed out that all lives matter, especially black lives as for a long time they haven't mattered. It was reported that the outcome of the work/learning that the Trust is conducting will advantage other groups of people.

Staff Story

The Chair welcomed Jo Potier, Associate Director of Organisational Development/ Consultant Clinical Psychologist and Lalith Wijedoru, A&E Consultant who were invited to September's Trust Board to provide feedback on the Team Time pilot that has been running in ED since April 2020.

The Board was advised that Team Time is based on the virtual version of Schwartz Rounds which were developed by the Point of Care Foundation in response to the Covid-19 crisis. Lalith and Jo have been piloting Team Time in ED since April on a twice weekly basis involving panellists from a variety of roles across ED (porter, housekeeper, nurse, consultant, service manager to name but a few). It was reported that the feedback from staff has been fantastic and the sessions have played a big role in supporting the department throughout the past few months.

Lalith advised of some of the issues that were being experienced in ED; challenging winter, issues with staff retention, low morale. With the support of Jo Potier a number of interventions took place and work commenced with staff. Lalith informed the Board of his determination to create a forum so that staff could be heard.

It was reported that Team Time centres around telling stories. Between April and July 2020 six formal sessions were held. The sessions had a predetermined theme and each staff member prepared a story focussed on that theme and shared it during Team Time. Feedback from staff highlighted that over 90% of staff members thought the sessions were exceptional. Analysis of the pilot also took place and it was found that there was an overarching theme of healing as a result of Team Time; staff were able to reveal themselves, they were heard and felt supported.

Lalith shared some of the staff stories and quotes from the sessions with the Board and reported that the Trust has been shortlisted for the Molyneux Prize. An application has been submitted for all story tellers and if successful two large portraits will be created to illustrate staff members from ED telling their stories.

Lalith shared a quote with the Board; 'We need to promote active listening with the intent to understand. If we feel that stories can change the world then our stories have the power to heal'. A question was raised as to whether the Board would like to engage in Team Time to tell their story.

On behalf of the Board, the Chair thanked Jo and Lalith for sharing the work that has taken place to support staff and highlighting the powerful impact it has had on the story tellers who participated in Team Time. The Chair agreed to share her story and invited members of the Board to share theirs too.

Jo Potier informed the Board of the great potential for this work to support the workforce. Lalith highlighted the amount of time that it took to progress the pilot but felt that the benefits outweighed this. If the Trust decides to progress this work via online platforms, it was pointed out that resources will need to be made available to staff who don't have access to IT facilities, and facilitators will be required.

Louise Shepherd thanked Jo and Lilith for the time, work and effort that they have committed to piloting Team Time and agreed that a discussion should take place to see if Team Time can be extended across the Trust. Melissa Swindell advised that work is taking place to look at a process for updating the Board on all of the work that is taking place across the Trust to support staff. Melissa Swindell felt that Lalith's account was very powerful and highlighted the importance of harnessing this work to support the workforce.
Action: MS/JP

Fiona Beveridge felt that the presentation was exceptional, and drew attention to a piece of work that has been conducted at Liverpool University via a Pulse Survey. The outcome of the survey highlighted that staff had received plenty of communications and were being kept updated but they felt they weren't receiving personal feedback from their line manager during the pandemic and this was an area that was missing. It was pointed out that it might be beneficial for the Trust to conduct something on similar lines to this to see if the workforce at Alder Hey has comparable views. Louise Shepherd agreed that time should be set aside to look into this matter and think about how it can be progressed.
Action: MS

20/21/114 Current Position and Plan:

Plan for Phase 3

Louise Shepherd introduced the plan for Phase 3 to the Board. Attention was drawn to the importance of preparing for the winter phase which will be underpinned by the knowledge and experience that has been gained as a result of the pandemic. It was pointed out that there are a lot of complexities to address and therefore it is imperative that the organisation's workforce is at the heart of the plan in order to drive it forward.

The plan has been split into three parts; **1.** Recognising that that Alder Hey has a wider role to play in the system, the North West and Cheshire and Merseyside in order to help aid recovery and promote the voice of children and young people. The requirement on the NHS to recover the big ticket items like cancer is overwhelming and there is very little capacity in the system to address this area of work for children and young people. Discussions took place early on in the year with the North West Region about the role of Alder Hey/Royal Manchester Children's Hospital as the pandemic unfurled. Alder Hey has tried to initiate further discussions about its role as the NHS moves into recovery. It was felt that it is critical and moral to do this to ensure that the voices of children and young people are heard. It was reported that the financial architecture is changing and funding will be allocated based on the population's health. This process will be fully formed by April 2021 and it was felt that being able to describe the requirements of the system/Cheshire and Merseyside will be critical in ensuring the flow of funds.

2. *Operational Delivery* – The Trust is looking at 3 tactical areas; 1. Recovery of elective work and achieving pre Covid-19 run rate targets by October 2020. 2. A response to winter, there will be an element of uncertainty around the challenges that winter will bring, for example, there is concern that there may be a second Covid-19 spike and a spate of flu at the same time. **3.** There is a specific focus on mental health and how the Trust is responding to it. It was pointed out that there are enormous mental health requirements following the pandemic. All three areas of this work is taking place across the whole of Cheshire and Merseyside. In addition to this the Alder Hey is addressing the People Plan.

3. *Finance* – In section 8 of the plan the current architecture for funding has been set out. It was reported that NHSI has made an attempt to include incentives in the system for delivery but how this translates at hospital level is unclear. Louise Shepherd advised the Board that the Trust is unable to confirm how the funds will flow and highlighted that there is an element of risk that the organisation will have to live with. A best assessment of the process has been incorporated in the plan for information purposes. Attention was drawn to the importance of ensuring that the Board is fully sighted and briefed on all risks going forward.

The Board was advised that the plan for Phase 3 doesn't include the backlog as the Centre doesn't have the funds to support this area of work. It was reported that the Trust has aspirations to reduce its backlog but detailed discussions will need to take place with teams to see what is doable. Louise Shepherd drew attention to the importance of ensuring that the governance and risk of the organisation is joined up to ensure there are no gaps.

The Board received an overview of the plan for Phase 3 and the following information was provided:

- Alder Hey and the wider system
    - Alder Hey is leading on the recovery of paediatric services across Cheshire and Merseyside. It was reported that a large piece of work has taken place across Cheshire and Merseyside to develop a model around recovery that encompasses an increase in planned referrals, increased pressures on children's services, levelling up of outpatient activity, delivering elective surgery, non-elective surgery, bed capacity and non-elective activity and modernisation of children's services. Alder Hey has written the chapter on children's recovery which articulates the challenges for children and young people across Cheshire and Merseyside. It was confirmed that this has been accepted into the Cheshire and Merseyside plan.
    - There is an ambition to develop a new Operational Delivery Network (ODN) in partnership with RMCH and colleagues from District General Hospitals to move towards a single system management approach for children and young people and to develop a system waiting list across the North West footprint. The focus of this collaboration is to ensure resilience of services, equity of access in restarting services across the region and to support the clinical networks to maximise access to services through the winter.
    - Alder Hey is leading on the mental health recovery for children and young people. There has been a significant request for investment for children and young people via the phase 3 plan and this has been submitted to the Centre as a specific Mental Health Plan.

- Alder Hey's approach to health inequalities will be addressed via three priority workstreams; 'Starting Well' which will address the development of multi-disciplinary teams, 'Alder Hey Action on Health Inequality' will define the Trust's prevention plan and 'Pubic Health and Prevention' will look at working in partnership with Liverpool City Council and the recruitment of a joint Public Health role. A further update on this area of work will be provided to the Board during October's Trust Board meeting.

20/21/114.1 **Action: DJ**

- Operational Plan

  - Progress in delivering restoration services *(level of capacity restored as a percentage of pre-Covid capacity in August 2020)*; Outpatient consultations 88%, ED attendances 88%, planned care operations 80% and diagnostic examinations 83%. It was reported that the Trust has planned for 95% of ED attendances pre-Covid level attendance, avoiding where possible physical attendance and offering alternative ways in which to receive treatment. 5% of higher acuity in terms of flu/RSV and 90% of elective levels of operations.
  - Plans for growing capacity include the expansion of the outpatient schedule with 600 face to face consultations and a digital outpatient suite.
  - Plans for delivering improved access to out of hospital care and mental health services will include sustaining the 24/7 mental health crisis line and looking at new pathways to increase capacity for ASD and ADHD. The Board was advised that the 24/7 crisis line is a priority for the Trust and it was confirmed that the CCG has agreed the funding to enable the Trust to provide a diagnosis for ADHD/ASD patients within 30 week of their referral being received. The Board was advised of the increase in admissions to hospital and the Dewi Jones via the Eating Disorder Service. It was reported that there has been a big impact on the service during the pandemic and that this is a nationally recognised problem.
  - In order to be winter ready the Trust is looking to extend the Emergency Department and have a virtual Emergency Department.
  - There is a workforce component that would require support in respect to some of the developments that the Trust would like to progress. The biggest expansion is in Community Service which relates to developments that have been presented to commissioners that will make a difference to capacity of care. Due to current financial uncertainty a report will be submitted to the Board in October to approve the financial element of the workforce requirements.

20/21/14.2 **Action: AB**

- Workforce Plan

  - 'We are the NHS' People Plan is an interim plan for 2020/21and has 4 areas of focus; looking after our people, belonging in the NHS, new ways of working and delivering care and growing the future. A further review of the People Plan will take place in the autumn of 2020 following the outcome of the spending review.

    It was pointed out that there are some specific areas that aren't included in the Trust's original 2019 People Plan that can be built in, but it was reported that Alder Hey will continue to focus on three priority projects that align closely with the 2020/21 national position to support the recovery

phase for the medium and longer term; wellbeing, agile working, equality, diversity and inclusion.

- Transformation Plan

  - Due to the unprecedented circumstances the Trust is operating in at the present time, it has been necessary to assess the Operational Plan for 2020 to ensure its response is focussed and narrower that the original year 1 of 'Our Plan'. Work has taken place to further develop its transformational projects to ensure alignment with the Trust's strategic priorities/team objectives to make sure projects demonstrate their value to one of more of these objectives. Also, with the support of KPMG and use of the Operational Excellence Model, the Trust has reduced its 'Must Do' projects from 29 to 11. It was pointed out that the Alder Hey wants to achieve the output of the broader plan whilst managing the required resources. The Board was advised that the next phase will look at the alignment of each programme with the organisation's governance arrangements.

- Financial Plan

  - The Board was reminded that the Trust has been operating under a fixed block payment model since April 2020 and has been paid a fixed level of income based on 2019/20 activity levels with no growth, no expectation to deliver efficiencies (CIP), and with a retrospective top up payment for any excess costs or Covid-19 expenditure, resulting in a reported breakeven position. It was pointed out that as long as the Trust is careful with its decision making and complies with benchmarking it will be funded to a breakeven position.
  - From the 1st of October 2020 the block payment model will cease and will be replaced by a system managed envelope that will be allocated by the ICS and distributed to providers via a lead commissioner. The payment model will be linked to delivery of the Phase 3 activity targets at a system level, with a penalty for failure to achieve targets and an incentive payment for additional activity above targets. It was reported that any activity over and above targets will be funded at 70% at national tariff and for Trusts who underperform there will be a reduction of 25% funding at national tariff. The Board was informed that there will be incentives for additional activity but the Centre hasn't confirmed if there is any new money therefore it is uncertain as to where the Trust stand if it over performs.

- Financial Risks

  - It was reported that there are a number of anomalies in the way allocations are being given to the Trust that cover some discrepancies; NICE cystic fibrosis drug that wasn't included in the run rate equates to a £5m discrepancy which it was felt would be resolved, mental health investments equate to £2m in total which relate to the 24/7 crisis care line and access to ADHD services. It was confirmed that the Trust will manage these risks but it is felt the Trust will be recompensed via the new model that commences on the 1.10.20.
  - There is a residual risk around the true cost of restoration in the winter.

- There is £1.5m of risk that relates to non-clinical income of which there is no national provision, for example, car parking, catering, and impact on research and education income.
- There are also issues around tariff changes and cost pressures that sit with the organisation.
- There is a risk of staff absence. This matter is to be addressed by the Exec Team. It was reported that the Trust is focussing on the repurposing of funds whilst being as productive as possible and ensuring funds reach the frontline.

The Chair highlighted the importance of focussing on priorities, especially those that the Trust is able to control, and acknowledged that the risks to the organisation are real. The Chair advised the Executive Directors that the Board is in full support of the Trust's Operational Plan for Phase 3 of the Covid-19 response.

Ian Quinlan reflected upon the discussion that took place around the financial plan and queried as to whether the Trust is in a positon to finance itself. It was felt that a refocus might be possible in respect to the maximising of investments, working capital, efficiencies and resources involved in on-going projects. John Grinnell agreed to look into this matter.

20/21/114.3 Action: JG

Fiona Beveridge felt that it would be beneficial to look at scenario planning for risks and test the organisation's appetite for using cash, so that an informed decision can be made if necessary.

Board Lead for Health Inequality

It was confirmed that Adrian Hughes has agreed to take on the role of Board Lead for Health Inequality.

Resolved:
The Board approved the Trust's Operational Plan (Phase 3 Covid-19 response) – August 2020 to March 2021.

20/21/115 Trust Wide Winter 2020 Flu Campaign

The Board was provided with an update on the 2019/20 flu campaign and an overview of the plans for 2020/21. The following points were highlighted:

- The Trust achieved the 80% target set by the Department of Health and the CCG and saw a 5.1% increase in percentage of staff vaccinated during the 2019/20 flu campaign.
- The Department of Health has outlined a requirement for 100% of staff to be offered the vaccination during the 2020/21 campaign, but the Trust's aim is for this to be 100% of staff employed by Alder Hey to have the vaccination within eight weeks of the start date (28.9.10).
- It was reported that data from the 2019/20 campaign indicates a lower uptake in certain areas, and the learning has identified areas of challenge and potential solutions to these challenges.
- The Board was informed of the development of a Flu App that allows staff to register and record that a vaccination has taken place, and enables documentation and reporting requirements through the use of live data. From an incentive perspective, rather than issuing the usual pen and sticker, the

Trust is building on its social duty to support the reduction of health inequalities through supporting the UNICEF vaccine for a vaccine campaign.

- Vaccinations will commence on the 21.9.20 and will be administered through peer vaccinators who will also visit staff in their work base. From the 28.9.20 Team Prevent will start to add in sessions based on the hours already agreed.
- The Board was asked to note that all hospital trusts have been asked to offer vaccinations to those clinically at risk and eligible patients attending ED and outpatient appointments. It was reported that a project was run last year to support this. The Trust is in the process of scoping how this will operate in 2020/21 with Alder Hey playing a leading role in providing vaccinations for the children and young people who visit the Trust through usual service delivery.
- The Chair confirmed that the Board was in full support of the 2020/21 flu campaign and approved the recommendations in the report. It was felt that either the Medical Director or Chief Nurse would be the appropriate person to champion and support the flu campaign.

Resolved:
The Board approved the following recommendations:

- Identify a champion from the Board to support the flu campaign.
- Promote flu vaccinations through getting theirs done, with photo opportunities to be arranged.
- Commit to achieving the ambition of vaccinating all frontline healthcare workers.
- Agree to the incentives identified.

20/21/116 Any Other Business

There was none to discuss.

20/21/117 Review of Meeting

The Chair highlighted the powerful effect that the first two agenda items had on members of the Board. It was pointed out that the overall input was interesting whilst being challenging, which helped the Board to think about crucial issues that affect everyone. It was felt that the Plan for Phase 3 was articulated well by the Executive Directors.

Date and Time of the Next Meeting: Thursday the 24th of September at 9:00am via Teams

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for the 24th of September 2020							
07.07.20		Patient Story	Invite Claire and Sean Robinson to participate in the forthcoming work around Therapy Services that is taking place to look at the barriers being experienced by patients/families who have to access services in the community following discharge from Alder Hey.	Lisa Cooper	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
07.07.20		Patient Story	Look into the possibility of supporting families without access to technology to enable them to participate in virtual consultations/meetings.	Kate Warriner	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
07.07.20	20/21/89.1	Covid-19 Risk Register	Submit a report to the Trust Board on the evaluation of the new 'Patient Safety Waiting List Dashboard'.	Adam Bateman	24.9.20	Closed	**18.9.20** - A report on the review into the number of patients waiting over 52 weeks in July 2020 has been
07.07.20	20/21/89.2	IPC Covid-19 Assurance Framework	Provide an update on the Trust's IPC Programme of work.	Nicki Murdock	24.9.20	Closed	**18.9.20** - This item has been included on the agenda. **ACTION CLOSED**
07.07.20	20/21/90.1	CQC - Final Report	Provide an overview of the governance and safety work that is taking place in the Division of Surgery. Include the detail in the CQC Action Plan.	Alfie Bass	24.9.20	Closed	**18.9.20** - This item has been included on the agenda. **ACTION CLOSED**
07.07.20	20/21/91.1	Year-End Quality Assurance	*Nursing Workforce Report for 2019/20* - Provide the Non-Executive Directors with background information on the history of Ward 4A and the recent challenges experienced on the ward.	Pauline Brown	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
07.07.20	20/21/91.2	Year-End Quality Assurance	*Q4 Mortality Report* - In order to provide additional information, conduct a deep dive into the cases reviewed where a patient is recorded as having learning disabilities. Ensure additional narrative is incorporated in future reports around the conclusion of reviewed cases relating to patients with learning disabilities.	Nicki Murdock	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
07.07.20	20/21/93.1	Serious Incident Report	Compare recent Serious Incident figures against data from previous years to ascertain improvement.	Pauline Brown	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
07.07.20	20/21/97.1	Alder Hey in the Park Campus Development Update	*Neonatal Development* - Submit the planning application for the new Neonatal Development to the Trust Board on the 24.9.20 for approval.	David Powell	24.9.20	Closed	18.9.20 - This item has been included on the agenda. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
08.09.20	20/21/113.1	Robust Response to the 'Black Lives Matter' movement and Improvement Plans for Supporting Black, Asian and Minority Ethnic Communities Locally.	Statement from the Chair and Chief Executive to be sent to all staff making them aware of the creation of the Task Force Group and its remit.	Dame Jo Williams/ Louise Shepherd/	24.9.20	On Track	**18.9.20** - An update will be provided on the 24.9.20.
Actions for the 29th of October 2020							
03.03.20	19/20/346	Key Issues/Reflections and items for information	Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff.	Pauline Brown	29.10.20	On Track	This item has been deferred until further notice due to the Covid-19 crisis.
02.06.20	20/21/60.1	Freedom to Speak Up	Compile a breakdown of the issues that SALS have addressed during the current year.	Kerry Turner	29.10.20	On Track	
07.07.20	20/21/91.3	Year-End Quality Assurance	*The Work of Alder Hey Youth Forum during Covid-19* - Provide an update in October on the work that has taken place between the Youth Forum and the NSPCC.	Lisa Cooper	29.10.20	On Track	
08.09.20		Staff Story	Liaise with Jo Potier to discuss the possibility of extending Team Time across the organisation.	Melissa Swindell	29.10.20	On Track	
08.09.20		Staff Story	Look at the possibility of conducting a Pulse Survey to obtain staff views in respect to the support the organisation has provided during the pandemic.	Melissa Swindell	29.10.20	On Track	
08.09.20	20/21/114.1	Plan for Phase 3	*Alder Hey and the Wider System (approach to Health Inequalities)* - Provide an update on the work that is taking place in partnership with Liverpool City Council and the recruitment of a joint Public Health role.	Dani Jones	29.10.20	On Track	
08.09.20	20/21/114.2	Plan for Phase 3	*Operational Plan (Expansion of Services)* - Submit a report on the financial element of the workforce requirements in respect to the developments that the Trust would like to progress.	Adam Bateman	29.10.20	On Track	

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log (April 2020-March 2021)

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
08.09.20	20/21/114.3	Plan for Phase 3	*Financial Risks* - Look at alternative solutions to mitigate the financial risk in the event that the Trust is not recompensed or does not receive the expected funding via the new model that commences on the 1.10.20.	John Grinnell	29.10.20	On Track	
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD
Thursday 24th September 2020

Paper Title:	COVID 19 Risk Register
Report of:	John Grinnell, Deputy Chief Executive/Director of Finance
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ■
Background Papers and/or supporting information:	COVID 19
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:	Resources identified to support management of COVID 19 risks as required.

1. Purpose

The purpose of this report is to enable the Trust Board scrutinise the COVID 19 risk register and provide assurance that the risk are being managed effectively.

2. Summary.

Analysis of the open and closed risks identified on the register shows that the majority of the COVID risks identified since the start of the pandemic have been effectively managed, excepting a small minority that need further work to meet the expected Trust risk management standards, i.e. risks without action plans to mitigate the risk, or risks not reviewed at least within agreed timeframes.

There are currently **35** risks identified on the COVID 19 risk register compared to **42** in the previous reporting period to board.

The current Trust COVID 19 risk profile for this reporting period is provided at **Appendix 1, Table 1** and the current risk heat map is provided at **Table 2** (evaluation of impact x likelihood for risks identified).

There are **6** high risks identified on the register, compared to **7** during the previous reporting period. Of the **6** high risks identified, **1** remain at a risk rating of **20** (risk 2182), **1** new risk identified with a risk rating of 16 (2236), 4 with a risk rating of 15 **(**risk 2143, risk 2180, risk 2178)) and risk 2178 has reduced from risk rating of **20** to **15**.

The majority of the risks identified on the register are in the moderate risk category i.e. **22** compared to 26 in the last reporting period. The register shows **3** identified high moderate risks (12), compared to **4** previously.

The overview at **Appendix 1, Table 3** shows the high and high moderate risk's, including progress with actions and trends. Although there is evidence of actions for all the risks identified, there is slow progress in mitigating 4/ 6 high risks and 2/ 3 high moderate risk. However in some cases mitigations are dependent on external forces, including ongoing developments around the pandemic and in these cases there is certain limitations in what can be achieved to mitigate.

Number of closed risks - removed from the risk register = **8 (refer to appendix 1, Table 4)**

Number of new open risks - = **5 (refer to appendix 1, Table 5)**

Number of risks with an overdue review date = **0**

Number of risks with overdue actions = **3 (refer to appendix 1, Table 6)**

Number of risks with no agreed action plan – 6 **(refer to appendix1, Table 7)**

Number of open risks with increased risk scores = **1**

- Risk 2165 – ' Risk of *an employee diagnosed as having COVID 19, where there is reasonable evidence that it was caused by exposure at work'* - Current risk rating now **9**.

Number of open risks with reduced risk scores = **4 (refer to appendix 1. Table 8)**

Number of open risks with no risk rating = **1 (risk 2154)**

Appendix 1

1. COVID Risk Register Profile - 31st August 2020 (Total 35)

Table 1

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk				No risk rating
1	2	3	4	5	6	8	9	10	12	15	16	20	25	
0	**0**	**0**	**2**	**1**	**4**	**3**	**9**	**6**	**5**	**4**	**1**	**1**	**0**	**1**
0 (0.00%)			**7 (20%)**			**22 (62.85%)**				**6 (17.14%)**				**(2.85%)**

2. COVID 19 Risk Register Heat Map - 31st August 2020

Table 2

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	1 Risk (5)	6 risks (10)	3 risks (15)	risk (20)	risks (25)
4 Major	1 risk (4)	3 risks (8)	3 risks (12)	1 risks(16)	1 risk (20)
3 Moderate	risks (3)	3 risks (6)	9 risks (9)	risks (12)	risks (15)
2 Minor	risks (2)	1 risk (4)	3 risks (6)	risks (8)	risks (10)
1 Negligible	risks(1)	risks (2)	risks (3)	risks (4)	risks (5)

1 - 3	Very Low
4 - 6	Low
8 - 12	Moderate
15 - 25	High/extreme

3. SUMMARY COVID 19 RISK REGISTER (Range 20 high – 12 high moderate)

Key	Medical Division		Surgical Division		Community and Mental Health Division		Research Division		Corporate function(s)	

Table 3

Strategic Objective	CQC Domain	Ulysses Ref.	Risk Description	Current Risk Score CxL	Trend	Target Risk Score CXL	Action plan	Progress update	Risk Owner	Governance
Delivery of Outstanding Care	Safe	**2178**	Risk of late or no presentation of C&YP who need treatment.	5x3 = 15	↓	3x3 = 9	Action plan in place	C&M Paeds network has instituted paediatric resource into 111; impact currently being audited but initial findings show positive results in terms of closure of cases at 111 (before reaching other services), however this is dependent on shielding resource which is due to come to an end. 111 First national initiative has subsequently been announced; all systems to have implemented by 1st December. Local work to determine staffing/model for C&M underway. Approach to routine capture of Late Presentations on Ulysses underway, currently developing the categories in Ulysses - expected go live for capture in September 2020.	Director of Strategy	SQAC

The Best people doing their best work	Well - Led	**2182**	Risk of Insufficient financial resource to meet demand	4x5 = 20	↔	3x3 = 9	Action plan in place	Working within the financial model currently provided by NHSI/E, Awaiting further guidance. Risk reviewed, still awaiting updated guidance from NHSI/E on financial framework for M7-12. We are expecting a continuation of the current regime for M5&M6 and are preparing draft plans for submission in September to NHSE/I on the remaining year.	Deputy CEO/ Director of Finance	RABD
Delivery of Outstanding Care	Safe	**1560**	Risk of patients breaching 18 weeks referral to treatment target (CHAMS) – 50% of children waiting more than 18 weeks	3x5 = 15	↔	3x1 = 3	Action plan in place	Single-session therapy and VIG intervention for families on the waiting list and increased group interventions for parents and carers ongoing. There has been a significant improvement in waiting time for first assessment, and slight improvement in overall referral to treatment wait. There are numerous actions in place to help reduce waiting times. This is regularly reviewed against a trajectory for compliance. 13 clinical psychology trainees starting in October, it is hopeful that there will be an improvement in overall waiting time when these positions start in post.	Director of Community and Mental Health	SQAC

Delivery of Outstanding Care	Safe	**2143**	. Delay in imaging and subsequent delay in treatment.	5x3 =15	↔	5x1 = 5	Action plan in place	There is improved compliance; however there is still a growing backlog of planned DM01 patients and non-DM01 patients. Risk is not to be reduced until at least the un-validated patients are reviewed.	Medical Division Director	SQAC
The Best people doing their best work	Safe	**2180**	Risk of not securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained	5x3 = 15	↔	2x3 = 6	Action plan in place	There are currently no critical issues with the stock of PPE. The PPE Predictor is showing a reasonably healthy outlook, with only FFP3 Masks (which have known supply problems) being a potential area of concern around mid-October. The PPE Predictor is updated weekly and is monitored closely by the Procurement Team. Any stock which is deemed as potentially creating an issue going forward is being sourced.	Chief Operating Officer	SQAC
The Best people doing their best work	Safe	**2236**	Reduction in research income due to COVID-19 contributes to financial deficit.		**New**		Action plan in place	The Division is working alongside other research intensive Trusts to communicate a joint message to the DHSC re the impact of COVID 19 on research income and proposed solutions. Activity plan and financial forecast for 20/21	Director of Research Division	SQAC

								presented to SDG on July 2020.		
Delivery of outstanding care	Well Led	**2181**	Increased risk to staff mental health and emotional wellbeing	4x3 = 12	↔	3x2 = 6	Action plan in place	Current capacity sufficient to meet demand for staff support and clear plan of work in place to mitigate against psychological impacts of COVID 19. Ongoing work to form part of new action plan as part of Change Programme going forward and discussed in monthly Staff support meetings from September 20.	Associate Director OD & CP	WOD
The Best people doing their best work	Safe	**2142**	Risk that staff contracting COVID 19. (catering staff)	4x3 =12	↔	3x2 = 6	Action plan in place	Free food offer ceased on 03/08/20. Small café/food offer opened in Institute. Footfall in the Atrium is currently light but will continue to monitor.	Facilities Manager	WOD
Delivery of Outstanding Care	Safe	**2213**	Risk of Increased exposure to a cyber-attack / cyber security incident - which could result in data confidentiality, integrity and availability being compromised.	4x3 =12	↓	4x2 =8	Action plan in place	The Trust is taking part in a regional Phishing Campaign which is scheduled to happen in the coming weeks. This will allow us to get an understanding of our users' maturity when it comes to spam mail and will allow us to do more targeted training. C&M are having some technical challenges with setting this up so we are awaiting a date as to	Chief Digital Officer	RABD

								when this will occur. Scope agreed with 3rd part implementation to commence in September. Darktrace and Pervade installed within AH (allows for the monitoring of system vulnerabilities in a 'live' view).		

4. Closed risks

Table 4

Risk reference	Risk description	Target
2138	*There is a risk that compliance with national nursing standards for safe staffing levels on wards and departments will not be met* - This risk and associated actions were related specifically to the emergency period associated with the spike in critical care requirement and anticipated staffing pressures for COVID related reasons. At the time of closure the Trust was in Phase 2 and approaching Phase 3. The Amber and Red nursing models set were for the emergency period only and have been formally stood down. Should there be a second spike in COVID cases, the nursing model will be reviewed again. **Risk closed 02/07/2020.**	3x2 = 6
2146	*Ability to provide a timely and effective safeguarding service* - Staffing in the Rainbow Centre has returned to pre-COVID levels, therefore risk closed. **Risk closed 21/07/2020.**	4x1 = 4
2156	*Staff members may fail to identify vulnerable children and young people and / or follow trust safeguarding* procedures - Risk reviewed - processes have returned to 'normal', therefore risk closed. Will review in the light of any surge in COVID 19. **Risk closed 21/07/2020.**	4x1 = 4
2139	*Possible delays to patient diagnosis and treatment as some laboratories who perform specialist testing of samples we send to them are not currently able to provide these services* - Risk closed as referral labs move back to routine activity. Routine monitoring of outstanding work by AH lab will continue to identify any overdue reports. **Risk closed 23/07/2020.**	4x1 = 4
2188	*The new starters may not get the support they need or the quality of their induction may not be as robust as usual due to the amount of new starters* - All students fully supported. ECP students have now completed their 3 month programmes and returned to University prior to restarting again in September as registered nurses. **Risk closed 04/08/2020.**	3x2 = 6

2248	AED training compliance including specifically decontamination. Associated issues regarding compliance with guidelines and civil contingencies Act.	Risk a duplicate of 2249; therefore removed.
2145	*AED training compliance including specifically decontamination. Associated issues regarding compliance with guidelines and civil contingencies Act* – Duplicate entry of risk 2249. **Risk closed 05/08/2020.**	3x2 = 6
2177	*Increased Risk of Infection for Clinical Staff* - There is no longer an issue with protective gowns and the hospital has a significant amount of stock, therefore risk closed. **Risk closed 30/08/2020.**	3x2 = 6

5. New risks identified

Table 5

Risk reference	Risk description	Current risk rating
2228	*Risk that the delays in access to theatre will result in suboptimal outcomes for children and young people*	3x3 = 9
2236	*Reduction in research income due to COVID-19 contributes to financial*	4x4 =16
2156	*Staff members may fail to identify vulnerable children and young people and / or follow trust safeguarding* procedures - Risk reviewed - processes have returned to 'normal', therefore risk closed. Will review in the light of any surge in COVID 19.	Risk closed 21/07/2020.
2249	Due to COVID, the (A&E) department is unable to comply with the training regulations as a department to manage a decontamination incident	3x3 =9
2248	AED training compliance including specifically decontamination. Associated issues regarding compliance with guidelines and civil contingencies Act.	Risk a duplicate of 2249; therefore removed.
2255	Risk of deterioration in physical condition due to lack of face to face physiotherapy	2/3 = 6

6. Number of risks with overdue actions = 3

Table 6

Risk reference	Current risk rating	Actions past expected date of completion	Target date set for completion
2177	9	1	01/05/2020
2153	6	2	29/05/2020
2215	12	1	07/08/2020

7. Number of risks with no agreed action plan = 6

Table 7

Risk reference	Current Score	Target score
2142	12	6
2157	9	Not stated
2199	8	8
2154	Not stated	4
2172	4	2
2267	12	Not stated

8. Number of open risks with reduced risk scores = 4

Table 8

risk	Risk Description	Previous and current risk rating
2178	*Risk of late or no presentation of C&YP who need treatment* (Communications)	↓20 to 15.
2213	*Increased exposure to a cyber-attack / cyber security incident*, *which could result in data confidentiality, integrity and availability being compromised* (IM&T)	↓15 to 12.
2201	*Staff contracting COVID due to non-compliance with safe social distance* (Ward 1C Cardiac)	↓15 to 10
2172	*Alcohol based hand sanitizer has the potential to cause static electricity when in contact with metal surface* (Health & Safety)	↓6 to 4.

END

Delivery of Outstanding care

Alder Hey Children's NHS
NHS Foundation Trust

Weekly operational performance report

21/09/2020

The Best People doing their best Work

Measure	Target	WC 14/09/2020 Last Week	WC 07/09/2020 2 Weeks Ago	WC 31/08/2020 3 Weeks Ago	WC 24/08/2020 4 Weeks Ago
Access to Care					
ED Treated within 4 Hours	95%	93.49%	94.52%	96.63%	98.65%
Bed Occupancy Midday	92%	81%	79%	71%	77%
No Child Unaccounted For **(YTD)**	0	1,901 (non compliance 8%)	1,862 (non compliance 8%)	1,747 (non compliance 8%)	
No Child Unaccounted For **(Prev Week)**	0	85 (non compliance 7%)	115 (non compliance 9%)	84 (non compliance 9%)	83 (non compliance 7%)
Unvalidated Outpatient Waiting List Size	Reduction in Trajectory	154,579	154,702	154,476	154,314
Adjusted Outpatient Waiting List Size	Reduction in Trajectory	52,696	53,418	52,850	53,066
Inpatient Waiting List Size	Reduction in Trajectory	6,196	6,092	6,057	6,051
Waiting Greater than 52 weeks	0	127	TBC	TBC	TBC
Patients waiting more than 52 weeks without a clincial review	0	0 - Community 0 - Surgery	0 - Community 0 - Surgery	4 - Community TBC - Surgery	1 - Community 5 - Surgery
Total number of consultations*	100% Sept-20	676	655	653	592
Total number of consultations; **% activity vs same month last year**		82.30%	81.60%	82.81%	83.00%
Proportion of all consultations provided virtually*	25%	47.83%	49.29%	50.32%	49.00%
Proportion of all consultations provided digitally*	TBC	10.59%	10.16%	10.25%	11.7%
Proportion of follow-up consultations provided virtually*	60%	51.4%	52.7%	53.1%	52.8%
Cancelled Operations due to non-clinical reasons	4	3	7	0	1 Cxld No Ward Bed
Sessions Delivered/Planned	139	121 COVID related Staffing	104 COVID related Staffing	100/113	125
Day Case restored activity*	80% Sept-20	66.2	68.4	72	72.9
Day Case restored activity; **% activity vs same month last year***		70.40%	72.80%	76.20%	82.50%
Elective restored activity*	80% Sept-20	17.5	15.3	15	17.6
Elective restored activity; **% activity vs same month last year***		85.30%	74.70%	73.20%	87.56%
Number of patients scanned*	90% Sept-20	224	223	223	214
Number of patients scanned; **% activity vs same month last year***		84%	91%	92%	86%
Safe Care					
Clinical Incidents resulting in moderte or above harm	0	0	0	0	4 (2x Moderate, 2x Catastrophic)
Pressure Ulcers 3 & 4	0	0	0	0	0
Sepsis: % Patients receiving antibiotic within 60 mins for ED	100%	TBC	62.5% (n=5/8)	80% (n=4/5)	80% (n=4/5)
Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients	100%	100% (n=3/3)	90% (n=9/10)	87.5% (n=7/8)	100% (n=4/4)
No. of Covid pos patients in the hospital	NA	0	1	0	0
Hospital Acquired COVID-19 Infections	0	0	0	0	0
Great Place to Work					
Non Covid Related Sickness		193 (5.08%)	193 (5.08%)	202 (5.32%)	205 (5.43%)
Covid Related Sickness		3 (0.08%)	6 (0.16%)	4 (0.11%)	4 (0.11%)
Absence Related to Covid - not inc sickness		57 (1.50%)	72 (1.90%)	56 (1.47%)	62 (1.64%)
Absence Related to Covid Inc Sickness		69 (1.58%)	78 (2.05%)	60 (1.58%)	66 (1.75%)
All Absence (total of above)		253 (6.65%)	271 (7.14%)	262 (6.90%)	271 (7.18%)

*** Denotes the value is based on month to date position of the month the week commences in**

Alder Hey Children's NHS
NHS Foundation Trust

Metric Notes

Metric	Note
ED Treated within 4 Hours	
Bed Occupancy Midday	Capacity Plan; Excluding CC, EDU & 3B
No Child Unaccounted For	EPPF completion within 48 hours
Unvalidated Outpatient Waiting List Size	New OP Waitlist. Any patient with an open pathway, open referral, a pend or booked appt - Unvalidated
Adjusted Outpatient Waiting List Size	New OP Waitlist. Excluding potential DQ & Future Appts
Inpatient Waiting List Size	New IP Waitlist. Any patient with an open pathway, open referral, a pend or TCI
Waiting Greater than 52 weeks	Services vaidated position as Friday last week.
Patients waiting more than 52 weeks without a clincial review	Services vaidated position as Friday last week.
Total number of consultations*	Include digital, tel and F2F (Aligned to Phase 3 Guidance)
Total number of consultations; % activity vs same period last year	Include digital, tel and F2F (Aligned to Phase 3 Guidance)
Proportion of all consultations provided virtually*	Digital and telephone (Aligned to Phase 3 Guidance)
Proportion of all consultations provided digitally*	
Proportion of follow-up consultations provided virtually*	MediTech Only & Digital and telephone (Aligned to Phase 3 Guidance)
Cancelled Operations due to non-clinical reasons	
Sessions Delivered/Planned	
Day Case restored activity*	Average per working day
Day Case restored activity; % activity vs same month last year*	DC & RegDays
Elective restored activity*	Average per working day
Elective restored activity; % activity vs same month last year*	
Number of patients scanned*	Average per working day
Number of patients scanned; % activity vs same month last year*	
Non Covid Related Sickness	Open ended absences not linked to Covid symptoms
Covid Related Sickness	Open ended absences where staff member is experiencing Covid symptoms
Absence Related to Covid - not inc sickness	Open ended absences where staff are Self-Isolating or Medically Suspended
Absence Related to Covid Inc Sickness	All Open ended absences related to Covid
All Absence (total of above)	All Absence (total of above)

*** Denotes the value is based on month to date position of the month the week commences in**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th September 2020

Paper Title:	**Quarter 1 2020 – 2021 Complaints & PALS report**
Date of meeting:	**15 July 2020**
Report of:	**Pauline Brown, Interim Chief Nurse**
Paper Prepared by:	**Liz Edwards, Head of Clinical Audit & National Guidance**

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	To receive the Current Complaints Performance report and update regarding previous concerns.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	n/a

Alder Hey Children's NHS Foundation Trust

Quarter 1:- April 2020- June 2020

1. Complaints summary

The Trust received 23 formal complaints during this period. One complaint from this quarter was initially raise as a PALS enquiry but escalated to a formal complaint at the request of the parent. In 2019/2020 Q1 the Trust received 23 formal complaints, therefore there is no change in quantity during same period last year.

It is important to note that the Covid 19 pandemic had a significant impact on services during this period. In an effort to assist NHS organisations, it was confirmed on 16 March 2020 that NHSE had granted a 3 month pause for Trust's to investigate new complaints. However as the Trust receives a comparatively low number of complaints, and as we had capacity to investigate complaints, the Chief Nurse made the decision to continue to manage new complaints in line with our policy where at all possible. Where a new complaint was received and clinicians were unable to respond in a timely manner due to COVID, there was an internal agreement to review investigative and response timescales on a case by case basis.

This unprecedented time impacted on the Trust's ability to progress some face to face meetings with complainants and in some cases caused a delay in finalising written responses. However, the ability to raise concerns and complaints was not compromised and the Trust provided a full service at all times.

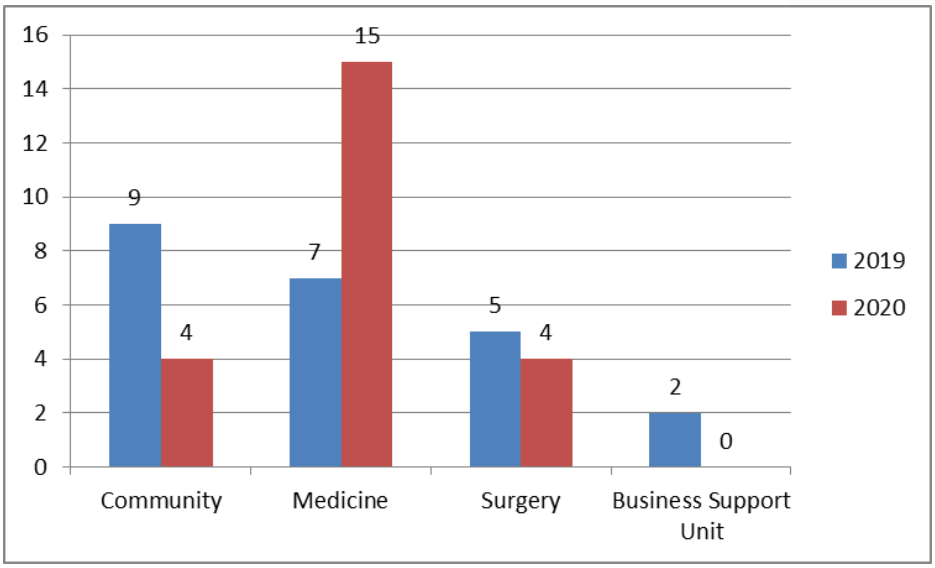
A review of the process to ensure concerns raised by MP's on behalf of their constituents was undertaken, and the Complaints Policy was updated to reflect the updated process that all MP concerns must be managed by the formal complaint method.

The category of complaints received in this quarter are:-

Treatment/Procedure	12
Access, Admission, Transfer, Discharge	4
Consent, Communication, Confidentiality	4
Medication	2
Clinical Assessments (Diag, Scans, Tests)	1

Complaints by Division in Quarter 1
The following graph demonstrates the amount of complaints received within each Division during Quarter 1 2020 - 2021 and includes a comparison from the same time period in 2019/2020.

Figure 1 - Number of complaints received by Division

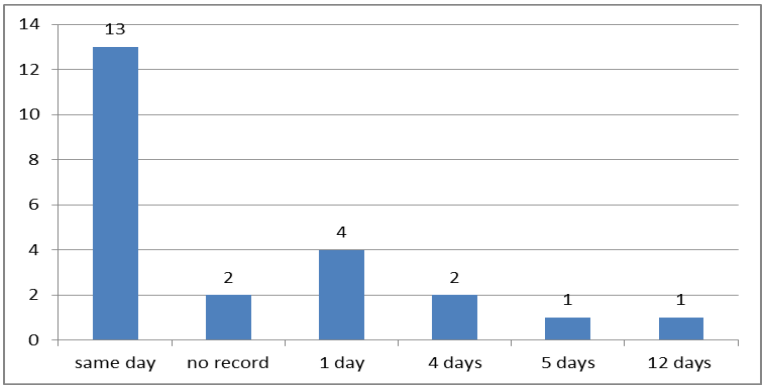


Report against three day acknowledgement

The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy.

In Q1 74% of complaints received were acknowledged within 3 days - 56% on the same day. In 2 cases there is no record of an acknowledgement.

Figure 2 – Days taken to acknowledge receipt of complaint



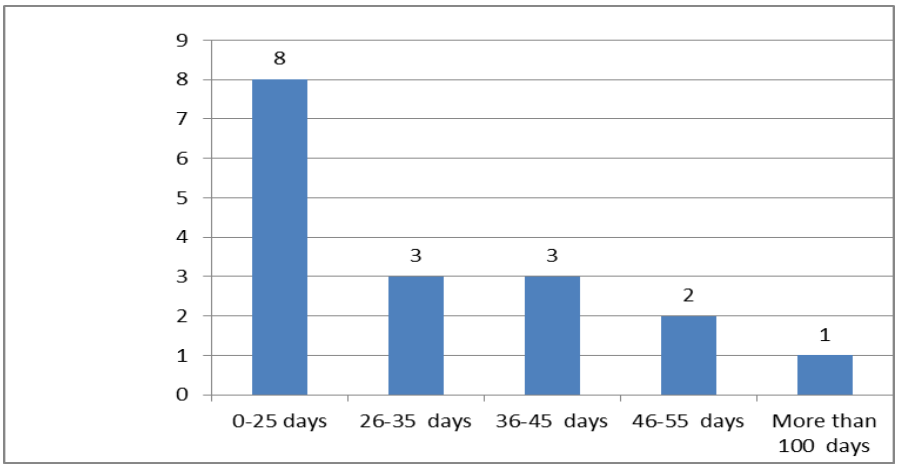
The Trust's internal timeframe for responding to complaints is 25 working days, however if the complaint is complex or multi organisational the potential for needing additional time to investigate is discussed with the complainant and an extended timeframe for response is negotiated.

The graph below shows the timeframes the Trust has responded to a formal complaint within Q1.

Of the 23 complaints received during this period, 9 are ongoing but within timescale.
17 complaints were responded to during quarter 1. The response times are illustrated in graph 3.

Delays in completion of responses have been a result of complex complaints and on occasions cross divisional complaints. On occasions, there has been a delay caused by the need for repeated quality checks to ensure that all aspects of the complaint has been included in the response with a comprehensive and clear explanation. Additionally the impact of the Covid pandemic has caused delays within the process.

Figure 3 – days taken to respond to complaint



Complaint outcome

Of the 17 responses, 6 complaints were upheld, 7 were not upheld and 4 partially upheld.

All complainants are fully up dated regarding any delays in response timeframes.

Actions resulting from complaints

These include

- Review of process for contacting parents when a child's care is under review
- Development of a SOP to manage change of demographic details when verbal instruction provided
- Review of meditech system to ensure that medications prescribed as an inpatient are not amended when medications are changed or prescribed as an outpatient.
- Complaints have been discussed with individual staff members involved

Referrals to Parliamentary & Health Service Ombudsman

Due to the Covid-19 pandemic, the PHSO paused work on NHS complaints on 26 March 2020 to help the NHS focus on tackling the pandemic. The PHSO have recommenced this work from Q2: 1 July 2020 and are now accepting new NHS complaints and progressing existing ones.

One case from quarter 2 2018/19 is still being assessed by the PHSO as to whether they plan to investigate or not.

One complaint from Q4 2018 (Medicine) – received information from PHSO planning to investigate; all records submitted as requested.

One complaint from Q3 2018 (Medicine) – received email from PHSO, advising they felt local resolution still possible. Community and Medicine now re looking at issues outstanding identified by PHSO.

2. PALS summary

In Q1 2020 – 20212 172 PALS contacts were received. In comparison to the same quarter in 2019 -2020 (338) this is a decrease of 166 and is thought to be due to the impact of the Covid pandemic on clinical activity within the Trust.

Figure 4 – PALS by Division

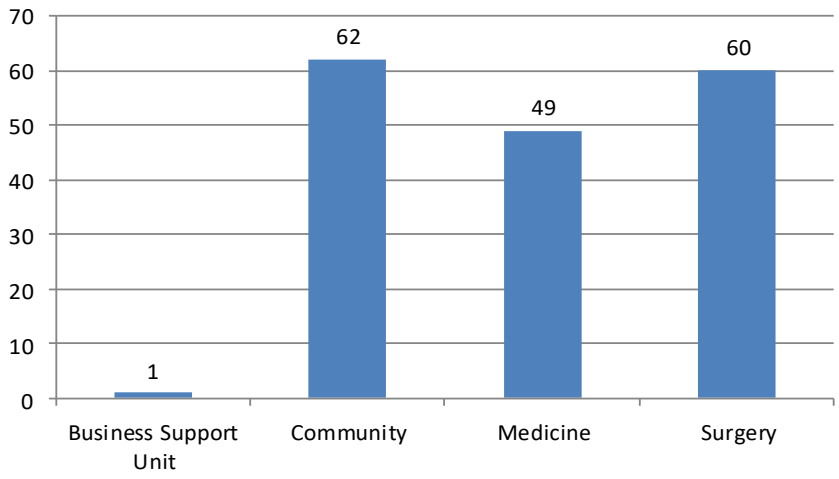
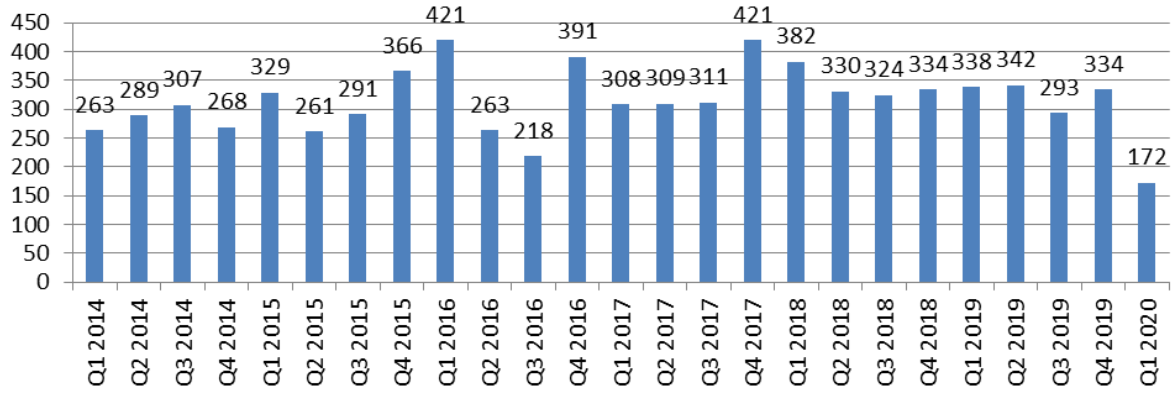


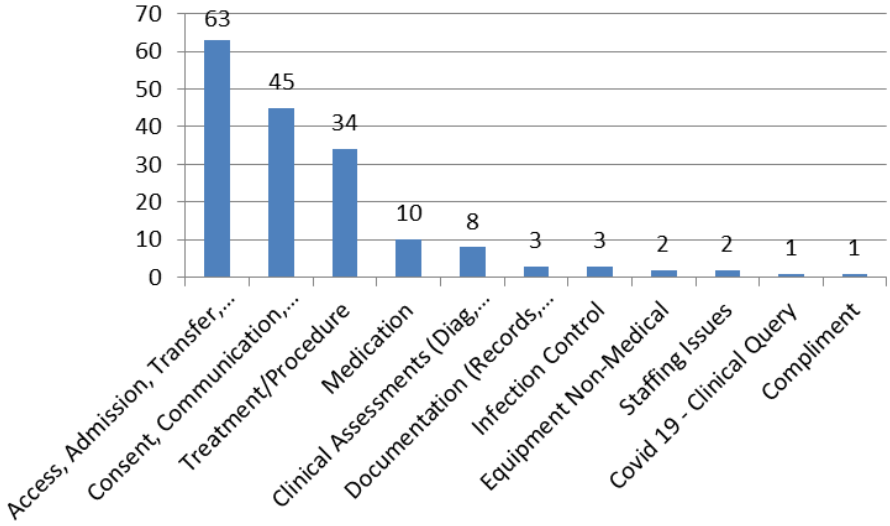
Fig 5- PALS contacts from 2014/15 – Q1 2020 / 2021

The table shows the significant reduction in the number of PALS contacts during this period.



Due to the Covid-10 pandemic, the PALS office was closed to family and visitors wanting to raise any concerns face to face, however clear posters were put up advising how concerns could be raised. Further improvements were made to accessibility of the PALS service as a Family Support Helpline was established as part of the Trust Covid-19 response and PALS issues could be raised through this route with the call handler then raising the issue of concern with the relevant Division to support, contact and investigate with the concerned family member.

Figure 6 – Themes identified



Key issues from PALS during Quarter 1

The main issues identified within Q1 relates to appointments management –waiting times.

PALS and complaints are communicated and fed back to senior staff at the three Divisional Integrated Governance meetings to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month

3. Compliments

Compliments continue to be recorded on the Ulysses system and shared with the relevant teams.

Two compliments were recorded during this period and have been shared with the relevant teams and staff.

- Mother of a patient on 4C

'Firstly, I just want to start with saying thankyou ! We have been in Alder Hey for 5 days with my newborn, we were on 4C . In particular, the nurses who were amazing were Gabby & Dee !
Finally I just want to say the cleaners and healthcare assistants on 4C were amazin, so kind and thoughtful'

- Mother of patient

Mum wanted to say a huge thank you to Mr Donne and his amazing secretary. She said that they have gone above and beyond to accommodate and care for her daughter in such hard times. Mr Donne said if mum could park outside the hospital he would come out and examine her daughter's ears as she has a chronic ear condition.
Mum says thank you and she is really grateful
Mr Donne has recognised that her daughter is shielding and this means a lot to mum

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 24th of September

Paper Title:	**Infection Prevention Services Q1 Board Report**
Report of:	**IPS Q1 2020-21**
Paper Prepared by:	***Dr Chris Parry*** *IPC Dr & Microbiologist*, ***Jo Keward*** *IPC Lead Nurse* , ***Carly Quirk*** Data Analyst

Purpose of Paper:	Decision Assurance Information Regulation	☐ x x ☐
Background Papers and/or supporting information:	N/A	
Action/Decision Required:	To note To approve	x
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**	x x **x** ☐ **x**
Resource Impact:		

INFECTION PREVENTION SERVICES (IPS) REPORT 2020-21 Q1 (1st April 2020 – 30th June 2020)

This report provides the challenges for delivery of the Infection Prevention & Control Work Plan 2020-21.

The work plan for 2020-21 consists of 17 objectives and a total of 199 deliverables. *At the end of quarter 1* ***55%*** (110/199) of the total of deliverables have been completed. ***15%*** (29/199) of the total deliverables are in progress (amber). ***1%*** *(3/199)* are classified as red. 2***9%*** (57/199) are classified as grey, these are objectives that cannot yet been progressed. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey
Q1	17	199	1% (3)	15% (29)	55% (110)	29% (57)

Table 1: Deliverables RAG rating

Table 2 below shows the total number of hospital acquired bacteraemia for Q1 2020-21 compared to Q1 2019-20.

Table 3 shows the cumulative total for 2020-21 compared to the total 2019-20.

Bacteraemia	Q1 20-21	Q1 19-20
MRSA	0	0
MSSA	1	2
E.coli	2	4
Klebsiella	3	2
Pseudomonas	0	1
Infections		Infections
Cdiff	1	0
Outbreaks	0	0

Table 2: HAI Q1 2020-21 compared to Q1 2019-20

Bacteraemia	Cumulative 20-21	Total 19-20
MRSA	0	0
MSSA	1	7
E.coli	2	8
Klebsiella	3	11
Pseudomonas	0	2
Infections		
Cdiff	1	1
Outbreaks	0	0

Table 3: Hospital acquired bacteremia Cumulative Total 20-21 and

Metric	Aim	Actual Number
HA-MRSA (BSI)	Zero tolerance	0
C.difficile	Zero tolerance	1
MSSA	Zero tolerance	1
CLABSI(ICU only)	Zero tolerance	6
Gram-Negative BSI	Zero tolerance	5
RSV	Zero tolerance	0

Table 4

The C.difficile case identified in QTR 1 was an oncology patient the case was considered to have been unavoidable and no lapse in care was identified.
A Post infection review is held for all hospital acquired MSSA and Ecoli BSI and the findings are presented at the IPCC bimonthly. QTR 1 findings will be presented at the IPCC in October 2020.
The 5 Gram negative blood stream infections shown above are broken down into the following organisms:

- 3 Klebsiella
- 2 E.coli
- 0 Pseudomonas

Table 5 below shows 2019-20 total show an internal target for 2020-21 and actual numbers for 2020-21 . The Trust has a zero tolerance for all HAI. The graph below also illustrates a 10% reduction from the previous year.

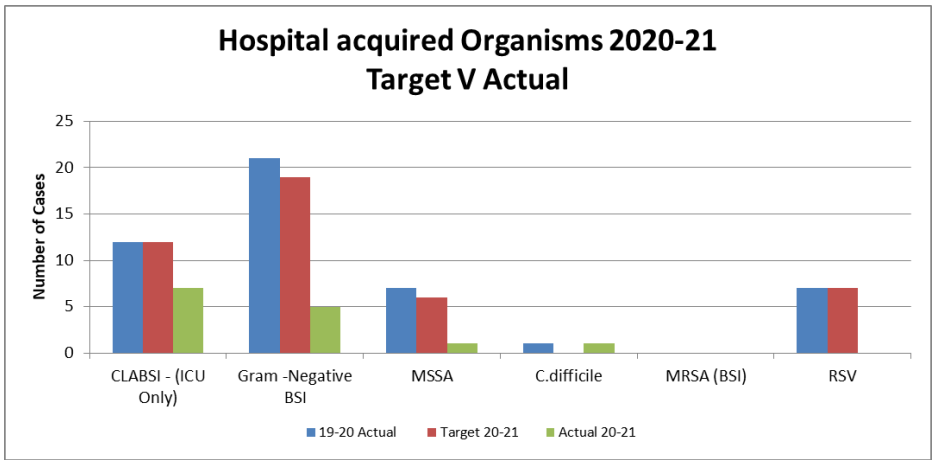


Table 5: Metric Data Actual VS Target.

Table 6 shows hand hygiene compliance for Q1 2020-21 across the Trust. 96.8% compliance for the quarter with 2969 opportunities.

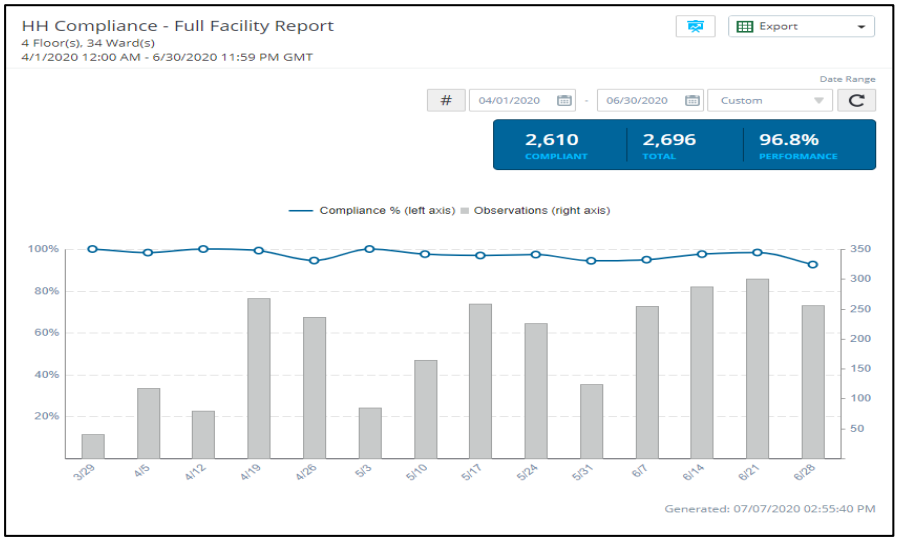


Table 6: Hand Hygiene Compliance Q1

Additional Activity/Achievements

Trust response to COVID 19

As part of the Trust response to the challenges of COVID 19 under the Safe care work stream our Medical Director /DIPC divided Infection Prevention & Control activity into 5 work streams during Q1.

1. **PPE**- Dr Beatriz Larru Infectious Diseases Consultant led this work stream and developed extensive and comprehensive guidance for the use of and management of personal protective equipment. The work stream includes the training of staff in use of PPE and Fit testing for FFP3 respirators and Hoods
2. **Trust Guideline –** Dr David Porter Consultant in Infectious diseases led this work stream which developed guidance for clinical teams on patient placement
3. **Patient testing –** Dr Chris Parry ICD & Consultant Microbiologist led on the work stream which developed processes and protocols for the screening of patients and staff for COVID *and the Test and Trace guidance following detection of COVID19 positive patients, carers or staff at AH.*
4. **Environmental cleanliness** –Led by Valya Weston ADIPC and Jo Keward, Lead Nurse for IPC. This work stream developed enhanced cleaning protocols and standard operating procedures.
5. **Patient Treatment** –Dr Andrew Riordan Consultant Infectious diseases developed patient Treatment guidance for the Trust

Community IPC Staff Member

A new IPC staff member for Community commenced in February 2020. The IPC work plan for 2020/21 includes a community project with an action plan identifying how IPC will be integrated into

the community division during the next year. This will include development of specific audits and an audit programme,

Inadequate Isolation Facilities in ICU and ED

The installation of Bioquel isolation pods with HEPA filtered air has taken place within HDU cubicle 40 and 2 PICU cubicles in the Green B pod. The conversion of an additional three cubicles in PICU to HBN compliant negative pressure isolation cubicles is due to start in September.

Highlighted Issues

Vancomycin Resistant Entercocci on PICU

During April we had a cluster of cases of VRE on PICU. Since the adults were discharged no further cases of VRE infection or carriage have been identified on critical care.
During April we managed eleven adults transferred from adult hospital trusts with severe COVID19 infection on PICU. Two patients had blood stream infection with a vancomycin resistant enterococcus (VRE) soon after transfer from the host hospital. A further patient had a blood stream infection with VRE two weeks later and a further two patients were found to have VRE faecal carriage. Four of the five isolates were the same molecular type. The VRE blood stream infections were all successfully with antimicrobials and central line removal. An investigation into this cluster of cases identified sessional use of the required PPE and the use of broad spectrum antimicrobials as

possible risk factors. Since the adults were discharged no further cases of VRE infection or carriage have been identified on critical care.

Hospital Acquired COVID 19

During Q1 there was one patient who acquired COVID 19 during their hospital admission. The child being treated on HDU was diagnosed in April 2020. She has fully recovered from COVID but remained an inpatient due to her complex medical conditions. There were no other cases on the ward at the time and the source of infection was unknown.
This hospital attributed case occurred prior to the introduction of screening of all patients for COVID on admission and weekly screening for COVID in critical care. There have been no cases since.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

24th September 2020

Paper Title:	**Alder Hey People Plan Update**
Report of:	**Human Resources & Organisational Development**
Paper Prepared by:	**Director of HR & OD**

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

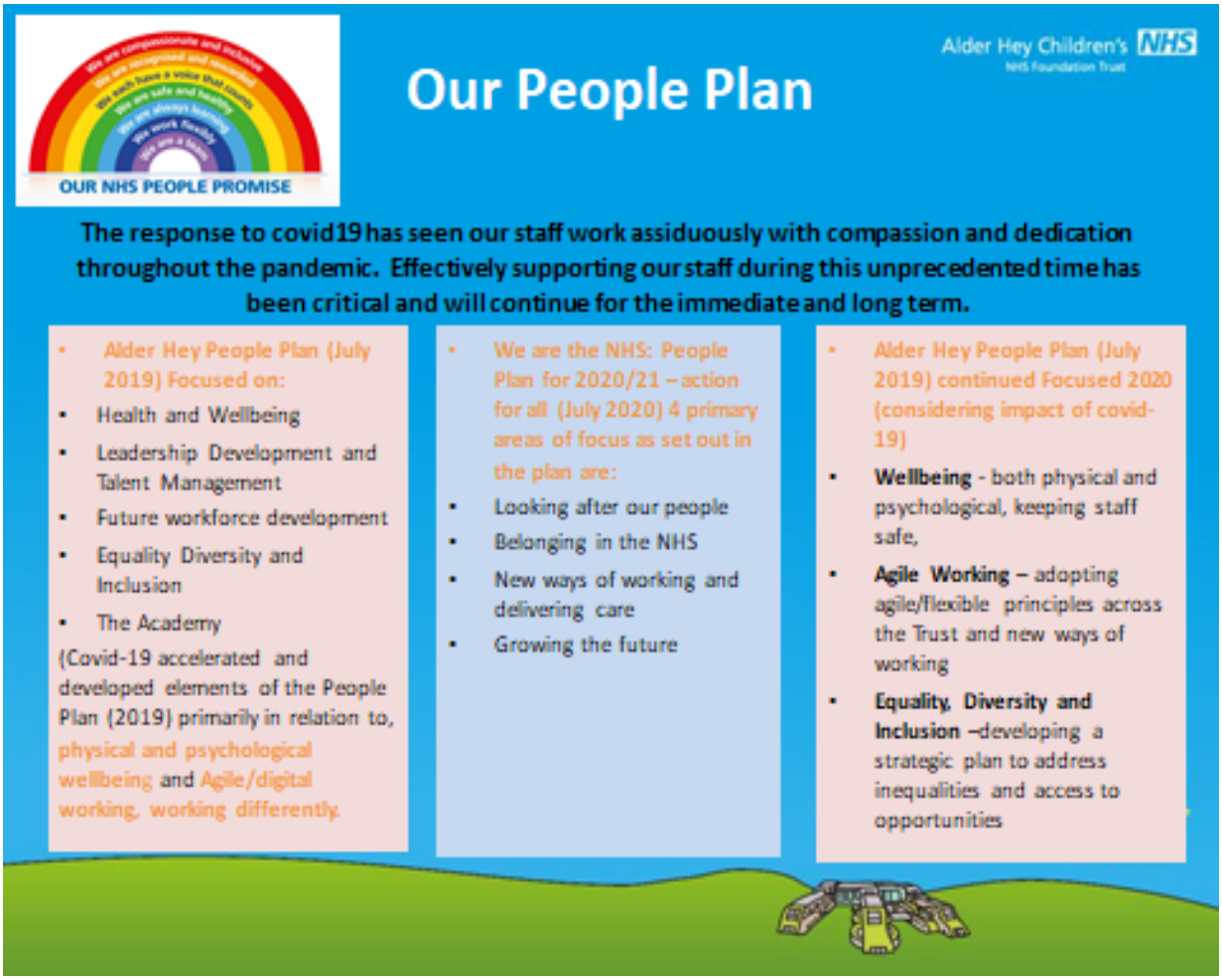
1. Purpose

The purpose of this paper is to provide the Board with a strategic update against the Alder Hey People Plan.

2. Introduction

At the Board meeting of 8th September 2020, the revised approach to the Alder Hey People Plan was approved (below), which outlined that the Trust will be focusing its activities on three strategic areas; Wellbeing, Flexible Working and Equality, Diversity & Inclusion, aswell as ensuring the Trust is responding to the additional requirements of the national People Plan.

A detailed workplan is being produced in support of delivery of the programme, alongside a review of resources needed to deliver the plan, which will be formally monitored at the People and Wellbeing Committee.



3. Wellbeing

The focus on staff wellbeing remains of paramount importance, and since the start of the pandemic:

- Over 300 staff have accessed the SALS service for a range of supportive measures
- Over 350 line managers have accessed specific on line learning to help them lead in challenging times
- Introduced CareFirst, a 24 hour Employee Assistance Programme (EAP)
- 100% of colleagues from BAME backgrounds have undertaken a risk assessment
- Over 80% of staff who are in 'at risk' groups have undertaken a risk assessment
- we have successfully set up, and are now continuing to run a legacy 'Wingman Lounge', which has been very well received by staff
- Supported a number of teams with Team Time, a virtual way to run Schwarz Rounds

The SALS team will continue to provide a range of supportive mechanisms for staff, and will develop the offer in light of staff feedback and in respect of additional actions as identified in the national People Plan.

3.1 Leadership

The Strong Foundations leadership programme was paused at the start of the pandemic, and will restart again at the end of September using online platforms to deliver the programme virtually. This will also be launched alongside new leadership support circles and coaching.

The Alder Hey Charity have approved funding to support ten members of staff to train as 'wellbeing coaches'. These people will have a central role as part of the SALS team providing a range of coaching support and interventions for staff across the organisation.

3.2 Sickness Absence

Table 1 - Sickness position 18th September 2020

Reason	%	No of Staff
Non Covid Related Sickness	5.29%	201
Covid Related Sickness	0.16%	6
Absence Related to Covid - not inc sickness	1.32%	50

Absence Related to Covid Inc Sickness	1.47%	56
All Absence (total of above)	6.76%	257

There are 27 people currently absent from work due to self-isolation, and 20 staff who have yet to return to work from a period of shielding; these are pregnant staff and staff with complex health conditions which are precluding a safe return to clinical duties. All are being supported to see how we can bring them safely back to work, either to their previous roles or a different role.

The wellbeing team continue to work with managers to support them with all aspects of absence management administration.

3.3 Staff Communication and Engagement

The Staff Survey 2020 will launch w/c 21st September 2020. As a result of COVID-19, the national survey has been amended to include additional questions about staff experience during the pandemic. As in previous years, all staff will receive a survey and we will be encouraging all staff to tell us their stories and give us their feedback.

4. Flexible Working

Across the Trust we still have a large proportion of staff (c1000), clinical and non- clinical, who have embraced the technology available and are supporting the Trust remotely in line with the advice and guidance from the Government.

The messaging to staff working from home has been very clear; we are not looking to bring people back to the office environment until the New Year (this will be dependent upon local and national position in relation to the pandemic), and we will work with teams over the Autumn period to help each team think about and plan how they will work in the future, with homeworking remaining an integral part of our new working practices.

Working with WKSpace, an organisation who are experienced in helping teams think about their space and how to use it differently, we are developing a plan to support staff and managers to work effectively in this new environment; this will include guidance for individual and teams, and specific support for managers to help them effectively manage remote teams.

5. Equality, Diversity & Inclusion

A Taskforce, commissioned by the Trust Chair and led by Claire Dove OBE, will commence in October 2020, and will be responsible for a focused review of process and practice relating to EDI, with a view to recommending and implementing specific actions to improve

EDI across the organisation. This will specifically focus on looking at access to jobs and opportunities, the role the Higher Education Institutions play in increasing diversity and how we use apprenticeships. A review of the resource required to support the Taskforce is currently underway, with initial explorations of setting up a regional EDI 'Centre of Excellence' across the specialist trusts.

The Terms of Reference for the Taskforce can be found in Appendix 1.

6. Governance and Ongoing Business

6.1 Case Management

The national Social Partnership Forum (SPF) issued a statement on the management of industrial relations during the pandemic in April 2020.The guidance confirms that disciplinary and other employment procedures will be paused during the pandemic but there are exceptions to this in the case of employees requesting them to continue or if the cases are serious or urgent then they will proceed. During the pandemic all cases have been managed on a case-by-case basis. Some cases have been placed on hold and others where there has been the agreement to proceed have been held virtually or in accordance with the social distancing measures and appropriately risk assessed.

In September there were a total of 18 employee relations cases as detailed below.

Table 2- Employee relations activity per division as of 18th September 2020

Division	MHPS	Disciplinary	Grievance	B&H	ET	Total
Surgery	3	2	2	1	0	**8**
Medicine	2	1	1	1	0	**5**
Community	0	1	1	0	0	**2**
Corporate	0	1	1	1	0	**3**
Grand Total	**5**	**5**	**5**	**3**	**0**	**18**

6.2 Workforce Key Performance Indicators – September 2020

KPI	%	Target
Mandatory Training	90.4%	90%
PDR (paused due to pandemic, restarted July 2020)	20%	90%
Sickness absence (non-covid related)	5.29%	4%

Appendix 1 – Taskforce ToR

Alder Hey Children's NHS Foundation Trust

EDI TASK FORCE

TERMS OF REFERENCE

Constitution	The Board has requested a Task Force be established, set up for a 6 month period initially, which will be responsible for a focused review of process and practice relating to EDI, with a view to recommending and implementing specific actions to improve EDI across the organisation.
Membership	Claire Dove, Non-Executive Director [Chair] Anita Marsland, Non-Executive Director Shalni Arora, Non-Executive Director Melissa Swindell, Director of HR & DO Mark Flannagan, Director of Marketing and Communications Pauline Brown, Acting Chief Nurse Raman Chhokar, Associate COO, Medical Division Annemarie Davies, Senior Project Manager, Community Division Sharon Owen, Deputy Director of HR & OD Jo Potier, Associate Director of OD
Attendance/Quorum	Given the focused nature of this Taskforce, all members will be asked to attend each meeting, with others co-opted in as and where necessary. Virtual participation in meetings through the use of video conferencing or other virtual means shall count towards the quorum.
Frequency	Meetings shall normally take place on a monthly basis. The Chair may at any time convene additional meetings of the Taskforce to consider business that requires urgent attention.
Authority	The Taskforce is responsible for providing strategic direction and board assurance in relation to workforce EDI matters, and making recommendations, as appropriate, on EDI matters to the Board of Directors, in support of the stated aim of 'looking after our people' and making Alder Hey the Best Place to Work.
Duties	The Taskforce has been delegated authority by the Trust Board to carry out the following duties: • Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey, and that our plans specifically

	support opportunity for education and employment for under-represented groups. There will be specific focus on: • Establishing a programme of Positive Action • Use of careful listening through networks to monitor and challenge progress • Review of recruitment practices **Performance Indicators** To monitor progress on achieving workforce standards and targets. To ensure timely and appropriate information is provided to the Trust Board to fulfil governance and monitoring duties, including: • WRES • WDES • EDS2
Reporting	The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the People and Wellbeing Committee along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action.
Conduct	The committee will develop a work plan with specific time-focused objectives. Members and attendees are selected for their specific role or because they are representative of a professional group/speciality/service line or division. As a result members are expected to: • Ensure that they read papers prior to meetings • Contribute fully to discussion and decision-making • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress • Represent their professional group or their speciality/directorate/division as appropriate in discussions and decision making • Disseminate and feedback on the content of meetings to colleagues in their speciality/service line/division via governance structures and processes. Agendas, papers and minutes to be distributed not less than 2 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.
Monitoring	The committee will assess its own performance and effectiveness by ensuring actions and activities are monitored and

Review	Committee Terms of Reference to be reviewed following 6 months of operation to determine if there is a requirement for the Taskforce to continue beyond 6 months.

DATE: **August 2020**

REVIEW DATE: **February 2021**

BOARD OF DIRECTORS

Thursday 24th September 2020

Report of:	FTSU Guardian
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards
Purpose of Paper:	To provide the Board with a summary of progress in the quarter to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the quarterly update report of FTSU activities, including cases brought to the FTSU team in the period as well as to outline the actions planned for the coming six to twelve month period.

2. Recommendation

The Board is asked to note the progress made to date, support the continued direction of travel and the specific initiatives proposed.

3. Evaluating Guardian/Champion Resource

The role of the FTSU Guardian is to support workers to speak up and to effect culture change to make speaking up business as usual, for an organisation of approximately 4000 staff, this requires support. Currently we have 6 FTSU Champions, which includes those staff working in SALS. Our aim is to ensure that the champions are reflective of the organisation population and to have representation within each division. Nationally and regionally, we are aware that the role of champions is under-utilized, as staff tend to migrate toward the Guardians, however, the importance of their presence should not be underestimated, as they provide a point of contact and in our case, are staff members who already have a 'connect' with staff, based on trust, therefore staff are more likely to feel comfortable to raise a concern.

Working with our communications team, we aim to hold a recruitment drive for more champions, during October's Speak up Safely campaign; this will serve to promote and enhance the role, and to ensure we achieve our vision for FTSU within the Trust. The requirement of the role, currently, is that staff are asked to undertake this service in addition to their existing role, this is often a blockage to recruit, therefore we should consider if 'protected time' can be given to support the delivery of this valuable service.

3.1 Communication strategy

October is set to be a busy time for FTSU, as well as a period when we are celebrating our staff, the NGO's Speak up Month runs during this period and we are planning to use the alphabet as a way to raise awareness and increase commitment. Working with our communications team we are also looking to re-launch Raise it Change and FTSU jointly as both of these methods of raising concerns, are now accessible via our Ulysses system. FTSU, using Ulysses as a platform to report, was first launched earlier this year, however the uptake to report this way has been low to date, therefore our approach requires an enhanced communication plan, which will focus on who has access to the data reported by individuals, other than the Guardian and Champions, as this appears to be where the greatest concern lies for staff.

3.2 FTSU Index

The Freedom to Speak Up (FTSU) Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture. The NGO states that 'a score of 70 per cent is perceived as a healthy. Working with NHS England, the National Guardian's Office has brought together four questions from the NHS Staff Survey into a 'Freedom to Speak Up (FTSU) Index'. These questions relate to whether staff feel knowledgeable, secure and encouraged to speak up and whether they would be treated fairly after an incident. We can see that organisations with higher FTSU Index scores tend to be rated as Outstanding or Good by CQC.

The annual NHS staff survey contains several questions that are helpful indicators of speaking up culture. The FTSU index was calculated as the mean average of responses to the following four questions from the NHS Staff Survey:

- % of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)

- % of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)

- % of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)

- % of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

This year's index is based on the results from the 2019 NHS Staff Survey

This year's FTSU Index result for Alderhey was 77.2%compared to last year's score of 78%. Below we can see the response to the 4 questions:

Year	2018	2019
17a	61.8%	58.1%
17b	90.6%	89.4%
18a	93.2%	93.1%
18b	69.3%	69.3%

There does appear, given this data, that there is a requirement to review the current reporting process to ensure that staff do feel 'safe' to raise a concern, however it should be noted that the NRLS data submission for this same period, saw an increase in reported incidents from 2018, which is encouraging:

- April 2018 to September 2018 2,531 incidents reported
- April 2019 to September 2019 2,554 incidents reported

3.3 Triangulating data

The FTSU Round up meeting, was scheduled for 4th May 2020, however this did not take place. This is being rescheduled with Anita Marsland as Chair and a cycle of virtual meetings will be confirmed. In preparation for this quarterly meeting, we will ask attendees to collate relevant data, to include incident reporting, sickness reporting, grievance and disciplinary data, SALS data, Raise it Change it queries and exit interviews. It is anticipated that this list will expand following the meeting.

3.4 Guardian Report content

The National Guardian's Office, has extended the submission of data, this will include Q1 and Q2 data, with the data portal opening on the 12th October.

Quarter 1, saw a total of 6 cases, brought to the FTSU team. Of these cases, 1 related to behaviour and relationships, 4 to systems and 1 recruitment process. Quarter 2, to date, has seen a total of 8 cases, 1 Bullying and Harassment, 1 staff safety, 1 infrastructure/ process, 1 recruitment process and 4 related to behaviour and relationships. Two of these cases were raised confidentially, 4 cases have been closed with positive feedback from the reporter regarding the service, there has been no

evidence brought to the FTSU Guardian that any staff member raising a concern has suffered a detriment as a result.

3.5 Participation in local and national networks

The Trust Guardian has been appointed, from the 1st May 2020, as North West Regional FTSU Chair. Since this appointment the scheduling of regional meetings has been increased from Bi-Annually to Bi-Monthly, this has been on the instigation of the Chair and in response to the feedback from the Guardians across the NW region. Meetings are split to include workshops that have only served to enhance a greater understanding of the role of the guardians and have been well received.

As the growth of the NGO continues and now includes organisations outside of Trusts, FTSU Guardians are being asked to support these newly appointed Guardians. Currently the FTSU Guardian is working with 3 new Guardians and Manchester Fire Service, offering support in setting up the service and direction to the Guardians on their role and how it needs to develop.

Kerry Turner
September 2020

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Thursday 24th September 2020

Report of	Development Director
Paper prepared by	Associate Development Director-Site (09/09/2020)
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Board of Trust Directors Report

September 2020

Campus Development report on the Programme for Delivery

1. Introduction

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

As of Month 3 in Quarter two of 2020/21 the programme Delivery Timetable rag rates projects against planned commencement date. Current RAG rating is of the end of Qtr. 1.

2. Programme Delivery Timetable

A new row has been added to the programme plan for monitoring of relocations from retained estate.

Table1. Sets out the planned programme for the years 2019-2023 (financial years).

Table 1.	19/20	20/21				21/22				22/23
Scheme	Qtr. 4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Year
Initial Park Reinstatement (Phase 1)										
Alder Centre occupation				*						
Acquired buildings occupation Future use under review										
Police station (LF) occupation			**							
Commence relocations from retained estate.										
Decommission & Demolition Phase 3 (Oncology, boiler house, old blocks)										
Main Park Reinstatement (Phase 2/90%)										
Infrastructure works & commissioning										
Clinical Hub Construction										
Clinical Hub Occupation										
Dewi Jones Construction										
Dewi Jones Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

*Current relocation date or the Alder centre is end of October, service functional from 2nd week in November.

** Police still unable have any discussions on the lower floor of the police station occupation due to COVID and additional policing numbers.

Both the Clinical Hub and Dewi Jones unit project is now on track and should still deliver within the planned timeframe.

Capital Cost

The development team fully appreciate the relevance of projects costs extending beyond available budget and how this could impact the overall capital monies available to the Trust. The finance department continues to support the Team in monitoring and taking relevant actions to make every effort to stay within the financial envelope available.

Table 2. Demonstrates the current anticipated capital cost of all projects for the campus developments along with relevant comments as of mid-September 2020.

Estates Savings Target	Budget	Best Case	Most Likely	Worst Case	Aug Comments
The Park	1,750	3,234	3,454	3,634	Based on estimates following quotes for Phase 1
Attenuation	600	600	750	800	The charity have now underwritten the funding shortfall @ £204k. Remaining overspend £113k which is under review with the architects. Most likely includes estimate for path
Alder Centre	2,184	2,297	2,347	2,367	
C Cluster Hub & Dewi	19,822	19,822	20,017	20,017	As agreed by Trust Board - £195k overspend
Infrastructure - Utilities	1,200	1,200	1,320	1,440	
Landscaping	481	481	529	577	Slight risk as the plan has not been developed. However there is potential to combine this with the Neonates
Infrastructure - Roads (inc s278)	858	858	944	1,030	
Demolition and decomm	2,356	2,831	2,831	3,000	Asbestos removal costs will exceed budget as higher than the cost estimated prior to CHP development – pressure is C. £300k. Possible increase in costs further £175k spend which would be paid for using Critical Infrastructure funding and offset with revenue savings.
Relocations	1,227	1,100	1,227	1,227	Mersey design working on police ground floor £6.5k
Neonatal	11,869	16,750	17,300	17,800	The Trust has agreed up to £16m. The current estimates are £17.3m
Development team	1,100	1,135	1,135	1,135	Slightly over budget
Institute re-works	360	120	300	360	
Office Requirement	3,000	2,570	2,570	3,050	Decision taken not to purchase Prescott Road following a review of desk requirements in light of gains made from home working during the covid 19 situation.
Staff removals	250	250	250	250	
Car Park	100	100	100	100	
Land Buy Back Scheme		1,000	1,500	2,000	Budget yet to be identified and value of purchase to be assessed
Critical Infrastructure Risk (CIR)	557	0	0	0	PDC funded scheme - to be used for Demolition and Infrastructure
ED Enhancements (UEC)	1,441	1,441	1,441	1,585	PDC funded scheme
Isolation Pods (Covid)	1,800	1,400	1,500	1,800	PDC funded scheme
	50,955	**57,189**	**59,515**	**62,172**	
Revised Budget	50,916	50,916	50,916	50,916	
Under/(Over) Budget	**-39**	**-6,273**	**-8,599**	**-11,256**	

The latest format of this table is to show a range of values from 'best case', 'most realistic' and 'worst case'. Principal concerns are:

- Neonatal overspend over original £12m budget; £4.8m - £5.9m
- Land Buy Back Scheme no budget; £1m - £2m
- Reinstatement of Springfield Park over budget; £1.5m - £1.9m

3. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Horticon have now commenced the park works and will complete Phase 1 in late December 2020. Liaison with the planning department at LCC continues regarding the amendment to the paths for approval no 18F/2409 and partial discharge of conditions for the wider park consent 19F/0916. Plan can be viewed in the PDF LD6074-003E-Contextual_plan (3) 29 jur	Presence of asbestos and other contaminants in the ground could be disturbed by development works to phase one of the park plans. (Risk 2116- Score 6) Drainage design, acceptance with United Utilities and agreement of costs with Beech Group. Public perception that the park phase one is not being delivered	Remediation and asbestos management plans have been drawn up and have been adopted by contractors involved in working on this site once passed by LCC. Monitoring of contractors implementation of plan will be undertaken by independent consultants who will complete a verification report. Finalise design and get approval from United Utilities and discharge conditions. Capacity lab to engage with groundworks on a regular basis and involve stakeholders.

Alder Centre

Current status	Risks & Issues	Actions/next steps
The Building has now been handed over to the trust for commissioning. An inspection and snag list has been agreed and final works will be completed before the opening of the Unit planned for the first two weeks in November. Furniture delivery is now back on track following COVID 19 delays with expected	Delay on Furniture order due to COVID 19 (Included in Risk 2203- score 9)	This risk will remain on the register until we take delivery of the furniture however we have assurance it will arrive when due by the suppliers.

delivery in mid-October The expenditure against the budget has undergone a review the predicted final spend will be over budget C. £160K, this is due to both COVID reasons and a number of small variations to the build. A temporary external footpath is required to connect to the car park, this sits approximately 3m above the building level and will require ramps to meet DDA/Part M requirements.	Expenditure to complete the Alder centre will exceed the budget available. (included in risk register 2226 - score 12)	The capital overspend will need to be incorporated into the overall capital budget with compromises/Value engineering/saving achieved against other projects within the campus programme.

Acquired Buildings Occupation (neighbouring sites)

Current Status	Risks/issues	Action/next steps
Knotty Ash Nursing Home **Acquired future plan/usage currently under review.** **Ability to expand campus and link into the hospital –**the Trust are still in the view that the most viable option for long term expansion space (Clinical services) would be to acquire the Vets, Job shop and Police Station on Eaton Road and will be seeking to discuss commercial deals that could be completed over the next 3-5 years with current occupiers/owners.		Keep up to date with business future plans/lease and potential for purchase of said buildings. Seek to maintain an interest and respond accordingly to any opportunities which present.

Police Station (lower floor) occupation

Current status	Risks/issues	Actions/next steps
Status unchanged since last report The Police have recently postponed any discussion about the Trust taking space in their building as they intend to use it themselves over the Covid crisis. It is unclear at present how long this postponement is likely to last. The status of this is likely to go red in QTR2	Police do not release the space while decisions are made in regards to additional police funding and its use. (2088 risk rating 12) This will mean a delay to the old	Development team together with the Director of HR and OD are currently working up the contingency plan.

	management block being vacated and therefore delay to demolition of the building.	

Relocations

Current status	Risks/issues	Actions
A set of moves have been agreed with the following departments in order to allow decommissioning and demolition of the Oncology, Genetics, Boiler House and Management Block. • Psychology move from the Catkin Building to the Institute in September • Scheduling and Booking will move to the upper floor of the Police station in September • Medical Records and Transcription will move to the Catkin Building in October. There are still some outstanding relocation plans to be confirmed this month relating to smaller departments currently housed in Genetics and the management block. A further phase of this relocation plan is still being progressed with input from the executive team in relation to a wider strategy and flexible working.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Executive approval for all relocations as they are required. Liaison with all service providers /departments to ensure timely planning for works to be completed.

Demolition Phase 3 (Oncology, boiler house, old blocks)

Current status	Risks/issues	Actions
This is currently at the planning stage and will be reliant on relocation of current building occupants to other locations and installation /diversion of current engineering and IM&T services.	Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12)	Executive approval for all relocations as they are required. Liaison with all services/departments.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
The current plan is to commence demolishing building still occupied on the retained estate in the Autumn of 2020 as they are vacated. A draft document setting out the options the formation of a Community Interest Company has been shared and presented to the Campus Steering Group. The next stage is that capacity Lab will be discussing this with the local community during September to assess their preferred approach/option They have a plan through a partnership and bid approach to generate funding and work with all stakeholders across the community and wider region. It is anticipated the partnership model will bring in funding to advance works beyond the base park (base park to be funded by Alder Hey in line with the land exchange agreement with LCC) in order to deliver the full vision for the park.	Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 12) LCC do not agree to a future Community Interest Company for Sustainability.	Weekly review of the programme and progress with Capacity Lab, with weekly presence on site. Capacity lab to hold regular discussion with LCC and also keep the local community up to date with progress.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Masterplan of Infrastructure works is currently being prepared. Roads and landscaping – the Trust is looking to appoint a design team during Qtr. 2.	Nil at present time.	Ensure timely process /programme is adhered to.

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions
Contract with Galliford Try was signed by the Chief Executive in July. Main works commenced early August.	Planning conditions are outstanding, these are to do	Liaison with Liverpool City Council (LCC) Highways department are

The Gabion wall has been completed to date and foundations for the main build are underway. There is ongoing discussion and liaison with Liverpool City Council in regards to a couple of amendments (cladding , slight reduction in space between the Dewi Jones and Hub buildings, changes to some of the window/skylights)	with traffic management LCC do not grant planning amendments.	ongoing with relevant requested information on the Alder Hey Travel and parking plans being submitted to LCC. Continue with weekly meetings with Galliford Try.

Demolition Phase 4 (Final)

Current status	Risks/issues	Actions
N/A at current time, planned for Qtr. 4. 21/22	Cost may exceed current allocated budget.	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks/issues	Actions
Following last month's Trust Board approval to start design work to increase the detail and therefore the cost certainty, the development team now have a series of meetings in place/commenced with a wide group of users to work through a detailed specification. Stage 2+ of the design process has highlighted some additional clinical requirements pushing the scheme over budget. A series of meetings with key stakeholders is underway to understand the additions and bring the scheme	Costs of new unit exceed current financial envelope. Project Co engagement extending the programme and increasing costs; • Planning and any	Plan to gain approval for submitting for planning at the end of September 2020.

back towards budget. The Division of Surgery together with the development team will be seeking Board approval in September to submit for planning and will then look to tender in late October/early November for the construction. The procurement route has been agreed in principle with Project Co.	unknown Section.106 or section S.278 costs • Impact of Covid-19 on construction costs. Cost of PFI management of the Process versus VAT savings. Not reaching agreement with PFI risks a workable interface with the CHP being achieve Planning permission fails to be achieved within the timescale of the overall programme delivery.	Firm up process with PFI management. Maintain open communication with the LCC planning departments.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
StepPlaces, the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support Several workstreams are taking place to review potential service enhancements. These include, Rehabilitation, Patient Hotel, independent living accommodation for complex needs CYP and outpatient rehabilitation.	Local community resistance to Trust non-development aspects and planning submission.	Maximise our offering/ support /negotiation on development content and opportunities. Work through each workstream and provide a business case for each to demonstrate requirements, sustainability and affordability.

Communications

Current status	Risks / issues	Actions/next steps
Comprehensive Communication plan developed which requires finalising and Trust Board Sign off. Due to COVID 19 this has not progressed over the last month. Weekly meetings 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.

Car Parking

Current status	Risks/Issues	Actions/next steps
As reported above as part of the overall reduction required (250 spaces) some 90 have been handed over to GT for their compound and around 50 spaces have been removed in order to site some additional facilities to support COVID. Still to be removed by the end of September is 110 spaces. The Trust have agreed a lease for space at the Thomas Lane playing fields, This will provide 134 spaces and will be open from 6am-6pm Monday to Friday. The lease is with the Trust appointed legal team who are progressing the lease and expect to take possession of the car park from mid-September. The criteria for allocating spaces are currently being agreed and will be rolled out communicated by the end of the Month. residential parking if Alder Hey do not reduce the current parking numbers. Retained estate planned reduction are detailed in the table below.	Car parking cannot sustain a reduction to current Numbers by June 30th 2020 (risk 2202- score 12) Staff resistance to change. Travel plan from Mott MacDonald does not provide realistic and evidenced solution.	Sign the lease option with LCC and implement a plan for staff to relocate to the new car park during September 2020. Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan. Review car parking requirements in view of the home working currently in play due to COVID 19 and what the future requirements might look like.

4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of September 2020.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th September 2020

Paper Title:	**Terms of Reference for Assurance Committees**
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:	BAF Risk 1.1 (Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement)

Alder Hey Children's NHS Foundation Trust

AUDIT AND RISK COMMITTEE

TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Audit and Risk Committee (the Committee). This Committee will be a formal Assurance Committee reporting to Trust Board.
Membership	**The Audit & Risk Committee Membership shall comprise:** Non-Executive Directors x 3 [one of whom shall be the Chair] *(The Chair of the Safety and Quality Committee will be a standing appointed member of the Committee)* One of the members will be appointed Chair of the Committee by the Board, who shall be a CCAB qualified accountant. The Chair of the Trust shall not be a member of the Committee. Overall throughout the working year, each member is expected to achieve 75% attendance at scheduled meetings. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the committee and the Trust's Annual Report.
Attendance	The following are expected to attend each meeting: Director of Finance Deputy Director of Finance Director of Corporate Affairs Internal and External Audit representatives For risk related items the following are expected to attend: Chief Operating Officer Divisional Directors Associate Director of Nursing & Governance The following would attend as required by the agenda: All other Executive Directors Associate Chief Operating Officers

	Other persons by invitation The Chief Executive (in their capacity as Accountable Officer) should be invited to attend, at least annually to discuss with the Committee the process for assurance that supports the Annual Governance Statement and to present the Statement. Secretarial support shall be provided to the Committee to take minutes of the meeting and give appropriate support to the Chair and Committee members.
Quorum	The quorum necessary for the transaction of business will consist of the Chair or nominated deputy, one other NED and one Executive Director. Virtual participation in meetings through the use of video conferencing or other virtual means shall count towards the quorum.
Frequency	Meetings shall be held not less than five times a year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. At least once a year, the Committee Members should meet privately with the External and Internal Auditors and the Associate Director of Nursing & Governance. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.
Authority	The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. The Committee will have primary responsibility for reviewing the effectiveness of the framework in place for the identification and management of risks and associated controls, corporate governance and assurance frameworks. The Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Statement of Internal Control.

Duties	The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), including its subsidiaries, that supports the achievement of the organisation's objectives. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective workplan to guide its work and that of the audit and assurance functions that report to it. As part of its approach, the Committee will have effective relationships with other key committees (for example, the Safety and Quality Assurance Committee) so that it understands processes and linkages. **Governance** The Committee will review the adequacy and effectiveness of: • All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board. • Statements within the quality account together with the external audit assurance. • The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification. **Risk Management** The Committee will assist the Board by providing oversight of risk across the Trust. This will be achieved by: • Overseeing the Trust's strategies for managing the key categories of risk to which it is exposed. • Considering whether risks are managed within the parameters of the risk appetite approved by the Board. • Reviewing the design, implementation and effectiveness of the Trust's Risk Management Framework to ensure they appropriately define how the organisation should manage or mitigate the principal risks and how they could threaten the business model, future performance, liquidity or reputation. Approve material changes to the Trust's Risk Management

Framework.

- Overseeing the development, maintenance and implementation of appropriate risk policies and approve or recommend for approval such policies to the Board, as set out in the 'Matters Reserved for the Board'.
- Assessing the effectiveness and quality of the risk reporting provided and the management of risks and emerging risks including, but not limited to, financial, regulatory, clinical and operational risks.
- Considering and periodically report to the Board on the Trust's risk culture demonstrated through observed behaviours and decisions, the control environment and achievement of agreed risk outcomes.
- Safeguarding the independence of and assess the adequacy, remit and performance of the "Risk Function".
- Ensuring the Associate Director of Nursing and Governance has direct access to the Chairman and other members of the Committee and vice versa.

Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board. This will be achieved by:

- Reviewing and approval of the Internal Audit Charter and Annual Plan ensuring that they are consistent with the audit needs of the organisation.
- Agreement of the fee cost of the proposed programme of work.
- Consideration of the major findings of internal audit work (and management's response and implementation of actions), and ensuring coordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation.
- A regular review of the effectiveness of internal audit.

Clinical Audit

Whilst the Committee is responsible for overseeing the effectiveness of internal control for the whole of the organisation's activities, in practice the detailed oversight of clinical activities is undertaken by the Safety and Quality Assurance Committee through the activity of Clinical Audit. The Safety and Quality Assurance Committee's Terms of Reference includes:

- In conjunction with the Audit Committee, commission and direct a Clinical Audit Programme to provide assurance of clinical quality.
- Responsible for monitoring the assurance provided via the quarterly Clinical Audit and Effectiveness Report and the Annual Clinical Audit Forward Programme and Update.

In reviewing the work of the Safety & Quality Committee and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the Clinical Audit function. This will be achieved by:

- Receiving the Annual Work Programme of Clinical Audit, and at the end of the year a summary of the results from completing the work programme including the implementation status of recommendations made.
- Receiving throughout the year from the Safety & Quality Committee notification of any significant findings arising from Clinical Audit's work.

The Safety & Quality Committee will also seek the input of the Committee in commissioning the Clinical Audit Annual Work Programme and include within its' Annual Report a section on its' oversight of Clinical Audit providing assurance as to its' effectiveness.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review any follow on actions required of the counter fraud work. This will be achieved by:

- Reviewing the systems, plans and actions taken to develop an anti-fraud culture.
- Reviewing the detailed Counter Fraud Plan.
- Consideration of reports produced by the counter fraud service.
- Ensuring that the counter fraud function has appropriate standing within the organisation.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will receive the work and findings of the External Auditor appointed by the Governors of the Trust and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor as far as the rules governing appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensuring co-ordination, as appropriate, with other auditors in the local health economy.
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Reviewing all external audit reports, including agreement of the Annual Audit Letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of

management responses.

- Ensuring that there is a clear policy for the engagement of external auditors to supply non-audit services.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in the preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Any Letter of Representation.
- Qualitative aspects of financial reporting.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Other

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission (CQC), NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work. This will particularly include the Safety & Quality Committee, Resources and Business Development Committee, Workforce and Organisational Development Committee and Innovation Committee who will provide an annual report on their work.

	Management The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, risk management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements. The Committee will receive assurance on compliance with Standing Financial Instructions. **Raising Concerns ('Whistleblowing')** The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties and ensure that any such concerns are investigated proportionally and independently.
Reporting	The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action. The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and the embedding of risk management in the organisation, the effectiveness of governance and the robustness of the processes behind the quality accounts.
Conduct	The committee will develop a work plan with specific objectives which will be reviewed regularly and formally on an annual basis. The committee will also review its performance on an annual basis. Members and attendees are selected for their specific role or because they are representative of a professional group / specialty / service line or division. As a result members are expected to: • Ensure that they read papers prior to meetings. • Contribute fully to discussion and decision-making. • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress. • Represent their professional group or their specialty/directorate/division as appropriate in discussions and decision making. • Disseminate and feedback on the content of meetings to colleagues in their specialty/service line/division via governance structures and processes. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.

Monitoring	The committee will assess its own performance and effectiveness annually by: • Undertaking a self-assessment of their performance against the Committee's Terms of Reference and own Objectives. • Considering the Terms of Reference (including its purpose and role) & work plan annually to ensure they remain relevant and up to date, and recommend any changes to the Board. The Committee Chair will ensure that an Annual Report of the Committee's activities is completed and submitted to the Board for approval. Each year the Committee will consider whether it wishes to set specific objectives (over and above the Terms of Reference). Periodically the Committee will consider the need for an external independent review of its effectiveness.
Review	Committee Terms of Reference to be reviewed following 6 months of operation and thereafter on an annual basis.

DATE: September 2020

REVIEW DATE: March 2021

Alder Hey Children's
NHS Foundation Trust

RESOURCES AND BUSINESS DEVELOPMENT COMMITTEE

TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Resources and Business Development Committee (the Committee). This Committee will be an Assurance Committee reporting to Trust Board.
Membership	Non-Executive Directors x 2 [one of whom shall be the Chair] Director of Finance Director of Operational Finance and Innovation Chief Operating Officer Director of Human Resources Chief Digital and Information Officer Overall throughout the working year, each member (or knowledgeable deputy) is expected to achieve 75% attendance at scheduled meetings. An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the committee and the Trust's Annual Report.
Attendance	The following would be expected to attend each meeting: Director of Corporate Affairs Associate Director of Finance Director of Marketing and Communications Development Director Director of Strategy & Partnerships The following would attend as required by the agenda: All other Executive Directors Associate Chief Operating Officers Other persons by invitation Invitation to Divisions re specific issues??

	Secretarial support shall be provided to the Committee to take minutes of the meeting and give appropriate support to the Chair and Committee members.
Quorum	The quorum necessary for the transaction of business will consist of the Chair or nominated deputy, one other NED and one Executive Director. Virtual participation in meetings through the use of video conferencing or other virtual means shall count towards the quorum.
Frequency	Meetings shall normally take place on a monthly basis and the Committee will meet not less than 10 times a year. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.
Authority	The Committee will operate under the broad aims of reviewing financial strategy, workforce strategy, performance, organisational and business development and strategic IM&T issues, to provide assurance to the Board that delivery in these areas supports the Trust's strategic pillars focusing on excellence in quality and patient centered care. The Committee has authority on behalf of the Board to: • Review and recommend business, operational and financial plans to the Board • Monitor performance assuring the Board that performance is being managed in line with plans • Ensure value for money is obtained by the Trust • Identify related areas of strategic and business risk and report these to the Board • Oversee the development of the Trust's long term financial strategy, its Business Development Strategy and its Investment Strategy
Duties	**Finance & Performance** • To receive and consider the annual financial plan for revenue and capital, and make recommendation to the Board. • To advise the Board on all proposals for major Capital expenditure over £500,000 and to approve proposals under £500,000 • The Committee will review the Trust's performance against key financial and external targets, including performance ratings (e.g. NHS Improvement metrics). • To monitor progress against CIP targets, working with the Clinical Quality Assurance Committee to ensure any risks to service quality are

	addressed • Ensure appropriate contracting arrangements are in place and review overall performance against contract. • To review PFI compliance and performance against the agreed metrics ensuring remedial actions are taken as appropriate. • Advise the Board on best practice and policy in relation to performance and financial management, including latest NHS Improvement guidance. • Examine specific areas of financial risk within the Board Assurance Framework and highlight these to the Board as appropriate. • To review Productivity and Efficiency. • To review the Trust's procurement policies and functions and ensure they are fully aligned with the savings plan. **Business Development** • To review the Trust's Operational Plan and to advise the Board in respect of that plan • To advise the Board and maintain an oversight on all major investments and business developments • To monitor performance of the business development plans • To scan the environment and identify strategic business risks within the Operational Plan and report to the Board on the nature of those risks and their effective management • To oversee delivery of the marketing strategy, including brand management, market positioning, marketing activity, market research and competitor analysis. • To advise and provide insight to the board on changing dynamics in the market and stakeholders **IM&T** • To have an oversight of the 'Digital Futures' Strategy • To advise the Board of IM&T developments (e.g. EPR, mobile technology, management information, clinical communication, patient entertainment) • To seek assurance that the GDE Project is delivered in accordance with agreed milestonesTo identify key risks within the Board Assurance Framework associated with the delivery of the 'Digital Futures' Strategy and ensure these are reported to the Board.
Reporting	The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure

	or require executive action. Sub Committees/ Working groups reporting to the Committee: • Procurement Advisory Group • Capital Projects Group • The Resources and Business Development Committee has no established sub-committees but it will receive information and assurances from the following: • Marketing and Business Development Committee • Procurement Advisory Group • Capital Projects Group The Committee will also receive regular reports on performance metrics which will include information compiled from Divisions.
Conduct	The committee will develop a work plan with specific objectives which will be reviewed regularly and formally on an annual basis. The committee will also review its performance on an annual basis. Members and attendees are selected for their specific role or because they are representative of a professional group/speciality/service line or division. As a result members are expected to: • Ensure that they read papers prior to meetings • Contribute fully to discussion and decision-making • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress • Represent their professional group or their speciality/directorate/division as appropriate in discussions and decision making • Disseminate and feedback on the content of meetings to colleagues in their speciality/service line/division via governance structures and processes. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.
Monitoring	The committee will assess its own performance and effectiveness annually by: • undertaking a self-assessment of their performance against the Committee's Terms of Reference and own Objectives; • considering the terms of reference (including its purpose and role) & work plan annually to ensure they remain relevant and up to date, and

	recommend any changes to the Board The Committee Chair will ensure that an Annual Report of the Committee's activities is completed and submitted to the Board for approval. Each year the Committee will consider whether it wishes to set specific objectives (over and above the Terms of Reference).
Review	Committee Terms of Reference to be reviewed following 6 months of operation and thereafter on an annual basis.

DATE: September 2020

REVIEW DATE: September 2021

Alder Hey Children's NHS Foundation Trust

SAFETY AND QUALITY ASSURANCE COMMITTEE

TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Safety and Quality Assurance Committee (the Committee).
Membership	Non-Executive Director x 3 one of whom shall be the Chair Medical Director Chief Nurse Director of Nursing Director of Finance Chief Operating Officer Director of Corporate Affairs Director of Human Resources and Organisational Development Divisional Directors Division Clinician Leads for Safety x3 **In attendance:** Deputy Medical Director Deputy Director of Nursing Associate Director for Nursing and Governance Director of Infection Prevention Control **As required:** Other persons by invitation The Chair of the Committee, with the agreement of the Board of Directors, shall have the power to co-opt additional permanent members external to the Trust.
Attendance	The members may nominate a deputy to attend on their behalf if they are unable to attend. Overall, throughout the working year, each member and attendee should attend in person in excess of 75% of scheduled meetings. Secretarial support shall be provided to the Committee to take minutes of the meeting and give appropriate support to the Chair and Committee members.
Quorum	A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors (one of whom must be the Medical Director or Chief Nurse, or their designated deputy. Meetings of the committee are permitted to be held by video conferencing or other such virtual means and attendance via these will count towards a quorum.

Frequency/ Duration	Meetings shall normally take place on a monthly basis for two hours and the Committee will meet not less than 10 times a year. Quality Assurance Rounds will take place monthly out with of the formal meetings but under the auspices of SQAC and their outputs considered by the Committee as part of its assurance process.
Authority	The Safety and Quality Assurance Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff in order to perform its duties and to call any employee to be questioned at a meeting of the committee as and when required. It has the power to ratify Trust wide policies on behalf of the Board of Directors and terms of reference of groups that fall within the scope of its delegated authority. It has powers to take legal advice and to commission external advice and reports. The Committee may also request specific reports from individual functions within the organisation as may be appropriate to the overall arrangements.
Duties	**Processes and Structure** • Ensure that the key risks to safety and quality are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate. • Assess the quality and equality impact of proposed service developments or service changes, including those arising from external strategic change programmes such as reconfiguration of clinical pathways, national initiatives such as Getting it Right First Time, and Sustainability and Transformation Partnership (STP) led changes in clinical services. • On behalf of the Board, champion and oversee the Trust's Quality Assurance Round programme, ensuring that themes and risks are captured and actioned as appropriate. • Ensure that robust quality governance structures, processes and controls are in place that reflect national guidance and best practice • Oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval • Ratify on behalf of the Board of Directors all Trust wide policies pertaining to safety and quality. • Ensure that all areas addressed through the Committee contribute where appropriate to the Annual Governance Statement. • Undertake an annual self-assessment of activities of the assurance committee as contained within the terms of reference. • Provide input to the Audit Committee on matters within its terms of

reference.

- Identify resource implications of introducing quality and safety initiatives and managing high risk clinical issues and take recommendations to the Board of Directors.
- Seek assurance on matters identified by the other Board assurance committees and remitted to SQAC as appropriate.

Safety

- Develop the strategy for patient safety and ensure that the Trust has the right structure and environment to deliver it.
- Agree and monitor specific high level safety KPI's to achieve the Trust's ambition of Zero Harm.
- Champion and drive the Trust's safety culture, by gathering information effectively, analysing it appropriately and taking actions to improve patient safety, to create the environment to continuously learn, learn the lessons from others and provide assurance to the Board.
- Monitor the management of high profile inquests, complaints**,** incidents and legal cases and receive completed SUI/RCA reports and case reports.
- Maintain oversight of key issues eg sepsis, mortality as identified through incidents, reviews and other mechanisms.
- Ensure corporate and Divisional review of all confidential enquiries, national service frameworks and other national clinical guidance and that recommendations for action are considered and implemented as appropriate within the Trust.
- Ensure that the Trust works collaboratively with relevant external statutory bodies in line with national legislation, reviews any relevant reports and implements associated guidance in a timely manner.
- Undertake a review of progress of clinically related action plans as delegated by the Board.
- Monitor strategic safety risks on behalf of the Board.

Quality

- Oversee the development and implementation of the next phase of the Trust's Quality Strategy
- Monitor any current CQC action plan and obtain assurance evidence that all requirements have been fully met
- Oversee compliance with CQC Standards and other statutory and mandatory requirements and evidence based guidance that pertain to the delivery of clinical services.
- Ensure the development and implementation of clinical outcome measures for all services and receive benchmarking data with peers where available.
- In conjunction with the Audit Committee, commission and direct a

	clinical audit programme to provide assurance of clinical quality • Ensure the effectiveness of the organisational arrangements for measuring and acting on feedback from our patients and families and that the methodologies used are in line with best practice nationally and internationally. • Oversee the development of effective working relationships with organisations that represent patients in order to maximize engagement opportunities. • Receive and review evidence and assurance from appropriate internal sub-committees and working groups. • Monitor strategic quality risks on behalf of the Board
Reporting	**Groups that report into the Safety and Quality Assurance Committee:** • **Divisional Integrated Governance groups** Each Division will report to the Committee on its key clinical risks and progress against action plans arising from the Trust's Quality Strategy. • **Clinical Quality Steering Group** The CQSG will submit a monthly key issues report to the committee in the form of the reporting template, minutes of the meeting, an annual report and ad hoc reports as and when requested or to support areas of concern. **Safety and Quality Assurance Committee Reporting**: • To ensure the Audit Committee is regularly updated on areas of performance / risk. • The Committee chair will report formally to the Board of Directors on its proceedings after each meeting on all matters within its duty and responsibility. • A Key Issues Report will be submitted to the Board on at least a quarterly basis. • The Committee will produce an Annual Report on its work for submission to the Board of Directors.
Conduct	The Committee will be responsible for monitoring the assurance provided by the following: **Clinical Quality Steering Group** • Clinical Quality Steering Group and other groups' Key Issues Report (Monthly) • Annual Clinical Quality Steering Group Report (annually) • Clinical Audit & Effectiveness Report (quarterly) • Annual Clinical Audit forward programme & update (2x year) • Patient Experience Report (Quarterly) **Trust Wide Assurance** • Board Assurance Framework – to review those BAF risks that relate to quality (monthly)

	• CQC compliance report (Quarterly) • External visits/accreditation report (annually) All Committee members and attendees will undertake work requested by the Committee within the identified timescales. It is essential that all members and attendees participate in the meetings. Punctuality must be observed for the Committee. All Committee members must feedback issues raised within the committee to their areas of responsibility. The Executive Directors are expected to represent the operational arms of the organisation within their portfolio or their specific area(s) of expertise. The Committee Chair will be responsible for setting the agenda for meetings of the Committee in accordance with the Committee work plan. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled only in exceptional circumstances and at the discretion of the Chair. Any other business to be notified to the Chair of the meeting in advance. Draft minutes and action plan to be circulated within ten working days of the last meeting.
Monitoring	The committee will assess its own performance and effectiveness annually by: • undertaking a self-assessment of their performance against the Committee's Terms of Reference and own Objectives; • considering the terms of reference (including its purpose and role) & work plan annually to ensure they remain relevant and up to date, and recommend any changes to the Board The Committee Chair will ensure that an Annual Report of the Committee's activities is completed and submitted to the Board for approval. Each year the Committee will consider whether it wishes to set specific objectives (over and above the Terms of Reference).
Other Matters	Committee Terms of Reference to be reviewed following 6 months of operation and thereafter on an annual basis.

DATE: July 2020

REVIEW DATE: January 2021

Alder Hey Children's NHS Foundation Trust

PEOPLE AND WELLBEING COMMITTEE

TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the People and Wellbeing Committee (the Committee). This Committee will be a formal Assurance Committee reporting to Trust Board.
Membership	1 Non-Executive Director [Chair] 2 Non-Executive Directors Director of Human Resources & Organisational Development Chief Operating Officer Chief Nurse Medical Director Director of Corporate Affairs Director of Marketing & Communications 1 x Senior representative from each Division Overall throughout the working year, each member (or appropriate deputy) is expected to achieve 75% attendance at scheduled meetings.
Attendance	The following would be expected to attend each meeting: Deputy Director of Human Resources Associate Director of OD Equality and Diversity Lead Chair of Staff Side Others will be requested to attend for specific discussions/updates. Secretarial support shall be provided to the committee to take minutes of the Meeting and give appropriate support to the Chair and Committee members
Quorum	The quorum necessary for the transaction of business will consist of the Chair or nominated deputy, one other NED and the Director of Human Resources and Organisational Development. Virtual participation in meetings through the use of video conferencing or other virtual means shall count towards the quorum.
Frequency	Meetings shall normally take place on a monthly basis and the Committee will meet not less than 5 times a year. The Chair may at any time convene additional meetings of the Committee to

	consider business that requires urgent attention.
Authority	The People and Wellbeing Committee is responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high quality patient and family centred care. In particular ensuring that the five strategic objectives relating to **The best people doing their best work** as set out in the Trust's People Plan are met: • Compassionate and learning culture • Leadership development and talent management • Wellbeing • Future workforce • Equality, diversity and inclusion • Alder Hey Academy
Duties	The People and Wellbeing Committee has been delegated authority by the Trust Board to carry out the following duties: • To oversee the development and implementation of the Trust's People Plan, to assure the Trust Board that the strategy is implemented effectively and supports the Trust's vision and values. • To monitor strategic workforce risks and report these to the Trust Board via the Board Assurance Framework. • To obtain assurance that the Equality, Diversity and Inclusion plans are being effectively implemented • To monitor compliance against strategic Health & Safety requirements, to ensure that the Trust is meeting its statutory obligations in relation to Health & Safety, and that plans are effectively implemented • To ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management. • To ensure robust and proactive plans are in place to support the personal and professional development of all staff. • To monitor the overall resilience of the organisation and staff, and support the development of a positive and healthy culture through appropriate measurement of engagement and wellbeing. • To ensure the optimum design and development of the workforce to ensure that the Trust has productive, engaged staff with the right skills, competencies and information to deliver outstanding care. • To ratify new and existing HR/Health and Safety policies and procedures, based on changes to legislation/regulations or best practice following development at other committees (Policy Review

Group/JCNC/LNC) and reflect the Trust's People and OD Strategy.

- To ensure effective arrangements to support partnership working with Trade Unions.
- To ensure that all legal and regulatory requirements relating to the workforce are met.
- To gain assurance that the Trust has an appropriate pay and reward system that is linked to the delivery of the Trust's strategic objectives and desired behaviours.
- To provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that they are dealt with in line with policy and national guidance.
- To monitor education, training and learning activities to ensure it complies with required regulations i.e. Learning and Development Agreement, Education Outcomes Framework Deanery, GMC Standards, CQC, Health Education England. Receive regular reports from Education Governance Group.
- Ensure that the Trust is meeting its legal obligations in relation to equality and diversity. This will include overseeing the development of the workforce elements of the Equality Delivery Scheme (EDS), Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans and ensure the effective implementation of the EDS by receiving regular reports against the action plans.
- Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey.
- Obtain assurance that the organisational Values and Behaviours Framework continues to be embedded and championed across the Trust.
- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.
- Ensure delivery of an improved strategy for internal communications, and monitor progress against this strategy. To advise of any significant issues identified through internal communications.

Performance Indicators

To monitor progress on achieving workforce standards and targets. To ensure timely and appropriate information is provided to the Trust Board to fulfil governance and monitoring duties, including:

	• Absence • Management and Leadership Development • PDR/appraisal • Education, Learning and Development activity • Occupational Health and wellbeing activity • Equality, Diversity and Inclusion activity • NHS staff survey/internal engagement measures The Committee will also agree and monitor the work programmes of various sub-committees and working groups reporting to the Committee, ensuring that action plans complement each other. Where new groups are established this will mean confirming the terms of reference and action plans of the sub-groups.
Reporting	The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action. Sub-Committees/Working groups reporting to the Committee: • Health & Safety Committee (for relevant Agenda items) • JCNC • LNC • Education Governance Group • BAME Network • Disability Network • LGBTQIA+ Network
Conduct	The committee will develop a work plan with specific objectives which will be reviewed regularly and formally on an annual basis. The committee will also review its performance on an annual basis. Members and attendees are selected for their specific role or because they are representative of a professional group/speciality/service line or division. As a result members are expected to: • Ensure that they read papers prior to meetings • Contribute fully to discussion and decision-making • If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meetings progress • Represent their professional group or their speciality/directorate/division as appropriate in discussions and decision making • Disseminate and feedback on the content of meetings to colleagues in their speciality/service line/division via governance structures and processes. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.

Monitoring	The committee will assess its own performance and effectiveness annually by: • undertaking a self-assessment of their performance against the identified areas of assurance and any other measures; • considering the terms of reference (including its purpose and role) & work plan annually to ensure they remain relevant and up to date, and recommend any changes to the Board; and • identifying areas of assurance for the following year. Committee Chair will ensure that an Annual Report of the Committee's activities is completed and submitted to the Audit Committee for scrutiny and to the Board for approval.
Review	Committee Terms of Reference to be reviewed following 6 months of operation and thereafter on an annual basis.

DATE: **September 2020**

REVIEW DATE: **March 2021**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 24th September 2020

Paper Title:	**Audit and Risk Committee – Chair's Highlight Report**
Date of meeting:	17th September, 2020
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 17th of September 2020, along with the approved minutes from the Audit Committee meeting that was held on the 16th of June 2020.
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

- Presentation on Risk Management from the Assistant Director of Nursing & Governance
- Board Assurance Framework
- Corporate Risk Register
- Analysis of the Trust Risk Register
- Outcome and recommendations from the self-assessment of the Integrated Governance Committee
- Progress report on the Internal Audit Programme
- Report on the implementation of agreed Internal Audit Recommendations
- Progress report on the work of the Anti-Fraud Specialist
- Report from the External Auditors on how data analytics is used in the audit process and how it can highlight potential areas for management focus
- Terms of Reference and Workplan for ARC
- Update on CQC Actions being overseen by ARC
- Policy for the engagement of External Auditors in non-audit work
- Update on the further development of the gifts and hospitality process
- Losses and special payments report
- Update on the recommendations in the ACORN (innovation partnership) report

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

None

4. Positive highlights of note

The Committee recognised the significant development and improvement of the Corporate Risk Register in the last 12-18 months. Following significant and ongoing oversight by the Executive and Divisions the Committee felt that the Register much better reflects the highest operational risks to the Trust.

The Chief Operating Officer described how the Care Delivery Board (ARC) will oversee the Corporate Risk Register and Trust risks following the allocation of risk management responsibilities between ARC and the CDB.

The two committees should enable detailed oversight by management and strategic oversight by the Non-Executive Directors although it is recognised that that reporting and challenge will develop as the two committees embed their new remits.

The Committee recognised the significant progress in delivering the Internal Audit Plan at this stage in the year, despite audit's being de-prioritised in Q1 due to the Trust's Covid 19 response. Thanks was expressed to both Management and Internal Audit in accommodating audits in this period.

A substantial opinion was provided by the Internal Auditors on the Trust's recording of Covid 19 expenditure.

5. Issues for other committees

There are no items to be notified to other committees.

6. Recommendations

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

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Alder Hey Children's
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Audit Committee

Confirmed Minutes of the meeting held on **Tuesday 16th June 2020 at 2:00pm**
Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mr J Grinnell	Director of Finance	(JG)
	Mrs R Lea	Associate Director of Finance	(RL)
	Ms K Jenkinson	Interim Accountant	(KJ)
	Mrs C Liddy	Director of Operational Finance	(CL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Ms. J. Preece	Governance Manager	(JP)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	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 R Tyler	E&Y Accounts Manager	(RT)
Apologies:	Mr G Baines	Assistant Director, MIAA	(GB)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)

Welcome and Introductions

The Chair welcomed the members of the Committee to the meeting and noted the apologies that were received from Gary Baines and Virginia Martin. The Committee was advised that the Resources and Business Development Committee (RABD) do not receive the Annual Report and Accounts therefore it was felt that it would be beneficial to invite the Chair of RABD, Ian Quinlan, to the meeting in order to have a combined overview of the draft accounts from a financial perspective and an audit process perspective. The Chair welcomed Ian Quinlan to the meeting.

20/21/19 Minutes of the previous meeting held on 30th of April 2020

Resolved:
The minutes from the meeting that took place on the 30.4.20 were agreed as an accurate record of the meeting.

20/21/20 Matters Arising and Action List

Action 19/20/07: *Draft Counter Fraud Annual Report 2019/20 (to provide an update on the identification of fraud risks within Ulysses to enable compliance with the annual self-assessment)* - Discussions have taken place with the relevant Executives to agree the risk scores for each of the seven thematic fraud risks in accordance with Alder Hey's risk management process. It was pointed out that there may be an additional risk to be included on Ulysses relating to staff working from home as a result of the pandemic. John Grinnell has agreed to sign-off this piece of work and the final fraud matrix will be submitted to the Integrated Governance Committee prior to providing MIAA with an update and the completion of this work will be reported to the September 2020 meeting.
ACTION ONGOING

Action 19/20/50.5: *MIAA Progress Report (to develop an Alder Hey internal audit questionnaire in conjunction with MIAA for introduction in 2020/21)* – A mechanism has been agreed for the questionnaire, which will be included in the final report of respective audits. **ACTION COMPLETED.**

Action 19/20/51: *Follow-up Audits (to include a summary table showing the percentage of recommendations implemented, partly implemented and not implemented)* – As no Progress Report was due to this meeting it was agreed to keep this action open and receive an update in September 2020. **ACTION ONGOING**

Action 19/20/60: *Acorn Assurance Review (to receive an update on the recommendations within the Acorn report, from the Innovation Committee)* – This item has been included on the agenda. **ACTION CLOSED**

Action 20/21/03.1: *Non-Clinical Claims Review (liaise with the Director of HR to agree a reasonable timeframe in which to conduct a review of non-clinical claims)* – Erica Saunders has liaised with the Director of HR and a timeframe has been agreed in which to conduct a review of non-clinical claims. An update will be provided on the 17.9.20. **ACTION ONGOING**

Action 20/21/03.2: *Non-Clinical Claims Review (look into the reasons for the Non-Clinical Claims audit being delayed)* – The delay of the audit was due to a senior member of staff being absent and the junior member of the team being unable to provide the relevant information. It was confirmed that this piece of work will recommence once business returns to normal. **ACTION CLOSED**

Action 20/21/05.1: *Final Internal Audit Plan 2020/21 (monthly catch-up meetings to take place between the Trust and MIAA to review the Internal Audit Plan for 2020/21 and the timings of the audit)* – Monthly catch-up meetings have been scheduled. **ACTION CLOSED**

Action 20/21/05.2: *Final Internal Audit Plan 2020/21 (following May's catch-up meeting with the Trust, provide a verbal update on the Internal Audit Plan for 2020/21)* – This item has been included on the agenda. **ACTION CLOSED**

Action 20/21/05.3: *Final Internal Audit Plan 2020/21 (a formal update report on the Internal Audit Plan is to be shared with the Audit Committee at the end of June 2020)* - It was agreed that the Committee will be provided with a monthly update via e-mail during the summer period. **ACTION CLOSED**

Action 20/21/07.1: *Counter Fraud Annual Report 2019/20 (circulate an e-mail with a link to enable the remote sign off of the 2019/20 Self-assessment Review Tool)* – It was confirmed that the Self-assessment Review Tool has been signed off. **ACTION CLOSED**

Action 20/21/07.2: *Counter Fraud Annual Report 2019/20 (liaise with John Grinnell re the outstanding investigations/cases awaiting closure)* – The two reports that were outstanding are closed with no further action or investigation required. **ACTION CLOSED**

Action 20/21/09.1: *E&Y Technical Update Report (E&Y to confirm as to whether the Trust can publish the 2019/20 Quality Report without an audit opinion)* – It was confirmed that the Trust is able to publish its Quality Report without an audit opinion. The Committee was advised that the Quality Report will be published later on in the year. **ACTION CLOSED**

Action 20/21/10.1: *Audit Committee Annual Report (Ernst and Young to provide comments to Jill Preece on the respective sections of the Audit Committee Annual Report in the event that any amendments are required to the accuracy of the factual information)* – Ernst and Young did not require any amendments to be made to the accuracy of the factual information. **ACTION CLOSED**

Action 20/21/10.2: *Audit Committee Annual Report (liaise with Jill Preece re the additional text referring to Covid-19 that is to be included in the Audit Committee Annual Report)* – It was confirmed that the report has been updated to reflect the additional text referring to Covid-19. **ACTION CLOSED**

Action 20/21/11.1: *Draft Annual Governance Statement 2019/20 (update the draft Annual Governance Statement to reflect the Chair's amendments)* – It was confirmed that the draft Annual Governance Statement has been updated to reflect the Chair's amendments. **ACTION CLOSED**

20/21/21 Amendments to the Internal Audit Plan.

The Committee was provided with an update on the amendments to the Trust's Audit Plan for the 2020/21 period. The following points were highlighted:

- It has been proposed that the Workforce Planning Review is to be deferred until 2021/22. As a result of this, the workforce planning requirements will be replaced by a Covid-19 Expenditure Review.
- Key Financial Controls are to be brought forward to Q2 from Q4.
- Delivery Management Office Review will be moved back to Q4 from Q3.
- Capital Project Management will be brought forward to Q2 from Q3.
- Mandatory Training will be moved back to Q4 from Q2.

The Chair queried as to whether the fieldwork for each of the audits will be completed by January 2021. The Committee was advised that MIAA are hoping to complete the majority of the work by January but it was pointed out that there may be a number of audits that won't be finalised until April 2021. If this is the case, there is a possibility that the Internal Audit Opinion might have to be submitted to the Committee in May 2021.

Attention was drawn to the importance of MIAA highlighting any issues that arise with the timing of the plan, and including additional columns to record the agreed date of audits and the process that has been used to conduct them, for example; advisory, checklist, etc.

Anita Marsland pointed out that the Trust has really challenged itself from a mandatory training perspective and queried as to whether it is acceptable to push the auditing of this area of work back to Q4. The Committee was advised that there was a national instruction at the beginning of the pandemic informing organisations that mandatory training could be paused appropriately/at local discretion, but it was pointed out that the majority of Trust's have plans in place to move forward with mandatory training to ensure compliance.

Attention was drawn to the concerns that have been raised by pockets of staff in respect to the risks associated with the non-compliance of particular mandatory training, for example; Information Governance, Safeguarding, Cyber. Following discussion, it was felt that the Exec Team should address this matter during a team meeting in order to move forward and

manage this area of work. MIAA advised that the audit could take place early on in Q4 to enable issues to be flagged in a timely manner.

20/21/21.1 Action: JG

The Chair restated the Audit Committee's prior request to be involved in the scoping meetings for the audits of Risk Management, DMO and Clinical Audit.

Resolved:
The Audit Committee received and approved the amendments to the Internal Audit Plan for 2020/21.

20/21/22 Ernst and Young External Audit Year End Report on the Trust's Accounts for 2019/20

Trust's Annual Report and Accounts for 2019/20

The Audit Committee received the draft Annual Report and Accounts for 2019/20.

Annual Report

Erica Saunders advised the Committee that the Trust has fulfilled all of the regulatory obligations that were placed upon the organisation, and in addition the narrative has been overlaid in the report to reference Covid-19 and its impact. Erica Saunders referenced the guidance from the DHSC issued in March with regard to 'Reducing the Burden' and confirmed that this has been reflected in the report, including the absence of the Quality Report. It was pointed out that there have been a number of sections included in the report around performance which are not obligatory anymore.

Annual Accounts

The Committee discussed the contents of the Annual Accounts for the year ending the 31st of March 2020, and John Grinnell highlighted the detail that led to the Trust achieving a surplus of £1.7m. It was reported that the Trust has spent just over £21m on Capital Expenditure and as at the 31st of March the cash in the bank was £90m.

Attention was drawn to the challenges that the Trust experienced earlier on in the year which initially affected the trajectory for 2019/20, and the development of the Recovery Plan that was instigated to address the consequences of the pandemic and help reach a year end position in line with the control total. The Committee was advised of the last minute challenges that occurred, especially around the revaluation of Alder Play, which were addressed following a discussion with Ernst and Young.

The Chair drew attention to the draft status of the 2019/20 Annual Report and Accounts and confirmed that she had made some minor comments on the report and had requested that additional information be included on the 2020/21 Forward Plan for Covid-19. Committee members were invited to feedback their comments in the event they noticed anything that needed amending.

The Chair queried the reduction in the allocation of PSF money. It was reported that the £4m PSF funding that the Trust received relates to the final year of the 'core

element' allocation included in the 2019/20 plan for achieving specific targets in the year. In previous years the Trust received bonuses and additional funding, this is not the case for 2019/20 which is why the figure seems significantly lower.

In relation to going concern, Ian Quinlan raised a query with regards to the period of time that an organisation has to declare that it has adequate resources to continue in operational existence following sign-off of its Annual Accounts, and felt that the wording 'foreseeable future' (note 1.2) should be amended to reflect a specific period of time, prior to finalising the report. Hassan Rohimun advised that from a going concern perspective Ernst and Young will be looking for confirmation of resources for a 12 month period from the date the audit opinion is provided. This will encompass 2020/21 and parts of 2021/22. Where there are uncertainties, additional questions will be raised.

The Chair pointed out that the Letter of Representation states two years in respect to going concern and queried as to whether this could be brought in line to reflect the narrative in the audit report which states 12 months. Richard Tyler advised that 2 years is the normal process as there are two elements to this area of work; the first twelve months is the going concern analysis that Ernst and Young are drawing a conclusion for and the Letter of Representation is to confirm that the Trust hasn't withheld any information that would render the Trust to cease as a going concern after the analysis period.

Following discussion, the Committee agreed to sign-off the Letter of Representation once the wording has been reviewed.

20/21/22.1 Action: KB

ISA260

The Audit Committee received the external Audit Results Report for year ending the 31.3.20. The following points were highlighted and discussed:

- The Committee was provided with an overview of the key points of the risk assessment and scope of the audit conducted by Ernst and Young;

  - *Valuation of Property, Plant and Equipment* – The Royal Institute of Chartered Surveyors (RICS) has issued guidance to valuers highlighting the uncertain impact of Covid-19 on markets that might cause a valuer to conclude that there is a material uncertainty. Caveats around this material uncertainty have been included in the year-end communication of relevant indices produced by the Trust's external valuer. It is considered that the material uncertainties disclosed by the valuer gave rise to an additional risk relating to disclosures on the valuation of property, plant and equipment. Ernst and Young have proposed to classify this as a key audit matter for inclusion in their draft audit opinion and report on the increased inherent risk. The Committee was advised that Ernst and Young have reviewed the work of the valuer with the support of their internal valuers, and have challenged the assumptions with management in respect to the appropriateness of disclosures.

- *Disclosures on Going Concern* – Financial plans for 2020/21 will need to be revised due to Covid-19. The DHSC has suspended normal NHS operational planning for 2020/21 and moved to block contract arrangements until June 2020, with a proposal to extend this until October 2020.

  Work will have to take place to look at cash flows and resources to ensure the Trust has sufficient cover for the anticipated liability for the 12 months from the reporting date. Ernst and Young have considered the unpredictability of the current environment giving rise to a risk that the Trust would not appropriately disclose the key factors relating to going concern, underpinned by managements' assessment with particular reference to Covid-19 and the Trust's actual year-end financial position and performance. It was also noted that there is no presumption of going concern for a Foundation Trust. Ernst and Young have therefore proposed to classify this as a key audit matter and report on the increased inherent risk. As a result of the increased risk to going concern the audit team has to undertake internal consultation within E&Y before the audit opinion can be issued.

- *Adoption of IFRS16* – The adoption of IFRS 16 by the DHSC GAM as the basis for preparation of NHS financial statements has been deferred to 2021/22. The Trust will therefore no longer be required to undertake an impact assessment, and disclosure of the impact of the standard in financial statements does not now need to be financially quantified in 2019/20. Therefore this is no longer considered to be an area of audit focus for 2019/20.

- The Chair asked as to whether the overall audit opinion would be completed by the 22.6.20 in time for June's Trust Board. Hassan Rohimun advised that Ernst and Young are endeavouring to meet the set timeline, but pointed out that work is taking place with the Finance Team to provide further information/evidence of the assessment following questions in terms of the assumptions on the cash flow forecast post March 2020/21. Hassan Rohimun informed the Committee that contact will be made in the event of any issues.
- It was felt that it would be pertinent to take some time to discuss and understand the additional query from E&Y in respect to the Trust's ability to remain a going concern in 2020/21. John Grinnell drew attention to the challenges of not knowing what the long-term funding mechanism is going to be for the NHS, and felt that it would be more appropriate to make a statement about the level of certain liquidity that the organisation has that places it in a strong positon with options and freedom that will help extend the period that Alder Hey has as a going concern, rather than falsely scenario plan beyond that.

  Richard Tyler advised that there are two strands appertaining to going concern. One relates to the declaration that is made in the financial statement/ disclosures as to why the Trust is secure in creating the Annual Accounts on a going concern basis. The second strand relates to the additional analysis that needs to take place to enable Ernst and Young to conduct an assessment of the level of planning to draw an audit opinion on the going concern basis, and

it is this additional analysis that is required to complete the audit. The additional analysis will look at the Trust's cash position, outflows, inflows, changes to funding and events that may occur to cause the cash position to be questioned.

The Chair pointed out that, in effect, the NHS is underwritten by the Government; therefore given the political nature of the NHS it is very unlikely that the Government won't fund Trusts, especially strong performing Trusts like Alder Hey. Taking this into account, the Chair queried as to whether the risk relating to going concern for 2020/21 is that significant.

It was reported that across the public sector as a whole there are considerations made in terms of continuity of services and there is guidance issued (*Practice Note 10*) which external auditors can follow in terms of auditing standards on the public sector in relation to going concern, but it was pointed out that there is still a requirement to look at an organisation's cash position. With regards to other Foundation Trusts where there are financial challenges, proposals have been made in audit reports for material uncertainties to be disclosed in relation to going concern, which some organisations are making. In light of this, Ernst and Young felt that it would be beneficial to get an assessment of the Trust's considerations of where the organisation is at and the factors that underpin these considerations.

It was queried as to whether this additional scrutiny could be carried out within a twenty four hour period to ensure deadlines are met. Following discussion, it was agreed that Ernst and Young will conduct analysis from a reverse testing perspective using the Trust's 5 year capital projections to support the process. Richard Tyler confirmed that he would liaise with Rachel Lea regarding this matter.

20/21/22.2 **Action: JG/RT**

- Attention was drawn to the following areas of the report:

  - ***Adjusted differences*** –
    1. Accounting for impairment in supporting TAC forms. £450k impairment has been appropriately reported in the financial statements. This impairment was treated as an annually managed impairment in the 2019/20 accounts, however NHSI have now directed the Trust to reclassify this impairment as a departmental expenditure limit. This adjustment has no impact on the financial statements.
    2. An accrual for Clinical Excellence Awards was included in the draft statements but relates to the 2020/21 award. This has been corrected to a 2020/21 transaction. This has the effect of increasing operating surplus for the year by £238k.
    3. **3.** Remuneration Report adjustments - Whilst having no impact on the financial statements it was reported that testing identified amendments to the Remuneration Report section subject to audit, which have been made. One impact of the corrections was to increase the reported pay multiple from 5 to 7.

- ***Draft Annual Report*** – It was reported that Ernst and Young will have to carry out some final checks on the draft Annual Report once it has been finalised.
- ***Significant Risks:*** *(Key Audit Matters)* - Richard Tyler informed the Committee that it is anticipated that there will be two key audit matters in the audit report, but advised that this is still undergoing consultation.
- ***Risk of Fraud or Error*** – There were none to report.
- ***Revenue Recognition*** – Ernst and Young were satisfied with the Trust's Revenue Recognition Policy and it was confirmed that a review of all evidence and testing has been completed.
- ***Valuation*** – It was reported that the valuer has issued a material uncertainty paragraph and confirmed that this won't be removed from the advice given to the Trust. Ernst and Young have drawn the Trust's attention to this matter and reflected it accordingly in the audit report.
- ***Letter of Representation***: *(Uncorrected Misstatement)* - It was confirmed that there is one uncorrected misstatement offsetting a PFI scheme in its initial set up and revaluation. The off set of £250k will be corrected in 2020/21. It was reported that this figure does not impact on the bottom line. Ernst and Young have reported this matter to the Trust so that it can be confirmed in the 'Letter of Representation' that the Trust does not believe this figure is material and on that basis hasn't been corrected it in 2019/20.
- ***Recommendations for Awareness*** – **1.** Following data analysis/mapping by the auditors it was found that there was underlying data from North East Patches (NEP) which contained a number of large debits and credits (£13m credit/£12.5m debit) that aren't always visible as a result of the process NEP use for dealing with call off orders. Ernst and Young have liaised with the Trust's Finance Team to make them aware of this information and have recommended that Trust ensures it has visibility and is satisfied with the accuracy of the underlying data and treatment of call off orders, and that NEP is aware of this issue.

  Ian Quinlan asked as to whether the auditors had queried the balance with NEP. Richard Tyler confirmed that contact had been made with NEP and testing of the credit and debit figures had taken place, with the net impact agreeing with the amount of £500k that had come out of the bank. The Committee was advised that it was the underlying data that had caused Ernst and Young to ask further questions and that there was no impact on the numbers.

  2. *Exit Cost Testing* – It was found that one exit cost of £15k had been agreed and paid in March 2019 but excluded from the 2018/19 exit package report. As the amount is trivial and not reported in the prior year figures the auditors accepted management's decision to include the amount in the current year costs disclosure. It was recommended that the Trust ensures that the exit packages disclosure is complete by comparing a list of exit packages to a list of leavers to identify any anomalies. **3**. *Exit Cost Testing* – It was reported that there was an exit package accrual for £62k that could not be supported by documentation of a decision or a letter to the employee. The amount has yet to be paid but it is understood from management that the decision was made during 2019/20 and the staff exit is still expected to occur. On this basis the accrual has not been adjusted and the impact on the financial statement is

considered trivial. It was recommended that the Trust should ensure that documentation supporting the decisions and calculations of exit packages are retained and available for inspection.

- ***Follow-up Recommendation*** – There is one follow-up recommendation outstanding from last year that relates to estimates. The balances were minimal but there was no evidence that the decision not to amend those estimates had been retained. This matter has been discussed with management and it is understood that a review process has been implemented and the relevant documentation has been reviewed.

- The Chair drew attention to the £250k uncorrected misstatement in the report and asked as to why this hadn't been addressed in 2019/20. The Committee was advised that the error wasn't identified until after the accounts had been closed. It was reported that a discussion took place with Ernst and Young to highlight the issue and to confirm that the discrepancy would be included as part of the 2020/21 accounts.
- The Chair queried the NEP data issue and asked as to whether it related to previous problems that have been experienced with NEP. It was reported that this matter related to the formatting of transactional details rather than a NEP issue and it was confirmed that the auditors are working with NEP to ensure an earlier data submission for 2020/21 to support next year's audit.
- The Chair asked as to whether Ernst and Young would be providing the Committee with an overview of the data analytic work that has been conducted. Hassan Rohimun confirmed that a more detailed report would be submitted to the Audit Committee in September 2020.

20/21/22.3 **Action: HR**

- The Chair queried the planned fee for the statutory 2019/20 audit work that was conducted by Ernst Young, and asked as to whether the £8,800.00 Quality Account element is going to be used for other audit procedures that arose as a result of Covid-19. Hassan Rohimun advised that additional input had been required to carry out the audit process for 2019/20, and pointed out that a proportion of the Quality Account work did take place. John Grinnell informed the Committee that this matter was raised on a previous occasion by Ernst and Young, but felt that a conversation should take place to discuss the overall fee.

20/21/22.4 **Action: JG/HR**

Resolved:
The Audit Committee commended the Annual Report and Accounts for 2019/20 to the Trust Board for approval, pending any relative amendments and inclusion of the outcome of the CQC report.

Letter of Representations

The Chair drew attention to the following narrative in the Letter of Representation - part B, point 4, bullet point 5:

'*The Trust has no knowledge of any identified or suspected non-compliance with laws or regulations, including fraud that may have affected the Trust (regardless of the source or*

form and including without limitation, any allegations by "whistleblowers"), including non-compliance matters: in relation to any allegations of fraud, suspected fraud or other non-compliance with laws and regulations communicated by employees, former employees, analysts, regulators or others'.

It was pointed out that Counter Fraud Services pick up on instances of fraud but to the best of the Committee's knowledge none of these instances have been significant or systemic. Hassan Rohimun suggested including additional text in the statement confirming that the Trust has no knowledge other than the instances that have been reported to the Audit Committee by the CFS. Following discussion it was agreed to amend the Letter of Representation prior to signing.

20/21/22.5 Action: JP

Resolved:
The Audit Committee commended the Letter of Representation to the Trust Board for signing, pending the agreed amendment.

20/21/23 Committee Annual Reports for 2019/20

The Audit Committee received the 2019/20 Annual Reports from the Assurance Committees that report into the Trust Board. The following points were highlighted and discussed:

- The Chair advised that the purpose of receiving an Annual Report from each of the Assurance Committees is to have transparency from the Committees and to ensure that the Audit Committee is fully sighted on all areas. It was felt that a small section should be incorporated in the Audit Committee Annual Report to acknowledge that the Audit Committee has received assurance from the Sub-Committees of the Board.

20/21/23.1 Action: KB

- The Chair queried as to whether the questionnaire element of the self-assessment exercise will be conducted for each sub-committee this year to enable the overall exercise to be completed (recognising that the desktop review part of the exercise was completed this for 2019/20). It was confirmed that the self-assessment exercise can be completed if the process is supported by all those concerned, as the value lies in the participation of committee members.
- The Chair drew attention to the lack of quoracy being experienced by RABD and queried as to whether there are any plans to address this issue. It was confirmed that quoracy is being reviewed as part of the streamlining of committees to ensure coverage right across the board.
- The Chair pointed out that there was no Divisional representation at any of the Workforce and Organisation Development Committee (WOD) meetings during 2019/20, and asked as to whether this matter is going to be addressed from a Divisional governance perspective. It was reported that this issue has been discussed by the Executive Team and it has been agreed that the Committee is going to be rebranded and have the relevant Execs and Divisional leads in attendance at future meetings. The Chair asked that confirmation of the membership and quoracy for WOD be updated in its Annual Report.

20/21/23.2 Action: JP

- The Chair asked for narrative to be included in the Innovation Committee Annual Report to advise of the purpose and involvement of the three external advisors who form part of the membership.

20/21/23.3 Action: JP

The Chair thanked Jill Preece for her support with compilation of the 2019/20 Committee Annual Reports.

Resolved:
The Audit Committee received and approved the 2019/20 Annual Reports of the Assurance Committees that report into the Trust Board.

20/21/24 Update on the Recommendations within the Acorn Report

The Audit Committee was provided with an update on the recommendations within the Acorn Report. The following points were highlighted:

- The Committee was advised that there has been a lot of progress on the recommendations within the report during the last two months, of which are being reported to the Innovation Committee.
- It was reported that a member of the Innovation Team is taking on a more proactive role from a Company Secretary perspective, ensuring that the Trust has visible information from its partners and Nova, and is working through the large amount of documentation that has been provided.
- The Committee was informed that work is progressing in respect to the closing of companies. In terms of the companies that the Trust is going to retain, there are a number of papers being submitted to the Innovation Committee for approval to ensure the recommendations are being adhered to.

Following discussion, the Chair requested that an update be provided in September to advise on the outcome of each of the recommendations in the Acorn Report.

20/21/24.1 Action: RL

Resolved:
The Audit Committee noted the update on the recommendations within the Acorn Report

20/21/25 Any Other Business

There was none to discuss.

20/21/26 Meeting review

There was nothing specific to highlight.

Date and Time of the Next Meeting: Thursday 17th of September, 2:00pm-5:00pm, via Teams

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Wednesday 24th June 2020 at 9:30pm, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	Claire Dove	Non-Executive Director	(CD)
	John Grinnell	Director of Finance	(JG)
	Claire Liddy	Director of Operational Finance	(CL)
	Kate Warriner	Chief Digital & Information Officer	(KW)
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:	Mark Flanagan	Director of Communications	(MF)
	Sue Brown	Associate Development Director	(SB)
	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Dani Jones	Director of Strategy	(DJ)
	Erica Saunders	Director of Corporate Affairs	(ES)
	David Powell	Development Director	(DP)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Stuart Atkinson	Associate Director Estates	(SA)
	Graeme Dixon	Head of Building Services	(GD)
	Russell Gates	Associate Commercial Director Development	RG)
	Nicki Murdock	Medical Director	(NM)
	Dame Jo Williams	Chair	(JW)

20/21/20 **Minutes from the meeting held on 27th May 2020**
Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/21 **Matters Arising and Action log**
Both actions on the log had been completed.

20/21/22 **Declarations of Interest**
There were no declarations of interest.

20/21/23 **Finance Report**
Month 2
RL gave a presentation highlighting key areas from the report: in Month 2, the Trust is reporting a trading deficit of £30k, this is an improved position from the NHSI plan. To reach this position there had been two main changes since the previous month: an increase in payment had been received from the Welsh commissioners, backdated to April and there had been a reduction in consumable spend due to reduced activity levels.

Year to date (YTD) the Trust is reporting a £1.7m deficit, £1.1m behind plan.

(YTD) Covid-19 spends are £2.7m, whilst a number of costs in relation to Covid-19 have reduced it is forecast for costs to continue at £1.3m per month until July 2020. It was agreed these costs would be reviewed with the Divisions to ensure all costs are still required.
Action: RL/Divisions

Going forward it was agreed the report would include pay and non-pay excluding Covid-19.
Action: RL

A submission has been made to NHSI for the £4.4m top up, however the Trust has been informed that the M1 top up payments are on hold across organisations, pending further review and audit.

Cash in the bank at the end of May was £111m, this is significantly ahead of plan. The financial plan is under review and will take account of the noted changes.

A slide was presented on the run rate analysis and how this will be used going forward to improve the position. Temporary Spend for the month was a similar position to 19/20, as activity is lower than this time last year a deep dive is underway to understand the high spend.

The Chair noted that as the Trust is receiving block payments in the report this hasn't been split between the Divisions. RL advised this would be developed.

Resolved:
RABD received and noted the M2 Finance report.

20/21/24 **Alder Hey in the Park Campus Development Update**

David Powell presented the June report and highlighted key achievements:

- Galliford Try has been issued with an advanced work contract for the Cluster and works have commenced
- Tender and evaluation for refurbishment works to the Nursing home concluded and preferred bidder selected.

Key risks include:

- Park: Delays to delivering the full Park, the report outlined the actions in place, the executive team will receive regularly updates to resolve any risks for the final delivery date of 2023.
- Police Station: Lower floor lease may no longer be available. Will continue to see if this is an option and will also review how agile working would support less desk spaces required.
- Neonatal Scheme: 6 risks were highlighted and are being worked through by the team.
- North East Plot Development: Hostile response from community over StepPlaces planning application. Engagement with the community and StepPlaces continues.
- Community Cluster: Value Engineering of external envelope gets rejected by Planners causing delays. This is being worked through with Liverpool City Council before being submitted for approval.

Resolved:
RABD received and noted the June 2020 Alder Hey in the Park report.

20/21/25 **PPE Manufacturing Proposals**

CL updated RABD that Alder Hey are leading on a local manufacturing proposal across Cheshire and Merseyside and are currently liaising with a number of local factories who would be able to provide support with PPE.

Options for providers for PPE alternatives i.e. gowns/aprons are also being looked. into.

CL provided assurances that the factory chosen would be working to British Standards. CD queried the low margins to ensure employees are paid the national rate. CL advised the reduction in price was in relation to a different material being used not the reduction of employee costs. CL did advise prior to contracts being agreed employment checks, to ensure staff are being treated fairly would be carried out.

As this is still being developed CL agreed to provide an update once further details had been agreed. A number of other opportunities were noted.

CD queried if masks are provided to patients and families as this is now a government requirement. CL referred to a project that developed reusable masks for patients and families and further opportunities that have arisen from this. The Charity have been selling the mask, the funds then pay for the free masks for patients and their families.

Resolved:
RABD noted to current position in relation to PPE proposals.

20/21/26 **Month 2 Corporate Report**

98.1% of patients attending the Emergency Department for treatment received care within 4 hours. On average ED are seeing around 110 patients each day, these numbers have been increasing. Excluding Covid-19 expected patients for this time of the year is 180 per day.

The Chair noted the high volume no longer attending ED and queried if it is known where these patients are going to instead. AB said there would be a range of reasons behind the lower numbers, going forward a virtual ED model is being looked into.

Cancer Care remains at 100% for 31 day and 62 day treatment.

April – May Elective waiting times have increased, clinical prioritisation is being used. Theatre sessions are now running as expected, prior Covid-19. Access to care has improved.

MS gave yesterday as an example noting 9.5% of the workforce are not on site in relation to Covid-19 and non Covid-19. It was noted compared across the region this was a low percentage. It was noted this would be a contributor to the high temp spend costs.

Resolved:
RABD received M2 Corporate report.

20/21/27 **Future Productivity and Benefit Opportunities**

JG gave a brief introduction. RL highlighted the monthly run rate deficit and the need to drive more value from the Alder Hey Pound. A slide was shared on the meaning of an overarching financial goal and the 4 key components to move this forward.

RL went through a number changes including a new addendum to SFI's recognising the post Covid-19 framework.

RABD discussed the importance of benefits realisation as well as tracking areas where time could be used better, how to track this and embedding as part of PDR's.
Action: RL/MF

AB noted the importance of being able to deliver the service needs of C&YP, possible changes included the continued increase of digital consultations. Currently the Trust is seeing over three hundred thousand patients per year it was noted that to deliver what is required from C&YP this number would increase to over four hundred thousand patients. RABD noted the importance of using a tool to capture time per patient as well as the financial cost.

Resolved:
RABD received the latest update on:

- Future Productivity and Benefit Opportunities
- Noted the actions going forward.

20/21/28 **Digital Update**

KW highlighted the significant amount of delivery, investment and change in digital across Alder Hey during 2019/20 detailed within the report.

Priorities for 2020/21 have been reassessed through the Digital Oversight Collaborative and Executive Team. A summary highlights the shape of the priorities and plans for 20/21 with a deep dive into the technology roadmap, paper-free and transcription.

Prior to moving to the new service desk in February, less than 10% of all tickets were resolved at the first point of contact level by the service desk. This is now averaging 40% resulting in front lint staff having their IT issue or requests responding to and fixed quicker. 64% of all requests and issues reported are now resolved the same day.

KW referred to the Meditech upgrade project that is due to be live next year. This will increase quality and productivity in relation to EPR.

A decision was made last year to move to Office 365 on a three-year agreement, this decision enabled the Trust to move so quickly to Teams during Covid-19 and will continue. Nationally this is being reviewed however as the Trust is part of a local agreement the Trust will review the 3-year deal next year.

RABD noted future plans in relation to scanning and that this was under review.

KW referred to a number of options in relation to transcription over the next 12 months. The Chair asked if there are any others where similar improvements could be made. KW said the Digital Front Door is one area that is being looked into. The Chair referred to other companies that use transcription companies in Eastern Asia as the work is completed by the next morning due to the time difference. KW said this had been looked it too however it is a costly option.

The Chair referred to a benefits realisation in relation to 50% reduction in medication errors and whether this is auditable. KW advised that it is and gave background into how this was achieved.

Resolved:
RABD received and noted:

- 2019/20 achievements
- Digital progress to support Covid-19
- Support priorities identified for 2020/21

20/21/29 **Marketing Report**

Resolved:
MF highlighted:

- Social stories will continue.
- Working with LHCH and social media
- Working with the local community in relation to Springfield Park.

20/21/30 **Board Assurance Framework**

ES highlighted the main areas of risks noting in association with Covid-19 and a need to review ongoing risks.

From the meeting today ES noted possible risks from the revised financial framework as well as the productivity and waste discussion.

ES also referred to Innovation risks noting they will need to be reviewed and include any required within the BAF.

The Chair queried the timeline line for when the revised BAF would be published. ES advised it was early stages and would keep the assurance committees updated.

RABD noted the areas above and agreed to move forward.

Resolved:
RABD received the monthly report and noted the discussion.

20/21/17 **Any Other Business**

Five Key Risk Areas
The Chair noted the above for 20/21 was yet to be agreed, this would be an item for further discussion at the next meeting.

Date and Time of Next Meeting: Wednesday 29th July 2020, 09:30, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Wednesday 29th July 2020 at 9:30pm, via Teams

Present:	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	Claire Dove	Non-Executive Director	(CD)
	Claire Liddy	Director of Operational Finance	(CL)
	Kate Warriner	Chief Digital & Information Officer	(KW)
	Melissa Swindell	Director of HR & OD	(MS)
In attendance:	Sue Brown	Associate Development Director	(SB)
	Mark Flanagan	Director of Communications	(MF)
	Russell Gates	Associate Commercial Director Development	RG)
	Rachel Lea	Acting Deputy Director of Finance	(RL)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies:	Graeme Dixon	Head of Building Services	(GD)
	Dani Jones	Director of Strategy	(DJ)
	John Grinnell	Director of Finance	(JG)
	David Powell	Development Director	(DP)
Agenda: **44.**	Steve Begley	Head of Procurement	(SBe)
48.	Sharon Owen	Deputy Director of HR & OD	(SO)

20/21/34 **Minutes from the meeting held on 24th June 2020**
Resolved:
The minutes of the last meeting were approved as an accurate record.

20/21/35 **Matters Arising and Action log**
The three actions had been included on the agenda.

20/21/36 **Declarations of Interest**
There were no declarations of interest.

20/21/37 **Alder Hey Pound: 5 Key Topics**
The Chair suggested the following 5 key topics for 2020/21:

- **Productivity** AB agreed to liaise with the Divisions for them to present regular updates to RABD.
- **Benefit Realisation** A programme of retrospective reviews of the benefit realisation of major capital projects or operating initiatives.
- **Cash**
- **CAPEX**
- **Building Projects**

Resolved:
RABD APPROVED the 5 Key Topics for 2020/21, any new forms of reporting will be included on the agenda.

20/21/38 **Finance Report**
Month 3
The trading position, excluding any COVID costs, in Month 3 is a £0.4m deficit, which is £0.1m more than NHSI had planned for. The cumulative trading position is a £2.1m deficit which is £1.3m more than expected by NHSI. They key drivers for this are detailed in the report.

The total top up payment that the Trust is forecast to require by the end of month 4 is £9.3m of which £5.4m relate to COVID 19 costs. RL advised COVID 19 costs are reducing and activity has increased.

Temporary Spend has decreased since last month although it is still higher than expected.

Key Financial risks going forward include the recurrent FIT target, further details on this are awaited from NHSI after September 2020. An update on the Children's Tariff is due to be presented at the September Trust Board.

The Chair queried the change for payment to non NHS businesses from 30 to 7 days. RL said the change had been implemented to support businesses through COVID-19.

The Divisional update had been included in the report.

Quarter 1 Financial Stock Take
The above paper has been included in the pack.

Resolved:
RABD received and noted the M3 Finance report.

20/21/39 **Alder Hey in the Park Campus Development Update**
Sue Brown presented the July report and highlighted key achievements:

- Contract with Galliford Try for the construction of the Cluster (Hub and Dewi Jones Unit) has now agreed and signed.
- 18 month Service level Agreement now in place with Capacity Lab to support engagement and setting up of a community Interest Company to support long term management/maintenance of the park, if required the agreement can ben extended for a further 6 months.
- Dedicated Senior Capital Project Manager commenced in post to manage the neonatal scheme.

Progress continues on:
- Police Station: A decision is still awaited as to whether the lower floor of the police station can be leased. Alternative plans are being reviewed.
- Alder Centre: A meeting is taking place tomorrow to challenge a number of additional costs that had not been included in the original plans.
- Community Cluster: Agreement on cladding of the cluster is to be approved.
- North East Plot: Planning applications on designs of the plot are being received.

Claire Dove asked for the latest position on the review of the number of staff requiring to work on site due to the working from home that has been

implemented. SB said she had been working closely with MS on this and a paper had been presented at the Executive meeting held yesterday.

Resolved:
RABD received and noted the July 2020 Alder Hey in the Park report.

20/21/40 **Handrail update**
Resolved:
RG updated RABD noting a paper outlining a number of recommendations would be presented at the August RABD meeting.

20/21/41 **Covid-19 Innovation update**
Resolved:
This item was deferred until the September meeting.

20/21/42 **Month 3 Corporate Report**
98.1% of patients attending the Emergency Department for treatment received care within 4 hours. On average ED are seeing around 120 patients each day, these numbers have been increasing. Excluding Covid-19 expected patients for this time of the year is 180 per day.

Cancer Care performance remains at 100%.

In June we continued to make good progress in reintroducing surgical services and the full theatre schedule is restored.

AB noted non-compliance with the referral to treatment time. The services most significantly affected are learning disabilities, paediatric surgery, spinal surgery and ENT. All patients who have had waited over 52 weeks have had a clinical review to expedite treatment where required or confirm they are safe to wait longer. We will continue to increase capacity in outpatients and surgery to ameliorate the waiting times being experienced.

Resolved:
RABD received M3 Corporate report.

20/21/43 **Future Productivity and Benefit Opportunities**
RL and AB gave a presentation on developing 5 KPI's for the Clinical and Corporate divisions to improve productivity and increase the annual number of patients being seen from 330k to 395k.

Resolved:
RABD received the latest position noting a further update would be presented at the September RABD.

20/21/44 **Procurement Monitoring**
SBe gave a presentation on procurement's response to COVID 19, difficulties the department has faced particularly in maintaining and procuring PPE and how this was managed through a weekly workstream group.

A query was raised in relation to the Government stockpile of PPE. CL noted that this was available and was used quickly.

The Specialist Trust's Procurement Alliance collaboration work, had been put on hold during the Covid-19 crisis, is now restarting. SBe highlighted the main areas of focus.

A slide on the future direction of procurement and key activities had been included. Claire Dove offered support in relation to Environmental Sustainability and social value.

On behalf of RABD the Chair thanked Steve Begley and the Procurement team for the management of PPE during COVID-19.

Resolved:
RABD noted the Procurement update in relation to PPE and the collaboration with the Specialist Trust's.

20/21/45 **Digital Update**

KW presented the report highlighting:

- The development of a clear, complete and accessible electronic patient record for Alder Care.
- The Digital Front Door is due to go live this month, July 2020.

The Chair asked if a benefits tracker is kept on the Technology Road Map, KW advised that it is and updates would be received through the monthly report.

Resolved:
RABD received and noted the Digital Report in relation to the development of an EPR system for the Alder Centre, progress with the technology roadmap and digital maturity programmes.

20/21/46 **Marketing Report**

Resolved:
MF highlighted:

- A Communications workstream has been set up by the PPE Steering Group to provide consistent support and education to staff regarding the latest PPE guidance.
- Weekly Staff Briefings are broadcast on a Wednesday lunchtime
- Working with the local community in relation to Springfield Park.

20/21/47 **Board Assurance Framework**

ES noted the review of the strategic risks:

- Vision of the park required further development SB and ES noted this would be managed outside of RABD.
- CQAC risks would be managed with Pauline Brown.

Resolved:
RABD received the monthly report and noted the discussion.

20/21/48 **Payroll Contract**

The current contract with ELFS is due to end 30th September 2020. SO highlighted the proposed new contract costs, with the potential for a further 5 years contract with ELFS, and the opportunity to extend for an additional two, one year extended periods.

The paper included an overview of the proposed cost, quality review and service provision, with additional consideration given to the regional collaborative position for corporate services.

A query was raised in relation to staff who had left the organisation and were still being paid. SO advised that this was in relation to the process for managers not completing leaving forms in a timely manner advising that this was being addressed.

RABD noted the efforts made into a collaboration piece with other local Trust's, and how currently this wasn't in a position to progress further.

Resolved:
RABD APPROVED the recommendation in the paper to continue to use the services of East Lancashire Finance Services for the purposes of payroll provision, on the basis of a three year contractual commitment. and the opportunity to extend for an additional two, one year extended periods.

20/21/49 **RABD Workplan**

As Jill Preece, Governance Manager is reviewing the committee timetable and reporting structure it was agreed this item would be deferred until this work had been completed.

20/21/50 **Any Other Business**

No further business was discussed.

Date and Time of Next Meeting: Wednesday 26th August 2020, 09:30, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

24th September 2020

Paper Title:	**People and Wellbeing Committee**
Date of meeting:	14th September 2020 – Summary 2nd March 2020 - Approved Minutes
Report of:	Claire Dove, Committee Chair
Paper Prepared by:	Jackie Friday, PAW Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent People & Wellbeing Assurance Committee meeting 14th September 2020 along with the approved minutes from the 2nd March 2020 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3 BAF 2.2 - Staff Engagement – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. **Introduction**

   The People & Wellbeing 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 strategic direction and board assurance in relation to all workforce matters including monitoring progress against workforce indicators and supporting the organisation in delivering a positive patient centred culture.

2. **Agenda items received, discussed / approved at the meeting)**
   - Staff Survey Action Plan Progress
   - People Plan Update
   - CQC Action Plan
   - Internal Communications Update
   - Leadership Update
   - Sickness Absence/Shielding Position Update
   - EDS2 & Workforce EDI Annual Report
   - WRES/WDES & Actions
   - Review & Agreed TOR and Work Plan 2020-21
   - Corporate Report Metrix
   - Board Assurance Framework
   - Workforce KPI's
   - Mandatory Training
   - PDR/Appraisal Update
   - HEE NW AV Update
   - Policies reviewed and ratified
     - Capability & Performance
     - Recruitment & Selection
     - Maternity
     - Grievance
     - Respect at Work
     - Equality & Analysis
     - Consultant & SAS Doctor Job Planning
     - Domestic Abuse
   - Minutes of Sub Committee/Working Groups reporting to the Committee
     - LNC – 29.01.2020 & 07.05.2020
     - JCNC – 24.02.2020
     - Education Governance 24.07.2020

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - Staff absence and ongoing ability to ensure safe staffing levels to respond to the pandemic and continue to provide clinical services, especially linked to winter planning

4. **Positive highlights of note**
   - Significant progress made on SALS
   - Significant support for leaders during and post-covid

- Annual EDI report
- Mandatory training compliance maintained at 90%
- Significant number of people policies ratified

5. Issues for other committees

- RABD – sickness levels

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Section 1

CONFIRMED **WORKFORCE & OD COMMITTEE**
MINUTES FROM MEETING
2rd March 2020

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr Ian Quinlan	Non-Executive Director	(IQ)
	Mr P OConnor	Deputy Director of Nursing	(POC)
In Attendance:			
	Ms E Palmer	Apprenticeship Assessor	(EP)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Ms E White	Care Pathways, Policies & Guidance (Part Attendance)	(EW)
	Mrs Kerry Turner	Trust LiA Lead/FTSU	(KT)
	Ms L Howell	Change Programme Project Manager (Part attendance)	(LH)
	Ms A Chew	Associate Director of Finance	(AC)
	Ms Z Connor	Senior HRBP	(ZC)
	Mrs J Potier	Associate Director of Organisational Development	(JP)
	Mr T Johnson	Staff Side Chair	(TJ)
	Ms H Blackburn	Medical Education & Revalidation Manager	(HB)
Apologies:	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs P Brown	Director of Nursing (Deputy for Chief Nurse)	(PB)
	Ms F Beveridge	Non-Executive Director	(FB)
	Ms L Cooper	Director of Children & Young People - CAMHS	(LC)
	Ms N Deakin	Change Programme Manager	(ND)
	Mr A Hughes	Divisional Director – Medicine	(AH)
	Mrs H Ainsworth	Equality & Diversity Manager	(HA)
	Mr A Bateman	Chief Operating Officer	(AB)
	Ms R Chhokar		(RC)
	Dr N Murdock	Medical Director	(NM)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
20/01 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 10th December 2019 and they were approved as an accurate record.			
20/02 **Matters Arising, Actions**	**The Committee considered the following under matters arising, any actions not mentioned will be progressed as part of today's agenda or brought back to a future**			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	meeting: **17/3 & 19/68 Equality Diversity & Inclusion** MKS advised that a review of the whole approach relating to EDI is required, this review will be a stocktake on all actions to ensure we are on the right track (review of objectives, WRES/WDES plan and HEI's to ensure we have a workforce that reflects the community we serve). CD & MKS to meet to discuss to ensure clear measures/actions are in place. **Committee Effectiveness & Performance Review** The Committee received a report prepared by the Governance Manager for Committee approval. The purpose of the report is to ensure effective corporate governance arrangements are in place to meet the requirements of the Board and also to comply with Monitor's Foundation Trust Code of Governance. Views of members of the WOD Committee will be sought through completion of an evaluation questionnaire and the overall process will be co-ordinated by the Governance Manager in conjunction with the Chair. When this process is completed the outcome will be presented to the Trust Board and Audit Committee. The report is noted as read. The Committee **ratified** the process.	Review a new approach to EDI	MKS/CD	
20/03 **Programme Assurance 'Developing our Workforce'**	**Programme Assurance Framework – March 2020** The Committee received a summary prepared by the Change Programme Manager. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream 'The Best People Doing Their Best Work' is recorded as read prior to the meeting. In the absence of ND, LH updated the Committee on latest developments. Highlighted as follows: **Catering Closure Report – received for information** MKS advised that the catering organisational change was successfully implemented within the 6 month time frame and no permanent members of staff were made redundant. Two other outstanding objectives (R&E2 Kitchen offer and Indicator Finance System) are to be undertaken by the Catering department as business as usual in close partnership with Finance and the Children's Health Park. IQ asked if it was too early to close the project down. The Committee discussed the detail outlined in the report that caused the delay to implementation of the kitchen offer, and acknowledged impact of this on the main objective (catering organisational change). MKS felt that the initial project was trying to capture everything, but recognised that the first phase affecting the main building had been completed. **E-Rostering** LH advised that E-rostering has been advanced through Programme Board and confirmed			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	that the Trust has been successful in receiving NHSi capital funding bid of £390,000 over 2 years. Soft market testing has been carried out and 'Softworks' have been identified at this stage as the preferred supplier. The recruitment for an E-Roster manager is taking place on 9th March. LH informed the Committee that a report will go to RABD at end of month to support due-diligence. Next steps is the recruitment of two support roles for technical support and administration, a Trust wide communication to inform staff and a full implementation plan. This will include a pilot area and managing a review of benefits and training needs analysis (TNA). MKS acknowledged the work that LH had completed and advised this project was near completion. MKS further advised that within the last fortnight she had received information concerning Specialist Trust work taking place relating to integration of processes for E-rostering so it was felt that to support the last bit of due-diligence this should be discussed at RABD. The Committee discussed what guarantees we had in place and if we had an early get out clause. LH advised of a visit to Ireland (where the supplier is used in all major hospitals) for assurance and felt confident of processes that will be tailored for the NHS and added that the first 3 months of the contract is cost free. The Committee **agreed** the process.			
Progress Against the People Strategy **20/04**	**Health & Wellbeing** • **Staff Advice & Liaison (SALS) Proposal – Action Plan/Next Steps (Jo Potier)** The Committee received the action plan prepared by the Associate Director of Organisational Development. The purpose of the plan is to outline all the different elements of the SALS proposal and the progress made for information purposes. The action plan is noted as read. JP advised that this project had accelerated somewhat following the CQC visit. Largely positive feedback received at Community event and comments taken on board. The LiA Big conversation had been well attended by a wide range of stakeholders including all services currently offering support to staff, with positive feedback received and key issues identified. Next steps are to review how it would fit with the pathway to counselling i.e. Occupational Health etc. JP advised that the project is gaining momentum and would like to commence a period of assessment to quantify the requirements needed to support staff. The Committee raised a number of observations: o CD referred to the sign posting to advise staff who to go to for support (i.e. point people in the right direction) and acknowledged this was an important aspect of this project. o KT advised that we have to signpost and thought the early intervention has the potential to grow really quickly.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	○ CD advised it was an important piece of work and we must ensure there is momentum to push this forward. ○ CD added it is important also that we have some way of monitoring it and the impact of it. ○ MKS advised that Team Prevent run a number of 'employee assistance programmes', one of which is a 24 hour helpline and acknowledged it may be a resource issue for AH. We could look at what Team Prevent has to offer. The Committee **noted** the progress made.			
20/05	• **Sickness Absence Plan & Update** The Committee received a presentation prepared by the HRBP and Deputy HRD. The purpose of the presentation is to give the Committee an overview of comparisons, FTE days lost and cost of sickness along with what the Trust is undertaking to support improved staff sickness. (See attached PDF for statistics). ZC referred to Cheshire & Merseyside comparisons (September 2019) and acknowledged that we are not significantly higher than other organisations, although the North West is higher than the rest of the country. MKS recognised that the composition of other comparators may be different to what we have at the Trust (i.e. Alder Hey has in-house facilities where others may be outsourced) KT confirmed that Birmingham had the same set up as us. ZC referred to the 3 year comparisons – 2017-2019 (target 4.00%) for Alder Hey and advised that we are not near our targets set. The spike has continued to January with winter pressures and since August short term sickness has seen a rise. ZC referred to Alder Hey's Top 10 reasons for absence for (January 2020) and AH's length of sickness (short term and long term) and confirmed that the highest FTE days lost was due to 'Anxiety/stress/depression/other psychiatric illnesses (33.1%). CD asked in monetary terms – what is the cost of this to the Trust. AC confirmed £2M. The Committee acknowledged that building on the SALS project would support this. FTE days/% lost by Staff Group (total) – ZC confirmed that Nursing & Midwifery along with Estates – Ancillary and additional clinical services registered the highest staff groups for FTE days lost. A number of questions were raised by the Committee – CD asked how do we manage repeat performance sickness (i.e. a couple of days per month)? . The Committee acknowledged that SALS is key, particularly in relation to mental health issues. TJ suggested reviewing comparator information to see the breakdown of different types of illness. CD advised that the statistics available really needs to be looked at more closely (drilled down) to see if there is anything glaringly			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	obvious that could be rectified. The Committee recognised that sickness puts pressure on other staff and is a burden on costs. Estimated costs by division and by staff group – as outlined in the presentation, all predominant daily costs are referred to, the detail of which will be discussed at the Health & Wellbeing Committee. As per the presentation – ZC outlined what the Trust is doing to support all of the above including: ○ Dedicated Wellbeing Team. ○ In-depth review and support plans developed for all complex cases. ○ Updated Sickness Absence policy to be ratified. ○ Dedicated HR support for all areas to provide guidance and advice on sickness management. ○ Analyse of absence reasons to provide targeted support and training. ○ Development of SALS programme. ○ Health and Wellbeing Action plan. ○ Financial Wellbeing ○ Time to Change Training Champions JP added in relation to interventions, looking at models to support long term stress. MKS added that Occupational Health and Trade Unions have a part to play also to help support staff back to work. The Committee noted financial implications of sickness at the Trust and acknowledged the ongoing action plan to support sickness and looked forward to seeing the positive outcomes. The Committee **noted** the progress made.			
20/06	**Leadership Development & Talent Management** • None to report this time			
20/07	**Future Workforce Development** • **Apprenticeship Update** The Committee received a report prepared by the Head of Apprenticeships. The purpose of the report is to provide the Committee with an update regarding apprenticeships activity, for information purposes. In the absence of the Head of Apprenticeships, the Apprenticeship Assessor outlined the activity to date. Highlights are:			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	○ Tender submitted to Department of Education via the Education Skills Funding Agency has been approved, this will the Trust to remain on the register as an Employer Provider. ○ Since March 2019 a further 31 staff have started and Apprenticeship, there are a further 16 in scope to start an Apprenticeship. ○ Apprenticeship week (3rd-7th February) – The Trust received approximately 30 expressions of interest and will follow this up with a tracking exercise to see how many turn into Apprenticeships. ○ The Apprenticeship Team joined the Liverpool City Region Apprenticeship Hub to give a presentation to 200 year 11 students at a School in Maghull to encourage students to consider working for NHS once they finished school. ○ New staff – a new Apprenticeship Tutor who can deliver Healthcare Apprenticeships has been appointed. This will support the Trust's medium to long term aspirations to upskill new HCAs joining the Trust, which in turn will support the Nurse Associate Apprenticeship pathway. ○ The Apprenticeship Team is in the process of moving from 'Frameworks' to 'Standards'. From 1st August 2020 all Apprenticeships starts will be on the high-quality reformed Apprenticeship Standards. ○ Apprenticeship of the year – We have been notified by Southport College that two staff have won Apprenticeship of the Year in their sector. • The Committee recognised the great work taking place with the Apprenticeship Team. The Committee acknowledged there is a requirement going forward to expand the offer to support diversity and review the possibility of external apprenticeships via recruitment (i.e. undergraduate nursing Apprenticeships/Nurse Associates). CD advised that we need to speculate and draw down on the Levy wisely as there may be other ways to utilise the Apprenticeship scheme. A strategic approach is required. The Committee **noted** the content of the report.			
20/08	**Equality, Diversity & Inclusion** • **Gender Pay Gap Report** The Committee received a report prepared by the Deputy Director of HR&OD. It is a legal requirement for employers to publish their gender pay gap. The purpose of the report is to provide context to help understand the findings and to enable the Trust to take steps to reduce any potential for gender inequality. The report is received for approval. The Committee noted that Gender Pay Gap differs to Equal Pay. Equal Pay			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	is in relation to pay differences between men and women who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a gender pay gap. The report is noted as read. The snapshot date for public sector organisations is 31st March 2019; this report therefore reflects our pay profile for the preceding 12 months from this date. SO gave an overview of how the data is collected and advised that the gender split of our workforce was 84% females and 16% males. This compares similarly with the overall gender profile of the NHS. SO outlined the gender pay gap summary statistics (Mean Pay Gap & Median Gender Pay Gap) and went on to outline the Proportion of Men and Women in each Salary Quartile Band and the Gender Pay Gap Bonus Pay for Medical and Dental (the report demonstrates that the Trust gender pay gap remains mainly with our Medical and Dental staff groups and is reflective of an ageing male workforce within this staff group). The Committee analysed the results received, with particular attention brought to medical males having longer service than female medical staff, which impacts upon salary. This number is reducing and consequently will have an impact on the pay gap. It was acknowledged that the reasons for gender pay gap are multi-factorial (i.e. terms and conditions, length of service, gender mix, pension, flexible working arrangements and salary sacrifice commitments) and this will have an impact upon the overall gender pay gap results. The report recommended specific objectives to reduce the gender pay gap and these will be incorporated into the 'People Plan Operational Plan and will be monitored by WOD. MKS advised that this report will be presented at Trust Board for approval to enable it to be published on the Trust and Government website in line with statutory reporting guidelines. The Committee **approved** the report.			
20/09	**The Academy** • **Health Education North West (HENW) Action Plan** The Committee received a covering report prepared by the Medical Education & Revalidation Manager along with Action Plan and Quality Review Outcome Report. The purpose of the report is to update the Committee on the Annual Assessment Visit - Action Plan (visit by HENW AAV took place in October 2019, subsequent Quality Outcome Report and Action Plan received January 2020) and provide assurance on			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	the progress made. The report is noted as read. HB outlined how the Action Plan was formulated with each action rated from 1-4. Particular attention was brought to an action that was rated 3 'Placements well below HEE standards and sustained improvements not at pace, despite action plan'. HB advised that this action relates to our handover processes within Medicine – The visiting team recorded that it was complicated and did not provide an educational experience. HB acknowledged this is a difficult area to handle and strenuous efforts have been made to see improvements. There has been a review of handover; this has resulted in a more effective process; however it is still being refined in conjunction with trainees. HB concluded that the action plan will be reviewed with the Medical Education Board members to ensure that the GMC survey brings a more positive response from trainees. Further consultation will be held with trainees to ensure that we see improved training and education. The Committee discussed the methods in place to agree how actions are rated. MKS advised that response to the Action Plan is still in draft form and will be presented to Trust Board to formally sign-off. HB to present to the next WOD with further updates to review progress. The Committee **noted** the progress made.			
20/10	• **Mandatory Training Update** The Committee received a report prepared by the Head of Learning & Development. The purpose of the report is to provide assurance to the Committee on the current and recent mandatory compliance trends and areas of focus taken. The report is noted as read. The Deputy Director of HR&OD gave an overview of progress to date. The Trust's overall Mandatory Training compliance has been consistently above 90% target now for the last 8 months and is currently 94%. A robust action plan has been implemented over the last 3 months to improve overall compliance. This will need to be sustained going forward as well as continuing to look at ways to improve Mandatory Training for staff and the Trust. As outlined in the report, SO gave an overview of the actions taken and the plans in place to sustain compliance, to ensure all staff groups remain above 90% target and continue to improve the compliance of all topics below 90%. The Committee recognised this achievement and **noted** the progress made.			
20/13	**Monitoring**			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• **Staff Survey 2019 – Survey and Plan/Approach** The Committee received a report and presentation prepared by the Associate Director of Organisational Development for information purposes. The purpose of the report is to advise on key themes to support the LiA Big Conversations that will take place within the Divisions (the vehicle to discuss the Staff Survey results and agree and implement actions). The 2019 NHS Staff Survey Results was shared with the Committee. All documents are noted as read. The Committee noted the final response rate for the Staff Survey that closed on 29th November 2019 was 62% a 2% increase on the previous year. MKS advised that the Trust is now compared to a different comparator group of hospitals than previously (Acute and Community combined Trusts) and we compare more favourably with this group. The Committee discussed staff morale and it was acknowledged that as we refine processes to support our staff we should see more positive outcomes. The Committee **noted** the progress made.			
20/14	• **Workforce KPI's – January 2020** The Committee received a regular report prepared by the Deputy Director of HR concerning the key KPIs relating to workforce monitoring for January 2020. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. The report is noted as read. SO advised that sickness is 5.7%, the average figure over last 3 months has marginally increased when compared to last year. Plan in place for sickness once health & wellbeing processes are embedded. PDR's will open again in April. Consistently not achieving correct pay, by and large due to notification of managers, processes to support this are being put in place to tighten this up (correct pay achieved 99.45). BME Recruitment over the 1% target, to be reviewed in April. The Committee discussed the overpayment errors made and agreed the importance of supporting a solution to retrieve money's owed to the Trust. The Committee **noted** the content of the report.			
20/15	**General** • **Marketing & Communications Report – February 2020** The Committee received the Report prepared by the Director of Marketing & Communications. The report is noted as read. The Committee **noted** the content of the report.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
20/16	• **Alder Hey People Plan – Update – February 2020** The Committee received the Report prepared by Senior HR Business Partner. This monthly report is presented the Trust Board meeting. The report is noted as read. The Committee **noted** the content of the report.			
20/17 **Key Workforce Risks – Review Of top Workforce Risks action planning against most significant risks**	• **BAF Assurance Framework – January 2020** The Committee received a regular (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work'. MKS advised that a refresh/review of workforce risk had taken place. The report is noted as read. The Committee **noted** the content of the report.			
20/18	**Workforce Risk Report January 2020** The Committee received the Human Resources Risk Register prepared by the Deputy Director of HR. The purpose of the report is to outline the internal monitoring processes for risks and the actions taken to reduce the risk. The Committee received an updated risk register. The report is noted as read. The Committee **noted** the content of the report.			
20/19 **Sub Committee Minutes**	The Committee received the minutes for the following for information. • LNC - 27.11.2019 • JCNC - 26.11.2019 • Health & Safety – 23.07.2019 The Committee **noted** the content.			
20/20 **Legislation, terms & conditions, employment policies/EIAs – review & ratification/approval.**	The Committee received the following policies and Equality Assessments for formal ratification/approval. • **Preventing & Managing Violence & Aggression at Work, Zero Tolerance Process & Protecting Lone Worker Policy** POC outlined the key areas for the Committee to be aware of; largely the policy remains unchanged apart from section 6. Based on national guidance a zero tolerance process has been added and further appendices have been included. Posters to support the policy are under review. CD asked if everyone was ok to ratify. TJ advised he was waiting for some evidence to come through, but would be happy to ratify and will raise concerns should the need occur.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **ratified** the policy and the equality analysis was **approved**. • **Pay Progression Policy** SO advised that this policy had been updated following national guidance and agreement had been reached by the Policy Review Group. The Committee **ratified** the policy and the equality analysis was **approved**. • **Supporting Sickness and Attendance Policy** SO advised that lots of consultation had taken place with this policy, with more supportive measures put in place and supportive language used. The key now is implementing this policy with in management processes. The Committee **ratified** the policy and the equality analysis was **approved**.			
20/21 Board Assurance	The Board Assurance Summary was discussed and completed for submission to the next Trust Board on 3rd March 2020. The Committee agreed, that due to Trust Board taking place the following day that a verbal update would be shared.			
20/22 AOB	None.			
Date of Next Meeting	**Wednesday 29th April 2020, 2pm, Tony Bell Boardroom, Institute in the Park**			

Action List

Minute Reference	Action	Who	When	Status
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			

17/21	• Feedback on outcomes of Change Programme Framework • Noted on 19/09/2019 that DMO support is in place for this ongoing action.	ND MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing
	Equality & Diversity			
20/20 17/13 19/68	• Review a new approach to EDI - CD & MKS to meet to discuss to ensure clear measures/actions are in place • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	MKS/CD HA HA/SM HA	TBS 1/4ly Update 6 monthly Review	 Ongoing Ongoing
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Ongoing
19/91	• Update on HEE action plan	HB	April 2020	Ongoing
	Nurse Associate Recruitment			
19/69	Develop a wider plan – to be reviewed	Vikki Hughes	April 2020	
	Mandatory Training & CQC			
19/73	To be standard agenda items going forward	MKS/JF	October 2019	Ongoing
19/106	Mandatory Training Action Plan	SO	February 2020	Complete
	Sickness Absence			
19/93	Update on progress of embedded new process.	SO	February 2020	Complete
	Apprenticeship			
19/90	Update on framework	GT	February 2020	Complete
	Reciprocal Mentorship Programme (RMP)			
19/109	Issue the RMP presentation to the Committee	JF/HA	ASAP	Complete
Key Workforce Risks				
19/111	Issue the correct version for November 2019	JF/SO	November	Complete

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 24th September 2020

Paper Title:	**Integrated Governance Committee**
Date of meeting:	11th March 2020 – Approved Minutes
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Cathy Umbers, Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Integrated Governance Committee meeting held on 11th March 2020, along with the approved minutes from the 15th June meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

Alder Hey Children's NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
11th March 2020
Time: 10:00-12:00
Venue: Institute in the Park, Tony Bell Boardroom

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mr J Grinnell	Director of Finance	(JG)
Mrs S Owen	Deputy Director of HR & L&D	(SO)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mr P O'Connor	Deputy Director of Nursing	(PO)
Mrs R Greer	Assoc. Chief of Op (Community)	(RG)
Mrs C Wardell	Director of Medicine	(AH)
Mrs E Hughes	Assoc. Chief Innovation Officer	(EH)
Mr D Eyre	Associate Director of Operational IM&T	(DE)
Mrs S Brown	Associate Director for Development	(SB)

In Attendance:

Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mr S De Clouet	Catering Manager Facilities	(SD)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mr J Taylor	General Manager – R&D	(JT)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mr P Sanderson	Head of Pharmacy	(PS)
Mrs S Stephenson	Head of Quality for Community	(SS)
Ms J Preece	Governance Manager	(JP)

In Attendance Other:

Mrs J Keward	Infection Control Nurse	(JK)
Ms L Calder	Minute Taker	(LC)
Mrs S Serir	Health Entrepreneur Innovation	(SS)

Apologies:

Mrs C Liddy	Deputy Director of Finance	(CL)
Mrs L Cooper	Divisional Director of Community	(LC)
Mr D Powell	Director of Development Directorate	(DP)
Mrs M Swindell	Director of HR & OD	(MS)
Mr M Flannigan	Director of Communications	(MF)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs C Barker	Chief Pharmacist	(CB)
Mrs V Weston	Assoc. Dir. of Infection Prevention	(VW)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs P Brown	Director of Nursing	(PB)
Mr S Atkinson	Interim Associate Director of Estates	(SA)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mr A Bateman	Chief of Operations	(AB)
Mrs N Murdock	Medical Director	(NM)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
	2.	Chair's introduction	At the IGC this morning Kerry Byrne (Chair) highlighted that most 'High' risks potentially will remain open for some time, therefore going forward please include the long term actions and associated plans with expected dates for completion, in addition to the short term actions that are providing short term mitigation. This will help demonstrate good management of the risks and provide the necessary assurance for Board. Please ensure all actions are SMART and there are consistent progress updates included on the risk assessments. **Note:** This process should also be applied to other risks and most definitely high moderate risks. **Graphs** The Chair advised of work that needs completing on the graphs. There needs to be whole numbers on the axis (no decimal points) and some graphs have no axis on them. **Cover Sheet** The Chair advised when completing the cover sheet can committee members tick the strategic objectives only relevant to their area. The Chair advised that she has been looking through the risk management reports and action plans for the last 18 months and can see the reports are looking the best she has seen them, in terms of detail provided.	Add these requirements into Action 19/20/83 Whole numbers on graph axis (no decimal points) and some graphs have no axis on them. On the Cover Sheet tick strategic objectives only	All All All	27th May 20 27th May 20 27th May 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			The Chair questioned if we needed strategic risk around COVID-19? Elaine Menarry (EM) advised this risk will come under the EPPR risk register and EM will update on COVID-19. KB advised if the meeting had been next week (16th March 2020) the Trust would have seen more changes. EM advised she will follow a similar process in developing this risk to that adopted for Brexit. JG advised there is a need for a corporate risk for COVID-19 and from an Exec perspective AB has got command of this on the strategic BAF.	relevant to their area.		
19/20/102	**2.1**	**Minutes of previous Meeting**	In relation to the previous meeting of the Integrated Governance Committee held on 22nd January 2020, the Chair asked for the Committee to check the minutes and notify LC of any changes. The Committee **APPROVED** the minutes as a correct record subject to any changes highlighted by committee members.	Advise of any updates to Jan 20 minutes	All	Asap
	2.2	**Action list**	The Committee reviewed each of the outstanding actions and updates have been included in the Actions Log at the end of the minutes.			
19/20/129	**2.4**	**Corporate Risk Register Review report**	Cathy Umbers (CU) presented the CRR (High Risks). **Summary** The content of this report is based on the information available on the CCR on Ulysses as of 5th March 2020, and is inclusive of all high risks on the register from 1st January to 2nd March 2020. There are currently **7 high risks** on the register. There were no high risks reduced during this reporting period. Two of the high risks reduced during the last reporting period have been increased again i.e. risk 1715, risk 1169 **Risks increased** **Risk 1715 increased to 15** - Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease. (Division of Surgery)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk 1169 increased to 15 - Fragile Medical Workforce within the Haematology Service. (Division of Medicine) CU advised there are no changes since the previous reporting period, in terms of progress with mitigating the 5 high risks that were reported on. However, there was clear evidence of justification for the increase of the 2 high risks (see above) that had been increased again. CU advised the committee that 25% (86) of all risks on the Trust Risk Register across all services and departments are in the high moderate category (risk rating 12). There needs to be a much more focused effort across the Trust on mitigating the high moderate risks. Many of these risks have been on the register for a considerable length of time, with inconsistent evidence on many around progress with actions to demonstrate they have been managed effectively to mitigate the risks. CU advised all staff over the next few months to look at the high moderates and to start working on reducing them, prior to the next reporting period. Revalidation meetings will continue to scrutinise, challenge and provide support as required. **Resolved** that: the Committee NOTED the contents of the paper	High moderate risks to be reviewed and reduced	All	27th May 20
19/20/130	**2.5**	**Board Assurance Framework (BAF)**	Cathy Umbers (CU) presented the Board Assurance Framework on behalf of Erica Saunders (ES) CU advised that there has not been any significant movement on the Brexit risk. Trust Board feels this is currently lying dormant but is continuing to monitor carefully as it is likely start to move again over the coming months			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			CU advised that COVID-19 was discussed at last Trust Board meeting and preparations are in the planning stage. A specific COVID-19 strategic risk is currently in the draft stage with a focus on "sustaining and maintaining clinical and operational delivery during the pandemic, with a purpose of maintaining safety". All strategic risks will include a focus on the pandemic as there is likely to be risk attached to all strategic objectives. John Grinnell (JG) advised of the strategic financial aspects to COVID-19. JG advised there are significant capital investments to consider. The Trust is stocking up on ventilators and PICU equipment, however the guidance at time of reporting remains unclear. The Trust has been advised that all reasonable costs will be reimbursed. JG also highlighted the importance of effective communications during this time and the need to get this right. EM advised PPE consumables and medicines are at the top of the priority list and this is also part of the planning to keep everyone safe. KB asked to meet with JG for a discussion around the Non-Executives and how to best use their skills. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/131		**BAF Deep Dive Report**	Sue Brown (SB) presented the Board Assurance Framework Deep Dive Report 3.1 to the committee on behalf of David Powell (Executive Director). SB advised that Strategic Risk 3.1 – 'Failure to fully realise the Trust's vision for the park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations' is currently sitting at a risk score of 9, with a target score of 6.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			The Alder Centre is in the process of being built. Also a cluster unit for the Community Division is part of the plan to bring the Dewi Jones Unit back on site. There are however, a number of operational campus risks related to this build, but these are being managed. Phase 1 – is the park plan. How fast this is developed will depend on the condition of the ground. With this in mind the park is not expected to be delivered till 2023. Medical Records, the Genetics building and the old boiler house once taken down will give 75% of the parkland to give back to the local council. The Development Team will put plans in place to move staff that are situated in these areas earlier than originally planned to enable this work to commence. SB advised the completion cost plan is £six million, which is over our original estimate. The NE plot has been sold to a developer and the Development Team are working with the developer and assisting with an area for staff accommodation. SB advised that the Development Team are providing assurance on the development plans by reporting into the Campus Steering Group with report updates periodically going to RABD and Trust Board and this report provides information on the current status. The community cluster report is going to RABD to approve all plans. Skills enhancement - Capacity Lab. The Development Team reviewed who has past experience of redesigning / landscaping park land.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			SB advised of the gaps in the plans. The Development Team are working with the reconciled plan versus the budget, full risk quantification and a stakeholder plan in terms of the whole site development. CU asked if the 5 top risks relating to the building were risk assessed and identified on the risk register. SB advised these risks are more around the financial aspect, however recently a different version of the report has been written and all the risks are included in the report to RABD. SB advised that the Development Team previously had the risks on share point, however if you go onto Ulysses all detail is now included on the risk register however, there is no timescale for actions to be completed at this time as this is in the decision making stage at this point. KB advised that it would be good to include certain reports referred to as part of the BAF Deep Dive at Trust Board. SB advised there are considerable issues around timescales and our capacity to present this scheme. The handing back of the park to the Liverpool City Council is very transactional and would be good to have the wider view from the Trust Board perspective. KB advised she will refer this back to Jo Williams, Trust Chair for consideration. The last 12 months the board is really honed in to meet the challenges around budget.	Discuss with J Williams the transactional nature of the park risk	KB	27th May 20
	3.	**Risk Register Management Reviews**				
19/20/132	**3.0**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. • Total number of risks = 56 • Number of new risks identified since the last reporting period = 6 (2080, 2107, 2109, 2110, 2111, 2112)			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks closed and removed from the risk register = 11 (722, 1551, 1731, 1816, 1878, 1914, 1965, 1985, 2022, 2025, 2052) • Number of risks with an overdue review date = 5 • Number of risks with no agreed action plan = 3 • Number of risks with changed risk scores = 11 (8 increased, 3 decreased) • Number of high/extreme risks escalated to the Executive Team = 2 (1715, 1984) both familiar to the IGC committee • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = There has been a significant reduction in the number of High Risks (15+) from 7 at the end of October down to 1 at the end of December 2019. **High risks with a score of 15+** **Risk no 1715 risk rating (15):** Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease. This risk was reduced initially however has increased back to a 15. IM&T are working on a solution. They are looking at a system that provides crystal clear images. **Risk no 1984 risk rating (15)**: Delays in children being able access cardiac treatment, and delayed step downs from critical care meaning that this capacity is not available for other patients. Following discussion, CU questioned if risk no 1984 continues to happen. AM advised there are still cancellations however this risk has now been realised and the flow out to 1C is still an issue. Last week was a very good week but every week is different due to a number of factors. CU stated this risk has been fairly long standing, with very little evidence of progress to mitigate, is it likely this risk will continue			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			to be high in the longer term? AM advised there is a working group in place and the group is looking at what can be done in the short term to reduce the risk in cardiac services. KB asked for more detail of what was being done to achieve the outcome from actions to mitigate this risk. JG advised the services are really challenged and have we all got a line of sight on capacity changes? AM advised there are daily challenges around this service and the actions currently in place are what the division can do realistically to keep the service safe. CU advised there is 1 action identified on the register currently, which is short term. AM advised the service is looking at challenges around areas. Cancelling operations on day of admissions is something the service has had to resort to to minimise the risk, however the service has completed a lot of work to ensure patients are kept safe. However, month by month this does vary which is a poor experience for families. There is a risk to outcome delay and some cancellations are connected to COVID-19. JG advised he is happy to hold an exec decision around this. **New risks** **Risk no 2080 risk rating 6:** Potential cancellation of cases due to ENT Theatre chair not being available. **Risk no 2107 risk rating 8:** Burns Unit Staffing – Patient safety and delivery of care. **Risk no 2109 risk rating 6:** Urology patients will not be seen when required and could have poorer outcomes as a result. **Risk no 2110 risk rating 9:** Cancellation of children's procedures on the day of their scheduled admissions.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 2111 risk rating 8: Clinical information not being available to make decisions (Gait Lab). **Risk no 2112 risk rating 6:** Medical Illustration – 1. Meditech Referrals not showing up in PACS. 2. Downloading images from PACS is unreliable. AM advised that the Surgery Division have reduced 7 risks in Theatre & Anaesthetics from discussions in the division, and 53 out of 56 risks have action plans in place. AM advised that the Surgery Division risk register is in a good position however on-going work is required. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/133	**3.1**	**Medicine Division**	Cathy Wardell (CW) presented the risk management report for Medicine. • Total number of risks = 81 • Number of new risks identified since the last reporting period = 3 (2089, 2095, 2099) • Number of risks closed and removed from the risk register = 13 (720, 1294, 1677, 1812, 1943, 1143, 1977, 1120, 1972, 1794, 1098, 1070, 1979) • Number of risks with an overdue review date = 2 • Number of risks with no agreed action plan = 1 (1835) • Number of risks with changed risk scores = 17 (4 increased, 13 decreased) • Number of high/extreme risks escalated to the Executive Team = 1			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			(1169) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **High risks** **Risk no 1169 risk rating 15 "Fragile Medical Workforce within the Haematology Service".** There have been lots of mitigations over the last few years with this risk. The current position is a shortage of haematology consultants. A Locum Consultant is developing a role between Alder Hey and Royal Liverpool University Hospital and this has helped mitigate this risk; however it is still a high risk and is being monitored closely. CW advised there is now a risk & governance support within the team and the division can see the positive impact the new person is having on the risk management position. **New risks** **Risk no 2089 (risk score 10) -** Scope for inappropriate antibiotics to be prescribed for other patients as not all patients with a multi-resistant organism have a special indicator (alert) on Meditech, therefore appropriate prompts are required within Meditech to aid with the process of prescribing the appropriate antibiotics. **Risk no 2095 (risk score 12) -** Unable to provide consultant cover for LTV patients in-hours. CW advised the risk is a small number of consultants covering in-hours LTV service with high risk of reduction in the service due to planned retirement of a consultant. Lack of expert advice leading to inadequate clinical care and deterioration of LTV patients. The service needs 1 full-time consultant.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 2099 (risk score 12) – Transition of young people with complex neuro disabilities to adult services. Clinically the work being delivered mitigates this risk however there is a financial risk associated with this cohort of young people remaining in paediatric care past their 18th birthdays. **<u>Risks with a changed risk score</u>** CW advised there are 17 risks with a changed risk score; 4 increased and 13 decreased. CW advised that most of the risks in the Division are within the clinical areas and 1% of risks have no agreed action plan, however risk management is much more embedded. CW advised that there is still a lot of work to complete in the Medicine Division, however is confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/134	**3.2**	**Community Division**	Sarah Stephenson (SS) presented the risk management report for Community. • Total number of risks = 43 • Number of new risks identified since the last reporting period 5 (2096, 2097, 2108, 2113, 2114) • Number of risks closed and removed from the risk register = 6 (1879, 2023, 1997, 1777, 1656, 1865) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 3 (decreased 1579,			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			1987, 1131) • Number of high/extreme risks escalated to the Executive Team = 2 (1131, 1270) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 1.(1131) – Potential for incorrect treatment and management for patients in the Community and Mental Health Division – related to the scanning of paper records decreased from 16 to 12. **<u>New risks</u>** **Risk no 2096 risk rating 6 – Until validated, unable to confirm if any patients are still waiting an appointment or have come to any harm.** Open referrals migrated over from Meditech 5 to Meditech 6 in a status of TBS (To be Scheduled) that require validation to confirm linked activity and correct referral status - oldest referral 03.07.91. Referrals being logged straight into a status of TBS (to be scheduled) and users not booking or pending an appt/notifying the relevant team that an appointment is required. Validation of patients in a status of TBS to be completed by end of March. **Risk no 2097 risk rating 12 – Clinical activity will be unable to grow in Outpatients**. Lack of clinic room availability for permanent Outpatient clinics. Current systems in place to manage clinic rooms unable to identify capacity to start new clinics. Clinic mapping being updated through clinical room audit of all OPD floors. SS advised one of the challenges is that capacity looks full but this is not the case. Technology is needed to know if the clinic rooms are full. CU advised for this issue to be risk assessed and associated risks to be identified on the risk register. **Risk no 2108 risk rating 12 - Risk of frustrated and dissatisfied**	Add to the risk register the need for a system to record the capacity of the clinic rooms.	SS	27th Mar 2020

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			parent(s)/guardians unable to make contact with Developmental Paediatrics. (Community Paediatrics). Lack of resource (people & process) within the Division to respond effectively to level of demand of phone calls from families. Due to high demand, families are not always able to reach the service by telephone. An initial audit of the calls received has been completed. Meeting to be arranged with IT to discuss systems available to improve responsiveness and business case being developed. **Risk no 2113 risk rating 12 - Risk of delayed diagnosis or treatment.** (Outpatients). Lack of assurance of function of POD system from Outpatients to the Laboratory. Clinical guideline in place but assumes a fully functioning POD system. Discussed at Patient Safety Meeting – a review of the POD system has been requested. SS advised this risk relates to the ADHD service. Transition of patients to Liverpool adult service by the end of March 2020 will reduce this risk significantly. The Division is looking at some investment from Liverpool CCG and planned trajectories. There are a lot of controls in place and it's just a timing issue of transition. **Risk no 2114 risk rating 9 - Capacity for phlebotomy provision for Outpatients clinics could be reduced in the event of high unforeseen GP demand.** (Phlebotomy). Unable to foresee or plan number of direct GP referrals for phlebotomy. Rotas in place, but due to varying clinical activity these can change. There are not enough GP slots to always meet the demand. Awaiting feedback following a meeting with the CCG to discuss potential options. **<u>Decreased Risks</u>** **Risk no 1579 decreased risk rating 6-4** - **Speech Therapy Waiting Times**. Sefton - Sefton SALT waiting times are reported in excess of			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			24 weeks in Sefton Speech therapy. Decreased in view of reaching expected 18 week longest wait trajectory prior to target of end March. **Risk no 1987 decreased risk rating 12-9** - **Not being able to progress improvements in the phlebotomy service.** Unable to progress with electronic solution for GP's to request blood tests for their patients due to prolonged testing period of the ICE system. Decreased following a review of the controls. **Risk no 1131 decreased risk rating 16-12 - Potential for incorrect treatment and management for patients in the Community and Mental Health Division (Community Division – Division Wide).** Large quantity of paper records in departments across the Division which are not yet scanned. Decreased following recommencement of CAMHS scanning January 2020. SS advised there has been a lot of work with IM&T to get processes in place and actions to support reduction. SS advised the committee that the Division are confident they are effectively managing the risks for Community and Mental Health, while recognising there is ongoing work required. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/135	**3.3**	**Research Division**	Jason Taylor (JT) presented the risk management report for the Research Division. • Total number of risks =8 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New risks** **Risk no 2094 risk score 6** - **Failure to comply with clinical trial regulations.** This issue is caused by a reduction in study audits that monitor local compliance with regulations. Recruitment of a QA Officer is underway to mitigate. JT advised the low & moderate risks comply with our case studies. We are nearly 100% bigger as a Division that where we were 3 years ago. JT advised that Clinical Research is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/136	**3.4**	**Infection Control Service**	Jo Keward (JK) presented the risk management report for Infection Prevention and Control. • Total number of risks = 7 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks</u>** **Risk no 2051 risk score 15** - Insufficient appropriately trained staff to care for patients admitted to the Trust with a suspected High consequence Infectious disease (HCID) **Risk no 2081 risk score 15 -** Staff developing HCID infections whilst delivering care to paediatric patients on the Infectious Diseases Unit at the Royal Liverpool Hospital. Jo Keward (JK) advised infection Prevention & Control will be adding a risk around COVID-19 for admittance not around ordering of stock etc. **<u>Closed risks</u>** **Risk 1919 Closed** - Failure to reach 80% compliance with front line staff influenza vaccination in 2019-20. This risk was closed as we have now met the 80% target. JK advised all risks have agreed action plans in place with no changes in profile and none to be brought to IGC's attention. Going forward, the IPC Team will be developing new risks. CU advised to be mindful not to have duplicated risks. In relation to influenza - will there be 2 risks one for a risk around influenza and patients and the other around influenza and staff? This will be 2 separate actions. JK advised IPC are satisfied with management of risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/137	**3.5**	**Facilities**	Mark Devereaux (MD) presented the risk management report for Facilities. • Total number of risks = 10 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Risk no 1470 risk score 12 –** Delayed response to major incident by staff that don't carry a bleep. MD advised this risk is linked to **Risk no 1921 risk score 15 –** Delay in patient care if a bleep fails**.** MD advised he is working with Leanne Fearnehough to reducing this risk but not for major incidents, this needs to be discussed. **Risk no 1103 risk score 12 – Inappropriate storage of beds in clinical and public areas.** This risk has been an issue for some time now and is around the storage of beds safely and identifying areas to store the beds, however staff are pushing beds out of wards causing an obstruction. There is no physical area to store these beds due to lack of storage. CU advised this risk needs to be reassessed and escalated if no evidence of progress to mitigate, as this risk has remained at high moderate for a number of years and there is no evidence of progress. A working group needs to be formed to look at this risk and include Estates and the Nursing Leads.	Risk no 1103 a working group to be set up to look at safe storage of beds and invite Estate, Chief Nurse and Nursing Leads	MD	27th Mar 2020

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			MD advised there are no changes since last reporting period and all risks are within review date and Facilities are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/138	**3.6**	**IM&T & Part 2 Global Digital Excellence**	Dean Eyres (DE) presented the risk management report for IM&T. • Total number of risks = 19 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 5 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 2 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New and closed risk** **Risk no 2024 Closed** Patients with Diabetes not being flagged upon admission. New process put in place to address this. Lead Clinician confirmed happy to close the risk. **Changed risk scores** **Risk no 947 risk rating decreased from 16-12 -** MEDITECH system resilience - reduced to 12 – Meditech system now backing up to a secondary location on site at the main hospital to give greater resiliency. **Risk no 1187 risk rating decreased from 16-12 –** New infrastructure currently provisioned on site at the main hospital so would allow for a			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			resilient solution to restore to in the event of a primary failure. **<u>Closed risks</u>** **Risk no 1347** – Data not saving correctly on the MEDITECH system **Risk no 1624** – Delivery of specialty packages impacting on GDE milestone. **Risk no 1962** – Risk of not delivering on closed loop medication verification. **Risk no 1792** – Windows 10 / ATP licensing risk. **Risk no 2024** Patients with Diabetes not being flagged upon admission in place. (as above) DE advised that all IM&T risks have been reviewed and are within review date. Risks at risk score 12 will reduce further. Diabetes and IM&T issues have been resolved and closed. DE advised that IM&T have improved greatly and have had a thorough review of the risk register and are comfortable with their current position. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/139	**3.7**	**Human Resources**	Sharon Owen (SO) presented the risk management report for Human Resources: • Total number of risks = 7 • Number of new risks identified since the last reporting period = 3			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			(2085, 2100, 2090) • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention IGC = 0 **New risks** **Risk no 2085 risk rating 4 -** HR do not own establishment data so are unable to report on accurate vacancy information. **Risk no 2100 risk rating 9 –** High levels of sickness absence impacting on staff availability to deliver patient care. **Risk no 2090 risk rating 9 -** We currently have a proportion of our staff who do not have a DBS in place due to the length of their employment and a number of staff who do not have an up to date DBS on file from the past 3 years. SO advised there has been a roll out for staff to complete their DBS. KB asked that for future reports could HR give an update to the new and closed risks. SO advised that the Human Resources are showing 100% compliance and are happy with progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/140	**3.8**	**Finance**	John Grinnell (JG) presented the risk management report for Finance.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 5 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 (decreased) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 JG advised that there was duplication of risk with supply chains and the duplication was closed. JG advised the committee that the Finance department have no overdue and no risks without agreed action plans and is 100% compliant at this point with the risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/141	**3.9**	**Building Services & Estates**	Graeme Dixon (GD) presented the risk management report for Building Services. • Total number of risks = 9 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 2 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks with a score of 15+</u>** **Risk no 1388 risk rating 20 – "Pipe corrosion"** GD advised there was discussion at the Liaison Committee with Exec attendance. Testing commences on the 30th March 2020. GD advised this is a piece of work being completed by SPV which should be finished by June 2020. Repairs will be completed if located and a report will be produced which GD will report back to the IGC Meeting on the 22nd July 2020. **Risk no 810 risk score 12** – Manual handling/MSD injuries to staff as a result of heavy doors within CHP. GD advised the majority of the doors have now been repaired and risk has been reduced. **Risk no 1978 risk score 12** – Patients and staff left vulnerable due to lack of specialist Fire Safety Advisor. GD advised Estates are interviewing staff to fill this post and in the interim John Spark, (previous Fire Safety Officer) has come back to the Trust to complete fire assessments so this risk is mitigated. **<u>On-going risks</u>** **Risk no 1958 risk score 12** – Defect in the roof of HDU/PICU building leading to water ingress into the Critical Care Unit. GD advised that Project Co will begin to repair the skylights. The work is to commence March 2020. **Risk no 825 risk score 10** - Internal Balconies – horizontal handrail facilitates climbing, risk of potential fall from balcony. Near miss with patient escaping from ward. KB advised that the balconies were			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			discussed at the last RABD meeting and a conclusion needs to be reached by the next RABD meeting on 25th March 2020. **Risk no 941 risk score 8** – Drug rooms have the potential to overheat above expected temperatures and therefore can cause drugs to become unusable due to the high temperature. GD advised this is a duplicated risk on Pharmacy. Paul Sanderson to discuss this with Stuart Atkinson. GD advised all risks are within review date and Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/142	**3.10**	**Development Directorate**	Sue Brown (SB) presented the risk management report Development Directorate. • Total number of risks = 14 • Number of new risks identified since the last reporting period = 6 (2101, 2102, 2103, 2105, 2106, 2116) • Number of risks closed and removed from the risk register = 5 (1957, 1956, 1879, 1318, 1574) • Number of risks with an overdue review date = 2 (now updated) • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 2 (Increased) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New risks** **Risk no 2101 risk rating 9 – The landscaping and perimeter wall**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			to the Alder Centre build will not be delivered in line with the commissioning planned date. **Risk no 2102 risk rating 9 – Reduction in staff morale and resistance to change.** **Risk no 2103 risk rating 12 – In adequate space for the storage of medical records.** SB advised the medical records storage area, when moved, will reduce 500 square metres. The division has a 6 months lead to complete the reduction in notes from hard copy to digital and this will be finished around Aug 2020. **Risk no 2105 risk rating 9 – Delay to demolition phase 3.** **Risk no 2106 risk rating 12 – The planned delivery date for the Clinical Hub and Dewi Jones Unit build could be delayed by 3 months.** SB advised regular dialogue and weekly meetings to ensure the contract discussions are completed during April 2020. This risk should come down as we believe the work is to be completed by 2023. **Risk no 2116 risk rating 6 –** Contaminants in site land due for redevelopment as park will be disturbed and cause health issues for contractors and others working or living hear the site. **<u>Increased risks</u>** **Risk no 1948 risk increased to 9** – Work with Architects to find the best solution that maintains the GIFA whilst not compromising clinical space. **Risk no 1955 risk increased to 6** – Persons with mobility issues may			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			not be able to evacuate the Institute building in a speedy manner thus endangering lives. KB asked of **risk no 1412** contract with Universities to support RE phase II not yet signed. Is the Trust any closer to signing the Universities up? SB advised that yes we are very close to having the contract signed. SB advised that the Development Directorate risks continue to reduce as progress is made, risks have been reduced within this reporting period, and the Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/143	**3.11**	**Health & Safety**	The risk management report for Health & Safety was presented as follows: • Total number of risks = 7 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 2 (799, 1386) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>Update on realised risks</u>** **Risk no 809 risk rating 8 – "Welfare Regulations – Retained Estate**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Blue light road – working group established and have met to discuss hazards/works and mitigations required in order to reduce the current risks. Estates have employed the service of a traffic management consultant to survey and feedback. In the interim, works agreed to reduce some the hazards identified are in the process of being commissioned. Poor lighting on retained estate – this has recently been resolved with installation of flood lights across key areas on the retained estate. There was a leaking roof of the Catkin building – Estates have commissioned contractors to survey the roof to ascertain the issues with a view to repairs being effected. This has now been resolved. **<u>Transferred and closed risks</u>** **Risk no 799 risk score 12** – **control of contractors** has been transferred to Building Services **Risk no 1386** – **Lift entrapment in CHP**. AK advised the work has now been completed and the risk is closed Manual handling is at 84.9% and need to achieve 90%. Areas non-compliant are staff who work the night shift and there is a block of staff in Surgical Division there are 190 staff not compliant, altogether there are 200 staff members not compliant in all. CU advised for the staff nurses who are non-compliant speak to the Chief Nurse or the Director of Nursing as staff need to be released to complete the training. The training session will take 10-15 minutes and the trainer will work around the staff to provide training sessions. **Risk no 1856 risk score 9 – Undertaking of risk assessments across the divisions.** AK advised environmental risk assessments are not happening in a timely manner, but plans are in development to	Speak to the Chief Nurse about nursing staff non-compliant in mandatory manual handling training	AK	27th May 2020

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			address. There has been some engagement from the Divisions as they need a strategy to take this forward and the plan will depend on how well the Divisions engage with this process. **Risk no 1863 risk score 9 – Inability to conduct Health & Safety Internal Audits**. AK advised the divisions are monitoring and reviewing H&S risks and reporting compliance at divisional governance meetings. Cannot undertake audits or internal inspections due to inadequate resource in the H&S Team. Issue of H&S specialist assessments requirement for complex needs. Recruitment has taken place for H&S Advisors. There is a big piece of work happening around this. AK & MS are still in conversations about the assessments as it's a complex plan. Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Draft plan regarding conducting H&S audits to be presented to next IGC	AK	27th May 2020
19/20/144	**3.12**	**Business Preparedness & Emergency Planning**	Elaine Menarry (EM) presented the risk management report for Business Preparedness & Emergency Planning. • Total number of risks = 7 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 4 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Closed/transferred risks **Risk no 1630** - Cyber Attack Action Card – risk transferred to IM&T **Risk no 1895** - Meditech Unplanned Downtime – risk transferred to IM&T **Risk no 1435** – **Closed.** Electronic Major Incident Booking in System – risk closed and risk referenced on the Emergency Dept. risk register risk no 2065 **Risk no 1377** – **Closed.** Up to date Large Scale Burns Plan – Plan updated and approved at the Emergency Preparedness Group. EM advised that since January 2020 the Tactical and Strategic Command arrangements have been formed and the Trust has been holding planning meetings in response to COVID-19. NHS England and Improvement published a 'preparedness and response' letter dated 2nd March 2020 and some of the key requests are: • Incident Management Team is set up functioning 7 days per week with a 24/7 single point of contact, along with processes for returning situation reports required nationally. • Ensuring PPE and ventilator equipment stock and management arrangements are in place and understood through the organisation. • Review business continuity arrangements to ensure business critical services are maintained. • Clearly identify how the Trust will implement the segregation of clinical areas in emergency depts. (ED), wards, critical care and diagnostic and intervention suites to support in the event of significant escalation in COVID-19 cases. • Tactical and Strategic command meet daily to discuss COVID-19.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			EM advised all risks are within review date and Business Preparedness & Emergency Planning is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/145	**3.13**	**Information Governance**	Cathy Umbers (CU) presented the risk management report for Information Governance. • Total number of risks = 7 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 1 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 **Risk no 1753 risk rating 8** - the risk compliance and providing evidence for the Data Security & Protection Toolkit has had the risk lowered from 9 to 8 as there has been more engagement from IT. There is a new Security Contractor in post who has dedicated support for IT around many of the risks for Toolkit areas that include Information Asset Management, this contract will end on 29th May when the risk will need to be re-evaluated. **Risk no 1892 risk rating 12** - IG Training compliance figure is required to be at 95% to enable the Trust demonstrate compliance with the Toolkit. The Trust was given a 6 month reprieve to reach this target. Additional methods are available to staff including an extra 70 face to face sessions and two ways of accessing online training.	Send to managers a list of the staff who have not completed the	S Owen	27th May 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Despite this the compliance is currently 90% and is 5% below target. Managers have been emailed and urged to send staff to training where they are non-compliant or due to reach this. All Divisions need to ensure that their staff are up-to-date with this mandatory training. CU advised as the trust is at 90% compliant, there is a need to keep pushing staff to complete the training otherwise will fail the Toolkit and the deadline is the end of March 2020. KB asked is there anything we can do to get this over the line of compliance? HR has a list of staff names who are non-compliant. Sharon Owen will do a refresh of the list and send out to staff and managers. **Risk no 1492 risk rating 12 -** Recording more than one address remains an issue, but there are actions in place to address. **Risk no 1613 risk rating 9 –** Adoption Policy processed. **Risk no 1828 risk rating 12 -** Data flow mapping the data flow mapping tool was revised to make it simpler and sent to all managers again in February 2020 with deadline of 6 March for response. Managers were contacted with an offer of help with the mapping from IG Officer and there has been some take up. CU advised this is mandatory and essential that is it completed. **Risk no 1893 risk rating 9 - Information Asset Register -** completion of the register is included in the data flow mapping exercise. There remains a necessity for updated training to be made available to IAA and IAOs around responsibilities and expectations. **Risk no 1893 risk rating 12 -** The accuracy of data from the National Spine remains a continuing risk. However this is outside the Trust control and there are internal mitigations in place to minimise the risk	mandatory IG training Follow up with Managers who have not completed the Data Flow Mapping Tool	S Crutchley	27th May 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			as far as possible. **Risk no 1903 – Fax machines** – KB asked have we set a deadline for this work to be completed? Who is taking the lead? CU advised in the absence of a representative from Information Governance she will speak to ES. CU advised the Committee that good progress has been made with managing the IG risks and IG and are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper	Risk 1903 speak to ES	CU	27th Mar 2020
19/20/146	**3.14**	**Medicines Management & Pharmacy**	Paul Sanderson (PS) presented the risk management report for Medicines Management & Pharmacy. • Total number of risks = 12 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of overdue actions across all risks = 2/25 • Number of risks with changed risk scores = 2 (1924, 941) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 1 (1924 national incident related to supply of parenteral nutrition for home patients decreased score 5) **Reduced risks** **Risk no 1924 risk rating 10 to 5 –** "Interruption to supply of			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			outsourced parenteral nutrition" PS advised this risk reduction is based on no clinical incidents since Aug 2019. **Risk no 941 risk rating 12 to 8 – "**Ambient temperature of medicine storage rooms at ward level". PS advised the Committee, Medicines Management & Pharmacy recognise that, while ongoing work is required, good progress has been made to date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/147	**3.15**	**Marketing & Communications**	Cathy Umbers (CU) presented the risk management report on behalf of MF for Marketing & Communications as follows. • Total number of risks = 3 (806, 807, 808) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 CU advised there were issues with the team not being able to access the Ulysses system; however this has now been rectified and Mark Flannigan will review the risks and identify any new risks prior to the next reporting period.	Review the Marketing & Comms risks following resolution of	MF	27th May 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper	system issues		
19/20/148	**3.16**	**Innovation**	Souhila Serir (SS) presented the risk management report for Innovation Dept. • Total number of risks = 5 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 SS advised there are no risks overdue review for the Innovation Dept. and are satisfied with management of risks. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/149	**3.17**	**Change Programme**	Natalie Deakin (ND) presented the risk management report for the Change Programme. • Total number of risks = 19 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 4 • Number of risks with an overdue review date = 1 • Number of risks with no agreed action plan = 1 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			need to be brought to the attention of IGC = 0 Risk no 1985 – policy not secure of funding Risk no 1322 – closed Risk no 1992 – Inspiring quality programme. The risk no longer to be reported on. ND advised there are no changed risk scores for this reporting period this was a typo in the Risk Management Report that was submitted. KB asked going forward can the Change Programme risk management report include more detail on the nature of the new and closed risks to give more understanding. ND advised the Committee that the Change Programme risks recognise that while ongoing work is required, good progress has been made to date. **Resolved** that: the Committee NOTED the contents of the paper	Include narrative on the nature of new and closed risks	ND	27 May 20
19/20/150		**National Data Opt Out – Trust Standard Operational Procedure**	CU advised the committee that the National Data Opt Out – Trust Standard Operational Procedure is a new procedure and has been approved via the Information Governance Steering Group. **Resolved** that: the committee RATIFIED the procedure			
19/20/151		**Food Safety Policy**	Steve Le Cout (SL) has updated the policy and outlined the changes. SLC advised there has been 4 minor changes to version 4 of the Food Safety policy and it has been approved via the Health & Safety Committee.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the committee RATIFIED the policy			
19/20/152		**Safe Haven Policy**	CU advised the committee of the policy changes and advised that the Safe Haven Policy has been approved via Information Governance Steering Group. **Resolved** that: the Committee RATIFIED the policy			
		Meeting Effectiveness Review	No specific discussion.			

Alder Hey Children's NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST COMPLETED

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
18/19/124	Risk no 1131 - Process for scanning and archiving clinical notes within Community Division. Scanning turnaround times for outpatient records have reduced from 32 days in September to 9 days in October. However, scanning turnaround times remain too long for inpatient records.	The scanning of notes is a Trust wide issue. The rapid scanning has been arranged and the outpatient's service is now complete. Rapid scanning have not brought back what the plan will look like going forward. This is a corporate Trust wide issue and may fall under Kate Warriner, Chief Digital Information Officer.	A Bateman	29th Nov19	11th March 2020	The Trust is going to extend the outsourcing of outpatient records with the internal records switching their focus to the inpatient backlog.
Chairs Intro	Risk management report template	Add in section on report template for update of outstanding action/s	CU	22nd Jan 19	19th Feb 2020	This was added in to the report and sent out to the committee members.
19/20/87	Risk no 1919 – Failure to reach to 80% compliance with staff influenza vaccination.	JK advised IPC have now reached 80% compliance and 2 new risks are to be added to the risk register - staff and influenza and patients and influenza.	JK?	11th Mar 2020		
19/20/92	Risk no 1388 - Corroded pipework	Arrange another meeting with Project Co. LC to speak to AG	LC	22nd Jan 20	5th Dec 2019	This will be on the agenda at the Exec to Exec meeting Jan 2020.
Chairs Intro	Risk register – Divisions and Corporate Functions	Risks on risk register ensure as up to date as possible and email CU to confirm completion.	All	22nd Jan 19	10th Feb 2020	Confirmed during the meeting that most risks are up to date.

Alder Hey Children's NHS Foundation Trust

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
19/20/54	Should there be a BAF Report on Pensions & Tax?	MS to add a risk for Pensions & Tax to the BAF. This has now been added to the risk register.	M Swindell	22nd Jan 20	9th Mar 2020	Report presented to Board 3rd Jan 20.
19/20/89	Risk management report	To include detail of any on-going work that is being completed by IT in the RM report.	CF	22nd Jan 20	9th Mar 2020	

Alder Hey Children's NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST OUTSTANDING

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
Chairs Intro	IGC Risk Management Reports – graphs.	Axis on graphs to incorporate whole numbers and not decimal points.	All	All future meetings		
Chairs Intro	New front cover sheet	Tick only the Strategic Objectives relevant to your division/corporate function	All	22nd Jan 19		
19/20/83	Risk Management Reports	Include in the "Risks Escalated to the Corporate Risk Register" table for each risk: • the long term actions and associated plans with expected dates for completion • the short term actions that are providing short term mitigation • when the risks are expected to reduce • Please ensure all actions are SMART and there are consistent progress updates included on the risk assessments. Whole numbers on graph axis (no decimal points) and some graphs have no axis on them.	All	9th March 20		

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
		• On the cover sheet tick strategic objectives only relevant to their area				
19/20/83	Risk no 1881 (risk rating 12) No reception staff, parents will attempt to gain access by either tailgating or using the door release button under the desk.	GD advised that work is due to commence shortly. The new desk has not been installed yet due to changes to a specification. Risk has been decreased to a 12. GD to provide an update at the next IGC Meeting.	A McColl	22nd Jan 20		
19/20/74	Risk 1893 Information Asset Management Tool. Need to discuss this area with IT as there is no funding available for tools which will prevent Information Asset Management from moving forward.	Speak to IT about funding available for tools and will report back to next IGC.	E Saunders	29th Nov 19		
19/20/84	Risk no 1169 Fragile Medical Workforce within Haematology Service	Reword title of the risk as it's a recruitment issue rather than fragile workforce	Adrian Hughes	22nd Jan 20		
19/20/94	Risk no 799 – Failure to control contractors on site (CHP) & Retained Estate.	ES & MS to speak about Control of Contractors Policy outside of IGC meeting.	ES/MS	22nd Jan 20		Update - risk has been transferred to Building Services
19/20/97	New risks	All new risks to include more details and information to enable readers to understand the risk	All	All future Meetings		

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
19/20/102	IGC minutes 22nd January 2020	Committee members to check the minutes and advise of updates	LC	27th May 20		
19/20/129	High moderates in the risk register	All high moderates to be reviewed and reduced.	All	27th May 20		
19/20/131	BAF Deep Dive Report – 3.1	KB to discuss with Jo Williams the transactional nature of the park.	K Byrne	27th May 20		
19/20/134	Capacity of clinic rooms	Add to the risk register the need for a system to record the capacity of the clinic rooms.	S Stephenson	27th May 20		
19/20/136	Add a risk to Infection Control Risk Register	Add risk around COVID-19 for admittance of transmitting not around ordering of stock etc	J Keward	27th May 20		
19/20/137	Risk no 1103 – Inappropriate storage of beds in clinical and public areas	A working group to be set up to look at safe storage of beds and invite Estate, Chief Nurse and Nursing Leads	M Devereaux	27th May 20		
19/20/143	Manual Handling Training non-compliance Risk no 1863 – Inability to conduct Health & Safety Internal Audits	Speak to the Chief Nurse about nursing staff non-compliant in manual handling training Draft plan regarding conducting H%S audits to be presented to next IGC	A Kinsella	27th May 20		

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
19/20/143	Risk no 1863 – Inability to conduct Health & Safety Internal Audits	Draft plan to be presented to next IGC meeting regarding conducting H&S audits	A Kinsella	27th May 20		
19/20/145	Risk no 1903 – Fax machines	Speak to Erica Saunders for an update on removal of fax machines	C Umbers	27th May 20		
19/20/145	Risk no 1892 – IG Training compliance figures	Send to managers a list of the staff who have not completed IG training	S Owen	27th May 20		
19/20/145	Risk no 1828 – Data flow mapping tool	Follow up with Managers who have not completed the Data Flow Mapping Tool	S Crutchley	27th May 20		
19/20/147	Marketing & Communications Risk Register	Review the Marketing & Comms risks following resolution of system issues.	M Flannagan	27th May 20		
19/20/149	Change Programme Risk Management Report	Include narrative on the nature of new and closed risks.	N Deakin	27th May 20		

Alder Hey Children's NHS
NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 11th May 2020**
Via Microsoft Teams

Present:	Mrs S Arora	Non-Executive Director (Chair)	(SA)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs C Liddy	Director of Operational Finance and Innovation	(CL)
	Dr F Marston	Non-Executive Director	(FM)
	Mrs K Warriner	Chief Information Officer	(KW)
In Attendance:	Prof I Buchan	Appointed Governor (External Advisor)	(IB)
	Mr M Flannagan	Director of Communications	(MF)
	Mr. J. Hague	External Advisor.	(JH)
	Mr I Hennessey	Clinical Director of Innovation	(IH)
	Mrs E Hughes	Assoc. Chief Innovation Officer	(EH)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mrs. N. Murdock	Medical Director	(NM)
	Prof. M Peak	Director of Research	(MP)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Apologies:	Mr Mark D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr R Guerrero	Clinical Director of Innovation and Consultant Congenital Cardiac Surgeon	(RG)
	Mrs L Shepherd	Chief Executive	(LS

20/21/03 **Apologies**

The Chair noted the apologies received from Marc d'Abbadie, Rafael Guerrero and Louise Shepherd.

20/21/02 **Declarations of Interest**

The Innovation Committee noted the declaration received from Fiona Marston in relation to her association with CEIDR.

20/21/03 **Minutes of the previous meeting held on 17th February 2020**
Resolved:
The minutes from the meeting held on the 17th of February 2020 were agreed as an accurate record of the meeting.

20/21/04 **Matters Arising and Action log**

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Action 19/20/24: *Innovation Limited Update (Acorn update)* **–** It was confirmed that this item is in progress and updates will be provided going forward.

Action 19/20/25 – *Innovation Performance Report (update on projects that will be continuing in the new financial year)* – Claire Liddy will provide an update under the relevant agenda items. **ACTION CLOSED**

Action 19/20/34: *Asthma Wearables (update on patent and data protection)* – This action relates to a previous product portfolio. It was agreed to roll this action over until a later date.

19/20/34 – *Working and Learning (plan to operationalise how aps will be deployed and managed)* – This action relates to a previous product portfolio. It was agreed to roll this action over until a later date.

Action: *Immersive City Building Business Case* – This business case has been delayed as a result of the Covid-19 Emergency Plan. The Project Plan is to be re-set and an update will be provided during July's meeting.

20/21/04.1 **Action: CL**

20/21/05 **Covid-19 Response Summary**

The Committee received an update on the Trust's innovation response to Covid-19. A number of slides were shared with the Committee and the following points were highlighted:

- A decision was made to repurpose the Innovation Team in order to focus on Covid-19. Projects were paused other than those that were supporting the crisis. The Innovation Strategy was accelerated to open the Innovation Portal, links were established with partners in LCRA and where possible projects took place in association with the Research Team.
- During the last eight weeks the Innovation Team has focussed on three areas of work in respect to Covid-19 problem solving; innovative sourcing/ rapid proto-typing, rapid digital improvement and commercial opportunities. The impact of this has helped improve safety in the hospital, improve the experience of patients and staff and improved operational efficiency.
- The Committee was advised of the rapid digital improvements that have taken place during the last three weeks along with the commercial opportunities as a result of sourcing and prototyping:

  - ***The Distancer*** – The Innovation Team is working in partnership with 3D Life Prints on a simple low-cost 3D printed handheld device which helps reduce the risk of contamination when moving through buildings. This could result in a 50% revenue share for Alder Hey, subject to contract.
  - ***ICL Visor*** – The Innovation Team has produced a visor that is now available to the NHS, UK wide. The Trust is in the process of negotiating a revenue share for the licence of this product. It was agreed to provide an update on this matter during July's meeting.
    Action: CL
  - ***Hygenie Project*** – The Committee was advised of the equity in this project which has been part funded by venture capital money. Due to the hand washing capabilities of this product, a touch version of the product is being fast tracked with tests concluding by June 2020. The product will track hand hygiene compliance ward by ward and improve management information.

- *Improving Patient Safety* – Work has been taking place on the development of Tele Health to keep patients safe via the use Telemedicine. On the 2nd of April the first virtual ward round between Alder Hey and the Liverpool Women's Hospital took place, along with virtual visiting (screen2screen).
- Attention was drawn to the benefits of the virtual assistants that have been implemented to respond directly to questions 24/7 thus reducing the demand on Community and Operational Teams to answer queries, and the Team Trak app and PPE app.
- *Innovative Solutions Portal* – Alder Hey's Innovation Centre has developed a new online portal for sourcing innovative alternative healthcare supplies and solutions to urgent healthcare challenges. It was reported that Alder Hey are

collaborating with Cheshire and Merseyside around a portal that can be used nationally.

- *Artificial Headquarters (AI HQ)* – The Trust has intentions of opening an AI HQ; which will include Business Intelligence power apps. This is a goal for 2020 which will be a post Covid-19 legacy.
- *Reflections* – The Team has reflected upon three important key areas that have progressed as a result of the Covid-19 crisis. It was pointed out that the Team has been able to test their skills in respect to rapid problem and design thinking, influence existing partnerships from an innovation perspective, for example, Liverpool City Region Head of Procurement Networks are looking toward Alder Hey as experts to progress new projects, and engaged with clinical business units in a positive manner e.g. the Team have participated in the NHS X Project and accelerated it to transform the CAMHS pathway.

The Chair commended the Innovation Team for the fabulous work that has taken place over such a short period of time.

A query was raised around the ranking of innovations in terms of schemes and their impact. Claire Liddy advised the Committee that there will be a need to enhance areas as the Trust becomes more sophisticated/mature and agreed to submit an impact report highlighting the projects that have been effective, those that require further resources and a proposal for the projects that the Team would like to progress.

20/21/05.1 **Action: CL**

Iain Buchan asked as to whether the Innovation Team would have done anything differently with the benefit of hindsight. It was felt that the only areas that the Team would have addressed differently is the early alignment of strategies and the prioritisation of the right projects to ensure broad senior support.

20/22/06 **Hy-genie Investment Proposal**

Claire Liddy provided the Committee with background information on the agreement that the Trust entered into in 2016 with Deep Bridge Capital and Nova. Since 2016 a number of companies have been formed, in which Alder Hey is a shareholder and many of the Trust's employees are founders.

It was reported that three companies remain active with the rest in the process of being closed down due to the idea not being successful. One of the active companies is Hand Hygiene Solutions which Alder Hey has a shareholding of 22%. The company has progressed to developing a prototype for a novel and innovative automated hand hygiene monitoring system that measures the usage of hand hygiene stations in a hospital setting. The prototype is at the point of being tested in a clinical environment to demonstrate its functionality and commercial viability.

Due to the capabilities of the product and the current crisis, the Trust felt that it would be beneficial to accelerate this project given its potential market value. It was agreed with the Director of Finance that Alder Hey would pay for the prototype of £34.5k to enable testing/evaluation to be conducted on site between May and June. It was reported that this figure will be recorded as a sale in the company which will promote the company and increase the attractiveness for other venture capitalists to invest and accelerate the company. In return for the investment Alder Hey is making on the prototype, the other shareholders in the company have committed to recognising the investment in future investment rounds in the form of a share option agreement.

The Committee was asked to note and approve that the Trust has committed to paying £34.5k for a prototype to be installed in the Pathology Department in Alder Hey Hospital for clinical testing, in return for a future share in the option agreement.

Attention was drawn to the lack of detail in the paper from a share options/ agreement perspective and a request was made for more transparency about the cost of shares. Claire Liddy advised that Deep Bridge Capital had agreed to match their share price as at the end of March 2020.

The Chair queried as to whether Richard Cooke has any share options. Claire Liddy advised that Richard Cooke is an active director of the company but doesn't have any shareholdings at the present time due to taxation issues. Once the business starts to generate revenue, Richard will receive equity as per the shareholder agreement.

For transparency and good governance, the Chair requested that the following documentation be shared with Committee members to enable an informed decision to be made in respect to approving the revenue of £34.5k in return for a future share in the option agreement:

- The Company's balance sheet.
- The Company's investments.
- Relevant information on Company Directors.
- Governance arrangements.
- Agreement for share options.
- Potential market value of the deal.

The Chair highlighted the importance of including the potential market value in the report to enable Committee members to understand the valuation of the share options. Claire Liddy advised that the original technology scouting and business plan was conducted by Nova with the Trust carrying out a governance review in terms of a strategic fit. It was reported that a new CEO has been appointed by Hand Hygiene Solutions, who is in the process of rewriting the business plan and valuations.

It was agreed to share the requested information and compile a report to enable Committee approval, during July's meeting.

20/21/06.1 **Action: CL**

An enquiry was made in respect to the amount of sanitisers that the Trust will receive for £34.5k. It was reported that the pilot will consist of thirty base units and thirty individual sanitisers which will be installed in the Trust's Pathology Department.

A number of questions were raised about the Hy-genie product. Following discussion, it was agreed that it would be beneficial to invite Richard Cooke to the next meeting to demonstrate the product.

20/21/06.2 **Action: CL**

20/21/07 **Charity Funding Update**

The Committee was advised that the Charity awarded the Trust with a sum of £390k to help the organisation accelerate its Innovation Strategy. On behalf of the Committee, the Chair thanked the Charity for their support.

20/21/08 Health Innovation Liverpool

The Committee was provided with an overview of the forthcoming opportunities that will arise as a result of Health Innovation Liverpool. It was reported that the Liverpool city region is led by the University of Liverpool who has decided to have an entity to propel innovation across the region to ensure work is taking place collectively under the banner of Liverpool Health Innovation. A series of meetings will take place over the coming weeks to look at a process for working collectively. It was pointed out that Alder Hey would like to be a founder of this entity given the innovative work that the Trust is involved in.

Iain Buchan pointed out that Health Innovation Liverpool has made considerable progress due to the impact of Covid-19. It has been necessary to look at recovery plans at a greater pace and focus than before, and conversations have taken place between regions re the economic strength and collaborative planning.

Iain Buchan felt that it was really promising to see an Investment from SCIOTEC and the Knowledge Quarter alongside the region wide virtual campus setting with integrated data. To receive a big investment during difficult economic times shows confidence in Liverpool.

It was pointed out that the diversity that Liverpool has over a distributed campus requires state of the art digital connections. The lesson that has been learnt in respect to the failure that cost the greatest number of lives during Covid-19 is the lack of co-ordination, for example, people dying in care homes with a poor flow of information between Social Care and Primary Care. To ensure a continuous long-term solution requires data to come together. Attention was drawn to the importance of Alder Hey and the Innovation Team being involved in digital innovation to support this system issue.

It was reported that Civic Data Co-operative is working with GPs to help them co-create and own the solution for the integration of data. It was pointed out that the value of longitudinal records will enable innovation to happen that wouldn't normally unless the data was brought together. The outcome of this work will be beneficial to the running of the service, provide opportunities around science, innovation in industry and will provide a system that will be trusted by the public. Iain Buchan informed the Committee that Health Innovation Liverpool is in the infancy stage of its creation and felt that it would be really positive for Alder Hey to be a core part of shaping it.

Following discussion, it was felt that it would be beneficial for the Committee to have clarity in respect to the roles of each constituents, the proposed governance and outputs in order to have a view of Alder Hey's role. Ian Buchan agreed to arrange for the Liverpool Partnership Board to share this information with the Committee.

20/21/08.1 Action: IB

The Committee discussed the forthcoming scale of the innovation opportunities and the greater sharing across Liverpool and Manchester as a result of Health Innovation Liverpool. The Chair asked that an update be provided on the progress of Health Innovation Liverpool at the next meeting.

20/21/08.2 Action: IB

20/21/09 Cheshire and Merseyside Innovative Solutions Portal Overview and next steps

Emma Hughes submitted a paper to the Committee to provide an overview of the Alder Hey Innovative Solutions Portal (ISP) and the collaboration between Alder

Hey, the Innovation Agency, Cheshire and Merseyside Health and Care Partnership and the Covid-19 Supply Response team (CSR).

It was reported that Alder Hey Innovation Centre has created a new open innovation portal focused on sourcing innovative solutions, to solve real world healthcare challenges. With the current Covid-19 priorities the 18 Trusts in Cheshire and Merseyside and others nationally have been inundated and overwhelmed with offers of alternative PPE supply. Therefore Alder Hey has expanded and fast tracked their portal to receive offers of alternative supply for the region. The portal will allow all needs from various Trusts and all supplier solutions to be directed, collated and assessed in one place in a consistent manner.

Presently the Trust is collaborating with the Innovation Agency, Cheshire and Merseyside Health and Care Partnership's and the COVID-19 CSR Team to provide this alternative supplies and sourcing service to the region.

The Committee was advised that the priority has been to launch the service regionally and ensure the process is working. Initially it was for the Cheshire and Merseyside region but discussions are also being held with the CSR equivalents in the broader North West region. If there is an uptake the portal will be lifted out of the Alder Hey innovation website and become the North West ISP. A future business model needs to be considered in addition to the costs to develop the service technically to meet broader regional needs. A sustainable commercial model will also need to be agreed.

John Hague pointed out that Alder Hey is doing something unique and felt that ISP should be kept specific to the Trust's Innovation Centre. John Hague highlighted his past experiences of dealing with innovative work and advised of the importance of selecting partners who are able to solve problems as the challenges become more sophisticated.

John Grinnell drew attention to the large amount of good will and support that has been generated across Cheshire and Merseyside following a regional call for help with PPE. It was pointed out that Covid-19 has challenged the sustainability of the Trust's supply chain. A question was raised about the Trust's role in terms of re-challenging itself to look at alternative solutions for supplies, for example, local v overseas production. Following discussion, it was agreed to keep ISP on the agenda.

20/21/09.1 **Action: EM**

It was reported that a soft launch of the full service and portal will take place on the 11.5.20. The Innovation Centre will be promoting ISP to all existing suppliers that Alder Hey has been working with. It was agreed to provide an update on the launch during July's meeting.

20/21/09.2 **Action: EM**

20/21/10 **Digital Innovation Pitch**

The Committee received a number of slides to provide information on a short-term Innovation Strategy in the form of an elevator pitch. The following information was provided:

- The concept for the world's first 'Living Hospital'.
- Through the use of immersive/sensor technology and Artificial Intelligence Alder Hey will become the most digitally advanced place in the world which would make it the safest place.

- Solving the biggest problems through the use of technology to create impact would improve outcomes and experience, better value for money, the Trust would be more operationally efficient and it would be a great place to work.
- *Next Steps* – Alignment will be required to the Transformation agenda, a business case will need to be compiled and an external profile will be required.

The Chair informed the Committee that the short-term strategy has been created so that the Trust is prepared in the event a digital opportunity arises post Covid-19, for example, if the Government are looking for exemplars in the NHS. The Chair drew attention to the request made by the Innovation Team for the Committee to approve the short-term strategy to enable further work to be conducted in preparation for the next meeting.

Kate Warriner offered her full support of the work taking place to enable Alder Hey to become the world's first Living Hospital, and provided an overview of the positive digital work that has taken place during the pandemic to keep the Trust connected with patients and families, whilst keeping everyone safe.

Mark Flanagan drew attention to the amazing work that is taking place via digital options but queried the benchmarking process for ensuring the uniqueness of what the Trust is doing. It was reported that not everything will be unique, the Trust is scouting for the best technology in the world which will be brought together in the strategy; immersive, sensor and AI to make Alder Hey the safest place.

Iain Buchan felt that the strategy needs to be more focussed as it may be difficult to address all six components to a high standard, especially in light of the Trust's competition that is already out there. Having a single organising principle to latch on to will make it easier to build upon. Currently there is a huge impact on the health of children as a result of the pandemic and it is vital to have an agile set of services that can become embedded in the community. It was suggested that the Trust should find a focus and then fit it with a like challenge that will emerge post Covid.

John Hague suggested establishing a Stimulus Board to obtain feedback from outside the sector and to acquire examples from other organisations. Following a discussion, it was agreed to look into look into this matter.

20/21/10.1 **Action: SA/CL**

Fiona Marston asked to see more clarity, focus and narrative highlighting the purpose of conducting this work and the problems that Alder Hey would be addressing.

Following discussion, it was agreed that the Innovation Team will commence to work on the short-term strategy, taking into account the feedback, and provide an update during July's meeting.

Resolved:
The Innovation Committee agreed for work to commence on the short-term strategy.

20/21/11 **Innovative Research**

Matthew Peak submitted a number of slides to the Innovation Committee in order to provide information on the following areas:

- Research process.
- Innovative research interventions;

  - DETECT Study
  - 3D Printing of Medicine
- Innovative research examples.
- Supporting clinical research;
  - Digital.
  - AI.
  - 3D.

Matthew Peak asked the Committee if it is possible to bring research and innovation together in a systemised way. The Chair agreed to look in to having the two areas of work sit together via aligned strategies and agreed to look into this matter.

20/21/11.1 **Action: SA/CL/NM**

Matthew Peak drew attention to the Trust's near success of a bid for an NHIR patient safety transitional research centre and felt that it would be worth submitting a further bid during the next round due to being in a stronger position to build an innovation platform going forward.

20/21/12 **Rapid Prototyping**

Iain Hennessey provided the Committee with an update on the rapid prototyping that has taken place in the Innovation Centre, pointing out that the Innovation Team has worked with industry partners on the design and production of a number of alternatives to help with the Trust's PPE issues to keep staff safe. The Committee received a live tour of the items that the Innovation Team have been working on to support the Covid-19 response:

- Alternative solutions for PPE.
- Building training visors.
- The distancer.
- Single use visors.
- Testing of new coveralls.
- No touch mask removal.
- Custom made face masks.
- Filming training videos.
- Telemedicine robots.
- Chatbots for patients and staff.
- Mental health app.
- ISP.
- Handover app.

The Committee was advised of the work that has taken place to ensure a better experience for staff members who have to wear PPE.

John Hague queried as to whether any of the rapid prototyping had been scaled outside of the Trust. The Committee was advised that 100,000 plastic masks have been sold throughout the country and are also being used in the care industry in Liverpool. NHS Glasgow have received 90,000 ICL visors, and samples of the distancer are being circulated to various organisations as well as hospitals in America and Canada.

Fiona Marston queried the recyclability of the plastic items that are being produced as an alternative for PPE by the Trust. It was reported that all items are recyclable but have to be disposed of via clinical waste which is not recyclable. A suggestion was made to put this issue out as a challenge on the innovation platform to see if a solution can be found.

The Chair queried the progress of the contract negotiations for the visor and the distancer. It was reported that the Trust has a 50/50 revenue share agreement with 3D Life Prints, the face masks packaging company have verbally advised that they wish to donate the majority of the profits to charity and ICL Tech have introduced Claire Liddy to their Director to negotiate a deal. The Chair noted the feedback and asked that the Committee has sight of the agreements in order to have an overview of the expected income/expenditure of contracts.

20/21/12.1 **Action: CL**

The Chair asked as to whether there had been any external Comms conducted to promote the recent work that the Innovation Centre has been doing. Claire Liddy advised that the Comms Team are working on a PR Plan and agreed to link in with the Team for an update.

20/21/12.2 **Action: CL**

20/21/13 **Short-term Innovation Strategy**

This item was discussed under agenda item 10.

20/21/14 **Board Assurance Framework**

The Committee received and noted the contents of the Board Assurance Framework for April 2020/21. It was felt that additional work needs to take place to reframe respective risks around finance and business modelling to ensure that the Committee is fully sighted on emerging risks. Erica Saunders agreed to liaise with Claire Liddy to address this matter.

20/21/14.1 **Action: ES/CL**

20/21/15 **Any Other Business**

The Chair asked Committee members to provide feedback on the overall outcome of the meeting.

20/21/15.1 **Action: All**

Date and Time of next meeting: Monday 6th July 2020, at 1300 via Microsoft Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 24th September 2020

Paper Title:	**Board Assurance Framework 2020/21 (August)**
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 2020/21

1. Purpose

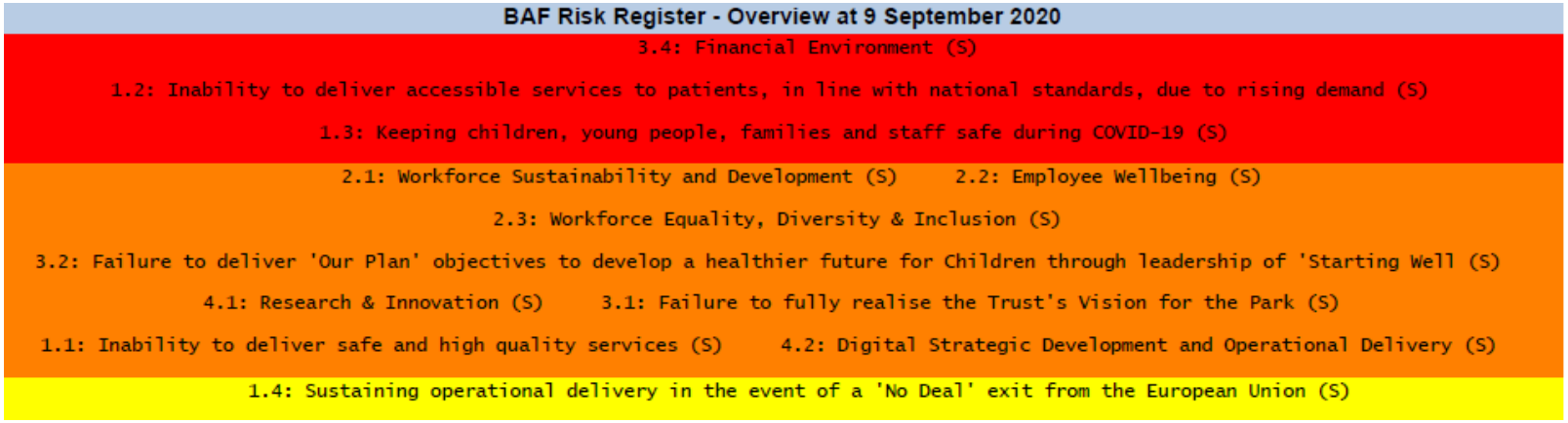
This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed,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

2. Review of the BAF

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.

Board members will notice that corporate risks are now linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B.

BAF Risk Register - Overview at 9th September 2020



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

3. Summary of BAF - at 9th September 2020

The diagram below shows that all risks remained static in-month

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 PB	**Inability to deliver safe and high quality services**		3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to rising demand**		**3x5**	3x2	STATIC	STATIC
1.3 AB	**Keeping children, young people, families and staff safe during COVID-19**		**5x4**	3x3	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**		3x2	3x1	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**		4x3	4x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**		3x4	3x3	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**		3x4	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**		3x3	3x2	IMPROVED	STATIC
3.2 DJ	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**		4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**		**4x5**	4x3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 CL	**Research & Innovation**		3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**		4x2	3x2	STATIC	STATIC

8. Changes since July 2020 report.

External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ)***
  Risk reviewed - no change to score in month. Additional control added re: Alder Hey's leadership of C&M Paediatric recovery.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  EDI action plans as identified through the NHS people plan are being addressed with specific leads.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  New Series of Monthly meetings to commence w/c 7th Sep. Each lead has been tasked with liaising with their professional bodies to scope o9ut current guidance and feedback on any risks/issues for the group to consider. No new National Guidance has been issued.

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to rising demand (AB)***
  Through the hard-work, determination and ingenuity of our teams we have made significant progress in restoring clinical services to children and young people. This is illustrated in the table and charts below. At the end of August 2020 we were ranked first in Cheshire & Merseyside for progress in restoring services. Level of capacity restored in August 2020 as a percentage of pre-Covid capacity: Outpatients Consultations 88% Emergency Department Attendances 88% Planned care Operations 80% Diagnostics Examinations 83% Despite this good progress, the number of patients waiting a long time (including over 52 weeks) is high and is not yet reducing. The patients are reportable in line with NHS guidance are waiting to access care in the Division of Surgical Care. We have experienced an issue relating to a reporting inaccuracy of long wait patients. Risk 2265 has been created to assess this risk and record our response to the issue. Our Safe Waiting List Management Programme is diagnosing the root causes of some of the challenges, which includes data quality, complex EPR and sub-optimal training, and our response to ensure no child experiences an avoidable delay in our care.

- ***Keeping children, young people, families and staff safe during COVID-19 (AB)***
  On keeping staff safe: Over the month of August we have seen a reduction in the numbers of staff who had previously been shielding. Ongoing individual risk assessments and environmental assessment are enabling staff to return to work in some capacity be that to site in own roles with measure in place to mitigate risk, or redeployed or working from home. There are currently 48 staff still shielding and these are all under review. We have made good progress in completing environmental risk assessments. However, in September our level of concern relating to potential hospital transmission amongst staff has increased following an incident on ward 3B and then in theatres which has led to a number of staffing having to isolate. Additional action will be taken around vigilance relating to PPE and environment. Our PPE predictor models shows adequate supplies, or appropriate mitigation, for the next 4 weeks.

On keeping patients safe: We have had no hospital acquired cases of COVID-19. We have had one inpatient with Covid-19 since the last review. In terms of patients waiting a long-time for treatment, we continue to have high rates of clinical review for patients waiting over 52 weeks. The number of ED attendances is rising but we continue to provide timely care to these patients.

- ***Inability to deliver safe and high quality services (PB)***
  CQC report published and associated comprehensive action plan submitted and underway to address the 1 "must do" and 51 "should do's" - number of actions already completed including the specific action plan to address the "must do. CQC have conducted an assessment of IPC BAF in August to identify themes, trends and risks that will inform the regulatory response and national oversight. The report is not a published report however has been shared with the Trust and is positive. High quality assurance reports received and presented at CQSG from Divisions including lessons learned and thematic analysis. Trust wide Quality Summit arranged for September to review systems in place to prevent avoidable Category 3 pressure ulcers as 3 have occurred this year.

- ***Financial Environment (JG)***
  Extension of current framework and arrangements for COVID reimbursement and top up has been confirmed to end of September. Awaiting guidance from NHSI on Phase 3 expected September.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed prior to September Board.

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF reviewed. Good progress against plans. Risk likely to reduce to target rating in next reporting period.

- ***Workforce Sustainability and Development (MS)***
  Action plans from the NHS people plan are being worked through by specific leads.

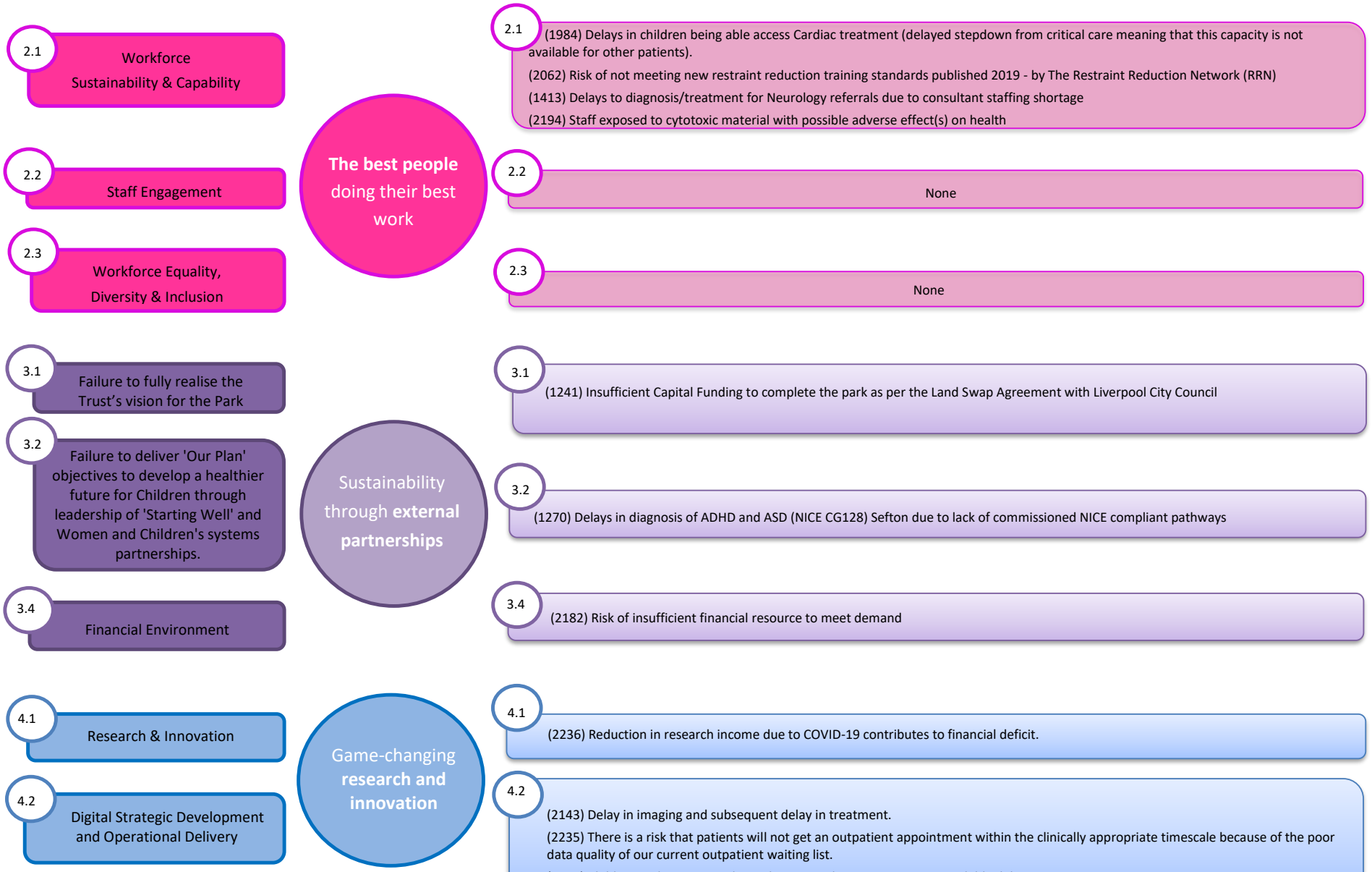
- ***Employee Wellbeing (MS)***
  Work on wellbeing continues via HR, SALS and the wellbeing team - there are a number of specific actions from the NHS People plan in relation to Wellbeing which are currently being addressed by allocated leads.

- ***Research & Innovation (CL)***
  Risk review – no change.

Erica Saunders
Director of Corporate Affairs
24 September 2020

Appendix A
Links between BAF and high scored risks – as at 7th September 2020

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	1.1 (1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage. Current RTT performance is 33% with 454 patients waiting over 18 weeks for a first outpatient appointment and 1,997 overdue follow up patients. (1984) Delays in children being able access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients. (1159) There is a risk that we are not able to make infectious waste safe prior to disposal, this would result in the stockpiling of CL3 waste which has to be stored on site until the device is repaired. The inability to make safe CL3 waste in a timely fashion contravenes HSE guidance. (2143) Delay in imaging and subsequent delay in treatment. (2192) Delay in treatment due to the ASU having to use one isolator for both CIVAS and cytotoxic products (2229) Unable to fully coordinate care for traumatically injured patients. (2233) Failure to meet QST Major Trauma peer review standards. (2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list. (2242) Risk of self-harm due to inappropriate clinical placement (2265) Children and young people on the waiting list experience an avoidable delay to care
1.2 Inability to deliver accessible services to patients, in line with national standards, due to rising demand		1.2 (1524) Young people over 16 years age are unable to access adult specific ADHD services which includes prescribing and review of medication. (1560) Patients breaching 18 weeks referral to treatment target (currently over 50% of patients) (2233) Failure to meet QST Major Trauma peer review standards.
1.3 Keeping children, young people, families and staff safe during COVID-19		1.3 (2178) Risk of not seeing C&YP who need treatment. Risk of late or no presentation and associated potential for harm. (1270) Delays in diagnosis of ADHD and ASD (NICE CG128) – Sefton (Covid 19 waiting times will increase further (2180) Risk of securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained
1.4 Sustainable operational delivery in the event of a 'No Deal' exit from EU		1.4 None


2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(1984) Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients).
(2062) Risk of not meeting new restraint reduction training standards published 2019 - by The Restraint Reduction Network (RRN)
(1413) Delays to diagnosis/treatment for Neurology referrals due to consultant staffing shortage
(2194) Staff exposed to cytotoxic material with possible adverse effect(s) on health
2.2
None
2.3
None
3.1
Failure to fully realise the Trust's vision for the Park
3.2
Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships.
3.4
Financial Environment
Sustainability through external partnerships
3.1
(1241) Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council
3.2
(1270) Delays in diagnosis of ADHD and ASD (NICE CG128) Sefton due to lack of commissioned NICE compliant pathways
3.4
(2182) Risk of insufficient financial resource to meet demand
4.1
Research & Innovation
4.2
Digital Strategic Development and Operational Delivery
Game-changing research and innovation
4.1
(2236) Reduction in research income due to COVID-19 contributes to financial deficit.
4.2
(2143) Delay in imaging and subsequent delay in treatment.
(2235) There is a risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our current outpatient waiting list.
(2265) Children and young people on the waiting list experience an avoidable delay to care

Board Assurance Framework 2020-21

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: 1984, 1413, 1159, 2143, 2192, 2233, 2235, 2242, 2265		
Exec Lead: Pauline Brown	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

Not having sufficiently robust, clear systems, processes and people in place to respond to competing demands presented by the current health and social landscape.

Existing Control Measures	Assurance Evidence (attach on system)
Quality Impact Assessments and Equality Impact Assessments completed for all planned changes (NHSE/I). Change programme assurance reports monthly - change programme currently on hold during Covid pandemic response and resetting	Annual QIA assurance report and change programme assurance report
Risk registers including corporate register inform Board assurance.	Risk assessments etc. and associated risks monitored via the Integrated Governance Committee. Trust Board informed vis IGC minutes. Divisional Integrated Governance Committee Minutes.
Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	Clinical Quality Assurance Committee, Trust Board and Divisional Quality Board minutes
Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.	Corporate Report - quality section, Trust Board and Divisional Quality Board minutes
Patient Safety Meeting monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	Minutes from trust Board, CQAC, Weekly Patient Safety Group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA Audit Report
Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).	Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees
Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes
Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	Board and sub-board committee minutes and associated reports
Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework	Minutes from NHSI Quarterly engagement meetings, CQC engagement meetings, Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly patient safety group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Patient survey reports and associated action plans
Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.	IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes.
Internal Nursing pool established and funded	Nursing Workforce report and associated Board minutes.
Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.	Trust Board (Nursing Workforce Report)
Annual Patient Survey reports and associated action plans	Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes.
Trust policies underpinning expected standards	Trust audit committee reports and minutes
CQC regulation compliance	CQC Action Plan monitoring via Board and sub-committees
CQC Regulation Inspection	Evidence accrued to support inspection process. Policies and pathways updated

Gaps in Controls / Assurance

1. Increasing demand system-wide
2. Workforce supply and skill mix

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. International recruitment in line with UK Guidance International nurses commenced in post Feb 20	31/10/2020	Nurses who joined the Trust from India in February have undertaken OSCE training in preparation for their OSCE test - this paused during peak of Covid however an NMC requirement again now

		In respect of the cohort of nurses who were delayed joining the Trust in April due to Covid, the Indian and UK Governments have formed an 'air bubble' and direct flights from India to the UK have started to resume as of 17 August 2020. Nurses will be required to quarantine for 14 days on arrival in the UK. As such, now progressing with next cohort
Alignment of workforce plans across the system	30/09/2020	Review of safer staffing SOP underway in line with winter planning

Executive Leads Assessment

August 2020 - Pauline Brown
CQC report published and associated comprehensive action plan submitted and underway to address the 1 "must do" and 51 "should do's" - number of actions already completed including the specific action plan to address the "must do".

CQC have conducted an assessment of IPC BAF in August to identify themes, trends and risks that will inform the regulatory response and national oversight. The report is not a published report however has been shared with the Trust and is positive. High quality assurance reports received and presented at CQSG from Divisions including lessons learned and thematic analysis. Trust wide Quality Summit arranged for September to review systems in place to prevent avoidable Category 3 pressure ulcers as 3 have occurred this year.

July 2020 - Philip O'Connor
no change to BAF score. Rota hub continues to be operational. New Roster implementation manager recruited. Safe staffing huddles embedded and recruitment plans in place both internally and externally

June 2020 - Philip O'Connor
no change to BAF score in month. Rota hub fully operational with staff in place to support. All staff have now returned to their substantive roles apart from those shielding. Change in govt advice re shielding with risk assessments needed for staff to be supported back to work safely. Gradual ramp up of services back to pre COVID levels with capacity increasing. Daily safer staffing huddles fully established across the Trust ensuring staffing in line with national guidance and staffing remains green. ECP students interviewed and allocated substantive posts for September starts but continue as BAND 4s until end of July as do the band 3's. Sickness remains high in certain areas. Still awaiting final CQC report

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to rising demand		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 1524, 1560, 2233		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x5	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand. A loss of capacity during COVID-19 has made access to 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 CQAC
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 - Operational Delivery Board as a forum to collectively address challenged areas and to submit 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

Gaps in Controls / Assurance

1.ED workforce plan aligned to demand and model of care aligned to type of presentations
2.Enhanced paediatric urgent care services required in primary care and the community
3.Additional capacity required in Specialist Mental Health Services and Community Paediatrics (ASD & ADHD). Request submitted to Sefton CCG for urgent investment and commissioning of NICE compliant ASD & ADHD diagnostic pathways.
4.Comprehensive, real-time and digital access times dashboard for Community Paediatrics and Specialist Mental Health Services.
5.Dynamic emergency demand and capacity model to reduce cancelled operations and more precisely predict surges in demand

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
i. New theatres, radiology and outpatients future service offer ii. Integrate workforce plan into the service plans so it is aligned to the goals of the service, the capacity they require and their new model iii. agree pay arrangements for additional work	28/09/2020	

iii. PPE sourcing strategy to ensure adequate suppliers		

Executive Leads Assessment

September 2020 - Adam Bateman
Through the hard-work, determination and ingenuity of our teams we have made significant progress in restoring clinical services to children and young people. This is illustrated in the table and charts below. At the end of August 2020 we were ranked first in Cheshire & Merseyside for progress in restoring services.

Level of capacity restored in August 2020 as a percentage of pre-Covid capacity:

Outpatients	Consultations	88%
Emergency Department	Attendances	88%
Planned care	Operations	80%
Diagnostics	Examinations	83%

Despite this good progress, the number of patients waiting a long time (including over 52 weeks) is high and is not yet reducing. The patients are reportable in line with NHS guidance are waiting to access care in the Division of Surgical Care.

We have experienced an issue relating to a reporting inaccuracy of long wait patients. Risk 2265 has been created to assess this risk and record our response to the issue. Our Safe Waiting List Management Programme is diagnosing the root causes of some of the challenges, which includes data quality, complex EPR and sub-optimal training, and our response to ensure no child experiences an avoidable delay in our care.

August 2020 - Adam Bateman
The effects of the increase in waiting times caused by COVID-19 have led to non-compliance with the referral to treatment time standard and 52 week standard. The services most significantly affected are learning disabilities, paediatric surgery, spinal surgery and ENT. We are now ensuring all patients who have had waited over 52 weeks have had a clinical review to expedite treatment where required or confirm they are safe to wait longer. We will continue to increase capacity in outpatients and surgery to ameliorate the waiting times being experienced. We have stabilised the number of children and young people waiting over 52 weeks for treatment. There were 91 patients waiting over 52 weeks in specialties reportable under national guidelines. 85 patients have had a clinical review with the remaining 6 patients being tracked for review within 7 days. In learning disability services (ASD & ADHD) we remain significantly concerned about the number of long waiting patients. In ASD there is 920 patients waiting over 52 weeks. In ADHD there are 670 patients on the waiting list for a new patient appointment or MDT assessment. In June we continued to make good progress in re-introducing surgical services and the full theatre schedule (n= 139 theatre sessions per week) is restored. We are now seeing improved utilisation (85.4%) of the operating lists, which is closer to pre-Covid-19 levels. In operative care, 68 our inpatient operating levels are at 71% of last year's activity. In day case. we are operating at 78% of last year's activity The Emergency Department is seeing attendance levels at 75% of our pre-COVID activity for this time of year. The highest day for attendances last week saw 130 patients treated. Radiology has restored c. 80% of pre-Covid 19 capacity. In outpatients we provided 1,989 face to face consultations last week compared to 4,854 pre-Covid-19. However, we have increased significantly the number of digital consultations and telephone consultations, which when added to the face-to-face consultations takes the total outpatient consultations 92% of pre-COVID levels.

June 2020 - Adam Bateman
The effects of the loss of capacity for planned and urgent care during COVID-19 continue; waiting times are increasing and in the Division of Community & Mental Health and the Division of Surgical we have some patients waiting over 52 weeks for care.

Presently we focused on the safe management of children and young people on the waiting list by getting the following components of the system right:
? Maximise capacity, safely
? Effective clinical review and prioritisation
? Provide a scorecard with helpful and accurate information against defined clinical and safety standards
? A single-version of the truth waiting list, with excellent data quality
? Good administration/ documentation of a patient's pathway
? Capacity & demand model that projects trends in waiting times

We continue to make progress in restoring services with an increase in face-to-face outpatient capacity of 300 patients per day from the 29 June 2020. From the 8 June our operating capacity increased to 110 session per week, from 70 sessions.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Keeping children, young people, families and staff safe during COVID-19		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: 2178, 2170, 2180		
Exec Lead: Adam Bateman	Type: External,	Current IxL: 5x3	Target IxL: 3x3	Trend: STATIC

Risk Description

There are risks to the physical and psychology safety and wellbeing of children and young people, and staff as a result of the effects of COVID-19. This includes, but is far from limited to, the potential for physical and psychological harm as a result of delayed access to care, isolation, psychological impact of lockdown, and risk of contracting the virus.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19 Plan agreed and being deployed	
Work programme on keeping our staff safe enacted	
Plan to establish adult invasive capacity progressed	
COVID Specific Scorecard in place	Scorecard to Strategic Meetings
Work Programme established looking at keeping Children & Young People safe	Agendas / Minutes / Actions
Access to Care Group re-established to monitor waiting lists	
24/7 CAMHS crisis line in-situ	Staff rota
Access to emergency and urgent operating theatres	Weekly capacity plan
Clinical review of waiting lists to identify clinically urgent patients requiring assessment and/ or intervention	Electronic patient record
Urgent face-to-face outpatient appointments maintained and digital outpatient consultations established	Outpatient schedule
Waiting list monitoring via weekly Access to Care Delivery Group	Minutes
All vulnerable patient cohorts across specialities (Medical and Surgical) identified	
Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative	
Continued to update vulnerable shielding patients with guidance and support as per government advice	
Face masks introduced for staff and visitors	
New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC	
PPE suppliers and innovations strategy to ensure adequate supply	PPE predictor 4 week forward look
Operational plan to increase restoration of capacity	Tracked weekly though Communication Cell Metric Report in Operational Delivery Board
Covid-19 testing service	
Covid-19 test and trace policy	

Gaps in Controls / Assurance

Recovery plan (protecting staff and recovering access times for patients) for phases 2 and 3 to be finalised

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
complete risk assessments for staff who are shielding	30/09/2020	Over the month of August we have seen a reduction in the numbers of staff who had previously been shielding. Ongoing individual risk assessments and environmental assessment are enabling staff to return to work in some capacity be that to site in own roles with measure in place to mitigate risk, or redeployed or working from home. There are currently 48 staff still shielding and these are all under review.
Keeping Children & Young People Safe Workstream	30/09/2020	Workstream continues to meet weekly. Specialities have populated vulnerable patient template to outline risk and considerations that may affect current pathway and identify alternative pathways
complete covid secure risk assessment	28/08/2020	

Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing. Awareness campaign of core messages relating to keeping staff safe from Covid-19 Programme of audits in local teams to check that compliance with core standards relating to keeping staff safe	30/09/2020	
Ensure actions that have been identified through COVID-secure risk assessments take place	08/09/2020	

Executive Leads Assessment

September 2020 - Adam Bateman
On keeping staff safe: Over the month of August we have seen a reduction in the numbers of staff who had previously been shielding. Ongoing individual risk assessments and environmental assessment are enabling staff to return to work in some capacity be that to site in own roles with measure in place to mitigate risk, or redeployed or working from home. There are currently 48 staff still shielding and these are all under review.

We have made good progress in completing environmental risk assessments. However, in September our level of concern relating to potential hospital transmission amongst staff has increased following an incident on ward 3B and then in theatres which has led to a number of staffing having to isolate. Additional action will be taken around vigilance relating to PPE and environment.

Our PPE predictor models shows adequate supplies, or appropriate mitigation, for the next 4 weeks.

On keeping patients safe: We have had no hospital acquired cases of COVID-19. We have had one inpatient with Covid-19 since the last review.

In terms of patients waiting a long-time for treatment, we continue to have high rates of clinical review for patients waiting over 52 weeks.

The number of ED attendances is rising but we continue to provide timely care to these patients.

August 2020 - Adam Bateman
On keeping staff safe: We have high compliance in the completion of risk assessment for at risk staff groups. Environmental risk assessments to identify and create covid-secure areas started the w/c 3 August. We had an incident with fit-testing of FFP3 masks and we have been working with the Health & Safety Executive to create an effective response plan and incorporate learning. We have no evidence of harm to staff but it has caused anxiety. Staff were fit-tested to US settings rather than UK settings. This has been corrected and we are re-fit testing staff. We are going to enhance our training to staff delivering the re fit-testing to be Fit2Fit accredited. Our PPE predictor models shows adequate suppliers, or appropriate mitigation, for the next 4 weeks. On keeping patients safe: We have had no hospital acquired cases of COVID-19. We have prioritised a clinical review of patients who are waiting over 52 weeks to check whether they are indicated as safe to wait or whether their treatment needs to be expedite. Of the 91 patients 88 patients have received a clinical review, with the 3 outstanding being managed for completion. By making good progress in restoring capacity we have consolidated the number of patients waiting over 52 weeks to treatment and we expect to reduce this number in August.

June 2020 - Adam Bateman
On keeping staff safe:
Our antibody testing results for staff at 7% is the lowest in the region and indicates a low infection rate of staff in the Trust and the extremely low prevalence rates amongst patients at Alder Hey.
Our supplies of PPE have been good and we have maintained access to equipment for staff and have support an increase in elective activity.
Comfort boxes have been provided to staff to provide them with some comforting items and to recognise their outstanding work.
Risk assessments of at risk members of staff have taken place.
We continue to support members of staff to work from home where possible.

On keeping patients safe:
We have made good progress in increasing access to care with capacity expanded in theatres, outpatients and Radiology. Nonetheless, there is significant further work to do to clear the backlog.
Our testing pathways for emergency admissions and surgical operations is in situ.
We have undertaken clinical reviews of patients on the waiting list who are considered to be at risk

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: External,		Current IxL: 3x2	Target IxL: 3x1	Trend: STATIC

Risk Description
Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity. 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020. No further updates received from NHSE as of at August 2020

Existing Control Measures	Assurance Evidence (attach on system)
National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	all previous plans held in abeyance for the moment. Project team are still present and able to mobilise as required. Work stream leads identified; previous risk assessments undertaken.

Gaps in Controls / Assurance
There maybe some very limited supply issues when we move from transition at the end of December 2020 but there is no immediate risk to supply other than business as usual fluctuations which would be considered as normal within the current risk profile. As we are in the midst of the pandemic we are unable to forecast future shortages or challenges with this. Group restarting from Sep 20

Executive Leads Assessment
September 2020 - Lachlan Stark New Series of Monthly meetings to commence w/c 7th Sep. Each lead has been tasked with liaising with their professional bodies to scope o9ut current guidance and feedback on any risks/issues for the group to consider. No new National Guidance has been issued.
February 2020 - Lachlan Stark Following review with specialty leads no issues identified
January 2020 - Lachlan Stark 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.

Board Assurance Framework 2020-21

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: 1984, 2062, 1413, 2194		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

Failure to deliver consistent, high quality patient centred services 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 WOD
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
Permanent nurse staffing pool to support nurse staffing numbers	Large-scale nurse recruitment event 4 times per year
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 WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD 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	75 skilled nurses to join the organisation across 2020/21
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to WOD OFSTEAD Inspection
Leadership Strategy Implementation	Bi-monthly reports to WOD

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 standard methodology to workforce planning across the organisation
4. Succession plans Board to Ward

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/09/2020	Departmental reports are being generated again to increase compliance.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. This includes the introduction of a pilot wellbeing team to support the management of sickness absence. Target is 4% absence rates across the organisation.	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/09/2020	Progress on activities attributed to this risk have been delayed. The NHS People Plan was published at the end of July 2020, activities to be reviewed in line with the Plan in September 2020
4. Succession planning to be completed for the Executive Team. To be rolled out to the Divisional senior management teams in January 2020	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.

Executive Leads Assessment

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

September 2020 - Sharon Owen Action plans from the NHS people plan are being worked through by specific leads.
August 2020 - Zoe Connor Activities related to this had been paused until end of June 2020. Action plans are being drawn up to implement key requirements to progress mitigations against this risk.
June 2020 - Sharon Owen Activities related to this have been paused until end of June 2020. During July a action plan will be drawn up to implement key requirements to progress mitigations against this risk.

Board Assurance Framework 2020-21

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: 3x4	Target IxL: 3x3	Trend: STATIC

Risk Description

Failure to support employee health and wellbeing which can impact upon operational performance and achievement of strategic aims

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Strategy. Wellbeing Steering Group ToRs
Action Plans for Staff Survey	Monitored through WOD (agendas and minutes)
Values and Behaviours Framework	Stored on the Trust intranet for staff to readily access
Staff Temperature Check Reports to Board (quarterly)	Board reports and mintues
Values based PDR process	New template implemented and available on intranet. Training for managers (appraisers) delivered.
Listening into Action Guidance and Programme of work	Dedicated area populated with LiA info on Trust intranet
Staff surveys analysed and followed up (shows improvement)	2018 Staff Survey Report
Reward and Recognition Group schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.	Reward and Recognition Meetings established; reports to Wellbeing Steering Group
BAME, Disability and LGBTQI+ Staff Networks	Meetings minuted and an update provided to WOD
LGBTQI+ Network launched December 2018	Monthly network meetings established and open to any staff member or volunteer who identifies as LGBTQIA+.
Leadership Strategy	Strategy implemented October 2018
Freedom to Speak Up programme	Board reports and minutes
Occupational Health Service	Monitored at H&S Committee
Time to Change implementation	Time to Change implementation

Gaps in Controls / Assurance

1. Staff Advice and Liaison Service (SALS) not yet implemented
2. Wellbeing team to support sickness absence not yet implemented
3. Junior Doctor experience not as positive as it should be

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Develop a proposal to implement a SALS service	30/06/2020	SALS is being progressed, as is the implementation of the wellbeing team.
2. Appoint to the wellbeing team	30/06/2020	Team Leader appointed; team to be appointed Jan 2020
3. Detailed action plan in response to 2018 HEE visit. Use of £60k welfare monies to re-purpose a new JD mess. JD Forum refreshed	30/06/2020	JD mess agreed, will be fully in place February 2020

Executive Leads Assessment

September 2020 - Sharon Owen
Work on wellbeing continues via HR, SALS and the wellbeing team - there are a number of specific actions from the NHS People plan in relation to Wellbeing which are currently being addressed by allocated leads.

August 2020 - Zoe Connor
The SALS team and Wellbeing Team have been established. Ongoing work taking place to review the Wellbeing offer available

June 2020 - Sharon Owen
Actions reviewed many of which are now complete. Wellbeing team and SALS team established in the organisation to support the Wellbeing strategy.

Board Assurance Framework 2020-21

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: 3x4	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

Existing Control Measures	Assurance Evidence (attach on system)
WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	- Bi-monthly reporting to Board via WOD on diversity and inclusion issues - Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs, monitored through WOD
Staff Survey results analysed by protected characteristics and actions taken by EDI Manager	monitored through WOD
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 WOD
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
Time to Change Plan	Time to Change Plan
Actions taken in response to WDES	- Monthly recruitment reports provided by HR to divisions - Workforce Disability Equality Standards - Bi-monthly report to WOD
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked until Nov 2020
BAME Risk assessments during COVID19. Evidence suggests that our BAME staff are potentially at greater risk if they contract covid 19- enhanced risk assessments have been conducted to date with 90% of BAME STAFF. Outstanding risk assessments are currently being addressed with departmental leads and managers.	90% completion of BAME risk assessments to date

Gaps in Controls / Assurance

1. Workforce not representative of the local community we serve
2. BME staff reporting lower levels of satisfaction in the staff survey

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	30/09/2020	HR Team supporting the development of WDES action plans to support activities attributed to this risk
1. Work with Community Engagement expert to develop actions to work with local community	30/09/2020	Activities attributed to this risk have been paused. EDI provision being reviewed with potential collaboration opportunities with other Trusts

Executive Leads Assessment

September 2020 - Sharon Owen
EDI action plans as identified through the NHS people plan are being addressed with specific leads

August 2020 - Zoe Connor
Ongoing consultations taking place with BAME colleagues during pandemic. Demographic risk assessments also in place to support staff during the ongoing response to COVID

June 2020 - Sharon Owen
Actions reviewed. Ongoing consultation is in place with BAME staff during the pandemic.

Board Assurance Framework 2020-21

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: 1241		
Exec Lead: David Powell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

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 or budget 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
Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions	
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.
Weekly review of status in respect of Covid 19 impact	Meeting record
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

Gaps in Controls / Assurance

1. Fully reconciled budget with Plan.
2. Risk quantification around the development projects.
3. Absence of final Stakeholder plan
4. COVID 19 is impacting on the project milestones

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete cost plan	01/09/2020	Turkington martin who provided the overall plan/vision for the park have been approached and a meting diarised to start to further develop the plan which can then go to tender, some estimation of cost will be achieved through working the plan up with Turkington Martin (Landscaping architects)
2. Agree Park management approach with LCC	31/10/2020	Discussions with LCC continue and most recently positive feedback on an agreement to lease additional car park space off site at Thomas lane sports field/car park. This is to be be agreed within the next month and lease put into place. A whole internal process on management of this is currently under discussion
Prepare Action Plan for NE plot development	20/10/2020	Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust

Executive Leads Assessment

September 2020 - David Powell
Prior to September Board

July 2020 - David Powell
Prior to Campus Steering Group

Board Assurance Framework 2020-21

May 2020 - David Powell Review pre-June Trust Board
April 2020 - Susan Brown Reviewed actions due to the impact of COVID and to update on progress of the cluster project/budget discussions and VE exercise.
March 2020 - David Powell Review with regard to Covid 19 planning.

Board Assurance Framework 2020-21

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 through leadership of 'Starting Well' and Women and Children's systems partnerships.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led		Link to Corporate risk/s: 1270		
Exec Lead: Dani Jones	Type: External, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

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

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)
'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
Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed.	
C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan	C&M C&YP Recovery Plan Narrative

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
2. Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate	30/09/2020	Refresh of Sefton plans underway following Covid; Dani Jones allocated as SRO for C&YP at Sefton Provider Alliance - priorities well aligned with North Mersey.
5.Develop Business Model to support centralisation agenda and Starting Well	30/09/2020	Refresh of One Liverpool priorities following Covid underway during June; priority areas of focus to be agreed at ICPG in July, and subsequent programme resource to be sought through reestablished Provider Alliance in July.
6.Develop Operational and Business Model to support International and Private Patients	30/09/2020	Paused through Covid period; for consideration as phase 3 and beyond plans developed
1. Strengthening the paediatric workforce	30/09/2020	Significant work through Covid and recovery; Mutual aid provided across NW and joined up recovery planning and approaches underway. Enhanced offer with C&M Paediatric Network and plan to further

		support each other on strengthening the paediatric workforce through Womens & Children's programme.

Executive Leads Assessment
September 2020 - Dani Jones Risk reviewed - no change to score in month. Additional control added re: Alder Hey's leadership of C&M Paediatric recovery.
July 2020 - Dani Jones Risk reviewed; action plans updated. Impact of Covid continues though work ongoing to shape the strategic direction for paediatrics across the region. No change to score in month. Pending review of BAF at September trust board.
June 2020 - Dani Jones Risk reviewed; no change to score in month. Restart following Covid and positive movement in actions. Full system reshape and governance underway and not yet settled; focus on ensuring C&YP are among the system priorities.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2182		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x5	Target IxL: 4x3	Trend: STATIC

Risk Description

Failure to deliver Trust control total and affordability of Trust Capital requirements.

Existing Control Measures	Assurance Evidence (attach on system)
Organisation-wide financial plan.	Monitored through Corporate Report
NHSi financial regime and Use of Resources risk rating.	Specific Reports (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 - Financial in-month and forecast position reported through SDG, Exec Team, RABD Ops Board and Trust Board - Financial recovery plans reported through SDG and RABD - Internal and External Audit reporting through Audit Committee.
Capital Planning Review Group	5 Year capital plan ratified by Trust Board
Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	Monthly Performance Management Reporting with '3 at the Top'
Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	Monitored through Exec Comm Cell and Exec Team
Weekly Sustainability Delivery Group overseeing efficiency programme	Weekly Financial Sustainability delivery meeting papers
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD
RABD deep dive into key financial risk areas at every meeting	RABD Agendas, Reports & Minutes
Weekly COVID financial update to Strategic Command	Agenda and Presentations

Gaps in Controls / Assurance

1. New COVID Financial Framework creates greater uncertainty
2. Affordability of Capital Plans
3. Cost of Winter escalating
4. Long Term Plan shows £3-5m shortfall against breakeven
5. Long Term tariff arrangements for complex children
6. Potential COVID Capital costs not covered centrally

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
5. Childrens Complexity tariff changes	30/09/2020	Paediatric tariff paper completed by CHA and shared with NHSI pricing team. A board meeting is taking place in September to confirm next steps and approach. Dialogue continuing with regional and national NHSI to find an interim solution for the gap.
1. Revised financial plan pending updated guidance from NHSI	30/09/2020	Alder Hey has progressed its financial framework for the remainder of the year, however we are still awaiting NHSI financial guidance which is due imminently.
6. Submit COVID Capital Costs through national system	30/09/2020	All claims for COVID capital spend has been submitted and are being reviewed as part of the national process with full reimbursement expected. Confirmation has been received for the ED COVID capital scheme, we are awaiting feedback on the remaining schemes.
4. Long Term Financial Plan	30/09/2020	Awaiting financial guidance from NHSI and have re-lodged unresolved financial gap. Revisit once NHSI guidance has been published and work up mitigating actions
2. Five Year capital plan	30/10/2020	Significant aspects of Capital Programme progressing e.g. cluster, Dewi, Neo. Further review of long term capital plan to be revisited once clearer8 the impact of COVID on our wider finances
3. Cost of Winter	30/09/2020	Revised Operational Plan due to be completed end of July 2020 which will incorporate winter capacity plans and any associated costs

1. RABD to oversee productivity and waste reduction programme	31/03/2021	

Executive Leads Assessment
September 2020 - Rachel Lea Extension of current framework and arrangements for COVID reimbursement and top up has been confirmed to end of September. Awaiting guidance from NHSI on Phase 3 expected September.
July 2020 - Claire Liddy COVID Financial arrangements including COVID reimbursement and top-up. Regime now extended until September 2020
June 2020 - John Grinnell Financial arrangements beyond M4 still remain unclear as national guidance awaited. Significant work underway with all divisions to create a new financial framework that will be fit for purpose in this new environment.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Research & Innovation		
Related CQC Themes: Responsive, Well Led			Link to Corporate risk/s: 2236		
Exec Lead: Claire Liddy	Type: Internal, Known		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Risk Description
Failure to grow research & innovation due to potential gaps in capacity and funding

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Programme assurance via regular Programme Board scrutiny	Reports to Programme Board and associated minutes
Establishment of Research Management Board	Research Management Board established.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise
Innovation team re-organised and funded to ensure adequate capability. Establish role of Managing Director of Research and Innovation to provide unified vision.	
Alder Hey Innovation LTD governance manual established	

Gaps in Controls / Assurance
Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete collaboration contract with University of Liverpool. This is a strategic agreement - deadline reset to March 2020 as part of 3 year join planning with UoL VP. Create standard approach to agree 3 year strategic R&I roadmaps with each University Partner	30/09/2020	Plans, data and costs now exchanged but final agreement still to be reached. Longstop date Dec 2019, but conclusion expected before this; timescale therefore revised.
Agree incentivisation framework for staff and teams: for research time & innovation time.	31/12/2020	Target date reset to 31/12/20

Executive Leads Assessment
September 2020 - Claire Liddy risk review - no change
July 2020 - Claire Liddy No change
June 2020 - Claire Liddy Risk reviewed - no change

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development and Operational Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2143, 2235, 2265		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x2	Target IxL: 3x2	Trend: STATIC

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

Lack of secondary data centre / disaster recovery - significant progress with new arrangements in place
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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber accreditation	30/09/2020	Good progress in place - work ongoing with specialist trusts to further develop cyber service
Commission Meditech DR at CCC and move primary Meditech infrastructure to AH	30/09/2020	Infrastructure built at CCC, technical handover to suppliers completed. Commissioning plan target during August.

Executive Leads Assessment

August 2020 - Kate Warriner
BAF reviewed. Good progress against plans. Risk likely to reduce to target rating in next reporting period.

July 2020 - Kate Warriner
BAF reviewed, good progress made against actions. Target to reduce risk following actions in September / October 2020.

June 2020 - Kate Warriner
BAF reviewed, good progress made, new core resilient infrastructure operational