Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 26th January 2023, commencing at 9:00am

Lecture Theatre 4, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (9:00am-9:15am)							
1.	**22/23/239**	**9:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/240**	**9:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/241**	**9:17 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **15th December 2022.**	**D**	Read enclosure
4.	**22/23/242**	**9:19 (1 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/243**	**9:20 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Strategic Update and External Partnerships							
6.	**22/23/244**	**9:30 (20 mins)**	**Strategy Update (Vision 2030):** • **Engagement Plan.** • **New governance arrangements.**	L. Shepherd/ J. Grinnell	To receive an update on the Vision 2030 Strategy.	**N**	Read report Verbal Read report

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7.	**22/23/245**	**9:50 (45 mins)**	**Growing Great Partnerships.** • **Key System Developments:** - **Healthcare Partnership Board Update.** - **ICS Update.** - **NW Specialist Services and Paediatric Networks Update.** - **Liverpool Place Update.** • **Strategic Partnership with LWH.** • **LNP Update.**	D. Jones L. Shepherd LNP	To receive the 'Growing Great Partnerships' quarterly report for information and discussion. To receive an update. To provide an update.	**N** **N** **N** **N** **N** **N**	Read Report Verbal This item was deferred
8.	**22/23/246**	**10:35 (10 mins)**	**Green Strategy Update.**	M. Flannagan	To receive an update on progress.	**A**	Read report
Operational Issues							
9.	**22/23/247**	**10:45 (60 mins)**	• **Integrated Performance Report for M9.** • **Finance Report for M9, 2022/23 and Forward Look.** • **Transformation Programme Governance Report.** • **IPC Update.**	Exec Leads/ Divisional Leads R. Lea N. Palin B. Larru	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M9 position and a forward look. To receive assurance. To receive an update on the current position.	**A** **A** **A** **A**	Read report Presentation Read report Presentation
10.	**22/23/248**	**11:45 (5 mins)**	**Industrial Action Update.**	N. Askew	To receive an update.	**A**	Read report
11.	**22/23/249**	**11:50**	**'ED at its Best' – Project**	ED Team	To provide an update.	**A**	Presentation

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		(15 mins)	**Update.**				
12.	**22/23/250**	**12:05 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
13.	**22/23/251**	**12:15 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 23.1.23** - **Approved minutes from the meeting held on the 12.12.22,**	I. Quinlan	To escalate any key risks, receive updates and note the approved minutes from the 12.12.22.	**A**	Read enclosure
Lunch (12:20pm-12:40pm)							
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
14.	**22/23/252**	**12:40 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
15.	**22/23/53**	**12:45 (5 mins)**	**Nurse Staffing Update.**	N. Askew	To receive an update.	**A**	See item 22/23/248
16.	**22/23/254**	**12:50 (5 mins)**	**Proposal to Obtain Veteran Covenant Healthcare Alliance Accreditation.**	N. Askew	To receive and approve the proposal to obtain Veteran Covenant Healthcare Alliance Accreditation	**D**	Read report
17.	**22/23/255**	**12:55 (5 mins)**	**Safeguarding Annual Report, 2021/22.**	N. Askew	For approval.	**D**	Read report
18.	**22/23/256**	**13:00 (5 mins)**	**Children in Care Annual Report, 2021/2022.**	N. Askew	For approval.	**D**	Read report
19.	**22/23/257**	**13:05 (5 mins)**	**Organ Donation Report, 2021/22.**	A. Bass	For noting.	**N**	Read report

Alder Hey Children's NHS Foundation Trust

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20.	**22/23/258**	**13:10 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's verbal update from the meeting held on the 18.1.23.** - **Approved minutes from the meeting held on the 14.12.22.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 14.12.22.	**A**	Read enclosure
The Best People Doing Their Best Work							
21.	**22/23/259**	**13:15 (10 mins)**	**People Plan.**	M. Swindell	To receive an update on the current position.	**A**	Read report
22.	**22/23/260**	**13:25 (5 mins)**	**People and Wellbeing Committee:** - **Chair's verbal update from the meeting held on the 18.1.23.** - **Approved minutes from the meeting held on the 7.12.22.**	G. Dallas	To escalate any key risks, receive updates and note the approved minutes from the 7.12.22.	A	Read enclosure
Strong Foundations (Board Assurance)							
23.	**22/23/261**	**13:30 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
24.	**22/23/262**	**13:35 (5 mins)**	**Audit and Risk Committee:** - **Chair's verbal update from the meeting held on the 12.1.23.** - **Approved minutes from the meeting held on the 10.11.22.**	K. Byrne	To escalate any key risks, receive updates and note approved the minutes from the 10.11.22.	**A**	Read enclosure
Items for information							

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
25.	**22/23/263**	**13:40 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
26.	**22/23/264**	**13:44 (1 min)**	**Review of meeting.**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief.	**N**	Verbal
Date and Time of Next Meeting: Thursday 23rd February 2023, 9:00am, Lecture Theatre 4, Institute in the Park, Alder Hey							

REGISTER OF TRUST SEAL
The Trust Seal was used in December 391: Letter of Indemnity – Neonatal/Urgent Care

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M9, 2022/23	R. Lea
IPC Report	B. Larru
Register of Shareholders Interests	R. Lea
CMAST Board Update	L. Shepherd

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 15th December 2022 at 11:00am**
via Microsoft Teams

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Mr. J. Kelly	Non-Executive Director	(JK)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
`	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/222	Dr. B. Larru	Director of Infection, Prevention and Control	(BL)
Apologies	Mr. G. Dallas	Non-Executive Director	(GD)

22/23/219 Welcome and Apologies

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

22/23/220 Declarations of Interest

The Board noted the declaration received from Fiona Beveridge in relation to her association with the University of Liverpool.

22/23/221 Minutes of the previous meetings held on Thursday 24th November 2022
Resolved:
The minutes from the meeting held on the 24th of November were agreed as an accurate record of the meeting, pending the following amendment:

- Record the attendance of the Assistant Chief Digital and Information Officer, Ian Gilbertson.

22/23/222 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 22/23/198.2: *Integrated Performance Report Overview (Additional information to be included in the summary page of the IPR on key projects and how the Trust is addressing them)* - A review has taken place to ensure correlation with the summary narrative and actions in the main report provided by Executive Leads. A further review of the summary page is to be conducted via the Exec Design Group in the New Year to test out any further improvements with colleagues now that the IPR has been reviewed a number of times at Board and committees. **ACTION CLOSED**

Action 22/23/182.2: *Board Assurance Framework Report (Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way)* – A piece of benchmarking work is taking place to ascertain the most effective response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **ACTION TO REMAIN OPEN**

22/23/223 Chair's and CEO's Update

The Chair paid tribute to the Executive Team for the exceptional work that has taken place during the year despite the challenges that the Trust has faced. Thanks were also offered for the preparation that took place to secure the requested derogations and deal with the RCN industrial action.

The Chair advised of her attendance at the Charity Board meeting in December and provided an overview of the financial support that has been attained to date by the Charity for the new Neonatal Unit. It was pointed out that the Charity is committed in terms of offering support to the Trust for forthcoming projects but will advise if they are unable to support particular areas of work. The Board was informed that the partnership between the Trust and the Charity is a very positive one.

Liverpool Clinical Services Review – The Board was informed that the review of clinical services in Liverpool has come to an end, but the final report is yet to be published. It was reported that the implications for Alder Hey are minimal with a recommendation to continue to build upon the partnership with Liverpool Women's Hospital (LWH) in relation to the new Neonatal Unit. This was a positive with regard to what has been developed in the city.

Attention was drawn to the two workstreams that the review focussed on; urgent care pathways essentially in the adult sector, and the issues relating to the Liverpool Women's Hospital. In terms of ensuring pathways become more effectively joined up and adult specialist trusts link in with the Royal and Aintree, it has been recommended that the city be broadly split into three areas; North, Central and South geographies (Broadgreen/Royal, Royal/Clatterbridge, Aintree/Walton Centre). It was confirmed that active discussions are taking place to address this recommendation and a positive approach is being taken to concentrate on pathways.

With respect to the second area of focus (LWH), a number of specific proposals have been made and it has been suggested that the Integrated Care Board (ICB) take ownership of this work in order to develop a future option for LWH and its services that keeps the organisation safe.

The Board was advised of the discussions that have taken place in respect to having a committee in common to bring the outcomes of the review together. It was felt that further understanding of what this means is required whilst ensuring that the overall process doesn't get overlaid with the governance. It was agreed to request a copy of the report and submit it to the Trust Board at January's meeting.

22/23/223.1 Action: LS

Industrial Action Update (15.12.22) – Approval was received for the 22 derogations requested to ensure staffing levels on wards and departments are maintained during industrial action. This was a major achievement and indicates the level of engagement and partnership working that the Trust has had with local union representatives and the regional/local Strike Committee. A night time staffing model has been implemented across the hospital for all wards, departments and essential services, and the Trust is supporting staff on the wards by enabling them to wear a badge provided by the Royal College of Nursing (RCN) to say that they support the strike. This has been welcomed by staff members.

The Board was advised that bed capacity and staffing levels are good, as is the general morale of staff members. As a result of the industrial action, it was confirmed that the Trust has had to postpone approximately 300 outpatient appointments and 40 elective cases, but urgent services remain open, and operations are taking place. The Trust has also established a significant contingency plan in response to the late derogation of the Walk-in Centres.

The Chair felt that the work that has taken place is a real testament to the relationships that have been established with staff and Trade Unions and thanked all those concerned.

Operational Update (Strep A) – The Trust has experienced incidents of Strep A threefold higher than 2021/22 and have seen up to 300/321 patients on certain days. In response to this huge rise in demand, a hub has been established for patients with Strep A/acute respiratory infections to enable greater capacity for children to be seen. The hub went live w/c 12.12.22 therefore the Trust is able to arrange an alternative appointment for patients rather than having to ask people to wait for an assessment in the Emergency Department (ED). It was confirmed that Alder Hey is looking sustain this model until the end of March 2023 in partnership with GPs and other colleagues.

The Board was informed of the national funding (£40m) that has been issued to support the Strep A response across the whole system. It was confirmed that discussions are taking place in respect to funding being allocated to the paediatric network across Cheshire and Merseyside (C&M) to support this issue.

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

22/23/224 Integrated Performance Report, M8

The Board received the Integrated Performance Report (IPR) for Month 8. An update was provided on the following areas of the IPR:

- Outstanding S*afety - Safe;*
  - There has been a continued improvement in the 60-minute target for the management of sepsis on in-patient wards and ED.

- There has been a continued reduction of restrictive interventions in the Tier 4 Mental Health Unit which has been driven by the improvement work that is taking place.

- *Outstanding Safety - Caring;*
  - There has been an improvement in the Trust's responsiveness to formal complaints, and 89% of PALS concerns have been responded to within the 5-working day KPI.
  - There has been a reduction in families who would recommend Alder Hey. This is mainly driven by the Trust's ED FFT figures.
- Recovery and Access – *Effective*
  - The backlog of clinical letters is continuing to reduce as a result of the work taking place.
  - The Trust is achieving the Was Not Brought (WNB) target as a result of using the AI predictor in the departments that have high WNB rates.
  - It was pointed out that further improvement work is required to address super stranded patients therefore the Trust is in the process of compiling a Repatriation Policy and discussions are taking place with the Paediatric Network about their involvement.
- Recovery and Access – *Responsiveness*
  - The Trust did not achieve the 104% ERF target for elective care in November but did attain a performance of 120% for new outpatient appointments.
  - Attention was drawn to the challenges being experienced around elective activity due to the reduction of out of hours/additional weekend activity following the issue of the rate card by the British Medical Association (BMA). The Trust is having discussions with its Local Negotiating Committee to agree a rate of pay that is affordable for the Trust in order to restore additional activity in January 2023.
  - There has been step change in diagnostic waiting times, with up to 73% of patients being seen within six weeks and a sustained performance of 100% in Radiology.
  - There is an indication that long waits *(> 52 weeks*) are reducing, with consecutive improvement each week. It was confirmed that the 'Dental Insourcing' model will commence in January which will help towards reducing long waits.
- Well Led – Great Place to Work – *People*
  - It was reported that staff turnover is currently at 14%. A detailed analysis took place at the People and Wellbeing Committee (PAWC), and sustainable interventions are being considered and presented via a newly established task and finish group.
  - The overall figure for sickness absence in November is 6.2%, which is above the 5% target. It was confirmed that interventions remain in place.
- Well Led – Financial Sustainability – *Finance*
  - The Trust is reporting a surplus of £1m in M8 which is in line with the plan. The year-to-date (YTD) position is £0.6m surplus in line with the plan.
  - The organisation is forecasting to achieve a £17.3m in year Cost Improvement Plan (CIP) target. This is predominantly non-recurrent which will result in a pressure carried forward into 2023/24, but it was reported that opportunities of £2.7m have been identified during the month which could take the recurrent gap down to £4.5m.
  - Planning guidance for 2023/24 is due to be published on the 22.12.22. Further detail will be provided during January's meeting on the guidance and the Trust's plan for 2023/24, which is underway.
  - Dani Jones advised that a session has taken place with senior managers about interconnecting the planning guidance and annual planning with the Vision 2030 Strategy.

- Well Led – *Risk Management*
  - The percentage of risks within review date has reduced substantially therefore focussed work will take place to address this matter during the coming months.
  - The Corporate Services Collaborative has reported 17% staff turnover in the cohort of departments that form the collaborative therefore it has been agreed to conduct a piece of analysis.
- Well Led – Safe Digital System – *Digital*
  - *Aldercare Programme:* Progress has been made across the whole breadth of the programme and it was confirmed that the ICB has signed off documentation for the additional funding that was allocated by the national team.
  - *Aldercare Gateway Review* – It was reported that the Trust passed through the programme gateway following a re-run of the gateway at the Programme Board on the 13.12.22.
  - It was pointed out that the score for BAF risk 4.2 (*Digital Strategic Development and Delivery*) has been increased as a result of the multiple programmes and priorities that the Trust has in 2023.

The Divisions of Community/Mental Health, Medicine, Surgery and Corporate Services gave an update on their respective highlights, areas of concern and provided a forward look as detailed in the new Integrated Performance Report for M8. The following points were raised:

Community and Mental Health

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

Medicine

- There has been an increased focus on sepsis training within the Division.
- There has been an increased focus on staff retention.
- *Nephrology Team* – The Trust has seen an increase in patients on haemodialysis due to a reduction in transplants. It was reported that the organisation is the process of acquiring two further machines as Alder Hey has capacity for 10 dialysis patients but is presently providing care for 14 with a further patient expected. In addition to this mitigation, the Trust is looking at compiling a business case in association with colleagues to enable the service to open 7 days a week, 12 hours per day.
- Attention was drawn to the successful collaboration work that has enabled the Radiology Department to open 'Hub 2' which is helping to reduce the four-hour wait for patients.

Surgery

- It was reported that the Director of Surgery, Benedetta Pettorini, will be chairing December's theatre update session in order to address a number of culture concerns. It was confirmed that an update on the feedback received from staff will be provided during January's update.
- The Division is due to commence a piece of work to look at standardising the prevention of surgical infections which will include a review of antibiotic prophylaxis and a wound care pre-operative bundle. The Board was advised that to have a stratified bundle for the prevention of surgical site infections will be the first of its kind internationally.
- The Division is in the process of recruiting to several teams which will help support activity.

Corporate

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

Resolved:
The Board received and noted the content of the new IPR for Month 8 and the updates included in this agenda item.

Infection, Prevention and Control (IPC) Update

The Board received an update on IPC across the Trust from the Director of IPC, Bea Larru. A number of slides were shared which provided information on the following areas:

- *Monthly metrics* - It was reported that there has been a significant increase in invasive group A streptococcal (IGAS) cases. It was confirmed that none of these patients were linked to each other, and this was confirmed by genotyping. There has also been a significant number of patients on Critical Care and Ward 1C colonised with Carbapenem-Resistant Enterobacteriaceae (CRE). This matter is being closely monitored.
- Vaccination Programme.
- Elevation in group A streptococcal disease in 2022/23.
- Public health response to the rise in IGAS infection.
- *Management of Tonsillitis* – A proposal is to be submitted to ED for the use of a pathway for managing tonsillitis *(integrating the FeverPAIN criteria with GAS rapid diagnostic test)*.

Louise Shepherd advised that further discussions have taken place in relation to a national response for paediatrics to the current IGAS crisis. It was reported that the Centre has asked Alder Hey for their thoughts on issues relating to point of care testing and the prescribing of antibiotics in terms of having a low threshold and making them available in the community. Bea Larru provided her professional view on this matter, and it was agreed to meet outside of the meeting to compile a strong response on behalf of the Trust in reply to the Centre's request.

22/23/224.1 Action: LS/BL

Attention was drawn to the opportunity for Cheshire and Merseyside (C&M) to support colleagues around the region once new IGAS pathways have been agreed.

Resolved:
The Board noted the IPC update.

22/23/225 Alder Hey in the Park Campus Development Update.

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

- *Neonatal and Urgent Care Development* – Enabling work has commenced and a letter of intent has been issued to Morgan Sindall to secure orders/ design element to mitigate predicted inflation risks. The Trust is continuing to work with the PFI provider, Project Co, with regard to the release that is required to enable the organisation to sign up to the arrangement.
- *Sunflower House Construction* – It was confirmed that the Trust is on target to move into Sunflower House by February 2023 as the two outstanding issues relating to 1. Quality issues to the finish of the building. 2. Sprinkler provisions

to the car park, are being progressed and completion is planned ahead of the target date.

- *Park Reinstatement* – Work is taking place to resolve a building regulation issue as quickly as possible so that the old Catkin Building can be vacated as this is key in terms of progressing the reinstatement of the park. The Board was advised of the public meeting that was called by local Councillor, Harry Doyle, in order to provide the local community with an update on the restoration of the park. It was reported that the meeting was well attended, and issues were raised about the delay to the park, the planned housing development on the North East plot and how this will affect primary care access for those living in the area along with travel arrangements, etc. During the meeting Alder Hey apologised to the community for the delay in the restoration of the park. It was felt that the meeting has opened a channel of communication between the local community and the Trust and an approach that will enable the Trust to reinstate the park to a high standard by 2023. The Board was advised that it is key that the Trust reinstates the park within the timeframe and that the quality is of the standard that has been agreed. The Chair highlighted the importance of keeping the channels of communication open with local people.

Resolved
The Board received and noted the Campus Development update provided on the 15.12.22.

22/23/226 Serious Incident (SI) Report

The Board was provided with oversight of incidents that are considered as serious following the guidance from the NHS England Serious Incident Framework (March 2015), and associated learning for the reporting timeframe from the 1st of November to the 30th of November. The following points were highlighted:

- It was reported that there has been a real focus in month on the closing down of action plans associated with previous RCAs. Thanks were offered to all of the teams who have supported this area of work.
- The Trust declared one Never Event during the reporting period (Ref: 2022/23391) which relates to a biopsy being undertaken on the wrong site as part of a research trial. This incident occurred in January 2022 but wasn't reported on the system as an incident until August 2022. There were a number of questions raised as to whether this incident met the threshold of a Never Event and therefore wasn't declared until November 2022. It was confirmed that an RCA is underway, and the panel have met. There is a lot learning and improvements to be made as a result of this incident, but it was confirmed that this was a no harm Never Event and the patient was able to continue with his treatment.

Kerry Byrne asked as to whether formal action plans are compiled following the learning from a Serious Incident (SI) and if so, where would they be tracked/ monitored? It was also queried as to whether there is a process in place to highlight the reoccurrence of a theme where learning and actions have been embedded. It was reported that formal action plans are raised for all (SIs) and are monitored via the Divisional governance structure. The central team receive assurance against each action and close them down accordingly. Learning is also shared on a weekly basis during the Patient Safety meeting. It was pointed out that work is taking place to strengthen the monitoring of themes/trends and thematic reviews are conducted where it is noted that an incident with the same theme has occurred again.

Resolved:
The Board received the Serious Incident report for the period from the 1.11.22 to the 30.11.22.

22/23/227 Complaints and PALS Report, Q2

The Board received an update and assurance on the performance against complaints and PALS targets in Q2 2022/23, a thematic analysis of the top reasons for complaints and PALS, action taken because of concerns raised, and achievements in Q2 2022/23. The following points were highlighted:

- Compliance with the 25-working day response time was 65% in July, 82% in August and 65% in September (average 71%) demonstrating the requirement for a continued focus on this area of work to ensure families receive a timely response to their concern.
- There was one new referral to the Parliamentary and Health Service Ombudsman (PHSO) during the reporting period. It was confirmed that the investigation has commenced and is at the review stage. It was also reported that the Trust has received notification that one of the complaints that was lodged with the PHSO has been closed. The PHSO was assured that the Trust had done everything possible in line with the PHSO framework and the Trust's framework to satisfy the complainant.
- There has been a sustained improvement in responding to and resolving informal PALS concerns within 5 working days with an average of 82% compliance. This has had a direct positive impact on families who raise a concern.

The Chair pointed out that there aren't any notices across the Trust providing details on the process for making a complaint and queried as to whether a piece of work needs to be conducted regarding this matter. It was confirmed that this is one of the actions included in the improvement plan. A suggestion was made about involving young people in the improvement work and introducing QR codes.

Resolved:
The Board received and noted the content of the Complaints, PALS and Compliments report for Q2.

22/23/228 People Plan Update

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

- The Trust is looking at practical ways in which to support colleagues who are feeling the pressure of the cost-of-living crisis most acutely. A number of initiatives have been implemented to help staff with management of finances, as highlighted in the report. The 'Pay it Forward' scheme has also been launched and other ideas are in development. It was confirmed that feedback from staff has been positive.
- It was confirmed that the Trust has appointed Chairs for each of the Trust's Staff Networks *(Disability Network,* Race, Ethnicity and Cultural Heritage (*REACH) Network and LGBTQ Network).* A senior mentor will be working alongside the new REACH Chair, and it was reported that a deputy Chair has also been appointed for the REACH network. Work will commence with the Chairs of the networks to re-instate network meetings in January 2023.

- The Board was advised that it has been agreed that the Chef's special low-cost healthy meal is to be expanded as an option for CYP, families and staff. Work is also taking place in association with Sophie's Legacy Plan in terms of looking at how the Trust can support hot meals and availability of food for parents and siblings of patients.

Resolved:
The Board received and noted the content of the People Plan highlight report.

22/23/229 Board Assurance Framework Report
Resolved:
The Board received and noted the contents of the Board Assurance Framework report as at the end of November 2022, acknowledging the scrutiny that had been undertaken by each of the assurance committees with regard to their respective risks, including deep dives.

22/23/230 Board Assurance Committees

RABD - The approved minutes from the meetings held on the 24.10.22 and the 29.11.22 were submitted to the Board for information and assurance purposes. During December's meeting the Committee discussed topics relating to the effects of inflation, the cost of living and how the Trust is going to address these matters. The Committee also noted the positive cash balance which has been in the £80m to £90m range for a number of months. Attention was drawn to a proposal that was received to commence a Private Patient workstream for the development of a Private Patient Plan. It was felt that approval should be attained from the Board as this area of work has been addressed on a number of occasions and will require resources and funding.

Louise Shepherd advised that the only caveat in terms of pressing ahead with a Private Patient workstream is that it needs to be part of the Trust's broader strategy and dovetail the work that is taking place in that space. It was confirmed that discussions have taken place on international work and a number of strategy sessions have been scheduled to look at the next steps for taking this element of the strategy forward.

SQAC – The approved minutes from the meeting held on the 16.11.22 were submitted to the Board for information and assurance purposes, and an overview of the significant items that were discussed on the 14.12.22 was provided (as per the highlight report submitted by the Chair of SQAC). It was reported that a deep dive took place during the meeting into BAF risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care)* which resulted in the risk score being raised to 20. It was recognised that innovations are taking place to address the front door.

PAWC – The approved minutes from the meeting held on the 31.10.22 were submitted to the Board for information and assurance purposes. During December's meeting there was a focus on; Divisional hotspots, attraction/retention, the new approach to induction and developments in appraisals which is to be linked to the Messenger Review. Jo Potier also advised of the alternative 'listening to staff' approach that is being piloted in ED. Agreement was reached to increase BAF risk 2.3 *(Workforce Equality, Diversity & Inclusion)* in line with current gaps in controls, although the Committee was assured that good progress is being made and the gaps in controls are being mitigated.

Innovation Committee – The approved minutes from the meeting held on the 10.10.22 were submitted to the Board for information and assurance purposes. During December's meeting the Committee received presentations and updates on the various programmes. There was also a focus on the CYP As One Platform, C&M Beyond CYP Programme and the new Research and Innovation (R&I) Committee. It was confirmed that a meeting has been scheduled to discuss the finer detail for the new R&I Committee.

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

22/23/231 Any Other Business

There was none to discuss.

22/23/232 Review of the Meeting

The Chair thanked everyone for their commitment and the hard work that has taken place during 2023 and wished everybody the very best for the festive period and the forthcoming year.

Date and Time of Next Meeting: Thursday, 26th January 2023 at 9:00am via Teams

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for January 2023							
24.11.22	22/23/198.3	Integrated Performance Report	*Staff Flu Vaccination Programme Update* - Liaise with the CEO of Liverpool Women's Hospital (LWH) about the provision of flu vaccinations for patients who attend LWH.	L. Shepherd	15.12.22	On track Dec-22	**15.12.22** - A discussion has taken place with the CEO of LWH regarding this matter. The Trust is awaiting feedback from LWH. **ACTION TO REMAIN OPEN**
Actions for March 2023							
27.10.22	22/23/179.1	Freedom to Speak Up (FTSU) Update	*Deputy FTSUG Position* - Review the current time provided to the FTSUG and consider as to whether this time could be increased. Compile a plan for moving forward.	K. Turner/ E. Saunders/ K. Byrne	15.12.22	Mar-23	
27.10.22	22/23/182.2	Board Assurance Framework Report	Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way.	E. Saunders	15.12.22	Mar-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **ACTION TO REMAIN OPEN**
Actions for April 2023							
24.11.22	22/23/198.1	Integrated Performance Report - Divisional Performance Update	*Division of Medicine* - Invite the Histopathology Team to April's meeting to provide an update on the work that is being undertaken by the team (post mortems and placenta work for North Wales/support for Birmingham Children's hospital, etc.)	M. Carmichael/ K. McKeown	27.4.23	On-track Apr-23	
27.10.22	22/23/176.1	Research and Innovation Committee Terms of Reference	*Alignment to RABD ToR* - RABD ToR to be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.	R. Lea	26.1.23	Feb-23	19.1.23 - This item has been deferred to February's Trust Board. ACTION TO REMAIN OPEN
Actions for May 2023							
24.11.22	22/23/208.1	Board Assurance Committees	Arrange for a patient story to be shared with the Board in May based on the Sensory Project that was discussed at SQAC.	K. McKeown	25.5.23	On-track May-23	
Actions for October 2023							
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
27.10.22	22/23/172.3	Integrated Performance Report Overview	Additional information to be included in the summary page of the IPR on key projects and how the Trust is addressing them.	J. Grinnell/ K. Warriner	24.11.22	Closed	**15.12.22** - A review has taken place to ensure correlation with the summary narrative and actions in the main report provided by Executive Leads. A further review of the summary page is to be conducted via the Exec Design Group in the New Year to test out any further improvements with colleagues now that the IPR has been used a number of times at Board and committees. **ACTION CLOSED**
24.11.22	22/23/198.2	Integrated Performance Report	*IPC Update* - Review the system processes that are in place to address the upward trend in RSV	A. Bateman	15.12.22	Closed	**20.1.23** - The Trust has created acute resiratory infection hubs with partners in Cheshire and Merseyside. **ACTION CLOSED**
15.12.22	22/23/223.1	Chair's and CEO's Update	*Liverpool Clinical Services Review* - Submit the final version of the report to the Board on the 26.1.23	L. Shepherd	26.1.23	Closed	19.1.23 - This item has been included on January's agenda.
15.12.23	22/23/224.1	IPC Update	Provide a response to the Centre on the issues relating to the current IGAS crisis.	L.Shepherd/ B. Larru	15.12.22	Closed	19.1.23 - This action has been addressed.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2022

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

Purpose of Paper:	Decision ■ Assurance ☐ Information ■ Regulation ☐
Summary / supporting information:	Supporting information provided as packs for the 6 Board Strategy sessions undertaken since April 2022.
Action/Decision Required:	To note ■ To approve ■
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Implications:	To be described in subsequent documents.

1. Introduction – summary of key risks and issues

This document provides an overview of the strategy development progress, outcomes from the 16.01.22 board development session, which focused on Futures, Engagement and Governance.

2. Background and current state

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

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

- Further engagement with our stakeholders,
- Development of our 'Futures' approach,
- Development of our People Plan and,
- Guiding principles in how our future governance structures, will support the achievement of the vision.

Vision 2030: Engagement

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

The engagement approach is designed to build on the conversations that have been undertaken to date with our partners, colleagues and children, young people, and their families (CYPF). This initial engagement has allowed us to refine the language and the development of a 'Our Story' which truly resonates with our culture and beliefs. The detailed plan, and narrative were socialized at the board strategy session (16.01.2023).

The initial engagement has indicated support for the strategies central positioning around the needs of CYPF and what it means for our colleagues. It is, recognised that throughout the subsequent strategy deployment stages – continuous involvement of our stakeholders will underpin how we implement change.

The Director of Communications is the SRO for the completion of the engagement plan (with weekly reporting into Strategic Execs). Engagement methods and approaches will be tailored to the needs of stakeholder groups.

Development of Futures

A corner stone of the Vision 2030 will be around the centrality that 'Futures' will play in addressing critical CYPF pain points alongside creating headroom through revenue generation. In the trusts board strategy development session (16.01.22) the blueprint for Futures 2030 was presented which detailed the future vision, design principles and functional approach.

The Futures blueprint was broadly supported; in this final quarter of 22/23 attention will now move to, enhancing the blueprint into a deliverable 'proposition' and development of the economic case, that will underpin the decision making in support of the emerging direction of travel.

A full detailed proposal and economic case will be presented to the trust board for Feb 2023.

Our People Plan

Our Chief People Officer will be leading the development of Our People Plan, utilising the intelligence insights gained through the strategy development. The early insights from this indicate the differing needs and expectations of our people. The changing needs of our people has also been reflected in the conversations undertaken to date with our colleagues. The development of the 2030 Strategy provides an opportunity to consider how 'Our People' plan is aligned and reflective of need.

A detailed proposal will be presented to March 23 Trust Board.

Governance Arrangements – Guiding principles

Aim: The Development of a new strategic governance model that gives our ambition space and capacity to thrive; and is compliant with current regulatory frameworks by April 2023.

High-level work has already started led by our Director of Corporate Affairs into considering the impact of the 2030 Vision on the formal governance structures of the Trust. This initial thinking has centered around the development of some guiding principles which will underpin a new strategic governance model (*naming conventions to be finalized*). The creation of a new governance structure will provide the foundations upon which the 2030 strategy will be delivered.

<u>Guiding principles</u>

- be simple and built to enable cross segment narrative
- remove organisational silos
- present a programme-based framework
- focus on agreed outcomes not on function
- foster cross function conversations
- present clear distinction between strategy and operational BAU
- define a clear rationale and methodology for corporate ROI and benefits realisation.

In overall terms the Alder Hey Board of Directors will retain all constitutional accountabilities and legal responsibilities. The proposed development of a new governance formation, will seek to service the external arm of Alder Hey, focused upon system issues and building our brand and business opportunities in partnership with others, but with an internal focus on the delivery of the 2030 Vision.

3. Conclusion

This paper consolidates progress and approvals to date in the recent strategy board session (16/01/23).

- The engagement plan has commenced and is underpinned around an opportunity for our stakeholders to have a conversation around our Vision 2030.
- The trust board at the Strategy Development session, approved the Futures Blueprint.
- Our Chief People Officer will be accountable for the delivery of the People Plan and ensuring the alignment with the 2030 Vision.

4. Recommendations & proposed next steps

The recommendations following this paper are to note the progress that has been made to date in the development of the engagement approach, Futures Blueprint and Governance Principles.

Next steps

1. Chief People Officer will be accountable for the development of the People Plan, which will be presented to Trust Board in March 2023.
2. The engagement plan will progress as outlined, with reporting into Strategic Execs on progress.
3. The detailed economic case will be presented to trust Board in Feb 2023.
4. The Director of Corporate Affairs to continue with the development of the Governance arrangement, aligned to the guiding principles.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Alder Hey Revised Strategic Governance Arrangements – Guiding Principles Initial Outline**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Director of Corporate Affairs

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

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey Revised Strategic Governance Arrangements – Guiding Principles Initial Outline

1. **Purpose**
The purpose of this paper is to provide a briefing to the board outlining the proposed governance arrangements that will support the implementation of the Alder Hey 'Group' Model that has been put forward as the preferred means of delivering our 2030 Strategy.

2. **Background**
In a number of early informal briefing papers, the CEO has described how, following the global pandemic we are emerging into a very different world from that which we knew in 2019 – a place where we are required by legislation to collaborate and forge formal partnerships with other healthcare providers to deliver the triple aim of the newly-constituted ICSs, a focus on improving the health of our population and delivering better outcomes for them in a way that addresses health inequalities.

This presents a new way of working for us all within the service, but for Alder Hey is an exciting opportunity to tackle some of the deep-seated challenges facing CYP in our Region by working in more formal collaboration arrangements with others who share our interest and desire to do so. At the same time, we have a renewed opportunity to radically change the way we deliver care, building on what we have learnt during the pandemic, using new technologies and digital platforms and leverage the power of our integrated Children's Health Campus to build new businesses/areas of interest in Education, Research and Innovation and across broader geographies, internationally.

This thinking has led to the development of the proposed Group Model as the basis upon which we think about and manage Alder Hey going forward in order to deliver our ambitions to 2030 to be a:

- healthcare provider to the global community
- internationally renowned CYPF community
- provider of personalised borderless healthcare experience leading to improved health and care outcomes.

3. **Principles**
A new strategic governance model that gives our ambition space and capacity to thrive needs to be designed and implemented. It must be compliant with current regulatory frameworks and suitable as a basis for innovation whilst maintaining corporate/board accountability, such that the corporate statutory board remains jointly and severally accountable for all aspects of 'corporate decision making' ie. to set strategic direction, risk appetite, governance structure and operating measures to ensure delivery of corporate objectives. However, if the model is to deliver a changed service, it must:
    - be simple and built to enable cross segment narrative

- remove organisational silos
- present a programme-based framework
- focus on agreed outcomes not on function
- foster cross function conversations
- present clear distinction between strategy and operational BAU
- define a clear rationale and methodology for corporate ROI and benefits realisation.

It also must provide a means by which Ambition 2030 may be given a specific corporate focus and governance framework for strategic decision making, effective risk assessment, reporting and assurance as well as accommodate external collaboration, multiple stakeholders and changing stakeholder mix across NHS, Non-NHS, Local, Regional, National and International partners.

In overall terms:

- The Alder Hey Board of Directors will retain all overarching constitutional accountabilities and legal responsibilities
- The creation of the Group structure will provide the foundation upon which the 2030 strategy will be delivered
- The Group Board will serve as the external arm of Alder Hey, focused upon system issues and building our brand and business opportunities in partnership with others but with an internal focus on the delivery of the 2030 strategy
- The Alder Hey Trust Board (as established constitutionally) will continue to take responsibility for delivery of outstanding patient care delivered by our best people, supported by strong foundations.

4. Structure

4.1 'Group' or Strategic Board - it is proposed that a new Strategic Board be created that will meet for an hour before the main Trust Board each month. It can potentially run a private meeting as required although this would need to be reported to the main Board. Its responsibilities will be:

- Strategy development and oversight of delivery
- External Horizon scanning and policy development
- Focus on strategic change programme through CYP lens:
    - Get me Well
    - Personalise my care
    - Improve My life chances
    - Bring me the future today
- Underpinned by a strategic step up in:
    - Experience
    - Revolutionising care
    - Building communities
    - Futures – RIDE and ventures
- ICS/ICB developments
- Committees in Common initial report back
- Brand enhancement
- Sustainability

Terms of reference for the 'Group' or Strategic Board will be drawn up with a supporting work plan. It is proposed that the new Board will have its own Board Assurance Framework.

Note: the nomenclature 'Group' Model has been used to date to differentiate between the existing governance arrangements and what is being proposed. It is recognised that this language may cause confusions among wider stakeholders and therefore the naming conventions will be subject to discussion and review before a decision is made.

Trust Board – the main Board of Directors will meet following the 'Group' Board and will receive a formal verbal report from CEO with regard to 'Group' items of business – having previously received the papers. The Trust Board will focus on delivering the operational plan, safety, people issues and associated assurance. The clinical Divisions will take a more prominent role at the main Board in terms of operational delivery and assurance.

4.2 Assurance committees

The existing board assurance committees will continue to report to the main Trust Board. The exception to this is likely to be the newly established Research and Innovation Committee which will report to the 'Group' Board. Other assurance committees covering each of the main aspects of Alder Hey Futures will be established to report to the 'Group' Board which will include Health Inequalities, Ventures, International etc. In addition, it is proposed that the current Strategic Executive team meeting takes on a formally recognised decision-making remit for key operational issues including investments, this will enable a fast paced response to the new environment and vehicle for oversight of new ways of working.

5. Roles and Responsibilities

There will be no changes to Non-Executive Director roles under the new governance model. The Trust Chief Executive will remain as the legally Accountable Officer. Implications for Executive Director roles will form part of the next phase of development once the guiding principles are fully developed and agreed.

6. Next Steps/Phasing

- Terms of Reference and work plan for the 'Group' Board will be developed for consultation
- Naming conventions for the new arrangements to be agreed
- Assurance committees for the Futures workstreams to be agreed
- Any required changes to Executive roles and responsibilities to be considered and agreed
- A formal proposal will be provided to the Board and the Council of Governors for approval.

Erica Saunders
January 2023

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	Growing Great Partnerships
Report of:	Dani Jones, Director of Strategy and Partnerships
Paper Prepared by:	Dani Jones, Director of Strategy and Partnerships

Purpose of Paper:	Decision **Assurance X** **Information X** Regulation
Background Papers and/or supporting information:	Link to BAF Risks. • 3.2 – risk of failure to deliver 'Our Plan' objectives to develop a Healthier Future for CYP through leadership of starting well/CYP systems partnerships. • 3.5 – new integrated care system architecture; risk of inability to control future in system complexity and evolving statutory environment. • 3.6 – risk of partnership failures due to robustness of partnership governance.
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 Sustainability through **external partnerships X** Game-changing **research and innovation** **Strong Foundations**
Resource Impact:	N/A

Growing Great Partnerships

1. Introduction

Alder Hey's strategic objective to 'grow great partnerships' calls out the Trust's ambition to both raise the profile of Children and Young People (CYP) and to improve CYP outcomes system wide – delivering the Trust vision of '*a healthier future for children and young people*'. To do this we must work in partnership. No single individual organisation addresses the totality of CYP needs, but Alder Hey provides a major fulcrum of CYP services and pathways.

As such it is a Trust priority to convene interconnected CYP collaboratives and communities at every system level – pulling efforts together, aligning priorities and addressing fragmentation and gaps in care system-wide. The Trust has made huge progress in these partnership ambitions and worked to ensure CYP are captured in system priorities.

The purpose of this quarterly report is to provide the Trust Board with an update, and assurance of progress and risk management against the Trust's strategic objective of *growing great partnerships*.

This quarter the report will focus in on:

National	• Children's Hospital Alliance
North West (Regional)	• CYP Specialist Services and delegation to ICS's • NW Paediatric Networks – Update
Cheshire & Merseyside (HCP & ICS)	• Health & Care Partnership (C&M HCP) • CYP in the Integrated Care System (C&M ICS) ○ Including "Beyond" ICS CYP Programme and Elective Recovery
Place Partnerships	• Liverpool Place ○ Contain Outbreak Management Fund (COMF) - Liverpool • Sefton Place • Knowsley Place
Partnership Governance	• Alder Hey Partnership Governance Audit *(prepared by Mersey Internal Audit Agency, MIAA)*

2. Children's Hospital Alliance (CHA – National)

Alder Hey continues to host, and jointly chair, the CHA with Great Ormond Street. The alliance of the 11 largest CYP trusts in England has worked together closely over difficult operational challenges, including major ED demands, industrial action impacts and CYP elective recovery, offering mutual aid and driving increased volume of elective activity through initiatives such as Super Saturdays. The CHA recently received the Performance Recovery HSJ Award in recognition of the impact on elective recovery performance and the collaborative approach taken.

CHA membership, including clinical leadership from Alder Hey, are contributing to both a systematised CYP prioritisation tool capturing the long-term harm for children on waiting lists, and the developing national Urgent Care strategy for CYP, due for publication in January 23. A collaborative bid for CYP Virtual Wards has been prepared and accepted by NHSE, with funding routes under identification.

Significant work is underway to address CYP health inequalities, including widespread adoption of Artificial Intelligence (AI) to identify CYP at risk of missing appointments; initiated and supported through the Alder Hey innovation team. The CHA has placed emphasis on addressing the cost-of-

living crisis, including supporting the implementation of 'Sophie's Legacy[1]', which is aligned with the NHSE Food Review team led by the Chief Nursing Officer. Alder Hey's Nursing and Health Inequalities leads are working internally on the Trust's response to supporting CYP, families and carers as appropriate through the cost-of-living crisis. There are no CHA risks for escalation to Trust Board.

3. North West (NW - Regional)

a. CYP Specialist Services – Delegation to ICSs

NHS England and NHS Improvement (NHSE/I) set out a roadmap for integrating specialised services within integrated care systems (ICSs)[2] in 22/23, as part of the broader NHSE/I reform. The majority of CYP specialised services operate on a North West footprint, meaning the delegation of planning and commissioning to ICBs requires partnership arrangements for multi-ICB regional and supra-regional services, through joint committees.

Shadow arrangements are in development for 23/24, pending formal delegation from April 24. Arrangements for the North West have not yet been finalised, but the working direction is towards a multi-ICB commissioning board that includes the 3 NW ICSs, and that can make formal commissioning decisions with the NW Integrated Care Boards (ICBs). From a children's services perspective –

- A greater proportion of the CYP pathway is specialist, than in adult specialist services.
- CYP services care for a wide range of conditions with a lower population prevalence but high complexity, requiring a concentration of specialist staff, infrastructure, and support services.
- CYP specialised services are experts in leading outreach, virtual care, hub and spoke models & access to research and education to advance preventative healthcare and keep CYP out of hospital.
- CYP clinical expertise (inc. specific expertise on complex conditions) is essential to play into commissioning discussions, keep pace with new evidence across the breadth of specialities, derive optimal care models, assess the benefits / risks of delegation.

Alder Hey and RMCH jointly lead the long-standing NW Paediatric Partnership Board (NWPPB – detailed within June 22's quarterly Trust Board update) and are committed to working in partnership with all 3 NW ICSs, partner providers and the wider commissioning system to help contribute provider and clinical expertise in shaping the NW Specialist CYP agenda through the delegation and beyond. Risks associated with delegation of specialist services are under assessment both nationally through the CHA and regionally in the North West and the Trust Board will be kept informed.

b. NW Paediatric Networks – Update

There are 5 NW paediatric Operational Delivery Networks (ODNs – see table). They are commissioned to drive clinical collaboration and effective clinical flows through networked provision of services.

Their roles include developing equitable, high standard services, improving access to services, providing impartial clinical advice and expertise, leading implementation of key national transformation / review programmes,

ODN	Host Trust
Congenital Heart Disease (CHD) All Age	Alder Hey
Neonatal Critical Care	
Paediatric Critical Care, Surgery in Children, Long Term Ventilation (PIC/SiC/LTV)	Joint host RMCH & Alder Hey – jointly governed via NWPPB
Major Trauma	Single budget held by RMCH
CYP Cancer	

[1] Creating change | Sophies Legacy

[2] https://www.england.nhs.uk/wp-content/uploads/2022/05/PAR1440-specialised-commissioning-roadmap-addendum-may-2022.pdf

and driving up standards and education. Alder Hey directly host two, and jointly host 3 more in partnership with Royal Manchester Children's Hospital (RMCH). Assurance on Alder Hey's performance as a host trust is provided biannually to RABD, and all ODNs report into the quarterly NWPPB.

Access to some NW specialist CYP services is not fully equitable or aligned with need. The national Women and Children's specialist programme of care, led by NW Specialist Commissioning, is driving 3 transformation programmes to address this: the *Neonatal Transformation (Critical Care) Review*, the *Paediatric Critical Care Review (level 1 & 2)* and the *Children's Cancer service specification* (Primary Treatment Centres and Paediatric Oncology Shared Care Units). Each review will impact the configuration of services in scope; all Trusts with neonatal and paediatric departments will be involved. The Trust is working with NW Specialist Commissioners, relevant ODNs and system partners to support development of the Case for Change for each review and will share formal intelligence on the potential impact for Alder Hey or wider system partners in C&M as it is available.

The Neonatal review has been pending for many years and a recent peer review by the North East Clinical Senate found Neonatal to have a compelling case for change. The PiC/SiC and CYP Cancer reviews are more recent and require varying degrees of further data and/or work. Respective ODNs provide delivery and thought leadership into these reviews, and to date have been involved in clinical engagement events, analysis of clinical outcomes, patient/family experience, workforce, estates, activity, capacity and patient flows and interdependencies.

Specialist Commissioners are working to ambitious timescales to drive the Case for Change, impacted heavily to date by Covid-19, recovery and system architecture shifts into ICSs (amongst other factors). A long-list of options and solutions is planned for October 2023 – shaped through patient engagement, patient reference and focus groups and clinician engagement. After this a true business case for each element of the reviews will be developed. Trust Board will be kept informed as the case for change develops and any Trust impact/risk is derived.

For Board awareness, one hosted ODN (CHD) currently has one red risk of 20 which is currently under review - *"delay in patient treatment resulting in potential harm due to the inequitable service provision and waiting times".* The ODN, NW Specialist Commissioners and partners have all recognised that this risk requires disaggregating to be more specific at local level, to target action where it is required to address issues. Once updated the risk will be assessed via the CHD ODN Board, the North West Paediatric Partnership Board (NWPPB) and reported via RABD's regular ODN assurance reporting. Individual risks around the current service model are reflected on the risk registers at RMCH, Alder Hey and the CHD ODN, and are overseen by the NWPPB. This is in addition to the day-to-day mitigation, outlined in previous quarterly Board updates.

4. Cheshire & Merseyside

a. Health and Care Partnership (HCP)

The Department of Health and Social Care and NHSE/I set the role of the Integrated Care Partnership (ICP) as a statutory committee which is formed between an NHS Integrated Care Board (ICB) and all upper-tier local authorities that fall within the same Integrated Care System (ICS) area (9 in C&M – see right).

The ICP plays a critical role in the ICS, bringing together a broad alliance of partners concerned with improving the care, health, and wellbeing of the population. It is jointly convened by local authorities and the NHS as equal partners to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

C&M has an established Health and Care Partnership, in place since 2020; this is the committee from which the C&M ICS's ICP will develop. C&M has elected to continue with the name Health and Care Partnership (HCP) as an established brand with partners and stakeholders. The HCP is where partners in the ICS come together to develop the C&M Integrated Care Partnership Strategy and strategic priorities.

Alder Hey play an active role in the HCP, and CYP are recognised as a priority in the draft interim HCP strategy.

- Alder Hey's Chair is a member of the HCP, representing the C&M Acute & Specialist Trust (CMAST) Provider Collaborative
- Alder Hey hosts the C&M "Beyond" CYP programme and contributed the CYP chapter of the draft interim HCP strategy. This represents both CYP as a population cohort, and associated CYP key priorities, including those driven by Beyond from the NHS Long Term Plan, those raised through CORE20+5CYP[3] (health inequalities), Marmot (All Together Fairer) recommendations in relation to CYP, and the C&M Directors of Children's Services collaborative agenda.

Next steps for C&M HCP include engagement on the draft interim strategy, and development of the delivery plan for the HCP strategy – the joint 5 year forward plan. This will be led by the Integrated Care Board, and partners including Alder Hey will be engaged in its development. Final publication is expected by June 23.

b. CYP in the Integrated Care System (ICS)

Trust Board received a full update on "Beyond" in December 22, including both progress reports and assessment of any risks for consideration at Trust Board.

"Beyond" is the ICSs CYP Transformation programme, and successes of note since December include reaching the final stages of the Health Equity Institute/Barnardo's bid to become one of 3 sites nationally to be selected to co-design a new health equity framework for CYP. The bid outcome is known but currently under embargo; Trust Board will be kept informed. "Beyond" is contributing significantly to the ICS's developing plans for CYP and driving the system response to the newly published CORE20+5CYP[4] health inequalities framework. A "Beyond" Conference is under scheduling for March 23, highlighting the work, with local CYP voices and key national CYP leads such as the Children's Commissioner for England.

Alder Hey continue to play an active role in both the CMAST (C&M Acute and Specialist Trusts) and the LDMHC (Learning Disability, Mental Health & Community) Provider Collaboratives. Within CMAST, Alder Hey lead the Paediatric Elective Recovery Group, bringing together regional paediatric teams to collaborate on advancing paediatric elective recovery. The team have successfully bid for £5m funding to establish an elective recovery hub for C&M and received £125k to set up a pilot hub to improve access to paediatric dental services. In addition, C&M's Virtual Ward programme has allocated funding to build upon the proof-of-concept virtual ward established at Alder Hey. The LDMHC provider collaborative has developed a proposal for future governance and commissioning arrangements for the ICB; ongoing work is underway to shape this with all system partners.

5. Place Partnerships

[3] NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

[4] NHS England » Core20PLUS5 infographic – Children and young people

At each Place local to Alder Hey, there are emergent or established CYP collaborative programmes and workstreams. In June 2022, the Growing Great Partnerships Paper updated the Board on emerging work at Place Level and whilst the Place system is still refining its infrastructure and resource, collaborative working is progressing.

One Liverpool Programme: Healthy Children & Families – This work programme is jointly led by Alder Hey's Director of Strategy and Liverpool City Council's Consultant in Public Health CYP lead (joint SROs). The segment ambition is to drive a better future for CYP and Families in Liverpool, working together to deliver the Liverpool City Plan / One Liverpool ambition of a 'healthier, happier, fairer Liverpool for all'.

The Segment will prioritise collective efforts on healthy children and families, working together to identify CYP/families at greater risk of poor health, focusing more on promoting good health and increasing healthy life expectancy, preventing illness and personalising services to support the needs of the CYP and Families population group. There are five emergent areas of focus and delivery identified collaboratively as key areas to address health inequalities across the city – *Better Start, Growing Well, Good Respiratory Health, Healthy Neighbourhoods and Mental Health & Emotional Wellbeing.*

This is a system approach working closely with partners from Liverpool City Council (Public Health and Children's Services), Liverpool Women's Hospital, Primary Care, Liverpool Place, Mersey Care and the Voluntary Sector. The work has key links with the Beyond Programme, implementing new models and pathways of care at Place.

Contain Outbreak Management Fund (COMF) Liverpool – The partnership between the Trust and Public Health Liverpool is strong. Through this the Trust has received COMF funding (a national allocation) to tackle poor and declining child health outcomes in Liverpool, as a direct impact of the coronavirus pandemic. In collaboration with Public Health colleagues, four schemes have been identified and are in the mobilisation phase. Each initiative will be fully evaluated and considered for future service development.

Healthy Weight Programme Mini Grant Scheme	Alder Hey is hosting a city-wide partnership grant scheme to create a prevention focussed, community based, partnership led approach to addressing healthy weight and improving mental wellbeing in children and young people. The bid was opened pre-Christmas and applications are currently under sifting and shortlisting.
Prevention in Pathways Targeted intervention	Alder Hey is creating a survey and design a toolkit that asks about and signposts to existing services around key health issues and the wider determinants of health: debt, fuel poverty, food poverty/insecurity, emotional wellbeing (child and mother), obesity, oral hygiene, household smoking, immunisations.
Restrictive Food Intake Pilot	Many children (in the hundreds) are currently open to services at Alder Hey and identified as having problems with eating linked to anxiety and/or sensory processing difficulties. Health consequences can include tooth decay, obesity, nutritional deficiency and/or weight loss. They do not meet criteria for specialist CAMHS or dietetics until their problems start to have a significant impact on their functioning. Alder Hey is designing and delivering a group intervention for families where children have a restrictive eating pattern that is not an eating disorder.
Mini Mouth Care Matters	Evidence suggests that oral health has been closely linked to the general health and wellbeing of the entire body. The proposal aims to put the mouth back in the body and empower medical & allied medical healthcare professionals to take ownership of the oral health care of any paediatric in-patient with a hospital stay of more than 24 hours.

Sefton Partnership - The 'Live Well Sefton' plan is emerging with one of the three ambitions being "Start Well". This will involve children and young people up to age 18, but also those up to age 25 years with additional needs. This ambition will focus on the 4 action areas –

- Early intervention and prevention – this element will include health interventions, for example embedding the asthma bundle and the Beyond priorities at Sefton Place
- Emotional wellbeing and mental health
- Children in care
- Transforming care (LD and autism)

The Trust is engaged across the breadth of governance of the Sefton programme and an influential partner within the strategic and operational element of delivery. Links are also developing with Knowsley Place through both Alder Hey's leadership teams and Beyond at a C&M level.

6. Alder Hey Partnership Governance - Audit prepared by Mersey Internal Audit Agency (MIAA)

This audit was carried out in Q3 2022, in line with the Trust's programme of governance review with colleagues at MIAA. Its overall objective was to ensure that the Trust has established robust governance arrangements with partner organisations and can demonstrate these are operating effectively.

The resulting opinion following review by MIAA is one of **"substantial assurance"** with "a good system of internal control designed to meet the system objectives, and that controls are generally being applied consistently". This will be presented to the Alder Hey Audit Committee in January 23.

Next steps are to continue with two recommendations of the review, including building upon the innovative approach to partnership quality assurance rounds (PQAR), rolling these out to key partnerships over the coming year. It is noted that the Trust is already underway in recommending undertaking a PQAR with other key partnerships; this is dependent on the agreement of partners to jointly undertake, but initial discussions have been positively received and further PQARs are to be scheduled.

7. Risks and Issues to Highlight

The Board is asked to be aware of the red risk of 20, which is currently under review, and held by the hosted CHD ODN, and to note both the oversight and mitigation arrangements.

The Board is asked to recognise the stage of development of the NW Case for Change for the three specialist reviews (Neonatal, PiC/SiC and CYP Cancer) and note that Trust Board will be kept informed as the case for change develops and potential impact / risks are known.

8. Recommendations

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Green strategy**
Report of:	**Green team**
Paper Prepared by:	Alex Pitman

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

1. Introduction – summary of key risks and issues

The draft strategy was presented to the Green Programme board, executive team and RABD last month and has now been consulted on more widely with feedback from around the trust.

The updated version is now presented for approval.

2. Background and current state

The NHS and the trust have committed to reaching net zero carbon emissions. We made good progress towards this in 2022 and also made significant financial savings.

2022 Highlights:

- Programme initiated by Mark Flannagan as SRO appointing Alex Pitman as project director
- Green programme board chaired by Garth Dallas established to give strategic direction
- Delivery and decisions group chaired by Adam Bateman created to deliver strategy
- Carbon footprint of trust in 2021/22 established
- In year carbon saving of > 15% and over £ 1m saving
    - Gas CHP (Combined heat and power plant) restored to operation
    - Refrigeration leaks fixed preventing loss of damaging gases
    - The Building optimisation team led by Lachlan Stark, has fine tuned heating, cooling, ventilation, lighting and water systems across existing buildings.
    - Ensured new and temporary buildings perform well from day 1 of operation.
    - Behaviour change programme started with focus on “shut doors and switch off”
    - Capital project underway to improve recycling with new compactors
    - Wide range of improvement projects identified to improve main building from
    - Reduction in use of our most environmentally damaging medical gases

We now need to build on this and deliver more and larger change. This strategy outlines the challenges and opportunities ahead.

We have made some recent progress in supporting an ICB wide approach to Green and have updated the paper to reflect this.

3. Recommendations & proposed next steps

We recommend that the board approve the strategy/

A business case will be presented to IRG (investment review group) in March detailing next steps and 2023/24 implementation plan.

Key next steps include:

- Energy efficiency investments in the main building
- Broaden involvement through creation of engagement groups, including CYP and our staff
- Launch event for strategy in April
- Funding for
    - green team
    - wider communication plan including CYP
    - clinical project support e.g. “Gloves off “project
- Broadening of programme to include more teams
- Expanded work with ICB and wider system

Delivery will continue to be managed through our delivery forum with the Green Programme board reviewing progress and strategy.

Progress reports will continue to be made to exec with quarterly assurance reports to RABD.

000036

NHS
Alder Hey Children's
NHS Foundation Trust

Delivering NET ZERO

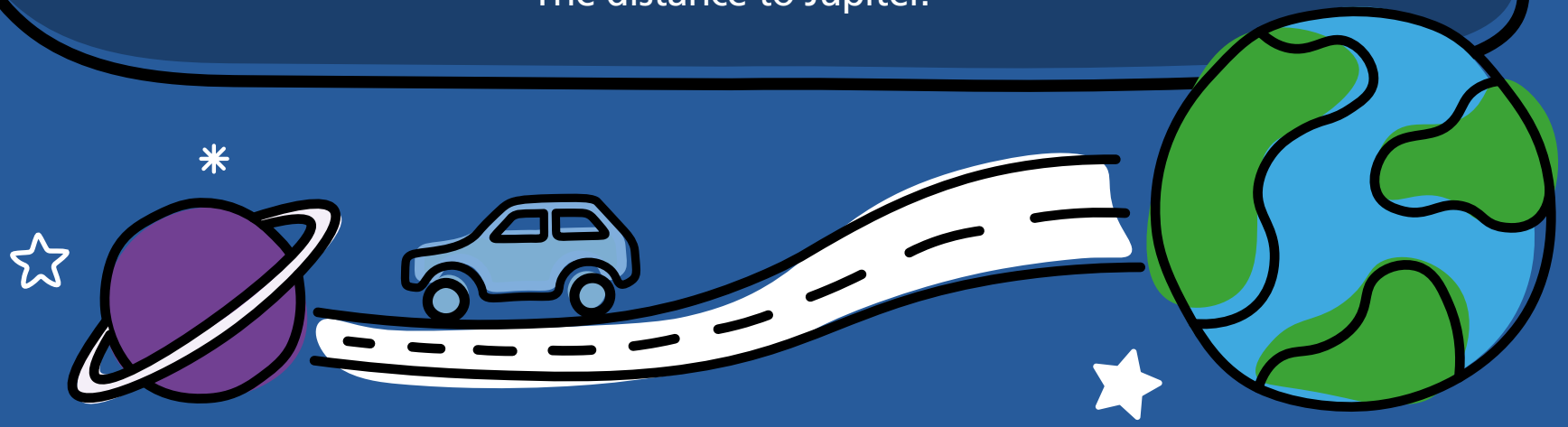
A healthier future for Children and Young People

Contents

PLEASE **CLICK** ON THE CONTENTS BUTTONS TO NAVIGATE TO EACH SECTION

CO2 (carbon dioxide) discharged into the atmosphere contributes directly to global warming – the heating of our planet. The result is hugely significant changes to our global and local climate, resulting in harm to health and loss of life. To stop global warming it needs a global effort and Alder Hey is pledged to play its part.

Alder Hey's buildings currently have a carbon footprint of 9,357 tonnes of CO2 per annum. **That's like driving 54,000,000km in a diesel car – the distance to the planet Mars.** Our wider carbon footprint including our supply chain is estimated at over 90,000 tonnes.
The distance to Jupiter.



Introduction

In March 2020 to play our part in tackling global warming the Alder Hey Trust Board committed to becoming a net zero organisation. Our Green Plan will deliver this, with some immediate action underway now, alongside a longer-term Programme to deliver a **net zero Alder Hey.**

Becoming net zero is central to our Vision: A healthier future for children and young people.

Our goal is not just an Alder Hey that meets specific targets on carbon emissions, i.e. is net zero, but one that holds "being Green" as one of our core purposes. **In short, going Green means an end to being engaged in climate change activity that harms our children and young people.**

It is part of our duty as an Anchor Institution in Cheshire and Merseyside to reduce our environmental impact.

To do this we need to make sure that we do no harm by addressing climate change in every aspect of our work. As a set of buildings, we can ensure that we remove harmful emissions from our sites.

As an employer, we can ensure that our people are supported in their own efforts to reduce their own carbon footprint. As a healthcare provider, we can address in all areas the activity we undertake, that what we use and what others use on our behalf, has minimal impact on our climate.

As a Research and Innovation leader we can seek news ways of doing things that are better for our planet.

Whilst making changes to net zero we have been able to and will continue to be able to identify cost savings that will both pay for the necessary actions and bring financial rewards back to NHS services. For example, to date, in our energy consumption we have locked in net savings of over £400k in 2022/23.

Our long term goals

- Net zero for emissions we control directly by **2036**
  (NHS footprint in diagram 1)
- Net zero for emissions we can influence by **2045**
  (NHS footprint plus in diagram 1)

Our interim goals

- Reduce NHS footprint by **15%**
  (from our 2021/22 base by 2024/25)
- Deliver >**£1m** year net saving
  (from 2023/24 onwards)

Alder Hey will play its part in delivering a net zero NHS

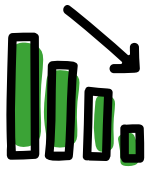
The NHS strategy greener NHS » delivering a net zero NHS assumes key steps to get to net zero.

These include:

We phase out gas usage in buildings

We phase out petrol and diesel for vehicles

We move to electricity for cars and heating



We transform our supply chains to produce low carbon products

NHS carbon targets

The Health and Care Act 2022 placed a legal duty on trusts to contribute to the UK's net zero target, building on the prior NHSE need for all trusts to have a Green Plan.

The NHS has set two key targets on carbon reduction from a 1990 baseline:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to **reach an 80% reduction by 2028 to 2032;**
- For the emissions we can influence (our NHS Carbon Footprint Plus), **we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.**

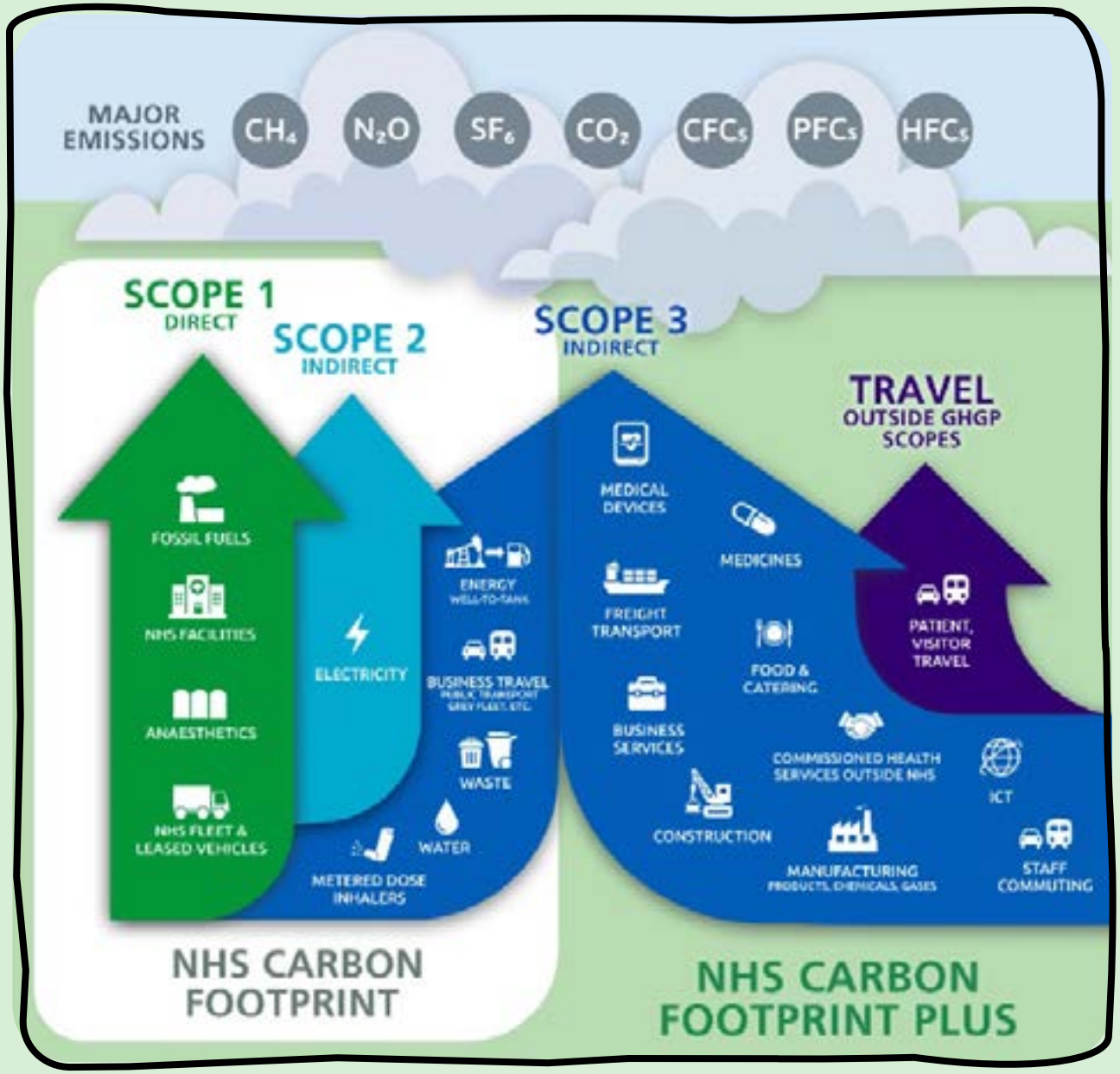


Diagram 1: Green House gas protocol scopes in the context of the NHS

Our duty of climate care

Alder Hey has a key role to play in tackling climate change

Climate change is a major health issue. The effects, from polluted, unclean, unhealthy air to changes in seasonal temperatures are already having a direct impact on the health of children and young people in our area.

As a leader in children and young people's health evidence, as an advocate for and with children and young people we have a duty to act. We have a duty to "Do no harm". To achieve net zero will require more than a series of operational actions, albeit they will be important.

We need to develop a shared "mission" amongst our staff, visitors and others with who we come into contact to be a Green Alder Hey that delivers understanding and behaviour change.

Alder Hey will "be Green" by making sure that...

Every member of staff understands our **shared "mission"** and their personal responsibility to take action.

Alder Hey is **transparent and active** in duty as part of our wider community to contribute to making Cheshire and Merseyside greener.

Taking **action in everything we do** to prevent the harm that climate change brings to children and young people.

Current actions

The Green Delivery Group has produced visual reminders to be green such as switching off lights, turning off PCs, etc.

We are developing a behaviour change and **Alder Hey Green Mission campaign.** Using an external agency is helping us develop a stronger campaign, increasing our expected savings.

The campaign brief is to: inform of the need; advise of the action we are pledged to take as Alder Hey; provide a shared rationale for individual own actions, with understanding that every action matters. This campaign will not be a one-off with short term immediate effects but a longer-term process of creating a shared sense of purpose and duty to all that we need to **"be green"** at every level.

Future actions

We will

- **Work** with our children and young people to explain our Green plans and the part they can play.
- **Embed** net zero as a shared objective for Alder Hey in our staff induction and training.
- **Broaden** our corporate measures to lock in reporting on progress to net zero across each area.
- **Make net zero** as a key objective for Alder Hey staff in their team and, where appropriate, individual annual objectives.
- **Set up** a staff led Green Network, linking up areas of expertise in achieving net zero with **Green Champions** in each area of our operations.
- **Ensure** that we highlight the need to **"be Green"** in every area: from staff induction and training to making it a mandatory measure in business cases before they are agreed.
- **Lock** into our Performance Review and corporate measures in reporting on progress to net zero.

Clinical insight helping tackle environmental causes of ill-health

Ian Sinha

Ian is a Consultant Respiratory Paediatrician at Alder Hey Children's Hospital as well as a Professor within the Division of Child Health at the University of Liverpool, where he researches paediatric asthma and neonatal lung diseases.

Ian and his team have led the way in using clinical insight to highlight the environmental causes of ill-health. They've started to tackle these through innovations like their Clean Air Clinic.

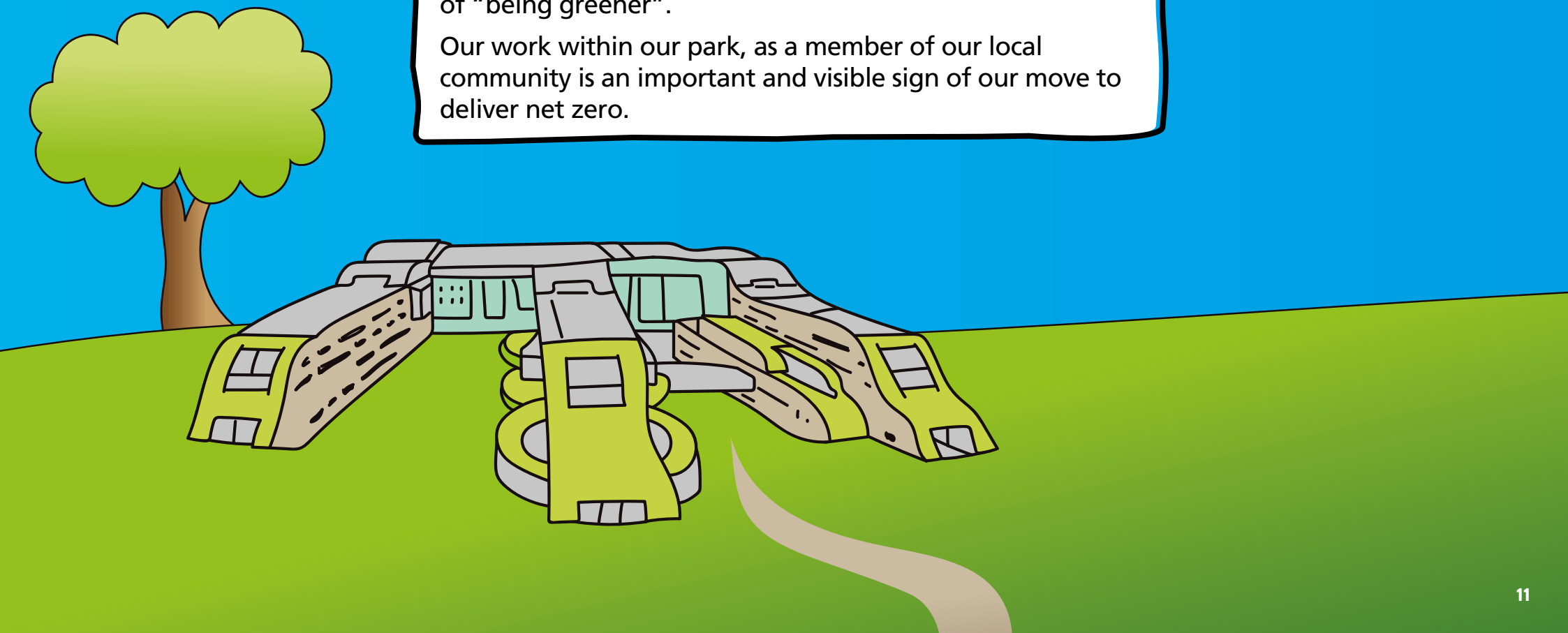
UK's Environment Agency Faces Legal Fight Over Landfill Fumes

Cold Homes Will Cost Children's Lives And Cause Long-Term Damage, Warn Experts

And… because Alder Hey in the Park is **Europe's only hospital sitting alongside a green space for our local community**, Springfield Park, we will ensure that this space helps us tackle climate change.

We will deliver our pledges to plant trees, develop the green spaces, create a setting that allows everyone in it to become closer to nature, and focus on practical examples of "being greener".

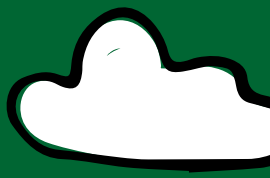
Our work within our park, as a member of our local community is an important and visible sign of our move to deliver net zero.

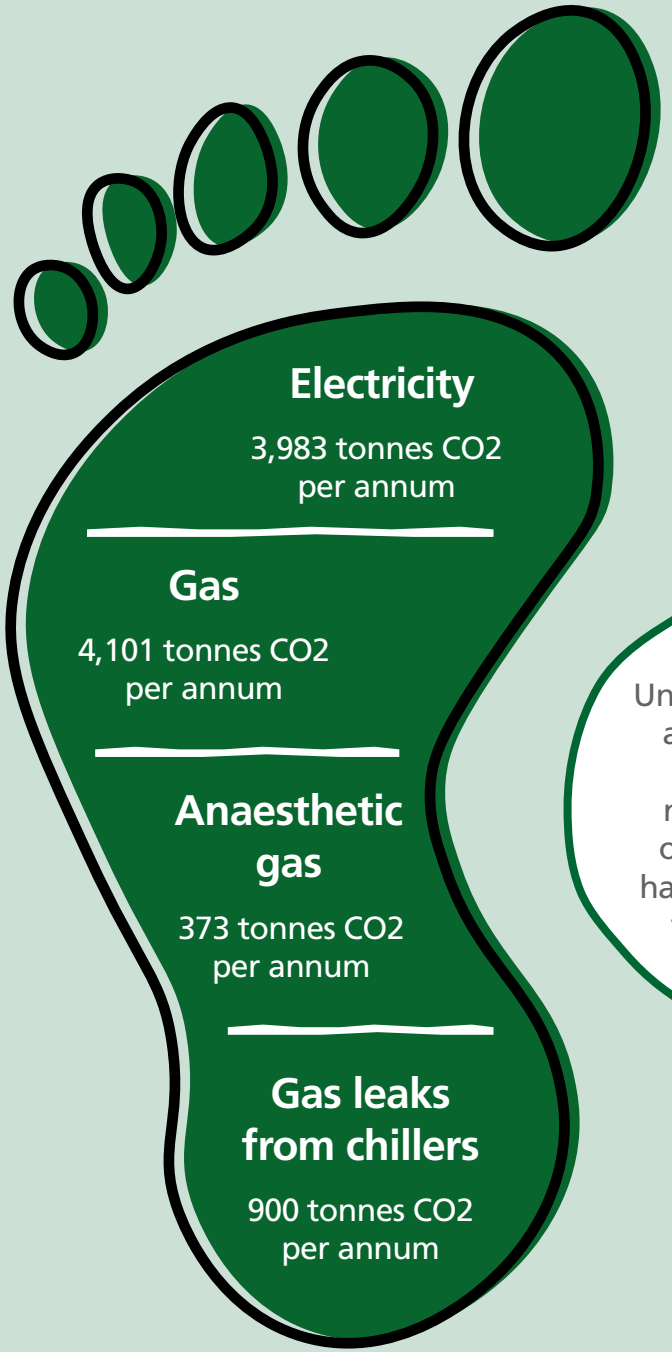


Our starting point

We have identified our start point as a measure of the emissions from our buildings. Effectively this is the energy we use and what goes up our chimneys and is the majority of the "NHS carbon footprint".

We plan to measure the other areas where we produce a carbon footprint as a task for 2022/23.

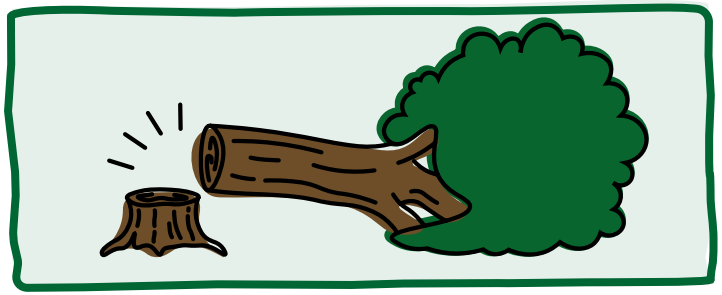




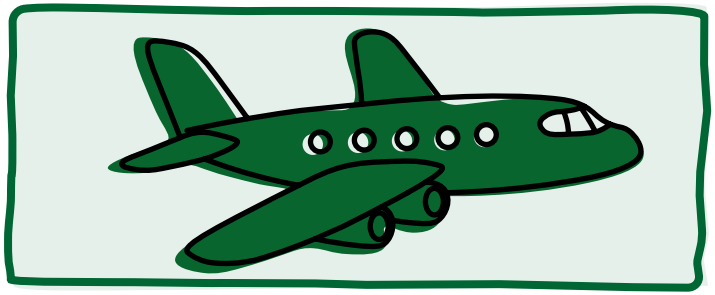
Units of measurement are tonnes of CO2 equivalent, the number of tonnes of CO2 that would have the same global warming impact.

Visualising tonnes of carbon is quite hard.

Our emissions for **just 2 days** are equivalent to chopping down all the trees in Springfield Park and burning them...



...Or we could fly everyone in the trust to New York and back.

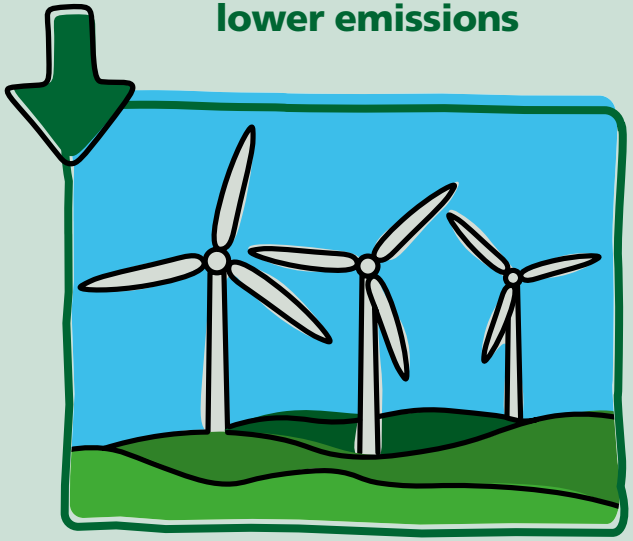


What is “net zero”?

Net zero means we have stopped adding to global warming.

The emissions we are adding to the atmosphere will be matched by an equivalent amount taken out. There are few proven ways to remove emissions so we must plan to almost eliminate our emissions.

Measures to **lower emissions**



For example:

- Invest in **green technology**

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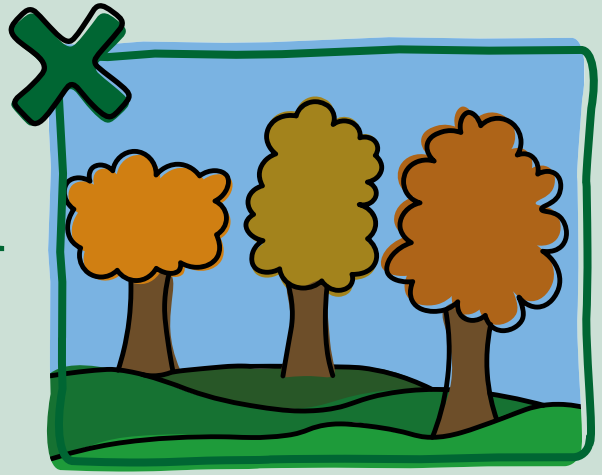
Measures to **remove emissions**



For example:

- **Forest expansions**
- **Direct air capture**

=

Net zero

Balance between amount of GHG produced and removed from the atmosphere

What a net zero Alder Hey will look like

For Alder Hey achieving net zero means changing nearly all our carbon footprint activities: from the buildings occupy and how we run them, to the medicines we give, to how people travel to our sites, to how we buy goods and services, to helping change individual behaviours of our staff and visitors. **And more.**

At high level the key changes we will make are:

Timeframe to end of each financial year

2022-27

Optimisation of our current activities

- **Deliver energy efficiency** by better use of our systems and specific savings through corporate and individual action
- **Improve recycling** of products (from bottles to gloves to gowns)
- **Make changes to travel** activity to reduce carbon emitting vehicle numbers to our sites
- **Prevent gas leaks** through repairing our main chillers
- **Green and carbon fully built** into decision making
- **New models of care** are Green by design

2027-32

Transformation of current systems

- **Key assets** that burn gas including all our boilers
- **Significant reduction in car parking** on our sites through modal shift to other forms of travel
- **Reduce all waste,** from plastics to gases
- **Low carbon models** of care move beyond trust
- We adopt local, **national and global changes** created by others

2032-37

Close to net zero

- **No carbon emissions** from the Campus building
- Most Trust related **journeys not by car**
- **No single use items** where possible, from PPE to instruments to packaging etc.
- Create a **re-use and circular economy**
- **Solution** for offsetting remain emissions

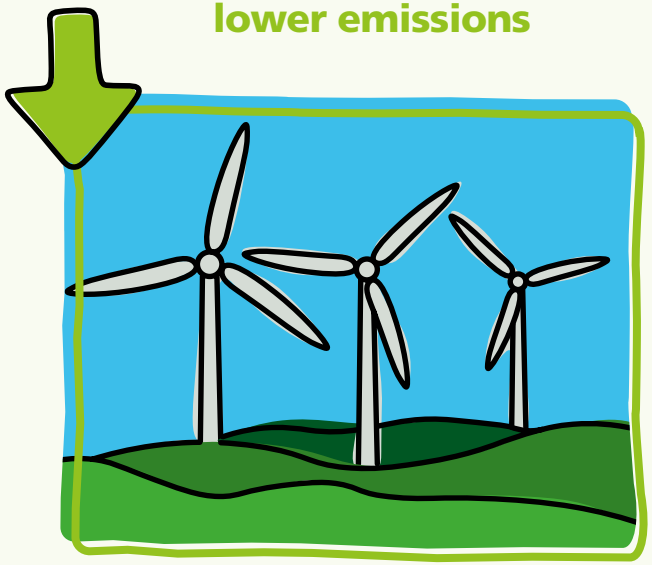
2045

Net zero

- Grid is **zero** carbon
- **Zero** carbon supply chain

If we do this we will become a net zero Alder Hey

Measures to **lower emissions**



For example:

- Invest in **green technology**

+

Measures to **remove emissions**

For example:

- **Forest expansions**
- **Direct air capture**

=

Net zero

Balance between amount of GHG produced and removed from the atmosphere

Progress to date

We have already made improvements in some areas such as changing the way we consume energy and changing our usage of anaesthetic gases to reduce their carbon footprint and impact on climate change.

We will move forward from this with a joined-up programme of work that runs deep into every part of Alder Hey, within every operational area to meets the Trust Board's mandate to develop a **Green Plan.** To oversee this, we have established a monthly high level Green Programme Board, chaired by a Non-Executive Director.

Under this is a Green Delivery Group with membership from Alder Hey staff, Mitie (our Facilities Management Company) and our PFI Special Purpose Vehicles (SPV) colleagues, who own our hospital building. **The focus of this group is to make immediate changes to deliver a reduced carbon footprint rapidly.** Its first focus has been on reducing energy consumption and, therefore, costs, as we head into the winter of 22/23.

We have already:

- **Repaired** key equipment including the Combined Heat and Power Plant and the chillers
- Started making **improvements** to heating and cooling, improving staff comfort as well using **less energy**
- Started our **energy saving campaign** with blogs and getting the basics right like lights turned off
- Made **big improvements** to medical gases
- **Cut energy by 5%** and **carbon by over 10%**

Delivering a net zero Alder Hey: areas for action

We have broken down our areas for delivery in a number of **key workstreams** each with their **own targets**, alongside **immediate and longer-term actions** as follows.

Energy

We are gradually improving optimising building systems for energy use

Short term goals:

- **Reduce** energy usage by **5%** in 2022/23 and by a total of **10%** in 2023/24

Long term goals:

- **Zero emissions** from energy by 2037

The main hospital building uses over 80% of our energy with electricity and gas currently being used equally. Prices have been extremely volatile but are expected to stay higher than historical averages. Current costs are £1 million per month.

The work to date has shown many long-standing problems e.g., heating on in summer, key equipment broken for years, areas consistently too cold all year round. We've started to fix these but there are still actions to take that provide significant cost-saving as well as carbon reduction opportunities.

Energy

Current actions

Key elements of the hospital building have not been functioning as designed with key assets out of action for years e.g., both CHPs, absorption chiller. **We have started to repair these** and will soon see more visible changes like the temporary chillers.

Building systems have not been optimised for energy use with heating and cooling both overused throughout the year in the PFI and beyond. This has used a lot of energy and made some areas of the hospital uncomfortable. We have done a series of trials and are **gradually improving** these with some good early results.

We are introducing Alder Hey wide communications with a focus on reducing consumption and energy waste e.g., our combined heat and power plants (CHP).

Future actions

We will continue to optimise the exiting building by improving the way it is controlled.

We will upgrade key assets (LED light roll out) and add new ones (more solar panels on our hospital roof).

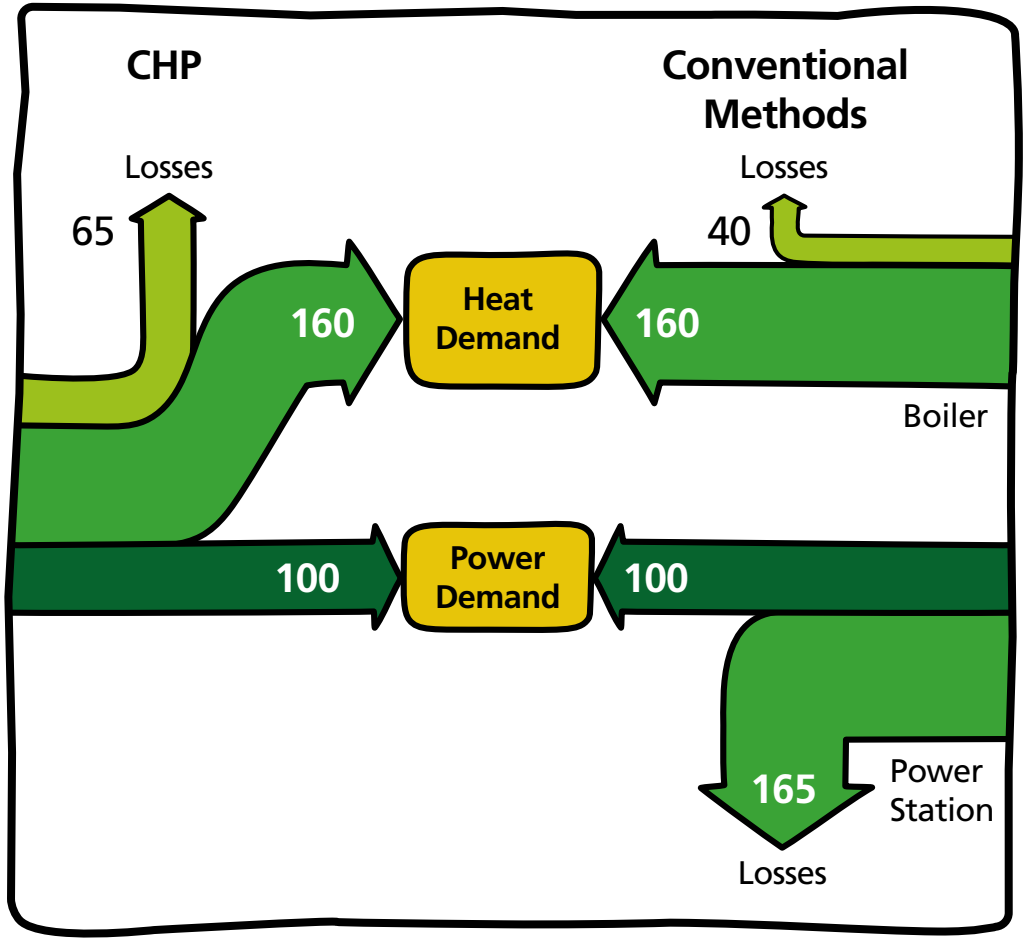
Repairing the CHP has helped us in the short term but in the medium term we need to **stop burning gas.** Our newest buildings have been built without gas from the start and we now need to replicate this in the older ones. Replacing the CHP and the gas boilers will be an **expensive** and **complex** project so we will develop a medium-term plan for this in 2023/24.

See case study below.

Energy case study

Our hospital was designed to be heated by a mix of technologies including heat pumps and gas boilers. The majority of our heating was intended to come from Combined Heat and Power plants (CHP). These are large engines that generate electricity and then collect the waste heat to warm up the building.

Our CHPs had not worked for some time so we've worked with the PFI team to get these repaired. The rise in energy prices have made this even better for us commercially and is **now saving us nearly £2k per day.**



Getting rid of gas, case study from Birmingham

We know we need to remove gas from our site but the ideal technology to replace this is not clear.

There are a wide range of technologies being investigated across the NHS to help **decarbonise hospitals.** The key funding route to date has been through SALIX, this is focusing its funding on replacing the oldest fossil fuel systems. Working out to how to do this in a PFI contract is one of our next challenges.

With the support of the Government's Public Sector Decarbonisation Scheme (PSDS), we have been granted **£54.3 million** in funding to improve upon the sustainability of our Women's Hospital and the Children's Hospital.

A portion of the funding has been allocated to implementing heat-generating 'bore hole' pumps so that we can naturally extract energy to power our hospital and significantly reduce our carbon footprint.

What is a borehole?

A borehole is a narrow shaft bored into the ground used to extract heat from the ground. In order to ensure no environmental implications, we ensure all water extracted from the bore holes is supplemented to keep the water table balanced. In the processes of extracting and supplementing water, we are able to generate heat from the boreholes and transfer this into energy. Borehole drilling is different and environmentally conscientious compared to 'fracking'.

Our journey so far...

We will be able to extract **2.4 megawatts of power** from our initial boreholes, **with plans to build eight in total,** all interconnected to sustainably power our hospital, all the while remaining carbon-neutral with no environmental damage. To build these boreholes, we have been working closely with the Geological Surveys team (Breathe Energy) to locate areas where water is present through ultrasound technology.

Gases

There is now a strong regional network for sharing improvement ideas with the medical gas commitee

Short term goals:

- **Zero leaks** in 2023/24
- Reduce desflurane to **5%** of volatile gas use by 2023/24

Long term goals:

- **Zero** desflurane, **zero** HFCs

Refrigerant gases are a significant part of our carbon footprint due to leaks in our chillers. This is not routinely reported by trusts and is not part of the Greener NHS programme. Comparing our leakage rates vs leaders e.g., ASDA and Waitrose show we have the potential to go to zero leaks.

Anaesthetic gases have a national data collection process allowing simple benchmarking. We also have a clinical team driving change in this area with a track record of improvement and are performing well. Last year we beat the national target of 10% desflurane use and we are now on target to get to 5% this year.

Gases

Current actions

The Medical Gas committee review gas usage on a regular basis and there is now a strong regional network sharing improvement ideas.

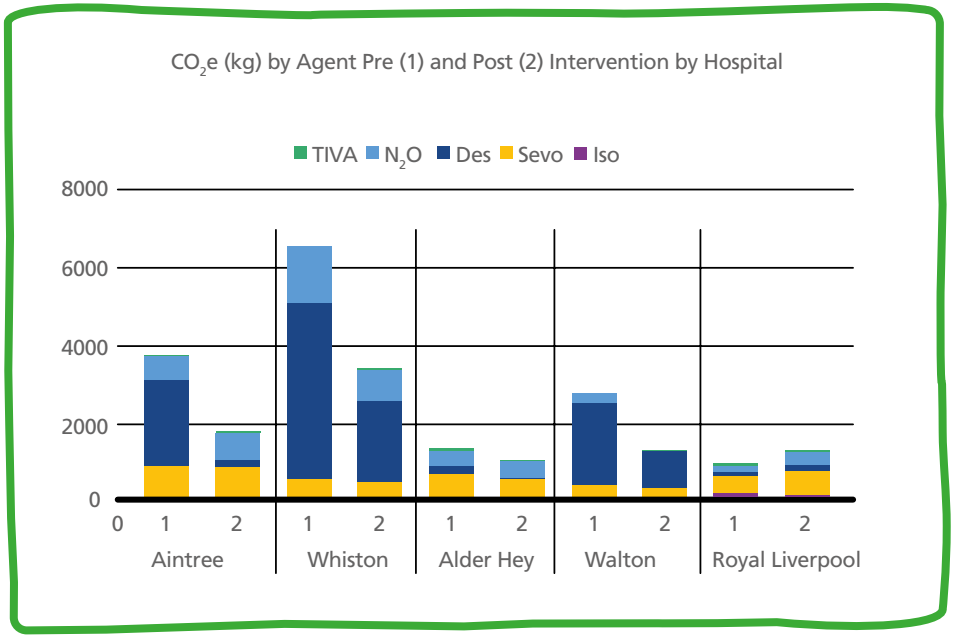
The chillers installed when we opened the hospital developed leaks and we had to install temporary replacements. **The chillers are now being repaired and the temporary chillers removed.**

Future actions

We will continue to reduce desflurane use eliminating the most harmful gas. As this reduces nitrous and Entonox will make up most of our emissions so we will investigate new solutions.

There are a range of innovative ideas being developed globally and we will continue to evaluate these with opportunities to reduce gas usage as well as capture used gases.

Case study



One of the recent improvement projects on gases was a great example of collaboration and improvement with **over 5,000 tonnes CO2e saved annually.** The DESTIVA (Delivering Environmental Sustainability through Informed Volatile Awareness) project was a collaboration across local trusts and drove rapid improvements.

This was recognised nationally by the Association of Anaesthetists with their paper winning a prize.

Travel

We have introduced new schemes such as the discount travel, cycle to work, and car share sheme

Short term goals:

- **Reduce** car travel to all our sites by **5%** by 2024/25
- Be part of a **Cheshire and Merseyside NHS Green Travel Plan** by end of 2023/24 that delivers a system wide plan for a shift to green and active travel

2037 Goal:

- **Zero emissions** from travel to Alder Hey services

In 2020 we conducted a Green Travel survey. This found over **80%** of journeys to site are by car, driving significant carbon emissions and impacting air quality more broadly. **The core lesson was that better infrastructure outside Alder Hey to enable staff alternatives to car travel is the key issue for making the shift.**

We have looked for plans introduced by other NHS bodies and the Christie Hospital provides a good example of sustained performance improvement (Green travel plan christie.nhs.uk) and we will use this as our start point benchmark for our own actions.

We have retained home working and increased appointments online, **saving an estimated 400 car journeys a day**.

Travel

Current actions

- We have retained home working and increased appointments online, saving an estimated 400 car journeys a day
- We have started working with the Merseyside Combined Authority (CA) and colleagues in NHS trusts across Cheshire and Merseyside to begin drafting a first **green and active travel** across all our bodies, in partnership with the CA.
- We have been selected by NHS England to be part of a travel innovation network **"Step up a Gear"** which will give us support from the national team and improve benchmarking.
- We are introducing a **car share scheme.**
- We are introducing, with Arriva, a **discount travel scheme** for city buses.
- We have introduced uptake of cycling to work through better awareness of the ability to do so (including making improvements to our changing facilities), holding Dr Bike sessions for staff to encourage bike maintenance and use, improving the **Cycle to Work Scheme** offer by raising the funding limit and elongating the pay back period.

Future actions

We will develop an integrated plan with the City Region that decarbonises transport but also unlocks **major health improvements** through **improving air quality** and **improving activity levels.**

The plan will include **support for active travel, electric vehicles, changes to the way we pay for car parking** and **we will work together with the City Region and the local NHS.**

Case study

Liverpool is starting to invest more in cycling infrastructure, creating a future with more active travel is great for air quality and health as well as carbon. There are some great international examples we can learn from.

"Over here in Assen, hospital car parking is free. There is also good quality cycle parking. On the day I took these photos neither were full. The problem complained of by residents around Addenbrookes doesn't exist here. In fact, while car parking often causes consternation for British people, it is rarely an issue in the Netherlands. There are adequate spaces where there need to be spaces, and relatively little need for parking because of people cycling for a large proportion of journeys.

There is a tendency in the UK for policies like this to be applauded by cyclists on the grounds that at least "something is being done" to encourage people out of cars. However I don't think it's helpful at all. Quite apart from the fact that it's a remarkable negative publicity campaign to go around hassling people when they are ill, I also believe it to be rather silly to get too excited about people being hassled out of cars on less than 1% of their journeys. These are not the journeys that need changing. What is needed to make a real difference is for people to be attracted out of cars on some proportion of the other 99% of their journeys. Perhaps once cycling is made into a safe and convenient option for normal people on an everyday basis, they'll also feel more like cycling for exceptional journeys such as to hospital."

Waste

We have designed a new compactor arrangement to improve our waste handling

Short term goal:

- **Reduce** 2023/24 waste costs by **£50k**

Medium term goal:

- **Halve** the amount of single use items by **2028**

Long term goal:

- All waste is **reused** by **2037**

We have similar issues to most NHS trusts in ensuring our bins are used properly and in providing transparent recycling facilities. In fact, given the relatively low volume of possible recycling we have instead a contract with providers that means we do not recycle on our sites, e.g. with separate bins for paper, plastics etc. Instead our contractor takes all our general (black bag) waste taken away in one and it is then sorted and partially recycled at the point.

Direct carbon emissions from waste treatment are low and alternative recycling approaches are unproven. In the medium term **our biggest opportunity is to throw less away from gloves and aprons to coffee cups,** a lot of our waste is single use items.

Waste

Current actions

We have designed a new compactor arrangement to improve our waste handling and improve the amount of cardboard we will recycle.

We are also adding a third compactor **reducing the number of vehicles** visiting sites to collect waste.

Future actions

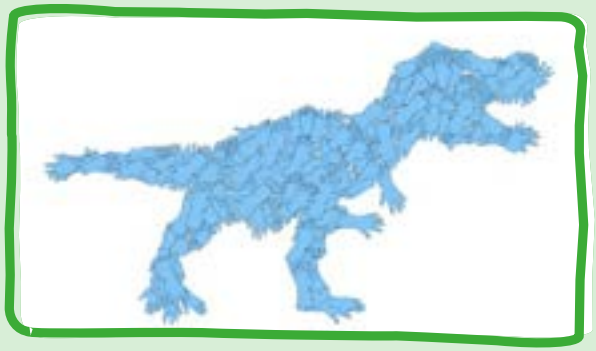
We will build on a range of pilots, like the Great Ormond Street one, to systematically **reduce the amount of waste we produce.**

We already have good data on some of our waste, for example we used 7 million gloves last year, but we need to improve this area. In 2023/24 **we will publish a breakdown of our waste and single use items.**

"Glove Off" case study

"**We have saved 21 tonnes of plastic, which is brilliant.** That's three and a half Tyrannosaurus Rex's worth of plastic!"

Great Ormond Street case study; "Glove off"



£90,000 saving from reducing glove use through behaviour change

Outcomes

In the 12 months prior to the Gloves Off campaign launching, **11.1 million pairs of disposable gloves were ordered.** This cost the trust **£289,599.32.**

In the year following the Gloves Off campaign, orders have decreased by 3.7 million pairs.

This resulted in only **7.4 million** pairs of disposable gloves being ordered, **saving over £90,000** and using 18 tonnes less plastic than prior to the campaign.

The trust also introduced **'Break-the-Chain'** week. This focused on breaking the chain of infection by educating staff around the trust, with every ward having a Break-the-Chain Champion delivering the training.

The training took a two-pronged attack, showing best practices for Covid-19 patient management and PPE guidance, with being glove aware coupled with the initial messaging.

The overwhelming result of the campaigns have been that the reduction in glove use has led to an improvement in hand hygiene.

There has been no adverse impact on infection rates, and staff have given feedback that they feel **more empowered** to make better clinical decisions.

Procurement & supply chain

Most of our total carbon emissions are within our supply chain – i.e. not under our direct control. At national level plans are in place to progressively increase standards and reduce emissions by suppliers (Greener NHS » Suppliers).

We are starting to develop our approach and how we will work with other local trusts

Short term goal:

- **Comply** with NHS supplier roadmap

Long term goal:

- **Zero** carbon supply chain

National net zero supplier roadmap

- **From April 2022:** all NHS procurements will include a minimum **10%** net zero and social value weighting. The net zero and social value guidance for NHS procurement teams will help **unlock health-specific outcomes** (building on PPN 06/20).
- **From April 2023:** for all contracts above **£5 million**, the NHS will **require suppliers to publish a carbon reduction plan** for their UK Scope 1 and 2 emissions as a minimum (building on PPN 06/21).
- **From April 2024:** the NHS will **extend** the requirement for a carbon reduction plan to cover all procurements. Suppliers will be **required to publish a carbon reduction plan** for their UK Scope 1 and 2 as a minimum.
- **From April 2027:** all suppliers will be **required to publicly report targets, emissions and publish a carbon reduction plan** for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.
- **From April 2028:** new requirements will be introduced **overseeing the provision of carbon footprinting** for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.
- **From 2030:** suppliers will only be able to qualify for NHS contracts if they can **demonstrate their progress** through published progress reports and continued carbon emissions reporting through the Evergreen sustainable supplier assessment

Procurement & supply chain

Current actions

At trust level we are starting to develop our approach and how we will work with other local trusts.

Developing common approaches to single use items like gloves will support the **waste project.**

Future actions

Develop a common approach to **energy procurement.**

Health care services

Short term goal:

- **Develop** measurement and **improvement** process in 2023/24

Medium term goal:

- Alder Hey treatments are **25% lower**

Long term goal:

- Alder Hey low carbon approaches **adopted across system and internationally**

To deliver the scale of change we need we will not just be able to do the same things better, **we will need to work in new ways.**

Lots of these changes are not stand alone **"Green"** projects and we will need to find new ways of measuring and integrating **"Green"** into wider change programmes.

Health care services

Current actions

Increased digitisation of services has already decreased travel to site by 400 journeys a day as well as giving wider benefits. This will continue as we deliver our 2030 model of care.

Our innovation team are working with a range of partners to develop new products. For example, the Needlesmart product is targeting over **15,000 tonnes of carbon saving.**

The medical gases teams continue to reduce gas emissions year-on-year.

Future actions

We can measure carbon most easily at hospital level or with one component like gloves or desflurane. It is currently harder to measure and compare a full treatment or procedure making improvement work more challenging. **We will develop new ways to do this and use this to build in low carbon decision making in our service designs.**

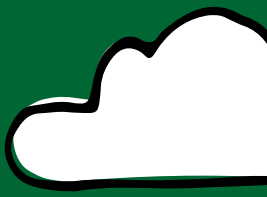
Medium term goal:

- **Award-winning leader of change.** Being green is a core part of Alder Hey values and culture

How to build in green decision making?

Energy prices end up making a significant difference to all sorts of business cases – our new CT scanner will use up to **£60k per year**, so we are adding these costs to our business case system and will broaden this in stages to add other Green issues like travel.

The practical stuff



Funding

We have a short-term goal to secure £100,000 of external funding in 2023/24.

We are monitoring all funding opportunities and bidding for all credible opportunities.

Scheme	Funder	Type	Size	Purpose	Status
Low carbon skills fund	SALIX	Revenue	£180k	Fund heat decarbonisation plans	Lost
Public Sector Decarbonisation Scheme (PSDS)	SALIX	Capex	£300k	Fund heat decarbonisation and some efficiency projects	Bid in October for Police Station
Big Bike Revival	Cycling UK	Revenue	£2.5k	Revive cycling	Won
SBRi Carbon research	SBRi	Revenue	£99k	Fund new clinical approaches	Submitted for Prem. Pathways projects
Step up a Gear	NHS England	Improvement support	TBC	Support innovation in travel	Won
Healthier Futures	NHS Greener Programme	Revenue	£15k	Support Greener innovations	Submitted for Gloves Off project. 2 regional bids fronted by AH won

Longer term we believe there will be opportunities to receive third party funding to help us deliver net zero.

We have already bid for a wide range of funding schemes from research to cycling and re-designing our heating systems. Most have been low value but larger amounts are available in future.

Looking ahead we will work with the Integrated Care Board and partners to identify or create successful funding applications.

Working together

As well as working within the trust we will work with colleagues across the NHS to share expertise and work together.

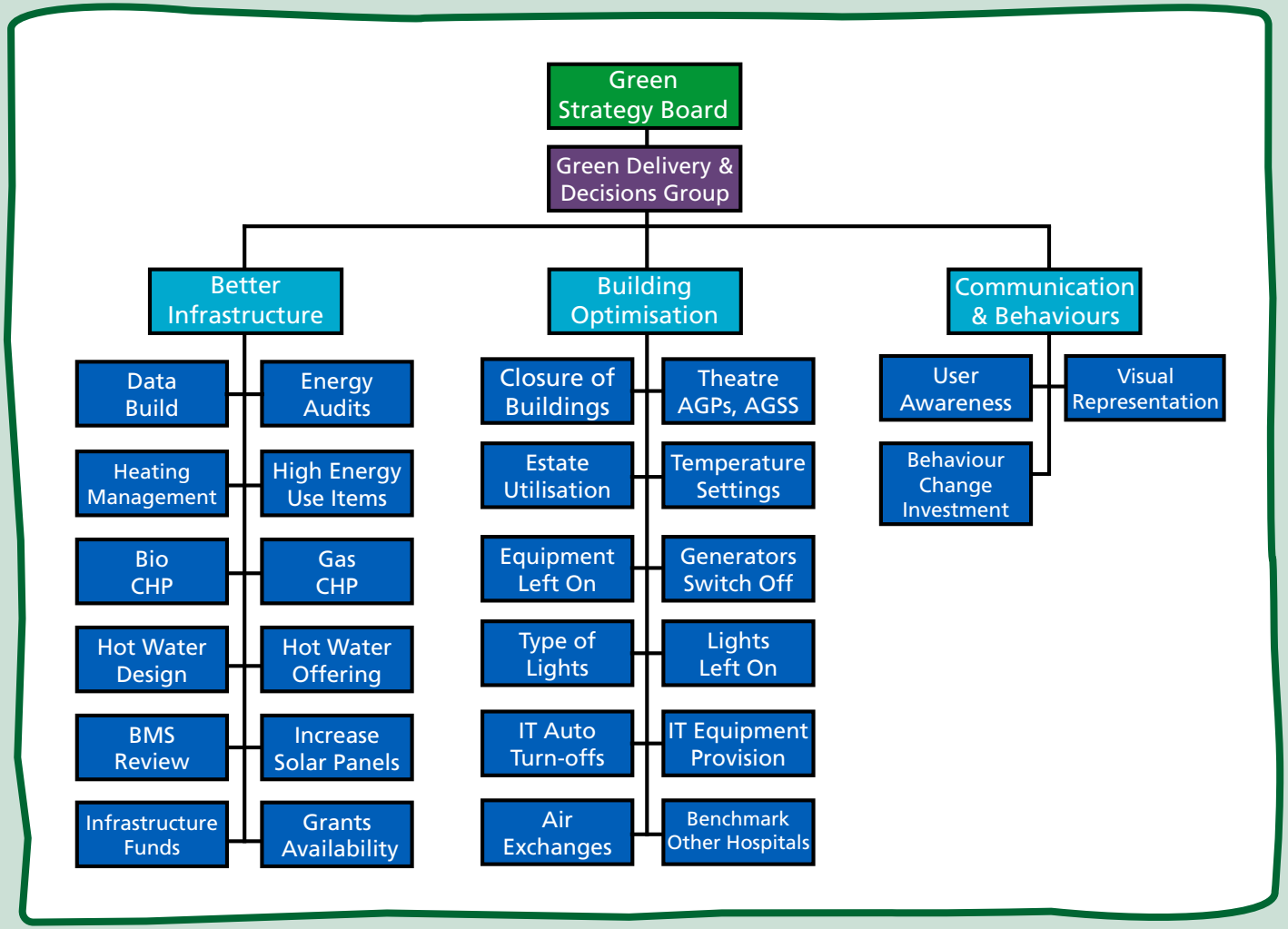
Some good models of improvement already exist with the medical gases teams working together across the region.
We've worked with the ICB team to start similar groups on energy and waste. **These are at an early stage but energy prices across the ICB are expected to be over £50m in 2023/24 so are a big opportunity.**

At national level we've joined the **Net Zero Buildings** project, a multi-discipline project to define low carbon standards.

More locally we've started working with Liverpool trusts and the City on travel.

UK Net Zero Carbon Buildings Standard

Governance



The Green Programme Board meets monthly to review strategy and provide programme assurance against the Delivery Group plan. This Programme Board reports to RABD which in turn reports to the Trust Board. Current membership is to the left, but we will expand this group to add representatives of the Green Champions, in order to provide a broad overview of operational needs.

The Delivery Group reports into Green Programme Board and meets monthly. This group approves decisions and changes required and tracks specific actions, e.g. changes to hospital temperatures.

Risks

As part of governance, we will monitor the risks associated with achieving net zero. The following risks are being added now and will be monitored by the Green Programme Board:

- **Failure to deliver** on reduction of energy usage impacting our costs
- **Insufficient Green Plan engagement** with impact on staff morale and survey scores
- **Resourcing and capacity** to deliver wider range of projects beyond estates
- **Capacity and capability** of NHS system to support and fund decarbonisation

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Find out more...

You can download a copy of Delivering net zero from our website www.alderhey.nhs.uk

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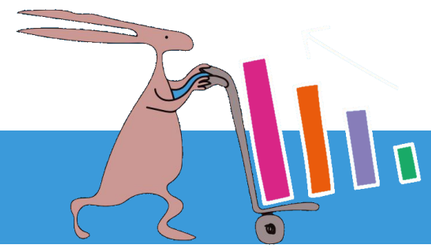
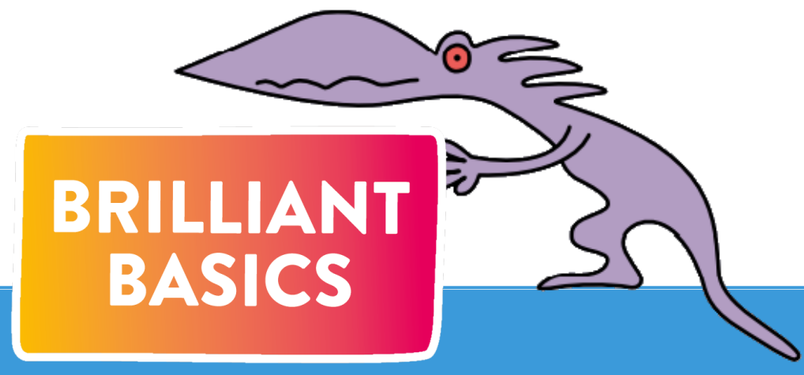
Integrated Performance Report

Published: January 2023



Contents



Icon Definitions

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

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

XmR chart

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

Process limits

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

Special cause variation & common cause variation

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

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

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

IPR Summary

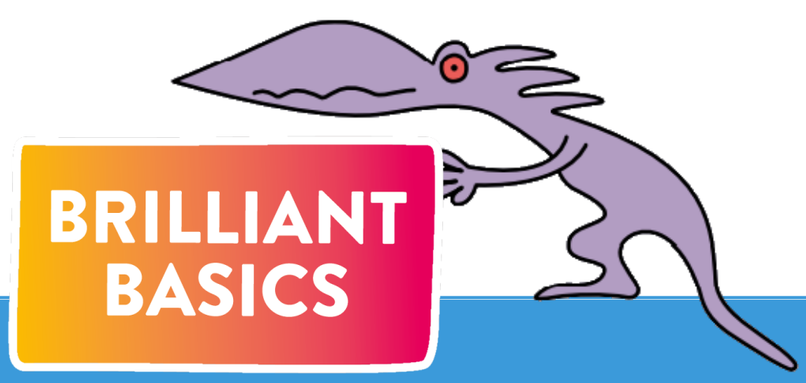
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

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

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

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

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



Outstanding Safety - Safe

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

Highlights:

• No new Never Events or Serious Investigations • No Cat 3 or 4 pressure ulcers and decrease in number of Cat 2 pressure ulcers reported. Divisions provided updated actions and assurance at December SQAC meeting • No hospital acquired infections reported • Requirement for physical restrictive intervention continues to be reported on • New Trust policy devised - C73 Overarching Restrictive Practices Policy for Use with Children and Young People - which sets out the overarching structures, legal frameworks and training provision that support the appropriate and legal use of restrictive practices

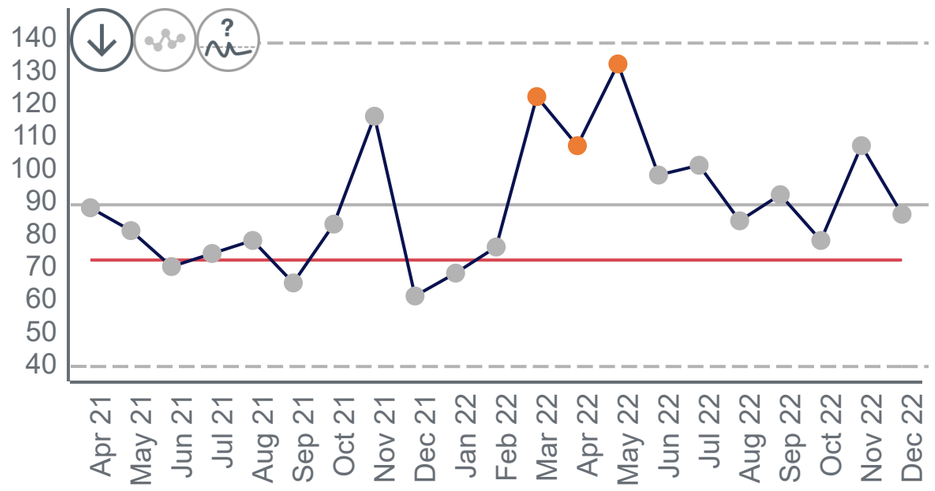
Areas of Concern:

Number of inpatients unexpectedly admitted to critical care continues to average around 25 patients per month. Deteriorating Patient workstream forms part of the Patient Safety Strategy

Forward Look (with actions)

A cleanse of Ulysses is underway in preparation for migrating to the new risk management system to ensure all historic incidents and PALS are closed

Number of Incidents rated Minor Harm and above



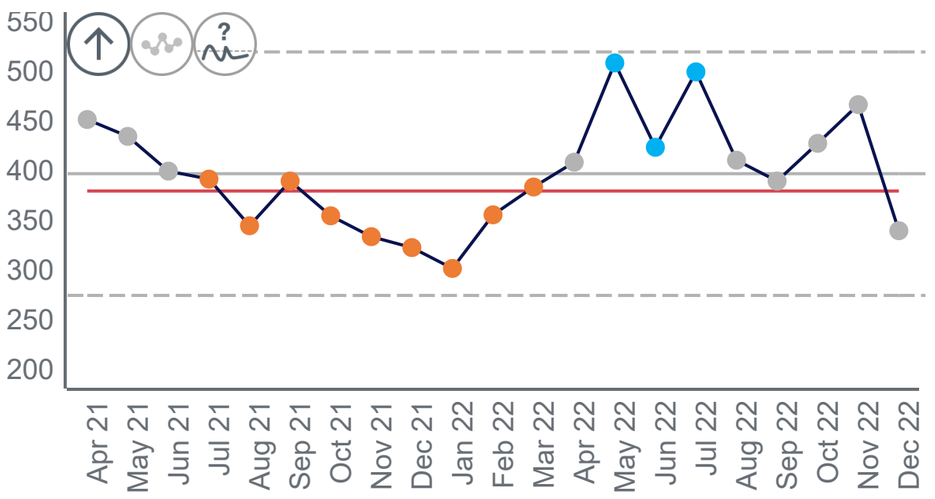
Technical Analysis:

Number of Harms per month remain stable and continues to demonstrate common cause variation. There is no evidence of underlying reduction in incidences of harm. Of the 86 incidents in Dec, 85 were minor harm and 1 moderate/major harm

Actions:

The category of harm for all reported moderate and above harms is reviewed and agreed at the weekly Patient Safety meeting for accuracy; all other incident categories are reviewed and validated within the Division.

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

A high number of Near Miss and No Harm incidents reflects an open reporting culture. In December this fell below the target for the first time in 9 months, but shows common cause variation and therefore is still described as inconsistently passing the target.

Actions:

Continue to encourage staff to report incidents as this reflects an open, transparent and learning organisation and culture

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	December 2022	86	89	72		
Number of Incidents rated No Harm and Near Miss	December 2022	340	397	380		
Number of Serious Incidents (Steis reported)	December 2022	0	1	0		
Number of Never Events	December 2022	0	0	0		
Sepsis % Patients receiving antibiotic within 60 mins for ED	December 2022	87	85	90		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	December 2022	82	89	90		
Number of Medication Errors resulting in harm (minor harm and above)	December 2022	5	4	4		
Pressure Ulcers G2-4	December 2022	4	4	5		
Use of physical restrictive intervention (MH Tier 4)	December 2022	5	14			
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)	December 2022	19	23	30		
Hospital Acquired Organisms - MRSA (BSI)	December 2022	0	0	0	L	P
Hospital Acquired Organisms - (C.Difficile)	December 2022	0	0	0	L	
Hospital Acquired Organisms - MSSA	December 2022	0	1	0		

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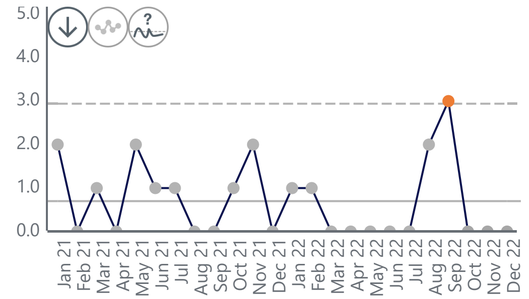
Integrated Performance Report | January 2023

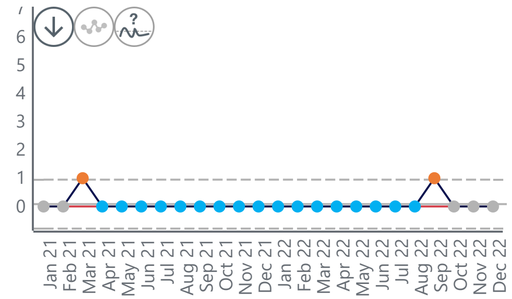
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

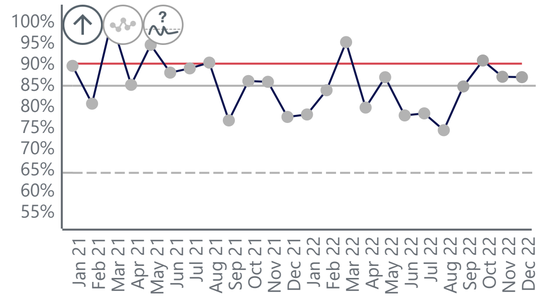
Number of Serious Incidents (Steis reported)



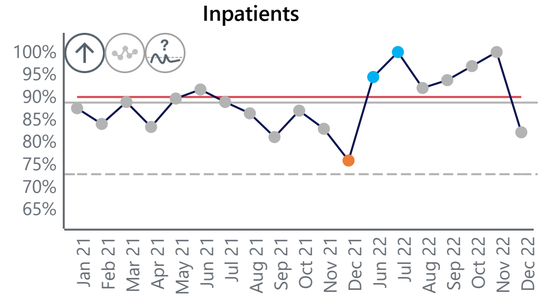
Number of Never Events



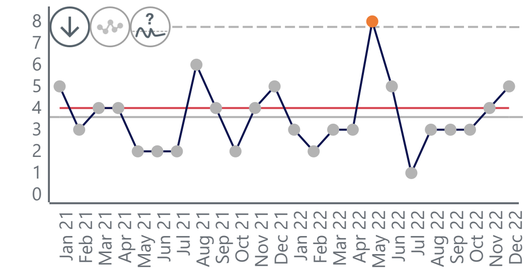
Sepsis % Patients receiving antibiotic within 60 mins for ED



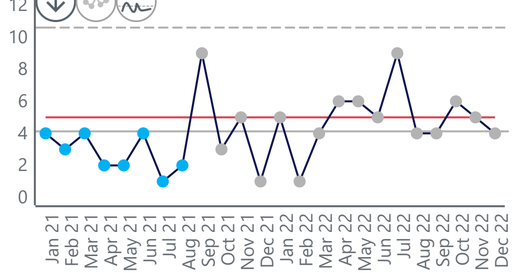
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



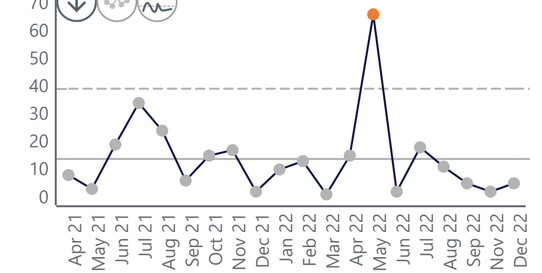
Number of Medication Errors resulting in harm (minor harm and above)



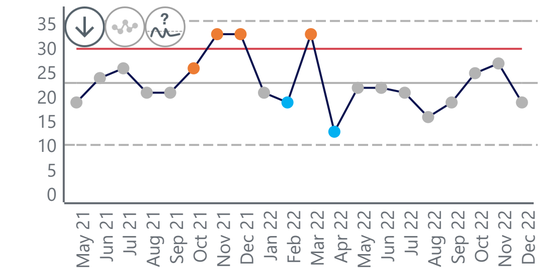
Pressure Ulcers G2-4



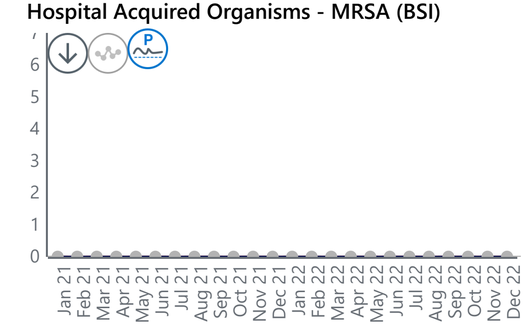
Use of physical restrictive intervention (MH Tier 4)



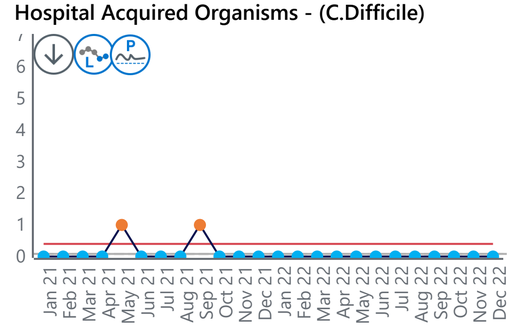
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



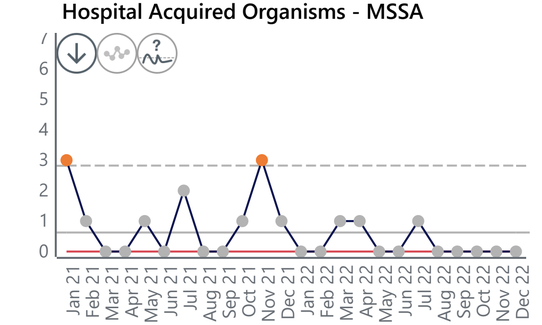
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Outstanding Safety - Caring

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

Highlights:

90% of PALS concerns responded to were within the 5 working day KPI (107 of 118). Notably, the Division of Surgery achieved 100% compliance and Division of Medicine achieved 98%. • 100% (5 of 5) of formal complaints were acknowledged within 3 working days and 87% (14 of 16) were responded to within the 25 working day timeframe providing these families with a timely resolution to their concerns; the other 2 complaints were responded to at Day 26

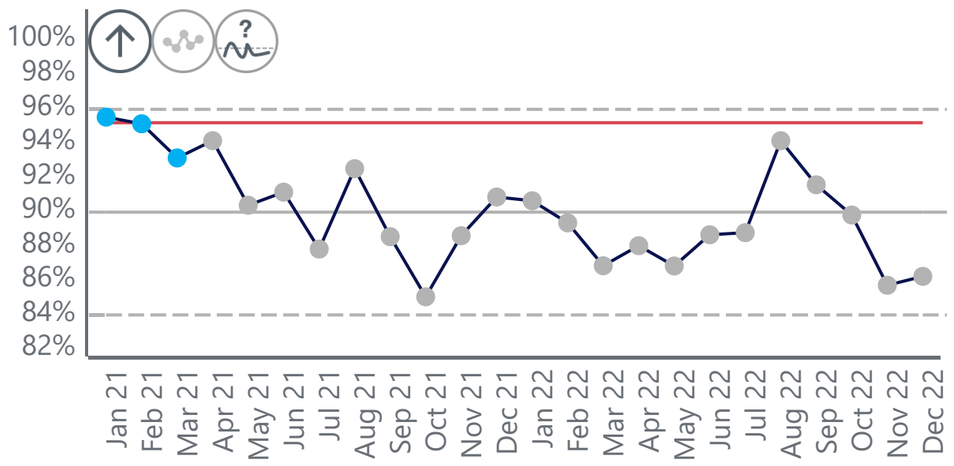
Areas of Concern:

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

Forward Look (with actions)

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

F&F Test - % Recommend the Trust



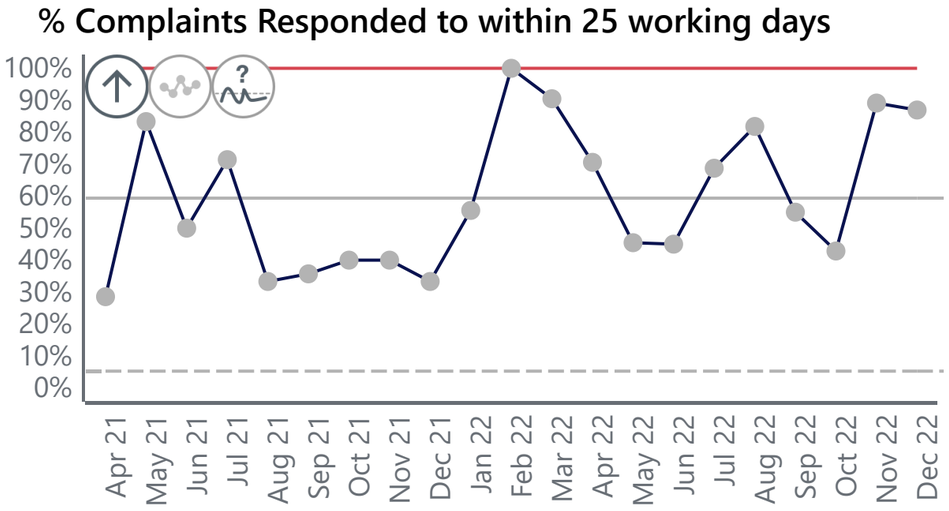
Technical Analysis:

Consistently falling short of the target. ED is 64%, with no area exceeding 95% target. Inpatients 90.1% which met target Mar - Oct 22, correlating Dec 21 (92.4%). Overall Dec figure of 86% is consistent with the previous month, whilst these are the scores during 2022 at this point the trend still demonstrates normal cause variation

Actions:

Targeted work to increase the response rate; posters with a QR code available in all cubicles. Volunteers visiting clinical areas again to collect feedback. An automatic text message is sent to all families

% Complaints Responded to within 25 working days



Technical Analysis:

In both Nov and Dec >85% of complaints were responded to within the 25 working day target. This is technically common cause variation, and needs to be sustained over a longer period of time to demonstrate consistent improvement.

Actions:

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

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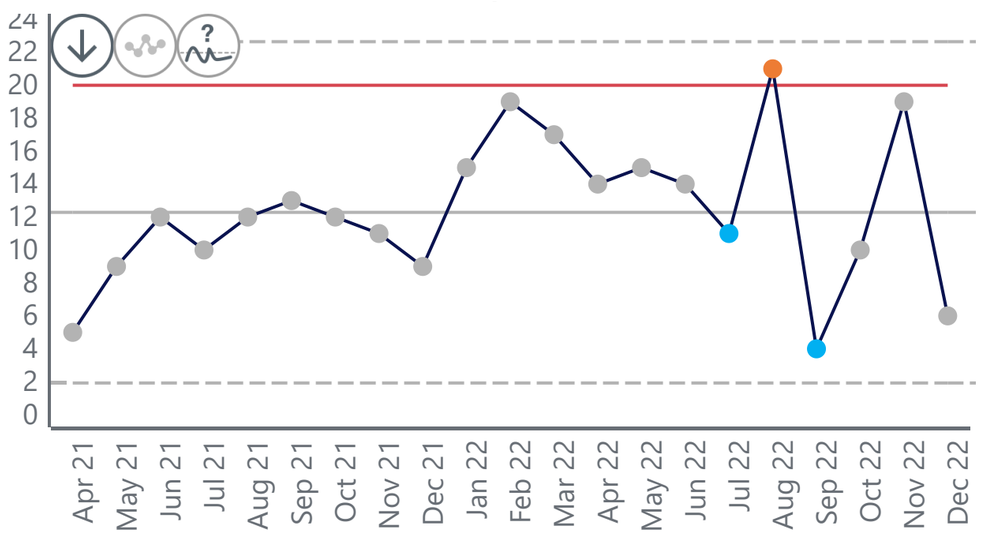
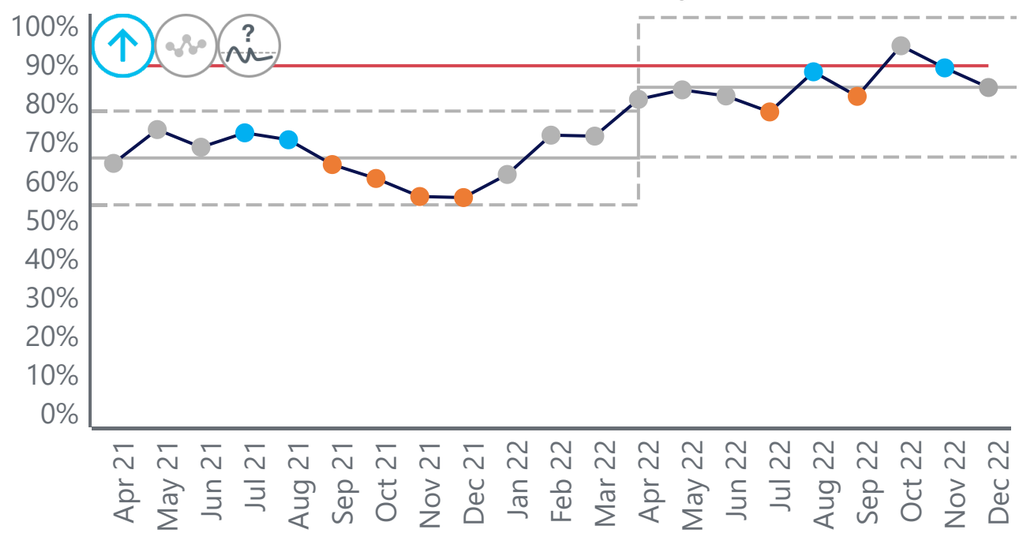
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	December 2022	86	95	90		
% Complaints Responded to within 25 working days	December 2022	87	100	59		
Number of formal complaints received	December 2022	6	20	12		
% PALS Resolved within 5 Days	December 2022	84	90	74		
Number of PALS contacts	December 2022	121	150	129		
F&F ED - % Recommend the Trust	December 2022	64	95	68		F

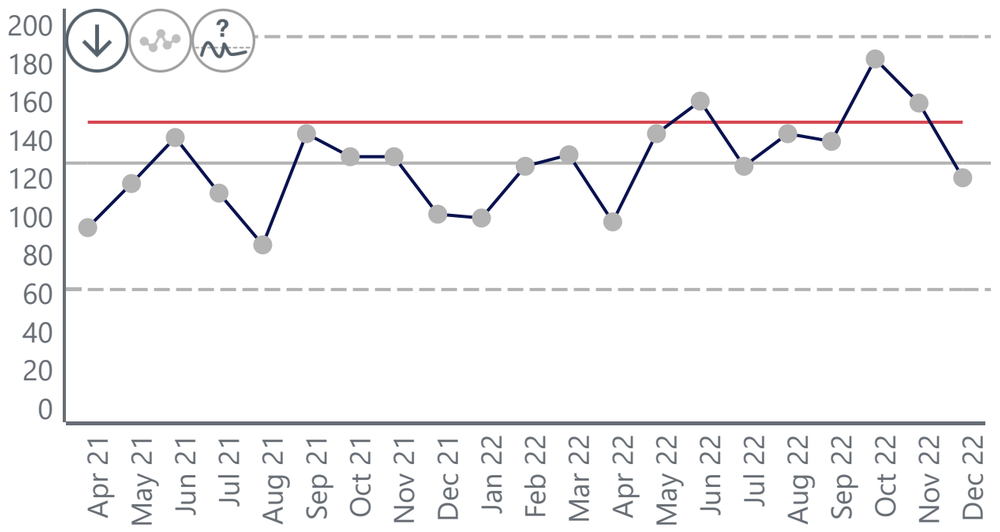
Number of formal complaints received



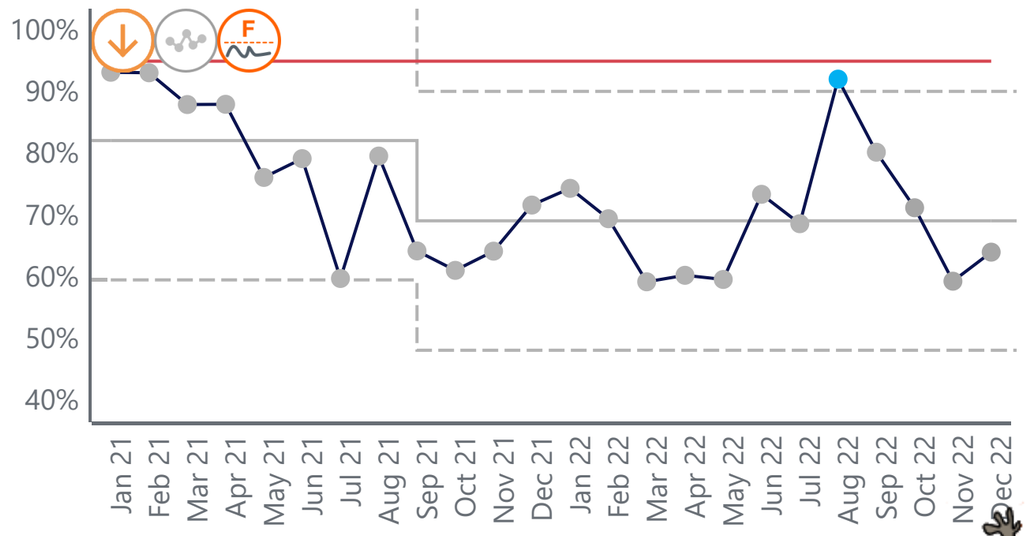
% PALS Resolved within 5 Days

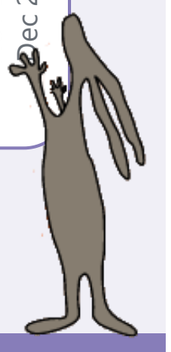


Number of PALS contacts



F&F ED - % Recommend the Trust





Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Created "Hub 2" in ED to provide enhanced streaming; 255 patients utilised this facility since 12 Dec • 1,232 GP Appts delivered, including up to 3 GPs per day • Actions put in place mean that 7% more patients seen within 4 hours in Dec (4,573 vs 4,279 in Nov) despite increase in attendances

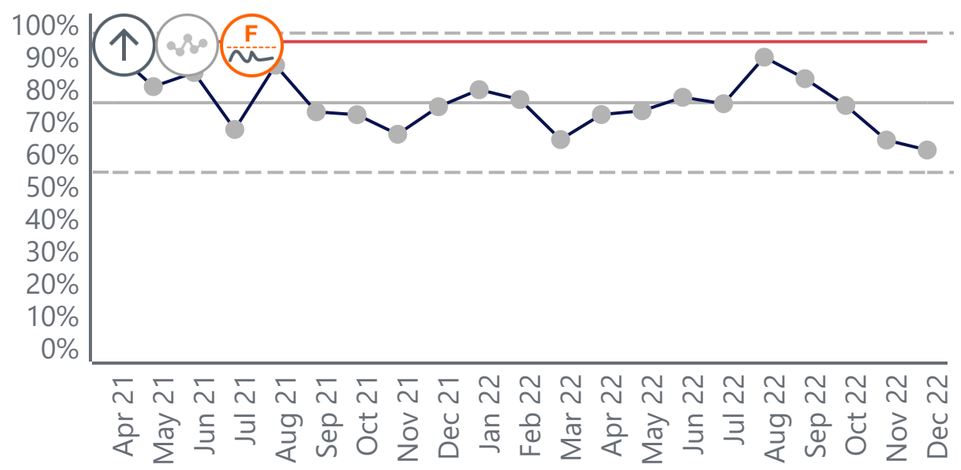
Areas of Concern:

• ED attendances were exceptional with 7,420 in Dec – this is 12% more than Nov (6,610) and 45% more than Dec 21 (5,103) • There were 138 patients >12hrs in Dept during Dec • Impact of industrial action and rate card on elective recovery • Flow remains challenged with Cancelled Operations (26) and Long Stay patients (36) both consistently over the target

Forward Look (with actions)

• Open additional capacity for ED streaming (modular build) from 30 Jan • Change booking process for height & weight clinics to reduce WNB rate • Expand virtual ward capacity and utilisation to reduce length of stay and the risk of cancelled of operations

ED: % treated within 4 Hours



Technical Analysis:

December performance of 62% is the lowest month since in this dataset (ie from April 21 onwards), although technically remains within the range of normal variation. During November and December there has been record demand, with attendances sometimes exceeding 300 per day.

Actions:

- Acute respiratory infection hub capacity and secured additional GP cover in January 2023 • Increased General Paediatrics with an additional consultant in the evening Mon- Fri • Open urgent care hub for green streams in new modular unit • Testing pre-triage diver

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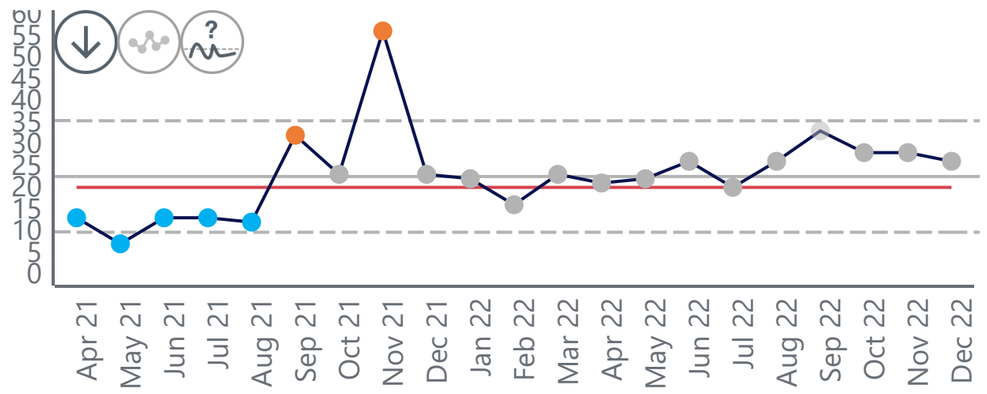
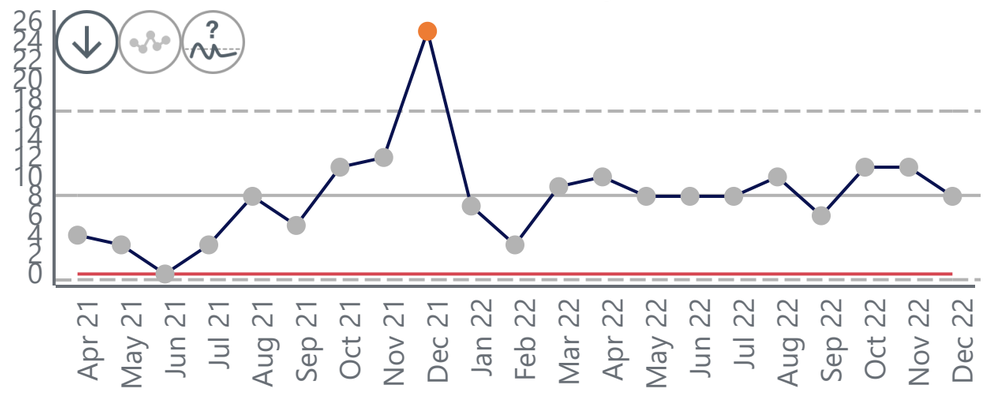
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	December 2022	62	95	76.15		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	December 2022	26	20	23.00		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	December 2022	8	0	8.10		?
Number of Super Stranded Patients (21 days)	December 2022	36	30	37.24		?
% Virtual Outpatients (national standard 25%)	December 2022	25	25	29.57		?
% Was Not Brought Rate (All OP: New and FU)	December 2022	10	10	9.85		?
% of Clinical Letters completed within 10 Days	November 2022	69	95	58.07		F

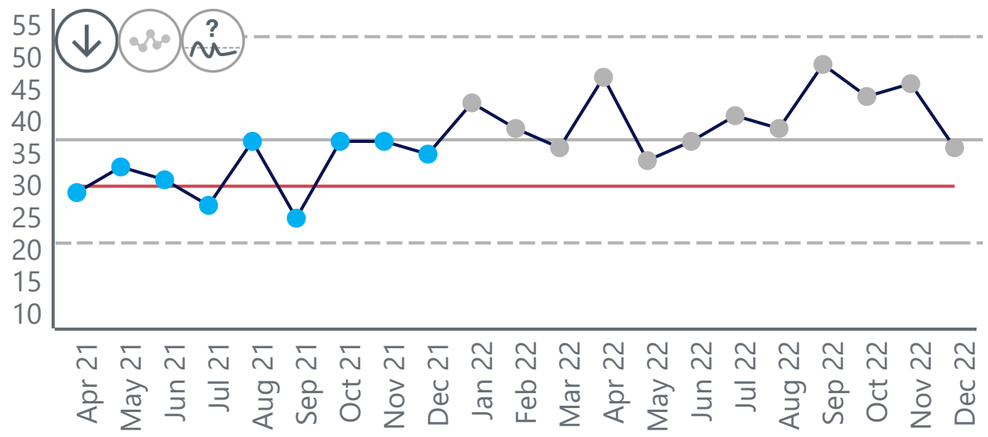
Number of Cancelled Operations (on day of admission for a non-clinical reason)



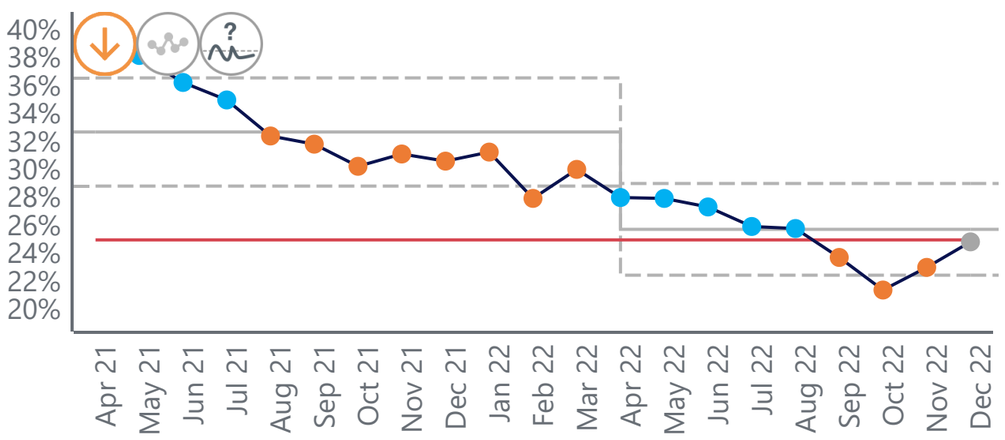
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



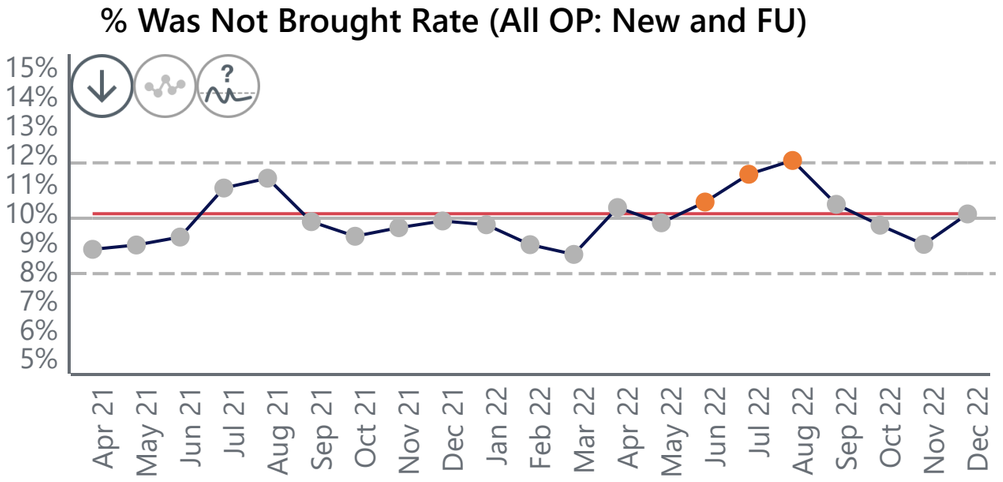
Number of Super Stranded Patients (21 days)



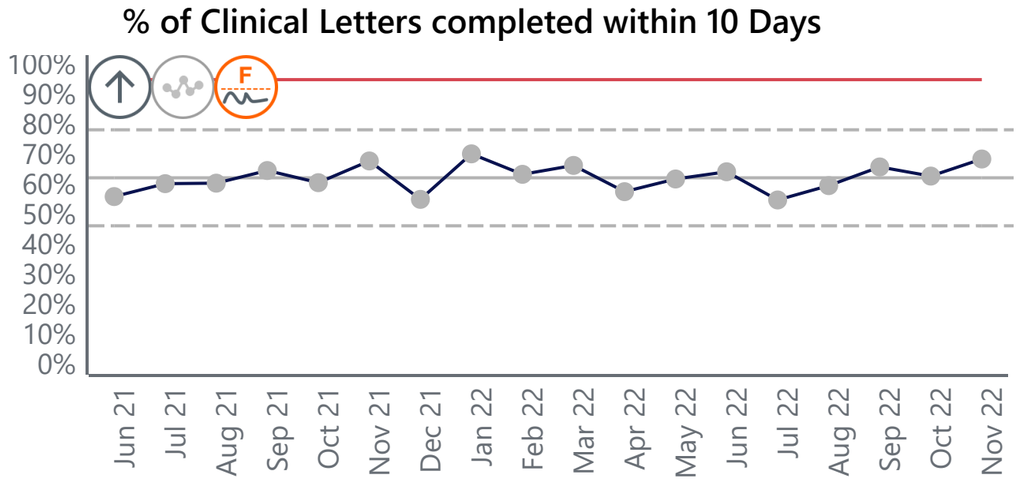
% Virtual Outpatients (national standard 25%)



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



% of Clinical Letters completed within 10 Days



Recovery & Access -Responsive

SRO : Adam Bateman, Chief Operating Officer

Highlights:

• Performance in elective and scheduled care has been strong given the headwinds of industrial action and reduce overtime• Diagnostic waiting times continue to show positive impact of improvement work • Access to cancer care • Excellent levels of outpatient recovery

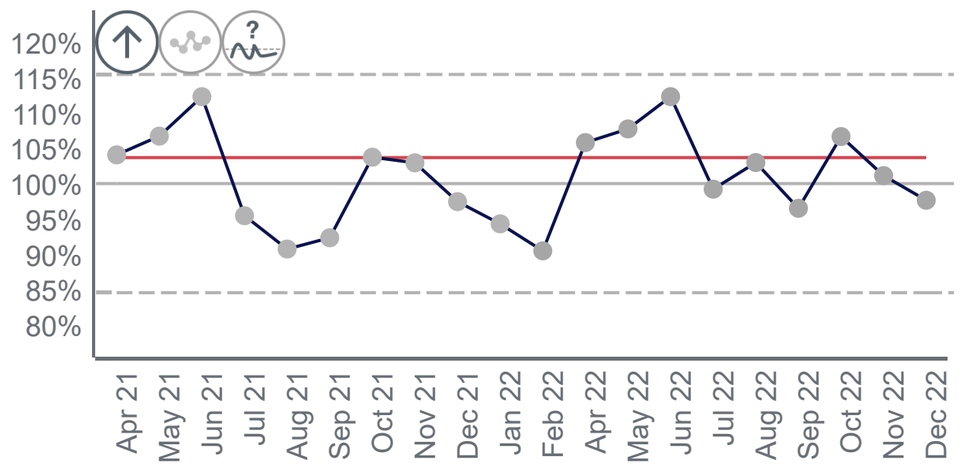
Areas of Concern:

• Reduction in long waits has plateaued, with a risk that mutual aid provided by Alder Hey to other Trusts and further Industrial Action may impact progress in Q4

Forward Look (with actions)

• High level of confidence we will achieve zero 78ww by end of Mar (in line with national standards). Dental and Spinal to ensure all potential 78ww patients have been allocated appointments by end of Jan • Dental Insource model to commence in January • Home Sleep Studies to commence in January

% Recovery for DC & Elec Activity Volume



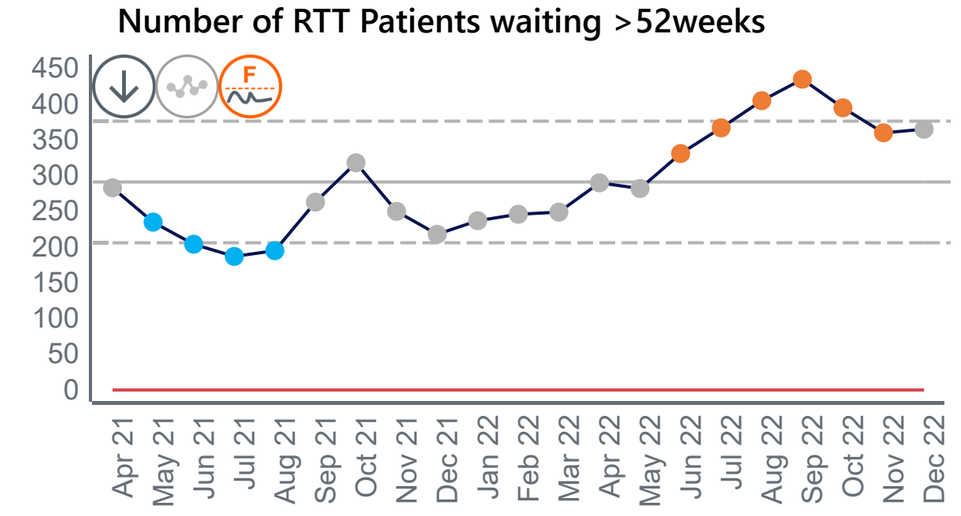
Technical Analysis:

Dec performance of 98% is below the target, however is comparable with the same month in 2021 – and this has been achieved despite 2 days of Industrial Action with associated cancellation of scheduled and elective activity.

Actions:

Seek to mobilise extra theatre and clinics following issuing of new rate of pay for additional work. Re-allocate under-utilised theatre lists to departments with long waiting times. Best in operative care continuous improvement work at specialty level, with productivity data, engagement sessions and PDSA tests of change

Number of RTT Patients waiting >52weeks



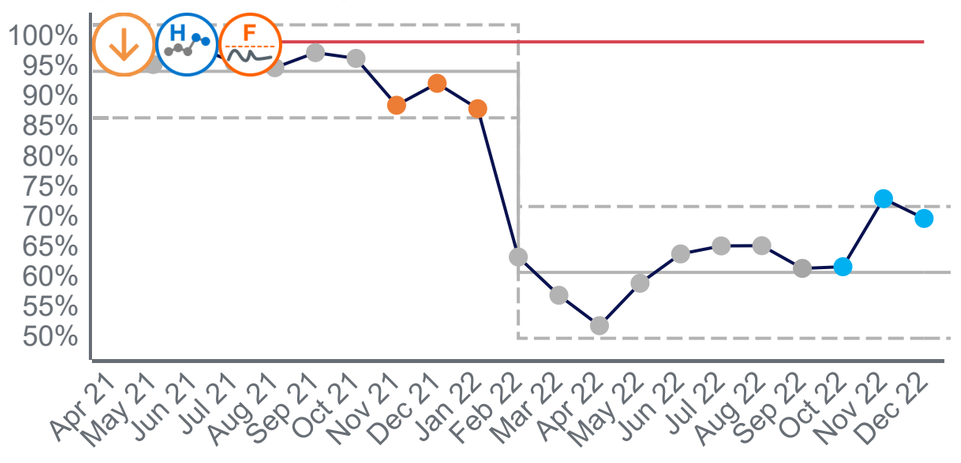
Technical Analysis:

In Dec there were 365 RTT patients >52wks; this includes 13 RTT patients >78wks. Dentistry has 243pts >52wks, 66.5% of the Trust total. The weekly reports show that the reduction in long waits has slowed, in part due to fewer working days in Dec (Industrial Action and Bank Holidays) with less capacity as a result.

Actions:

Seek to reinstate additional theatre capacity Focus on achieving zero OP >40wks for majority of specialities, enabling IP waits to be <52wks. Dental Insource Model to commence in Jan. Dental and Spinal to ensure all potential 78ww patients have treatment booked by end of Jan. Business case and productivity plans for ENT and Paediatric Surgery

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

The Baseline was reset in Feb following Safe Waiting List Management validation and correction of reporting. In Nov and Dec, Special Cause variation has been observed which demonstrates the success of the improvement actions taken in Radiology and Urodynamics to reduce waiting times.

Actions:

Home Sleep studies to commence in Jan, doubling capacity from 8 to 16 patients per week. Gastroscopy waiting list validation and additional capacity plan to be finalised by Division of Medicine

Recovery & Access -Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	December 2022	98	104	101.34		?
Number of RTT Patients waiting >52weeks	December 2022	365	0	291.19		F
Diagnostics: % Completed Within 6 Weeks of referral	December 2022	70	99	62.78	H	F
RTT Open Pathway: % Waiting within 18 Weeks	December 2022	54	92	62.54	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	December 2022	100	100	99.40		P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	December 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	December 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	December 2022	100	100	92.50	H	?
Cancer: Faster Diagnosis within 28 days	December 2022	94	75	93.48	H	P
% Recovery for OP New & OPPROC Activity Volume	December 2022	112	104	101.79	H	?
% OPFU Activity Volume	December 2022	96	85	106.54		F
Waiting List Size	December 2022	23328		19,095.57	H	?

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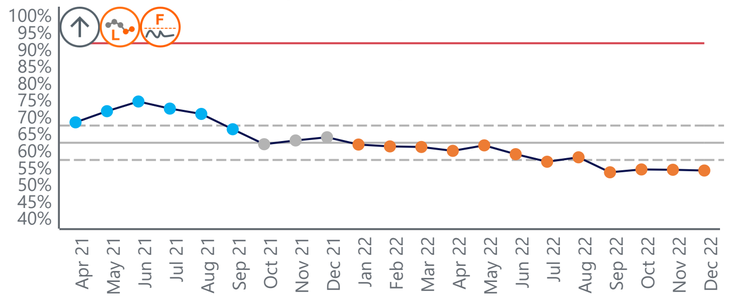
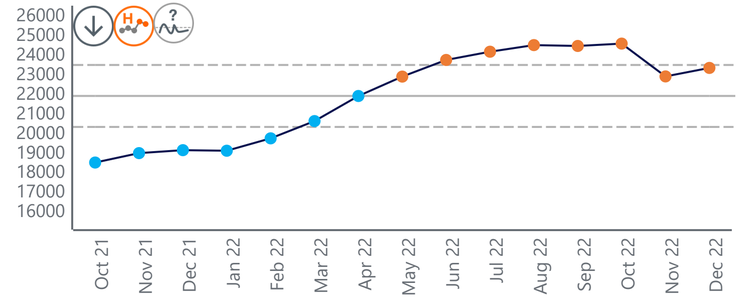
Alder Hey Children's NHS Foundation Trust

Recovery & Access -Responsive - Watch Metrics

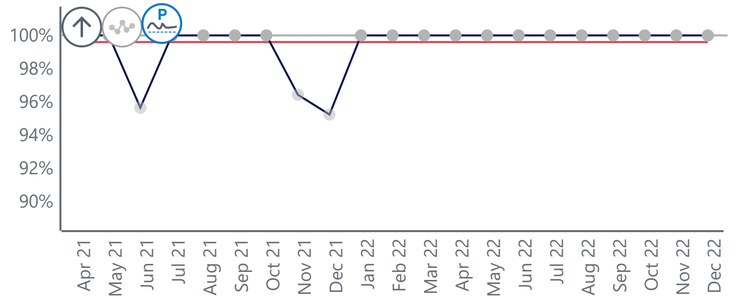
RTT Open Pathway: % Waiting within 18 Weeks



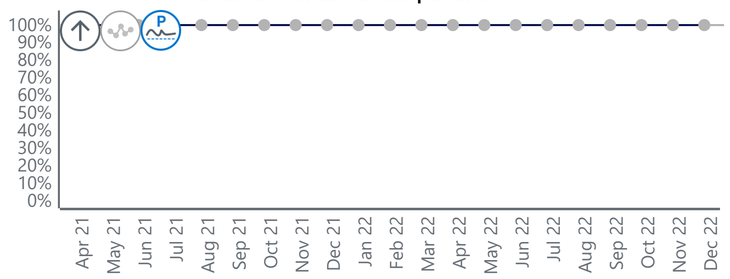
Waiting List Size



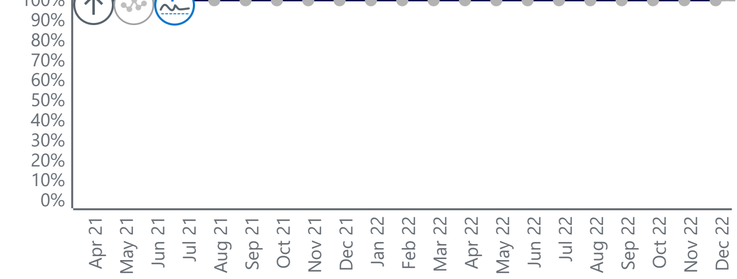
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



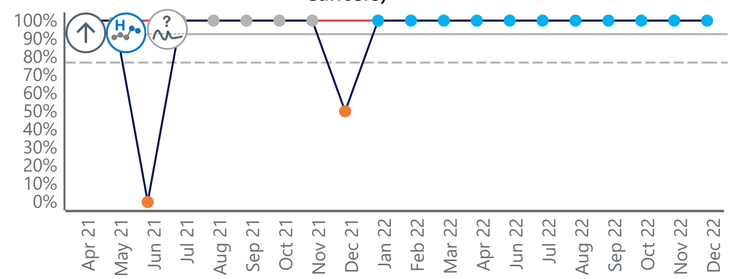
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



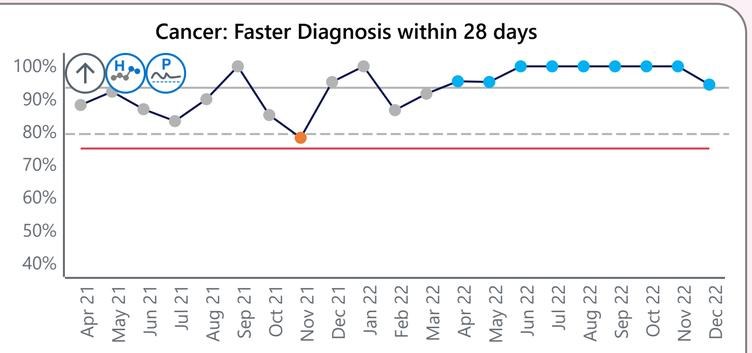
All Cancers: 31 day wait until subsequent treatments



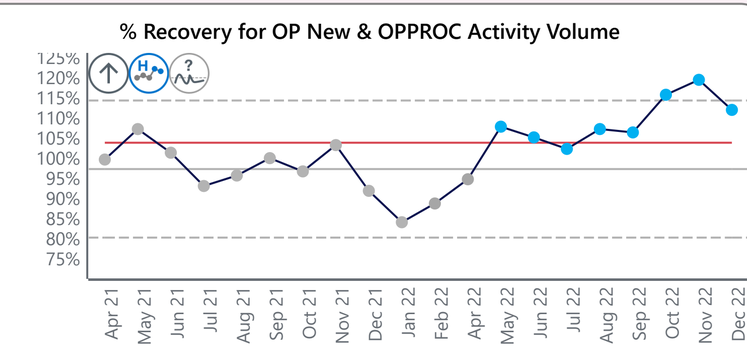
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



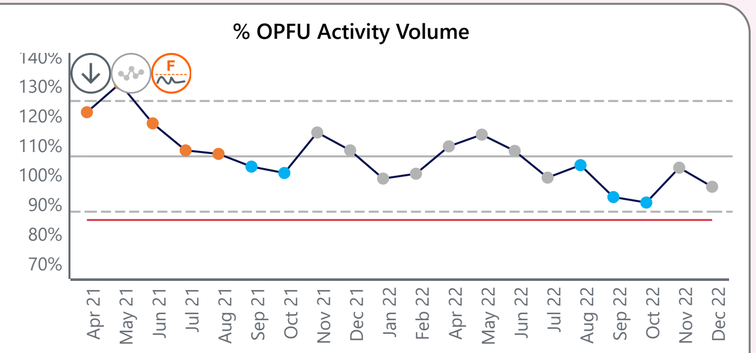
Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



% OPFU Activity Volume



Well Led - Great Place to Work - People

SRO : Melissa Swindell, Chief People Officer

Highlights:

• Mandatory training compliance remains above target, at 93%, which is a further increase from last month • Sickness absence remains above the 5% target. Whilst there had been a 4/5 month period of reduced absence (albeit it still above target), we have now started to see a steady increase in absence from Nov onwards, which is reflective of the regional position.

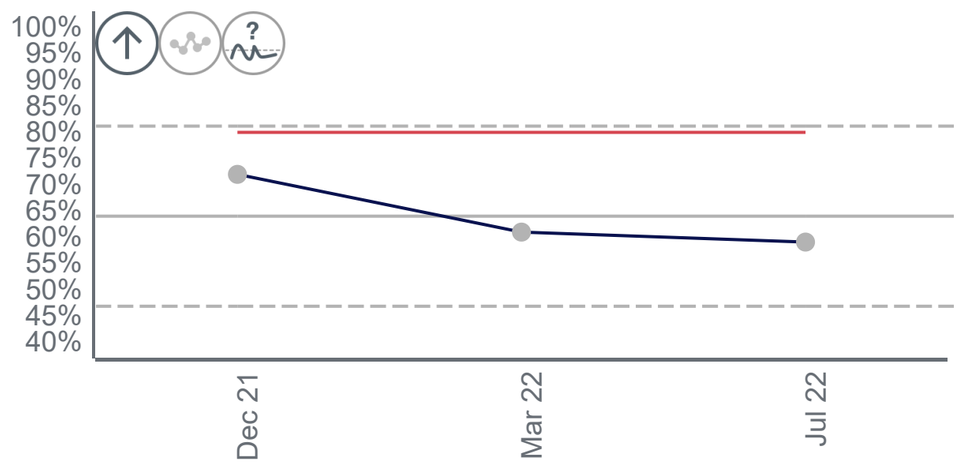
Areas of Concern:

• Staff availability remains an area of concern, particularly sickness absence & retention • PDRs are a concern in this context, as it is through these discussions, we review performance, objectives and review development need and career aspirations. These discussions can provide a clear indicator if we foresee retention issues. Only 47% PDR's completed in the Trust, this needs to be addressed by divisions.

Forward Look (with actions)

• Increased focus on turnover and retention initiatives which will be captured in the Trust long term plan on attraction and retention. People and Wellbeing Committee will continue to receive detailed analysis and oversight of this.

% Staff who recommended Alder Hey as a place to work



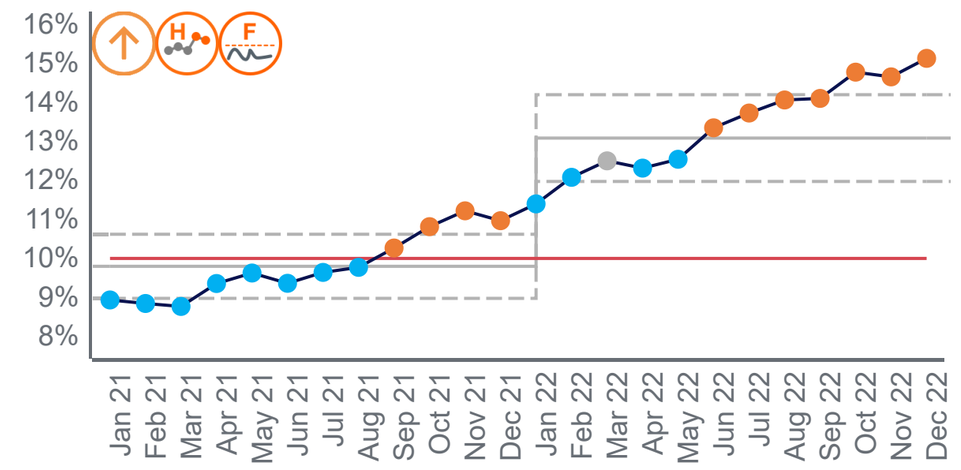
Technical Analysis:

Given current frequency of the data it is not possible to observe statistical trends. Data points are consistently below the 80% target, and are lower than Dec 21. The full national staff survey in autumn 2022 closed with a 54% response rate.

Actions:

The Staff Survey with a response rate of 54% confirmed that 69% of those staff would recommend Alderhey as a place to work. Throughout January departmental data packs will be generated, as well as providing guidance on a full action plan. (Staff Survey Information remains currently under embargo outside of the organisation)

Staff Turnover



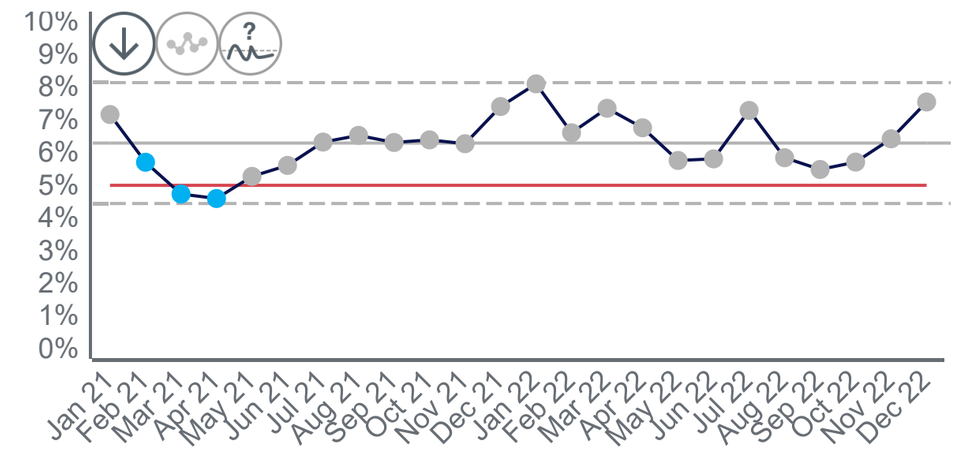
Technical Analysis:

This data raises significant concern due to special cause variation driving a substantial increase in turnover rate. December 2022 was the highest month of the year. This level of staff turnover is creating substantial risk for the Trust.

Actions:

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

Sickness Absence (Total)

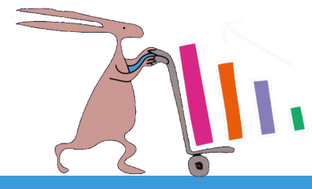


Technical Analysis:

Total absence in Dec is 7.7%, which is above the 5% target and higher than the same month the previous year (7.4%). This comprises STS at 3.3% and LTS at 4.5% (both above target). This is still demonstrating common cause variation and further actions are required to demonstrate improvement.

Actions:

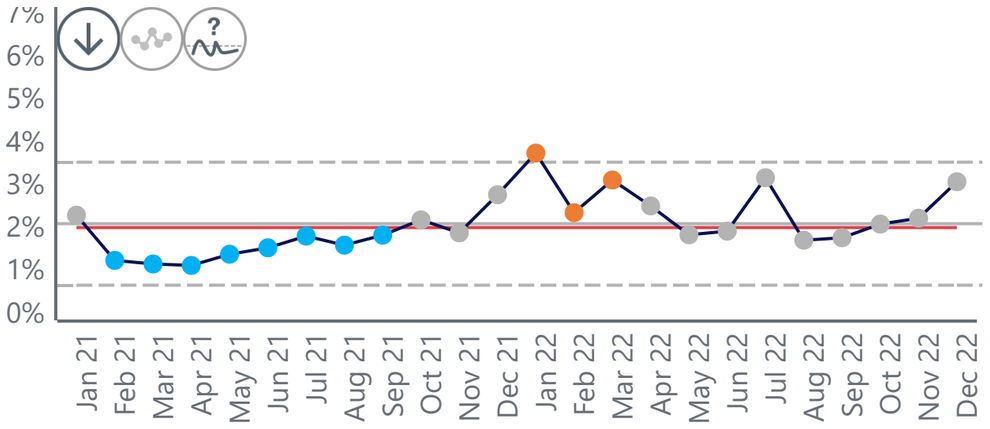
Interventions remain in place which include: Early intervention though Occupational Health, launch of new management training, HR surgeries, SALS support, designated HR support per division. Detailed analysis to be presented to PAWC.



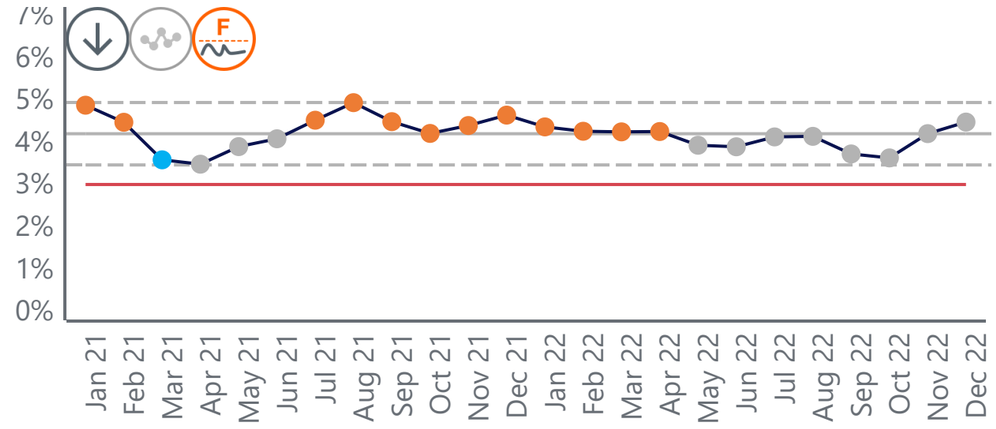
Well Led - Great Place to Work - People - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Staff who recommended Alder Hey as a place to work	July 2022	59	80	64.03		?
Staff Turnover	December 2022	15	10	13.06	H	F
Sickness Absence (Total)	December 2022	8	5	6.29		?
Short Term Sickness	December 2022	3	2	2.09		?
Long Term Sickness	December 2022	4	3	4.20		F
Mandatory Training	December 2022	92	90	92.19		P
% PDRs completed since April	December 2022	47	90	46.47		F
Medical Appraisal	December 2022	89	100	62.40	H	F

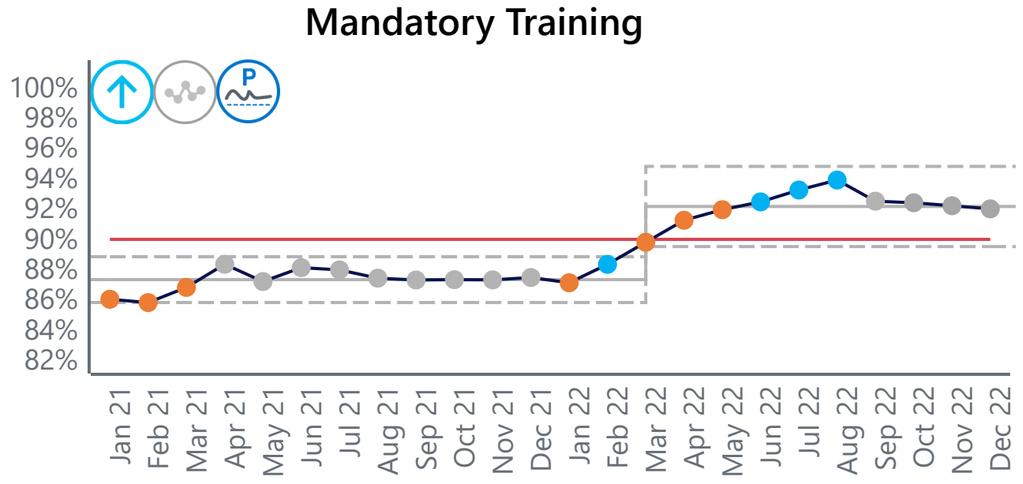
Short Term Sickness



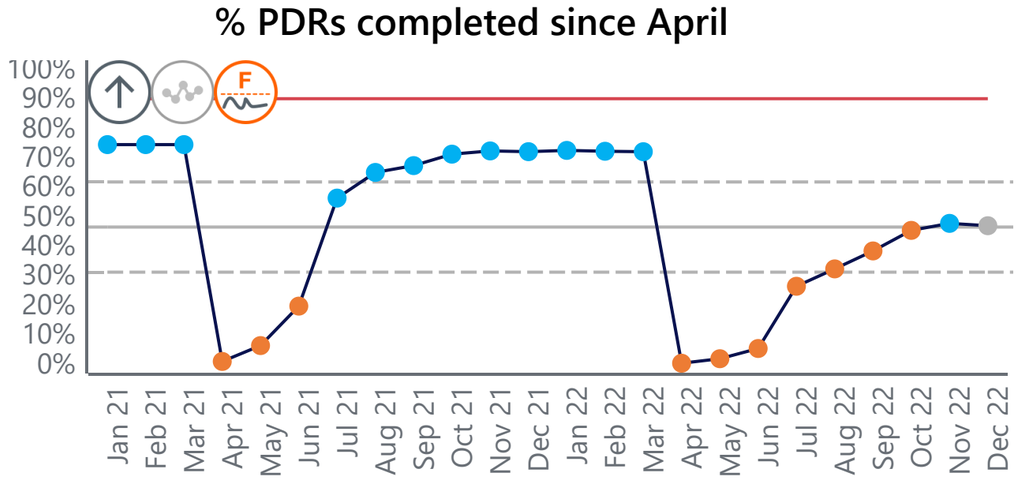
Long Term Sickness



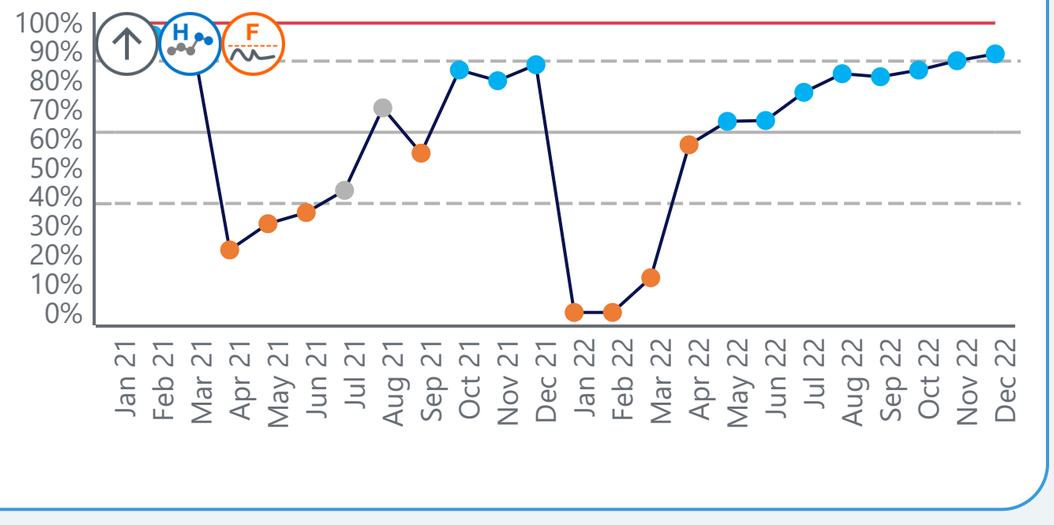
Mandatory Training



% PDRs completed since April



Medical Appraisal



Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Highlights:

For December (M9), the Trust is reporting a surplus of £1m which is in line plan. The year to date position is £1.6m surplus in line with the plan. The Trust is forecast to achieve its control total of £4.6m and discussions are underway with RABD and Trust Board regarding further improvement due to one off non recurrent benefits. Forecasting to achieve £17.3m in year Cost Improvement Plan target. A continued improvement in the month of recurrent CIP achievement now at 70% of the identified target. Cash has remained high in line with the plan as capital spend increases in future months.

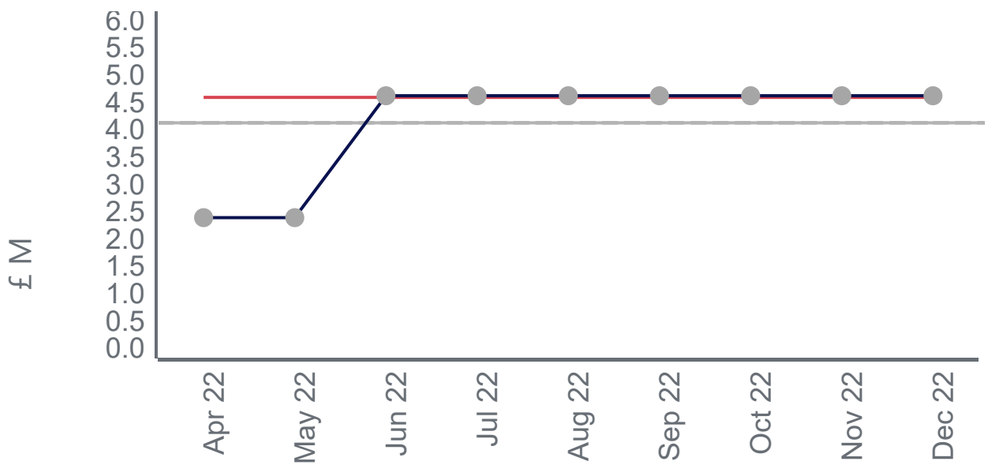
Areas of Concern:

A 30% gap remains in recurrent CIP identified with no transformational schemes in the plan. Challenges remain as we head into 23/24 financial year including inflationary pressures within energy, drugs, non pay and an increase in temporary/premium pay despite activity below 19/20 levels. Not achieving the 104% ERF threshold.

Forward Look (with actions)

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

Revenue Position (Year End Forecast)



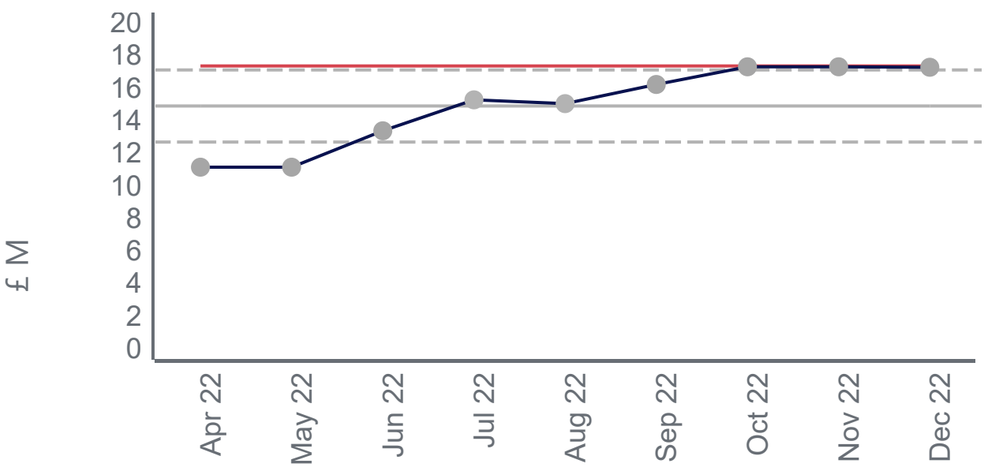
Technical Analysis:

Forecast to achieve £4.6m control total surplus with potential to improve further subject to ongoing discussions

Actions:

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

CIP Position In Year (Year End Forecast)



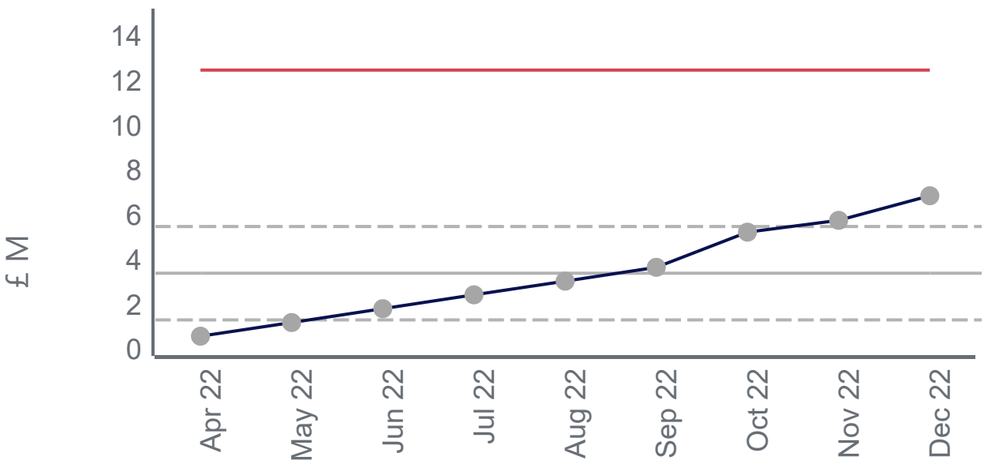
Technical Analysis:

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

Actions:

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

CIP Position Recurrent/Full Year Effect



Technical Analysis:

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

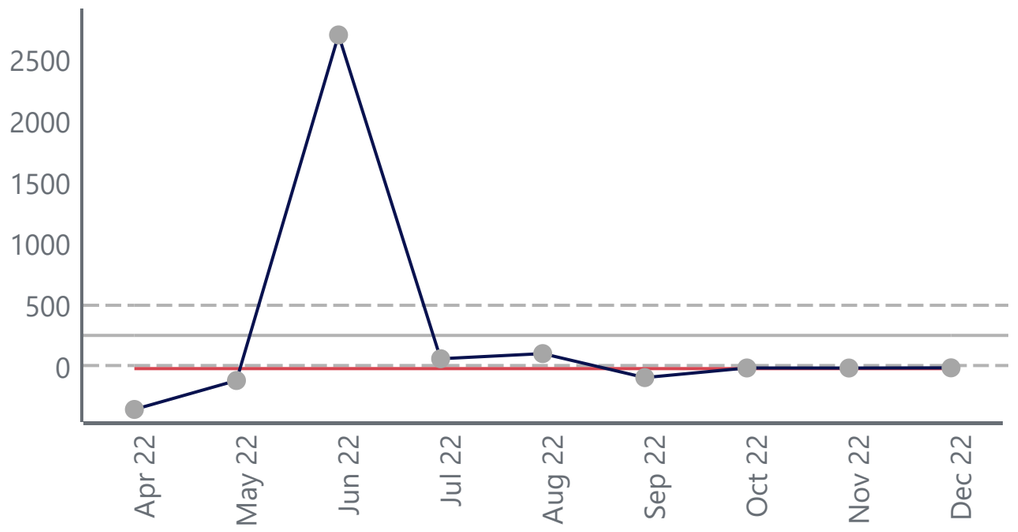
Actions:

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

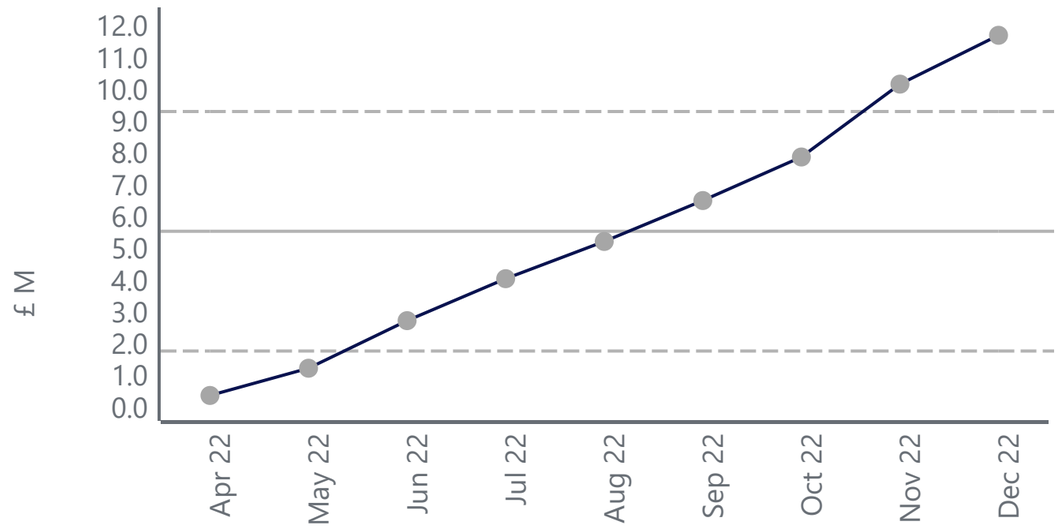
Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	December 2022	5	5		
CIP Position In Year (Year End Forecast)	December 2022	17	17		
CIP Position Recurrent/Full Year Effect	December 2022	7	13		
Revenue Position (variance to date)	December 2022	6	0		
CIP Position (delivered to date)	December 2022	12			
Cash	December 2022	84,372,000			

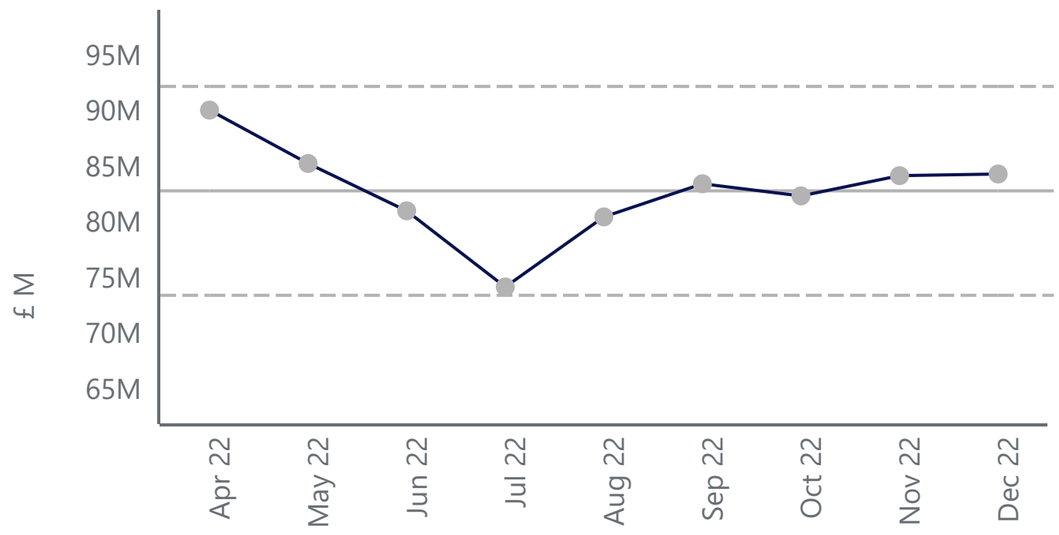
Revenue Position (variance to date)



CIP Position (delivered to date)



Cash



Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Highlights:

• Work ongoing via monthly review of Divisonal and Corporate Functions' high moderate longstanding risks (risks with a score of 12 on the risk register >12 months) as part of risk revalidation meetings with Corporate Governance/Risk team • Corporate high risks (risk score 12+) reviewed via corporate services collaborative • Monthly risk register validation meetings continue with corporate oversight • Improving risk management approach within medicine division providing assurance of risk oversight and management

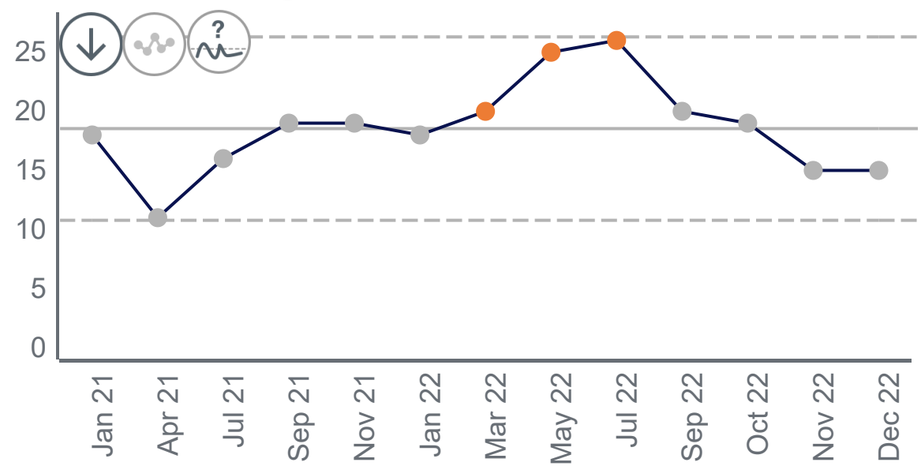
Areas of Concern:

• One risk with no agreed action plan escalated to division

Forward Look (with actions)

• Procurement of risk/incident management system to enable standardised approach concluded. Implementation plan in development with GO LIVE date May 23 • Corporate Service collaborative report to be developed and shared at Risk management forum • Ongoing cleanse and update of risk registers continues focused work with service leads/divisions with oversight from corporate governance team • Individual risk management training being offered as requested/required • Refresh of risk management training with staff once procurement of new risk management system implemented

Number of High Risks (scored 15 and above)



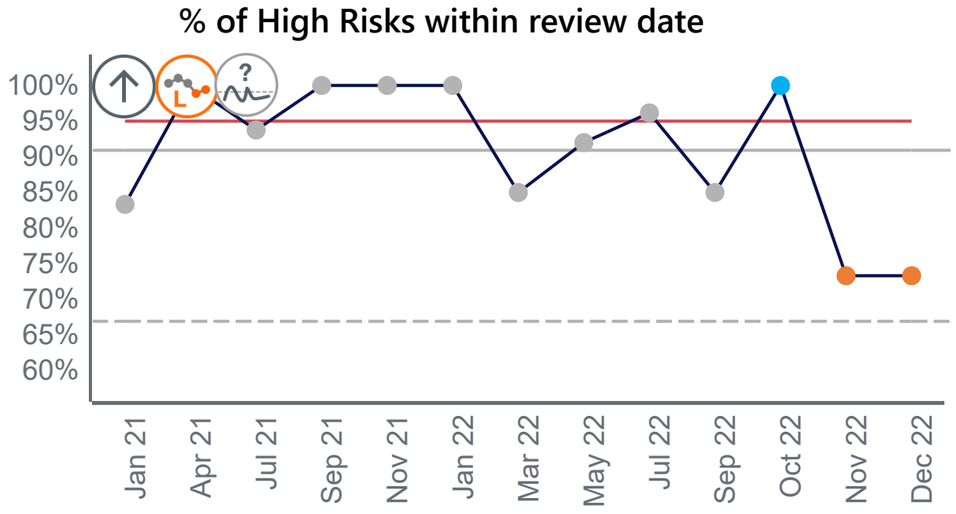
Technical Analysis:

There are a total of 15 High Risks in Dec, which is stable and within the normal range. This data has been collected on a monthly basis since Sept 22, which will enable more meaningful analysis of trends.

Actions:

As of end Dec 22 there are 15 high risks (risks scored 15+) a decrease from 19 reported in Nov 22

% of High Risks within review date



Technical Analysis:

At the end of Dec, 4/15 high risks were overdue review, meaning just 73% are within review date. This is consistent with Nov performance and is showing special cause variation with two points close to the lower limit. Action is required to address this and move back to the 95% target in future months.

Actions:

The 4 risks overdue reviews have been escalated within the relevant Divisions. This data will be continuing to be collected monthly with oversight and assurance of mitigation provided at Risk Management Forum

Well Led - Safe Digital Systems - Digital

SRO : Kate Warriner, Chief Digital and Information Officer

Highlights:

• AlderC@re Gateway 1 successfully completed • Business Case approved for Risk and Incident Management solution • Business Case approved for AlderC@re national funding • National approval received for AlderC@re funding

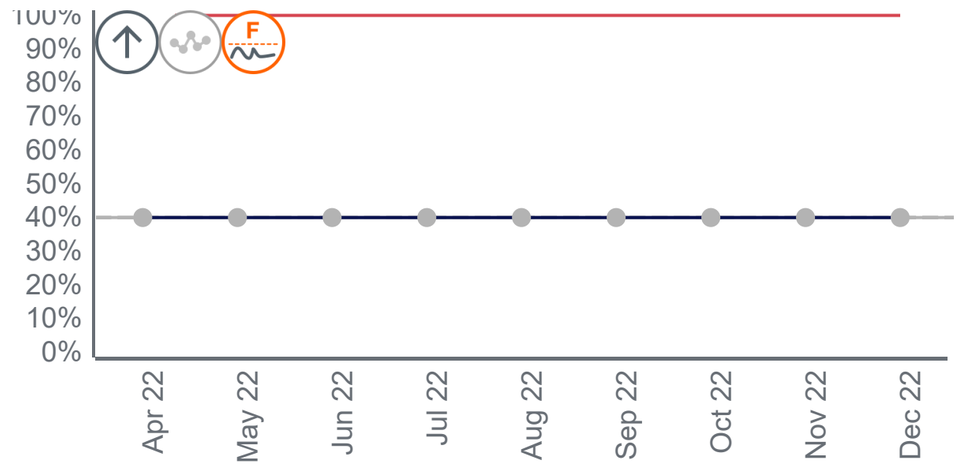
Areas of Concern:

• Dates have been provided for all priority issues for AlderC@re however the delivery of the solutions needs closely monitoring • Resource constraints against priority programmes and issues recruiting to key roles are a challenge which are under review • Impact on Website and Intranet timing until Trust branding strategy is finalised

Forward Look (with actions)

• AlderC@re Gateway 2 and Patient Journey cycle 3 • Finalise Go-Live date and plans for AlderC@re • Agree deployment plan for Risk and Incident Management System • Progression with AlderheyAnywhere deployment and integration with health care communications platform • Progression with intranet and website projects

Alder Care - Divisional Critical Criteria



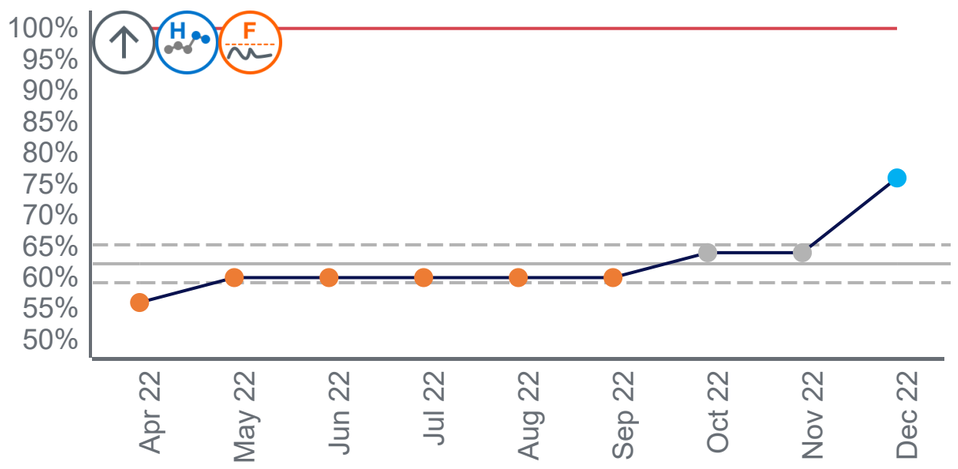
Technical Analysis:

6/15 critical criteria complete. Remainder awaiting system build or key decisions (e.g. waiting list management). Performance metric is for "sign off" so percentage only increases once each item is fully signed off. Three items reviewed in December but further review required in January.

Actions:

1. Ongoing development for remaining items.
2. Continue to review 3 items for potential sign off.

Alder Care - % System Build Completion



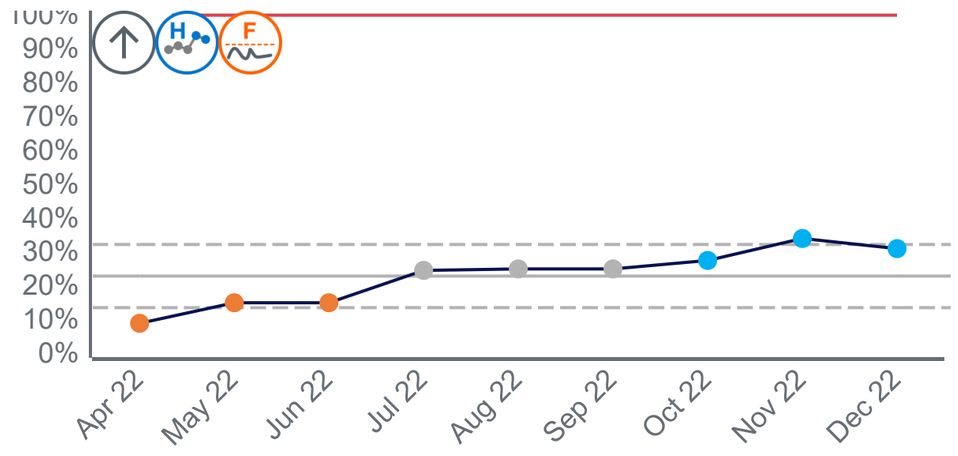
Technical Analysis:

This metric monitors build across all workstreams. Further validation of build continued through cycle 2 of "Patient Journeys" with clinical and operational teams and cycle 3 planned for January 2023.

Actions:

1. Continue build and review during "Patient Journeys" cycle 3.
2. Monitor progress on EPMA build.
3. Review BAU requests for impact on AlderCare programme.

Alder Care - % Speciality documentation build

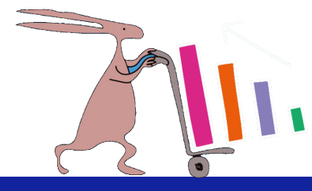


Technical Analysis:

18 of 58 specialties with changes required to their documents have now been actioned. Orthopaedic documents in the process of being reviewed with the service with over 80 documents processed. Formal sign off processes continue (8%).

Actions:

1. Continue build (31%) and sign off process (8%).



Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• No children & young people waiting over 52 weeks in Developmental Paediatrics or Therapy services • Sustained delivery of virtual appointments (above 45% since April 2021) • Routine and Urgent waiting times for Eating Disorder Services continue to be achieved • Compliance with mandatory training requirements continue to be above 90%

Areas of Concern

• Increased sickness absence across the Division • Was Not Brought Rate continuing to be above 10%• Number of young people waiting for Mental Health Services above 52 weeks increased • Continued increase in demand for ASD and ADHD diagnostic pathways • Estates issues impacting on staff working environment

Forward Look (with actions)

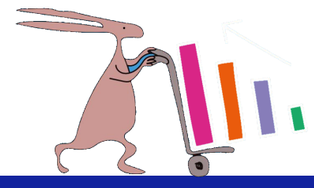
• Deep dive into areas with increased sickness with support from HR team • Approach to community clinical measurement clinics under review to address challenges in clinic attendance, new model to be in place by end of March • Number of additional posts in Mental Health Services commenced in December and January which will support reduction in waiting times by end of February • Moves planned into Sunflower House and 3SM building

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	December 2022	11	15	19.19		
Number of Incidents rated No Harm and Near Miss	December 2022	46	80	73.76		
Use of physical restrictive intervention (MH Tier 4)	December 2022	2		10.56		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	December 2022	0	6	3.00		
Number of PALS contacts	December 2022	37	45	42.95		



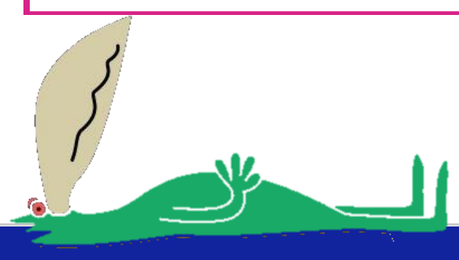
Divisional Performance Summary - Community & Mental Health

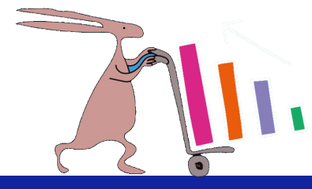
Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	December 2022	51	25	53.97		P
% Was Not Brought Rate (All OP: New and FU)	December 2022	14	10	14.50		F
% of Clinical Letters completed within 10 Days	November 2022	67	95	58.43		F
CYP1 - Number of visitors to the site	December 2022	1503		1,355.20		?
CYP1 - Number of Referrals	December 2022	110		87.65		?
CYP1 - Number of Referrals Accepted	December 2022	57		35.10		?

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	December 2022	0	0	2.14		?
RTT Open Pathway: % Waiting within 18 Weeks	December 2022	49	92	55.08	L	F
% Recovery for OP New & OPPROC Activity Volume	December 2022	76	104	131.45		?
% OPFU Activity Volume	December 2022	88	85	130.26		?
CAMHS: Number of Patients waiting >52weeks	December 2022	17	0	5.05	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	December 2022	58	92	63.79		F
CAMHS: Paired Outcome Scores	July 2022	35	40	32.19		?
CAMHS: Crisis / Duty Call Activity	December 2022	549		660.19		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	December 2022	94	95	63.44		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	December 2022	100	95	71.67		?
ASD: % Incomplete Pathways within 52wks	December 2022	75	90	73.95		?
ASD: % Referral to triage within 12 weeks	December 2022	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	December 2022	81	90	81.91		?
ADHD: % Referral to triage within 12 weeks	December 2022	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	November 2022	14	100	9.37		F
IHA: % complete within 20 days of referral to Alder Hey	November 2022	24	100	26.81		F





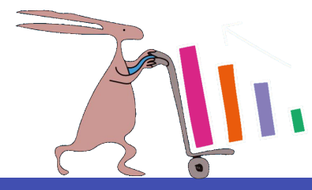
Divisional Performance Summary - Community & Mental Health

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	December 2022	15	10	12.77	H	F
Short Term Sickness	December 2022	3	2	1.71		?
Long Term Sickness	December 2022	5	3	3.95		?
Mandatory Training	December 2022	94	90	94.72		P
% PDRs completed since April	December 2022	51	90	52.81	L	F
Medical Appraisal	December 2022	82	100	56.87		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	December 2022	2	0	5.62		?



Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• 100% Complaints response compliance since October 2022 • Sustained reduction in children in hospital over 21 days • Sustained recovery above 104% for Outpatients • Sustained achievement of all Childrens Cancer Standards

Areas of Concern

• ED Attendances in December were 7420; increased waiting times and overcrowding; impact on patient experience • Deterioration in Sepsis Compliance in ED and across Wards 3B and 3C; deep dive completed and action plans in place • Diagnostics recovery impeded by industrial action and delays with Home Sleep Equipment • Continued challenges with long waits in Neurology and Gastroenterology

Forward Look (with actions)

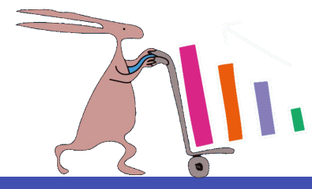
• ED Improvement Plan in place; expansion of physical ED footprint by 8 extra spaces by end of January; new processes introduced • Sepsis Improvement Plan led by Associate Chief Nurse • Home Sleep Service Go Live Feb 2023 • Gastro service review ongoing • Discussion with RMCH re Neurology shared service

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	December 2022	20	15	20.48		
Number of Incidents rated No Harm and Near Miss	December 2022	131	140	148.38		
Sepsis % Patients receiving antibiotic within 60 mins for ED	December 2022	87	90	85.20		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	December 2022	80	90	90.41		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	December 2022	3	6	4.67		
Number of PALS contacts	December 2022	42	45	42.67		
F&F ED - % Recommend the Trust	December 2022	64	95	68.34		F



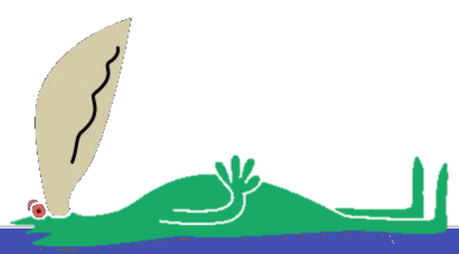
Divisional Performance Summary - Medicine

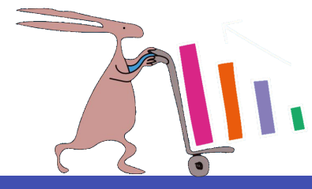
Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	December 2022	62	95	76.15		?
Number of Super Stranded Patients (21 days)	December 2022	23	20	27.14		?
% Virtual Outpatients (national standard 25%)	December 2022	29	25	36.82	L	P
% Was Not Brought Rate (All OP: New and FU)	December 2022	9	10	9.04		?
% of Clinical Letters completed within 10 Days	November 2022	62	95	57.02		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	December 2022	101	104	112.41		?
Number of RTT Patients waiting >52weeks	December 2022	21	0	14.71		?
Diagnostics: % Completed Within 6 Weeks of referral	December 2022	70	99	65.69		F
RTT Open Pathway: % Waiting within 18 Weeks	December 2022	56	92	68.57	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	December 2022	100	100	99.40	H	?
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	December 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	December 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	December 2022	100	100	92.50	H	?
Cancer: Faster Diagnosis within 28 days	December 2022	94	75	93.48	H	P
% Recovery for OP New & OPPROC Activity Volume	December 2022	150	104	103.87	H	?
% OPFU Activity Volume	December 2022	96	85	111.43		F





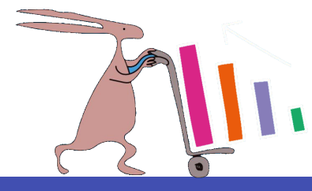
Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	December 2022	15	10	12.88	H	F
Short Term Sickness	December 2022	4	2	2.39		?
Long Term Sickness	December 2022	5	3	4.59		F
Mandatory Training	December 2022	91	90	91.26		?
% PDRs completed since April	December 2022	44	90	45.05		F
Medical Appraisal	December 2022	88	100	60.14		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	December 2022	-8	0	-1.83		?



Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• Maintained 0 Never Events • Retained 100% compliance with PALS response • % WNB rate remained below target/volume of virtual attendances increased for 3rd consecutive month • % clinical letters completed within 10 days improved • Super stranded patients decreased for 2nd month • Diagnostics significant improvement

Areas of Concern

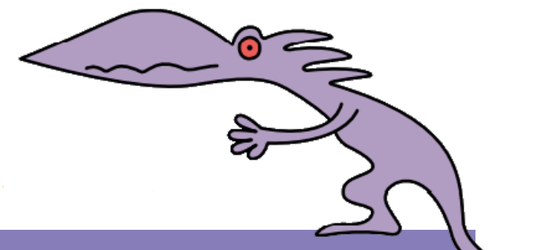
• Cancelled Operations on the day above target although patients re-booked within 28 days improved • Elective recovery remains below target although improved in month- IA impacted significantly •OP New & Proc reduced in month •Sickness absence increased in month (Long term) • Staff turnover remains a concern

Forward Look (with actions)

• Cancelled Operations deep dive completed- improvement plan in place • Deep dive review of OP NEW & PROC for December- IA strike had some impact • Continue focus on theatre recovery- additional sessions in schedule following agency recruitment • Continued focus on RTT targets • Focus on retention- deep dive complete with actions planned in key areas

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	December 2022	54	40	48.10		
Number of Incidents rated No Harm and Near Miss	December 2022	153	150	158.62		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	December 2022	86	90	85.34		



Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	December 2022	3	6	4.10		
Number of PALS contacts	December 2022	33	45	35.29		

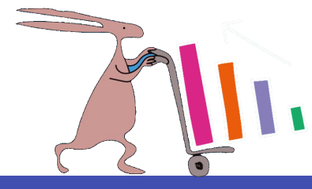
Divisional Performance Summary - Surgery

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Cancelled Operations (on day of admission for a non-clinical reason)	December 2022	26	20	21.00		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	December 2022	7	0	7.14		?
Number of Super Stranded Patients (21 days)	December 2022	13	30	10.05		F
% Virtual Outpatients (national standard 25%)	December 2022	19	25	17.28		F
% Was Not Brought Rate (All OP: New and FU)	December 2022	9	10	8.66		?
% of Clinical Letters completed within 10 Days	November 2022	74	95	58.72		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	December 2022	95	104	90.24		?
Number of RTT Patients waiting >52weeks	December 2022	344	0	274.33	H	F
Diagnostics: % Completed Within 6 Weeks of referral	December 2022	67	99	38.66	H	F
RTT Open Pathway: % Waiting within 18 Weeks	December 2022	54	92	61.11	L	F
% Recovery for OP New & OPPROC Activity Volume	December 2022	96	104	98.50		?
% OPFU Activity Volume	December 2022	98	85	100.20	L	?



Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	December 2022	13	10	12.29	H	F
Short Term Sickness	December 2022	3	2	2.42		?
Long Term Sickness	December 2022	4	3	3.81		?
Mandatory Training	December 2022	90	90	91.53		?
% PDRs completed since April	December 2022	40	90	41.07		F
Medical Appraisal	December 2022	93	100	65.65	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	December 2022	-8	0	-3.94		?

Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

• No major changes in month. The Collaborative group has not met since the last report but risks reported to Risk Management Forum on 9th January and are kept under review.

Areas of Concern

• Turnover rates will continue to be a focus for the group as will the financial position going into 2023/24, particularly in relation to CIP opportunities. Plan to use benchmarking information available for C&M to explore 'back office' models.

Forward Look (with actions)

• Next steps for Collaborative is to identify 3 to 5 improvement opportunities tied to operational plan.

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	December 2022	15	10	14.54	H	F
Sickness Absence (Total)	December 2022	8	5	6.72		?
Short Term Sickness	December 2022	3	2	1.66		?
Long Term Sickness	December 2022	5	3	5.06		F
Mandatory Training	December 2022	94	90	92.42	H	P
% PDRs completed since April	December 2022	57	90	50.45		F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	December 2022	-10	0	-10.66		?

000109

Safe Staffing & Patient Quality Indicator Report
September 2022

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT		Pals	Complaints
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at	CHPPD Rate		RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good		
Burns Unit	94%	-	100%	-	1897.75	**95**	19.98	14.73	0.71	4.35%	0.20	20.00%	0.00	0.00%	0.00	0.00%	25.00	5.01%	0.00	0.00%	0	18	0	4	9	100%	0	0
HDU	61%	45%	67%	39%	6887.75	**294**	23.43	29.87	13.23	17.49%	3.05	38.17%	0.00	0.00%	0.00	0.00%	220.19	11.77%	0.00	0.00%	6	63	0	2	5	100%	0	0
ICU	50%	56%	49%	37%	13392	**396**	33.82	29.87	12.19	7.17%	-2.45	-40.30%	2.99	2.08%	0.00	0.00%	183.92	4.25%	2.00	1.19%	20	120	0	1	0	-	0	0
Ward 1cC	86%	67%	83%	48%	6554	**471**	13.92	13.92	-3.35	-5.73%	-0.12	-2.25%	1.00	1.58%	0.00	0.00%	141.70	7.42%	14.12	8.63%	4	25	1	3	9	100%	0	0
Ward 1cN	86%	100%	100%	-	3032	**190**	15.96	15.96	3.75	10.65%	1.43	58.85%	0.00	0.00%	0.00	0.00%	59.40	7.21%	0.00	0.00%	0	13	1	4	7	100%	0	0
Ward 3A	83%	65%	87%	76%	6657.75	**681**	9.78	10.19	0.45	0.93%	3.21	20.09%	0.00	0.00%	0.00	0.00%	106.44	7.24%	46.65	14.18%	1	23	0	8	49	95.92%	1	0
Ward 3B	78%	73%	73%	100%	3908.5	**369**	10.59	10.59	-1.71	-4.90%	-1.85	-31.52%	0.00	0.00%	0.00	0.00%	131.46	10.39%	40.12	27.18%	0	19	2	19	3	100%	0	0
Ward 3C	87%	68%	82%	87%	6398	**766**	8.35	7.93	-1.06	-2.08%	5.15	47.20%	0.00	0.00%	0.00	0.00%	181.29	11.22%	6.00	4.73%	7	43	2	3	12	91.67%	0	0
Ward 4A	84%	83%	84%	127%	8217.5	**766**	10.73	10.19	-0.31	-0.47%	1.38	16.22%	0.00	0.00%	0.00	0.00%	194.79	9.42%	0.00	0.00%	2	37	0	3	43	93.02%	0	0
Ward 4B	67%	73%	67%	67%	6799	**516**	13.18	9.35	-2.13	-5.57%	2.91	7.38%	0.92	2.16%	0.00	0.00%	150.01	11.65%	227.68	23.21%	2	47	0	10	14	92.86%	0	0
Ward 4C	83%	98%	84%	88%	6588.7	**715**	9.21	11.51	-2.40	-4.98%	-0.50	-4.38%	0.00	0.00%	0.00	0.00%	122.57	7.61%	29.75	8.42%	5	62	1	10	27	100%	1	0

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

Medicine

Ward 3B and 4B had low fill rate for both day and night shifts due to continued higher levels of sickness. A continued focus with Ward managers, HR, Matrons and Heads of Nursing to ensure we are supporting staff and managing cases in line with policy timeframes, occupational health referrals are in place and welfare meetings conducted.

Surgery

Wards 3A and 4A RN fill rates stayed over 80% in September however HCA shifts on 3A continue to have a low fill rate due to high levels of sickness at 14%, although this has reduced from 35% in August. The ward prioritises HCA cover for patients requiring a 1:1 as per the risk assessment.

Critical Care

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

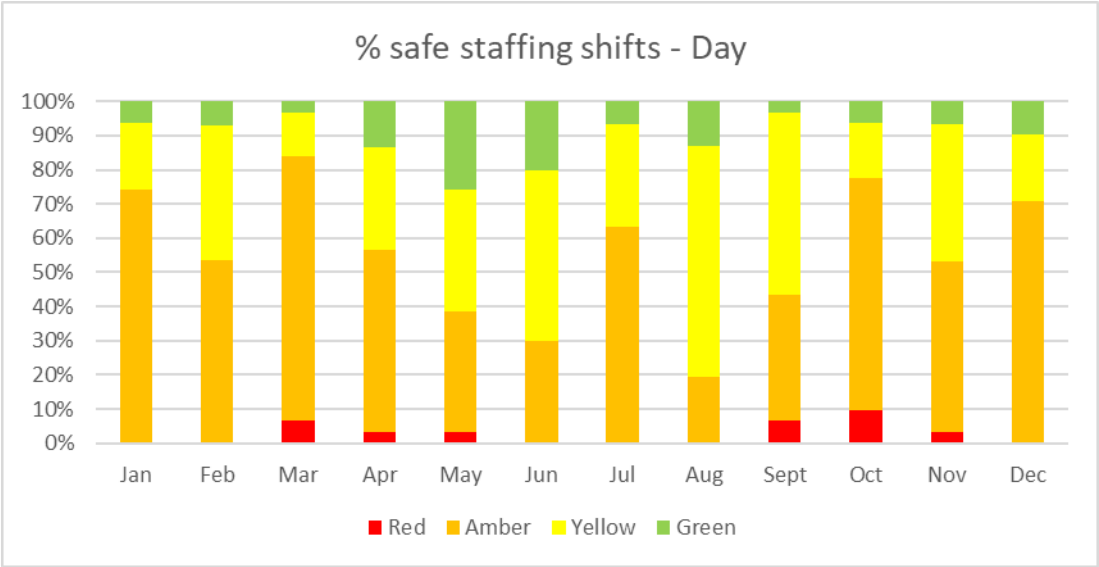
Summary

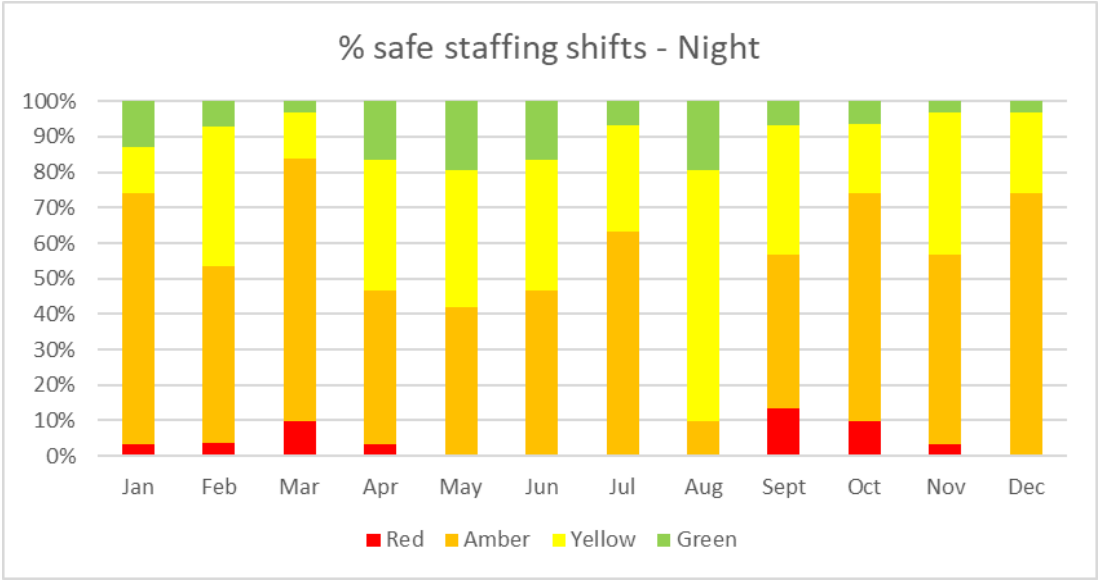
CHPPD compare equally and well with other paediatric hospitals and trusts, with no areas of concern.

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

Summary of December staffing

There has been an increase in amber days during December but 0 red days.


% safe staffing shifts - Day
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Red
Amber
Yellow
Green


% safe staffing shifts - Night
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sept
Oct
Nov
Dec
Red
Amber
Yellow
Green

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Transformation Programme Governance Report**
Report of:	**J. Grinnell – Deputy CEO**
Paper Prepared by:	N.Palin – Associate Director of Transformation

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	**Trust Board 22/23/06**: Operational Plan 22/23 Trust Integrated Performance Report
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 identified in this report

1. Executive Summary

The purpose of this report is to provide the trust board with assurance around the adherence to the programme management standards; for programmes designated as strategically important as part of the 2022/23 Operational Plan (*approved at Board April 22).*

This paper also details the approach to managing the transition to the 2023/24 Change Programme.

Summary Governance results Qtr.3 22/23: -

- 87% of programmes have been rated as green for the adherence to the governance standards.
- Two programmes are rated as green for overall programme delivery – which is an improvement from the previous quarter. All other programmes are rated as amber for delivery assurance.

The recommendations, following this report is to: -

- Note: There are no risks for escalation following the completion of this assurance assessment.
- Approve: The transition approach for the 2023/24 Change programme scope.

2. Background

How

The assurance rating is designed to support the 'Change teams' alongside the SRO – to rate the level of confidence that the programmes will achieve their intended benefits, with quality, cost, and time scale. It is designed to improve control and therefore the achievement of sustainable change.

The assurance rating is undertaken by the Head of the DMO Team – in a semi-independent manner utilising documented evidence '*opposed to verbal reassurance'*. Table 1 details the key areas which the assurance assessment is undertaken against. There is complete transparency with the programme teams, around the expected standards and the evidence required. The SRO is accountable at a programme level to ensure the adherence to the standards.

The assurance ratings form part of the monthly reporting to strategic executives and are also provided to the appropriate committee, with a written commentary designed to justify the ratings and highlight areas of good practice and areas for improvement. There are three ratings, Green (standards achieved), Amber (standards achieved in part), Red (No evidence of standard being achieved).

Table 1: Assurance categories – Governance and Delivery

Overall Governance					Overall delivery rating		
Project Team	Scope	Risk management	QIA	EIA	Targets	Milestones	QI approach

Assurance Assessments

This report details only strategically important programmes, which are part of the trusts Operational Plan 2022/23 and being delivered under a change project management (PMO) methodology. The same approach however is also applied to Operational Important projects utilising a PMO methodology.

Table 2 details the current high-level assurance ratings, plus summary comments relating to the rating scores. Appendix (1) provides the further narrative descriptions that detail the rationale in the assessment scoring; to provide full transparency and identification of areas for improvement.

**This paper does not include the performance against the key driver measures, as this is detailed within the Integrated Performance Report*.

Table 2: Programme and Rating

Programme *(SRO)*	Driver *	Governance rating	Overall Delivery rating	Overall Qi approach rating
Advancing Outpatients *Chief Operating Officer*	104% Activity Elective & Daycase and outpatient			
Productive Theatres *Chief Operating Officer*				
Patient Safety *Chief Medical Officer / Chief Nursing Officer and AHP/HCP Lead*	25% Reduction in harms			
Brilliant Basics Chief Nursing Officer and AHP/HCP Lead				
Workforce Planning Chief People Officer	>80% of staff recommend a place to work			**NA****
Great Space to Work Chief People Officer				**NA****
Digital – Aldercare Chief Digital and Information Officer	100% Safety Compliance			**NA****

**QI standards have not been applied to these programmes, given their transactional nature.*

Overall Assessment

- 87% of programmes have been rated as green for the adherence to the **governance** standards.
- Two programmes are rated as green for **overall delivery rating** – which is an improvement from the previous quarter.
    - All other programmes are rated as amber for delivery assurance (*based on milestones delivery completion – either in Qtr.4 or 2023/24*).

It is a positive quarter 3 position that most programmes have established good routines regarding governance, particularly the effective management of risks.

The productive theatres programme has been reviewed with the Divisional Leadership Team. A review of the scope and benefits was undertaken – this assessment identified the 'operational nature' of the current scope and areas of success (utilisation in Surgical Day Case and clinical involvement). The focus for Qtr. 3, has been the on separation of the operational and project elements and the development of transitional (control plans), to allow the operational elements to be handed over into BAU. Regular status meetings and highlights reports are shared and agreed with the Divisional senior leadership team.

Transitional Management – 2023/24

Managing the transition from current change programme, into 2023/24 is a key priority for Qtr. 4. The aim is to ensure an alignment between strategy deployment, prioritisation, and resource allocation. To make sure that we are focusing on the areas that are most important to strategic success and to our stakeholders.

As part of the Strategy 2030 development process, we completed a high-level stock-take of projects (N.B not *all these projects / programmes have resources from the trusts Delivery Management Office).* This stock take identified that we have many projects in progress across the trust, which could present a risk of duplication and competing priorities. The below table details the outlined approach for the management of the transition – from the plethora of projects to the prioritisation, closure, and hand over to BAU.

As we finalise the scope for the 2030 the programme for 2023/24 it's important to acknowledge that projects, will be at differing points in the project life cycle; and are not intended to realise and fully release benefits this financial year (e.g., *Alder Care and Patient Safety*).

Date	Action	Who
24 Feb	**Review existing Transformation Programmes** - Business critical - In scope of 2030 Strategy priority areas - Recommendations (*Hand over to BAU / Closure / profile into scope of 2030 Strategy)*	Associate Director of Transformation (*with Exec colleagues*)
23 March	**Proposed 2030 Change Programme** - Approved by Strategic Executives	Strategic Exec
30 March	**2030 Change programme** - Submission to trust board for consideration	Strategic Board

The governance and assurance arrangements for managing the Change Programme – will form part of the scope of the Governance developments. In accordance with programme management standards, interdependency mapping, benefits, EIAs/QIAs etc will be developed, following an approval of the high-level scope of the 2023/24 Change Programme.

3. Conclusion

The report provides a high level of assurance regarding the programme management standards for governance. The report details good levels of progress around programme delivery at this 9-month stage. The transitional stage outlined provide an overview of the proposed approach for approving the scope of the 2023/24 change programme.

There is no risk for escalation following the governance and delivery assessment.

4. Recommendations

- Report is noted
- Approve the transition approach for the 2023/24 Change programme scope.
- No risks for escalation following the completion of the governance assessment.

Appendix 1: Full Governance assurance table

Programme *(SRO)*	Driver *	Overall Governance rating	Overall Delivery rating	Overall Qi approach rating	Summary Comments
Advancing Outpatients *Chief Operating Officer*	104% Activity Elective & Daycase and outpatient				• There is evidence of good stakeholder engagement from CYPF • Risks have been scored and uploaded to Ulysses (in date) • The PIFU EA QIA is signed off. B&S and D&I pending. • Milestone plan on track. • Benefits tracker is showing positive trend. • 21 specialities on PIFU, (5 pending Jan 23) 3500 PIFU episodes to date. WNB rate Dec 22-
Productive Theatres *Chief Operating Officer*					• Recently taken over by Ellie Johnson • Productive Theatre Board (PTB) closed in October 22 • New IP Theatre Improvement Board recently established, meeting weekly • Some PDSA trials have been concluded with a summary report written. Others are in progress. • Weekend cover has been re-funded through March 23. • Milestone plan on track. • Benefits tracker is showing some positive trends particularly in SDU.
Patient Safety *Chief Medical Officer / Chief Nursing Officer and AHP/HCP Lead*	25% Reduction in harms				• This programme comprises many workstreams, and all of which are at different stages of progress. • The Patient Safety Board meets monthly and has clear governance structures and attendance from stakeholders. • Of the 11 EA QIAs for programme, 3 have been approved, 5 are pending approval and 3 are yet to be completed. • Majority of profiled milestones not due for completion until March 2023. • Medication Safety and Deteriorating Patient workstreams are demonstrating a high level of adopting a QI approach. • There is evidence of lessons learned and key challenges, captured well.
Brilliant Basics Chief Nursing Officer and AHP/HCP Lead					• This project has been split into 3 workstreams; Leading for Improvement; Learning for Improvement and Delivering Improvement. • There is an abundance of evidence of stakeholder engagement across the trust including a newly launched BB support request portal. • Risks are held on a local risk register, reviewed regularly at project meetings and these are also featured on Ulysses and reviewed. • Some milestones have been reprofiled and there is evidence that these changes are approved by the SRO. • There is also a benefits tracker evidenced albeit some measures are not easily tracked at this stage and do require further development.

Programme *(SRO)*	Driver *	Overall Governance rating	Overall Delivery rating	Overall Qi approach rating	Summary Comments
Workforce Planning Chief People Officer	>80% of staff recommend a place to work			**NA****	• This project has been split into phases, phase 1 being the Establishment of Control. There is a project brief available but no PID at this stage which would not be expected given the nature of phase 1. • There is a comprehensive project plan and progress of milestones is clearly tracked by % completed to-date. • A benefits tracker will be expected once the project moves to phase 2. • Risks and issues are held in a local register and are up to date. • EA/QIA is not required for phase 1.
Great Space to Work Chief People Officer				**NA****	• Effective project team in place and reports into Campus Steering Group. • PID and Programme brief available. • Key stakeholders are engaged, and risks are managed on Ulysses however some are out of review date. Risks are also captured in a local risk register. • Not all EIA/QIAs are evidenced. Milestone plan is available and tracked. In terms of benefits for this programme, these are predominately outputs and are being delivered as per the plan albeit some are delayed.
Digital - Aldercare Chief Digital and Information Officer	100% Safety Compliance			**NA****	• Numerous project teams are in place and all workstreams report into Aldercare Board which meets fortnightly. • Programme plan is largely on track and a comprehensive gateway review process. The programme passed through gateway 1 in December 22. There is evidence of a well-used action log to support delivery of the milestones. • There is a Statement of Planned Benefits (SoPB) document which is actively updated. There are several baselines and targets yet to be confirmed. This is making progress and is an ongoing activity. Any new benefits highlighted via the patient journey cycles are logged in the benefits log (cycles due to end April 23). • There is a comprehensive risk register which is submitted to each Aldercare Board with high-level risks discussed by exception. • An EA/QIA has been completed, approved, and signed (Nov 22).

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Industrial Action and Nurse Staffing Update**
Report of:	**Chief Nurse**
Paper Prepared by:	Chief Nurse

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

Industrial Action and Nurse Staffing update to Trust Board

Introduction

This paper provides an overview to the Trust Board of the industrial action by the RCN on 15th and 20th December. The Trust developed a good partnership approach to the local strike committee and were able to secure all 22 derogations requests to maintain patient safety.

Staff Support

In the lead up to the industrial action a variety of support was offered to staff which included:

- Q&A sessions
- Manager briefings
- Regular all staff communications
- Meetings with RCN reps
- Access to professional nurse advocates (PNA)
- Access to Pastoral Care Nurse particularly for nurses from overseas
- Access to Sals
- Emotional support sessions
- Evening chief nurse drop in
- Liaison with HEIs and Practice educators to support student nurses

On the day all clinical areas had senior nursing presence, executive team visited the picket line and staff on strike were provided with hot drinks and a morning breakfast, as well as support from local businesses and the general public.

Activity Rescheduled

In anticipation of the strike activity was reduced as shown below. The booking and scheduling team offered alternative dates when calling each family personally.

Date	Elective Activity	OPD activity	Total
15th December	39	251	290
20th December	24	231	255
Total	**63**	**482**	**545**

ED

Concerns were raised that ED may see additional activity as the local walk in centres did not receive derogation until the morning of 15th December. Contingency plans were in place which helped with streaming on the day.

Date	ED Attendances	ED performance
15th December	250	72%
20th December	316	68%

Staff supported to strike

The derogation process enabled the Trust to support many staff across the organisation to strike. The data below captures those staff from rosters who were able to take part if they chose to. For context AH employs just under 1200 nurses and health care support workers. Those not captured on this data set work in other areas that were supported to strike or were rostered for a day off.

15th December 2022

Derogated RN	Derogated HCA	Rostered RN + NA / AP	Rostered HCA	Rostered NHSP	RN available to strike	HCA available to strike	Total staff on strike
140	25	221 + 10	69	11 RN + 7 HCA	94	37	132

20th December 2022

Derogated RN	Derogated HCA	Rostered RN + NA / AP	Rostered HCA	Rostered NHSP	RN available to strike	HCA available to strike	Total staff on strike
140	25	226	74	9	93	62	117

Feedback

All staff found the exec visibility positive on the day and staff fed back about how supported they had felt in making their personal choice. The only on the day sickness was 7 staff (15th) and 6 staff (20th), a mixture of RN and HCA's which will be followed up individually.

Staff who were in derogated areas were grateful for the opportunity to spend time on the picket line and for the RCN supplied badges showing support for the action. In all but one area staff were professional in their approach.

Challenges

Staff reported that the derogation numbers were better than usual staffing for their areas. We worked to the RCN request for night time staffing levels, these were supplied and not inflated. The most up to date nurse staffing provision by ward is included in this pack, which demonstrates that all areas have minimal vacancy, staffing gaps are driven by unavailability of staff.

In addition, the monitoring of Care Hours Per Patient Day (CHPPD) shows that most areas within the trust meet or exceed staffing levels when compared to the national benchmark.

The exceptions to this are HDU and 4c. HDU have staff in place in supernumerary status and will shortly be included in the staffing numbers. 4c have plans to introduce the supernumerary coordinator role which will help bring the ward in line with national peers.

Ward	CHPPD	National Benchmark	
Burns	23.08	7.91	
HDU	25.82	31.06	
ITU	38.24	31.06	
1c C	15.22	15.22	
1cN	14.83	14.83	
3a	10.66	11.00	
3b	13.01	13.01	
3c	9.72	8.60	
4a	11.35	11.00	
4b	13.94	10.30	
4c	9.60	11.30	
AH Over			
AH On target			
AH Under			

Nurse staffing position

Nurse recruitment has been a key focus under the nursing workforce plan over the last two years. Of note, except for HDU and 4b, most wards are close to their establishment, and in some cases over established. HDU continue to recruit to replace team members who joined the new response team and 4b are undertaking a full staffing review given the specific needs of the service. 4a and ED have a small level of vacancy.

The poor perception of nurse staffing is driven by unavailability and short-term sickness on a backdrop of 14% unavailability gap across the organisation. This will reduce to 10% once supernumerary staff are in the numbers.

PICU and theatres should be commended for their work and focus on recruitment to these hard to recruit to areas.

Excellent progress has been made in this area and the senior nursing team will now focus on retention. The perception of short staffing will need to be addressed through the development of ward level staffing profiles, increasing transparency of the data. In addition, the introduction of supernumerary coordinators in all areas following the approval of the recent business case will be undertaken.

In Summary

The planning in relation to industrial action has enable this to be managed successfully whilst maintaining patient safety and minimising impact onto to children, young people and families. The IA working group will continue to meet weekly and update staff with relevant information and support as IA continues across a range of sectors which may have a direct or indirect impact on staff and the Trust.

Ward	Established Budget	SIP	New Starters	Vaccancy	Matt Leave	LTS	Secondment / HR	Unavailable	Actual Gap	Gap %	Notes
HDU	85.65	71.13	7.76	6.76	3.14	3.66	2.17	10.97	17.73	20.70	
PICU	171.13	165.70	19.00	-13.57	6.75	2.76	2.84	35.35	21.78	12.73	
Burns	17.54	16.32	0.00	1.22	0.00	1.00	1.00	2.00	3.22	18.36	
Ic Cardiac	65.77	70.76	1.60	-6.59	4.76	0.92	2.52	8.20	1.61	2.45	
3A	63.21	62.23	2.00	-1.02	5.38	3.53	0.77	9.68	8.66	13.70	
4A	75.03	70.48	1.00	3.55	3.00	1.92	1.92	6.84	10.39	13.85	
Ip Theatres	151.19	148.20	5.00	-2.01	7.26	4.76	3.90	15.92	13.91	9.20	
DSU	23.28	24.42	0.00	-1.14	0.00	2.79	0.00	2.79	1.65	7.09	
SAL	26.70	29.40	0.00	-2.70	1.00	5.00	0.00	6.00	3.30	12.36	
Surgery Total	**679.50**	**658.64**	**36.36**	**-15.50**	**31.29**	**26.34**	**15.12**	**97.75**	**82.25**	**12.10**	
3b	41.92	42.07	0.00	-0.15	4.36	2.00	0.76	7.12	6.97	16.63	
3c	58.88	62.91	5.00	-9.03	2.00	5.24	4.52	11.76	2.73	4.64	
4b	87.93	78.14	3.00	6.79	5.56	11.74	3.80	21.10	27.89	31.72	
4c	61.60	59.32	0.00	2.28	3.59	1.84	2.38	7.81	10.09	16.38	
ED	98.43	91.70	2.00	4.73	4.77	4.53	2.66	11.96	16.69	16.96	
MDU	8.04	8.59	0.00	-0.55	0.00	1.00	0.00	1.00	0.45	5.60	
Medicine Total	**356.80**	**342.73**	**10.00**	**4.07**	**20.28**	**26.35**	**14.12**	**60.75**	**64.82**	**18.17**	
Total	**1036.30**	**1001.37**	**46.36**	**-11.43**	**51.57**	**52.69**	**29.24**	**158.50**	**147.07**	**14.19**	

Notes:

- Unavailable total includes Mat leave, LTS, HR / Secondment and staff working in a supernumerary capacity.
- Mat Leave is 11.6 WTE higher than planned (40 WTE)
- LTS remains high

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday 26th January 2023

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

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development report on the Programme for Delivery

January 2023

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 1 in Quarter 4 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	SPV contract support	Weekly liaison meetings held, deadlines raised in Trust/SPV liaison meetings, escalated within SPV team.
Sunflower House / Catkin	Fire Compliance; Sprinklers	MSFR advised sprinklers are required within buildings car park, reviewed and confirmed independently. Process started of installing sprinklers as a mitigation prior to agreement for their need. Reviewing requirement and in terms of occupation.
Temporary Modular Office (Alder Centre)	Programme delay	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works. Water disinfected and results back 26th January 2023. Building Control occupation certificate expected on the 26th January 2023, planning move for the 30th January 2023.
Main Park Reinstatement	Vacation of Catkin, linked to Alder Centre Temporary Modular project.	Programme workshops held with Park Contractor to condense programme and complete within required timescales.

3. Programme Delivery Timetable

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

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

4. Project updates

Neonatal and Urgent Care Development

Current status	Risks/issues	Actions
Phase 1 of the enabling works to create a temporary ED car park have completed. Phase 2 of the enabling works complete; service investigations. Phase 3 Blue light road diversion LOI and JCT issued to commence, started on site with site set up. Works started 5th December 2022. MSC engaged, LOC / LOI issued to commence contractor design element and place early orders. Phase 4 Service diversions provisional start date March 2023 Main build provisional start date April 2023, completion Dec 2024 Finalising contract documents and award.	Project Co engagement extending the programme and increasing costs.	Continue working with Project Co to mitigate impact. Updated team at AH/SPV liaison meeting. Escalated within SPV.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Accepted takeover of Catkin element, Crisis team occupied and fully operational, clinics live within building. Agreed take over for Police station element, works inspected and accepted by Merseyside Police. Planning the signature of the lease and their occupation.	Fire Compliance; Sprinklers	MSFR advised sprinklers are required within buildings car park, reviewed and confirmed independently. Process started of installing sprinklers as a mitigation prior to agreement for their need. Reviewing requirement and in terms of occupation.

Modular Office Buildings

Current status	Risks/issues	Actions
Larger unit by Alder Centre being provided by LOR; construction completed, furniture installed, commissioned ready for occupation. Smaller unit in Police Station car park being provided by Portakabin. Project on hold due to police station lease not in a position to sign; for takeover of the former police station.	Programme delay, alder centre modular Programme delay, police station modular	Programme delay due to compliance issues with water, fire and building control. Delay impacting on demolition of Old Catkin, working up mitigations to not impact park works. Water disinfected and results back 26th January 2023. Building Control occupation certificate expected on the 26th January 2023, planning move for the 30th January 2023. Programme delay due to delay in lease agreement for former Police station. Moves held and alternative accommodation agreed with users. Lease being fast tracked.

Police Station

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

Park reinstatement

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

NEW Mini Master Plan for Eaton Rd frontage

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

Fracture and Dermatology

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

Surgical Day Case

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

EDYS

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

Communications

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

5. Trust Board of Directors

The Board of Directors is requested to receive and acknowledge the update provided as of 26th January 2023.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Minutes of the meeting held on Monday 12th December 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Shalni Arora	Non-Executive Director	(SA)
	Adam Bateman	Chief Operating Officer	(AB)
	John Kelly	Non-Executive Director	
	Claire Liddy	Managing Director of Innovation	
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital and Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Cath Kilcoyne	Deputy Director of Business Development	
	Andy McColl	Associate Chief Operational Officer, Performance	
	Clare Shelley	Associate Director Operational Finance	(CS)
	Mark Flannagan	Director of Communications	(MF)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Gary Wadeson	Associate Director – Income, Contracting & Commissioning	
Agenda item:	Alex Pitman	Green Plan, Project Manager	

22/23/139 Apologies:

Mark Carmichael	ACC, Medicine	
John Grinnell	Deputy CEO/CFO	
Rachel Lea	Deputy Director of Finance	(RL)
Erica Saunders	Director of Corporate Affairs	(ES)
Dani Jones	Director of Strategy and Partnerships	(DJ)

22/23/164 Minutes from the meeting held on 29th November 2022
The above minutes were approved as a true and accurate record.

22/23/165 Matters Arising and Action log
Surgery Deep Dive
RABD received the financial benefits from the actions presented at the November RABD.

All other actions had been included on the agenda.

22/23/166 Declarations of Interest
There were no declarations of interest.

22/23/167 Finance Report
Month 8 Financial Position
M8: An in-month trading surplus of £1.0m in November was achieved which is in line with the planned financial position. Year to date (M1-8) the Trust is reporting a surplus of £0.6m again in line with plan, which was profiled to move into a surplus in the second half of the financial year to reach the required £4.6m surplus by the end of March.

The main drivers for the improved year-to-date position include CIP delivery, benefit from additional interest payment, recovery of additional income within the community division and other non-recurrent benefits such as rates rebate.

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

The Trust is now forecasting to meet its in year CIP challenge of £17.3m subject to the delivery of schemes still in progress. Progress has also been made with regards to the recurrent CIP target of £12.5m with a further £0.6m identified in month and opportunities of £2.1m identified thus taking the total recurrent identified to £8m reducing the recurrent gap to £4.5m once opportunities have been transacted (£7.2m in M7).

GW gave a verbal update on block payments.

Resolved:
RABD received and noted the M8 Finance report.

22/23/168 Neonatal Service Development Opportunities

AMc introduced the paper highlighting service development opportunities arising from the extension to the hospital building identified to RABD in September 2021.

After a detailed discussion RABD agreed Trust Board approval would be required for any further progression. If approved by Trust Board this would be discussed further at a future RABD. A number of RABD members noted that further discussions would take place at Executive Committee prior to TB approval.

Resolved:
RABD Received details on development opportunities and agreed Trust Board approval would be required before any further action was progressed.

22/23/169 Debt Write Off

Debts proposed for December write off are the last of the ageing salary overpayment debts which were not invoiced. The total amount of salary overpayments that have been invoiced and are outstanding on the debtors ledger at present is £167k. A bad debt provision is in place therefore this will not adversely affect the trading position.

EK highlighted there is £16k in relation to CCI that is outstanding however this is not ready to be included as a bad debt. EK agree to confirm at the January RABD if there are any further large sums of bad debt to be presented.
Action: EK

Resolved:
RABD APPROVED the December debt write off £14,145.65.

22/23/170 Financial Strategy – Key Financial Areas

CS gave an overview of the paper circulated.

JK queried the section on investment, CS noted this would be discussed at the Executive Committee this Thursday and would be presented for approval to Trust Board. CS noted all comments will be incorporated into a revised paper that will be presented to Trust Board.

Resolved:
RABD received and discussed the paper on Financial Strategy

22/23/171 Board Assurance Framework Deep Dive: The Park

JO'B gave an overview of the risk to fully realise the Trust's vision of the park noting the current position along with short and long term mitigations.

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

22/23/172 Campus update

JO'B highlighted the following points from the campus update:

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

Resolved:
RABD received the monthly update in relation to the Campus.

22/23/173 Digital Futures Strategy – progress update

KW highlighted the points below following the circulation of the paper:

- Launch of the Alder Hey Symptom checker available on the website, access of this was over 7,000 for this weekend.
- Increase to a digital BAF risk and the detail behind this was presented to RABD.

Resolved:
RABD noted the current position in relation to Digital Futures Strategy.

22/23/174 AlderC@re Programme

KW highlighted from the report:

- Continue to work towards a go live date of August 2023, if possible the earliest the programme would go live is June 2023.
- An update on the second cycle of patient journeys was received.
- Details on the re-run of the gateway process were noted.
- Alderc@re plan on a page was included within the papers.

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

22/23/175 Innovation Commercial Activity

RABD received the year to date and forecast position, mitigations and sales opportunities.

A discussion was held around the proposed grants. The Chair queried if grant specialists are employed to manage the applications. CL advised expanding a team to support grants would be beneficial.

Resolved:
RABD received and noted the bi monthly innovation position.

22/23/176 Month 8 Integrated Performance Report
Resolved:
M8 report was received.

22/23/178 Green Plan
The Green Plan Strategy had been presented at the Executive Committee on Thursday and would be presented at the January RABD.
Resolved:
RABD received and noted the green paper.

22/23/179 Board Assurance Framework
Resolved:
RABD received and noted the risks being monitored through the BAF.

22/23/180 Capital Project Management and Procedure policy
Resolved:
The above policy was deferred to the January RABD.

22/23/181 Any Other Business
Private RABD section
The Chair queried due to the number of commercially sensitive items presented at RABD whether a private RABD section was required. The Chair agreed to discuss this further with Erica Saunders outside of the meeting.

22/23/182 Review of Meeting
The Chair noted good discussions, any further development on private patients would firstly need to be approved by Executive Committee and then Trust Board.

Date and Time of Next Meeting: Monday 23rd January 2022, 1330, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st December 2022
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

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

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidents that are considered as serious incidents following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st – 31st December 2022.

2. Background

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

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

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

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

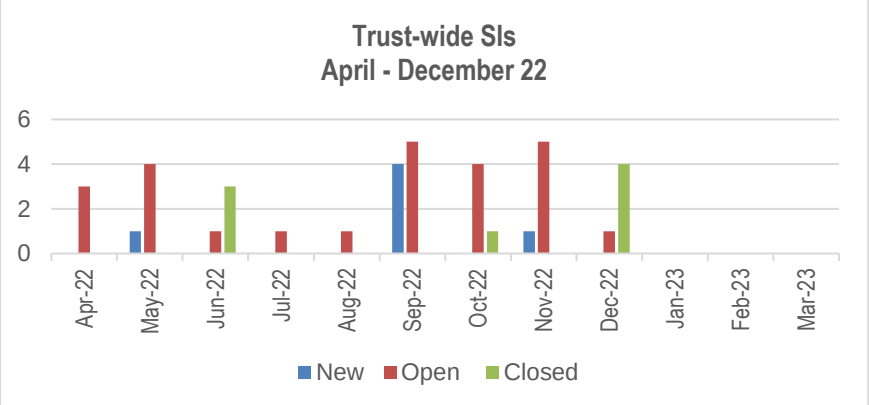
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status December 2022



3.2.1 Declared Serious Incidents

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

3.2.2 Open Serious Incidents

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

Table 1 Open SIs December 2022

StEIS reference	Date reported	Division	Incident	Summary
2022/23391	10/08/2022 (reported to StEIS 02/11/2022)	Research	Never Event – wrong side biopsy.	Refer to appendix 1 for detail.

3.2.3 Serious incident reports

3.2.4 SI action plans

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

6 SI action plans remained open, of which:
- **5** SI action plans are within their expected date of completion
- **1** SI action plan was completed and closed

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

3.3 Internal level 2 RCA Investigations

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

3.4 Duty of Candour

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

5 Duty of Candour responses (1 initial duty of candour and 4 final duty of candour responses) were required and completed within expected timeframes during the reporting period (1st – 31st December 2022).

4. Learning from serious incidents

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

SI action plan completion is monitored internally via CQSG, to ensure barriers to completion are addressed and learning is embedded across the organisation as required. Immediate lessons learnt from all SIs are outlined in appendix 1.

The main themes identified from the completed SI investigations and action plans were:

- Lack of communication / documentation
- Delay in transfer / escalation for medical review
- Failure to follow systems & process
- Suboptimal staffing
- Lack of professional curiosity
- Lack of knowledge / skillset

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

4 SI investigations were completed in the reporting timeframe (1st – 31st December 2022).

5. Next steps

- Highlighted to divisional leads the importance of ensuring SI action plan records are contemporaneous and accurately maintained on Ulysses.

- Support and engagement continue to be offered by the corporate governance team to assist the divisions with the completion of SI action plans by the expected deadlines.

6. Recommendations

The Trust Board is asked to:

- Consider the content of the report
- Note the improvement in completion of RCAs within expected timeframes
- Agree the level of assurance provided

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2022/ 23391	Never Event – wrong side biopsy.	**January 2022**: Trial company informed of wrong side biopsy: Trial monitor agreed biopsy could be used, with no requirement for further operation. Deviation from protocol recorded on trial record. Advised that an internal investigation into the error to be carried out by the Trust. Timely investigation not undertaken due to delay in reporting of incident. Commissioners/CQC informed: Never Event confirmed. Consent form did not stipulate body side to be operated on. Research trial protocol was not followed. Handover from clinical fellow to surgeon not documented. No direct handover from research team to surgery team. Site marking was carried out by the surgeon whilst the patient was on SALS. Unknown if the parents were involved in this site marking. Delay in reporting incident. Lack of clarity and ownership for undertaking review of case.	Requests for theatre slots now state body side and site. Copy of the Muscle Biopsy alert form completed by research team/PI and biopsy request sent to Pathway Coordinator (PCO) surgical secretaries. Research nurse now involved in theatre huddle and handover to confirm the body side and site. PCO to ensure side and site is recorded on Amborder. If it is not received in the request from the surgeon, it should be clarified with them before booking. Ward staff reminded to cross reference surgical site with consent form in line with WHO checklist. Theatre staff reminded to check site and side on consent form as part of sign in process. Report findings to be shared with all teams involved to ensure learning is disseminated. Cross division incidents need a clear escalation/review pathway. **December 2022:** Panel held; report is being written.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Extension date agreed by commissioners	Number of extensions
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	8 2 actions outstanding on track to complete by deadline.	30/06/2022	31/01/2023	30/11/2022	2 Escalated to Divisional leads Weekly meeting with action owner in place
2021/17974	16/07/2021	01/09/2021	Medicine	Preparing child's case for discussion at national forum. Identified that care provided for eradication is outside of usual clinical pathway	13 1 action outstanding due for completion 31/01/2023.	31/08/2022	31/01/2023	01/11/2022	2
2022/19971	14/09/2022	16/09/2022	Surgery	Never Event – retained foreign object post procedure.	6 2 actions outstanding on track to complete by deadline.	31/01/2023			0
2022/20586	06/09/2022	27/09/2022	Medicine	Staff exposure to highly contagious organism.	11 All actions completed.	31/12/2022			0
2022/20661	17/08/2022	28/09/2022	Surgery	Category 3 pressure ulcer under plaster cast.	2	31/01/2023			0

					1 action outstanding.				
2022/20851	18/09/2022	29/09/2022	Surgery	Patient death after discharge.	8 8 actions outstanding on track to complete by deadline.	31/01/2023			0

Appendix 3

Learning from SIs		
StEIS reference	**Theme**	**Learning and Actions**
2021/12203 Deteriorating patient requiring transfer to HDU.	Lack of communication / documentation	PEWS scores were not fully completed. Communication disseminated to relevant staff as reminder of documentation requirements. Patient safety bulletin sent Trust-wide following discussion of incident at weekly Patient Safety Meeting regarding ensuring vital signs are recorded entirely and at the correct frequency for the patients.
	Delays in transfer / escalation for medical review	Communication sent to relevant staff to remind staff of appropriate escalation of clinical concerns.
2021/25961 Patient relapsed during receipt of active leukaemia treatment.	Failure to follow systems & process	The difference in units between the Minimal Residual Disease (MRD) result and the guidelines caused confusion. Important that the team assess any risks associated with the interpretation of the MRD results in the new ALL protocol to be implemented in 2022 to prevent future incorrect treatment decisions. Additional decision aid flow sheets/crib sheets received from the National Leukaemia study group for the new protocol.
	Suboptimal staffing	Suboptimal staffing levels for Consultant Haematologists - Risk added to the risk register. Risk reference 2684 – current risk score 16

2021/12387 Patient suicide whilst under care of CAMHS.	Lack of professional curiosity Safeguarding – referral was not completed via the Trust electronic system	Clinical assessment did not include consideration of risk assessment in relation to risk of sexual exploitation - Working group established to review current training and its application in practice. Not all community services use the Trust electronic system for referrals. Process and pathways for safeguarding referrals agreed with Associate Chief Nurse and Associate Director for Safeguarding and Statutory Services and will be disseminated through revised training. Review of current digital pathways for safeguarding processes to be rolled out as part of Meditech Expanse. Several appointments took place whereby practitioners were unable to see or speak directly with the child - Written into SOP that 1 contact out of 3 must include direct contact/virtual but visual contact with the child.
2022/2634 Missed opportunity to diagnose a patient.	Lack of knowledge / skillset	Failure to consider all causes of presenting condition and the need for clinical review to ensure resolution of symptoms. Education tools about the causes and management of presenting condition are now available via ED handbook.
2022/19971 Never Event – retained foreign object post procedure.	Failure to follow systems & process	Final instrument checks not completed due to human error. Report shared with team
2022/20586 Staff exposure to highly contagious organism (non-clinical).	Lack of professional curiosity / failure to follow systems & process	The potential diagnosis of Brucella, or other high-risk organisms, was not considered in line with recent travel history by either the requesting clinician or the BMS and the staff member performing the initial processing of the positive blood culture did not check the clinical details before sub venting in the Class II cabinet - SOP updated and reinforced procedures relating to handling of samples at CL3 (containment level 3). Staff learning exercise was also implemented. HSE Inspection-report pending

2022/20661 Category 3 pressure ulcer under plaster cast.	Lack of communication / documentation	No identified lapses in care. Ensure patient's named consultant is informed of any ongoing tissue viability management following Orthopaedic management Plaster cast discharge leaflet to be reviewed and confirm there are no ambiguities.
2022/20851 Patient death following discharge.	Lack of communication / documentation / failure to follow systems & process	Unexpected death of patient following discharge. No root cause identified but incidental findings noted for learning included: 1. Due to a lack of DETECT devices available at the time of observations being taken, staff document observations on paper and enter them retrospectively into a DETECT device. To discuss the availability of DETECT devices at the deteriorating patient steering group and share the relevant guidelines for the documentation of patient observations with Nursing team on Ward 1C. 2. Ineffective communication between clinical colleagues leading to consultant making decisions about discharge without all the relevant clinical information being available 3. Trust medication management policy to be reviewed to ensure the escalation process is clearly defined for staff to follow. 4. Patient not monitored in line with the Trust's ACE inhibitor guidelines following an increased dose of Captopril - ACE inhibitor guidelines to be shared with all nursing staff on ward 1C.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Proposal to Obtain Veteran Covenant Healthcare Alliance Accreditation.**
Report of:	**Chief Nurse**
Paper Prepared by:	Chief Nurse

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

Alder Hey Children's NHS Foundation Trust

Proposal to obtain Veteran Covenant Healthcare Alliance Accreditation

Introduction

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

Background

The term Veteran in VCHA refers to any ex serving member of the armed forces, along with current serving members reservists, their families and children. A veteran may have served one day of service and may have ceased to work for the armed forces.

Children and families of service personnel may suffer detriment due to the requirement of service life to move to various parts of the country, and internationally, which can have a negative impact on their health and wellbeing needs.

The armed forces covenant gained royal assent in December 2021 and was enacted in November 2022. There are specific requirements around this in terms of access to services which will need to be in place.

Armed forces covenant

A **promise from the nation** to those who serve or have served and their families to be treated fairly.

Healthcare providers are expected to:

- Ensure this community **does not experience disadvantage** as a result of their service compared to other citizens.
- **Special consideration** is appropriate in some cases for those who have given the most such as the injured or bereaved.
- Family members should **retain their places on NHS waiting lists** if moved around the UK due to the service person being posted.
- Veterans should receive **priority treatment** for a **service related health condition/injury**, subject to clinical need.
- Cared for in a way which reflects the nation's moral obligation and by healthcare professionals with an **understanding of the Armed Forces culture.**

VCHA Assessment Process

NHSE/I support the implementation of the assessment programme with a regional lead to support our local assessment and delivery of 8 core standards as shown below. Further detail on each standard is in the appendix.

The assessment process can be grouped into the following stages

Stage 1 – Commitment by the board to signing the armed forces covenant

This is a public statement of intent which triggers the assessment process. Board approval is sought at meeting in public and the signing of the covenant (legal requirement for NHS trusts) is undertaken.

This is a pivotal moment for the trust to begin celebrating the start of the assessment journey and raising awareness for staff alongside children, young people, and families. We will also renew our defence recognition award (currently bronze) as it is due its 5 year renewal.

Stage 2 – working group and governance

A small leadership team are enacted to undertake a gap analysis of the standards and work towards compliance. This will include a review of policy, identifying reservist and service staff as well as processes to identify CYP and families of the forces.

Stage 3 – Training and education and promotion

Training and education for staff on identifying service families and the additional resources they can access for support. In addition, the Trust actively promotes the armed forces such as remembrance day, veterans week and reservist week activities. The trust forms close working relationships with local armed forces and support services.

Approach
Develop our working group which will include:

Executive Sponsor – Chief Nurse
Clinical Lead – Chief Nursing Information Officer
Management Lead – HR (TBC)
Education Lead – Director of Academy
Comms - TBC

It is suggested the group report into the EDI steering group. Whilst not a protected characteristic, this is a discreet group of individuals with specific needs and the ethos of the covenant is no disadvantage, which aligns with the work of the EDI steering group. From the EDI steering group this will report to PAWC and on to Trust Board.

Summary

This is a fantastic opportunity for the Trust to demonstrate its commitment to providing equity of care to our armed forces community, including our patients and staff.

Recommendation

Trust Board are asked to:

- Support the application to begin the process of accreditation
- Approve the governance structure outlined above
- Approve the signing of the covenant

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Alder Hey Children's Foundation Trust

We, the undersigned, commit to honour the Armed Forces Covenant and support the Armed Forces Community. We recognise the value Serving Personnel, both Regular and Reservists, Veterans and military families contribute to our business and our country.

Signed on behalf of:

Alder Hey Children's NHS Foundation Trust

Signed:

Name: Louise Shepherd

Position: Chief Executive Officer

Date: 5th January 2022

Signed:

Name: Dame Jo Williams

Position: Chair

Date: 5th January 2022

Alder Hey Children's NHS Foundation Trust

The Armed Forces Covenant

An Enduring Covenant Between

The People of the United Kingdom

His Majesty's Government

– and –

All those who serve or have served in the Armed Forces of the Crown

And their Families

The first duty of Government is the defence of the realm. Our Armed Forces fulfil that responsibility on behalf of the Government, sacrificing some civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our Armed Forces. In return, the whole nation has a moral obligation to the members of the Naval Service, the Army and the Royal Air Force, together with their families. They deserve our respect and support, and fair treatment.

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

This obligation involves the whole of society: it includes voluntary and charitable bodies, private organisations, and the actions of individuals in supporting the Armed Forces. Recognising those who have performed military duty unites the country and demonstrates the value of their contribution. This has no greater expression than in upholding this Covenant.

Section 1: Principles of the Armed Forces Covenant

1.1 We **Alder Hey Children's NHS Foundation Trust** will endeavour in our business dealings to uphold the key principles of the Armed Forces Covenant, which are:

- *no member of the Armed Forces Community should face disadvantage in the provision of public and commercial services compared to any other citizen*
- *in some circumstances special treatment may be appropriate, especially for the injured or bereaved.*

Section 2: Demonstrating our Commitment

2.1 We recognise the value that serving personnel, reservists, veterans and military families bring to our service and to our country. We will seek to uphold the principles of the Armed Forces Covenant, by:

- **Promoting the Armed Forces:** promoting the fact that we are an Armed Forces-friendly organisation, to our staff, children, young people and families, suppliers, contractors and wider public.

- **Veterans:** supporting the employment of veterans, recognising military skills and qualifications in our recruitment and selection process; working with the Career Transition Partnership (CTP) to support the employment of Service leavers;

- **Service Spouses & Partners:** supporting the employment of Service spouses and partners; partnering with the Forces Families Jobs Forum (https://www.forcesfamiliesjobs.co.uk/); and providing flexibility in granting leave for Service spouses and partners before, during and after a partner's deployment.

- **Reserves:** supporting our employees who are members of the Reserve Forces; granting additional paid/unpaid leave for annual Reserve Forces training; supporting any mobilisations and deployment; actively encouraging members of staff to become Reservists;

- **Cadet Organisations:** supporting our employees who are volunteer leaders in military cadet organisations, granting additional leave to attend annual training camps and courses; actively encouraging members of staff to become volunteer leaders in cadet organisations; supporting local military cadet units; recognising the benefits of employing cadets/ex-cadets within the workforce.

- **National Events:** supporting Armed Forces Day, Reserves Day, the Poppy Appeal Day and Remembrance activities;

- **Children and young people:** recognising the impact of service life on CYP and families and working to minimise the impact on their emotional and physical health and well-being

2.2 We will publicise these commitments through our literature, on staff notices, and on our website, setting out how we will seek to honour them and inviting feedback from the Service community, our staff and our children, young people and families on how we are doing.

Alder Hey Children's NHS Foundation Trust

Board of Directors

Thursday, 26th January 2023

Paper Title:	**Safeguarding Children and Adults at Risk Annual Report 2021-2022: Safeguarding and Statutory Services**
Report of:	Nathan Askew, Chief Nursing Officer Lisa Cooper, Director Community & Mental Health Services
Paper Prepared by:	Nichola Osborne, Associate Director for Safeguarding & Statutory Services

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

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Alder Hey Children's
NHS Foundation Trust

Safeguarding Children and Adults at Risk Annual Report 2021-2022

Safeguarding and Statutory Services

Executive Summary

The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2021 to 31 March 2022, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

This Annual Report has been compiled by members of the Safeguarding and Statutory Services Leadership Team who joined Alder Hey from May 2022. As such a condensed overview of the work activities undertaken by the Alder Hey Safeguarding Team during 2021/2022 are included in this report. These have previously been included in the quarterly safeguarding assurance reports received by the Clinical Quality Steering Group (CQSG). This report is intended to provide an overview and 'snapshot' of that work.

Whilst there are good safeguarding systems in place across Alder Hey there continues to be challenges as safeguarding continues to evolve, in both complexity and scope. With new and emerging risks in respect of contextual safeguarding being identified. As a result, Alder Hey must ensure that its safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee its safeguarding arrangements so as to provide assurance that adults and children at risk of abuse or neglect are safeguarded in its care.

The Safeguarding Team remains committed to ensuring that children, young people and adults at risk using Alder Hey services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with Trust colleagues and key partners to continuously improve systems to safeguard children, young people and adults at risk.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (referred to as 'Alder Hey' throughout the report) safeguarding governance arrangements and a retrospective view of the work completed by the Safeguarding Team within Safeguarding and Statutory Services from 01 April 2021 to 31 March 2022, to ensure the Trust meets its statutory responsibilities in respect of safeguarding children and adults at risk.

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4. The content of this report will be used to inform Commissioners and may be used to inform Local Safeguarding Children Partnerships (LSCP) and Local Safeguarding Adult Boards (LSABs).

5. The report outlines the Alder Hey safeguarding governance arrangements and safeguarding activities within and relating to the Trust. It is designed to highlight key issues, working arrangements and recent developments.

6. Safeguarding is 'everybody's business' and the Alder Hey Safeguarding Team works to ensure that it continues to be the 'golden thread' running through all our services.

7. Primarily, it remains the responsibility of every NHS-funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently, and conscientiously applied; the well-being of those children and adults is at the heart of what we do (NHS England, 2019).

8. The Safeguarding Team works collaboratively with divisional colleagues and multi-agency partners to safeguard children and adults in our care who have been harmed or are at risk of harm.

Alder Hey and Safeguarding Commissioning Arrangements

9. Alder Hey is one of four stand-alone children's specialist providers in the country. Alder Hey provides a full range of secondary services to its local paediatric population as well as tertiary and quaternary care for a footprint stretching across the Northwest of England and beyond.

10. NHS England principally commission the Trust for tertiary and quaternary care with the commissioning of secondary care services, across a wide population base, via several Clinical Commissioning Groups (CCG) (now "Place") within the Cheshire and Merseyside region; Liverpool Clinical Commissioning Group (Liverpool Place) acting as coordinating commissioner for the most part.

11. Alder Hey provides care for approximately 330,000 children and families each year. The Trust became a Foundation Trust in August 2008 and leads research into children's medicines, infection, inflammatory diseases, and oncology. The Trust has a broad range of hospital and community services, including many accessed directly via primary care referral. The Trust is a recognised Major Trauma Centre and is one of four national Children's Epilepsy Surgery Service centres. The Trust is a designated national centre for head and facial surgery as well as a centre of excellence for heart, cancer, spinal and brain disease. Alder Hey is the only national centre of excellence for childhood lupus and the only experimental arthritis treatment centre for children.

12. Liverpool Place is the lead commissioner for the Alder Hey Safeguarding and Statutory Services across Liverpool, Sefton, and Knowsley. Liverpool Place undertakes a coordinating role on behalf of NHS South Sefton, NHS Southport and Formby and NHS Knowsley Places.

13. The Rainbow Centre is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding service across the whole of Alder Hey. The facilities include office space, a video interview suite and dedicated meeting rooms, as well as two dedicated examination suites, which provide a calm, sympathetic environment where children who are suspected of being abused can be medically examined and interviewed.

Legislative Frameworks - Safeguarding Children, Young People & Adults at Risk

Safeguarding Children and Young People

14. Safeguarding children and young people and promoting their welfare is defined as:

- Protecting children from maltreatment.
- Preventing wherever possible impairment of children's health or development.
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care.
- Taking action to enable all children to have the best outcomes.

15. Child protection is defined as being part of safeguarding and promoting welfare. It is the work done to protect specific children who are suffering, or are likely to suffer, significant harm.

16. The Working Together to Safeguard Children (2018) guidance states that*: 'Children are best protected when professionals are clear about what is required of them individually, and how they need to work together.'*

17. In addition, the guidance states that *'effective safeguarding of children can only be achieved by putting children at the centre of the system and by every individual and agency playing their full part, working together to meet the needs of our most vulnerable children.'*

Safeguarding Adults at Risk

18. Safeguarding Adults at Risk of Abuse is defined in the Care Act (2014) as meaning:

- Protecting the rights of adults to live in safety, free from abuse and neglect.
- People and organisations working together to prevent and stop both the risks and experience of abuse or neglect.
- People and organisations making sure that the adult's wellbeing is promoted including, where appropriate, taking fully into account their views, wishes, feelings and beliefs in deciding on any action.
- Recognising that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances and therefore potential risks to their safety or wellbeing.

19. Providers' safeguarding arrangements should always promote the adult's wellbeing. Being safe is only one of many things that adults want for themselves and there can be some challenges in balancing safety and freedom in a way which protects and fulfils human rights. Providers and other professionals where relevant, should work with the adult to establish what being safe means to them and how that can be best achieved.

20. Responsibilities for safeguarding are enshrined in international and national legislation. Safeguarding for both children and adults has transformed in recent years with the introduction of new legislation, creating duties and responsibilities which need to be incorporated into the widening scope of NHS safeguarding practice.

21. Regardless of the developing context, all health organisations are required to adhere to the following arrangements and legislation (NHS England, 2019):

<table>
<tr><th colspan="3">Legislation for All</th></tr>
<tr><td colspan="3">▪ The Crime and Disorder Act 1998
▪ Female Genital Mutilation Act 2003
▪ Mental Capacity Act 2005
▪ Convention on the Rights of Persons with Disabilities 2006
▪ Mental Health Act 2007
▪ Children and Families Act 2014
▪ Modern Slavery Act 2015
▪ Serious Crime Act 2015</td></tr>
<tr><th>Safeguarding Legislation Specific to Children</th><th>Safeguarding Legislation Specific to Young People Transitioning into Adults, including Children in Care</th><th>Safeguarding Legislation Specific to Adults</th></tr>
<tr><td colspan="2">▪ United Nations Convention on the Rights of the Child 1989
▪ Children Act 1989 and 2004
▪ Promoting the Health of Looked After Children Statutory Guidance 2015
▪ Children and Social Work Act 2017
▪ Working Together to Safeguard Children Statutory Guidance 2018</td><td>▪ The Care Act 2014
▪ Care and Support Statutory Guidance – Section 14 Safeguarding</td></tr>
<tr><td colspan="3"></td></tr>
</table>

Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff 2019	Looked After Children: Knowledge, skills and competencies of health care staff 2020	Adult Safeguarding: Roles and Competencies for Health Care Staff 2018
Framework Specific to both Children and Adults		
Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2019		

Alder Hey Safeguarding Governance Arrangements

22. The Chief Nurse is the Board Executive Lead for safeguarding children and safeguarding adults at risk, with the Chief Executive retaining overall statutory responsibility. The Alder Hey Safeguarding Team forms part of Safeguarding and Statutory Services which sits within the Community and Mental Health Division. Day to day Director support for Safeguarding is the responsibility of the Director Community & Mental Health Services.

23. The Safeguarding Team is led by the Assistant Director for Safeguarding who also undertakes the role of Clinical Director for Statutory Services which includes Children in Care and Adoption Service.

24. The Assistant Director for Safeguarding is the identified statutory lead for Child Sexual Abuse and Exploitation, Prevent and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Lead as required by the Standard NHS Contract.

25. The Assistant Director for Safeguarding meets with the Chief Nurse regularly in relation to safeguarding matters, providing briefings to the Senior Leadership Team as appropriate to discuss issues such as serious incidents, unexpected child deaths and allegations against staff members.

Named Professionals for Safeguarding

26. Alder Hey has both a Named Nurse and Named Doctor for Safeguarding in line with the requirements of all NHS Providers as set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) (2019). The Assistant Director for Safeguarding leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.

27. Alder Hey's Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring safeguarding training is in place. They work closely with the Assistant Director for Safeguarding, Designated Professionals for Safeguarding in the relevant CCGs, and the LSCBs/LSABs.

Reporting Arrangements

28. Quarterly and annual reports regarding safeguarding are provided to the Alder Hey Clinical Quality Steering Group (CQSG) and the Community & Mental Health Divisional Governance meeting for scrutiny and oversight as part of our safeguarding governance arrangements. Key issues from this report are subsequently reported up to the Clinical Quality Assurance Committee and Divisional Board and subsequently to the Executive Board by the Chief Nurse or Director Community & Mental Health Services as necessary.

29. Information is also provided quarterly to Designated Professionals at Liverpool Place who act as 'Lead Commissioner' in line with Key Performance Indictors (KPIs). Regular feedback regarding the level of assurance and quality if KPI submissions is provided by Designated Professionals at quarterly Business Meetings with the Assistant Director for Safeguarding and Named Professionals.

30. Representatives from Alder Hey attend relevant LSCP and LSAB meetings and forums as appropriate.

Peer Review

31. The Safeguarding Team meet on a weekly basis to discuss, and quality assure Child Protection cases being managed within Alder Hey. In addition, there is a formal peer review process with the Radiology Department on a quarterly basis. Arrangements for six monthly joint peer review with the Safeguarding Service from Manchester Children's Hospital ensures there is a consistent approach to the medical safeguarding investigation process by the two specialist tertiary services within the Northwest (Northern Heads).

32. In relation to the Sexual Assault & Referral Centre, historically there were bi-monthly Peer Review Case Discussion Meetings with the Rainbow clinical team and the Forensic Medical Examiners (FMEs). There have been challenges regarding reviewing cases virtually due to the sensitive nature of cases and images which were unable to be viewed securely on a virtual platform.

33. Any procedural issues identified within the various case discussion processes are subsequently taken to the 'Rainbow Management Meeting', which provides a forum for discussion of such issues with partner agencies. This meeting is chaired by the Named Doctor and is attended by partner agencies from Social Care and the Police from all the boroughs covered by the service. The meetings are also attended by the lead Forensic Medical Examiner.

Alder Hey Safeguarding Service Structure

34. The Safeguarding Team is an integral part of Alder Hey's Safeguarding Service. The Team works from the Rainbow Centre and is known across the Trust as the 'Rainbow Team'.

35. The Specialist Nurses and Practitioners within the team provide support to the Rainbow Doctors involved in child protection investigations. The Team also receives a significant number of safeguarding orders via our Electronic Patient Record System (EPRS) Meditech from across the Trust in relation to other child protection issues. These may include concerns regarding parental substance misuse, parental mental health concerns, domestic abuse, chronic neglect, deliberate self-harm, non-attendance known as 'Was Not Brought', or complex discharge issues.

36. The Safeguarding Team will attend multi-agency meetings including strategy meetings, professional meetings, pre-discharge meetings, Child Protection Case Conferences, and Court hearings where appropriate.

37. The Safeguarding Nurse and Practitioners within the team provide safeguarding supervision to nursing and allied professional groups on all aspects of safeguarding. They also provide support should staff be required to produce a Court report or attend Court. The team also deliver safeguarding mandatory training across the Trust.

38. The Rainbow Centre is a dedicated Examination Centre and child protection service. Our doctors, supported by Health Care Assistants and nurses, examine, and advise on the medical aspects of suspected or actual child abuse. This includes physical and sexual abuse, presenting in the community, Emergency Department (ED), or in our inpatient wards or Outpatients Departments.

39. The Safeguarding Team includes:

Whole Time Equivalent (WTE) or Programmed Activities (PAs)	Roles
1.3 WTE	Consultants Available for Child Protection work until midnight
1.3 WTE	Middle Grade Doctors Available for Child Protection each day during core working hours and as part of the on-call rota during the weekends
4 PAs	Named Doctor for Safeguarding
2 PAs	Forensic Lead for the Children's SARC
1 WTE 1 PA	Assistant Director of Safeguarding Clinical Director for Statutory Services
1.0 WTE	Named Nurse for Safeguarding Children, Young People and Adults (Band 8a)
5.2 WTE	Safeguarding Nurse / Practitioner (Band 7)
1.0 WTE	Lead Clinical Psychologist (Band 8a)
1.0 WTE	Clinical Psychologist (Band 7)
1.0 WTE	Physician Associate (Band 7)
1.6 WTE	Health Care Assistants (Band 3)
3.0 WTE	Admin Support (Rainbow Centre and SARC Psychology Service)

40. The Safeguarding Team follows the good practice principles highlighted in the National Service Framework for Children (2004), Working Together to Safeguard Children document (2018), the Children Act (1989, 2004) and The Care Act (2014) and aims to promote child and adult centred care, whilst helping and supporting families through the child protection process. The Team also supports the safeguarding of vulnerable adults whilst recognising the Mental Capacity Act (2005) and the need to 'Make Safeguarding Personal'.

41. The Rainbow Centre offers a multi-agency approach to the treatment of abused children with close liaison between Police, Children's Social Care, and hospital-based personnel. The facility includes two dedicated examination suites, a video interview suite and dedicated meeting rooms.

42. Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit which receives patients from the local and

regional areas, e.g., North Wales, Merseyside and Cheshire, and across the wider Northwest.

43. The Safeguarding Team works closely with Burns and Plastics, Critical Care, Orthopaedics, Paediatric Surgery, Neurosurgery, Ophthalmology, Radiology, CAMHS and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.

44. By arrangement with those Places, Police and Children's Services, any children requiring medical examination, are referred as per protocol to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist child protection on call team. This includes a first on call specialist trainee/specialty doctor/physician associate and second on call consultant. Children and young people are admitted to hospital by the team as required.

45. For those children and young people who are inpatients and concerns of possible abuse are raised, the Consultant with responsibility for the child will follow the relevant Alder Hey Safeguarding procedure and make a referral to the Consultant on call for the Rainbow Service.

46. The Rainbow Team provides the paediatric input for joint examinations with Forensic Medical Examiners (FME) for examination of children with suspected sexual abuse. A Consultant takes the role of Forensic Lead for the children's Sexual Assault Referral Centre (SARC), located within the Rainbow Centre, to ensure that high standards are maintained, and that existing staff have regular training updates.

47. The Rainbow Team is also required to attend multi-agency meetings to discuss findings of medical assessments, produce confidential medical and or Court reports and respond to information requests from both partner agencies and the LSCPs in relation to the LCSPR Process or other safeguarding partnership functions, such as multi-agency audit or performance management.

Safer Recruitment Practices and Managing Allegations Against Staff

48. A vital element of the Trust safeguarding arrangements is our robust safer recruitment practices and arrangements for dealing with allegations against people who work with children or vulnerable adults.

49. Alder Hey has a robust Recruitment & Selection & Policy', this includes the requirement for Disclosure and Barring Service (DBS) checks as part of our safer recruitment arrangements in line with the NHS Standard Contract General Conditions.

50. Offers of employment at Alder Hey are made on a conditional basis as they are subject to satisfactory NHS safer recruitment pre-employment checks, including verification of identity, right to work, references, qualifications, professional registration (where appropriate), a DBS check and Occupational Health check.

51. Once employed, all staff are subject to DBS checks every three years during their employment with the Trust.

52. Alder Hey Procedures for Safeguarding Children and Vulnerable Adults (Version 14) have been written in line with the Children Act (1989) Children Act (2004), Working Together to Safeguard Children, a guide to inter-agency working to safeguard and promote the welfare of children (2018) and Local Safeguarding Children Partnership policies and procedures.

53. Section 18 of the Procedures for Safeguarding Children and Vulnerable Adults (Version 14) is used when allegations are made against a person who works with children and their own family has been subject to child protection investigations or criminal prosecution.

54. It is essential that any allegation of abuse made against a professional who works at Alder Hey is dealt with fairly, quickly, and consistently, in a way that provides effective protection for the child and at the same time supports the person who is the subject of the allegation

55. Allegations may relate to a person who works with children who has:

- Behaved in a way that has harmed a child, or may have harmed a child
- Possibly committed a criminal offence against or related to a child
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children

56. The above-named procedures clearly identify the relevant senior leaders who must be informed in the event of a concern.

Safeguarding Policies

57. The Trust has a suite of safeguarding policies which include all relevant thematic areas of safeguarding which are in line with legislation and local, regional, and national guidance.

58. All safeguarding policies and procedures are ratified by the CQSC. An overview of all safeguarding policies and procedures is detailed below including the date issued and the date of review:

Policy Name	Date Issued	Review Date
M2 – Safeguarding Adults Policy	November 2021	November 2024
M3 – Safeguarding Children Policy	November 2021	November 2024
M70 - Domestic Abuse and Violence Policy	September 2020	September 2023
M69 – Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) Policy	January 2021	September 2022
RM19 – Prevent Policy	June 2021	June 2024
C69 – Chaperone Policy	February 2020	February 2023
Merseyside Joint Agency Protocol – Sudden Unexpected Death in Childhood (SUDIC)	June 2020	
Standard Operating Procedure Name	**Date Issued**	**Review Date**
Procedures for Safeguarding Children and Vulnerable Adults (Version 14)	January 2020	January 2023

59. Section 13 of Procedures for Safeguarding Children and Vulnerable Adults (Version 14) outlines processes in relation to Child Protection of Children in Specific Circumstances.

- Abuse by children and young people
- Bullying
- Children and Young People presenting with Deliberate Self Harm Behaviour
- Children Involved In / At Risk of Sexual Exploitation (CSE)

- Out of Area Looked After Children
  Emotional Support for Victims of CSE And Sexual Abuse
- Organised or Multiple Abuse
- Harmful Practices
- Forced or early marriage
- So-called 'honour'-based violence
- Female Genital Mutilation (FGM)
- Child Abuse linked to a belief in spirit possession or witchcraft or other spiritual or religious belief
- Dog Bites

60. All policies and procedures are reviewed and updated in line with any changes in legislation or guidance.

Safeguarding Training

61. The SAAF (2019) outlines that "all Health providers must ensure staff are appropriately trained in safeguarding adults, children, Prevent, domestic violence, the MCA and deprivation of liberty at a level commensurate with their role and in line with the intercollegiate document".

62. Safeguarding is a key part of our Trust mandatory training requirements in order to develop and embed a culture that ensures safeguarding is acknowledged to be everybody's business and the 'Golden Thread' throughout all of our services.

63. The Safeguarding Team provides mandatory safeguarding training for both clinical and non-clinical staff in accordance with the Royal College of Paediatrics and Child Health (RCPCH) standards, Royal College of Nursing (RCN), General Medical Council (GMC), Nursing & Midwifery Council (NMC) and Working Together (2018).

64. The Safeguarding Training Strategy is based on the RCPCH and RCN Intercollegiate Documents, which provides a framework to indicate the level of safeguarding training required for individual staff groups. Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Fourth Edition Intercollegiate Document (January 2019) suggests specialist trusts such as Alder Hey should be accessing additional mandatory training, which would include more in-depth safeguarding children knowledge, safeguarding adults and Looked After Children.

65. Level 1 and 2 safeguarding children training is completed via e-learning (with additional face to face sessions for staff unable to access online learning). Staff requiring level 3 safeguarding children and level 2 safeguarding adults were being offered training face to face in person or via Microsoft Teams to maintain their compliance.

66. Compliance for safeguarding and prevent training has been as follows throughout 2021/2022:

Training (Target: 90%)	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
Safeguarding Children Level 1	**91.6%**	**91%**	**92.5%**	**92.3%**
Safeguarding Children Level 2	**88%**	**89.5%**	**91.4%**	**91%**
Safeguarding Children Level 3	**85.9%**	**85.7%**	**87.4%**	**84.8%**

Safeguarding Children Level 4	**100%**	**100%**	**100%**	**100%**
Safeguarding Adults Level 1	**92.2%**	**91.3%**	**92.5%**	**92.3%**
Safeguarding Adults Level 2	**91.3%**	**91.7%**	**91.1%**	**89%**
Safeguarding Adults Level 3	**100%**	**100%**	**100%**	**100%**
Safeguarding Adults Level 4	**100%**	**100%**	**100%**	**100%**
MCA & DoLS	**85.9%**	**91.3%**	**87.4%**	**84.8%**
Prevent – Basic Awareness	**90.7%**	**91.3%**	**98.9%**	**92.3%**
Prevent - WRAP	**85.9%**	**85.7%**	**87.3%**	**90%**
Domestic Abuse Awareness	**92.2%**	**91.3%**	**92.5%**	**92.3%**
Criminal Exploitation Awareness	**92.2%**	**91.3%**	**92.5%**	**92.3%**
Criminal Exploitation Targeted	**85.9%**	**85.7%**	**87.3%**	**84.8%**

67. The Safeguarding Team have continued to provide additional safeguarding training sessions in a bid to recover the compliance targets which have been affected by the Covid 19 pandemic. Training figures for safeguarding mandatory training have reduced to below the 90% compliance target set by Liverpool Place during the year in some training sessions. This was due to a combination of team capacity, a move to online delivery online learning and reduced staffing numbers across the Trust.

68. The Safeguarding Team have continued to highlight the reduction in staff compliance to senior leads, team leaders and individual staff. Training compliance continues to be shared with Designated Professionals at Liverpool as part of the KPI quarterly reporting submission.

69. Training is also included in the safeguarding quarterly report submitted to SQAC to ensure senior oversight and action regarding supporting non-compliant staff to access mandatory training. The Safeguarding Team work closely with the Learning and Development Manager and receive regular reports identifying all staff that are within 90 days of becoming non-compliant.

70. In addition, the Safeguarding Team has delivered additional internal targeted training, with topics reflecting Multi Agency ‘Spotlight on’.

Statutory Safeguarding Enquiries and Reviews

71. The Safeguarding Team are required to contribute to the following statutory safeguarding reviews which are commissioned by LSCPs and LSABs:

Domestic Homicide Reviews (DHRs)

72. A DHR is convened by the Local Community Safety Partnership Board, is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Safeguarding Adult Reviews (SARs)

73. A SAR is a multi-agency process that considers whether serious harm experienced by an adult or group of adults at risk of abuse or neglect, could have been predicted or prevented.

The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

Local Child Safeguarding Practice Reviews (LCSPRs)

74. A LCSPR is a locally conducted multi-agency review in circumstances where a child has been abused or neglected, resulting in serious harm or death and there is cause for concern as to the way in which the relevant authority or persons have worked together to safeguard the child. LCSPRs replaced Serious Case Reviews.

75. This area of work is extremely time consuming, complex and involves reviewing distressing information. As a result, this has a significant impact on the capacity of the Safeguarding Team.

76. The Safeguarding Team also contribute to the review of cases of concern or 'near miss' scenarios which do not meet the threshold for a statutory safeguarding review.

77. The Safeguarding Team have a statutory responsibility to ensure that recommendation for the Trust from reviews are appropriately actioned. This involves embedding learning and providing evidence to give assurance to Designated Professionals, LSCPs and LSABs that learning has been embedded.

78. The Team have not contributed to any SARs during 2021/2022. Themes in respect of safeguarding children reviews included domestic abuse, parental and child mental health, neglect, substance misuse, adverse childhood experiences (ACEs), suicide, child sexual abuse (CSA), child sexual exploitation (CSE) and child criminal exploitation (CCE).

79. Key learning themes from all safeguarding reviews across the life course include communication and information sharing between agencies, service user engagement, lack of professional curiosity and professional challenge and the need for improved record keeping.

Channel Panel

80. The Channel Panel is an early intervention safeguarding programme and the element of the national Prevent strategy that provides bespoke support to children and adults identified as being vulnerable to radicalisation, before their vulnerabilities are exploited by terrorist recruiters who would encourage them to support terrorism, and before they become involved in criminal terrorist related activity.

81. Like other safeguarding interventions, Channel Panel works by identifying individuals at risk of radicalisation via referral, assessing the nature and extent of the risk and then developing a support plan for the individual concerned. It is a confidential and voluntary programme. Referrals come from a wide range of partners including the police, health professionals, schools, youth offending teams, children's and adult services as well as members of the public.

82. The Channel Panel takes a multi-agency approach tailoring support to individual need. The type of support available is both bespoke and wide ranging and includes help with accessing mainstream services such as education, career advice, dealing with mental or emotional health issues, drug/alcohol abuse and theological or ideological mentoring from a specialist Channel Intervention Provider who works with the individual on a one-to-one basis.

83. As with other safeguarding work streams, Channel Panel is fluid in terms of the number and complexity of cases at any given time. The Assistant Director for Safeguarding and Named Nurse for Safeguarding has supported the Channel Panel during the period of this report not just by attending and contributing to the meetings but also by information sharing, acting as a conduit between Channel Panel and Alder Hey Services.

Contributions to Local Safeguarding Adult Boards (LSABs) and Local Safeguarding Children's Partnership (LSCPs)

84. The Alder Hey Safeguarding Team continue to work with Designated Professionals to support the work of the LSCPs and LSABs (Liverpool, Sefton, and Knowsley) where appropriate. This has included developing action plans in response to recommendations and findings from Rapid Reviews/Critical Incident Meetings and Local Child Safeguarding Practice Reviews (LCSPRs) and Safeguarding Adult Reviews (SARs), ensuring they are robust and actively address any areas for practice improvement.

85. The Safeguarding Team has a vital role in embedding findings, recommendations and learning in front line practice; and ensuring Alder Hey can evidence impact of intervention. The team also takes a lead role in identifying wider thematic learning and ensuring that these themes inform our planning for workforce development, training, and quality assurance processes.

Impact of Covid on Safeguarding

86. The Covid 19 pandemic proved to be an unprecedented challenge for the NHS. The Safeguarding Team has worked with divisional colleagues and multi-agency partners to ensure that statutory processes were fulfilled, and that vulnerable children, young people and adults remained a priority during this challenging period.

87. At the start of the pandemic the Safeguarding Team worked with to adapt service delivery to prevent disruption to statutory safeguarding processes. The Safeguarding Team continues to use virtual platforms to communicate with partner agencies for strategy meetings, Initial and Review Child Protection Case Conferences and multi-agency teleconferences.

Challenges During 2021/2022

Covid 19 Pandemic

88. As detailed above the Covid Pandemic had a significant impact on the work of the Safeguarding Team as we were required to act quickly and dynamically to meet competing needs. As a result, planned work was deferred and delayed such as safeguarding audits.

89. The Safeguarding Team had to quickly adapt to working from home with minimal staff working in the Rainbow Centre to comply with Covid 19 environmental restrictions.

Capacity of the Safeguarding Team

90. The capacity of the Safeguarding Team was significantly challenged by the volume of activity, high staff sickness rates and high staff turnover within the team. By the end of Quarter 4 in 2021/22 all Pathway Co-Ordinator Admin roles were vacant within the team.

This significantly impacted on the teams' ability to collect data, process Child Protection Medical Reports and manage day to day activity within the Department.

Safeguarding Priorities for 2022/2023

Implementation of Integrated Care System (ICS)

91. During 2022/2023, the implementation of the ICS will have implications in respect of safeguarding arrangements. The Safeguarding Team will work with and support Designated Professionals in respect of this transition.

Covid 19 Recovery

92. The full impact of Covid 19 in relation to the abuse of children and young people is yet to be seen, in that for some children and adults, home is not the safe place it should be, and that the Coronavirus pandemic brought with it additional dangers and risks.

93. Crimes such as child abuse, child sexual exploitation, domestic abuse (including 'honour'-based abuse), sexual violence and modern slavery, typically take place behind closed doors, hidden away from view. The measures introduced in response to Covid 19 made these crimes more prevalent and less visible. It is anticipated that the Trust may continue to see a surge in demand for safeguarding services as and children and vulnerable adults become more visible.

Alder Hey Safeguarding Review by Liverpool Place (CCG)

94. Following a commissioned review by the Director Community & Mental Health Services of the Alder Hey Children in Care Service Offer in October 2022 by Liverpool Place, it was agreed that there would be a consecutive review in safeguarding once the children in care review had concluded. The intention of the Safeguarding review was to elicit how to deliver the safeguarding function at Alder Hey whilst achieving effectiveness and value for money.

95. The Safeguarding Service Review commenced in September 2021 and concluded in April 2022. A priority during 2022/2023 is implementing the recommendations from this review and development of an action plan to address them within the Safeguarding Team.

Embedding the New Leadership Team

96. There were several significant changes anticipated within the leadership team for Safeguarding and Statutory Services. The Assistant Director for Safeguarding and Clinical Director for Statutory Services left the Trust after 25 years in post. A new Associate Director for Safeguarding and Statutory Services has been recruited and commenced in post in May 2022.

97. The Named Nurse for Safeguarding Children, Young People and Adults at Risk also left the Trust in May 2022. A new Named Nurse has been appointed and commenced in post in August 2022.

98. The new Named Nurse for Children in Care commenced in post in March 2022. This was a new role within the Trust.

99. The above significant changes within the leadership of the team provide an opportunity for a fresh look at the Service. A priority for 2022/2023 is to embed the new leadership team and produce a comprehensive workplan for the Service.

Planning for Transition to Liberty Protection Safeguards

100. The implementation of the new Liberty Protection Safeguards (LPS) remains on hold nationally. Alder Hey Safeguarding Team will continue to plan for the transition to LPS and continue to attend the Cheshire and Mersey LPS Provider Forum.

Conclusion

101. The Safeguarding Team continues to ensure that Alder Hey meets its statutory responsibilities and has clear governance processes to oversee Trust safeguarding arrangements to provide assurance that adults and children at risk of abuse or neglect are safeguarded in our care.

102. Work continues to train and develop the Alder Hey workforce to recognise and respond to abuse to safeguarding children, young people and adults at risk in the Trust's care at the earliest opportunity.

103. There are good safeguarding systems in place across the Trust. However, there continues to be challenges as safeguarding continues to evolve, in both complexity and scope, and with new and emerging risks in respect of contextual safeguarding. As a result, the Trust must ensure that all safeguarding interventions are proactive and developed in tandem with the pressures and challenges within local communities.

104. The Safeguarding Team remains committed to ensuring that children, young people and adults at risk using our services are safe, and that their health needs are met. The Safeguarding Team will continue to work collaboratively with all Trust colleagues and key partners to continuously improve systems to safeguard.

105. This Safeguarding Annual Report for 2021/2022 has focused on the governance arrangements in place to deliver the safeguarding agenda; and the role that the Safeguarding Team plays in providing assurance, both internally and externally, so that the Trust fulfils its statutory safeguarding responsibilities.

106. The Safety and Quality Assurance Committee (SQAC) are asked to note the content of this report and accept assurances that systems and processes are in place to ensure Alder Hey Children's NHS Foundation Trust fulfills its statutory safeguarding responsibilities.

Alder Hey Children's NHS Foundation Trust

Board of Directors

Thursday, 26th January 2023

Paper Title:	**Children in Care Annual Report 2021-2022: Safeguarding and Statutory Services**
Report of:	Nathan Askew, Chief Nursing Officer Lisa Cooper, Director Community & Mental Health Services
Paper Prepared by:	Nichola Osborne, Associate Director for Safeguarding & Statutory Services Rebecca Davidson, Named Nurse Children in Care

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

Alder Hey Children's
NHS Foundation Trust

Children in Care
Annual Report 2021-2022

Alder Hey Safeguarding and Statutory Services

Executive Summary

The purpose of this annual report is to provide an overview of Alder Hey Children's NHS Foundation Trust (AHCH) arrangements for Looked After Children 'Children in Care' and a retrospective view of the work completed in relation to this by the Safeguarding and Statutory Services Team for the reporting period 01 April 2021 to 31 March 2022. This annual report provides assurance that the Trust meets its statutory responsibilities in respect of Children in Care.

The work activities undertaken by the Trust's Safeguarding and Statutory Services Team, have been documented within the quarterly Key Performance Indicator Reports which have been prepared for the Clinical Commissioning Groups (CCG), and service delivery in line with the agreed service specification. Internal reporting has also been provided throughout the year 2021/2022 into the Community & Mental Health divisional governance forums. This report is intended to provide an overview and 'snapshot' of that work.

Since 2010, there has been a 1% incremental increase year on year in the number of Children in Care nationally. Currently Alder Hey primarily serves, for Children in Care Services, three Local Authorities (Liverpool, Sefton and Knowsley), with the local increase exceeding the national increase as shown below:

- **Liverpool Children in Care -** 6.32% increase
- **Sefton Children in Care -** 7.9% increase
- **Knowsley Children in Care -** 1.93% increase

In addition, to the increasing numbers of Children in Care, it is evident that there has been an increase in the complexity of the health and social care issues being experienced by Children in Care. This requires Alder Hey to be adaptive in how it serves Children in Care and those transitioning who are subject to care orders into the adoption process and beyond.

Placement provision has seen shifts over the past year with Children in Care being more transient. There has been an increase, both nationally and locally in the number of children being placed outside their home Local Authority area.

The Safeguarding and Statutory Services Team continually seek to ensure that the Trust meets its statutory responsibilities in relation to Children in Care and has clear governance processes to ensure the health needs of Children in Care are met.

Introduction

1. The purpose of this report is to provide an overview of Alder Hey Children's NHS Foundation Trust (AHCH) arrangements for Looked After Children 'Children in Care' and a retrospective view of the work completed by the Safeguarding and Statutory Services Team from 01 April 2021 to 31 March 2022 to outline how AHCH meets its statutory responsibilities in respect of Children in Care.

2. This is the first Annual Report for Children in Care completed on behalf of Alder Hey and has been completed by the new Named Nurse for Children in Care who came into post at the end of March 2022. Due to joining Alder Hey at the end of the financial year, this report has been compiled from available information and data. Some local statistics and data for 2021/2022 had not been collected and is therefore not available for use within this report.

3. The report also includes information to demonstrate the delivery of AHCH statutory services and partnership working with Community Children Looked After (CLA) Health teams in line with the service specification agreed by the NHS Clinical Commissioning Groups (CCGs), namely NHS Liverpool CCG, NHS South Sefton CCG, NHS Southport & Formby CCG and NHS Knowsley CCG (known hereafter as "'the CCGs') as the Responsible Commissioner.

4. Children in Care are referred to in legal terms as 'Looked After Children'. In England and Wales, the term 'Looked After Children' is defined in law under the Children Act 1989.

5. A child is 'Looked After' by a Local Authority if they are in their care, or they are provided with accommodation for more than 24 hours by the Local Authority. Looked After Children 'Children in Care' fall into four main groups:

   - **Section 20:** Children who are accommodated under voluntary agreement with their parents.
   - **Section 31 or Section 38:** Children who are the subject of a care order (s31) or interim care order (s38).
   - **Section 44 and 46:** Children who are the subject of emergency orders for their protection.
   - **Section 21:** Children who are compulsorily accommodated; this includes children remanded to the Local Authority or subject to a criminal justice supervision order with a residence requirement.

6. The term 'Looked After Children' includes unaccompanied asylum-seeking children (UASC), children in friends and family placements, and those children where the agency has authority to place the child for adoption. It does not include those children who have been permanently adopted or who are subject to a special guardianship or residency order.

7. Our children in Merseyside have requested that we refer to them as Children in Care or 'Our Children' and therefore this will be the term used in this report going forward where appropriate.

8. Children in Care share many of the same health issues as their peers however these are often more significant and complex and are more likely to be unmet. Many Children in Care continue to experience significant health inequalities once they have entered the care system. Meeting the health needs of these children and young people requires a clear focus on access to services. This approach can be assisted by the delivery of effective services and ensuring availability of individual practitioners to provide and co-ordinate care.

9. This report will be shared with Designated Professionals in Clinical Commissioning Groups (CCG) and may be used to inform relevant Local Safeguarding Children Partnerships (LSCP) Annual Reports and Local Authority Corporate Parenting Boards.

10. The report focuses on key drivers of work including the local and national context, Alder Hey arrangements for Children in Care and work with commissioners and other key partners.

11. The NHS has a major role in ensuring the timely and effective delivery of health services for Children in Care (Department of Education, 2015) therefore this report includes information about service performance and sets out the objectives and priorities for the coming year.

Statutory Frameworks, Legislation and Guidance

12. There are several pieces of legislation and guidance which inform responsibilities and requirements regarding working with Children in Care. The key documents are summarised below:

Legislation for All	**Legislation and Statutory Guidance Specific to children**
• The Crime and Disorder Act 1998 • Female Genital Mutilation Act 2003 • Mental Capacity Act 2005 • Convention on the Rights of persons with Disabilities 2006 • Mental Health Act 2007 • Children and families Act 2014 • Modern Slavery Act 2014 • Modern Slavery Act 2015 • Serious Crime Act 2015	• Promoting the Health of Looked After Children Statutory Guidance (2015) • United Nations Convention on the Rights of the Child 1989 • Children Act 1989 and 2004 • Children and Social Work Act 2017 • Leaving Care Act (2000) • Working Together to Safeguard Children Statutory Guidance (2018) • Looked After Children: Knowledge skills and competencies of health care staff (2020) • The Care Planning, Placement and Case Review (England) Regulations (2010)
Frameworks and Guidance	
• Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019) • Special educational needs and disability code of practice: 0-25 years (Department of Education and Department of Health, 2015) • Who Pays? Determining responsibility for payments to providers (NHS England, 2015). • NICE Guideline PH28: Looked After Children and Young People (2010, updated 2015) • NICE Quality Standard QS31: Looked After Children and young people (2013) • Future in Mind: Promoting, protecting, and improving our children and young people's mental health and wellbeing (2015). • Who Pays? Determining responsibility for payments to providers (2013)	

- National Tariff Payment System (2019)
- Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies (2013)
- Guide to the Children's Homes Regulations, including the Quality Standards (2015)

National Profile of Children in Care

National Data

13. The demographics for Children in Care nationally are taken from the Statistical First Release (SFR) England. The full SFR is due to be published for year ending 31 March 2022 in December 2022. Therefore, the below data relates to the data published in November 2021 for the year ending 31 March 2021.

14. It is recognised that for the year ending 31 March 2021, there has been an ongoing potential impact noted for Children in Care due to the Covid 19 Pandemic, which is reflected in the statistics.

15. The number of Children in Care in England and Wales has increased every year since 2010. The number of Children in Care in England is up 1% on 2020 to 80,850 on 31st March 2021. The Children in Care population is growing faster than that of the UK child population (Department of Education, 2018).

16. The number of Children in Care who were adopted fell by 18% to 2.870 compared to 3,440 in 2020. This downward trend has continued since the peak in 2015. The large decrease in adoption orders over the year, is felt nationally to be driven by the impact on court proceedings during the pandemic, where cases progressed more slowly or were paused.

17. Nationally the number of unaccompanied asylum-seeking children (UASC) was down 20% on last year, to 4,070. Although this had also decreased slightly the previous year (2020), this year has seen a much steeper fall and is likely due to travel restrictions during the year.

18. National data reflects the following characteristics of the Children in Care population
    - Males account for 56% of Children in Care
    - 10-15-year-olds account for 39%, 23% aged 16+ years, 19% aged 5-9 years, 14% aged 1-4 years and 5% aged less than 1 year.

19. As of 31st March 2021, data identified that 'abuse or neglect' was the primary need for two thirds (66%) of Children in Care, continuing the pattern of increase observed over recent years.

Health Findings

20. Children in Care are offered statutory health assessments to monitor the physical, development and emotional wellbeing continually through their journey in care.

- 86% reported as being up to date with their immunisations, down slightly from 88% last year.
- 91% reported as having had their annual health assessment, up slightly from 90% last year.
- 89% of under 5s reported as having development assessments up to date, this is up from 88% last year.
- Dental checks up to date have fallen significantly during the pandemic. In 2021, only 4 in 10 CLA had had their teeth checked by a dentist, a large decrease on the proportion in 2020. However, this is not unexpected given the difficulties faced by the whole English population accessing dental care during the pandemic

Local Profile of Children in Care

Overview of Merseyside Children in Care

21. Liverpool, Sefton, and Knowsley data reported nationally has been outlined in tables below to give an overview of Merseyside Children in Care. In line with the increases being seen nationally, this data shows that the number of Children in Care in Merseyside has increased again from the previous year. The table below compares data published nationally from 2019/2020 with data from 2020/2021. 2021-2022 data is not yet publicly available:

Numbers of Children in Care	2019/2020	2020/2021	% Increase/Decrease
Liverpool	1,424	1,517	6.3% increase
Sefton	566	613	7.9% increase
Knowsley	307	313	1.93% increase

22. Provision of placements within the Local Authorities is a national challenge, with placement types varying based on individual children's family network, vulnerabilities and needs. The table below compares data reported nationally from 2019/2020 with data from 2020/2021 looking at the number of children placed outside of their home Local Authorities:

Children in Care Placed Out of Borough	2019/2020	2020/2021	% Increase/Decrease
Liverpool Children placed outside of Local Authority area	619	679	9.7 % increase
Sefton Children placed outside of Local Authority area	211	236	11.8% increase
Knowsley Children placed outside of Local Authority area	149	223	14.76% increase

23. Reflective of the above data, which saw an annual increase in the number of Children in Care placed outside of their home Local Authority, the below table demonstrates an overall increase of Children from other Local Authorities placed within the three CCG area which Alder Hey serves:

Number of CiCOLAs	2019/2020	2020/2021	% Increase/Decrease
Children in Care of Other Local Authorities (CiCOLAs) placed in Liverpool	256	276	7.8% increase
CiCOLAs placed in Sefton	279	286	2.5% increase
CiCOLAs placed in Knowsley	217	223	2.7% increase

Overview of Alder Hey Children's NHS Foundation Trust Data

24. Alder Hey are commissioned to provide Initial Health Assessments (IHA) for Children in Care within the three CCG areas, Liverpool, Sefton, and Knowsley. The table below compares Alder Hey data regarding the number of IHA's requested in 2020/2021 with the data for 2021/2022:

IHA Requests	2020/2021	2021/2022	% Increase/Decrease
Liverpool	541	478	11.6% decrease
Sefton	211	161	23.6% decrease
Knowsley	100	80	20% decrease
Children in Care of Other Local Authorities (CiCOLA)	67	107	59.7% increase

25. A decrease in requests across the three CCG areas was noted, this is potentially due to the number of children placed out of borough at the point of becoming Children in Care, whereas the number of children placed within the CCG areas from other Local Authorities increased.

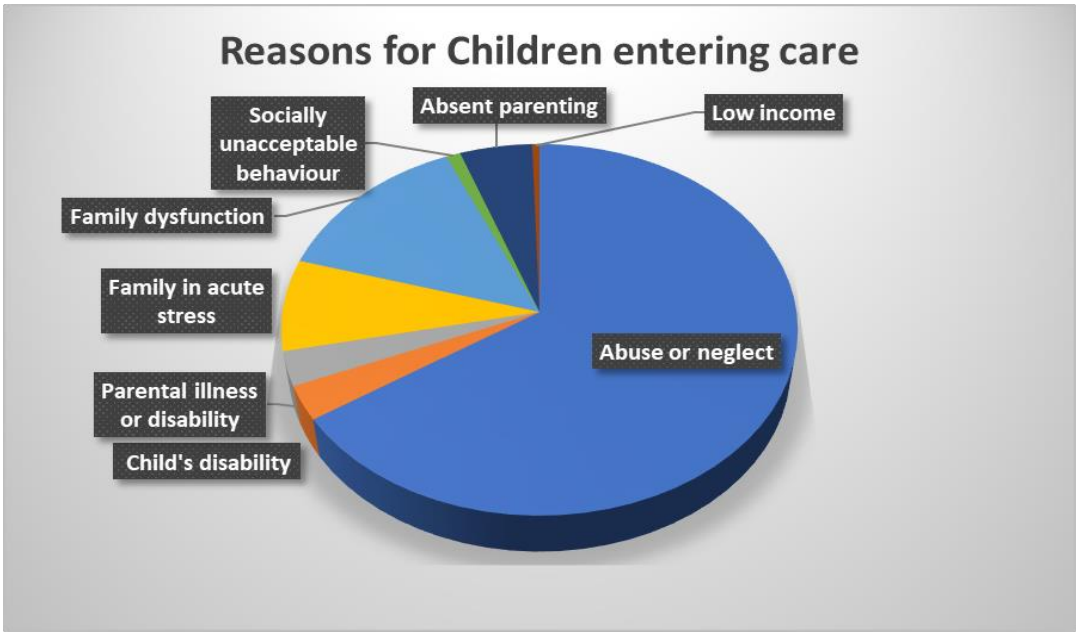
26. In addition to IHAs, Alder Hey are commissioned to complete adoption medicals for Children in Care within the three CCG areas, Liverpool, Sefton, and Knowsley. The table below compares the number of IHA's requested for 2020/2021 with the data for 2021/2022:

Adoption Medical Requests	2020/2021	2021/2022	% Increase/Decrease
Liverpool	125	92	26.4% decrease
Sefton	58	30	48.2.6% decrease
Knowsley	25	22	12% decrease
Children in Care of Other Local Authorities (CiCOLA)	8	5	37.5% decrease

27. The noted decrease across all areas in the request for Adoption medical assessments is reflective of the national 18% decrease in children adopted in year ending 2021.

National Data: Reasons and Placement Provisions

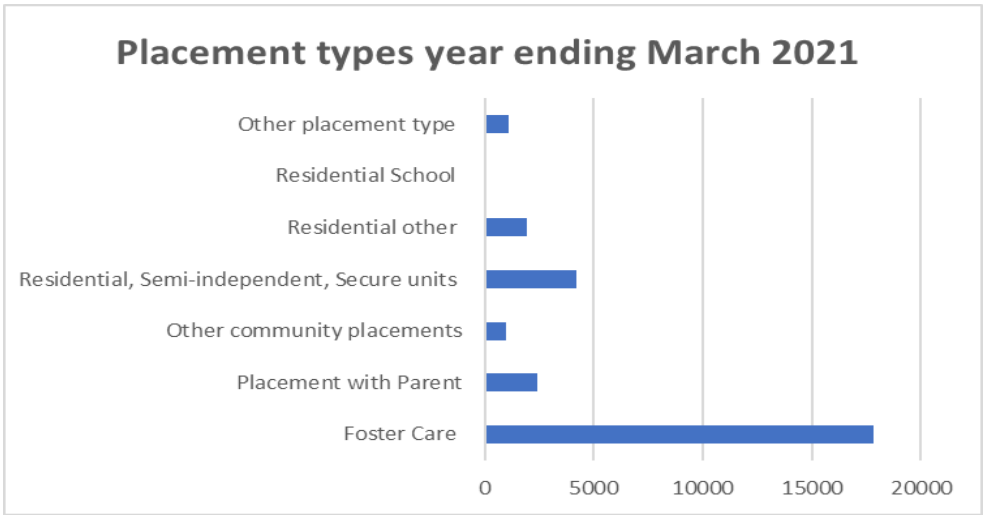
28. Most children come into Local Authority care due to abuse or neglect, and for these reasons Children in Care are acknowledged as being one of the most vulnerable groups in society.



England, 31st March 2021 Source: SSDA903

29. It is recognised that Children in Care have significantly higher levels of health needs than children and young people from comparable socio-economic backgrounds who have not been in Local Authority care. This is due to past experiences, a poor start in life, care processes, placement moves and transitions. Additionally, these issues can impact on equitable access to both universal and specialist health services.

30. The national picture is that fewer children started to be looked after in foster placements; more were placed with parents, or looked after in secure units, children's homes, and semi-independent living.



The Health of Children in Care

31. Two thirds of Children in Care have been found to have at least one physical health complaint such as speech and language problems, bedwetting, coordination difficulties or sight problems. There are also generally higher levels of teenage pregnancy and drug and/or alcohol use (Department of Education, 2015).

32. Statutory guidance (Department of Education, 2015) states that CCGs and officers within the Local Authority who are responsible for Children in Care services should recognise and give due account to the greater physical, mental, and emotional health needs of Children in Care in their planning and practice.

33. Local data regarding specific health needs of Children in Care within the CCG areas Alder Hey are commissioned for is not currently available. Alder Hey aim to work closely with its community partners to ensure the health and developmental needs for Children in Care are addressed quickly and robustly to improve long term health and wellbeing outcomes.

Mental and Emotional Well Being

34. As highlighted Children in Care will already have experienced trauma and difficulties over and above those experienced by most of their peers. Most will have suffered abuse or neglect, or experienced bereavement, disability, or serious illness in one or both parents. Many of our children have come from disadvantaged backgrounds.

35. Being a Child in Care can involve major and sometimes traumatic upheaval. Changes and a lack of permanence in the arrangements for many Children in Care are unsettling and can hamper effective work by professionals. Alder Hey Community Mental Health Services for Liverpool and Sefton work closely with Children in Care and their parents and carers to provide a personalised service.

36. Children in Care are more likely to have difficulties with their mental health. Nationally almost half of Children in Care have diagnosable mental health issues. Additionally, 11% are reported to be on the autistic spectrum and many others have developmental problems (Department of Education, 2015).

37. If mental health needs are unmet, it can increase children's risk of a variety of poor outcomes, including placement instability and poor educational attainment (Bazalgette, Rahilly and Trevelyan, 2015) and subsequently poor mental health into adulthood.

Impact of the Covid-19 Pandemic

38. The pandemic has created a major health crisis that impacts on every individual and family across the UK. However there needs to be a specific focus on the impact on children when their parents or other members of their family, foster carers or adopters are having to respond to the crisis by making major adjustments to their lives. (Coram-BAAF, 2021).

39. The impact that this has on them cannot be underestimated. When it comes to children and young people in care, these issues may be significantly amplified because:

- Their experiences of high degrees of instability and insecurity in their lives.
- The questions that they may have about what might happen to them – 'Will I catch the virus?'; 'Will you still look after me?'; 'Are my mum or dad or brothers or sisters ok?'; 'Will I still go to school?'.
- The potential for the uncertainty, anxiety and stress associated with the crisis to trigger previous traumatic memories and reactions.
- The impact of the limitations to forms of social contact which require establishing workable boundaries in the family, especially for teenagers.
- Their opportunities to spend time with family members or siblings whom they are not living with being limited.
- Managing the transition back to school in September and coping with the changes to the daily routines and physical environment of the school brought about by the response to Covid.

40. The impact of the Covid Pandemic had an ongoing effect on service delivery throughout 2021/2022. Due to restrictions and the requirement for isolation with infection and shielding, services were delivered by a hybrid approach of face to face, virtual or telephone appointments.

41. Alder Hey aimed to move over the course of the year to delivery of IHAs being predominantly face to face as this method of delivery is in the best interest of our children. This stance was outlined within the Joint Position Statement 'Initial Health Assessment for Looked After Children' (Royal College for Paediatrics and Child Health (RCPCH) and Royal College of Nursing (RCN), December 2020)

Borough	Total Number of IHA's completed 2021/2022**	Number of IHAs completed virtual or by telephone 2021/2022**
Liverpool	380	148
Sefton	162	77
Knowsley	70	35

**** Data is taken from local records, which may have some inaccuracies**

Alder Hey Safeguarding and Statutory Assessment Service Governance Arrangements

42. The Chief Nurse is the Board Executive Lead for safeguarding and Children in Care; with the Chief Executive retaining overall statutory responsibility. Services for Children in Care are provided by the Safeguarding and Statutory Services which sits within the Community and Mental Health Division.

43. The Safeguarding and Statutory Services is led by the Assistant Director for Safeguarding who also undertakes the role of Clinical Director for Statutory Services which includes Children in Care and Adoption Services.

44. The Assistant Director for Safeguarding meets with the Chief Nurse and Director Community & Mental Health Services regularly in relation to safeguarding and Children in Care matters, providing briefings to the Senior Leadership Team as appropriate.

Named Professionals for Children in Care

45. Named Professionals for Children in Care are a requirement of all NHS Providers as set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) (2019) and Looked After Children: Roles and Competencies of Healthcare Staff - Intercollegiate Document (RCN and RCPCH, 2020). The Assistant Director for Safeguarding leads the Named Professionals in their statutory responsibilities to ensure Trust safeguarding arrangements are robust.

46. Alder Hey has over the period of 2021/2022 has worked towards the recruitment of full-time dedicated Named Nurse for Children in Care. The post of Named Nurse has been filled from the end of March 2022, when Children in Care and Adoption responsibilities were transitioned over from the Named Nurse for Safeguarding.

47. Historically there has been a hybrid role for the role of Children in Care Named Doctor and Designated Doctor. Work will be undertaken in 2022/2023 to review this arrangement and work with Commissioners to clearly separate the Named and Designated Doctor roles and responsibilities. This work will ensure that the requirements of the Intercollegiate Document are fulfilled and there is clarity regarding these vital statutory roles for Children in Care.

48. Alder Hey Named Professionals have a key role in promoting good professional practice within the Trust, supporting the local safeguarding system and processes, providing advice and expertise for staff, and ensuring training regarding Children in Care is in place. They work closely with the Assistant Director for Safeguarding, Designated Professionals for Children in Care in the relevant CCGs, and with Local Authority Partners.

Reporting Arrangements

49. Quarterly and annual reports regarding Safeguarding and Statutory Services are provided to the Alder Hey Clinical Quality Steering Group (CQSG) and Community & Mental Health Divisional Governance meeting for scrutiny and oversight as part of our safeguarding and Children in Care governance arrangements. Key issues from this report are subsequently reported up to the Safety Quality Assurance Committee

and Divisional Board and subsequently to the Executive Board by the Chief Nurse or Divisional Director as necessary.

50. Information is also provided quarterly to Designated Professionals at Liverpool Clinical Commissioning Group (LCCG) who act as 'Lead Commissioner' in line with Key Performance Indictors (KPIs). Regular feedback regarding the level of assurance and quality of KPI submissions is provided by Designated Professionals at quarterly Business Meetings with the Assistant Director for Safeguarding and Named Professionals.

51. Representatives from Alder Hey attend relevant LSCP and Corporate Parenting meetings as appropriate.

Designated Professionals for Children in Care

52. The roles of the Designated Nurse and Designated Doctors are to promote the health and welfare of Children in Care by assisting CCGs and other commissioners of health services in fulfilling their responsibilities to improve the health of Children in Care and by influencing strategic health policy.

53. Alder Hey is commissioned by the CCGs to provide the Designated Doctor for Children in Care function to each CCG area. The Designated Doctor role is intended to be a strategic one, separate and distinct from any responsibilities for individual Children in Care and other clinical roles within Alder Hey they may hold. The Designated Doctors within this role sit under the governance arrangement of the individual CCG.

54. As outlined above in paragraph 48, Alder Hey will work with Commissioners to ensure that the arrangements are clear regarding the commissioning of Designated Doctor roles from Alder Hey with dedicated time clearly outlined within relevant doctors' job plans.

Challenges During 2021/2022

55. There have been several challenges experienced during 2021/2022 which have impacted on the work of the service and include:

- Long term sickness within the Paediatric Team over the course of 2021/2022, impacted on clinic capacity and timeliness of IHA and Adoption Medicals.

- Working within a global pandemic meant continued requirement to self-isolate for families and staff which presented booking, scheduling, and assessment challenges.

- Hospital and Safeguarding team activity increased internally and externally. This resulted in Named Nurse for Safeguarding, who was also fulfilling the Named Nurse for Children in Care role, facing conflicting priorities, between Safeguarding and Children in Care activity.

- The Somerset judgement in January 2022 impacted on the completion of Adoption Medicals, due to multiple historical requests and medical requiring Adoption Medical Advisor addendums and change to overall adoption medical processes.

- There have been ongoing barriers to the timeliness of IHA medicals, this has been a multifaceted issue, with late notifications from community LAC teams being one of the main issues.

Achievements for 2021/2022

56. There have been a range of achievements in relation to the Service for Children in Care during 2021/2022 which have been outlined below:

- The team continued to adapt to utilise virtual appointments for adoption and IHA medicals, rather than cancel appointments when children were unable to be brought for their face-to-face appointments due to the requirement to self-isolate as a result of Covid-19.

- Paediatricians supported a significant number of additional slots being added to their clinics or added an additional full clinic to their rota to support the gaps in resource during period of significant sickness and absence.

- New trainees who joined over the course of the year received an induction into Safeguarding and Statutory Services and had an opportunity to shadow long standing members of the Paediatric Team during IHA assessments prior to working independently in clinics. LAC reflective practice sessions have also been offered to support clinician knowledge and skill.

- There was robust working between the Safeguarding Team, inpatient ward staff and community partners to support a vulnerable Child in Care during a prolonged admission and cohesively raise child exploitation (CE) awareness.

Key Priorities for 2022/2023

57. Alder key priorities for 2022/2023 will be as follows:

- To progress the recruitment of a Named Doctor for Children in Care to fulfil the statutory organisational requirement and strengthen the specialist knowledge and training offered to staff delivering Children in Care services across Alder Hey.

- To work with Commissioners, Community Health teams and Local Authority colleagues to review the information sharing processes associated with Children in Care, aiming to identify barriers and promote effective working across services.

- To review data collection processes and tools internally, to ensure consistency and accuracy of data collated to inform internal and external reporting.

- Work to clarify Designated Doctors roles and associated workplans to ensure statutory roles are carried out in full and effective.

- To complete a business case to consider additional funding for the Children in Care administration, nursing, and clinical team to promote higher quality of services and provision across the Trust.

- Full review of Children in Care policies and procedures to be completed for all aspects of Safeguarding and Statutory Services across Alder Hey.

- Training opportunities related to Children in Care to be explored for appropriate Trust wide job roles to support experience of children and families/carers.

- Reduce the number of incidents, PALs and complaints associated to Children in Care and children subject to adoption orders, through review of demographic change processes and general staff training and awareness. In addition, to review of information sharing processes with partner community Children Looked After health teams and Local Authorities.

- Improve the quality of IHAs, to ensure health assessments are age appropriate, recognising risk and demonstrating discussion and signposting of relevant public health topics.

Conclusion

58. Alder Hey Safeguarding and Statutory Services Team continue to ensure that the Trust meets its statutory responsibilities in relation to Children in Care and has clear governance processes to monitor the arrangements of commissioned health services for Children in Care.

59. As a result of the number of Children in Care being placed outside of their home Local Authority, there needs to be a review of information sharing processes across services for these children, to minimise the impact of delays to treatments and health interventions when they move between placements and geographical areas.

60. Work continues in partnership with the community Children Looked After teams to achieve timely and quality services for Children in Care, ensuring positive communication and information sharing is achieved.

61. The Safeguarding and Statutory Services Team is committed to meeting the health needs of the Children in Care population of Merseyside and Cheshire, in addition to Children in Care accessing Alder Hey services from wider areas.

62. The Safeguarding and Statutory Services Team will continue to work collaboratively with the Local Authorities, Cheshire and Merseyside Integrated Care Board and key partners to continuously improve systems and quality of care.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Organ Donation Report, 2021/2022**
Report of:	**Clinical Lead Organ Donation**
Paper Prepared by:	Dr. Carla Thomas

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

Context

Organ and tissue donation saves and improves the lives of thousands of UK citizens every year. It can offer comfort to the families of donors through the knowledge that something remarkable came from their loss.

Following implementation of the Organ Donation Taskforce recommendations in 2008, UK deceased donation has risen and the transplant waiting list has fallen. However, although significant positive steps have been taken, there remains a mismatch between donation and transplantation. Furthermore, in children, deceased donation has not grown at the same rate and the same transplant benefits have not occurred.

National Strategic Plans

UK Paediatric and Neonatal Deceased Donation – A strategic plan [2019]

- Aim to significantly increase the rates of paediatric and neonatal deceased donation in the UK.
- Aim to normalise practice, minimise variation and promote excellence in care, ensuring that donation is considered a routine part of end-of-life care on PICU.

Organ Donation and Transplantation 2030: Meeting the Need – A ten-year vision for organ donation and transplantation in the UK [2020]

- Living and deceased donation will become an expected part of care, where clinically appropriate, for all in society.

Organ Donation at Alder Hey Children's Hospital

Every death on PICU is audited by NHS Blood and Transplant (NHSBT) to assess if best practice is followed in relation to the identification and referral of potential organ donors [Potential Donor Audit].

2021-2022 Performance

Audited Deaths = 58
Neurological death testing rate = 44% [The percentage of patients for whom neurological death was suspected that were tested for death by neurological criteria.]
DBD [Donors after brain death] NHSBT Referral Rate = 88.8%
DCD [Donors after cardiac death] NHSBT Referral Rate = 43.3%
Family Approach involves SNOD = 20%

1 Organ donor, resulting in 6 transplants; 2 kidneys [2 x Adult recipients], heart, liver, double lung and stomach, bowel and pancreas [4x Paediatric recipients].
3 Missed potential organ donors

Recommendations

1. Re-establish Alder Hey Children's NHS Foundation Trust Organ and Tissue Donation Committee and appoint chair.
2. Ensure deceased organ donation national policies, guidelines and best practice implemented and followed consistently within the Trust.
3. Ensure staff within the Trust are adequately trained.
4. Champion and promote organ donation at Alder Hey Children's NHS Foundation Trust.
5. Events to promote organ donation during organ donation week (19^{th} – 25^{th} September 2022)

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	18th January 2023 – Summary 14th December 2022 – Approved Minutes
Report of:	Kerry Byrne, Non-Executive Director
Paper Prepared by:	Kerry Byrne

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 18th January 2023, along with the approved minutes from the 14th December 2022 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

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

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

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

- Divisional Governance Review Update
- Patient Safety Strategy Board Update
- DIPC Exception Report
- ED Activity Update
- Sepsis Update
- Safeguarding and Statutory Services Briefing
- Update from the Clinical Quality Steering Group
- Ockenden Report update and proposal for responding to Kirkup Report
- Overview of the Patient Safety Incident Response Framework (PSIRF)
- Children in Care Annual Report
- BAF
- Discussion on Risk Appetite and Tolerances for Clinical Safety and Effectiveness Risks
- IPF for SQAC and Divisional Reports
- Child Abduction Policy (Ratified)

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

None

4. Positive highlights of note

- We received a further update on reporting on sepsis and asked the Sepsis Team and IM&T to further develop the day to day and real-time monitoring and reporting of sepsis to reduce the time needed from the Sepsis Team to investigate and manually adjust data.
- The Ockenden update showed that 54 of the 68 areas relevant to Alder Hey and the Liverpool Neonatal Partnership have been addressed with the remaining areas to be complete by end of March 2023.
- An overview of the changes resulting from the requirements of PSIRF was provided. PSIRF will replace the Serious Incident Framework in 23/24 and requires significant changes to process and culture.
- We presented the Board proposed risk appetite and tolerances for clinical safety and effectiveness risks and discussed their implementation and any challenges arising. The Divisions are going to look at their practical implementation and further discussions will take place to agree any potential changes required and how best to implement.

5. Issues for other committees

None.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Safety and Quality Assurance Committee
Minutes of the meeting held on
Wednesday 14th December 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Interim Chief Medical Officer	(Aba)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Deputy Chief Executive	(JG)
	Christine Hill	Pathology Manager	(CH)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jo Revill	Non Executive Director	(JR)
	Jackie Rooney	Director of Quality & Governance	(JR)
	Melissa Swindell	Director of HR & OD	(MS)
	Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)

In attendance:

	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Natalie Palin	Associate Director of Transformation	(NP
22/23157	Bea Larru	Director Infection Prevention Control	(BL)
	Jill Preece	Governance Manager	(JP)
	Will Weston	Medical Services Director	(WW)
	Peter White	Chief Nursing Information Officer	(PW)

22/23152 Apologies:

Adrian Hughes	Deputy Chief Medical Officer	(AH)
Dani Jones	Director of Strategy	(DJ)
Erica Saunders	Director of Corporate Affairs	(ES)
Paul Sanderson	Interim Chief Pharmacist	(PS)
Sarah Wood	Safety Lead, Surgery Division	(SW)

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

22/23/153 Declarations of Interest
SQAC noted that there were no items to declare.

22/23/154 Minutes of the previous meeting held on 16th November 2022 – Resolved:
Committee members were content to **APPROVE** the notes of the meeting held on 16th November 2022.

22/23/155 Matters Arising and Action Log
Action Log – action log was received and updated.

22/23/156 Patient Safety Strategy Board update

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

WW advised that the Patient Safety Strategy Board had met on 13.12.2022 and that not all updates may not be included within the meeting pack given that that the meeting had only just taken place. WW alluded to the 3 key aims and the 13 workstreams covering insight, involvement and improvement. Colleagues had been applying scrutiny to workstreams 12-17. Significant success over the past month related to the development of a communications plan.

November 2022 was the safe month across the organisation, which was launched via a staff broadcast introducing the new Patient Safety Strategy. A number of communication activities had taken place in month including the publishing of the SharePoint site which is available to all staff, there had been a variety of blogs, from senior leaders covering topics such as PSIRF and patient safety culture. A big conversation was held with over 50 attendees, and colleagues hosted 3 stall dates within the atrium, promoting feedback from patients, families and staff, together with insight following evaluation of the survey responses collected.

2023 Communications plan had been drafted which the Deputy Director of Comms presented to Patient Safety Strategy at its meeting on 13.12.22. This included a comprehensive list of patients and staff engagement items planned for throughout the next calendar year, enabling the opportunity to continue two way discussions to aid understanding and promote the Patient Safety Strategy programme as a whole.

Challenges relate to further work required regarding using meaningful programme specific data and metrics, and focussing on those areas that will result in the most impact.

WW sought approval from SQAC to update the Trust Board on the work of the current patient safety board and also inform the board of the changes that will be associated with PSIRF.

FB referred to the first slide, and in particular the Workforce workstream and highlighted items 2-12, FB also referred to the transfusion workstream and queried whether these workstreams had been scrutinised. WW advised that this had been discussed at Patient Safety Strategy Board meeting on 13.12.22 and colleagues had agreed to close down this workstream. The data had identified that incorrect classifications had been used and this would be addressed and would be monitored through the Division of Medicine governance structure.

FB alluded to the consistency regarding the date format displayed on the slides and requested whether that for future reporting that the dates could be displayed in a consistent format to enable easy review for committee members, WW confirmed that this would be addressed and actioned as appropriate.

FB thanked WW for informative update.

Resolved: SQAC received and **NOTED** the Patient Safety Strategy Board Update and endorsed the request to present the Patient Safety Strategy Board update to Trust Board to raise Patient Safety Strategy at the highest level across the organisation.

Resolved: SQAC agreed it beneficial to receive PSIRF update at SQAC at January 2023 meeting, following an update on PSIRF at Board of Directors meeting in February 2023, ensuring appropriate time is allocated at Board and SQAC.

Delivery of Outstanding Care
000192

Safe

22/23/157 DIPC Exception Report

SQAC received the DIPC Exception report, key issues as follows:

- Vaccination rates had been included within the DIPC report, NA advised on the challenge this year across the whole NHS with regards to vaccination rates. Flu vaccination rate for staff is currently 47%, the organisation usually reaches 85%. Information had been shared widely to staff regarding ways for staff to record flu vaccination, if they had been vaccinated within the community or GP. NA anticipates that the rates would increase, this is very much mirrored across the system in terms of Cheshire & Merseyside. Alder Hey are ahead of other Trusts which are at around 30% rate.
- The Trust continues to offer covid vaccine.
- Track and trace would continue until the end of this year, and that there is a plan for some level of support towards the end of the financial year. Covid levels within the community are quite low at present. FB referred to the learning from COVID track and trace and how this survives in the future when COVID funding is removed.
- High levels of RSV and Strep A - colleagues are focussed on respiratory pathway in totality, hence that the Trust is continuing to support the use of wearing face masks, particularly for acute site, with some allowances made for different services within the community and offsite provision.

KB referred to the UKHSA infections and alluded to the E.coli patient aged 23, and queried whether this related to a a super stranded patient unable to transition. BL advised that this was a complex care case, a neurology patient who was on 4C, and confirmed that this was not a long stay stranded patient.

FB referred to the effective use of track and trace team, and the longer term prospect once covid funding is removed, and how this survives in the future once covid funding is removed. BL advised that the IPC team had recently recruited to a Band 6 nurse to work within the IPC Team. BL stated that the management of any outbreaks is one of the components of IPC workload which would need to be managed by IPC within the team. BL stated that the IPC team had managed outbreaks multiple times, and that the same approach would be applied.

FB welcomed the focus on Strep A within the DIPC report.
FB thanked BL for DIPC update

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

22/23/158 Assurance ED Assurance Activity Monthly Update

SQAC received and **NOTED** the ED Assurance Activity Monthly update
KB requested whether SQAC could receive a detailed analysis regarding ED at its Best, to enable assurance for SQAC. JRe echoed KB comments. UD confirmed that this update could be provided to SQAC at January 2023 meeting.

JRe sought clarity regarding 'rounding' within the waiting room, as she was not familiar with this terminology. CW advised that colleagues had introduced an hourly round (comfort round) with a designated nurse or HCA to check on patients and ensure communication is improved.

SQAC agreed it beneficial for an offline discussion to be held regarding what level of information is to be shared at January 2023 meeting.

Resolved: Offline discussion to be held with UD & FB to agree what level of information is to be provided to SQAC at January 2023 meeting.

SQAC welcomed the ED at its best report at January 2023 meeting.
000193

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

22/23/159 Mortality Report

SQAC received the Mortality Report.

Resolved: SQAC received and **NOTED** the Mortality Report

22/23/160 Divisional update on Pressure Ulcer Action Plan

CW presented the Divisional update on Pressure Ulcer Action Plan, individual divisional updates were provided to SQAC in September 2022 outlining the position for inpatient ward areas, and the action plans to support improvement. With the aim to reduce hospital acquired skin damage. Divisions have been working closely to provide a joint report, to ensure shared learning across the Trust.

The report provided an overview of progress and associated action plan.

CC detailed the introduction of prophylactic dressing within Orthopaedics which had already resulted in a significant improvement.

CW acknowledged the joint working and advised that working in collaboration had been extremely positive.

NA stated that this was a helpful report, and welcomed the increase in compliance with pressure ulcer audit within the Medicine division. NA alluded to the poor variable compliance on 4A which translates into an area of a high level of risk, and stated that 4A should be the Gold standard, given the patient workload, NA advised that he would like to seek assurance that this is being fully addressed at ward level, and that a rapid improvement would be evident.
CC advised that the Division had made some changes regarding oversight and support.

KB queried the status of the Community Division report. JP advised that the Division of Community & Mental Health continue to be compliant, and that the work highlighted in the original report was regarding amending the tool, to ensure that it was more useable in the community, this work had continued.

FB stated that part of this focus is learning across the organisation and that SQAC would be seeking assurance that no learning opportunities are being missed, and that conversations are inclusive. JP expressed apologies to SQAC for this omission and advised that Community & Mental Health updates would be included within the next report.

JG sought clarity with regards to 0 grade 4 pressure ulcer, despite the Division of Surgery stating that there is 1, within the orthopaedic service, CW stated that this case was in February 2022 and is not within the timeframe.

FB thanked CW & CC for informative report, and stated that it was helpful to see the collaboration. FB welcomed the continuation or SQAC receiving future Quarterly Pressure Ulcer Action Plan reports to include contributions from all three divisions.

Resolved: SQAC received and **NOTED** the Divisional Update on Pressure Ulcer Action Plan and welcomed Pressure Ulcer Action plan update at March 2023 meeting.

22/23/161 Transition Update

SQAC agreed to defer the Transition Update to the January 2023 SQAC meeting to ensure

that the Committee have sufficient time to review the report in advance of the meeting.
NA expressed his personal thanks to JP for ongoing support, and advised that there are still a number of issues currently being worked through with regards to Transition. SQAC welcomed the positive progress report at January 2023 meeting.

Resolved: SQAC agreed that this report would be deferred until January 2023 meeting.

Clinical Governance Effectiveness

22/23/162 CQSG Key issues report

NA provided update on CQSG Key issues report, key issues as follows:-

- Good progress had been made across numerous areas during November 2022, CQSG meeting held on 13.12. 22 had a good level of engagement and assurance provided.
- Division of Surgery - gap in medical workforce noted which is impacting on service delivery and the recovery plan, with plans in place to mitigate.
- Division of Medicine - 20% increase month on month attendance in AED attendances, exacerbated in month by Strep A. Mitigations in place include additional bays and OPD rooms for triage purposes and hourly comfort rounds undertaken within AED waiting room.
- Community & MH Division report challenges with court requests and subject access requests, with work underway to review pathway to ensure a timely response.
- Research Division – current high turnover rate of 31%. Staff temperature checks in place, CQSG requested this issue be added to the risk register and benchmark with Research Divisions across the Northwest.

JG queried what process is in place to respond to pressures in ED, and queried whether there is a requirement to regroup on this issue, JG also sought clarity whether refreshments are being provided and welcomed a summary on what actions are being taken to address the ongoing challenges to ascertain whether any further support could be provided. CW welcomed this and advised that the comfort round does help for children, young people and families, and that improved communication with families is providing positive results.
CW stated that long wait times in ED creates anxiety and frustration, however it is important to support families as much as possible. CW welcomed a regroup to address.

NA advised that the Trust would continue to receive poor feedback on ED experience until such time that the organisation can change the approach, and that there does not seem to be the will within the clinical teams to change this. Allowing patients to wait in excess of 12 hours will always result in a poor patient experience. It was agreed that the Medicine Division to continue to liaise with clinical colleagues in this regard.
AB referred to the two aspects regarding how the organisation organise care, and advised that during the past week colleagues had used this as an opportunity to bring forward the new models of care, booking appointments for lower acuity of patients, with more of this type of approach which is critical. ED internal hub had been established for minor injuries. AB referred to the small personal touches, i.e., Musicians keeping patients entertained and refreshment provisions which need to help aid and improve the services provided.

FB stated that infection prevention control does prohibit issues which allow patients to enjoy patient experience, with some services not feasible given the need for IPC measures.

SQAC agreed that the CQSG Chairs report from the meeting held on 13.12.22 would be circulated to SQAC for noting.

SQAC received and **NOTED** the CQSG Key issues report,

Resolved: SQAC received and **NOTED** the CQSG Key issues report from meeting held on 13.12.22, CQSG Chairs Key would be circulated following SQAC meeting.

22/23/163 NICE Compliance Update Quarter 2 – 21st July -30th September 2022

JR presented the NICE Compliance update for Quarter 2; Key issues as follows:-
JR reminded SQAC that the report is evolving and welcomed feedback on areas for improvement for future reports.
NICE is progressing in line with expected standards nationally, with 67 NICE publications received in Quarter 2, of which 15 were relevant to the Trust. There are 141 NICE guidelines open cumulatively during Quarter 2 . Highest proportion of publications are within the Medicine Division.

- 4 guidelines are overdue of baseline assessment
- 52 open guidelines at assessment stage and 89 open guidelines with recommendation and action planning stage.
- Next steps - JR is working with divisions to improve compliance with baseline assessment
- NICE guidelines are being reviewed in terms of governance process, any breaches are escalated to divisional leads and escalated to Divisional Directors.
- SQAC **NOTED** the number of publications aligned to the Division of Medicine compared to the Division of Surgery and the Division of Community & Mental Health. JR advised on current NICE process and timeframes in comparison with other peers across the ICS. JR had met with the Northwest Audit NICE Chair and that there is some disparity in how Alder Hey report data.

SQAC **NOTED** the publications aligned to the Medicine Division and agreed to the level of assurance provided.
FB questioned the time needed to reach the required position.
JR stated that capacity can be a real challenge. Alder Hey are continuing to review processes, for example, giving the full 3 months for review instead of the current 1.
KB welcomed SQAC receiving a report detailing the rolling monthly trend regarding the number of open Guidelines, to provide detail of compliance against the 3 month trajectory.
KB stated that similarly she would welcome compliance with the action timescales that are agreed once the assessment had been undertaken. KB referred to those older guidelines, and stated the importance of not losing sight of these. KB welcomed bar charts within future reports. JR advised that this data would be incorporated within the next report.

FB stated that she would be happy to be involved in any discussions with JR & KB if required.
LC queried whether the way guidelines are assessed and allocated could be reviewed. JR agreed to review this.

SQAC agreed that it was helpful for committee to know which guidelines had been removed.
FB stated that this was originally an appendix to the report, however FB took the view to remove appendices given high number of meeting papers within SQAC meeting pack. FB stated that importance of SQAC being assured that there is a good robust process around it, and know which group is monitoring this.

JR, KB, ES & AB have previously had discussions, SQAC agreed that a report would be shared at February 2023 meeting from the collective group.

SQAC **NOTED** the work in progress, and the need for continued improvement to be evidenced, with further assurance required regarding process regarding new guidance received and outstanding guidance.

FB thanked JR for continued work, and highlighted the importance of linking across the

group regarding clinical audit process. FB welcomed update at February 2023 SQAC meeting.

Resolved: SQAC received and **NOTED** the NICE Compliance Update and welcomed update at February 2023 meeting.

22/23/164 Risk/Incident Management Update

PW, Chief Nursing Information Officer, provided an update on the Risk/Incident Management System, PW advised that he is leading on project to deliver Risk & Incident Management System and provided background detail.

A presentation was given which included some examples of the new system and the next steps in the procurement and deployment activity.

FB thanked PW for informative update and advised that SQAC are looking forward to seeing improvements which the new system can assist with. KB expressed her thanks to the teams involved for continued work. NP sought clarity whether PW anticipated any risks regarding completion of this programme alongside work of Alder Care. PW stated that the implementation should be ahead of AlderCare, Training for the majority of users would be regarding access and completing reports.

LC welcomed this system and sought clarity whether she would be able to generate her own reports, PW confirmed that this would be possible. PB stated that a significant challenge is that the governance team provide an outstanding service to individuals and teams, however this does not translate throughout the organisation. LC welcomed an update regarding other modules for a comprehensive suite. FB queried whether the new system encompassed access for the whole of Community & MH Division, PW confirmed this was the case.

JG referred to the rapid implementation, trying to ensure that the system is a more detailed cultural piece on how people apply risk, and sought clarity whether thought had been given regarding the Organisation Development process alongside, and to use this as an opportunity to progress further. PW was in agreement with these comments, and referred to how the entire organisation would change as this would help staff at the bed side, and would benefit colleagues to improve care. JG queried how these issues could be brought together and use the Brilliant Basic approach to align.
NA stated that offline work would continue to address issues.

JR stated that Divisions are being challenged to understand and triangulate data. Prior to implementation of In phase Divisions need to ensure good housekeeping, to ensure that no old data is migrated, JR made a plea to ensure that any old actions are closed.
FB stated that SQAC welcome the implementation of the new Risk and Incident Management System and welcomed the roll out.

NA expressed his personal thanks to PW and teams for ongoing work.

Resolved: SQAC received and **NOTED** the Risk and Incident Management update.

Well Led

22/23/165 Board Assurance Framework

SQAC received and **NOTED** the Board Assurance Framework.
NA referred to BAF risks 1.1 and 1.4 both of which had provided assurance to SQAC previously in terms of a high level deep dive, which is reflected within the Board Assurance Framework, with good levels of control in place. NA referred to challenges regarding winter pressures, the planned industrial action and challenges regarding access. With controls updated as appropriate.

KB referred to BAF Risk 1.1. and sought clarity with regards to the 3 gaps currently which are not aligned, and queried the data anomaly NA agreed that he would review offline to ensure that this is rectified for the next BAF update.

Resolved: NA to review Risk 1.1. and update as appropriate

Deep Dive Risk 1.2 - Children and young people waiting beyond the national standard to access planned care and urgent care

AB presented Deep Dive on Risk 1.2. – Children and young people waiting beyond the national standard to access planned care and urgent care

AB advised that by undertaking the deep dive that this has led to key enhancements, change in risk score and further rigour of the actions in place, and future actions scheduled. AB advised that there are a number of children and young people who are currently waiting over 52 weeks for treatment, there are currently 360 children. These patients have started to reduce incrementally over the last 8 weeks period, however there is a capacity gap within dentistry, and as a result the Trust cannot deliver the national standard in this financial year. The diagnostic standards are also tracked which had demonstrated an improved position in the last two month period.

ED remains extremely challenged, linked to exceptional levels of demand.

AB proposed that the risk score be increased from 15 to 20 which is reflective of the current demand, various industrial action and ongoing challenges with the BMA rate card.
All mitigations are in place, with numerous actions being undertaken through the divisions and Partners.

Strep A is causing significant increase in presentations. In response to this an ED model had opened up a 2nd hub in Radiology.

Other mitigations include investments that had been made on the elective side to consultant anaesthetists.

Long term mitigations

- Build and staff new urgent care facility
- ED @ its best programme – improving paediatric urgent care provision in Walk in Centres and establishing virtual urgent care.
- Establishing a paediatric dental hub in C&M, secured 125K to support this.
- In January 2023, sleep studies service would introduce new technology to undertake sleep studies at home and reduce waiting times.
- Open new paediatric elective hub having secured £5M of national investment

FB expressed thanks to AB.
KB referred to the document within the BAF, and questioned whether it aligned to the main Board Assurance Framework, and queried whether there was a timing difference as it appeared not to have been updated.
KB advised that the May and June dates may need updating further. AB advised that the Risk would be updated to reflect the current ongoing work to address current position.
KB stated that she is comfortable with the assurance provided with regards to the Board Assurance Framework.

Resolved: SQAC **APPROVED** the suggested approach to increase the risk rating from 15 to 20.

SQAC received and **NOTED** the Deep Dive Risk 1.2 and the assurance provided.
FB thanked AB for update and acknowledged SQAC assurance with regards to Risk 1.2, SQAC noted the pressures and ongoing activity.

Resolved: SQAC received and **NOTED** the Deep Dive and the assurance that this provided and **APPROVED** the risk rating from 15 to 20.

22/23/166 Divisional reports by exception/Quality Metrics update

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

- Challenges with regards to delivery of activity plan of 104%, extra investment in Head of Nursing, with increased time to focus on delivery plan.
- Challenge regarding staffing issues during the winter period and the impact on Industrial action, division are being supported as appropriate. Staffing hubs established to ensure safety, with a comprehensive safe staffing model in use.
- NHSE are supporting wellbeing project on PICU and HDU.
- Various specialties had been successful with presentations and posters nationally and internationally.

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

- Mandatory Training - 90%, UD had requested Division of Medicine colleagues to ensure that they are booked into APLS and BLS training if currently non-compliant.
- Renewed focus on staff retention and turnover which is currently 13.85%, with the Division having an increased focus to understand the issues of concern. Division are working on a project regarding reward and recognition.

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

- Areas of concern continued to remain increase in referrals to mental health services, ASD, and ADHD Services.
- Staff recruitment, retention and workforce turnover - challenges as the Division are starting to see staff who are applying for posts at Alder Hey and prior to interview, the candidates are declining interview as they are offered a higher pay grade.
- All moves had been successfully completed, new Catkin is established, with positive feedback received to date from Children & Young People. Move to Innovation Park went as planned with excellent feedback received.
- Friends and Family Test scores remain over 95%
- Division had been successful in a bid to the charity for base camp (large dome), that will form part of the park and Alder Hey as part of a commitment for social prescribing for children on waiting list. Wider collaboration with third sector. LC would provide update on this at February 2023 SQAC meeting.

FB acknowledged the recurring themes across the division in terms of staffing pressures, turnover, and winter pressures.

FB thanked all Divisions for update.

Clinical Governance Effectiveness

22/23/167 Incident Reporting and Management Policy

SQAC received and **RATIFIED** the Incident Reporting and Management Policy

Serious Incident Management Procedure

SQAC received and **RATIFIED** the Serious Incident Management Procedure

After Action Review Procedure
000199
SQAC received and **RATIFIED** the After Action Review Procedure

22/23/168 Any other business

NA advised that the IPR in the meeting pack showed no never event in November 2022, however the meeting pack presented to Trust Board shows 1, NA stated the error in data collection. NA referred to the incident which happened in January 2022, which wasn't reported until August 2022. NA stated that this was a no harm never event, and related to a wrong site biopsy, this had no impact on the clinical trial, and no harm to the patient, all internal procedures were followed at the time. Colleagues are currently undertaking an RCA which would likely identify learning form the incident and our reporting processes.

22/23/169 Review the key assurances and highlight to report to the Board

Positive updates were received regarding:

- Patient Safety Strategy Board update was received, SQAC **NOTED** the positive position. SQAC agreed that colleagues should support the raising of the Patient Safety Strategy Board profile with a Patient Safety Strategy Board update report to Trust board, with future focus at SQAC on PSIRF, and at Trust Board.
- ED Assurance Emergency Department Activity monthly update received, SQAC requested further detail regarding ED at its best at January 2023 SQAC meeting.
- Divisional Update on Pressure Ulcers was received, which detailed the learning across the organisation, SQAC **NOTED** the improvement in the data, SQAC welcomed future Quarterly Report, with Community & Mental Health Divisional data incorporated.
- NICE Compliance Report was received, with robust discussion held, SQAC recognised that this is work in progress, and that future improvements are required to the report to provide improved assurance.
- SQAC received update on Risk/Incident Management framework, and received an overview of new system, which was positively received by SQAC.
- SQAC received a Deep Dive of BAF Risk 1.2 – Children and young people waiting beyond the national standard to access planned care and urgent care. SQAC were in agreement to raising the level of risk and continued to remain focussed on this risk. SQAC welcomed the innovations established to assist in managing the risk.
- Divisional updates were received, SQAC **NOTED** the staffing pressures across all three divisions, together with retention issues and pressures from upcoming Industrial action, none the less positive updates were received from Medicine Division e.g., with regards to Nephrology wrap round support, and ED@its best.
- Positive updates received from Community & MH Division regarding recent moves to the new Catkin, and Innovation park. SQAC **NOTED** FFT success and the Community & MH Division acquiring funding for the (Dome), Base Camp.
- SQAC **NOTED** concern from the Surgery Division with regard to the impact on industrial action and activity.
- Positive update received from Surgery Division regarding leadership development away day which was recently held with focus on well-being and resilience, SQAC also **NOTED** the upcoming presentation to staff regarding theatres focussing on improvements.
- SQAC Ratified Incident Reporting & Management Policy, Serious Incident Management Procedure and After Action Review Procedure.

21/22/170 Date and Time of Next meeting

FB thanked all for attendance

Next meeting to be held on 18th January 2023 at 9.30 am

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

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

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

1. Introduction

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

2. People Metrics

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

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

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

PDR's for senior colleagues has remained static at 85% completion. PDR completion is an area of concern for the Trust, with only 47% of overall staff having a current PDR completed. The Trust target of 90% is to be achieved by the end of March 2023.

Are We Well Led? People Section: HR Metrics					Trustwide Workforce Headcount: 4,157
	KPI	Target	Oct 22	Nov 22	Dec 22
Absence	Sickness Absence (in month %)	5%	5.90%	6.40%	6.72%
	Short Term Sickness Absence (in month %)	2%	2.72%	2.75%	1.93%
	Long Term Sickness Absence (in month %)	3%	3.17%	3.65%	4.79%
	Return to Work Completion (in month %)	100%	66.36%	75.13%	73.30%
Turnover	Staff Turnover (rolling 12m %)	10%	14.56%	14.82%	15.33%
	Leavers (Headcount)	-	51	40	42
	Time to Hire (pre-employment checks)	30 days	39	40	24.5
Diversity	Proportion of BAME Staff in Workforce (in month%)	-	10.22%	10.40%	10.40%
Pay Accuracy & Spend	Pay Accuracy (%)	99.5%	99.37%	99.33%	99.28%
	Value of Overpayments (£)	-	£39,316.53	£45,240.05	£41,693.62
	Temporary Spend (£'000s)	-	£1,319.68	£1,509.98	Unavailable
Training & Appraisal	Mandatory Training (in month)	90%	92.38%	92.22%	92.01%
	PDR band 7+ (from 01/04/2022)	90% (by end of July 22)	84.65%	85.14%	85.04%
	PDR all AFC (from 01/08/2022)	90% (by end of March 23)	45.35%	49.37%	46.93%
	Medical Appraisal (from 01/04/2022)	90% (by end of March 23)	83.82%	87.04%	89.39%

3. Staff Survey

The annual Staff Survey closed on 25th November 2022 with a response rate of 54%. A full and detailed analysis of staff Survey is currently underway and will be presented throughout Jan/Feb 2023 across the Trust, to support divisional 'big conversations' and focused action plans. Staff Survey detail is still currently under embargo.

4. Industrial Action

Further to RCN strike action in December 2022, the RCN have announced further dates of strike action in January and February 2023. RCN will strike on 18th and 19th January 2023, however Alderhey is not participating in these two days of strike action. On 6th and 7th February 2013, two further days of RCN strike action will take place and RCN members at Alderhey will be called to participate in those two days of strike action.

The Chartered Society of Physiotherapists (CSP), have met the legal threshold for strike action, and will call CSP members out to strike at the Trust on 26th January 2023. This will be a 24 hour period of strike action.

The BMA are out to ballot the opinions of junior doctors relating to strike action and will close on 20th February. Further information will follow.

The Trust continues to work closely with all staffside colleagues, as well as providing frequent Trust wide communications and updated FAQ's. Gold/tactical command structure in place as well as ongoing staff support through the Trust SALS Service.

5. Financial Wellbeing

We continue to review financial wellbeing and the impact of this on staff, in light of the ongoing economic climate. The Trust offers of practical support include the following:

- Fixed pay date: we will now be paid on the 27th of each month, helping colleagues to manage finances more effectively. This will start from November.
- Rapid access to Citizens Advice Bureau advice/support/guidance, available through SALS
- 25% discount for staff in Alder Hey Charity Shops; all you need to do is show your Alder Hey staff pass
- Buy a 'Blue Light Card' for £5 and claim the full cost back through the Trust's expenses system. A Blue Light Card gives access to significant discounts across a range of retailers, including supermarkets
- As part of our ongoing financial support and well-being we have partnered up with Wagestream, a leading financial wellbeing company, to give Alder Hey staff the ability to access and use their salary ahead of payday

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

'Pay it Forward' scheme has now launched. 'Pay it Forward' will enable those staff who are in the fortunate position to do so to pay for an extra hot drink or meal when

purchasing their own. This fund can then be accessed by other staff who need it through a discreet voucher scheme, administered by SALS, Trade Unions and the Chaplaincy.

Sharon Owen
Deputy Chief People Officer
January 2023

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on 7th December 2022 Via Microsoft Teams

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

Alder Hey Children's NHS Foundation Trust

22/23/096 **Declarations of Interest**
No declarations were declared.

22/23/097 **Minutes of the previous meeting held on 31st October 2022**
The minutes of the last meeting were approved as an accurate record.

22/23/098 **Matters Arising and Action Log**
Action log was updated accordingly.

22/23/099 **Industrial Action Update**

MS highlighted Alder Hey continues to work with the RCN in preparation of the planned strike action due to take place on 05/12/2022 & 20/12/2022. First meeting with the RCN strike committee has now taken place and was both positive and productive, and the aim is to continue working together.

RCN have requested a venue onsite for initial meetings to take place to ensure internal focus is given. Alder Hey have agreed to accommodate. Ongoing conversations with the RCN reps are taking place with the aim to conduct a planning meeting chaired via Nathan Askew taking place twice weekly

Other unions continue to ballot and we will provide a further update in due course.

GMB & Unite are currently balloting the Ambulance Service across the region.

Chartered Society for Physiotherapy will close their ballot on 12/12/2022 with the anticipation of the BMA opening their ballot for Junior Doctors in January 2023.

Next steps: NA and wider team are working on all derogations, mindful of any impacts to service provisions. There is a plan to pull together the relevant structure of information to present to RCN today/tomorrow.

22/23/100 **Monitor Progress against the People Plan - People Metrics**

Medicine Division:

- Mandatory Training rate for the division continues to improve.
- PDR Rate remains stable.
- Return to work has decreased and remains a challenge, division continues to push through around plans for improvement.

Next steps: Team continues to monitor data and drive improvements across the division.

Community & Mental Health Division:

- Staff Survey rate is at 62.7% - increase from previous months data and continues with good progress.
- PDR Compliance continues to be monitored and areas continue to be encouraged to complete – remains stable.
- Time to hire highlights a slight gap within the Recruitment Team and has now been filled.

- Employment Relations cases continue to be well managed within the division, regular meetings are taking place with support from HR Leads.
- Sickness Absence rate for the division is above trust target which is improving compared to the previous month. Team continues to focus on the challenges and progress with regular catch-up meetings with HR, Finance and Recruitment Leads.
- Turnover data for the division has been broken down for initial focus with ongoing monitoring highlighting most of the percentages relates to leavers.

Surgical Division:

- Long Term sickness rate for the division has decreased compared to the previous month.
- Mandatory Training is above trust target and the division push forward with prioritising within clinical areas to ensure completion.
- Return to work rate has decreased. Division is preforming a deep dive to address the challenges relating to system, e-roster and ESR issues identified, and additional support is being provided by HR leads. Divisional Workshop has been created to help manage staff for support. Two Nursing Leads have been appointed to help improve on return-to-work compliance.
- Divisional Away-Day took place on 02/12/2022 with Nursing Leads and Operational Leads which was successful. This provided motivation within the team around winter and recovery challenges.
- Division has increased psychology support for staff on the front line both working on and off the wards with the aim to roll out wider comms across the trust which will help the environment by encouraging staff to work together.
- Turnover within the division is high and team are conducting a deep dive around fix term contracts which has been identified as a high rate which is included in the data collection.
- Workforce plan: Division is progressing with a piece of work involving all areas including specialities to reduce the number of temporary contracts for 2023 and remains ongoing.

Next steps: Initial focus remains a priority within the division. Deep dive will be conducted in relation to fix term contracts and address all system challenges relating to PDR completion.

Research Division:

The Committee received and noted the data updates on the content of the Divisional Metrics within the Research Division and took the paper as read.

Corporate:

- Sickness absence has decreased compared to previous month's data and continues to be monitored.
- Turnover has reported 17 leavers for the month of October 2022 reflecting an increase compared to the previous month. This is associated to the expiry of the

end of fix term contracts division is investigating contracts due to end in accordance with future vacancies including clinical roles.

- Mandatory Training remains stable. Access to equipment is being explored to ensure staff have access and time to complete.

Next Steps: Division continues to monitor data and explore further opportunities for fix term contracts.

Trust Metrics:

The Committee received and noted the content of the Trust Metrics and took the paper as read.

Turnover Report:

SO presented the Quarterly Turnover Report to the Committee noting the progress to date:

- Trust turnover position has increased up to 14.5% with 33 leavers.
- There is a plan to conduct a deep dive relating to fix term contracts.
- Benchmarking piece of work is being conducted per staff group to reflect and capture a true figure trust position and will report into the EDI Steering Group. A Task & Finish Group will be created to review all figures with the plan to capture early and explore staff reasons in order to make a difference achievable.
- Induction position: 50% of Alder Hey employers are leaving as they reach their 2-year employment timeline and is being further investigated around the reasons to ensure areas are providing development opportunities and are receiving support.

Resolved:
Trust turnover rate has increased and remains high. Divisions will explore end of fix term.

22/23/101 **Progress against the Internal Communications Plan**

Committee received the Internal Communications Plan report and noted progress to date and took the report as read.

Action: Provide an update at the next Committee on the new intranet update. Soft launch and on track for launch in Feb 2023.

Resolved:
Committee received the Internal Communications Plan report and noted progress to date.

22/23/102 **Induction Review – Project Update**

DS presented the induction review – project update to the Committee highlighting main key points by exception:

- The Induction process is being reviewed in order to improve staff experience and reduce the number of turnovers.

- L&D are creating a one-day event supported by local induction to improve good experience for new starters. SALS & L&D Team working alongside staffside colleagues. Feedback from listening events has been collated from managers and staff and proposed changes come into effect from January/February 2023 to change the experience of new staff starting in the organisation.
- Looking at recruitment processes to introduce a buddy system for new starters by selecting an individual to help support new starters as a point of contact.
- Plan to utilise Trac systems in order to view where processes are up to help reduce volume of contact within recruitment which will be trialled in January 2023.
- Process in place around producing post cards to improve experience and provide feedback on the experience entering into the new role.
- Welcome packs will be given onsite; pen, pad and water bottle and reusable cup for all new starters.
- Arranging tours around the trust for new staff including existing staff.
- Creating a wellbeing induction process.
- Working with IT to help support process of setting up new email account/laptop and ID badge to help managers with capacity. IT will create a process where they will receive an alert notification when a new starter is due and providing the relevant information in readiness.
- Plans to produce a new page on the intranet homepage with guidance of documents that are helpful for new staff.
- Plan to host an event following a couple of weeks/months of starting to present the opportunity for feedback and what further improvements can be implemented.

Next Steps: Committee noted the progress made and agreed further exploring into the key challenges highlighted has potential success.

22/23/103 **PDR Review – Project Update**

DS presented the PDR review – project update around progress highlighting main key points by exception:

- DS/MS met to discuss improving PDR completion which must include a review performance. There is an electronic system in production needing minor adjustments and ready to launch following national guidance.
- Staff engagement has been given initial focus to ensure staff at Alder Hey feel valued and Managers are taking the appropriate leadership in this area

Next Steps: L&D await further national guidance instruction for the planned launch of an elective system to complete PDRs within the organisation.

22/23/104 **Listening to Staff – A Refreshed Approach**

JP provided the Committee with a presentation overview on the current position following the progression on the listening events happening across Alder Hey.

JP informed the Committee there is a development in progression relating to different strategies on responding to staffing raising concerns. “Ask the Execs” has been well received within the trust and departments across the trust continues to pull together to

implement new ideas and opportunities for improvement around better engagement by exercising the 5 standards:

- Compassion:
- Attending
- Understanding
- Empathising
- Helping

JP announced the trust has a new team temperature check relating to measuring staff wellbeing including the level of safety staff are delivering to patients. This is presently being trialled in ED with a designed QR code using smart phones which provides direct linking – there are 30 questions taking an average of 5 minutes to complete. Feedback is obtained and areas can perform and monitor to make those comparisons

Resolved:
Team is proposing this new tool rollout to review different workstreams with the use of intelligent action on how to improve our everyday working abilities. Working progress.

The Messenger Review

MS presented the Messenger Review document, noting that Alder Hey are linking some of the recommendations to the work being developed by the L&D, OD and HR functions. Still awaiting national guidance on this review.

Resolved:
Committee received and noted the review

22/23/105 **Six Monthly Health & Safety Update Including Dashboard**

The Committee noted the progress to date of the six monthly health & safety including dashboard and agreed an initial focus is needed around flexibility.

Resolved:
Committee noted progress to date.

22/23/106 **Equality, Diversity & Inclusion Steering Group Update**

SO referred to the Equality, Diversity & Inclusion Steering Group highlighting the first meeting has now commenced chaired by Garth Dallas, Non-Executive Director.

Terms of reference was presented at the meeting and has been agreed submit to a further follow up meeting planned for November 2022.

SO confirmed an annual workplan has been produced and will take the direction from the membership group which will consist of Network Chairs and Exec Sponsors. There has been a number of applications received following an expression of interest and the team are hoping to appoint within the designated areas in time for the next meeting.

Alder Hey's new EDI Lead Angela Ditchfield will commence in post in January 2023 and we will work in partnership with Clatterbridge.

Resolved:
Committee noted progress made within EDI Leadership / Meeting structure.

22/23/107 **Risk 2.3 Deep Dive**

- **Equality, Diversity & Inclusion**

A deep dive into the strategic risk relating to EDI was undertaken. SO informed the Committee that the risk was currently scored at 15 with a target risk score of 6. There are a number of controls in place to mitigate the risk, paying particular attention to the gaps identified, there are now structures in place to resolve.

SO noted the team are hoping to appoint the new Network Chairs and Exec Sponsors which is taking place next week should decrease the score sore in the coming months.

Action: EDISG update to be provided in 6 month's time to monitor progression and risk score.

Resolved:
The Committee received the Board Assurance Framework Deep Dive Risk 2.3 'Equality, Diversity & Inclusion"

22/23/108 **Board Assurance Framework**

The Committee received the Board Assurance Framework detailing November 2022 updates noting a piece of work to be undertaken to ensure mitigations are in place and making progress in line with the WRES/WDES.

Resolved:
The Committee received and noted the latest position of the Board Assurance

22/23/109 **Ratify Polices**

- **Professional Registration Policy**

Professional Registration Policy was introduced to the Committee. An overview had been submitted to the Committee.

Action: TJ to circulate Professional Registration Policy via email for virtual ratification from the Committee Membership.

Resolved:
Committee agreed subject to virtual ratification.

22/23/110 **Health & Safety Committee (HSC)**

The Committee received the approved minutes of the HSC meeting held on 17th May 2022.

22/23/111 **Joint Consultative and Negotiation Committee (JCNC)**

The Committee received the approved minutes of the JCNC meeting held on 19th October 2022.

Alder Hey Children's NHS Foundation Trust

22/23/112 **Local Negation Committee (LNC)**

The Committee received the approved minutes of the LNC meeting held on 9th August 2022.

22/23/113 **Education Governance Steering Group**

The Committee received the approved minutes of the EGG 11th August 2022.

22/23/114 **Any Other Business**

No other items of business were raised.

22/23/115 **Review of Meeting – Chair's Report to Board**

- Turnover remains a crucial focus.
- Induction review; key learning points for the trust were noted from discussions.
- PDR review; good progress being made with continued support
- Good progress on staff survey.
- EDI Steering Group making good progress as drives forward

The Chair thanked the Committee for today's insightful discussion and challenging questions and comments.

Date and Time of Next meeting
Wednesday 18th January 2023 at 2pm via MS Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

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

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

Board Assurance Framework 2022/23

1. Purpose

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

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

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

2. Review of the BAF

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

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

3. Overview at the 13th of January 2023

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

BAF Risk Register - Overview at 13 January 2023
1.2: Children and young people waiting beyond the national standard to access planned care and urgent care (S) 4.2: Digital Strategic Development & Delivery (S) 3.4: Financial Environment (S) 3.5: ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system compl (S) 1.4: Access to Children and Young People's Mental Health (S) 2.1: Workforce Sustainability and Development (S) 2.3: Workforce Equality, Diversity & Inclusion (S)
1.3: Building and infrastructure defects that could affect quality and provision of services (S) 3.1: Failure to fully realise the Trust's Vision for the Park (W) 3.2: Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of (S) 4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S) 1.1: Inability to deliver safe and high quality services (S) 2.2: Employee Wellbeing (S) 3.6: Risk of partnership failures due to robustness of partnership governance (S)

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

Report generated by Ulysses

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

4. Summary of BAF – at 12th January 2023

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

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

5. Summary of December updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ)***
  Risk reviewed; no change to score in month. Key progress in Vision 2030 development and C&M CYP / Beyond. Controls, actions and evidence reviewed.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ)***
  Risk reviewed; no change to score in month. Developing proposal for ICB CYP Board - TBC. Controls and actions reviewed.

- ***Risk of partnership failures due to robustness of partnership governance (DJ)***
  Risk reviewed; no change to score in month - but this will move based on significant assurance in MIAA audit and subsequent recommendations/actions. Evidence, controls and actions updated.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions closed and risk reviewed.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Weekly meetings with the SPV, LOR & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. There has been some notable recent success in getting the gas combined heating and power unit into action, and remedial works to the chillers (now on course for completion in January 2023) with the temporary ones on the top level of the car park being removed mid-January to ensure resilience over the festive period. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipe work and skylight leaks) that are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. Project Co/Mitie are seeking a standstill agreement and details of the proposal are awaited.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB)***
  Over 1,800 C&YP were treated in December 2022 relative to December 2019. This level of demand is unprecedented, and the proportion of patients treated within 4 hours decreased. In response we mobilised acute respiratory infection clinics in collaboration with primary care. We opened an additional ED area for low acuity patients and updated the symptom checker to include advice for families on Strep A (with c. 70,000 views in December). In elective care we

faced the headwinds of industrial action which reduced the number of patients we treated, and less additional activity is being undertaken as we negotiate the levels of pay for medical staff undertaking additional duties. The number of long wait patients has plateaued, rather than reducing. Recovery (as measured by the number of patients treated) for outpatients was strong at 112%, with elective care reduced to 98%. In order to support the elective recovery programme we have changed the rate of pay for additional work (although the effect of this on uptake is unclear as yet) and invested in agency staff in theatres.

- ***Inability to deliver safe and high-quality services (NA)***
  This risk has been updated based on feedback from SQAC and now should be aligned. Controls remain in place and progress has continued in relation to gaps in control, notably in increasing compliance with AB administration.

- ***Financial Environment (JG)***
  Risk reviewed. Updated action plans and control measures to reflect current position following release of the national planning guidance and expected completion dates.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  End of Year Review.

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed. Score remains appropriate. Progress with recruitment of permanent positions within iDigital Senior Management Team. Recruitment and retention focus in place. Work ongoing regarding timing of key programmes in 2023.

- ***Workforce Sustainability and Development (MS)***
  Risk reviewed and action remain on track - risk score remains high.

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

- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People (CL)***
  Reviewed in January 2023. no change to risk score but note the new corporate risk of financial sustainability.

- ***Access to Children and Young People's Mental Health (LC)***
  Risk reviewed and action relating to waiting lists and validation completed

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000218

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

Strategic Aim — Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.2
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	2.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.2 & 2.1 & 1.4
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	4.2
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 & 2.1
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants	2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	2.1
2657	No consistent method for recording and communicating resuscitation decisions across the trust	
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2100	Risk of inability to provide safe staffing levels	2.1
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.2
2755	There would be a risk to the delivery of high quality services for Children and Young People.	1.2 &2.1
2746	The risk of patient harm due to a lack of clear guidance and a training structure. Patient harm due to the use of a drainage system that is not ordinarily used within the trust.	
2754	The Division of Surgery currently does not have a sustainable financial plan and is currently forecasting a year end deficit position.	3.4

000219

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2753	There is a risk that Children and young people could wait beyond a reasonable time frame to access care. This could potentially impact on their outcome. Current waiting times within a number of Surgical specialties do not support the strategic objective of the delivery of outstanding care.	1.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 2.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal.	1.1 & 2.1
2755	There would be a risk to the delivery of high quality services for Children and Young People.	1.1 & 2.1

000220

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

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

000221

BAF Risk

2.1 Workforce Sustainability & Capability

(3x5=15)

Strategic Aim

The best people doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1 & 2.2
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 1.2
2740	No dedicated Dietician within Cardiology therefore currently not complying with CHD standards	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2684	Risk the Trust will be unable to deliver high quality paediatric haematology service (non-malignant and malignant, including lab work) due to 50% reduction in the Consultant workforce and resulting impact on the remaining 2 WTE Consultants	1.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2196	Risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal)	1.2
2755	There would be a risk to the delivery of high quality services for Children and Young People.	1.1 & 1.2
2741	The ability to maintain OFSTED ratio's as a result of staff availability/turnover Health and Safety concerns operating the nursery in its current position in the centre of a building development	

000222

BAF Risk 2.2 Employee Wellbeing (3x3=9)

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

Related Corporate Risk(s)

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

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000223

BAF Risk

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

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

3.4 Financial Environment (4x4=16)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2754	The Division of Surgery currently does not have a sustainable financial plan and is currently forecasting a year end deficit position.	1.1

000224

BAF Risk

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

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

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

000225

BAF Risk

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

Strategic Aim

Related Corporate Risk(s)

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

BAF Risk

4.2 Digital Strategic Development and Delivery

(4x4=16)

Related Corporate Risk(s)

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

000226

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Safety & Quality Assurance Commitee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

December 2022 - Nathan Askew
This risk has been updated based on feedback from SQAC and now should be aligned. Controls remain in place and progress has continued in relation to gaps in control, notably in increasing compliance with ABx administration

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

current position.
September 2022 - Nathan Askew this risk has been reviewed and appropriate assurance continues in place. Gaps in assurance are progressing and actions are on track
August 2022 - Nathan Askew the risk has been reviewed and the assurance processes remain valid and in place. The three areas of gaps in assurance remain but the work to improve these is currently under review and are actively being monitored through the patient safety board. No additional gaps in control have been identified
July 2022 - Nathan Askew the risk has been reviewed and the assurance processes remain valid and in place. The three areas of gaps in assurance remain but the work to improve these is currently under review and are actively being monitored through the patient safety board. No additional gaps in control have been identified

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Children and young people waiting beyond the national standard to access planned care and urgent care		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 2233, 2383, 2597, 1902, 2501, 2501, 2463, 2517		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 4x5	Target IxL: 3x3	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Urgent Care Improvement Group overseeing several improvement workstreams: PLACE - GP streaming relocation to OPD - complete FUNDING - business case submitted for approval to increase nursing and decision makers - Complete SUPPORT - external company engaged to support GP stream - complete; funding for 22/23 requested via CCG - pending WORKFORCE - subject to funding workforce required including out of hours - pending CAPACITY & DEMAND - review of demand and capacity by stream - pending EXPANSION - urgent care village development to increase assessment capacity and capability - PAUD build 23/24 - pending	31/01/2023	Actions remain in progress, with exec oversight through the ED@Best programme
The following actions are being undertaken to improve the RTT performance: Expand the criteria of patients who can be booked onto a weekend list - ongoing External dentist given priority weekend lists - complete Recruit new honorary contract dentist - complete, mid-Sept 2022 Additional weekend capacity has been granted in May - complete Additional weekend capacity to be identified in June Increase number of complex patients planned per list - ongoing Allocate a Consultant Anesthetist on all dental lists - ongoing Consideration of temporary job plan changes to increase capacity - meeting scheduled w/c 23rd May Trial use of VR for older patients to avoid GA and increase productivity - started	20/01/2023	The insourcing company is currently going through the procurement process and will begin clinical activities in January 2023

Executive Leads Assessment

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

January 2023 - Adam Bateman
Over 1,800 C&YP were treated in December 2022 relative to December 2019. This level of demand is unprecedented and the proportion of patients treated within 4 hrs decreased. In response we mobilised acute respiratory infection clinics in collaboration with primary care. We opened an additional ED are for low acuity patients, and updated the symptom checker to include advice for families on Strep A (with c. 70,000 views in December).

In elective care we faced the headwinds of industrial action which reduced the number of patients we treated, and less additional activity is being undertaken as we negotiate the levels of pay for medical staff undertaking additional duties. The number of long wait patients is now plateaued, rather than reducing. Recovery (as measured by the number of patients treated) for outpatients was strong at 112%, with elective care reduced to 98%.

In order to support the elective recovery programme we have changed the rate of pay for additional work (although the effect of this on uptake is unclear as yet) and invested in agency staff in theatres.

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

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

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

000230

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

January 2023 - Graeme Dixon
Weekly meetings with the SPV, LOR & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. There has been some notable recent success in getting the gas combined heating & power unit into action, and remedial works to the chillers (now on course for completion in January 2023) with the temporary ones on the top level of the car park being now being removed mid-January to ensure resilience over the festive period. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipe work and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. P Co/Mitie are seeking a standstill agreement and details of the proposal are awaited.

December 2022 - Graeme Dixon
The majority of historical defects are now resolved. There has been some notable recent success in getting the gas combined heating & power unit into action, and remedial works to the chillers (now on course for completion in January 2023) with the temporary ones on the top level of the car park being removed mid-December. Both of which are supporting energy efficiency and cost control. Nonetheless, there are two unresolved historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues were discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. A commercial discussion is open in relation to the number of service failure points accrued.

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

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	01/02/2023	Date extended due to supplier issues
Actions from mental health workforce plan to be delivered which includes: -Improving workforce availability rate to >90% -Task & Finish group with aim to increase headcount of external staff through marketing of services and the organisation and enhancing job roles and adverts -Delivery of staff wellbeing schemes -Staff retention to be improved through review of job plans and education/training opportunities	28/04/2023	Job description task and finish group arranged regarding job roles/descriptions. Continue to meet with Cheshire & Merseyside group (workforce survey)

Executive Leads Assessment

January 2023 - Lisa Cooper
Risk reviewed and action relating to waiting lists and validation completed

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	28/02/2023	as above
3. Development of a methodology to roll-out across the organisation.	30/04/2023	Project plan on track
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	01/03/2023	Attraction and Retention Project identified as key project for 22/23

Board Assurance Framework 2022-23

Executive Leads Assessment
January 2023 - Sharon Owen Risk reviewed and action remain on track - risk score remains high
November 2022 - Sharon Owen Risk is escalated and discussed at board, PAWC and through divisional management as staff availability continues to pose considerable risk. Industrial action now confirmed for some staff and this is managed through tactical command.
October 2022 - Sharon Owen Risk reviewed - no in month change to risk score. Actions are on track. The focus of availability remains sickness and turnover.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

Board Assurance Framework 2022-23

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way
3. Rising demand for SALS support and permanent resource not yet in place to ensure sustainability of provision for staff
4. Increase in self-reported rates of burnout and work-related stress as assessed via 2021 Staff Survey and consistent with national picture for NHS staff
5. Lack of private space to support staff and wellbeing activities
6. Likely psychological impacts on staff in the event of industrial action

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	28/02/2023	SALS booth ordered. Awaiting delivery. No further update re staff container space. Will seek update at next HWB Steering group.
Business case in development and now awaiting opportunity to present at appropriate forum whilst SALS also seeking external funding sources and opportunities for income generation to assist with current cost pressures.	28/02/2023	Discussion with finance confirming that business case to be considered as part of annual planning process to be concluded end March 2023. Meeting arranged to set budget with finance and to review any non-recurrent monies available to add additional temporary capacity into SALS in the short term
Mental Health training for line managers ("Strengthening Others") being developed by SALS/OD to be rolled out to all leaders and managers as a module of Strong Foundations and as stand-alone training available to all via recorded presentation and monthly drop ins run by SALS	31/01/2023	Training now complete and due to be launched to whole organisation via comms on Monday 16th January
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	28/02/2023	Debrief guide still in draft form. To be further developed and finalised by end Feb. Guide to be aligned with guidance also developed by Emergency Preparedness and Response lead via a meeting with him in January.

Executive Leads Assessment

January 2023 - Jo Potier
Risk reviewed and actions updated to reflect December activity. No change to risk rating.

December 2022 - Jo Potier
Risk reviewed and new controls added to reflect increased support to staff during industrial action and increased support to ED during additional significant pressures. Actions reviewed and updated. No change to risk rating.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Executive Leads Assessment

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

January 2023 - Melissa Swindell
Actions closed and risk reviewed.

November 2022 - Melissa Swindell
risk reviewed, action updated

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Create a plan to fix drainage from Phase 1/Agree plan for Phase 2/3	28/02/2023	Awaiting Laboratory results on soil samples
Set up Joint Planning meeting with community	31/03/2023	Team appointing a community liaison officer.

Executive Leads Assessment

January 2023 - David Powell
End of Year Review

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

November 2022 - David Powell
Prior to November Board

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver	Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached)
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey
Capacity Plan identifies beds and theatres required to deliver BD plan	Daily activity tracker and forecast monitoring performance for all activity.
Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board.
Internal review of service specification as part of Specialist Commissioning review	Compliance with final national specifications
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly). Partnership update & refresh of North West Paediatric Partnership Board schedule and arrangements undertaken Feb 22 Sept 22 - NWPPB Chairs Report to Trust Board attached
'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019 2030 Vision development underway with Trust Board - will succeed Our Plan once approved in early 23/24
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board
Gap / risk analysis against all draft national service specification undertaken and action plans developed	Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance
Involvement of Trust Executives in partnership governance arrangements	ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year)
Implementation of the 'Healthy Children and Families' partnership group for One Liverpool.SRO Dani Jones jointly with Melisa Campbell LCC PH confirmed.	
C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan	C&M C&YP Recovery Plan Narrative
One Liverpool - Provider Alliance action plan	Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities.
C&M "Beyond" Children's Transformation Programme - AH host and lead for C&M	Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) 4.10.21 - C&M CYP Programme now in full flight & progressing positively. New system initiatives re: THRIVE MH model & Obesity underway; LD / Autism & Respiratory in planning. Recruitment to CYP team underway. 9.11.21 - Presentation to ICS (HCP) Board - successful. Confirmation of funding for Y2 of programme received. 25.11.21 - Presentation of programme to Alder Hey Board. Fully endorsed.

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

January 2023 - Dani Jones
Risk reviewed; no change to score in month. Key progress in Vision 2030 development and C&M CYP / Beyond. Controls, actions and evidence reviewed.

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
4. Long Term Financial Plan	31/03/2023	This work is now included as part of the optimisation work underway and originally expected Dec but due to issues outside of our control, now expected February. Annual planning and budget setting is due to be complete end of January and this will include a full bridge and detail of WTE/Activity and £ to inform the overall trust plan.
2. Five Year capital plan	31/03/2023	Awaiting confirmation of CDEL for 23/24 and 24/25 following release of national planning guidance. Capital planning underway as part of Trust 23/24 annual planning process. Capital management group to be held early feb to review requests against expected CDEL and to present to TB in Feb.
1. Monitor closely impact of inflation increases 2. Ensure procurement processes followed to obtain value for money 3. Regular reporting to strategic execs and assurance to RABD and Trust Board	31/03/2023	Gap in control and actions added

Executive Leads Assessment

January 2023 - Rachel Lea
Risk reviewed. Updated action plans and control measures to reflect current position following release of the national planning guidance and expected completion dates.

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

Board Assurance Framework 2022-23

November 2022 - Rachel Lea BAF risk reviewed, and score remains at 16 due to the uncertainty of the financial landscape going into 23/24 and beyond. Planning is underway both internally and across C&M for 23/24 and will feed into the ongoing financial risk.
October 2022 - Rachel Lea Risk reviewed and actions updated with latest progress. Risk score remains at 16 due to current uncertainty in future years. Work is underway as detailed in the actions.
September 2022 - Rachel Lea Risk reviewed and actions updated. Current risk score maintained at 16 to reflect the latest forecast for 22/23 and emerging risks with regards to inflation and other costs pressures.

Board Assurance Framework 2022-23

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

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

Board Assurance Framework 2022-23

Uncertainty over future commissioning intentions (see BAF 3.4 re finance
Future delegation of Specialist Commissioned services into ICSs - shadow arrangements under definition

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	31/03/2023	Continuous monitoring, influencing and relationship building ongoing ICS-wide - contributing to the C&M HCP strategy, building the Beyond programme, Alder Hey representation at all possible C&M groups.
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of proposed population need based allocation formula (not yet shared)	31/03/2023	As above entry 7.9.22

Executive Leads Assessment

January 2023 - Dani Jones
Risk reviewed; no change to score in month. Developing proposal for ICB CYP Board - TBC. Controls and actions reviewed.

December 2022 - Dani Jones
Risk reviewed; no change to score in month. Controls actions and evidence updated. Significant ongoing engagement in the developing ICS at multiple levels.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

Sign up from further partners to engage in PQAR - in development (dependent on both parties subscribing)

Executive Leads Assessment

January 2023 - Dani Jones
Risk reviewed; no change to score in month - but this will move based on signfiicant assurance in MIAA audit and subsequent recommendations/actions. Evidence, controls and actions updated

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

Executive Leads Assessment

January 2023 - Claire Liddy
review Jan 23. no change to risk score but note the new corporate risk of financial sustainability

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

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of Alder Care Programme	30/06/2023	Programme review complete, new go live date to be agreed in 2023
Recruitment linked to new iDigital operating model underway Maximising opportunities of collaboration	03/04/2023	Recruitment of perm positions to senior management team complete. Recruitment and retention plans in progress
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development
1. Proposed change freeze of all digital programmes from April particularly in the context of preparation for Aldercare go live 2. Review of all other programmes with implementation to be achieved before April	28/02/2023	Change freeze proposal in development, review of programmes to be initiated

Executive Leads Assessment

January 2023 - Kate Warriner
BAF reviewed. Score remains appropriate. Progress with recruitment of permanent positions within iDigital Senior Management Team. Recruitment and retention focus in place. Work ongoing regarding timing of key programmes in 2023.

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

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

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

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 26th January 2023

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

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 12th of January 2023, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 10th November 2022.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Update on the implementation of actions arising from the IT Hardware Asset report (produced following the theft of Trust iPads)
- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register and Trust Risk Register Report
- Presentation of risk management processes within Surgery
- Internal Audit Plan for 23/24 (Approved)
- HFMA Financial Sustainability Report
- Internal Audit Progress and Follow Up Reports
- Anti-Fraud Progress Report
- ARC Workplan
- Risk Assessment Policy (ratified)

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

None

4. Positive highlights of note

- IM&T advised that the majority of the recommendations raised within the IT Hardware Asset Report have been implemented. ARC have asked MIAA to independently confirm this to the next meeting given the number and priority of the recommendations.
- All Trusts were mandated to undertake a detailed financial sustainability assessment and report the outcome to the Centre, including any actions required where weaknesses were identified. MIAA was also mandated to undertake an independent review of the supporting information of 12 key questions. Two minor recommendations only were raised by MIAA which management confirmed have been actioned.

5. Issues for other committees

During review of BAF risk 3.2 we discussed the gap in assurance relating to service derogations and asked which assurance committee had oversight of these. Whilst RABD receives some reporting on derogations it was advised that bringing together the details of all derogations into one paper to present to RABD periodically would be an enhancement to the current reporting.

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 10th November 2022**
Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Ms. J. Revill	Non-Executive Director	(JR)
In Attendance:	Mr G Baines	Regional Assurance Director, MIAA	(GB)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Mrs R Lea	Deputy Director of Finance	(RL)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Miss. J. Preece	Governance Manager	(JP)
	Ms. J. Rooney	Assoc. Director of Nursing and Governance	(JR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr. D. Spiller	E&Y Accounts Manager	(DS)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Mr. J. Wilcox	Divisional Accountant	(JW)
Apologies:	Mr H Rohimun	Executive Director, Ernst and Young	(HR)

22/23/73 Introductions and Apologies

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

22/23/74 Declarations of Interest

There were none to declare.

22/23/75 Minutes from the Meeting held on the 15th September 2022
Resolved:
The minutes from the meeting that took place on the 15th of September were agreed as an accurate record of the meeting.

22/23/76 Matters Arising and Action Log

Matters Arising

It was confirmed that the Risk Management Strategy has been ratified.

Action Log

Action 20/21/57.1: *Internal Audit Progress Report (Non-Clinical Claims/Clinical Claims - Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* – It was confirmed that the outcome of this piece of work will be conducted in Q4 2022/23 and

submitted to the Audit and Risk Committee in Q1 of 2023/24. This item will be included on the work plan. **ACTION CLOSED**

Action 21/22/65.1: *Update on the Risk Management Process within the Division of Medicine (Exec Team to review the job description/remuneration for the Governance Lead role in order to support the retention of staff in this role)* – It was confirmed that a benchmarking exercise has been completed via the ACCN network, and currently the Trust's job descriptions/renumeration for the Divisional Governance Leads roles are in line with other paediatric trusts and governance roles in general. **ACTION CLOSED**

21/22/87.1: *Trust Risk Register Analysis (Conduct a piece of work to confirm that the information being reported in terms of zero/low risks by a number of areas across the Trust is correct. Divisional Leads to provide an update during January's Audit and Risk Committee*) – It was confirmed that work remains ongoing across the Divisions. Three services have been identified during monthly risk validation review meetings as having low/no risks (IPC, Research and Innovation) and are now reporting relevant risks on the risk register. **ACTION CLOSED**

21/22/87.2: *Trust Risk Register Analysis (Look at a governance reporting structure for the risks of services that sit under the remit of an Executive Lead rather than within a Division)* – It was confirmed that the Corporate Services Collaborative is meeting on a regular basis to discuss the risks/metrics of the twelve Corporate services collectively and a mechanism is to be implemented to enable the Collaborative to feed into the RMF. The Audit and Risk Committee will receive updates on this area of work via the RMF and an update will be provided on the outcome of the Corporate Performance Review in due course.
ACTION CLOSED

Action 22/23/13.1: *Internal Audit Follow Up Report (Project Management Review - RL to liaise with the Development Team to see if the overdue recommendations can be implemented within the next three months with an update to be provided to the June meeting)* **-** It was confirmed that this action can be closed as a result of the detail in the Internal Follow-up Report. **ACTION CLOSED**

Action 22/23/15.1: *Counter Fraud Annual Report 2021/22 (Provide an update on the work that has taken place to progress the Fraud Champion's role)* – The Trust is in the process of appointing a new Fraud Champion (FC) due to the role becoming vacant.
ACTION TO REMAIN OPEN

Action 22/23/27.1: *Waiver Activity Report (Include Waivers that haven't been approved in future reports)* – This action will be discussed during agenda item 22/23/84.
ACTION CLOSED

Action 22/23/35.2: *Internal Audit Follow Up Report (Provide an update on future plans for addressing Consultant Job Planning actions)* – Erica Saunders agreed to liaise with the Medical Director on 1. Whether penalties are to be included in the policy in the event job plans aren't completed and 2. Discuss other processes that can be implemented to ensure job plans are completed. Once the policy has been amended it will be shared with the LNC for re-approval. **ACTION TO REMAIN OPEN**

Action 22/23/49.1: *Trust Risk Management Report (Trend be included in future Trust Risk Management reports to show the progress that is being made with the 25 long standing*

high moderate risks) – (RMF). Jackie Rooney advised that she is currently reviewing the Trust Risk Management Report in this regard. **ACTION TO REMAIN OPEN**

Action 22/23/59.1: *Risk Management Strategy Policy (Following amendments, circulate the Risk Management Strategy Policy to the Committee for virtual approval)* – This action has been addressed. **ACTION CLOSED**

Action 22/23/59.2: *Board Assurance Framework (BAF)/CRR (Review the risks in the BAF that don't have corporate risks linked to them, using a tactical/operational risk lens)* – An exercise has been conducted and it was found that the majority of corporate risks were scored appropriately. There are a small number of risks that could potentially be escalated therefore a discussion will take place with the respective owners to see if these risks need to be incorporated on the CRR. **ACTION CLOSED**

Action 22/23/59.3: *CRR (Confirm as to whether the CRR report can identify the two different types of risks on the CRR (short-term v long-term)* – The Chair agreed to discuss this action with Jackie Rooney outside of the meeting. **ACTION CLOSED**

Action 22/23/59.4: *CRR: Staffing Levels Risk (Liaise with Melissa Swindell to 1. Discuss the benefits of having risk 2100 on the CRR, taking into account the similar risk that has been included on the BAF/individual team risk registers. 2. Discuss the way in which risk 2100 is worded)* – This action links into a wider piece of work following a request from the People and Wellbeing Committee. Work will take place to look at the overall workforce risks from a strategic perspective in terms of the linkages between the three stand-alone BAF risks and will factor risk 2100 which is included on the CRR. It was agreed to close this risk on the basis that a decision on risk 2100 will made via the work that is taking place. **ACTION CLOSED**

Action 22/23/60.1: *Update on the Risk Management Process within the Division of Medicine (Discuss the possibility of having a risk item on all agendas to ensure that risk is discussed at each meeting across the Divisions thus becoming business as usual for all)* – A monthly meeting has been established with the Divisional Governance Leads and another with the Associate Chief Nurses to discuss various items. A request has been made to share good practice across the Divisions and work is also taking place on standardisation whilst being mindful that similarities reach each of the Divisions. **ACTION CLOSED**

Action: 22/23/60.2: *Update on the Risk Management Process within the Division of Medicine (Discuss using the Brilliant Basics methodology to trial the use of huddle boards in potential areas in the Division of Medicine based on three top risks and a weekly check in)* – It was reported that the Division of Medicine is trialling the 'ED at its Best' programme in terms of using the huddle process to address the Division's risks. John Grinnell agreed to liaise with Cathy Wardell and provide an update on the outcome of the pilot. **ACTION TO REMAIN OPEN**

Action: 22/23/61.1: *Internal Audit Progress Report (DPST Review - 1. Confirm as to whether the two non-compliant actions relate to 2021/22 or whether they are new actions as a result of a change in standards. 2. Confirm the process for overseeing the action plans for the two non-compliant actions)* – It was confirmed that the two non-compliant actions are new as a result of the change in standards, and that the MIAA Technology team will be liaising with the Trust to follow-up on this area of work. **ACTION CLOSED**

Action 22/23/61.3: *Internal Audit Progress Report* (*EPR Upgrade - Review the remit of the Audit and Risk Committee and RABD, taking into account that RABD has been monitoring the progress of the EPR project, to look at a way of enabling the Audit and Risk Committee to receive updates/assurance on the implementation of the upgrade*) – It was confirmed that each of the sub-committees receive an assurance report on transformation projects that are relevant to themselves; with EPR being specific to RABD. The Board also receives an overview of the organisation's main projects. Taking all of this into account, it was felt that the Audit and Risk Committee receives the appropriate assurance on the Trust's project management process through the commissioning audits of project management processes and DMO oversight and reporting of projects. **ACTION CLOSED**

Action 22/23/62.1: *Internal Audit Follow-up Report (Exec team to be made aware of the issue relating to recommendations/actions not being fully implemented within agreed timeframes. Management to provide a substantive response in terms of agreeing a pragmatic approach for 1. A general principle that requesting an extension should only be as a result of exceptional circumstances. 2. Applying this principle to address the consultant job planning actions that are outstanding)* – It was confirmed that this action has been addressed and will be monitored going forward. **ACTION CLOSED**

Action 22/23/62.2: *Internal Audit Follow-up Report (Discuss the reinstatement of the internal process used for monitoring follow-up recommendations)* - It was confirmed that this process has been reinstated and is discussed at Exec Team meetings on a regular basis. **ACTION CLOSED**

Action 22/23/64.1: *Internal Audit Junior Doctor Proposal (Circulate a high level scope to members to provide further information on the reasons for requesting a Trust wide assurance review of the process used for bringing junior doctors into the organisation, to enable the Committee to make an informed decision in terms of approving the request)* - A discussion will take place outside of the meeting to review the draft scope that was circulated on the 9.11.22 and agree as to whether the audit will go ahead. **ACTION TO REMAIN OPEN**

Action 22/23/68.1: *Emergency Preparedness Resilience and Response (EPPR) Annual Assurance Report (Confirm the date when the last EPRR audit took place)* – It has been more than five years since an EPRR audit has been conducted, therefore MIAA has agreed to consider this area of work when planning future audits to ensure it has been risk assessed appropriately. **ACTION CLOSED**

22/23/77 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF as at the 30.9.22. The following points were highlighted:

- The Committee was informed that the risks on the BAF have been scrutinised by the respective Assurance Committees.
- BAF risk 2.1 *(Workforce Sustainability and Development)* - It was reported that the People and Wellbeing Committee is focussing on staff retention/turnover via a top level piece of assurance work. This issue is also being discussed in a number of forums in order to think about the actions that the Trust needs to take to address this matter.

- The Committee was advised of the deep dive into BAF risk 1.1 (*inability to deliver safe and high-quality services)* that took place during October's Safety and Quality Assurance Committee, and the scrutiny that is taking place in appropriate places in terms of the financial environment. With regards to external risks there is a predominant focus at Board. Attention was drawn to a new issue relating to financial protocol that the Centre has just published which will feature in future iterations of the BAF.
- It was reported that the BAF has been submitted to the RMF to make colleagues aware of the organisation's strategic risks to ensure that linkages are being made in documents in terms of operational and strategic risks.

A discussion took place on the static nature of the scores in the BAF. Jo Revill felt that as a new NED it would be beneficial to be able to see the increase/decrease of risk scores in the report on a monthly basis. It was pointed out that there is less volatility and movement in the BAF risk scores due to the strategic nature of the document. The Committee was advised that risk owners review their respective risks on a monthly basis along with the likelihood score.

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 30.9.22.

22/23/78 Risk Management Forum (RFM) Update; including Corporate Risk Register, Trust Risk Management Report and approved minutes from the last meeting of the RMF

The Committee received an overview of the RMF that took place on the 25th of October 2022. The Chair of the RMF advised that the level of engagement was good from colleagues across the Divisions/departments and reported that a number of new risks are to be included on the risk register going forward as a result of the current environment. It was felt that the necessary amount of time/attention was given to areas of concern during the meeting, including the BAF, the Trust Risk Report, the Corporate Risk Register (CRR) and issues highlighted by the Divisions/reports from other services.

Corporate Risk Register

The Committee received the CRR for the reporting period from the 1.8.22 to the 30.9.22. The following points were raised:

- There are a total of twenty high risks that are open on the CRR.
- It was reported that one new risk with a score of 16 has been included on the CRR. This relates to the Haematology Service - Reference 2684 *(unable to deliver a high quality elective paediatric haematology service).*
- The risk ranking of risk 2196 has been increased. This relates to CAMHS *(risk of deteriorating wellbeing and behaviours in children and young people with severe learning disability (non-verbal) caused by insufficient number of clinicians appropriately trained in working with children and young people with severe learning disability (non-verbal) with experience of Positive Behavioural Support, resulting in service users not getting assessment and intervention in a timely manner).*
- The Committee was advised that four risks have been closed/removed and there are four high risks with a decreased risk score.

- It was reported that the Trust is in the process of procuring a new risk management system. Once the new system is in place, the Governance Team will conduct a piece of work with the Divisions around the wording of risks to ensure risks are articulated in a much improved way.

The Chair referred to risk 2589 (*Inability to safely staff Catkin and Community Clinics due to historical working patterns and workforce establishment which does not allow flexibility within the team to cover gaps in the rota due to short term sickness, annual leave or increased clinically activity*) and queried the long term plan to address this risk. The Committee was advised that a business case was approved on the 10.11.22 for staffing arrangements at the Catkin and outpatient clinics in the community.

Attention was drawn to risk 2650 *(Theatres Day Case Recovery - Unable to reprocess endoscopes, delay in treatment due to list/procedure cancellations, endoscopes not available for emergency procedures*) and it was queried as to whether this risk should be left open until the new equipment is in situ. It was reported that the risk has reduced as a result of having an on-site second endoscope decontamination unit, but it was felt that the risk owner should review the risk to determine whether it should be closed ahead of receiving the replacement system. Jackie Rooney agreed to liaise with the risk owner.

22/23/78.1 **Action: JRO**

Trust Risk Management Report

The Committee received the Trust Risk Management Report for the reporting period from the 1.8.22 to the 30.9.22. The following points were raised:

- There are 301 risks on the Trust Risk Register with 66% of those risks accounting for a moderate score.
- The top 5 risk categories are clinical, staffing levels, HR, IM&T, finance and governance.
- It was reported that there were 30 new risks identified in the reporting period, 36 closed, 5 with an increased score and 25 with a decreased score.
- In terms of next steps, work will continue with risk owners/Divisions to cleanse their risk registers and challenge likelihood scores. A review is also ongoing in terms of reviewing long standing moderate risks (12+) that have been on the risk register for over 12 months. These risks are reviewed on a monthly basis with the risk owners which has resulted in five longstanding high moderate risk scores being reduced in this reporting period and one risk being closed.
- The Committee was advised that evidence is used from other aspects of work, e.g. Quality Assurance Rounds to support risk management across the Trust. As a result of this it has been identified that a number of services have risks that aren't included on the register and some have risks that have been ranked too high which will be challenged via the RMF.

The Chair drew attention to the narrative in the report which states that the risk profile excludes network risks and queried as to whether these risks should be included on the Trust Risk Register in order to monitor them. The Chair was provided with an explanation of the assurance that is required by the Trust in terms of the risks that relate to the clinical networks hosted by the Trust and the partnerships that have been established. It was pointed out that the Trust has a stake in the governance of the of the networks/partnerships and therefore requires assurance in terms of their risks. Following

discussion it was agreed to look at incorporating the respective risks in January's Trust Risk Management Report.
Action: JR

The Chair pointed out that the Internal Audit recommendation for monitoring overdue risks and risks without a plan has been closed due to having processes in place to oversee this area of work. It was felt that the Trust is starting to see a slight improvement in terms of overdue risks but the level of overdue risks without an action plan is still much higher than it should be. It was reported that the data in the report is a snapshot from two months ago and as of the 10.11.22 there is nothing overdue in relation to the 19 high risks that the Trust has.

Following a request by Garth Dallas, background information was provided along with an update on the mitigations that have taken place to address risk 2548 *('unable to provide the clinical records in the required timescales - Breech of GDPR /Court and Police timescales' caused by an increase in access to health records requests)*. It was reported that a deep dive took place on this risk during October's RMF and the Committee was advised of the recovery work that has been conducted to reduce the backlog of requests and systematise the prioritisation process. It was confirmed that progress is being made and this area of work is heading towards a trajectory for recovery. Work is also taking place to look at having an automated system in order to streamline/accelerate the process to address requests. Garth Dallas queried as to whether the Trust has seen an increase in requests over the last two years. It was reported that there has always been a large volume of requests but it is commensurate with the increase in safeguarding, family Court of Protection and family proceedings with looked after children.

Resolved:
The Audit and Risk Committee received and noted the RMF update, CRR, Trust Risk Management Report and the approved minutes from the meeting held on the 30.8.22.

22/23/79 Fire Arrangements for New Buildings – Catkin Centre and Sunflower House

The Committee received a report on the fire arrangements for the new Catkin Centre and Sunflower House. A summary of the key risks/issues was provided along with background information and the mitigations that were implemented following a rigorous process, that was led by a qualified Fire Consultant, which included a full consultation with Merseyside Fire and Rescue Service (MFRS), Building Control and the Trust's Fire Team.

On the 17.10.22 the Trust received a letter from MFRS asking for their concerns to be placed on record about the lack of sprinkler provision to the car park underneath the new buildings. The Committee was assured that the Trust is compliant with fire safety regulations and was advised that a building control assessment took place to confirm that the Trust's infrastructure and evacuation procedures are safe and in line with guidance. Following receipt of the letter from MFRS it was agreed to seek a further independent review, which is underway with a target completion date of the 25th of November 2022. The findings will be reviewed by the Development and Fire Teams and shared with MFRS, with any recommendations actioned to support the findings.

Questions were raised by Garth Dallas and Jo Revill respectively about whether the cost of installing a sprinkler system is an issue and whether it could be fitted retrospectively. The Committee was advised that the independent assessments that were previously

carried out suggested that this type of system is not required and that the Trust's evacuation plan was adequate based on the design of the building. There is also an element about how public money is spent, but given the strength of the letter that was received it was felt that the proportionate response was to acquire a further independent assessment to see if it is consistent with the advice that has already been received, and whether the outcome of the assessment indicates that the Trust should invest in the sprinkler system.

In terms of fitting a sprinkler system retrospectively, it was pointed out that this is a possibility but a collective review of the assessments/advice would have to be conducted to determine as to whether it would make a significant enough mitigation to warrant the additional capital monies that would be required to install the system.

The Chair pointed out that the mitigations in place seem sufficient but was unable to assess their appropriateness without seeing the correspondence from MFRS. The Chair felt that conducting an independent review was the right thing to do in order to provide an informed response to MFRS. Following discussion, it was agreed to share the correspondence from MFRS with the Committee and provide an update on the outcome of the independent assessment during January's meeting.

22/23/79.1 Action: AB
22/23/79.2 Action: AB

22/23/80 Internal Audit Progress Report

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

- One review has been finalised during the reporting period and received a high assurance opinion; Mortality and Morbidity.
- One review is currently in the draft report stage; Data Quality.
- There are three reviews in the field work stage; Partnership Governance, Improving NHS Financial Sustainability and Cyber Review (*Medical Devices*).
- There are three reviews at the planning stage; Assurance Framework, Junior Doctors (*non-consultant spend*) and Workforce Planning.

It was reported that MIAA has received a request to defer Workforce Planning to 2023/24 and replace it with an ESR Payroll Review. The Chair advised that the initial Workforce Planning Review should have taken place in 2021/22 but was deferred due to a high priority issue relating to recruitment processes within HR. The Chair informed the Committee that Workforce Planning is a key process for the Trust and therefore didn't feel that it was appropriate to defer this review again.

It was confirmed that discussions have taken place with the Chief People Officer, MIAA and the Director of Corporate Affairs and it has been agreed to conduct the Workforce Planning audit in two parts; 1. To provide a current position statement. 2. To look forward in terms of the planned work and whether it covers all key expected aspects of workforce planning. It was felt that this would offer insight as to where the Trust is at in respect to workforce planning and offer assurance on forward plans. The Chair asked Committee members for their feedback on this matter.

John Grinnell drew attention to a piece of internal work that is due to commence on the workforce which is still in its design stage in terms of establishing an appropriate approach to workforce planning in the organisation's current environment. It was felt that in order to get to the heart of some of the workforce issues the audit needs to be impactful/ meaningful to get the most out of it and it was pointed out that using a template will not achieve this type of outcome. John Grinnell confirmed his support of the audit but asked that it be done in a way that joins up the design and the planning process of the audit.

Committee members agreed that workforce planning is a high priority area, and that the scope for the audit needs to be thought about carefully to ensure the review adds value. It was concurred that the scope should be of a bespoke design therefore the Chair requested that a small group come together to relook at the scope and agree a way forward. The group is to include the Chair, John Grinnell, Erica Saunders, Kath Stott and Melissa Swindell.

22/23/80.1 Action: KMC

The Chair referred to the Mortality and Morbidity Review that received high assurance from MIAA and asked that the Committee recognise this fabulous outcome and that thanks be relayed to the team involved in this work.

22/23/80.2 Action: ABASS

The Chair advised that potentially the Committee may receive seven audit reports during January's meeting whereas this meeting has received few. It was pointed out that traditionally MIAA provide audit updates on a quarterly basis but that doesn't always fit in with scheduled Audit and Risk Committee meetings. When compiling the 2023/24 Internal Audit Plan, MIAA have confirmed that they will provide a schedule confirming at which ARC meeting the Committee can expect to see the outcome of specified audits. This will enable the Committee to identify any deviations.

22/23/80.3 Action: KS

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

22/23/81 Internal Audit Follow-up Report

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

- Of the 9 recommendations that have fallen due in the reporting period; 5 have been implemented, 1 was superseded and 3 relating to the Consultant Job Planning Review are still partially implemented with approval requested from the Audit and Risk Committee for extensions.

The Chair reflected upon the partially implemented recommendations from the Consultant Job Planning Review and felt that recommendation 5 should be classed as implemented due to the actual thrust of the recommendation being implemented in an alternative way; the process relating to personal objectives has changed and they are now included in the appraisal process rather than being in the job plan.

It was pointed out that the recommendations date back to 2018 but a lot of traction has taken place since the Director of Medicine, Urmi Das, took over as the lead for this area of work in 2020. Following discussion it was agreed to extend the deadlines as requested and invite Urmi Das to April's meeting to receive an update on progress.

22/23/81.1 Action: KMC

The Chair referred to recommendation 3 *(post project assessments/benefits realisation exercises on all projects)* and advised that following a discussion with MIAA it has been agreed to amend this recommendation to partially implemented and extend the deadline to the 30.6.23 to enable the developed process to be put into practice. The Chair queried as to whether the developed process could be used to conduct a post project assessment on the new Sunflower and Catkin buildings during Q4 2022/23. Rachel Lea confirmed that a post project assessment could take place on the new buildings during Q4 2022/23 or Q1 2023/24.

22/23/81.2 Action: KS/RL

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

22/23/82 External Audit General Update

It was reported that a call has been scheduled for December to discuss the commencement of the planning stage for the 2022/23 audit and the data that will be required. The Committee was advised that the timetable is yet to be determined by the Centre but, once agreed, dates will be advised to the Audit and Risk Committee in line with the reporting timetable for the final accounts visit in May 2023.

Resolved:
The Audit and Risk Committee noted the update.

22/23/83 Progress against actions from the Audit and Risk Committee Self-Assessment

The Committee received an update on the current status of the progress against actions arising from the 2022 Audit and Risk Committee self-assessment exercise. It was confirmed that the majority of the remaining actions detailed in the report are dependent on future processes due to be undertaken in the second half of 2022/23 or during Q1 of 2023/24.

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

22/23/84 Waiver Activity Report

The Committee received a report that set out the activity in relation to approved waiver requests during the period from the 1st of April 2021 to the 31st of October 2022. The following points were highlighted:

- There were 32 waivers approved during the reporting period with a value of £1.1m. It was confirmed that this is a slightly lower value compared to the previous year.
- The Procurement team continues to challenge and reject any waivers that do not meet the waiver criteria following the implementation of a new form and process

for waivers. As a result of the new process, five waivers have been rejected on these grounds since the 1st of April 2022. The Committee was advised that additional information will be included in future reports on the reasons as to why waivers have been rejected.

The Chair asked as to whether an appendix could be included in the report to provide details of the approved and rejected waivers. It was confirmed that this information was embedded in the cover sheet of the report but will be circulated separately.

22/23/84.1 Action: RL

The Chair queried the reason for the lack of a reduction in waivers during the reporting period as there had been a significant increase in the number of waivers during COVID, particularly relating to PPE and therefore it was expected that the number would reduce to pre-COVID levels. The Committee was advised that analysis will need to take place to drill down and establish the reasons/themes for this. Following discussion, it was agreed to provide additional information in future reports for context purposes and include two line graphs (number/value) in order to track figures.

22/23/84.2 Action: RL

22/23/85 Any Other Business

There was none to discuss.

22/23/86 Meeting Review

The Chair confirmed that an update will be provided to the Board to advise of the independent review that is taking place following receipt of the letter from MFRS which raises concerns about the lack of sprinkler provision to the car park underneath the new buildings.

Date and Time of the Next Meeting: Thursday 12th January 2022, 2:00pm-5:00pm, LIP.