Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 27th October 2022, commencing at 9:45am

Lecture Theatre 4, Institute in the Park, Alder Hey

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Staff Story (9:45-10:00)							
1.	**22/23/167**	**10:00 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/168**	**10:01 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/169**	**10:02 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **29th of September 2022.**	**D**	Read enclosures
4.	**22/23/170**	**10:05 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/171**	**10:10 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**22/23/172**	**10:20 (55 mins)**	**Integrated Performance Report - Overview; including:**	K. Warriner/ A Bateman	For information.	**N**	Read report
			• **Integrated Performance Report for M6 and Q2 stocktake.**	Exec Leads/ Divisional Leads	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues.	**A**	Read report
			• **Transformation Programme Governance Report.**	N. Palin	To provide assurance.	**A**	Read report
			• **Digital, Data and Information Technology update.**	K. Warriner	To receive an update on the current position.	**A**	Read report
			• **New NHS England Operating Framework.**	L. Shepherd	For information.	**N**	Verbal

Alder Hey Children's NHS Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Strategic Update							
7.	**22/23/173**	**11:15 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	D. Powell	To provide an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	**22/23/174**	**11:25 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
9.	**22/23/175**	**11:30 (10 mins)**	**Safeguarding Our Children, Young People and Families Against Failings in Care.**	N. Askew	To provide assurance to the Board.	**A**	Read report
Game Changing Research and Innovation							
10.	**22/23/176**	**11:40 (10 mins)**	**Research and Innovation Committee - Terms of Reference.**	J. Chester/ E. Saunders	To receive and approve the Terms of Reference for the Research and Innovation Committee.	**D**	Read report
Sustainability through External Partnerships							
11.	**22/23/177**	**11:50 (10 mins)**	**Sefton Place Partnership Agreement.**	D. Jones	For approval.	**D**	Read report
The Best People Doing Their Best Work							
12.	**22/23/178**	**12:00 (10 mins)**	• **Workforce Disability Equality Standard (WDES) Report, 2022.** • **Workforce Race Equality Standard (WRES) Report, 2022.**	E. Saunders E. Saunders	To receive and note the WDES report, 2021. To receive and note the WRES report, 2021.	**A** **A**	Read report Read report
13.	**22/23/179**	**12:10 (10 mins)**	**Freedom to Speak Up - Update.**	K. Turner/ G. Foden	To receive an update on the current position.	**A**	Read report
14.	**22/23/180**	**12:20 (10 mins)**	**Freedom to Speak Up Review Tool for NHS Trusts and**	E. Saunders	To receive an update on the current position and introduce the new tool kit.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Foundation Trusts – Half Year Update.				
Lunch (12:30-12:50)							
Strong Foundations (Board Assurance)							
15.	**22/23/181**	**12:50 (15 mins)**	**Financial Update for M6, 2022/23.**	R. Lea	To receive an update on the current position.	**A**	Presentation
16.	**22/23/182**	**13:05 (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
17.	**22/23/183**	**13:10 (15 mins)**	**Board Assurance Committees; report by exception:** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 24.10.22.** - **Approved minutes from the meeting held on the 26.9.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 19.10.22.** - **Approved minutes from the meeting held on the 20.9.22.** • **Innovation Committee:** - **Chair's verbal update from the meeting that took place on the 10.10.22.** - **Approved minutes from**	I. Quinlan F. Beveridge S. Arora	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			the meeting held on the 8.8.22.				
Items for information							
18.	**22/23/184**	**13:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
19.	**22/23/185**	**13:29 (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 24th November 2022, 9:00am-2:30pm, Lecture Theatre 4, Institute in the Park, Alder Hey							

REGISTER OF TRUST SEAL
The Trust Seal was used in October
389: Telehealth Contract – Solis Healthcare

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Register of Shareholder Interests	R. Lea
Financial Metrics, M6, 2022/23	R. Lea
IPC Report	B. Larru
New NHS England Operating Framework	L. Shepherd

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 29th September 2022 at 11:00am**
Room 2 & 3, Liverpool Innovation Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. N. Askew	Chief Nurse	(NA)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. A. Bass	Acting Chief Medical Officer	(ABASS)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Dr. F. Marston	Non-Executive Director	(FM)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance:	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(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)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. D. Powell	Development Director	(DP)
	Mrs. E Rees	Executive Assistant (minutes)	(ER)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Staff Story:	Mr. C Dutton	Mental Health Practitioner	(CD)
22/23/134	Dr. B Larru	Director of Infection Prevention & Control	(BL)
Apologies:	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Dr. J. Chester	Director of Research and Innovation	(JC)

Staff Story

The Chair welcomed the Carl Dutton (Mental Health Practitioner for CAMHS) who had been invited to September's Board to provide an overview of the work with Children and Young People in the Forest School. Carl emphasised the therapeutic benefits to be gained from CYP interacting with nature. A number of slides were shared with the Board to provide the following information:

- A little about me
- Natures Health Benefits
- Feedback from the Children
- The future

The Chair thanked Carl for his inspirational talk and all the work helping young people to improve their mental health by getting involved in activities outside. It was suggested to link in

with Cllr Barbara Murray and the work with the governors for the hospital in bloom as well as the green programme for any children and young people wishing to volunteer.

22/23/129	**Welcome and Apologies** The Chair welcomed everyone to the meeting and noted the apologies received.
22/23/130	**Declarations of Interest** The Board noted the declaration received from Fiona Marston in relation to her association with the Liverpool School of Tropical Medicine.
22/23/131	**Minutes of the Previous Meeting** The minutes from the meetings held on the 28 July 2022 were agreed as an accurate record of the meeting.
22/23/132	**Matters Arising and Action Log** **Action 21/22/65.1:** *Approach to End of Life Care when there is a dispute (Provide a progress update on the Trust's process that supports end of life discussions and agreements)* – It was agreed to close the action and integrate it into discussions for lessons learnt. **ACTION CLOSED** **Action 22/23/82.1:** *Corporate Report (Medicine - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance*) - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during October's Trust Board. **ACTION TO REMAIN OPEN** **Action 22/23/87.1**: Board Assurance Committees. (SQAC - Look into the shared learning and support that is available across C&M, for example, Alder Hey has offered support to other trusts across the System with presentations of children with sepsis). It was agreed that this would be picked up via the ICB Quality Committee. **ACTION CLOSED** **Action 22/23/114.1:** Board Assurance Committees. (SQAC (Safeguarding Review) - Liaise with Lisa Cooper and Nathan Askew to agree as to whether the outcome of the Safeguarding Review should be shared with 'Beyond' as there are a number of important recommendations in the report that appertain to the wider system). The discussion had taken place. **ACTION CLOSED**
22/23/133	**Chair/CEOs Update** The Chair advised that she had recently attended the HCP Meeting, which was an Integrated Care Partnership with 9 Local Authorities. Louise Gittins, leader of the Cheshire West and Chester Council was nominated as the Chair and noted that she emphasised the need to focus on children and young people.

	The Chair advised that Louise Shepherd had given an excellent presentation at the Charity Board Strategy Day and the Charity were happy to offer support wherever they could, although they also had the same financial challenges and would be scrutinising cases. **Resolved:** The Board noted the Chair's and CEO's update.
22/23/134	**Operational Issues** **IPC** This item was covered under section 22/23/144.
	Operational Overview of Recovery, Q2 2022/23 The Board received an Executive Lead's update on the progress with Q2 priorities as set out within the Operational Plan for 2022/23, which was presented by Adam Bateman. The overall elective recovery performance in August was good at 103% for elective work. The value of the elective recovery fell to 96.5%, against the 104% target. This reduction in value was associated with the short-notice loss of theatre sessions due to a short-term rise in staff absence. There had been an increase in patients waiting over 52 weeks with the biggest challenge in dentistry, and a plan was in place to address this. Rate card issues were affecting clinicians committing to additional sessions. A full assurance report on the safe waiting list had been discussed in RABD which included updates on sleep studies and urodynamics. A national bid had been submitted via the CHA for a virtual ward to start in December to help mitigate any emergency surge during the Winter; feedback as to whether this had been successful was expected by the end of the week. Fiona Marston asked how the Trust was going to focus on staff wellbeing and Adam Bateman confirmed that a large part of the Winter Plan detailed the proposals for supporting staff. **Resolved:** The Board noted the operational overview of recovery for Q2.
	Forward Look for Winter 2022/23 The Board received an update on the Forward Look for Winter, which was presented by Adam Bateman. He advised that lots of modelling work and scenarios had been taking place and they were looking for a temporary extension to the Emergency Department to create a small facility with 4 consultation rooms for lower acuity patients. He added that this had been approved at the Executives meeting last week and would go live in December/January. He advised that the virtual ward was another key element along with the welfare offer to staff and vaccination programmes. He noted that they would be looking at the medical model which would include discharges, length of stay and repatriation but this wasn't included in the plan. Adrian Hughes asked about the regional picture and whether they would be escalating the structure to silver/gold. Adam Bateman confirmed that he had been in contact with the

	network and Cheshire and Merseyside would be kept on silver command; this would only escalate to gold if a Trust needed mutual aid. **Resolved:** The Board noted the Forward Look for Winter 2022/23.
	M4 Integrated Performance Report The Board received the M4 Integrated Performance Report for August and the Executive leads' fed back on their respective areas: Recovery – this had been presented in the operational update and noted the ED performance was 90%. Outstanding Safety – It was noted that the 25% reduction in harms target had remained static for the last 3 months and the data would be reviewed. The largest area of incident reporting was 'no harm and near miss' which would be reviewed. Garth Dallas asked about the ongoing issues with Sepsis. Nathan Askew advised that the sepsis steering group was being refreshed and an update would be provided at the SQAC meeting in October. Great Place to Work – The metric for >80% recommend as a place of work had 3 points of data which included a national pulse check and noted the response for this had been poor. The next data point for this would be the full Staff Survey. Staff turnover had increased over the last 2 years and Divisions were looking at the data to identify the hot spots with a focus on exit interviews. The Chair referred to the proposed tax changes and the impact on our senior clinicians. Melissa Swindell confirmed that the Trust was awaiting further details from the centre. Financial Sustainability – 8 metrics were being monitored which were in line with plans. The CIP target had been met but the majority of this was non-recurrent. The capital plan was slightly behind but still forecasting to achieve at year end. Safe Systems – A wider report was being presented on AlderC@are later on the agenda and noted that the metrics were in line with expectations and there were no areas of concern. *Surgery* There had been a gradual increase in medication errors; Surgery would be working with the Medicine Division to look at training, education and awareness. PALS and Complaints were being responded to within the national timeframes and the recovery plan was in line with the Winter Plan. There had been an increase in high value cases and the waiting list had also increased and would be reviewing individual pathways. Louise Shepherd noted that there had been an increase in referrals across the country and we needed to think about a forward plan. The North West Paediatric Board were looking at how trusts worked together across the patch. Adam Bateman advised that the waiting list growth over the last 6 months was 24% and this included some challenging specialties. Alfie Bass stated that the adult hospitals didn't fully appreciate the increase as children and young people

	didn't have a co-originated focus and trying to identify someone to discuss the issues with was the biggest challenge. The Chair asked that if some data and analysis could be produced then it could be fed back via the Chair and Chief Executive forums. *Medicine* It was noted that there was a renewed effort on PDR and turnover analysis was underway focussing on exit interviews and personal development. Short term sickness had reduced however long-term sickness had increased. There were access challenges in Gastroenterology and Dermatology and plans were in place to address these. The job planning sign off process had commenced. *Community & Mental Health* It was noted that the CAMHS Pharmacist had now started in post and that the number of incidents had increased due to issues with the interpreter services. This was an issue across Cheshire and Merseyside and the concerns had been escalated. There were a number of complaints received and one in particular by the Rainbow Centre which the Chair had agreed that the Board would hear the young person's experiences. A meeting of the Board would be a 'listening session'. The sensory pilot had its final meeting and a report was being prepared. There had been an improvement in ASD waiting times.
22/23/134.1	**Action – A 'listening session' to be arranged for the patient story to be shared.** Garth Dallas asked about the issues with the interpreter services. Nathan Askew advised that there had been some concerns moving to one provider however the range of services they provided were better particularly around sign language and hard of hearing but agreed he would follow up the concerns up with the ICB.
22/23/134.2	**Acton – The concerns regarding the new interpreter services to be followed up with the ICB.** Shalni Arora asked why the data had been redacted due to data quality. Kate Warriner advised that there had been an issue with the system which had now been resolved and would circulate a revised report. Jo Revill referred to services commissioned by the ICB and if a service was ineffective how would this be resolved. Nathan Askew advised that this service was via the Health Procurement Group and noted that the concerns would be monitored through SQAC along with the associated actions. **Resolved:** The Board received and noted the M4 Integrated Performance Report.
	Developing the New Integrated Performance Report The Board received a proposal for the development of a new integrated performance report, which was presented by Kate Warriner. It would come into effect in October for performance monitoring. It was noted that the report was more accessible, and a lot of work had taken place to develop it. There would be opportunities to refine it further if required.

	The Chair advised that this was going to streamline the dashboard and some training was required to understand the report in more detail. Garth Dallas referred to page 87 which had been redacted and asked for this to be explained. Kate Warriner advised that there had been an issue with the incident reporting which had now been resolved and would reissue a copy of the report. It was noted that there were still a high number of metrics in the new report, but these included a number of regulatory metrics. There would be a top level mini report for each of the areas for the Executives to focus on. Innovation would also be included from October. **Resolved** The Board approved the: 1) The prototype design of the new IPR 2) The list of metrics for inclusion in the new IPR 3) The monthly timetable for producing the IPR with executive sign off prior to finalisation and circulation of the report each month
22/23/135	**Liverpool Clinical Services Review** The Board received an update on the Liverpool Clinical Services Review, which was presented by Louise Shepherd. She advised that Carnall Farrar had been appointed by the ICB and was leading the Review; work was ongoing with all trusts over the Summer and a series of meetings had been held with the Executive teams. A workshop had taken place which detailed 12 areas of opportunity identified and the main conclusion was that there was a duplication of services. An area identified was the urgent care pathways on long term conditions and emergency care and a piece work would be undertaken to look at these in further detail. She noted that there would be implications for Alder Hey and that other areas for opportunity that were not identified that the Trust should still progress with.
22/23/136	**ICS Development Update** The Board was provided with an update on the development of the ICS, which was presented by Dani Jones. A number of slides were shared that provided information on the following areas: • What was new since July? • ICS Roadmap for Integrating Specialist Service • C&M ICS Governance developments • 2 Provider Collaboratives – CMAST & MHLDC ○ There was lots of debate on where CYP would sit in the collaboratives and agreed the Trust should sit between both. It was noted that funding for specialist services would be delegated to the ICB and currently this was under funded which could be a risk. • Alder Hey's Leadership role for CYP The Board noted the update on the development of the ICS. **CMAST Leadership Board Terms of Reference** The Board received an update on the CMAST Governance proposals, which was presented by Erica Saunders. It was noted that some of the feedback

	from other trusts was that different arrangements had been proposed with MHLDC and agreed to amend slightly to reference this. The Board agreed to: • Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board • Approve the establishment of a Committee in Common with Terms of Reference as proposed • To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals.
22/23/137	**Alder Hey in the Park Campus Development Update** Rachel Lea advised that there had been some cost pressures with the Neonatal and Urgent Care Development. She noted the delays with the Catkin Centre and Sunflower House; however the handover of the Catkin building would take place next week. She referred to the modular building and there was a programme delay due to the lease agreement for former Police station and alternative accommodation was being looked at. The Chair advised that a number of community events were planned for 5th and 19th November for Springfield Park and leaflets had been distributed. Garth Dallas asked whether a date for the proposed public meeting had been agreed. John Grinnell advised that some dates had been received but nothing had been confirmed as yet but would follow this up.
22/23/137.1	**Action – John Grinnell to follow up on the arrangements for the public meeting**. **Resolved** The Board received and noted the Campus Development Update.
22/23/138	**Gender Identity Development Service** The Board received an update on the Gender Identify Development Service, which was presented by Louise Shepherd. She advised that weekly meetings were taking place at national level and the formal programme would be commencing shortly; a secondee from the ICB would be joining to support Lisa Cooper. There were no timescales as yet as these were set nationally. It was noted that the governance arrangements would need to be agreed formally at a future Board meeting and to receive a full report by the end of year. **Resolved:** The Board noted the update on the service.
22/23/139	**Brilliant Basics Update** The Board received an update on the Brilliant Basics Programme, which was presented by Nathan Askew. He advised that over the last 6 months the report demonstrated how much work had gone into the programme. The achievements focussed on the 3 main workstreams. The overall programme had been rated green for programme management standards and progress

	was on track against the key milestones. An update was received on each of the workstreams given by the Executive lead: • Leading for Improvement – work continued on the leader standard format and daily safety briefings had been introduced led by an Executive. It was noted that coaching and development approach would be revised in the context of the Vision 2030 work. • Learning for Improvement – the team had done a fantastic job in embedding the training required. • Delivering Improvement – continued focus was on ED its best and staff wellbeing. Nathan Askew advised that planning for the next 12 months was being undertaken and would be reflecting on the learning from this year. He added that the model used in ED would be used in other areas. **Resolved:** The Board noted the Brilliant Basics update for September 2022.
22/23/140	**Serious Incident Report** The Serious Incident report was submitted to the Trust Board to provide a performance position for open and closed incident investigations that met the serious incident criteria and were reported externally to the Strategic Executive Information System (StEIS). The Board received an update on the never event which had occurred and would be reflected in next month's report. It was in relation to a dental procedure with a retained mouth guard that had resulted in no harm to the patient. An initial review had been completed with the learning shared. It was noted that lots of good work had taken place and there was one outstanding investigation for a high-profile case which was being reviewed tomorrow. **Resolved:** The Board received and noted the contents of the Serious Incident report.
22/23/141	**Nurse Staffing Report** The Board received the Nurse Staffing Report, which was presented by Nathan Askew. He introduced the Board to the new format which used E-Roster to capture the data and included Fill Rates, CHPPD, HR Metrics, Balancing Safety Metrics and Incidents. It was noted that the reporting came from the Centre so the report would always be 2 months behind. Nathan Askew advised that there was one anomaly for HDU and a further deep dive was required. Kerry Byrne noted that would be helpful to have a couple of sentences of narrative for 1C to draw out the issues. The Chair advised that it was an interesting report with clear, patient reported outcomes. **Resolved:** The Board noted the position statement for Nurse Staffing Report.
22/23/142	**Complaints and PALs Report**

	The Board received the Complaints and PALs report, which was presented by Nathan Askew. The number of complaints remained the same but compliance with the 25 day response rate and increased. There were no new ombudsman cases and a number of cases had been closed with minimal outcomes for the Trust. PALs concerns continue to rise and there was an action plan in place with MIAA which was on track. **Resolved:** The Board noted the position statement for Complaints and PALS for Q1, 2022/23.
22/23/143	**Mortality Report Q1** The Board received the Mortality report, which was presented by Alfie Bass and reported that mortality rates were reducing to pre-covid levels. The Board was advised that there was one avoidable death in this reporting period. There has been a considerable amount of learning from this case and how these particular cases were escalated. A piece of work is to be conducted via the patient safety strategy workstream for deteriorating patients which will also link to Hospital at Night. R**esolved:** The Board noted the contents of the Mortality update for Q1.
22/23/144	**DIPC Report Q1** The Board received an update on Infection, Prevention and Control within the Trust, which was presented by Bea Larru. She advised that asymptomatic testing had changed and had ceased from 31 August, however face masks would continue to be worn in clinical areas to protect patients. She added that there had been a small increase in hospital acquired infections and action was being taken to address the increase. She advised that a survey had been undertaken to listen to people's views on IPC however only small number had taken part in the survey. This gave the department some honest feedback and in summary the results showed: • More presence by the department • Better explanation of policies • Improved communication • Reported issued earlier She stated that there were challenges and the department was struggling to be everywhere across the Trust. The Chair commented that IPC was everyone's business and how could we support the department moving forward? Nathan Askew stated that it was a really helpful and honest reflection and he would be surprised if organisations across the country were having the same conversations. He noted that he would be working with the IPC team and to look at the increased use of the data which should see some changes.

	Lisa Cooper stated that it was about the IPC needs tor the whole organisation and not just the Hospital as there were some bespoke services in the Community and support was required from the team for the Divisions. It was noted that some revised communications would be issued to the Trust regarding the recent changes and to reaffirm the continued use of masks and the awareness of bacterial transmissions. The Chair thanked Bea Larru and the team as they made a huge contribution and that the Trust would need to find better ways to support the team. **Resolved:** The Board noted the DIPC update.
22/23/145	**Liverpool Health Partners** The Board received and supported the proposal for Liverpool Health Partners organisational change.
22/23/146	**North West Paediatric Partnership Board – Chair's Report** The Board received and noted the report.
22/23/147	**Growing Great Partnerships** The Board received an update on the growing great partnerships element of the strategy, which was presented by Dani Jones. She noted that the 'Beyond' update would be presented to the Board in November. Following a successful bid from the Contain Management Outbreak Funding (COMF), funding of nearly £1m had been received for the grass roots public health work. **Resolved:** The Board received and noted the report.
22/23/148	**People Report** The Board received an update on the People report, which was presented by Melissa Swindell. She advised the Board that Fiona Marston would be stepping down as chair of the People and Wellbeing Committee and as Wellbeing Guardian for a short period of time to carry out some consultancy work for Alder Hey. The key highlight from the report was the potential risk for industrial action which had been included on the risk register. The unions were going to ballot and the smaller trade unions were in the consultation phase and depending on the outcome would liaise with the operational teams. **Wellbeing Guardian Dashboard** Fiona Marston advised that all trusts had been asked to appoint a Wellbeing Guardian as a link for the Trust and the Board; they provided oversight and assurance. She added there were 3 phases to the implementation, the first was to undertake the diagnostic and to agree the priority actions and this was completed last year. The second phase was to address the actions and the third phase was to complete the actions. She advised that there was a detailed dashboard with rag ratings for the 9 principles with all but one in progress.

	She advised that the PAW Committee had approved the move to phase 3 and asked the Board for ratification. The Board agreed to • Formally approve the completion of Phase 2; and • Confirm progression to Phase 3 of implementation
22/23/149	**Additional Christmas Bank Holiday Proposal** The Board received the proposal to award an additional day's leave to staff as a wellbeing day, to acknowledge and thank staff for their hard work. The proposal this year will be for this to be taken by colleagues, where possible, on Friday 23rd December 2022. **Resolved:** The Board supported the proposal to award an additional day's leave and the Executives would discuss any operational issues.
22/23/150	**AlderC@re Programme** The Board received the detailed report on the Alder Care Programme, which was presented by Kate Warriner. It was noted that the new go live date would be August 2023 and a new team was in place to support the programme. October 2022 was a key month for user engagement with the launch of Patient Journeys across the Trust. There were still some significant risks and following a meeting with Meditech good progress had been made in regard to the recent issues. It was noted that there is support in place from the National Team. **Resolved:** The Board noted the latest position with the planning for AlderC@re deployment in 2023.
22/23/151	**Forward Look/Financial Environment** The Board was provided with an update on the Forward Look, which was presented by Rachel Lea. She advised that the Trust had set a control total of £4.6m, however there was a £4m risk due to the rising costs of energy prices and this had been flagged with the ICB. The key drivers/risks were: • Inflation pressures - Energy with high inflation, although there would be a benefit from the government support and supplier issues with drugs. • CIP – there was a current gap of £2m identified against the target and a recurrent gap of 80% which would require a shift in transformation. • Winter & Activity – pay run rate, which was expected to reduce and elective recovery. There were a number of actions in place with external support from MIAA and a refocus on transformation along with a review of the data available. **Resolved:** The Board noted the position on the Forward Look/Financial Environment.
22/23/152	**Board Assurance Framework Report**

	The Board was provided with assurance on 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, which was presented by Erica Saunders. 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. Each assurance committee had addressed the risks assigned during the month, with PAWC receiving a deep dive in relation to the risk relating to staff wellbeing. **Resolved:** The Board received and noted the contents of the Board Assurance Framework report as at the end of August 2022. **Board Assurance Framework Policy** **Resolved:** The Board approved the Board Assurance Framework Policy.
22/23/153	**Emergency Preparedness, Resilience and Response Annual Assurance Report** The Board received the EPRR Self-Assessment Report in order to provide formal approval in line with its legal and statutory requirements to meet NHS England EPRR Core Standards and the Civil Contingencies Act 2004. The following points were highlighted: • There were 64 standards the Trust was required to assess itself on. From the Trust's self-assessment; 59 of the standards have been declared as 'fully compliant' and 5 standards 'partially compliant'. The standards have a relevant action plan to ensure full compliance within the next 12 months. • A 'deep dive' that was conducted to gain additional assurance into a specific area, this however did not contribute to the Trusts overall compliance. For 2022 - 2023 the 'deep dive' topic is evacuation and shelter and holds 13 'deep dive standards'. • From the Trusts self-assessment into the 'deep dive'; 6 standards have been declared as 'fully compliant' and 7 as 'partially compliant'. The Chair thanked Jacob Gray who had produced a robust plan this year. **Resolved:** The Board formally approved the EPRR Self-Assessment Assurance Report.
22/23/154	**Board Assurance Committees** *Audit and Risk Committee* Kerry Byrne asked the Board to note the memo from the Anti-Fraud Fraud Specialist relating to the Bribery Act 2010 and the Trust Anti-Bribery Strategy. The approved minutes from the meeting on 14 July 2022 were submitted to the Board for information and assurance purposes. During the meeting that took place on 15 September 2022 the advisory report on the IT Hardware Asset Management Review that had been commissioned following the loss of the iPads, was received and actions noted. *RABD*

	The approved minutes from the meeting held 25 July 2022 and 22 August 2022 were submitted to the Board for information and assurance purposes. During the meeting that took place on 26 September 2022 there was a focus on the rising energy costs. *SQAC* The approved minutes from the meeting held on 20 July 2022 were submitted to the Board for information and assurance purposes. *People and Wellbeing Committee* The approved minutes from the meeting held on 3 August 2022 were submitted to the Board for information and assurance purposes. *Innovation Committee* The approved minutes from the meeting held on 19 April 2022 were submitted to the Board for information and assurance purposes. The Committee was advised of the Trust's successful pre-development bid following submission to the Metro Mayor's Liverpool City Region strategic investment fund.
22/23/155	**Any Other Business** There was none to discuss.
22/23/156	**Review of the Meeting** The Chair emphasised that it was good to meet face to face and requested that the Board meet back on site at Alder Hey. She highlighted the good work being undertaken by all teams, the need to care for the staff and the need to be sighted on the key risks. The Chair thanked everyone for their input and agreed that the extraordinary board would be called a 'Listening Event' and to try and convene as many of the Board as possible to hear the story.
	Date and Time of Next Meeting: Thursday 27 October 2022 at 9.30am at L4, Institute in the Park

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 October 2022							
30.6.22	22/23/82.1	Corporate Report	*Medicine* - Provide an update on the actions that have been agreed/taken to address the reduction in diagnostic performance.	U. Das	28.7.22	Oct-22	**28.7.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during September's Trust Board. **29.9.22** - The Division of Medicine is working with the Radiology team to address the reduction in diagnostic performance. A timeline has yet to be agreed. A further update will be provided during October's Trust Board. **ACTION TO REMAIN OPEN**
29.9.22	22/23/134.1	Integrated Performance Report, M4	Follow up the concerns regarding the new interpreter service with the ICB.	N. Askew	27.10.22	On track Oct-22	
29.9.22	22/23/137.1	Alder Hey in the Park Campus Development Update	*Planned community events for Springfield Park* - Follow up on the arrangements for the public meeting.	J. Grinnell	27.10.22	On track Oct-22	
Actions for November 2022							
28.7.22	22/23/111.1	Equality, Diversity and Inclusion Steering Group (EDISG) Update	Submit a workplan in October for the EDISG along with a highlight report following future meetings.	M. Swindell/ G. Dallas	27.10.22	Nov-22	**20.10.22** - The EDISG workplan will be submitted to the Board in November 2022. **ACTION TO REMAIN OPEN**
29.9.22	22/23/134.1	Integrated Performance Report, M4	Listening Session' to be arranged to enable a specific patient story to be shared with Board members.	L. Cooper/ K. McKeown	Nov-22	On track Nov-22	
Status							
Overdue							
On Track							
Closed							

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
24.6.21	21/22/65.2	Approach to End of Life Care when there is a dispute	Provide a progress update on the Trust's process that supports end of life discussions and agreements.	A. Hughes	28.7.22	Closed	**28.7.22** - It was agreed that an update would be provided during September's meeting. **29.9.22** - It was agreed to close the action and integrate it into discussions for lessons learnt. **ACTION CLOSED**
16.12.21	21/22/214.1	Chair's/CEO's Update	Invite Dr. Fulya Mehta to a future Board to provide an update on her new role as the National Clinical Director for Paediatric Diabetes.	K. McKeown	28.7.22	Closed	**22.7.22** - Dr. Fulya Mehta has agreed to attend October's Trust Board meeting to provide an update on her new role as the National Clinical Director for Paediatric Diabetes. **ACTION CLOSED**
30.6.22	22/23/87.1	Board Assurance Committees.	*SQAC* - Look into the shared learning and support that is available across C&M, for example, Alder Hey has offered support to other trust across the System with presentations of children with sepsis.	N. Askew/ A. Bass	29.9.22	Closed	**29.9.22** - It was agreed that this would be picked up via the ICB Quality Committee. **ACTION CLOSED**
28.7.22	22/23/114.1	Board Assurance Committees	SQAC (Safeguarding Review) - Liaise with Lisa Cooper and Nathan Askew to agree as to whether the outcome of the Safeguarding Review should be shared with 'Beyond' as there are a number of important recommendations in the report that appertain to the wider system.	D. Jones	29.9.22	Closed	**29.9.22** - A discussion relating to this matter has taken place. **ACTION CLOSED**
28.7.22	22/23/104.1	Operational Issues	*Integrated Performance Report Proposal* - Submit a full new version of the Integrated Performance Report to the Board in October 2022.	A. Bateman/K. Warriner	27.10.22	Closed	**20.10.22** - This report has been included on October's agenda. **ACTION CLOSED**

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Integrated Performance Report Overview**
Report Of:	Adam Bateman, Chief Operating Officer John Grinnell, Deputy CEO Kate Warriner, Chief Digital and Information Officer
Paper Prepared by:	Andrew McColl, ACOO Kate Warriner, Chief Digital and Information Officer

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

Integrated Performance Report Overview

1.0 Introduction

This paper provides the Board of Directors with an overview of the Integrated Performance Report (IPR), which has been produced in the new format for the first time this month.

This follows papers which have been presented to Board of Directors in July and September regarding the development of the IPR, along with the NHS England and Improvement (NHSEI) Board Development session and training during 2022 which described the national 'Making Data Count' principles.

The IPR has been developed using the Brilliant Basics approach, including a significant amount of stakeholder input across the Trust.

2.0 Overview of the Integrated Performance Report

2.1 IPR Key Changes

The new IPR includes the following key changes:

- Reduction in overall length of the report, with fewer metrics, so it is more concise and using one of the Brilliant Basic principles, enables the Board of Directors to 'focus on what matters'
- Move from red, amber, green (RAG) ratings to the use of statistical process control (SPC) measures in accordance with NHSEI making data count guidance
- Use of watch / drive metrics to differentiate priorities. It is noted that the drive metrics have been selected in this category based on a desire to drive improvement – therefore it is expected that a number of these will not initially be achieving set targets, but will evidence improvement over time
- Structured sections of narrative to succinctly celebrate successes, highlight areas of concern and focus on actions
- Divisions have succinct performance summary for Board of Directors with additional details to be reported at Executive led Performance Reviews

2.2 Annual Plan and CQC Alignment

The report is structured around the CQC Domains and clearly aligns to the 5 Priorities from the 2022/23 Annual Plan

Annual Plan Priority	CQC Domain
Outstanding Safety	Safe
Outstanding Safety	Caring
Recovery and Access	Effective

Recovery and Access	Responsive
Great Place to Work	Well Led – People
Financial Sustainability	Well Led – Finance
Safe Digital Systems	Well Led - Digital

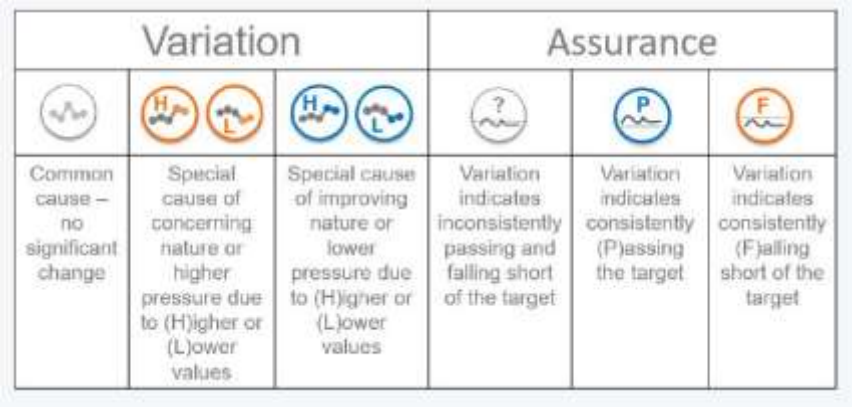
Each section of the report contains an Executive narrative, including highlights, areas of concern and forward look with actions.

Drive metrics include a technical analysis, to give insight to the trends and statistical significance – along with actions to drive improvement

2.3 Navigating and Interpreting the IPR

The metric summaries show the Variation and Assurance icons, to assess performance at a glance as per national Making Data Count principles, and SPC charts for all watch metrics are also included so Trust Board can review any specific issues.

The icons are demonstrated in the figure below. As a rule of thumb, icons in blue show a positive trend, icons in orange show a deteriorating trend, icons in grey show no significant statistical changes to performance.



When put together, a guide to the variation and assurance definitions are highlighted below:

Assurance / Variance Icon Combination	Assurance / Variation Description	Combination Definition
	Achieving Target & Special Cause Improvement	Achieving target with improving trend
	Achieving Target & Common Cause Variation	Achieving target with no significant change
	Achieving Target & Special Cause Concern	Achieving target with declining trend
	Inconsistently Achieving Target & Special Cause Improvement	Inconsistently achieving target with improving trend
	Inconsistently Achieving Target & Common Cause Variation	Inconsistently achieving target with no significant change

	Inconsistently Achieving Target & Special Cause Concern	Inconsistently achieving target with declining trend
	Not Achieving Target & Special Cause Improvement	Not achieving target with improving trend
	Not Achieving Target & Common Cause Variation	Not achieving target with no significant change
	Not Achieving Target & Special Cause Concern	Not achieving target with declining trend

In order to provide a summary position across the Trust performance, a summary of headline performance metrics will be provided within the IPR within the matrix below. This will be iterated over time with feedback from colleagues.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Achieving target with improving trend	Inconsistently achieving target with improving trend	Not achieving target with improving trend
	Common Cause	Achieving target with no significant change	Inconsistently achieving target with no significant change	Not achieving target with no significant change
	Special Cause - Concern	Achieving target with declining trend	Inconsistently achieving target with declining trend	Not achieving target with declining trend

3.0 Future Developments

As this is a new format of the IPR, there are planned further developments which will be made. These will be informed by feedback from the Board of Directors based on their experience of using the IPR in practice. Developments in pipeline currently include:

- Total Waiting List Size to be included in IPR from November
- Research Divisional Summary to become Research & Innovation Summary, as a combined report for November Board of Directors report
- Sub Committees to receive tailored reports which are consistent in format and methodology to the IPR but with additional metrics and detail which is

appropriate to the committees. A transitional approach has been taken in October with further refinement in November and December

- Divisional Performance Review packs to be produced which are consistent in format and methodology to the IPR with additional metrics and detail which is appropriate for these meetings noting IPR only contains a Divisional Summary
- Review of currency for selected metrics – to be implemented from April 2023. For example:
    - Number of Harms to be changed to Harm per 1,000 Patient Days, to enable external benchmarking
    - Events which are rare (eg Never Events, some HAIs) to be reported as time since last event, which is more meaningful than several months of nil returns
    - Some metrics do not entirely suit the SPC format, and review most appropriate format to show performance in these areas
- In April 2023 all metrics will be reviewed to ensure:
    - Ongoing alignment to the Strategy Refresh, 2023/24 Annual Plan noting any new national guidance, and agreed improvement priorities for the Trust
    - Inclusion of metrics for Estates and Facilities, for example Building Safety, Water Safety, Fire Safety Compliance, Cleanliness

The Executive Design Group will remain in place to oversee these and other future developments over the coming months.

4.0 Conclusion

The Board of Directors are asked to note the content of this report for information and to support the use of the new Integrated Performance Report

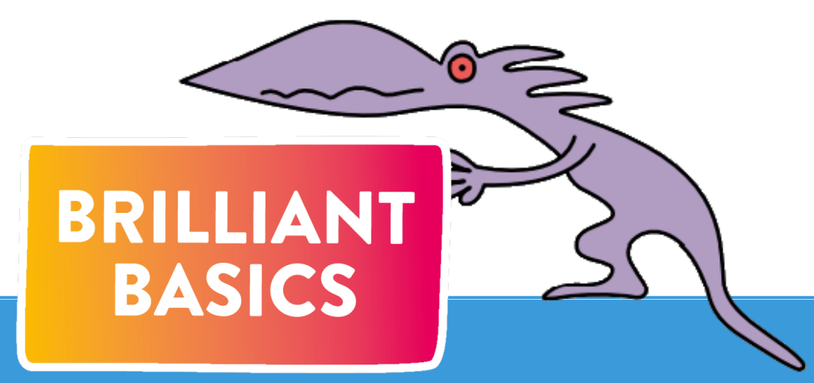
000025

NHS
Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report

Published: October 2022

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

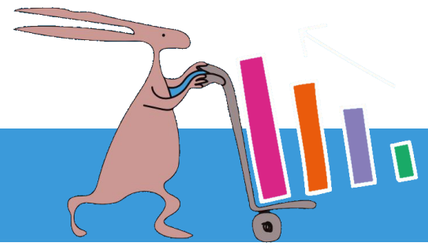
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

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

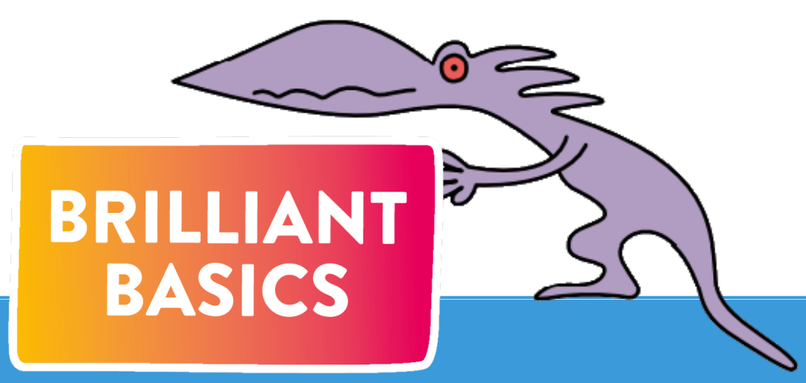
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

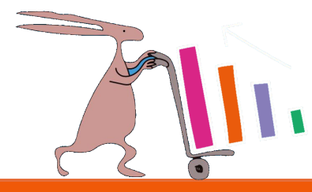
		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Infection Control metrics demonstrate performance is consistently achieving target with an improving trend		PDR, Diagnostics, PALS Complaint Management and Recurrent CIP metrics are not achieving targets but demonstrating improvement
	Common Cause	Cancer, Mandatory Training and Overall Financial position metrics are consistently achieving targets	Level of Harm, Sepsis, Recovery and Staff Recommending Alder Hey as place to work metrics are inconsistently achieving target and are yet to evidence statistical improvement	ED Performance and Overall Sickness metrics are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern	Virtual Adoption metrics within Outpatients is consistently achieving targets with a declining trend		Access & Staff Turnover metrics are not achieving targets with a declining trend

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

- 17.7% of our metrics are consistently achieving target
- 53.4% of our metrics are inconsistently achieving target
- 28.9% of our metrics are not achieving target, 4 metrics are demonstrating special cause improvement

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





Outstanding Safety - Safe

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

Q2 Highlights:

• No hospital acquired MRSA or C.Diff infections reported in Q2, only 1 MSSA in July • Patients receiving antibiotics within 60 minutes for management of sepsis in in-patient wards has been above target for last 4 months and if sustained will indicate an underlying improvement

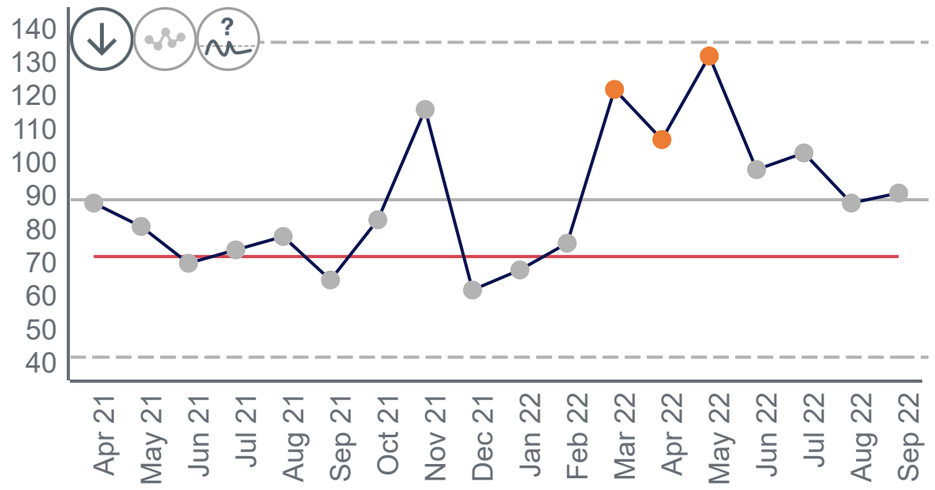
Areas of Concern:

• 4 incidents (Across Aug & Sep) reported to StEIS inclusive of Never Event and a Category 3 Pressure Ulcer; one StEIS relates to a non clinical incident • All statutory regulations met and investigations commenced.

Q3 Forward Look (with actions)

• Timely investigation and conclusion of the 4 new RCA investigations within 60 working days • Working group in place to implement the new Patient Safety Incident Response Framework (PSIRF) as part of the Trust Patient Safety Strategy.

Number of Incidents rated Minor Harm and above



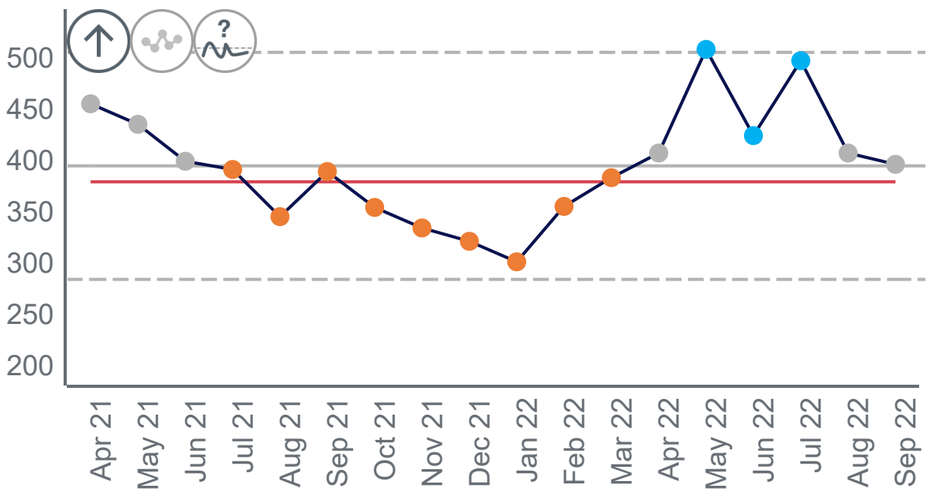
Technical Analysis:

Number of Harms per month have been stable and consistently within the normal range, however 7 consecutive points above the average indicates a concern that incidents of harm may be increasing. There were 6 Moderate Harms in Jul-Sep, compared to 2 in Apr-Jun. The Never Event in Sept was categorised as "No Harm".

Actions:

Areas of concern will be escalated to the Patient Safety Strategy Board in which there is absolute focus on triangulating data across the Trust to continuously improve patient safety. Focus in November will revolve around data driven decisions and objective methodologies to bring about consistent reductions in patient harm.

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. May and July showed 2/3 points near the upper limit which indicated a potential increase in reporting. In Aug and Sep this has returned towards the mean showing common cause variation, but remains above (passing) the target.

Actions:

All staff encouraged to continue to report no harm and near miss incidents as opportunities for the Trust to learn and make any necessary changes to improve safety.

Outstanding Safety - Safe - Metric Summary

Metric	Date	Value	Mean	Target	Variation	Assurance
Number of Incidents rated Minor Harm and above	September 2022	92	89	72		?
Number of Incidents rated No Harm and Near Miss	September 2022	396	395	380		?
Number of Serious Incidents (Steis reported)	September 2022	3	1	0	H	?
Number of Never Events	September 2022	1	0	0	H	?
Sepsis % Patients receiving antibiotic within 60 mins for ED	September 2022	85	84	90		?
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	September 2022	94	87	90		?
Number of Medication Errors resulting in harm (minor harm and above)	September 2022	3	4	4		?
Pressure Ulcers G2-4	September 2022	4	4	5		?
Use of physical restrictive intervention (MH Tier 4)	September 2022	5	15			?
Number of Unplanned Admissions to Critical Care (HDU/PICU)	September 2022	65	69	30		F
Hospital Acquired Organisms - MRSA (BSI)	September 2022	0	0	0		P
Hospital Acquired Organisms - (C.Difficile)	September 2022	0	0	0	L	P
Hospital Acquired Organisms - MSSA	September 2022	0	1	0		?

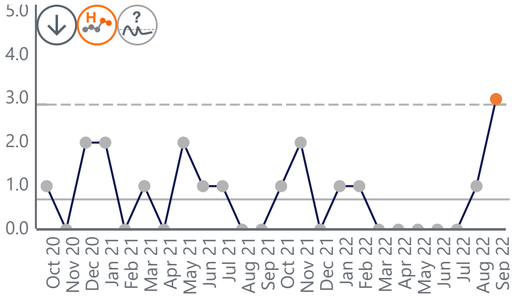
000031

Integrated Performance Report | October 2022

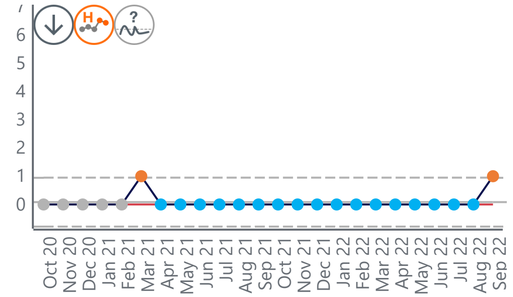
Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Safe - Watch Metrics

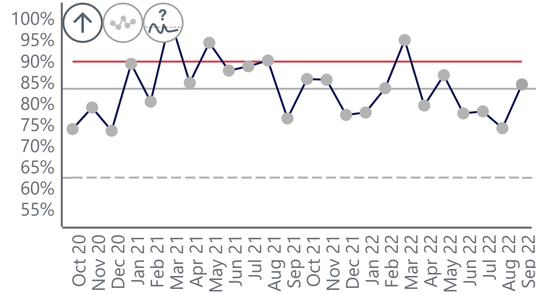
Number of Serious Incidents (Steis reported)



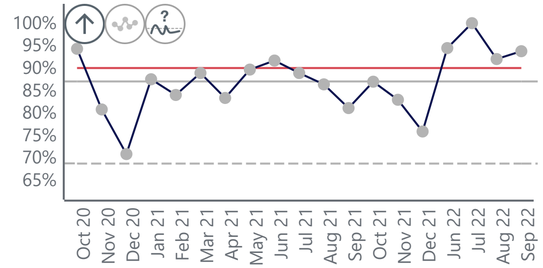
Number of Never Events



Sepsis % Patients receiving antibiotic within 60 mins for ED



Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



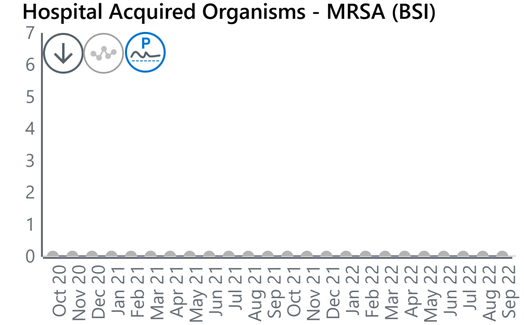
Number of Medication Errors resulting in harm (minor harm and above)

Pressure Ulcers G2-4

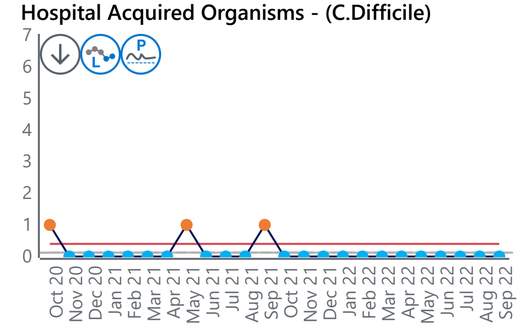
Use of physical restrictive intervention (MH Tier 4)

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

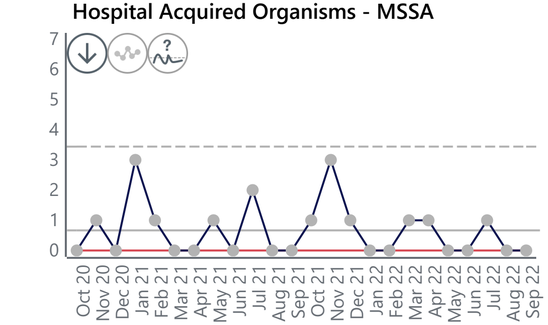
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Integrated Performance Report | October 2022

Alder Hey Children's NHS Foundation Trust

Outstanding Safety - Caring

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

Q2 Highlights:

• Sustained improvement in responding to informal PALS concerns within 5 working days over Q2; Divisional Governance teams have set up a process to monitor all concerns on an at least weekly basis • Medicine and Surgery achieved 100% compliance with resolving the concerns of families in month.

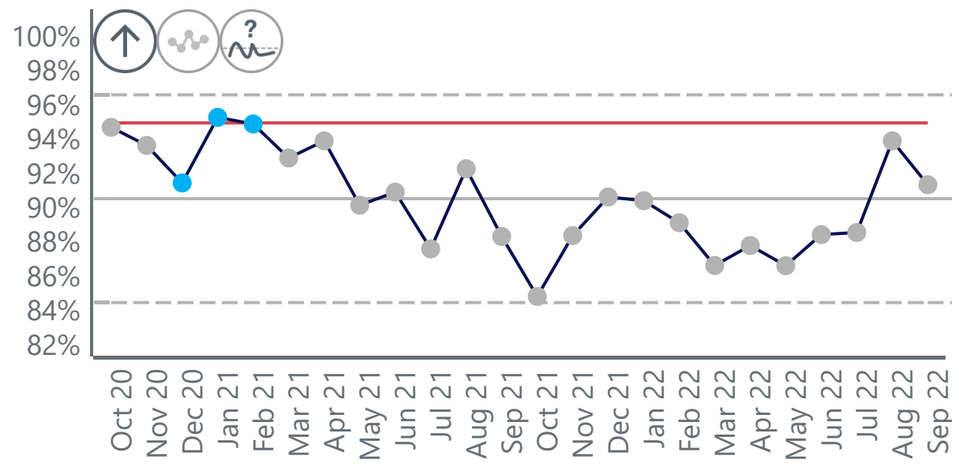
Areas of Concern:

• Some Business support services who receive PALS concerns are not responding in a timely manner; focused targeted work in place to assist these services to address concerns.

Q3 Forward Look (with actions)

• Increase the opportunities for children and young people to raise concerns or issues through QR codes. Patient Experience and Engagement Strategy being devised.

F&F Test - % Recommend the Trust



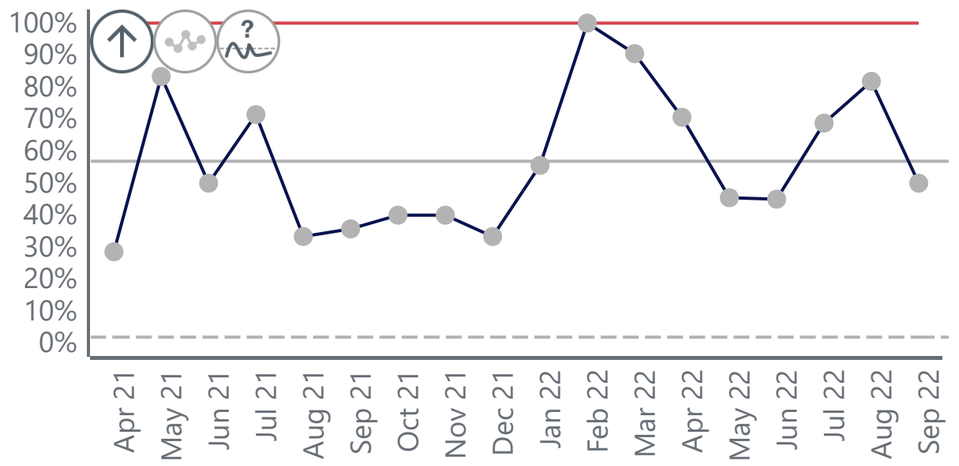
Technical Analysis:

Consistently falling short of the target – ED is at 80% and all other areas >90% in Sep, with Mental Health and Inpatients exceeding the 95% target. Currently demonstrating normal cause variation, with peak in Aug 22 related to lower volume of attendances in ED.

Actions:

ED at its Best Programme continue to make improvements to enhance the experiences of families; new FFT posters with QR codes in every ED cubicle and on every ward to encourage feedback • Divisions have established Patient Experience sub-groups with FFT part of the monthly agenda to identify trends and drive improvements.

% Complaints Responded to within 25 working days



Technical Analysis:

The current average is 57%. Due to low volumes this metric is statistically sensitive (i.e. 1 breach represents a high percentage) - but improvement work is still required to achieve more consistent performance

Actions:

Divisions sighted on requirement to respond to families within 25 working days. Process in place to apply for an extension in exceptional circumstances as set out in the new Complaints policy however will still show as a breach.

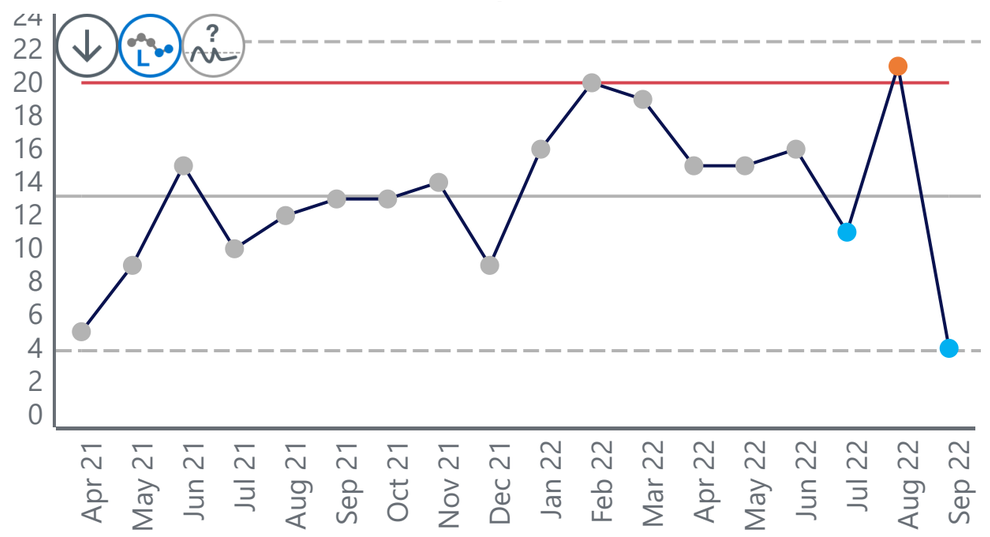
Integrated Performance Report | October 2022

Alder Hey Children's NHS Foundation Trust

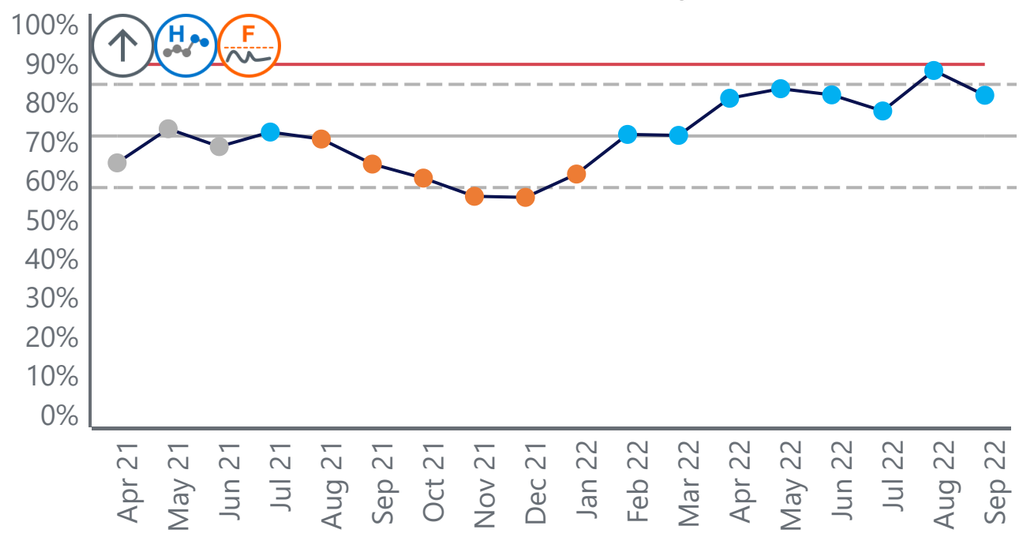
Outstanding Safety - Caring - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	September 2022	91	95	91		?
% Complaints Responded to within 25 working days	September 2022	50	100	57		?
Number of formal complaints received	September 2022	4	20	13	L	?
% PALS Resolved within 5 Days	September 2022	82	90	72	H	F
Number of PALS contacts	September 2022	147	150	129		?
F&F ED - % Recommend the Trust	September 2022	80	95	69		F

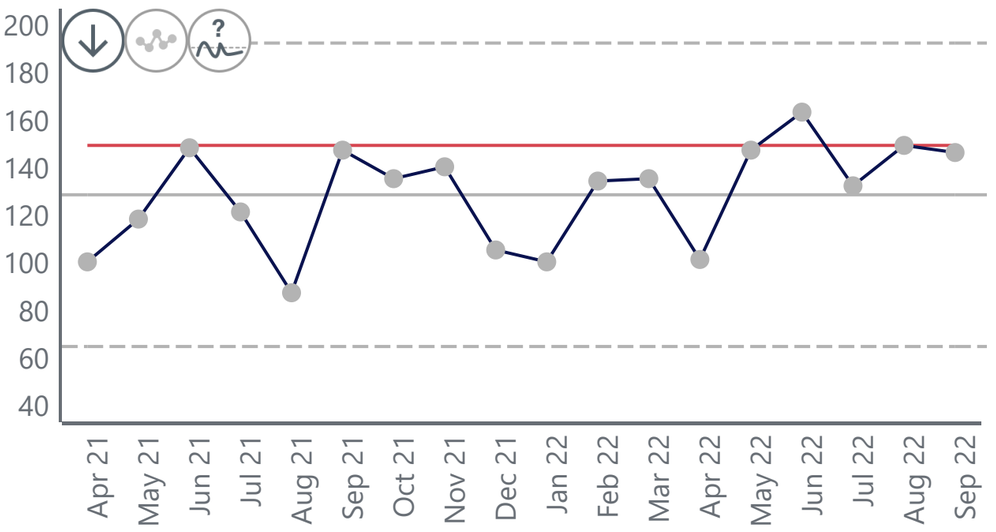
Number of formal complaints received



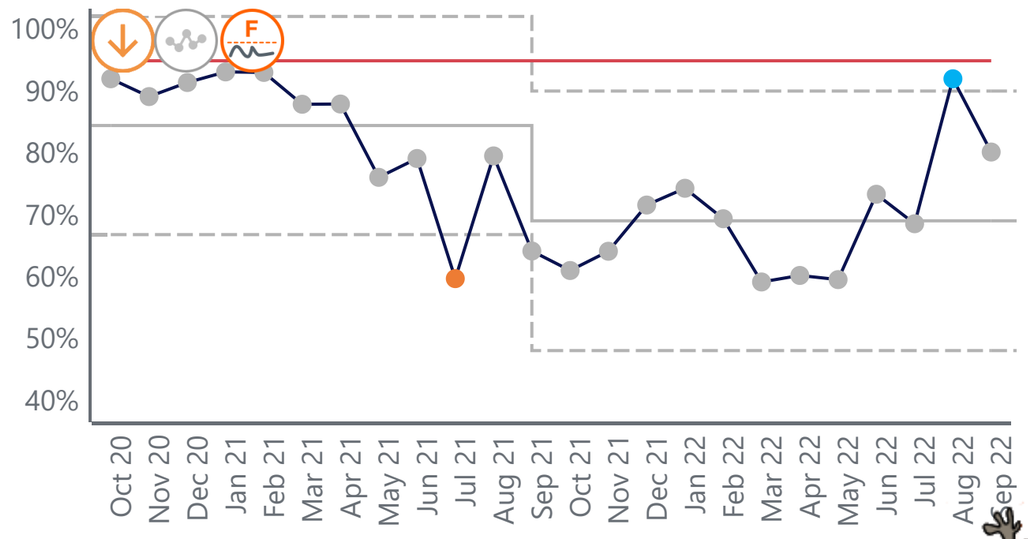
% PALS Resolved within 5 Days

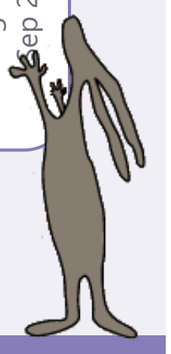


Number of PALS contacts



F&F ED - % Recommend the Trust





Integrated Performance Report | October 2022

Alder Hey Children's NHS Foundation Trust

Recovery & Access - Effective

SRO : Adam Bateman, Chief Operating Officer

Q2 Highlights:

• ED performance significantly above the mean in Aug and Sep and higher than the corresponding months in 2021-22 • Business case submitted and approval given for investment in the ED extension to improve flow, reduce overcrowding • The proportion of appointments delivered virtually has consistently achieved the target but as we reduce f/up activity and restore clinics we must review our approach to sustaining this in H2

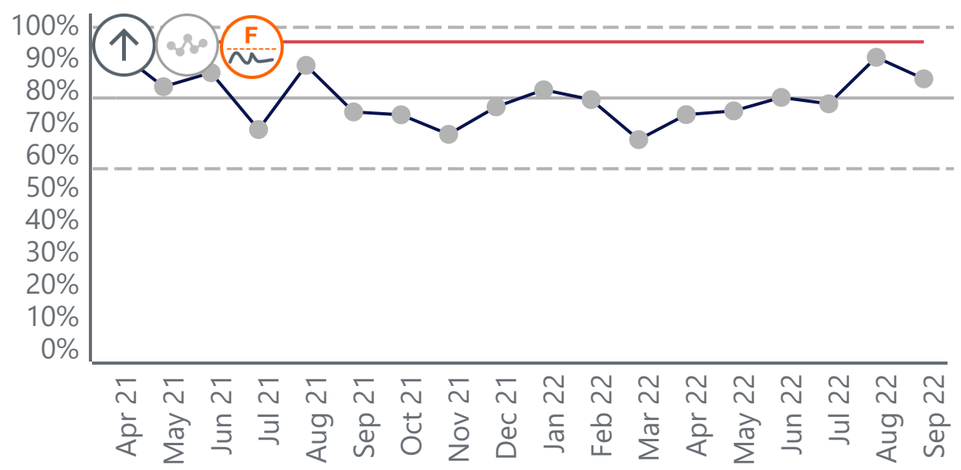
Areas of Concern:

• ED Performance against 4 Hr target and 12 Hr Time in Dept remains challenged • 33 cancelled operations in Sep (target <20) with pressure on bed capacity and flow due to non-elective admissions • Virtual OP reduced below target, in part due to reducing OPFU in place of F2F OPNew • Completion of clinic letters significantly below 95% target, but Divisions focus on reducing backlog and bringing down longest times.

Q3 Forward Look (with actions)

• Open an ED extension and have 4 additional ED consultants • Set higher threshold for delaying theatre lists to reduce cancelled operations • In Oct, 5 specialities with highest WNB rate will have a new service to support (higher risk) patients to attend appointments • On long stay patients: detailed trend analysis, commence complex stay improvement work sponsored by CMO and open virtual ward.

ED: % treated within 4 Hours



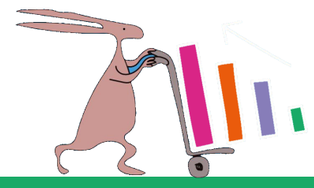
Technical Analysis:

Performance in August and September are above the mean and are the two highest points over the last 12 months, but at this stage demonstrate common cause variation. The peak in August correlates with lower volume of attendances.

Actions:

ED at its Best Programme to oversee actions including: Increased low acuity steaming to scheduled GP appointments; Improved staffing resilience; review and relaunch key ED Dept functions (eg Boards Rounds, Huddles, role cards); Utilise Digital solutions to support flow.

Integrated Performance Report | October 2022

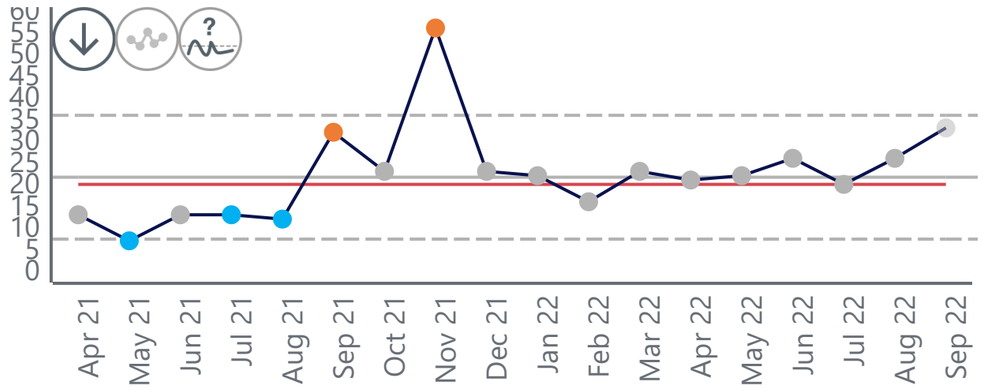


Alder Hey Children's NHS Foundation Trust

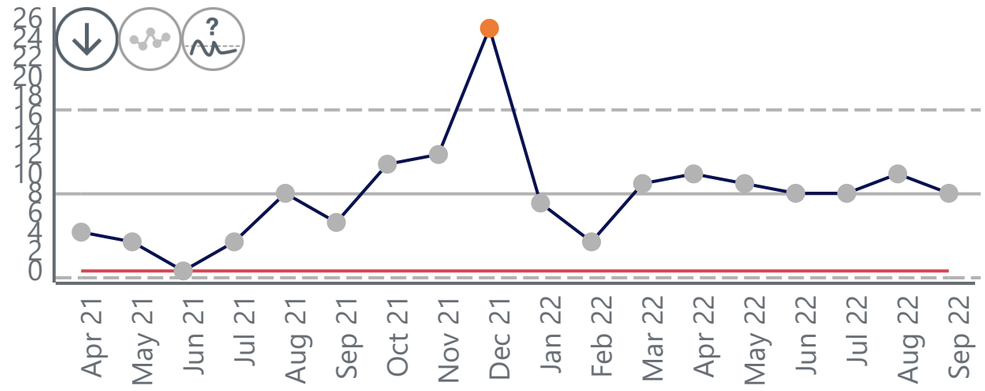
Recovery & Access - Effective - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	September 2022	84	95	77.65		F
Number of Cancelled Operations (on day of admission for a non-clinical reason)	September 2022	33	20	22.28		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	September 2022	8	0	7.94		?
Number of Super Stranded Patients (21 days)	September 2022	50	30	36.50		?
% Virtual Outpatients (national standard 25%)	September 2022	22	25	30.56	L	P
% Was Not Brought Rate (All OP: New and FU)	September 2022	10	10	9.87		?
% of Clinical Letters completed within 10 Days	September 2022	66	95	57.22		F

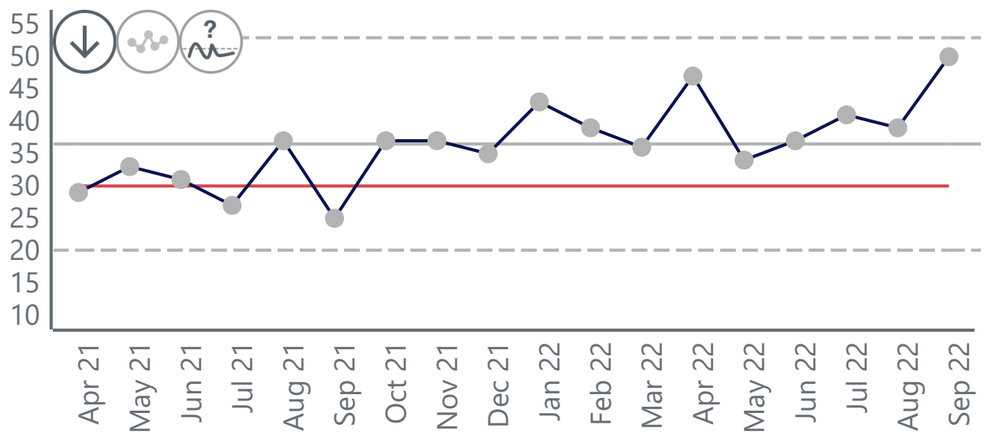
Number of Cancelled Operations (on day of admission for a non-clinical reason)



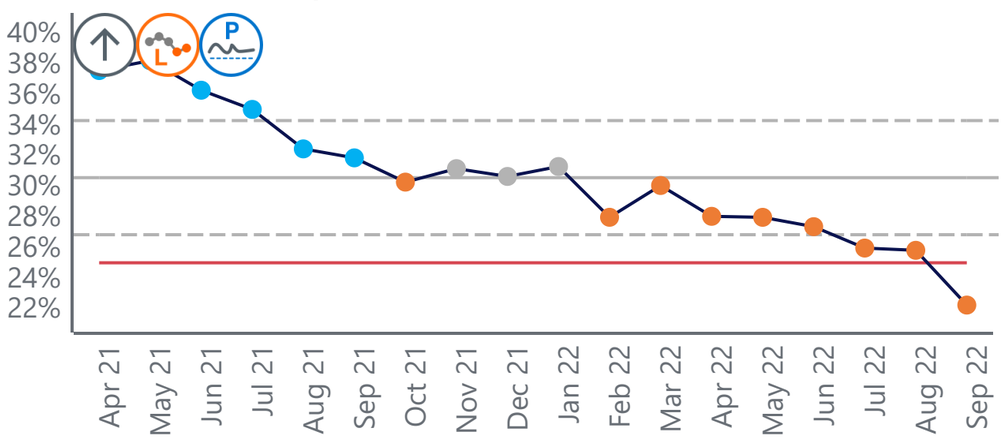
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days



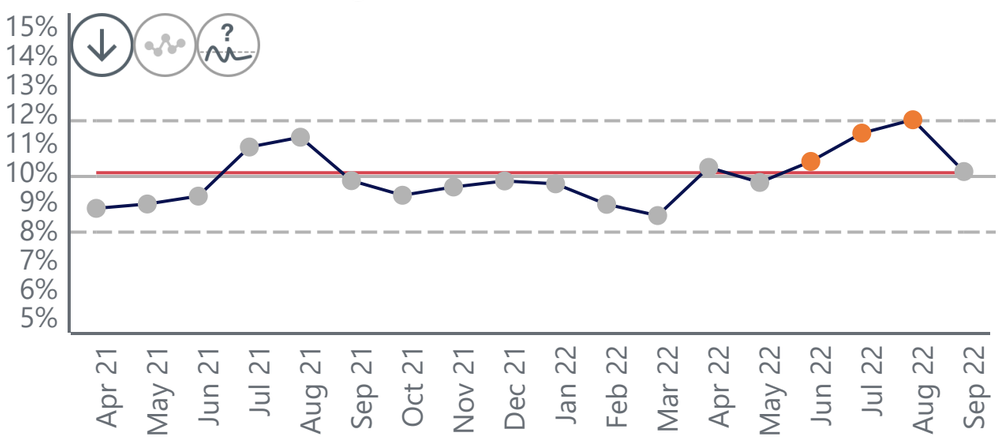
Number of Super Stranded Patients (21 days)



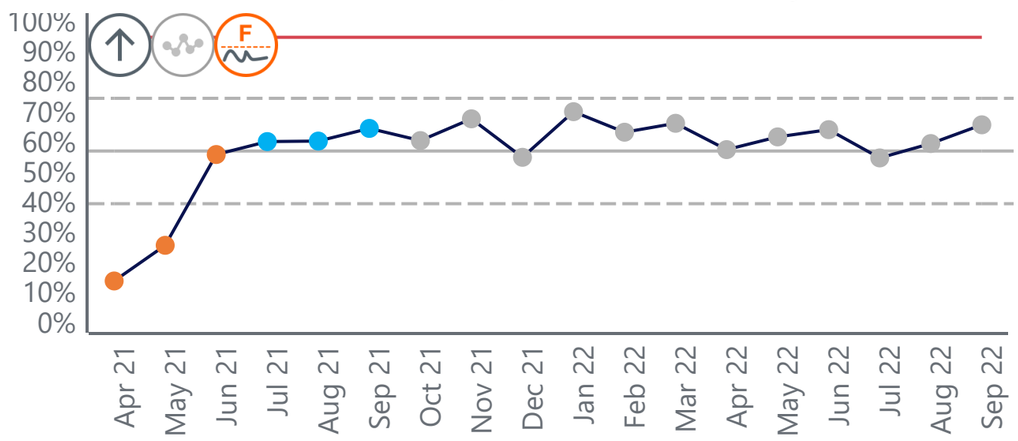
% Virtual Outpatients (national standard 25%)



% 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

Q2 Highlights:

• Recovery when measured by the number of patients treated, remains strong at >104% for the period Apr-Sep (although ERF value below 104% due to case mix) • Community Paediatrics have zero patients >52weeks • Reducing the backlog of patients waiting over 6 weeks for a diagnostic test (from 250 (July) to 150 in (Sep)) • 100% compliance with national cancer standards throughout Q2 • We are reducing follow-up activity, driven by PIFU.

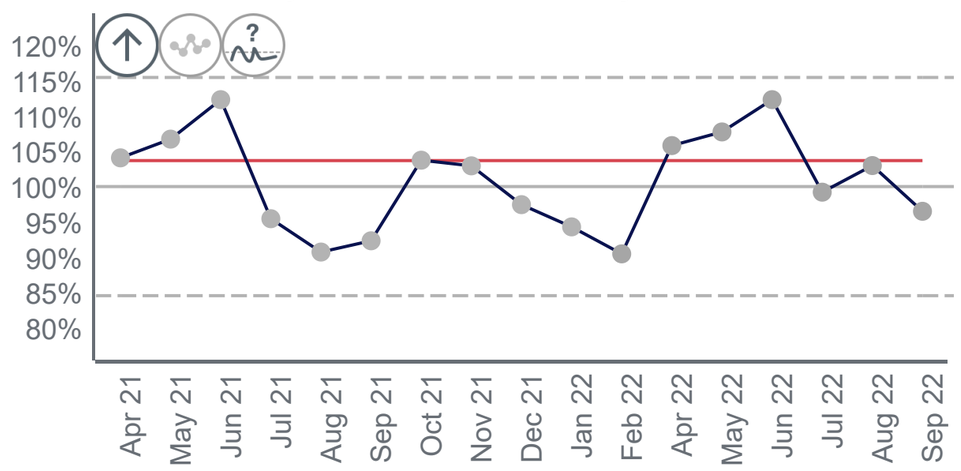
Areas of Concern:

• Recovery (as measured by volume) reduced to 97% in September, with the State Funeral reducing activity by c. 4% fall. Recovery in Surgery was 89% and we must focus on support to surgical recovery • The number of patients waiting >52wks continues to rise, driven by Paediatric Dental access challenges (OP 34 higher than trajectory).

Q3 Forward Look (with actions)

Number of 52 ww patients to reduce to 322 by March 2023 with all bar three specialties • In paediatric dentistry we will utilise an in-sourcing model to increase capacity •Review a business case to invest in agency staff to increase theatre lists • To improve ERF value performance we are testing high throughput surgery lists; raising the threshold to delay theatre lists to make this very exceptional and running extended theatre days • Diagnostic to improve following a 75% increase in Urodynamics and home sleep studies

% Recovery for DC & Elec Activity Volume



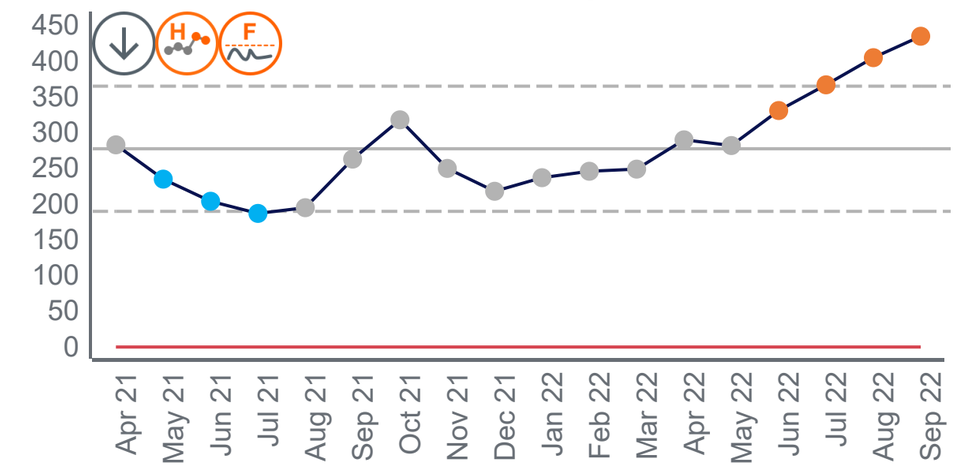
Technical Analysis:

Last 3 months below target, but cumulative average since April 22 is 104.2% (passing the target). Overall this shows normal variation, and reflects a similar seasonal pattern as last year – ie passing the target in Q1 and falling short in Q2.

Actions:

Raise threshold for delaying theatre lists. Review case to employ agency theatre staff. To improve ERF value: further adjust mix of lists to high complexity, 'super saturday', extended days and clarify waiting list initiative payment

Number of RTT Patients waiting >52weeks



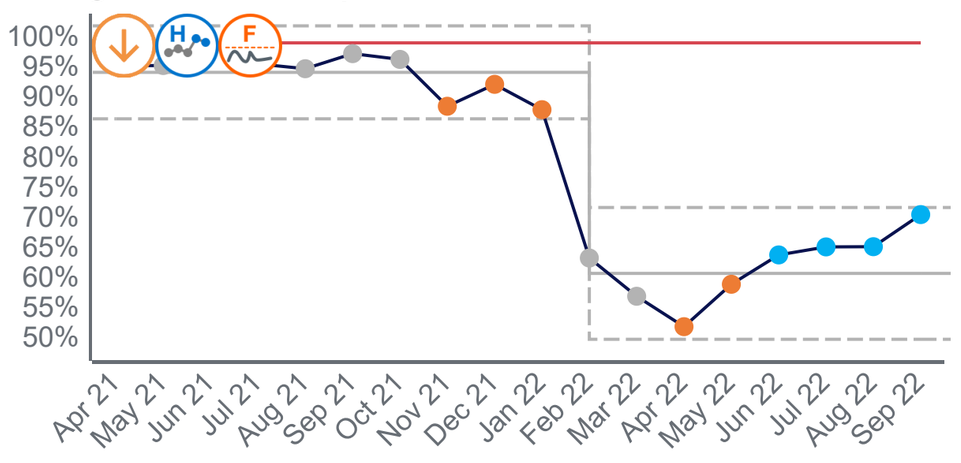
Technical Analysis:

Special cause variation observed in recent months, primarily due to increase in Dental patients >52wks, which represents 68% of the total. This includes 6 number of patients >78weeks.

Actions:

Weekly monitoring of all patients >40 weeks and patient level actions to expedite appointments. Spinal Surgery tracking every patient weekly to manage 78 week waits. Dental Insourcing model will commence in Nov, with key actions to secure contract sign off and Anaesthetic/Radiology cover for weekend theatre lists.

Diagnostics: % Completed Within 6 Weeks of referral



Technical Analysis:

Special cause variation was observed due to correction of reporting following Safe Waiting List Management validation. Baseline reset accordingly, and recent performance above the new mean but insufficient points to demonstrate improvement at this stage.

Actions:

MRI achieving 99% standard. 75% increase in Urodynamics capacity implemented in Sep. Home Sleep studies equipment now ordered, service to start in November which will increase service capacity by 100%.

Recovery & Access - Responsive - Metric Summary

Metric	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	September 2022	97	104	101.20		?
Number of RTT Patients waiting >52weeks	September 2022	435	0	277.50	H	F
Diagnostics: % Completed Within 6 Weeks of referral	September 2022	70	99	61.92	H	F
RTT Open Pathway: % Waiting within 18 Weeks	September 2022	54	92	63.88	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	September 2022	100	100	99.30		P
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	September 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	September 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	September 2022	100	100	91.18	H	?
Cancer: Faster Diagnosis within 28 days	September 2022	100	75	92.70		P
% Recovery for OP New & OPPROC Activity Volume	September 2022	102	104	99.22		?
% OPFU Activity Volume	September 2022	93	85	108.29		F

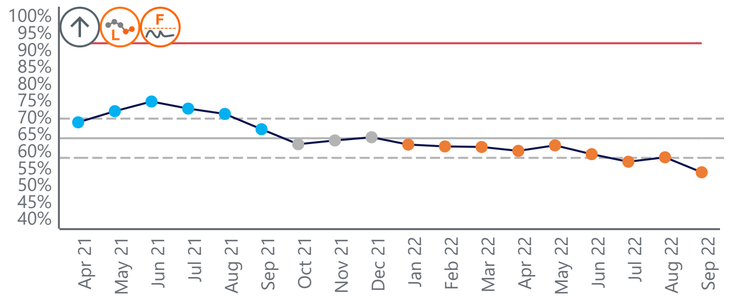
000038

Integrated Performance Report | October 2022

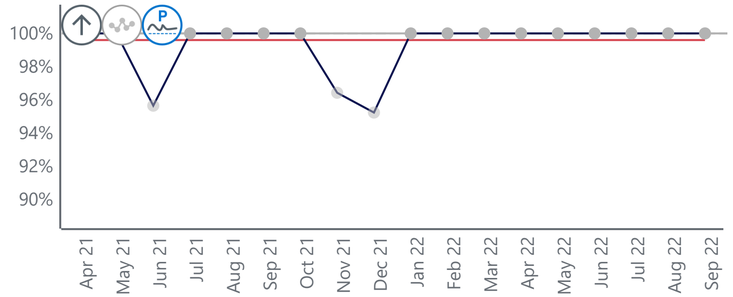
Alder Hey Children's NHS Foundation Trust

Recovery & Access - Responsive - Watch Metrics

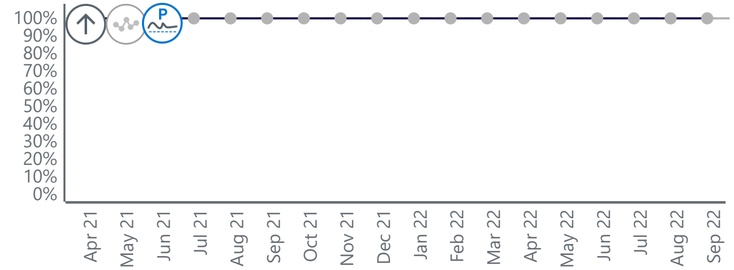
RTT Open Pathway: % Waiting within 18 Weeks



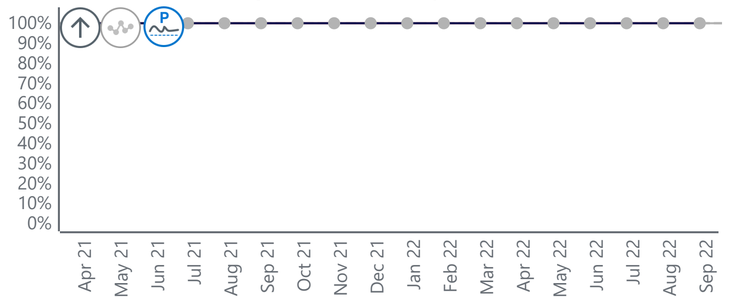
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



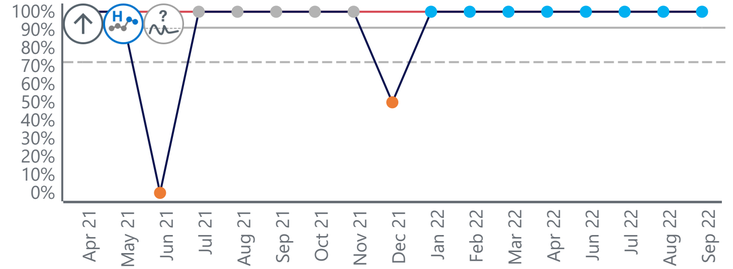
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



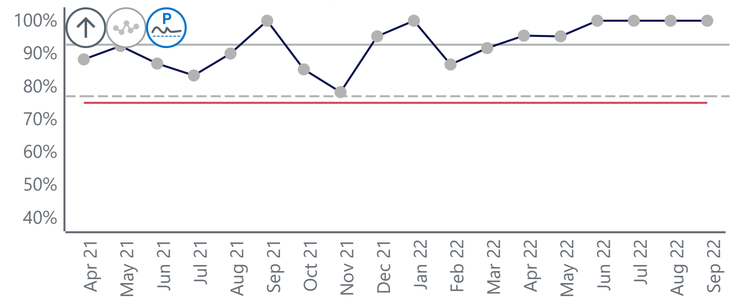
All Cancers: 31 day wait until subsequent treatments



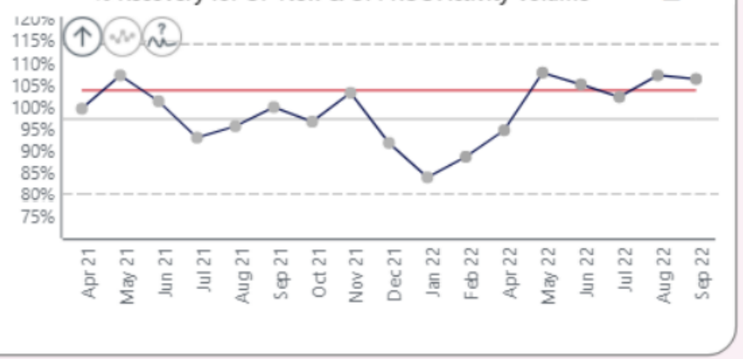
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



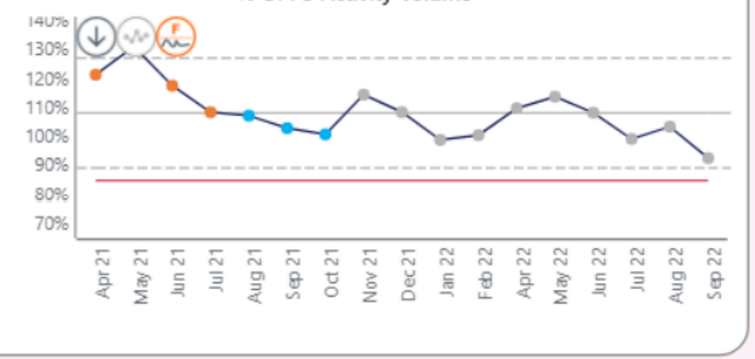
Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



% OPFU Activity Volume



Great Place to Work - Well Led - People

SRO : Melissa Swindell, Chief People Officer

Q2 Highlights:

• Mandatory training remains above target at 92% throughout Q2 • Sickness absence remains above the 5% target however it is positive that this has stabilised again with 4/5 recent months below the average and closer to the target, following a sustained period which was consistently above the average of 6.2% (during Jul 21 – Apr 22).

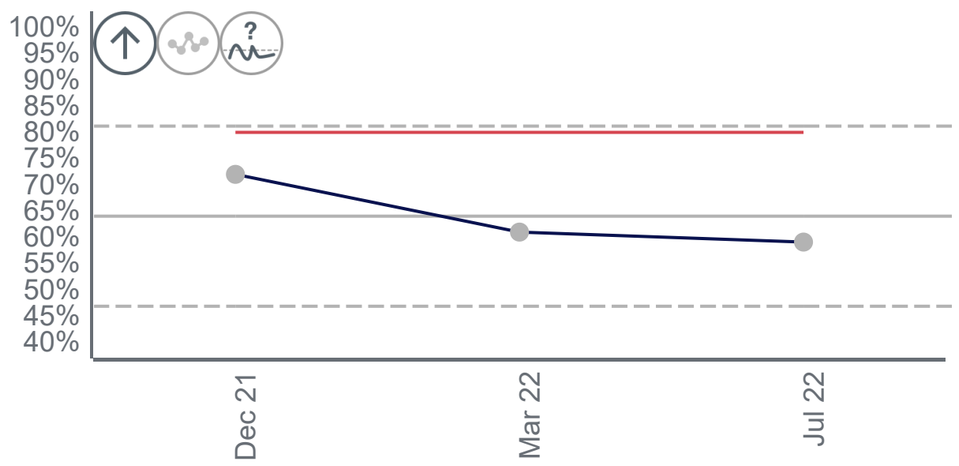
Areas of Concern:

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

Q3 Forward Look (with actions)

• Increased focus on turnover and retention initiatives which will be captured in the Trust long term plan on attraction and retention (currently in development).

% Staff who recommended Alder Hey as a place to work



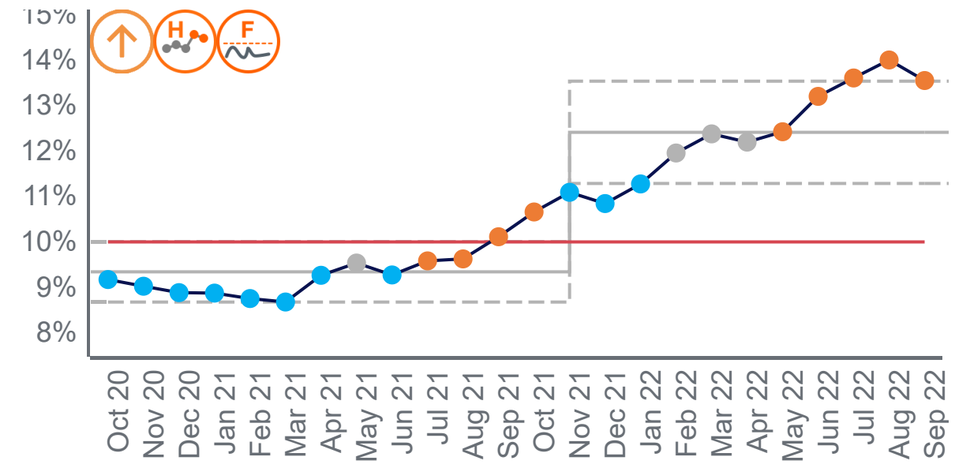
Technical Analysis:

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

Actions:

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

Staff Turnover



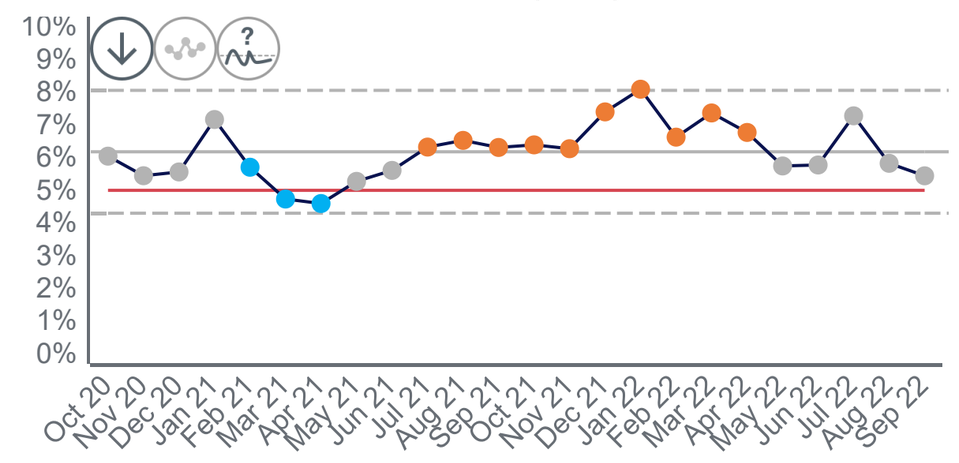
Technical Analysis:

This data raises significant concern due to special cause variation having been observed over a sustained period of time. The mean has been reset at 12.4%, and the lower control limit is now 11% which means the 10% target will not be achieved without substantial intervention.

Actions:

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

Sickness Absence (Total)



Technical Analysis:

Total absence is just above the 5% target (STS within 2% target, but LTS above the 3% target), and Sep is the lowest data point for 16 months. Whilst this is positive in month, it remains within common cause variation range and needs actions to be sustained over a longer time period to demonstrate an underlying improvement.

Actions:

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

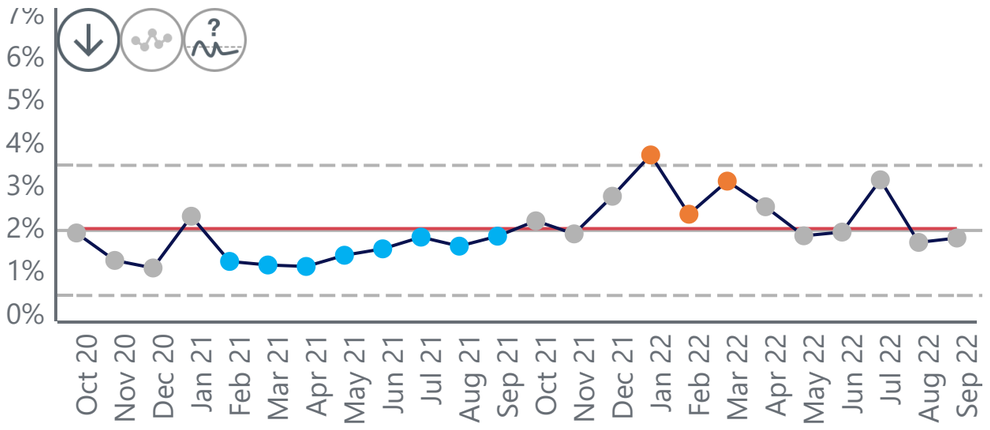
Integrated Performance Report | October 2022

Alder Hey Children's NHS Foundation Trust

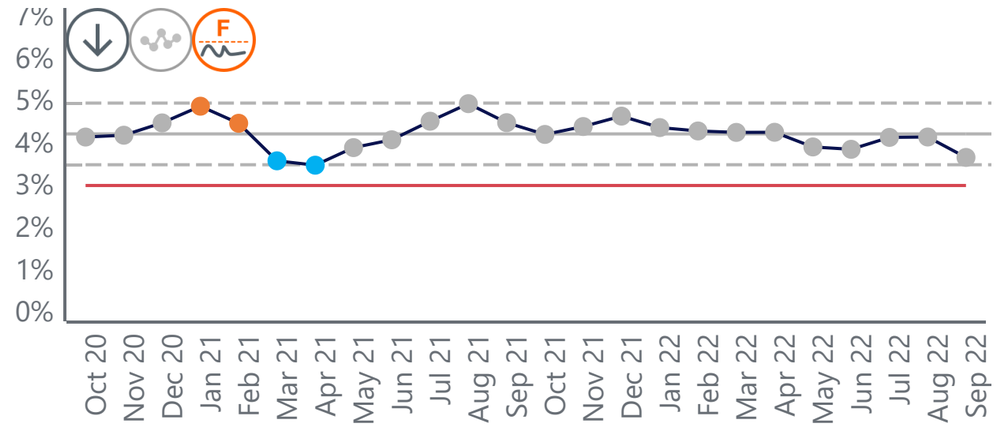
Great Place to Work - Well Led - People - Metric Summary

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	September 2022	14	10	12.41	H	F
Sickness Absence (Total)	September 2022	5	5	6.18		?
Short Term Sickness	September 2022	2	2	1.96		?
Long Term Sickness	September 2022	4	3	4.22		F
Mandatory Training	September 2022	93	90	92.17		P
% PDRs completed since April	September 2022	38	90	49.37	H	F
Medical Appraisal	September 2022	82	100	63.52	H	F

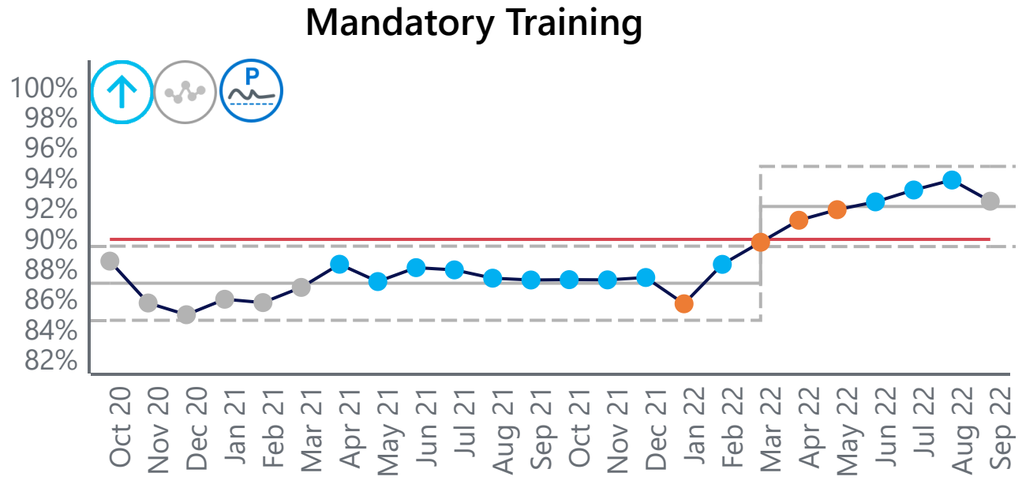
Short Term Sickness



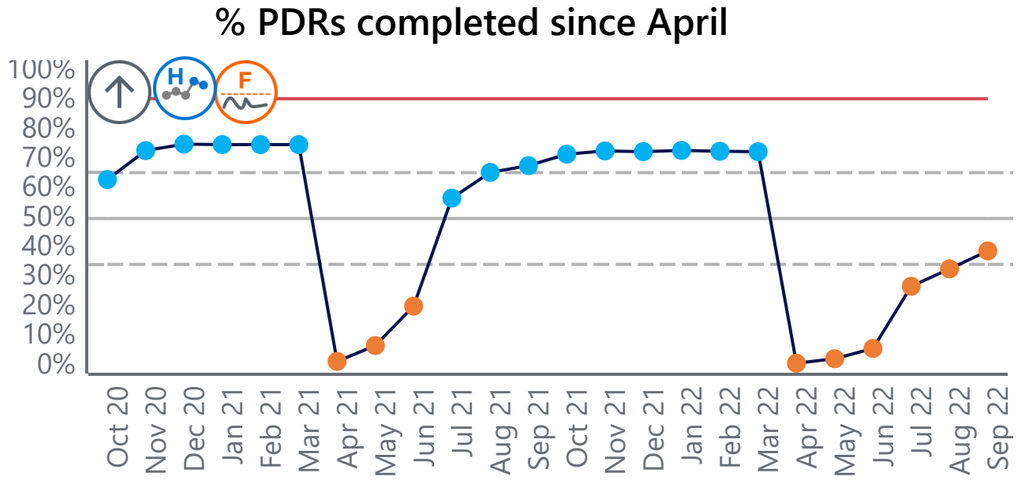
Long Term Sickness



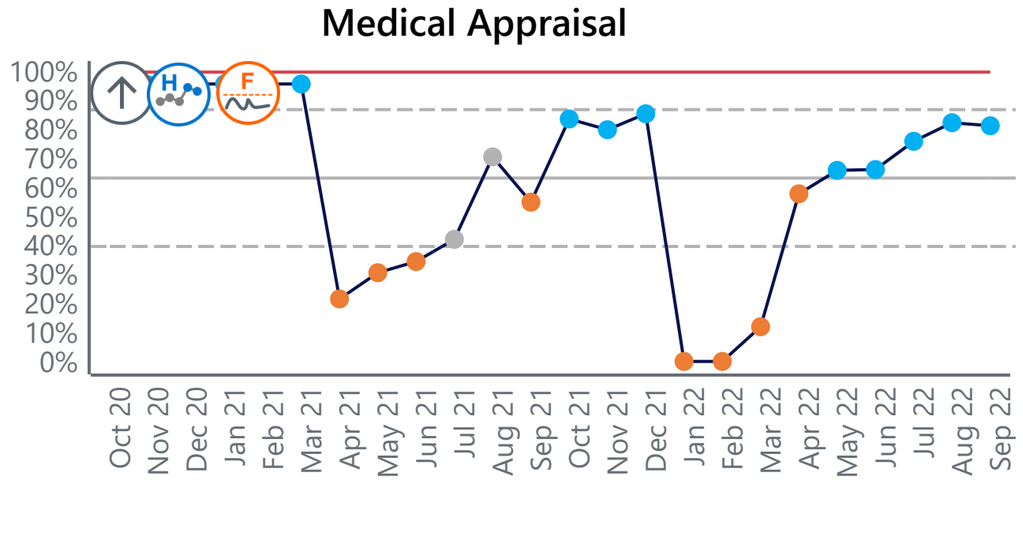
Mandatory Training



% PDRs completed since April



Medical Appraisal



Integrated Performance Report | October 2022

Alder Hey Children's NHS Foundation Trust

Well Led - Financial Sustainability - Finance

SRO : Rachel Lea, Deputy Director of Finance

Q2 Highlights:

• For September (M6), the Trust is reporting a deficit of £0.2m which is in line plan. • The year to date position is a £1.5m deficit in line with the plan approved. • The CIP targets have been achieved during Q2 on a non recurrent basis. • Cash has remained high during Q2 in line with the plan as capital spend increases in future months.

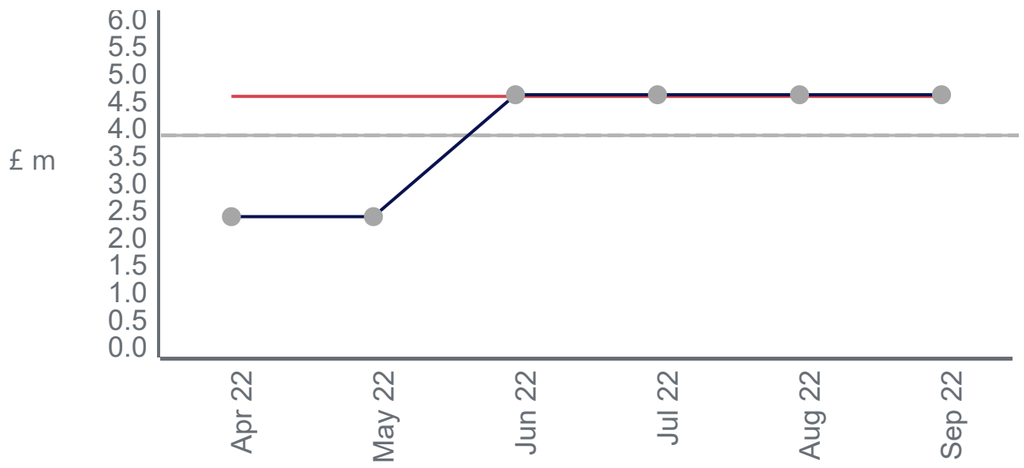
Areas of Concern:

• Lack of recurrent CIP identified with a lack of transformational schemes. • Challenging £4.6m control total surplus plan by end of the financial year with key drivers: 1. Increased energy cost not all mitigated. 2. Increase in temporary/premium pay despite activity below 19/20 levels. 3. Inflation/high usage pressure in drugs with no additional income. 4. ERF threshold not met with uncertainty on clawback in Q3/Q4.

Q3 Forward Look (with actions)

1. Continued cost control to reach the £4.6m surplus requirement by end of the financial year. 2. Increased focus on recurrent efficiency. 3. Further divisional finance panel meetings scheduled. 4. Triangulation of costs/activity/workforce. 5. Working groups understanding 3-4 key areas of focus for each division including Junior Doctors/ APNP/ Drug spend. 6. Deep dive continues into drug spend.

Revenue Position (Year End Forecast)



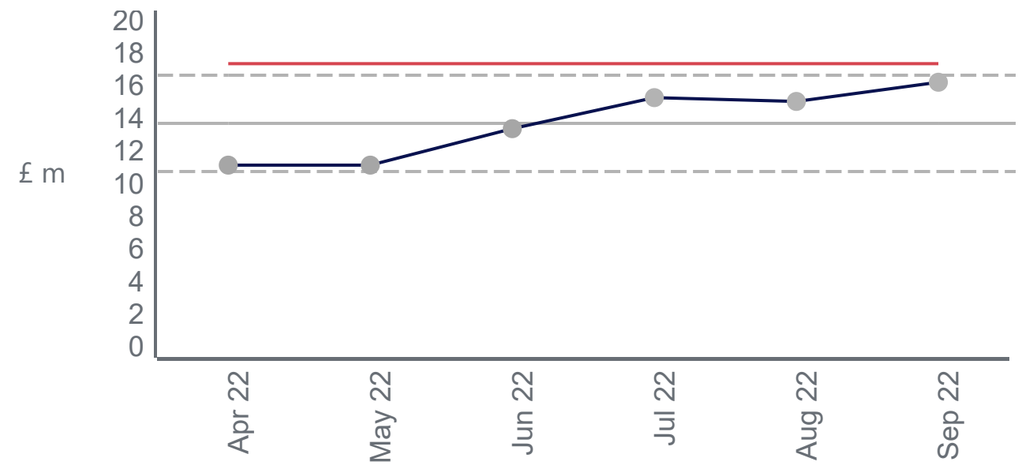
Technical Analysis:

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

Actions:

Continue to monitor inflationary pressures risk and mitigations

CIP Position In Year (Year End Forecast)



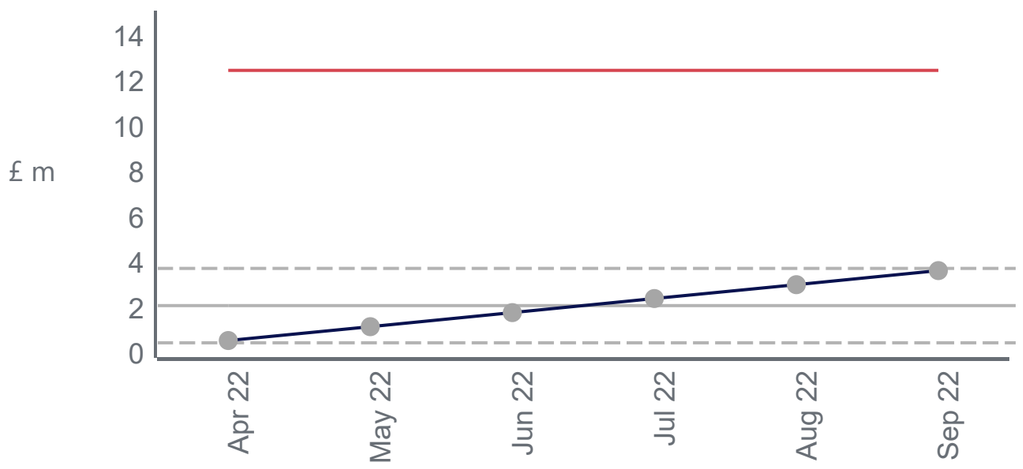
Technical Analysis:

£1m gap remains to achieve the CIP target in full, 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:

Only 30% CIP identified as recurrent, with £9m left to be identified and delivered in the remaining 6 months.

Actions:

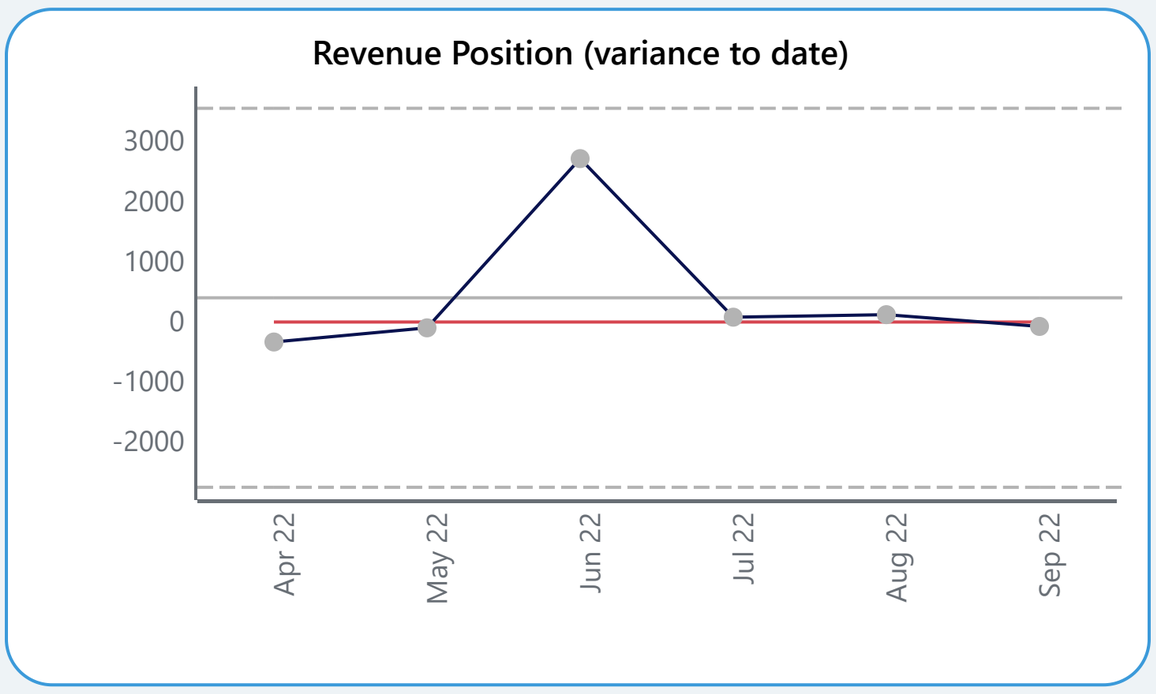
Support required with exec leads and transformation to identify the large scale opportunities either through existing programmes/projects or if not likely to deliver, for new schemes to be agreed and supported.

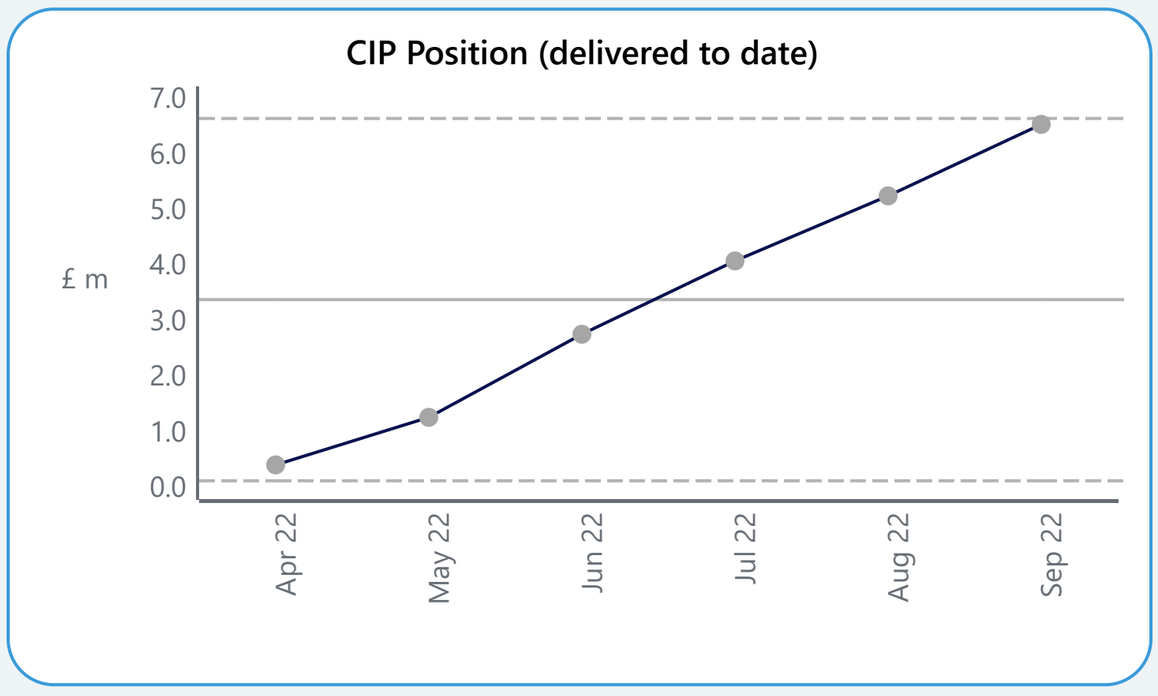
Integrated Performance Report | October 2022

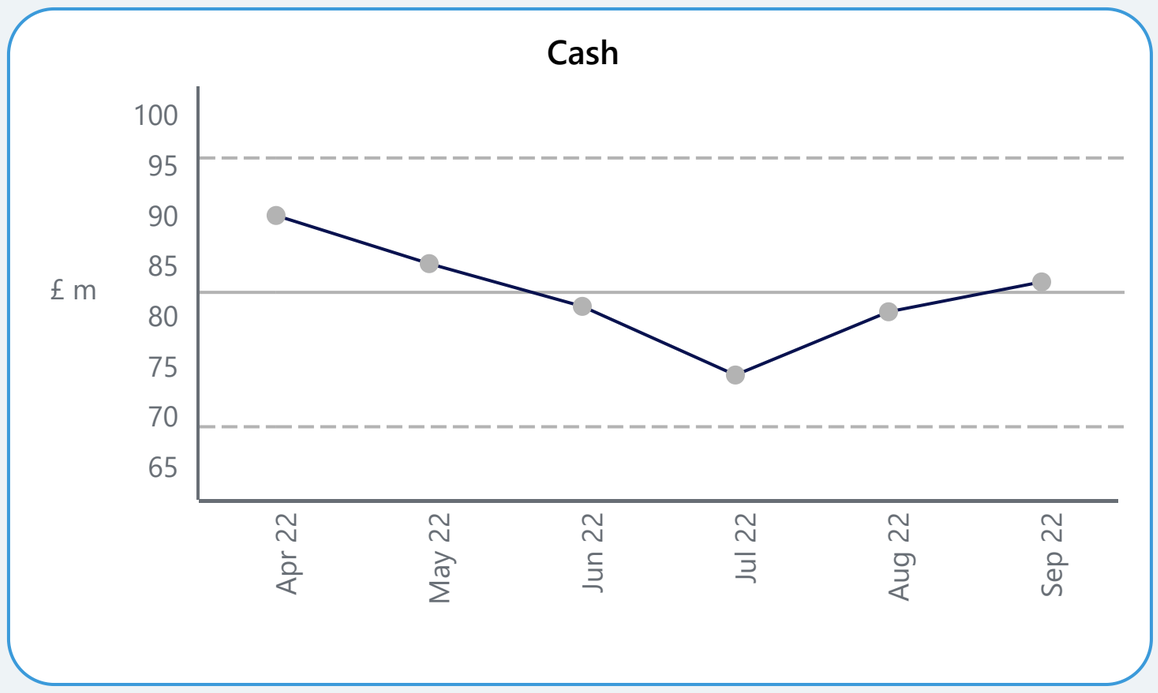
Alder Hey Children's NHS Foundation Trust

Well Led - Financial Sustainability - Finance - Metric Summary

Metric	Date	Value	Target	Variation	Assurance
Revenue Position (Year End Forecast)	September 2022	5	5		
CIP Position In Year (Year End Forecast)	September 2022	16	17		
CIP Position Recurrent/Full Year Effect	September 2022	4	13		
Revenue Position (variance to date)	September 2022	-73	0		
CIP Position (delivered to date)	September 2022	7			
Cash	September 2022	83,494,000			







Well Led - Risk Management

SRO : Erica Saunders, Director of Corporate Affairs

Q2 Highlights:

• All Divisional and Corporate Functions' high moderate longstanding risks (risks with a score of 12 on the risk register >12 months) reviewed with monthly oversight of progress from corporate governance team • Monthly risk register validation meetings continue with corporate oversight.

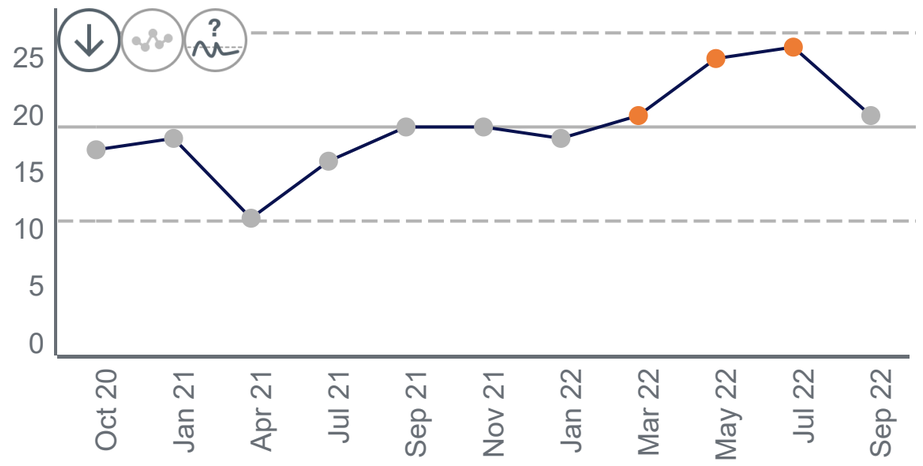
Areas of Concern:

• Some services are not reviewing risk registers in a timely manner • Limited understanding of risk process with individuals.

Q3 Forward Look (with actions)

• Ongoing review of open risk, risks with no risk score and overdue actions with relevant teams • Services to continue with cleanse and update of risk registers: focused work with service leads/divisions with oversight from corporate governance team • Refresh of risk management training with staff once procurement of new risk management system implemented.

Number of High Risks (scored 15 and above)



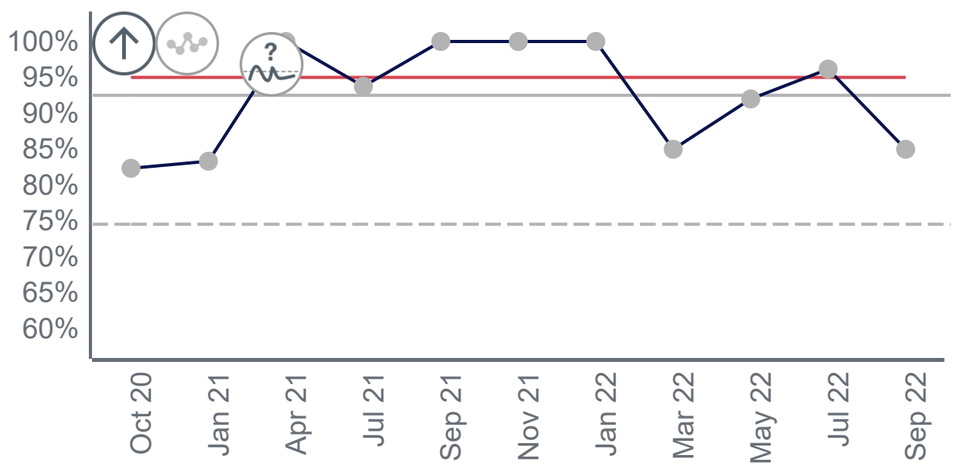
Technical Analysis:

The total number of High Risks is stable (ie New High Risks are identified as others are mitigated). Despite May and Jul having 2 points close to the upper limit, latest figure has returned to the mean. This data will be collected on a monthly basis going forward.

Actions:

Oversight and assurance of mitigation and progress provided at Risk Management Forum.

% of High Risks within review date



Technical Analysis:

At the end of Sep, 3/20 risks were overdue their review date. In general performance shows normal cause variation and fluctuates above and below the 95% target. This data will be collected on a monthly basis going forward.

Actions:

Oversight and assurance of mitigation provided at Risk Management Forum.

Well Led - Safe Digital Systems- Digital

SRO : Kate Warriner, Chief Digital and Information Officer

Q2 Highlights:

• Mobilisation progressing with digital and data futures strategy programmes • Successful deployments include launch of digital communications in outpatients and remote monitoring for wound surveillance • AlderC@re progresses with planning for summer 2023 go live; progress being assessed through patient journey demonstrations during Oct • Location has been confirmed for the AlderC@re Simulation Suite

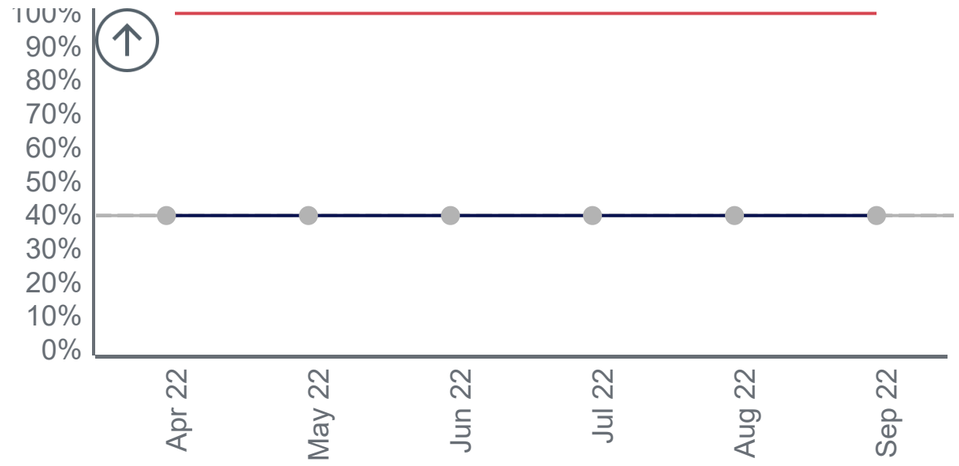
Areas of Concern:

• Work continues with Meditech to review and resolve outstanding priority 1 issues, particularly for electronic prescribing • There are dependencies and deployment schedules that need to be fully defined between AlderC@re and the proposed new theatre system, options to be presented to Executive team • Resource are closely monitored re demands from a range of Trust priority programmes.

Q3 Forward Look (with actions)

• New Models of Care theme of digital/data futures strategy is starting to develop including programme/project scope • Consent will be relaunched in Oct with the removal of paper from surgery processes • A review of the AlderC@re go live dates to be confirmed post patient journeys • An Alderc@re gateway review will take place assessing progress including build and clinical safety planning.

Alder Care - Divisional Critical Criteria



Technical Analysis:

6/15 critical criteria complete. Remainder awaiting system build or key decisions (eg waiting list management). Progress impacted by reset, additional resource in place, planning to be completed by end of November. Decision on theatre system approach will impact. Critical criteria are part of gateway review for clinical safety

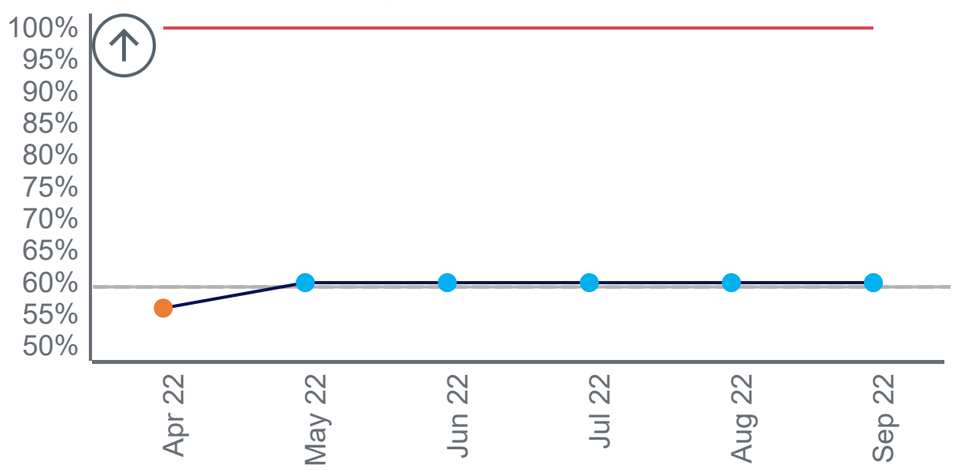
Actions:

1. Project Manager to develop a plan for each remaining item

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

3. Theatre system position to be reviewed Oct / Nov 2022

Alder Care - % System Build Completion



Technical Analysis:

This metric monitors build across all workstreams. The build is being validated through patient journeys with clinical teams. Build for prescribing due to start in November following delivery of developments on priority issues from Meditech. Approach to theatres build will need to consider the impact of the new theatre system

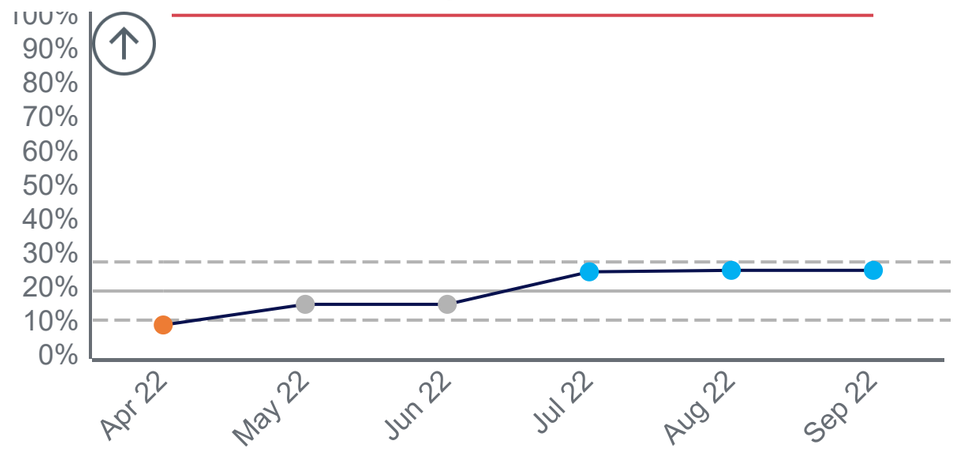
Actions:

1. Validate build metric following patient journeys

2. Commence prescribing build

3. Assess impact of potential new theatre system on AlderCare build

Alder Care - % Speciality documentation build



Technical Analysis:

14 of 57 specialties have identified changes to their documents which have now been actioned. Orthopaedic documents in the process of being amended, with over 80 documents to be reviewed. A sign off process is being developed and the first formal sign off processes will start from November 2022

Actions:

1. Complete development of sign off process

2. Schedule specialty reviews for remaining areas

Divisional Performance Summary - Community & Mental Health

SRO : Lisa Cooper, Community & Mental Health Division

Highlights

• Zero over 52-week waiting times in Community Paediatrics • Routine and urgent children & young people with an eating disorder to be seen within the national timeframes • Mandatory training across the Division remains above 90% • Strong financial performance with CIP plans in place.

Areas of Concern

• Access for specialist Community Mental Health Services remain challenging with an increase in young people waiting >18wks • IHAs for CYP who are new into care are not being completed in all cases within 20 working days; range of 16-28 days • Overall time to complete ASD and ADHD assessments is stable (75-80% completed within 52wks) but below aspiration of 30wks • Waiting times for community SALT remain challenged.

Forward Look (with actions)

• Improvement plan in place for ASD waiting times using Brilliant Basics QI approach • Community SALT pilot (Oct start) to test new model with schools to support early intervention and reduce waiting times • Improving IHA turnaround times focussed on job plan reviews so capacity meets demand. Ongoing discussions with Liverpool and Sefton Places regarding commissioning and system arrangements for IHAs.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	September 2022	18	15	19.78		
Number of Incidents rated No Harm and Near Miss	September 2022	65	80	74.56		
Use of physical restrictive intervention (MH Tier 4)	September 2022	1		11.71		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	September 2022	0	6	3.28		
Number of PALS contacts	September 2022	51	45	41.56		

Divisional Performance Summary - Community & Mental Health

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Virtual Outpatients (national standard 25%)	September 2022	56	25	54.70		P
% Was Not Brought Rate (All OP: New and FU)	September 2022	15	10	14.60		F
% of Clinical Letters completed within 10 Days	September 2022	69	95	57.65		F
CYP1 - Number of visitors to the site	September 2022	1480		1,271.00		?
CYP1 - Number of Referrals	September 2022	121		77.82		?
CYP1 - Number of Referrals Accepted	September 2022	48		30.82		?

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of RTT Patients waiting >52weeks	September 2022	0	0	2.22		?
RTT Open Pathway: % Waiting within 18 Weeks	September 2022	48	92	56.15	L	F
% Recovery for OP New & OPPROC Activity Volume	September 2022	107	104	120.17		?
% OPFU Activity Volume	September 2022	102	85	113.41		F
CAMHS: Number of Patients waiting >52weeks	September 2022	5	0	3.94	H	?
CAMHS: First Partnership - % Waiting within 18 weeks	September 2022	50	92	65.27	L	F
CAMHS: Paired Outcome Scores	July 2022	35	40	32.19		?
CAMHS: Crisis / Duty Call Activity	September 2022	709		656.78		?
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	September 2022	90	95	44.10		?
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	September 2022	100	95	70.00		?
ASD: % Incomplete Pathways within 52wks	September 2022	74	90	74.23		?
ASD: % Referral to triage within 12 weeks	September 2022	100	100	100.00		P
ADHD: % Incomplete Pathways within 52wks	September 2022	85	90	84.77		?
ADHD: % Referral to triage within 12 weeks	September 2022	100	100	100.00		P
IHA: % Complete within 20 days of starting in care	August 2022	6	100	8.03		F
IHA: % complete within 20 days of referral to Alder Hey	August 2022	10	100	21.28		F

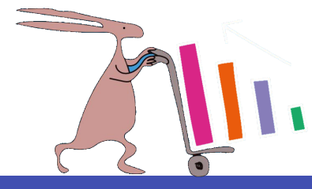
Divisional Performance Summary - Community & Mental Health

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	September 2022	14	10	12.17	H	F
Short Term Sickness	September 2022	1	2	1.56		?
Long Term Sickness	September 2022	4	3	3.73		?
Mandatory Training	September 2022	94	90	94.78		P
% PDRs completed since April	September 2022	44	90	56.53		?
Medical Appraisal	September 2022	86	100	58.76		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	September 2022	5	0	5.65		?



Divisional Performance Summary - Medicine

SRO : Urmi Das, Division of Medicine

Highlights

• Sustained Improvement in Inpatient Sepsis treated within 60 minutes • Continued improvement in resolving complaints informally via PALS and subsequent reduction in formal complaints • Sustained achievement across all Cancer standards • Sustained Elective, Day Case and Outpatient Recovery • Mandatory Training remains compliant.

Areas of Concern

• Variable performance against the 60-min standard for treatment of Sepsis in ED • FFT in ED variable, reflects waiting times variation • Access for CYP remains a challenge for OP, IP and Diagnostics • ED Performance challenged in relation to volume of attendances • Sickness absence remains area of focus • Turnover improved in month • Increase in the number of CYP "super-stranded" (+21 days LOS).

Forward Look (with actions)

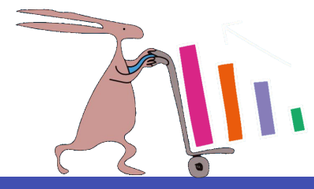
• Recovery plans in place; sustainability plans drafted for Neurology, Neurophysiology, Dermatology • Staff Engagement Plan finalised; staff newsletter relaunched, next edition focused on Response to Big Conversations • Head of Nursing in ED focusing on Sepsis and FFT • ED@Best Programme continues • EDEx Streaming capacity approved to go live Dec 22 • Winter Program launched including focus on LOS and refresh of CUR.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	September 2022	17	15	19.78		
Number of Incidents rated No Harm and Near Miss	September 2022	148	140	143.17		
Sepsis % Patients receiving antibiotic within 60 mins for ED	September 2022	85	90	83.63		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	September 2022	95	90	89.67		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	September 2022	2	6	4.56		
Number of PALS contacts	September 2022	48	45	40.89		
F&F ED - % Recommend the Trust	September 2022	80	95	69.14		



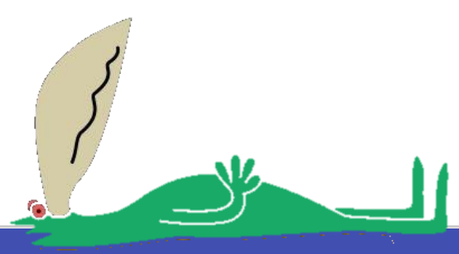
Divisional Performance Summary - Medicine

Effective

MetricName	Date	Value	Target	Mean	Variation	Assurance
ED: % treated within 4 Hours	September 2022	84	95	77.65		?
Number of Super Stranded Patients (21 days)	September 2022	36	20	26.78		?
% Virtual Outpatients (national standard 25%)	September 2022	30	25	38.34	L	P
% Was Not Brought Rate (All OP: New and FU)	September 2022	9	10	9.05		?
% of Clinical Letters completed within 10 Days	September 2022	60	95	56.78		F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	September 2022	105	104	113.24		?
Number of RTT Patients waiting >52weeks	September 2022	52	0	13.06	H	?
Diagnostics: % Completed Within 6 Weeks of referral	September 2022	75	99	65.51		F
RTT Open Pathway: % Waiting within 18 Weeks	September 2022	54	92	70.69	L	F
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	September 2022	100	100	99.30	H	?
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	September 2022	100	100	100.00		P
All Cancers: 31 day wait until subsequent treatments	September 2022	100	100	100.00		P
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)	September 2022	100	100	91.18	H	?
Cancer: Faster Diagnosis within 28 days	September 2022	100	75	92.70		P
% Recovery for OP New & OPPROC Activity Volume	September 2022	117	104	101.26		?
% OPFU Activity Volume	September 2022	102	85	113.41		F



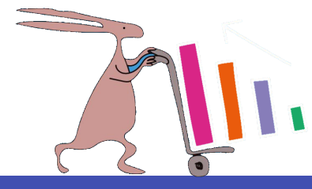
Divisional Performance Summary - Medicine

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	September 2022	13	10	12.53	H	F
Short Term Sickness	September 2022	2	2	2.24		?
Long Term Sickness	September 2022	5	3	4.47	H	F
Mandatory Training	September 2022	91	90	91.41		?
% PDRs completed since April	September 2022	31	90	48.08		F
Medical Appraisal	September 2022	85	100	61.42	H	?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	September 2022	1	0	-1.78		?



Divisional Performance Summary - Surgery

SRO : Benedetta Pettorini, Division of Surgical Care

Highlights

• IP Sepsis <60mins over target at 91% • Continued high levels of reporting of incidents with no harm & near miss • OPFU , although not reaching target, has exhibited special cause variation which is positive this is reflecting benefit of actions: PIFU, pathway reviews, clinical validation • Sickness levels in line with trust targets and showed special cause variation in September.

Areas of Concern

• There were 33 cancelled operations in Sept (above target of 20) • ERF position remains a challenge in Sept - reduction in Cardiac cases and Spinal overperformance reduced. • RTT patients waiting >52wks increased but was in line with trajectory. Challenge remains in Dentistry and Spinal Surgery • 1 Never Event in month, no patient harm.

Forward Look (with actions)

• Financial analysis for recruitment of agency staff to support theatre activity & increase in sessions • Update SOP for starting theatre lists • LOS workstreams to be launched • Continued focus on reducing waiting times below 52wks. Action plan for Dental includes Insourcing model (commence Nov) • Focus on bringing completion of clinical letters within target via Governance meeting and weekly failsafe actions.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	September 2022	55	40	48.22		
Number of Incidents rated No Harm and Near Miss	September 2022	169	150	159.94		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	September 2022	91	90	83.19		

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	September 2022	0	6	4.72		
Number of PALS contacts	September 2022	40	45	39.17		

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)	September 2022	32	20	20.06		?
Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days	September 2022	8	0	6.89		?
Number of Super Stranded Patients (21 days)	September 2022	14	30	9.67		F
% Virtual Outpatients (national standard 25%)	September 2022	13	25	17.35	L	F
% Was Not Brought Rate (All OP: New and FU)	September 2022	9	10	8.68		?
% of Clinical Letters completed within 10 Days	September 2022	69	95	57.39	H	F

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
% Recovery for DC & Elec Activity Volume	September 2022	88	104	89.12		?
Number of RTT Patients waiting >52weeks	September 2022	383	0	262.22	H	F
Diagnostics: % Completed Within 6 Weeks of referral	September 2022	30	99	33.40		F
RTT Open Pathway: % Waiting within 18 Weeks	September 2022	55	92	62.17	L	F
% Recovery for OP New & OPPROC Activity Volume	September 2022	95	104	97.00		?
% OPFU Activity Volume	September 2022	84	85	101.52		?

Divisional Performance Summary - Surgery

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	September 2022	12	10	11.64		F
Short Term Sickness	September 2022	2	2	2.29		?
Long Term Sickness	September 2022	3	3	3.97	L	F
Mandatory Training	September 2022	92	90	91.70		?
% PDRs completed since April	September 2022	40	90	43.64		F
Medical Appraisal	September 2022	76	100	66.43		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	September 2022	-7	0	-3.46		?

Divisional Performance Summary - Research

SRO : John Chester, Clinical Research Division

Highlights

• Lead recruiter of research participants amongst 19 NHS Trusts in North West • Zero Complaints or PALS concerns • Number of academic studies opened higher than target • Appointment of novel roles to advance clinical research - Consultant in Paediatric Research and Urgent Care to further develop industry collaborations and GP to further develop Primary Care opportunities for Clinical Research Facility.

Areas of Concern

• Downward trend of participant recruitment due to reduction of number of studies in recruitment phase and impact of individual study recruitment strategies • Zero commercial studies opened however pipeline for commercial in future months remains encouraging • Staff turnover (12mth rolling) at 19.9% with majority of leaving reasons being promotion – note that the 19.9% figure equates to 14.91 leavers in previous 12 months.

Forward Look (with actions)

• Ongoing focus to balance trials portfolio with available resources: relevant studies to be closed to create capacity for new opportunities • Making Research a Great Place to Work improvement programme overseeing actions including introduction of career development opportunities, exploring use of fixed term contracts and benchmarking re pay • Long-term operational plan to enable R&I Strategic Framework under development.

Safe

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	September 2022	0	2	0.11		P
Number of Incidents rated No Harm and Near Miss	September 2022	2	10	1.60		?

Caring

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of formal complaints received	September 2022	0	2	0.00		P
Number of PALS contacts	September 2022	0	15	0.00		P

Divisional Performance Summary - Research

Responsive

MetricName	Date	Value	Target	Mean	Variation	Assurance
Number of Patients Recruited into Research Studies	September 2022	114	100	822.00	L	P
Number of New Studies - Academic	September 2022	4	3	3.17		?
Number of New Studies - Commercial	September 2022	0	1	1.06	L	?
Number of Active (Open) Studies - Academic	September 2022	149	130	135.83	H	?
Number of Active (Open) Studies - Commercial	September 2022	37	30	38.89		P
Number of Grants Awarded	September 2022	0		0.00		

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	September 2022	20	10	16.10	H	F
Short Term Sickness	September 2022	1	2	1.22		?
Long Term Sickness	September 2022	2	3	4.24		?
Mandatory Training	September 2022	93	90	92.88		P
% PDRs completed since April	September 2022	40	90	60.25		?

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	September 2022	33	0	-194.60		?

Divisional Performance Summary - Corporate

SRO : Erica Saunders, Director of Corporate Affairs

Highlights

• Corporate Services Collaborative group has been established and is meeting regularly: focus is on key workforce and finance metrics plus risk registers • Oct meeting agreed to channel all corporate services space and environment requests through the group and consider a collective vacancy control process to mirror that in clinical divisions.

Areas of Concern

• Lack of engagement and attendance by some corporate services heads of department which may lead to a lack of cohesion and consistency of application of agreed processes.

Forward Look (with actions)

• Collective problem statement to be agreed by the group for presentation at the first formal Performance Review • Risk profile to be kept under review • 'Hotspot areas' approach to continue for HR and £ metrics with drill down and mutual support approach across the areas • Focus on systematising processes and decisions across all areas via the CSC as a proxy divisional board • Encourage areas who have not been regular attenders to get involved.

Well Led - People

MetricName	Date	Value	Target	Mean	Variation	Assurance
Staff Turnover	September 2022	14	10	14.14		F
Sickness Absence (Total)	September 2022	5	5	6.71		?
Short Term Sickness	September 2022	1	2	1.52		?
Long Term Sickness	September 2022	4	3	5.19		F
Mandatory Training	September 2022	94	90	91.69	H	?
% PDRs completed since April	September 2022	40	90	52.74		F

Well Led - Financial Sustainability

MetricName	Date	Value	Target	Mean	Variation	Assurance
Revenue Position (variance to date)	September 2022	0	0	-11.06		?

000057

Safe Staffing & Patient Quality Indicator Report
June 2022

	Day		Night		Actual hours	Patients	CHPPD		Vacancy				Turnover (Leavers)				Sickness				Medication incidents		Staffing Incidents		FFT			
	Average fill rate - RN	Average fill rate - HCA	Average fill rate - RN	Average fill rate - HCA	Total	Total count of Patients at Midnight	CHPPD Rate	National benchmark	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	RN - FTE	RN - %	HCA - FTE	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	93%	-	90%	-	1818	**94**	19.34	13.12	-1.21	-9.21%	0.20	20.00%	0.00	0.00%	0.00	0.00%	15.80	3.00%	24.00	100.00%	4	13	1	4	6	100%	0	0
HDU	68%	56%	69%	46%	7427.25	**330**	22.51	30.35	8.74	11.71%	3.05	38.17%	0.00	0.00%	0.00	0.00%	203.17	10.11%	4.84	6.17%	4	43	2	2	0	-	0	0
ICU	74%	100%	77%	100%	15272	**408**	37.43	30.35	18.89	11.24%	-8.45	-138.98%	1.77	1.26%	0.00	0.00%	211.40	5.03%	33.00	19.60%	17	75	0	1	4	100%	0	1
Ward 1cC	89%	78%	86%	57%	6855.75	**488**	14.50	13.79	-8.38	-14.59%	0.80	15.01%	0.00	0.00%	0.00	0.00%	57.73	2.86%	5.29	3.89%	6	17	0	0	6	100%	0	0
Ward 1cN	84%	0%	96%	-	2766.25	**173**	16.85	16.85	8.61	24.17%	1.43	58.85%	1.00	3.78%	0.00	0.00%	98.52	12.23%	0.00	0.00%	2	9	0	1	2	100%	0	0
Ward 3A	88%	82%	90%	73%	7028.25	**702**	10.18	10.18	-0.50	-1.06%	1.68	10.51%	0.00	0.00%	0.00	0.00%	97.17	6.64%	65.97	20.90%	3	15	1	5	36	94.44%	3	0
Ward 3B	76%	97%	71%	-	4076.25	**281**	14.51	9.96	-2.99	-7.93%	-1.82	-31.01%	1.00	2.47%	0.00	0.00%	140.14	11.60%	31.60	21.41%	0	19	1	17	3	100%	1	0
Ward 3C	86%	75%	80%	92%	6336.75	**728**	8.83	8.83	-4.75	-9.31%	4.15	38.04%	0.92	1.68%	0.00	0.00%	180.55	10.99%	27.60	21.77%	3	21	0	1	12	100%	0	0
Ward 4A	81%	55%	85%	60%	7647	**695**	11.00	10.59	-1.18	-1.80%	-0.23	-2.70%	0.61	0.92%	0.00	0.00%	130.53	6.51%	6.13	4.17%	4	20	0	3	31	100%	2	1
Ward 4B	67%	82%	63%	79%	7181.5	**552**	13.07	11.38	-4.93	-12.41%	2.17	5.50%	0.61	1.41%	1.69	5.13%	179.55	13.69%	175.86	18.05%	2	36	1	7	7	85.71%	1	1
Ward 4C	82%	75%	81%	78%	6222.5	**767**	8.11	8.11	-8.42	-17.12%	0.34	2.98%	0.00	0.00%	0.00	0.00%	126.09	7.48%	30.92	9.45%	5	31	0	7	23	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

Wards 3B and 4B had a low fill rate of Registered Nurses due vacancy. Staff have been appointed to both areas and are due to commence in post in October. Wards 3B, 3C and 4B also have continued higher levels of sickness. A full overview of absence is taking place 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.

4B had several staff on secondment that have been reviewed and staff brought back to the ward where appropriate to support the establishment. The matron has reviewed the 1:1 risk assessments for HCA cover to ensure patient safety and due to the high numbers of 1:1's required on the ward these are reviewed on a daily basis.

Surgery

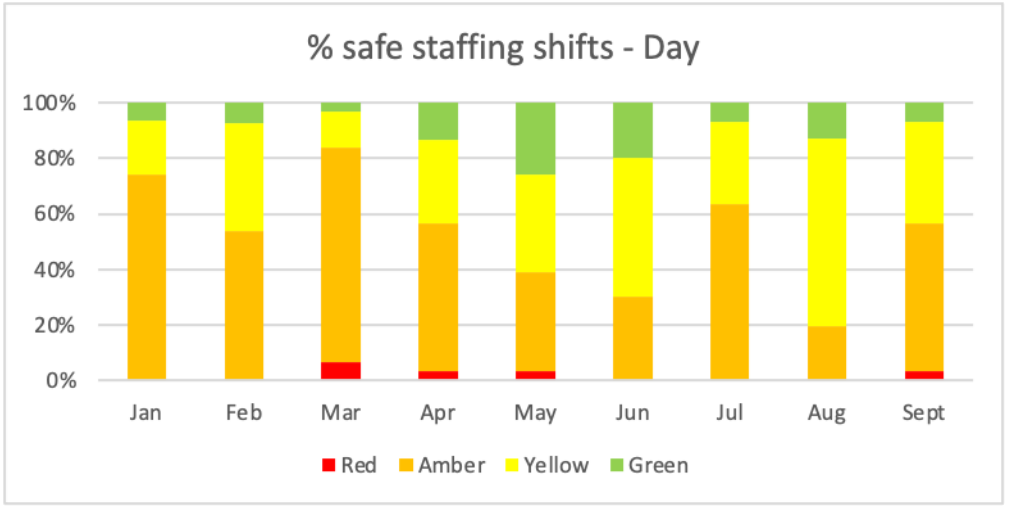
HDU and ICU had a low fill rate of Registered Nurses due to a vacancy. The 8.45 FTE over establishment on ICU for unqualified includes the international nurses awaiting UK registration, who will then be deployed into the numbers. Sickness levels on HDU were 10% and 5% on ICU. ICU had 17 medication incidents which is a reduction of 9 from May, with no incidents requiring escalation. Pals and complaints numbers were low across critical care unit.

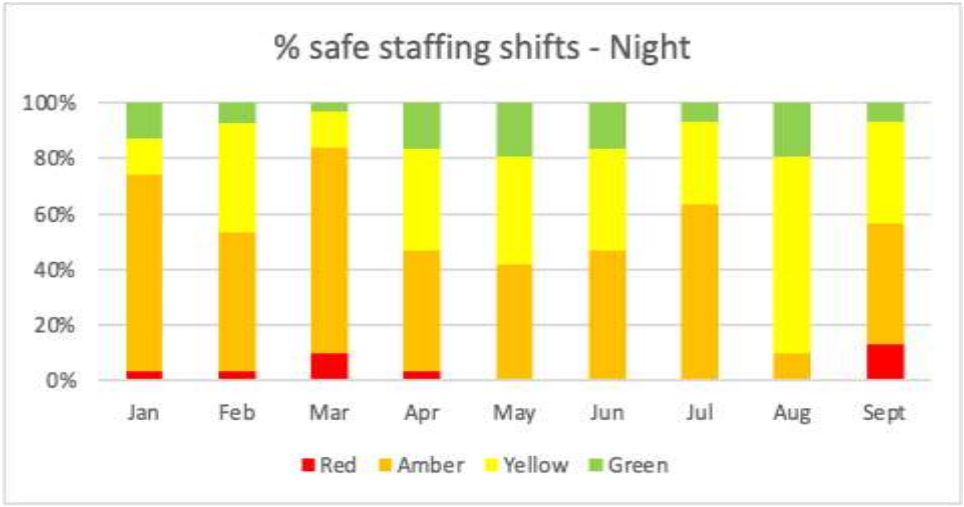
On the surgical wards, 3A and 4A had low fill rate for HCAs for the month of June. Sickness rate for HCAs on 3A was 20% and there was minimal uptake for additional shifts. The wards prioritise HCA cover for patients requiring a 1:1 as per the risk assessment. 1c Neo reported vacancy is in line with additional posts received through Neonatal Critical Care Review (NCCR) in May, with recruitment plans underway.

Summary

CHPPD compare equally and well with other paediatric hospitals and trusts with the exception being Oncology and Burns. Both these areas have s higher CHPPD hours compared to the national benchmark. Further work will be undertaken to understand the drivers for this.

Safe staffing had been improving with the majority of shifts green and yellow in August. There has been a significant increase in red and amber staffing ratings in September. The winter incentive will be reinstated to help address low temporary staffing fill rates.





Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

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).*

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's designed to improve control and therefore the achievement of sustainable change.

Summary rating results Qtr.2 22/23: -

- 86% of programmes have been rated as green for the adherence to the governance standards.
- All programmes are currently rated as amber for delivery assurance.

The recommendations, following this report is to: -

- Review milestones for Qtr. 3, to ensure clarity between a deadline and a milestone; and provide further assurance around delivery achievability.
- There are no risks for escalation following the completion of this assurance assessment.

2. Background

Historically the trust board has received a monthly governance report from the Delivery Management Office, with an assessment of programmes against the core Project Management Standards. Due to Covid-19 this habit was paused, and the reinstatement of this assurance, provides an opportunity to reintroduce the rigor and transparency to trust board.

How

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 openness with the programme teams, around the expected standards and guidance on 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. **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 *	Overall Governance rating	Overall Delivery rating	Overall Qi approach rating	Summary Comments
Advancing Outpatients *Chief Operating Officer*	104% Activity Elective & Daycase and outpatient				• EIA / QIA require sign off; milestones require updating. Benefits are trending positively • BB tools are being used at the programme level.
Productive Theatres *Chief Operating Officer*					• The programme scope has changed multiple times since project initiation. • The scope changes have been escalated to the SRO and improvements to the ongoing leadership from the Division have been agreed. • Metrics in day case theatres are trending positively and the team locally is driving improvements.
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. • Whilst the EIA/QIA is completed for the overall strategy individual workstreams need to now sign off completed documentation. • 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.

Programme *(SRO)*	Driver *	Overall Governance rating	Overall Delivery rating	Overall Qi approach rating	Summary Comments
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.
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 plan however this now needs updating and 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. No EIA/QIA is 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. • There is a Statement of Planned Benefits (SOPB) document however several projects are awaiting input from a benefits expert to define their project specific benefits. • There is a programme plan on a page which looks largely on track and a gateway review process which is aiming towards some strict criteria to progress through gateway 1 which is scheduled for November 22, but as expected with a programme of this scale, there are some milestones that are delayed. • There is a comprehensive risk register which is submitted to each Aldercare Board with high-level risks discussed by exception. • The programme is still awaiting the completion of an EIA/QIA however this has been captured as an action at the Alderc@re Board.

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

Overall Assessment

- 86% of programmes have been rated as green for the adherence to the **governance** standards.

It's a positive 6-month position that most programmes have established good routines regarding governance, particularly the effective management of risks.

The only programme currently not rated as green for governance is Productive Theatres, due to scope changes. These concerns have been escalated to the SRO and corrective action has been taken, which has had the impact of improving governance and ownership from the Division. Appendix 1, details key successes from each of the programmes, year to date (including Productive Theatres).

- All programmes are currently rated as amber for **Overall Delivery**. Most programme milestones are scheduled to be completed for Qtr. 4.

Overall, an amber rating for programme delivery (at this six-month stage) indicates a good level of progress.

Many of the programmes have profiled completion of a high proportion of milestones for completion in quarter 4. The profiling of milestones within quarter 4 may indicate that some are 'completion deadlines' rather than milestones. A review of the remaining programme milestones will support an assessment of the likelihood of the full programme benefits being achieved.

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 6-month stage. A review of the remaining programme milestones will support an assessment of the confidence rating around programme delivery.

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

4. Recommendations

- Report is noted
- A review of milestones for Qtr. 3, to ensure clarity between a deadline and a milestone (*delivery achievability*)
- No risks for escalation following the completion of the governance assessment.

Appendix 1: Highlights Programme Delivery (Year to Date)

Programme	Highlights
Advancing Outpatients	**Patient Initiated Follow Ups (PIFU)** • 16 specialties utilising Patient Initiated Follow Ups (PIFU) and 1500 patients on PIFU • 9% of follow ups (within PIFU specialties) moved to PIFU - overall target against all follow ups is 5% - being overachieved • 4 specialties pending go live in October (Neurosurgery, Urology Nurses, Chronic Pain, Physio) • New PIFU dashboard in development PIFU dashboard • Feedback from family under Respiratory Clinic June 2022 *"PIFU is a great way to access service at the right time with the right person. The access has to be when the help is needed it is given."* **WNB AI Tool** • Alder Hey designed and developed an artificial intelligence predictive analytics tool to be used to identify children and young people likely to WNB using health inequality markers • A pilot to test the tool, in which families were contacted, ran across 3 specialties has shown to reduce the risk of WNB rate by an overall 42% • A business-as-usual process of contacting families began in October 2022 - targeting 5 specialties >80% risk rating (Trauma & Orthopaedics, Ophthalmology, Respiratory, Audiology, Rheumatology and Community Paediatrics.) • New WNB dashboard is in development New WNB dashboard
Productive Theatres	• **Productive Theatres – Paediatric Surgery Trial** *'Great engagement from theatre and Daycase staff both days, very proactive, real sense of wanting to succeed'* Charlotte Melling, Consultant Surgeon • **Productive Theatres – Paediatric Surgery Trial** 10 additional patients will have their surgery in October with no additional resource deployed – instead effective list planning, improved flow, and teamwork! • **Results of trial within Surgical Day Case** (Oct 22) ✓ 100% of AM lists starting on time ✓ 100% of PM lists finishing on time ✓ 97.5% in session utilisation ✓ 0% on the day nonclinical cancellations
Patient Safety	• **Patient Safety Specialist** [Mr Chris Talbot] and Programme Team started in post (October 2022). • **Data Driven Decisions:** Seeking to understand overall impact of improvement projects on the Trust driver metric of 25% reduction in harms, a review of data from clinical Patient safety incidents was undertaken. • **Culture:** Proposal to repeat staff safety surveys using a combination of accredited surveys to aid in safety climate and culture measures. • **Communications Plan:** Provisional plans drawn up to convey the patient safety strategy, including its component parts and interlinkage with other trust-wide programmes e.g., Brilliant basics, strong foundations.
Brilliant Basics	**Learning** • 6 Teams coached and trained on track to meet / exceed target • 65 managers and matrons trained in BB **Delivering** • BB approach being used to support the patient safety programme • 29% of milestone completed, 4 more schedule for delivery in quarter 3 • HSJ – Partnership award submitted with (*KPMG & POC)*

Workforce Planning	**Pilot completed** • Facilities SiP (staff in post) information aligned in ESR and the Ledger • Research SiP (staff in post) information aligned in ESR & the Ledger - trialling split costing of posts **Wider Roll out – plan developed** • Prep. work being undertaken for the Surgical Care Division to align the information in ESR and the Ledger • Outline of process to support ongoing maintenance agreed (pending final comments and testing in pilot areas)
Great Space to Work	• Staff engagement sessions completed for teams moving into three storey modular build • Supporting staff to prepare for occupation of new buildings • Ensuring that necessary readiness and snagging issues resolved for Catkin and Sunflower House, supporting a 'great staff experience'
Digital – Alderc@re	• Programme replanning undertaken, additional programme resources and expertise in place, programme expecting a go live in 2023 • Positive patient journeys programme delivered in October 2022 with positive feedback from staff involved • Good engagement with Medical Board • National support for programme has progressed well

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

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

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

Alder Hey Digital, Data and Information Technology Update

1. Executive Summary

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

Key headlines include:

- Update on Integrated Care System (ICS) and Liverpool Place Digital Strategies
- Formal closure of Digital Futures and launch of Digital and Data Futures 2022
- Launch of the new Integrated Performance Report
- AlderC@re Update
- Good Operational performance

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

2. National and Regional Digital Update

Regionally, there are a number of digital workstreams underway as part of the newly formed Cheshire and Merseyside Integrated Care System and Liverpool Place.

The draft Digital and Data Strategy for the Cheshire and Merseyside Integrated Care System has been developed and Alder Hey were able to contribute to its development. It is currently being socialised across the different stakeholder groups prior to final sign off. The strategy outlines a vision to ‘invest in digital and data to enable intelligence into actions’

The Strategy is based around 3 main goals:

1. Strong digital and data foundations
2. ‘At scale’ digital and data platforms
3. System wide digital and data tools and services

It is strongly underpinned by a number of critical success factors focusing on: digital inclusivity, financial sustainability, working towards net zero targets and developing/retaining a highly skilled workforce.

The Liverpool Place Digital and Data Strategy for Health and Social Care sets out a ‘journey to 2025’ and focusses on 4 key pillars:

- Empowering people: Digital access to the NHS and digital tools to self-manage health, care and well-being
- Boosting health and care service quality, capability and efficiency
- Innovation, sustainable health and social care services, economic development and high-value jobs
- Improving the digital and data Infrastructure and cyber security resilience for Liverpool’s health and care system

The strategy aligns with, complements and will help to deliver key national, regional and local strategic objectives.

There is strong alignment between the Liverpool Place and ICS Strategies and the 4 key themes set out in Alder Hey's refreshed digital strategy - Digital and Data Futures. There is a clear emphasis on working as a region to improve the health of the population through technology and analytics, developing our workforce and ensuring they have the right skills and tools to do their jobs and finally, ensuring we have the safest, resilient infrastructures to protect the data of our staff and patients.

3. iDigital Service Update

3.1 Excellence in Informatics Accreditation

In summer 2022, the iDigital Service were successfully awarded with the Level 3 accreditation for Excellence in Informatics as part of the Skills Development Network professional framework. This is a huge achievement for the Service, with level 3 being the highest level that can be attained. The following areas were highly commended:

- Strong engagement across teams, shared learning from TUPE processes
- Lots of examples of a positive learning culture with opportunities to learn, grow and progress
- Adoption and development of professional portfolios providing examples and benefits during focus groups
- Communication channels in place with a culture of organisation openness and transparency
- Strong feeling of family and support

3.2 External Awards

Since the previous board report, the iDigital service has been recognised nationally through the Health Tech News (HTN) Awards, winning the 'Partnership of the Year' Category. This is testament to the success of the shared service, the can do attitude of teams and the brilliant support from both organisations.

Alder Hey were awarded a 'highly commended' recognition within the HTN Awards for the development and delivery of the 'Online Symptom Checker' which has received thousands of visits from our Children, Young People and Families

3.3 iDigital Service Development

The iDigital service continues to develop and grow. The most recent developments include the TUPE of the Information Governance teams from Liverpool Heart and Chest Hospital (LHCH) and Alder Hey into iDigital which formally completed successfully on 8th August 2022.

The Information Governance service includes the following areas:

- Information Governance
- Health Records
- Access to Health

The consolidation of these teams has helped to provide a strengthened service to both Trusts and supported career progression and talent management.

4. Digital and Data Futures Progress

4.1 Digital and Data Futures 2022

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

Digital and Data Futures is based around 4 core themes:

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

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

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

This theme is aimed around how digital technology will support new models of care at scale including key priorities such as elective recovery and enable the reshaping of clinical services. Through solutions like remote monitoring and increased access to services virtually, children and young people can receive care and be kept safe remotely, reducing the need for unnecessary attendances or follow ups.

The 'New Models of Care' Programme Board met for the first time in September and will meet again in October. One of the first major workstreams will be the deployment of the AlderHey @nywhere platform. The aim is to integrate the platform with the Trusts Digital Communication solution so children and young people have one single point of access to the Trusts virtual services. Stakeholder engagement is commencing for the AlderHey @nywhere platform in October and a deployment plan will be developed for November 22.

The new Intranet project is progressing well, with the site maps now signed off. Development of the Intranet is due to be complete by the end of this year, ahead of a go live in February 2023. Go live for the new website is March 2023.

4.2 Outstanding Records and Safe Systems

This theme focusses on making a step change improvement in the usability of our digital systems and electronic patient records. Alongside this will be an evolving Digital Safety Programme reviewing and expanding on existing technologies and improving the levels of clinical decision support.

eConsent is being well utilised throughout Alder Hey and the Trust are working towards hospital wide paperless consent for all Surgical specialties in October with floorwalking support is in place for 2 weeks to support to help with the transition.

Digital Dewi Jones went live in September with height, weight, allergies and observations are all being regularly updated on Meditech. Electronic prescribing is safely being used and the bedside medication verification processes followed. Feedback from the team has been really positive and Dewi are keen to continue on their digital journey.

The tender process for a new Risk and Incident Management solution is well underway and the Trust is aiming to award the contract to a preferred partner in October.

4.2.1 AlderC@re

Work continues on the AlderC@re Programme with some key activity throughout October including:

- Collaborative sessions with Meditech, Clinical and Operational and Digital teams to walk through scenario-based patient pathways within the system to understand how mature the design and build of the system is
- Detailed work to review the benefits profile has started, with significant progress made
- The establishment of a Simulation Suite, on the Mezzanine in the main hospital, which will allow users to familiarise themselves with the system well in advance of go-live, in a setting that resembles different parts/services of the hospital.

The next gateway review for assurance is underway with the expectation to be completed in November 2022. The outputs from the October activities and gateway review will provide an indication for the go live date in 2023.

Discussions with NHS England have been positive and led to national support for the programme, recognising it as a “first of type”, with a national MEDITECH Expanse group to be established, and potential national funding to support the deployment of AlderC@re.

4.3 Healthier Populations through Digital, Data and Analytics

This area will focus on empowering our staff, children, young people and families by making information as accessible, digestible and accurate as possible, for them to make key decisions and transform service delivery.

The service has been working collaboratively with Operational colleagues to deliver the new Integrated Performance Report to the Board of Directors for 27th October. This is a much more modern approach, consolidating the existing reporting into Drive and Watch metrics whilst applying making data count principles, creating the report in Power BI.

Alongside the transformational element there is a focus on business as usual which includes ad hoc data requests, dashboard creation, external submissions, change requests and coding discharges.

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

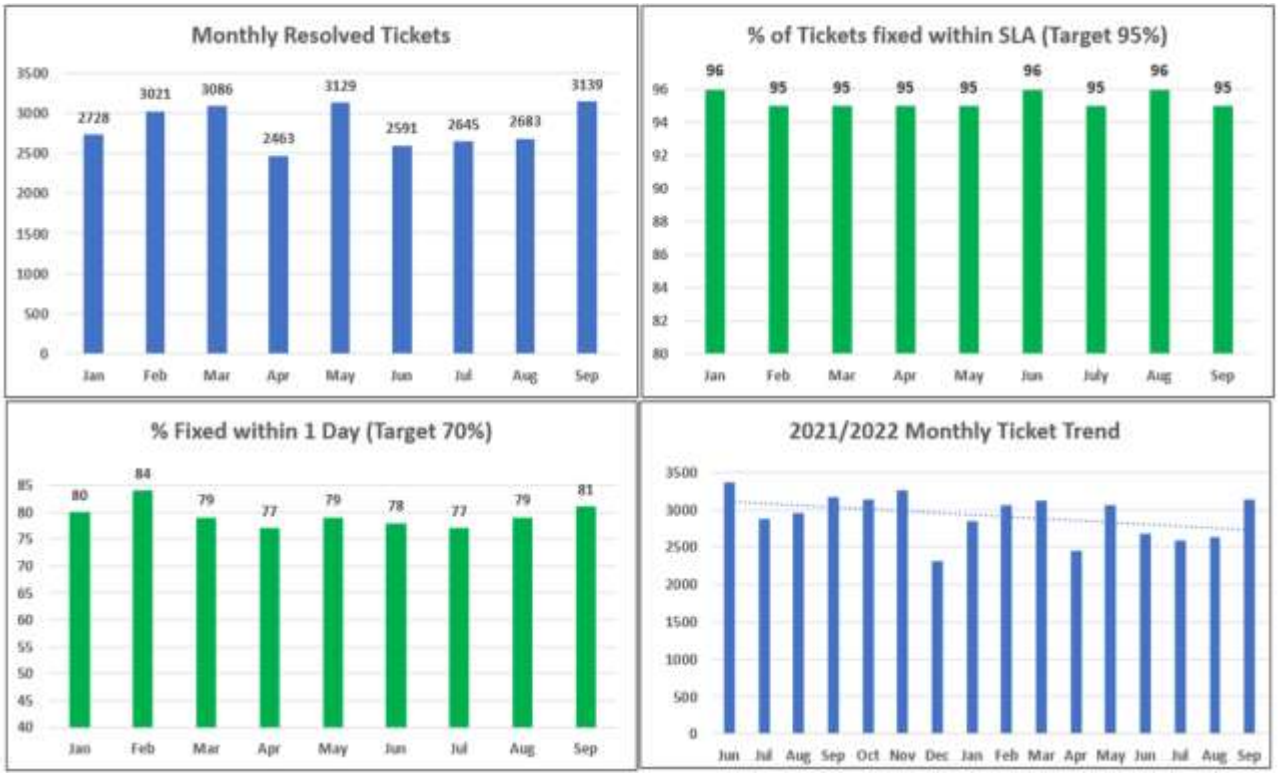
4.4 Technical roadmap and Operational Service Excellence

This theme focusses on ensuring the service maintains a consistent level of high-quality service delivery and providing a clear roadmap to improve our security, infrastructure and devices, providing our staff with the best tools to do their jobs

From a security perspective, there has been significant work to improve the resilience of our system and database backups. The Trust has now successfully achieved its secure email accreditation status, which provides a good level of assurance in regard to cyber security.

This report provides performance to the end of September 2022. Key highlights include:

- Despite increased tickets in September we have 8% less tickets raised so far in 2022 compared to last year
- Ticket resolutions continue to consistently meet our 95% SLA target



5. Summary and Recommendations

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

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

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

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

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

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday, 27th October 2022

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

Campus Development report on the Programme for Delivery

October 2022

1. Introduction

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

As of Month 1 in Quarter 3 of 2022/23 the programme Delivery Timetable RAG rates projects against planned commencement date.

2. Salient Points

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Cost Pressure of due to market inflation, availability of labour and / or materials.	Aim to secure reduction in costs via value Engineering, redesign, and commercial agreement; and additional support through management of other capital funds and seek increase in charity support.
Sunflower House / Catkin	Programme delay; Take over planned for 28th October 2022 Quality issues	Pre-take over meetings held and plans agreed with contractor to take over the building. Holding back from Completion due to quality issues. Issues with CLT finish, process agreed with contractor to provide samples for agreement to address issue.
Temporary Modular Office (Alder Centre)	Programme delay	Programme delay due to delay in power connection due to limited access onto Sunflower / Catkin site – whilst still a building site. Connection booked in for after take over of project, staff held in current accommodation.
Temporary Modular Office (Police Station)	Programme delay	Programme delay due to delay in lease agreement for former Police station. Moves held and alternative accommodation agreed with users.
Main Park Reinstatement	Vacation of Catkin, linked to Sunflower House / Catkin,	Programme reviews held weekly to keep on top of all

	modulars projects, IP2 and Histo projects and their programmes.	interdependent projects, with mitigations put in place to ensure programme is kept on track.

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 Development Contractor Selection								
Neonatal and Urgent Care Enabling – Car Park								
Neonatal and Urgent Care Enabling – Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (July 2024)								
Sunflower House / Catkin Construction								
Sunflower House / Catkin Occupation								
Temporary Modular Office (Alder Centre)								
Temporary Modular Office (Police Station)								
Police Station Design								
Police Station Construction								
Relocations								
Demolition Phase 4 (Final)								
Main Park Reinstatement (Phase 2-100%) **COMPLETE**								
Main Park Reinstatement (Phase 3)								
Mini Master plan (Eaton Rd Frontage) 2 phases to plan								
Medical Photography / Orthotics **COMPLETE**								
Innovation Park 2								

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. Infrastructure enabling stopped to allow main contract programme to be reduced and alternative delivery method being investigated. Agreeing and seeking approval regarding funding, to allow project to proceed. Finalising contract award.	Project delays in contractor selection and appointment. Programme delay due to contractor selection and pause of enabling works. Substantial cost increases expected due to market inflation, availability of labour and / or materials Project Co engagement extending the programme and increasing costs.	Fast tracking cost and programme elements. Establishing early works and enabling schemes to maintain momentum. Looking at alternative delivery methods. Aim to secure reduction in costs via value Engineering, redesign, and commercial agreement; and additional support through management of other capital funds and seek increase in charity support. Continue working with Project Co to mitigate impact.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Completion date delayed until 28th October 2022. Accepted takeover of Catkin element, in process of occupying. Crisis team occupy on the 27th October 2022, clinics start on the 31st October 2022. Agreed take over for Police station element, works inspected and accepted by Merseyside Police. Planning the signature of the lease and their occupation.	Further programme delays. Quality issues being experienced on site.	Pre-take over meetings held and plans agreed with contractor to take over the building. Holding back from Completion due to quality issues. Issues with CLT finish, process agreed with contractor to provide samples for agreement to address issue.

Modular Office Buildings

Current status	Risks/issues	Actions
Larger unit by Alder Centre being provided by LOR; construction completed, furniture installed, awaiting final utility connections to HO building and begin commissioning and occupation. Smaller unit in Police Station car park being provided by Portakabin. Project on hold due to police station lease not in a position to sign; for takeover of the former police station.	Programme delay, alder centre station modular Programme delay, police station modular	Programme delay to Alder Centre module due to delay in power connection due to limited access onto Sunflower / Catkin site – whilst still a building site. Connection booked in for after take over of project, staff held in current accommodation. 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, awaiting HO of Catkin / SH to proceed. RIBA Stage 3 complete, layouts agreed with Stakeholders and progressing to tender / direct award.	Lease agreement.	Working closely with MP to accept new police station in SH, progress to HO and sign lease.

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Phase 1 of the park is now operational. Grassed area re-seeded and grass recovering. High cuts and tidying being performed. Standing water being experienced. MUGA works commenced.	MUGA lighting Standing water being experienced	MUGA lighting utility connection being provided by LCC, working closely to ensure this is provided in time. Soil samples being taken, installation being tested and design reviews booked to asses and understand issue. Propose rectification as nest phase is constructed.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Landscaping completed for Phase 2 with number of paths started. Phase 3 started. 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 to complete and seed the majority of this Phase in June 22, with a planned early hand back in Summer 2023.	Campus moves delay park	Programme reviews held weekly to keep on top of all interdependent projects, with mitigations put in place, to ensure programme is kept on track.

NEW Mini Master Plan for Eaton Rd frontage

Current status-	Risks/issues	Actions
No further progress required at the moment Design is now complete, taking in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Part of the scope will be funded by the 2 development sites as and when these are brought forward.	If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8) Insufficient budget to complete the work.	Plan the appropriate start date for the works to coincide with other works on site.

Innovation Park 2

Current status	Risks/Issues	Actions/next steps
Works progressing well on site. HO date of 21st October 2022 Pre-occupation commenced	None	None

North East Plot Development

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

Communications

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

5. Trust Board of Directors

The Board of Directors is requested to receive and acknowledge the update provided as of 27th October 2022.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	Serious Incident, Learning and Improvement report 1st – 30th September 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 ☑
Background Papers and/or 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:	The action required is both to note and approve the report. 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
Associated risk(s):	Managed via risk register

1. Purpose

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

2. Background

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

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

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

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

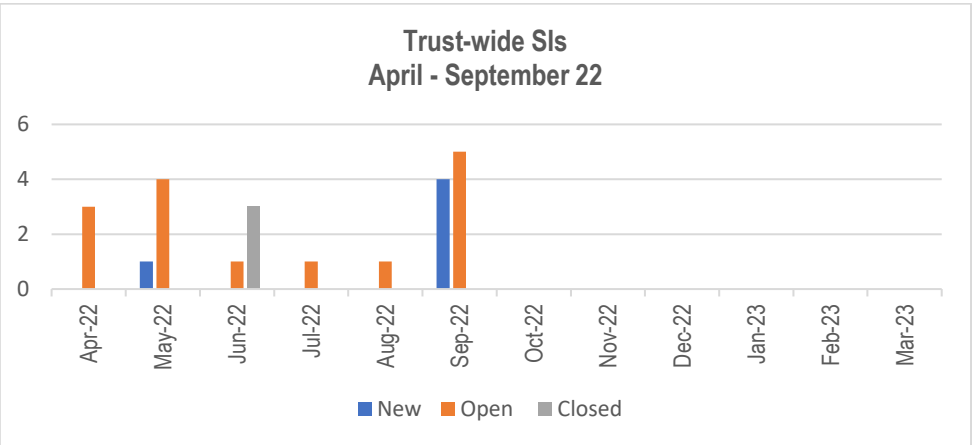
3. Local context

3.1 Never Events

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

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status September 2022



3.2.1 Declared Serious Incidents

The Trust declared **4** StEIS reportable incidents (*1 non-clinical) that met the SI criteria during the reporting timeframe (1st – 30th September 2022).

3.2.2 Open Serious Incidents

4 SIs open during the reporting period as outlined in table 1

1 SI investigation panel concluded, draft RCA and action plan pending stakeholder feedback

Table 1 Open SIs September 2022

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

3.2.3 Serious incident reports

3.2.4 SI action plans

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

- **3** SI action plans overdue expected date of completion which have been escalated with the relevant division
- **3** SI action plans were confirmed closed by commissioners
- **4** SI action plans submitted to commissioners pending closure
- **1** SI action plan completion date extended by commissioners
- **1** SI action plan completion date pending extension request to commissioners

3.3 Internal level 2 RCA Investigations

The Trust declared **zero** internal level 2 RCA investigations during the reporting timeframe 1st – 30th September 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 were required and completed within expected timeframes during the reporting period (1st – 30th September 2022).

4. Learning from serious incidents

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

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

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

- Influence of human factors
- Failure to follow process / guidelines
- Lack of situational awareness
- Lack of communication
- Lack of escalation
- Lack of documentation

5. Next steps

- Ongoing review of open SIs with overdue actions plans to be undertaken by Divisions as a matter of urgency.

- Divisions to ensure all evidence is provided as part of action plan submission to inform assurance process.

- SI action plan completion continues to be monitored internally via CQSG.

- Themes and trends from SIs to be reported to Trust Board once outstanding RCAs have concluded.

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

6. Recommendations

The Trust Board is asked to:

- Note the content of the report
- Note ongoing actions to address open SI overdue action plans
- 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
2021/ 24660	Traumatic death from penetrating neck injury	Incident was initially identified as catastrophic, however following in-depth review, incident reclassified as a near miss but StEIS reportable due to potential for learning.	A comprehensive level 2 investigation undertaken **September 2022:** RCA draft report completed. Report is pending stakeholder feedback and will be shared with Liverpool PLACE leads on 1st November.
2022/ 19971	Never Event – retained foreign object post procedure.	Failure to follow the AfPP standard and NatSSIPs guidance for checking instrument tray prior to completion of a surgical procedure which led to a dental mouthguard being left in situ, being removed in the recovery room Anaesthetic screen not completed on EPR, resulting in incomplete information	Discuss with HR, Theatre Manager, Theatre Matron and Surgical Director. Failure to follow AfPP standards should be investigated in line with the Trust disciplinary policy/ NHSE Just culture. **September 2022:** 72-hour review completed and sent to commissioners. Initial duty of candour completed. Staff interviews in progress.
2022/ 20586	Staff exposure to highly contagious organism (*non-clinical).	A HG3 organism can occur at any time in any patient Importance of checking clinical details before processing specimens. Adhering to the SOP Staff need to understand that a Class II cabinet at CL2 is not the same as Class I at CL3.	Culture plates moved into the CL3 room incubator, and the discard jar (used to aliquot etc) was placed in an autoclave tin in CL3 room for autoclaving prior to disposal. All further specimens were dealt with in CL3. All staff were informed of the situation. Staff at the local and national reference laboratory were consulted. Exposure assessment flowchart and exposure list issued by the reference laboratory was implemented.

		Theatre team need to consider seeking specialist IPC advice if a patient has an uncommon infection. Documentation of the incident needed to be clearer and succinct	High risk staff were identified and given prophylactic antibiotics for 21days, and baseline bloods were tested. All low-risk staff were identified, list collated and information sheets given to all staff. Local Heath protection team were informed.. **September 2022:** 72-hour review completed and sent to commissioners. Duty of Candour not formally applicable, but all relevant staff have been informed. Investigation underway.
2022/ 20661	Category 3 pressure ulcer under plaster cast.	Standard practice was followed. No lapses in care identified.	Dressing applied to protect fragile skin integrity. Window cast applied for regular skin/ wound review. Wound is healing well. **September 2022:** 72-hour review completed and sent to commissioners. Initial duty of candour completed. Investigation commenced.
2022/ 20851	Patient death following discharge.	Tabletop review 27/09/2022: Panel concluded that further detail and discussion with the family in relation to medication history, discharge plan and discharge documentation is required as part of the investigation process	Rapid Review undertaken by the surgical Division on the 20/9/2022. **September 2022:** 72-hour review completed and sent to commissioners. Initial duty of candour completed. Investigation commenced. Note: Case now subject to coroner's inquest

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Date action plan due
2019/23494	24/10/2019	25/10/2019	Medicine	Outstanding laboratory test results identified	All actions completed – sent to commissioners for closure.	30/04/2020
2019/21208	25/09/2019	26/09/2019	Surgery	Never Event – retained foreign object post-procedure	0	Closed by commissioners 21/09/2022.
2020/608	08/01/2020	09/01/2020	Medicine	Misdiagnosis of tumour	All actions completed – sent to commissioners for closure.	30/06/2021
2020/19349	08/10/2020	12/10/2020	Medicine	Inappropriate clearance of C-Spine	0	Closed by commissioners 07/09/2022.
2020/12954	09/07/2020	10/07/2020	Corporate Services	Incorrect settings on port-a-count machine resulting in staff being incorrectly passed on an FFP3 mask	All actions completed - sent to commissioners for closure.	20/12/2021
2021/1919	03/01/2021	15/01/2021	Medicine	Transfer from Bangor. Treated according to advice, patient suffered raised intracranial pressure requiring shunt	11 4 actions outstanding. Service Manager liaising with consultant to progress remaining actions. Next divisional meeting 28/10/2022.	30/04/2022
2021/12203	27/05/2021	10/06/2021	Medicine	Deteriorating patient requiring transfer to HDU	12	01/06/2022

					1 action outstanding. Extension requested from commissioners.	
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	8 2 actions outstanding**.** Extension requested by surgery governance team for both actions to 30/11/2022.	30/06/2022
2020/23828	11/12/2020	18/12/2020	Corporate Services	Waiting list data quality issues with 52 week waits	0	Closed by commissioners 21/09/2022.
2021/25961	15/12/2021	21/12/2021	Medicine	Patient relapsed during receipt of active leukaemia treatment	11 1 action outstanding.	31/07/2022
2021/17974	16/07/2021	01/09/2021	Medicine	Preparing child's case for discussion at national forum. Identified that care provided for eradication is outside of usual clinical pathway	13 5 actions ongoing – extension granted (13/10/2022) by commissioners	01/11/2022
2022/1581	18/01/2022	24/01/2022	Surgery	Category 4 Pressure Ulcer	All actions completed – sent to commissioners for closure.	31/08/2022

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	Safeguarding our Children, Young People and Families Against Failings in Care
Report of:	Nathan Askew, Chief Nursing Officer
Paper Prepared by:	Nathan Askew, Chief Nursing Officer

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	N/A
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 at present

Alder Hey Children's NHS Foundation Trust

1. Report Purpose

The purpose of this paper is to provide assurance to Trust Board regarding the quality and safety of our services and the methods in place to safeguard children, young people and families against failings in care.

2. Introduction

Following the BBC panorama investigation (October 2022), into the abuse of patients in the care of another NHS trust, the Executive Team considered it prudent to seek assurances that safeguards are in place to prevent a similar situation occurring at Alder Hey.

Whilst Alder Hey provides care to children with a mental health need at the Trust's Tier 4 Children's Inpatient Unit, it is critical that the Trust considers the key learning themes from the investigation across all its services.

Services which place the voice of children, young people and families at the centre of governance, service design and delivery and have the mindset that 'this could happen here' are most likely to identify toxic culture and take appropriate steps to address this, and safeguard children and young people.

3. Assurance

The issues raised in the BBC program demonstrated a toxic culture, leading to the abuse and ill treatment of the patients involved. This has been seen in other national investigations and services. The key question for the Trust Board is to assess the level of assurance surrounding our systems and processes that enable our children, young people and families to voice any concerns, how as an organisation we are assured that staff are supported to speak up and how we ensure that care is aligned to best practice.

The specific questions that the Trust Board should be assured on are below with a short summary of assurance.

<u>Could this happen here?</u>
We should acknowledge it will never be possible to provide assurance that similar occurrences could never happen here.

However, the assessment in appendix 1 provides a significant level of assurance around our systems and processes to minimize the risk. In addition most of our children and young people have a resident adult who advocates on their behalf which in itself creates a more open culture within out acute setting.

<u>How would we know?</u>

Appendix one demonstrates a robust suite of methods for gaining insight into this area, in relation to children, young people and their families as well as our staff.

How robust is the assessment of services and the culture of services?
The paper provides examples of the many tools used to assess the culture and ethos of wards and departments both within the divisional teams and objectively through staff external to the environment. Having this feedback via a variety of routes provides significant assurance. The information gained through feedback is routinely triangulated.

Are we visible enough and do we hear enough from patients, their families and all staff on a ward e.g. the porter, cleaner, Health Care Assistants?
Senior leaders and the executive team have good systems to be visible to our children and young people and staff throughout the organization. "Go, look, see" is an embedded part of brilliant Basics with executive leaders linked to all wards and departments.

Appendix 1 provides an assessment of the Trust's systems and process and seeks to identify good systems of control, and highlights gaps to be addressed as part of this review.

In addition to the areas assessed the following three key areas should be reviewed:

a). Safer recruitment practices including training

How does the Trust ensure that we recruit staff with values that align to the NHS and care of children and young people? How is the Trust assured, through the training and development of staff that there is a clear expectation of the level of care and compassion that is expected to be delivered and the culture of openness. These questions should form part of the refreshed people strategy and link to the OD plans for the Trust.

b). Roll out of improved safeguarding training

Following the recruitment of a new Assistant Director of Safeguarding & Statutory Services, the Trust's current safeguarding training is being reviewed in line with the updated national intercollegiate guidelines. This will need to involve a more detailed focus on aspects such as Deprivation of Liberty Safeguards and Trust Board safeguarding training.

In addition, the training will need to ensure that staff are aware of the need to raise concerns relating to the behavior of other staff as appropriate through the many routes detailed in the assessment section of this paper. The Communications Team will develop a strategy to increase visibility of this messaging to all staff.

c.) Language and terminology

A review of language and terminology used by all staff when working with complex and challenging children and young people within acute paediatric settings.

4. Conclusion

This review has identified robust systems and processes in place to safeguard the children, young people and families in our care. As with any review there are areas for improvement that have been identified and will be captured in an action plan.

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

5. Recommendation

Trust Board are asked to note the content of the assessment and the actions needed for improvement will be monitored through Trust Safety Quality and Assurance Committee (SQAC).

Next steps

Areas for improvement will be assessed and incorporated into an action plan to clearly demonstrate improvement.

Alder Hey Children's NHS Foundation Trust

Appendix One:

Theme	Aim	Method	Site	Assurance	Gaps in assurance	Immediate Actions
Safeguarding of care	Assurance that children, young people and families are able to voice concerns	PALS	All	Number of PALs continue to increase, and regular reports of the themes and trends reports through CQSG, SQAC and Trust board. Responsiveness in resolution is increasing	Assurance at divisional level that themes and trends are being addressed	Each division to demonstrate PALs and complaint's themes action plan through SQAC
		Complaints	All	Formal complaints process in place which has been reviewed by MIAA. Improvement plan in place and responsiveness in resolution in line with policy is increasing	Assurance at divisional level that themes and trends are being addressed	As above
		Complaints	Tier 4	How To Complain About Care and Treatment and specifics of How to Complain If Detained Under the Mental Health Act posters are displayed in several prominent positions around the unit. Advocate is also able to complain on young person's behalf. Young people detained under the Mental Health Act are advised of their rights at regular	Assurance at divisional level that themes and trends are being addressed	As above

				intervals in line with the code of practice. Unit has a weekly "You Said We Did" group on the ward where young people can raise issues that are not formal complaints and can resolve any concerns quickly at a local level.		
		ACT	Acute	Imminent relaunch of the ACT team on the acute site. The team will be visible and visit the clinical areas 24/7. Independent from the clinical team they will be able to monitor the care delivered	None	None
			Tier 4	Currently off site though moves to new unit imminent. The ACT team will visit the Tier 4 unit when on site to mirror the acute wards	Tier 4 unit off site but move is imminent	None
		Advocacy	Tier 4	Independent advocacy is in place for all CYP at the Tier 4 Inpatient unit. Widely advertised across the unit. Advocate attends CPAs to represent young person views	None	None
			Acute	Independent advocacy is in place for children and young people who are detained under Mental Health Act on the acute site	No provision of advocacy for physical health or LD patients though patients	None

					usually have a resident carer	
		Care, Education and Treatment Reviews (CETRs)	Tier 4	Where applicable (LD/Autism) a community CETR is completed prior to any Tier 4 gatekeeping assessment and admission. Tier 4 Unit staff will attend assessment as required. Once admitted CETRs take place every 12 weeks and are held in line with CPAs to avoid additional meetings for the young person, family and community teams If a young person is diagnosed with LD/Autism during an inpatient admission, NHS England are informed and commence the CETR process as described above.	None	None
		Health Watch	All	Good relationship with Healthwatch who are part of the Trust's Patient Experience group and also conduct independent visits, receiving feedback directly from families	None	None
		CQC feedback	All	Monthly engagement meetings with CQC. Any issue raised from CYP, families or staff is discussed and investigated	None	None

		Patient stories	All	Regular patient stories to divisional board meetings and to Trust Board, these have included a range of stories from CYP and families in the care of our services.	None	None
		Feedback from Children & Young People	Tier 4	Weekly 'You Said, We Did' meetings are held at the unit and open to all children to attend. Weekly 'mutual help' meetings (Safewards) in place. Unit staff attend the CAMHS participation meeting monthly and link into wider participation projects in the Trust when they arise (e.g. MHA accessible information project, new build patient input). Young person and parent/carer feedback is sought on discharge (service experience questionnaire). Children's care is collaborative (e.g. encouraging children to be involved in their care plans, informed choice/consent in treatment options, there is a document for the young person	None	None

				to input their views into the MDT meeting). The unit classroom has termly Student Council meetings. There is a monthly parent/carer meeting which combines information, participation and support Parent/carers can link into the wider CAMHS parent participation and education sessions.		
	Staff are able to raise concerns	Raise it change it	All	All staff are able to submit concerns via raise it change it. Decrease in numbers using this route which is mirrored through increase in FTSU	None	None
		Freedom to speak up	All	FTSU guardian is active across all areas of the organisation. Developing a network of FTSU champions to increase provision and access for staff of all professions. Themes are regularly reported to board	None	None
		Exec Visibility	All	All areas have a nominated exec lead who spends some time each month with their link area.	Variability in attendance by execs and recording of this	Reiterate expectation of exec leads and monthly report of visits to execs

		Quality Assurance Rounds	All	All areas have at least one QAR a year where they are able to flag concerns directly to an exec and non-exec member.	None	None
		Workforce Indicators	All	Workforce indicators such as sickness, turnover and employee relations cases such as bully and harassment are monitored through People and Wellbeing Committee (PAWC) and through to trust board	None	None
	Assessment of Services	Ward & department Accreditation	All	All wards have one accreditation through peer review each year. This is an opportunity to test culture and compliance with the CQC domains.	There are plans to roll out to all departments	Implementation of the departmental accreditation tool to non-ward areas.
Peer Led support	To ensure peer led support and feedback is in place		Tier 4	Unit is part of QNIC accreditation which is peer led	None	None
Restrictive interventions	To minimise the use and impact of restrictive practice	Long term segregation	All	Long term segregation is not used in any area	None	None
		Seclusion	Tier 4	Robust policy which includes the use of and recording of seclusion	Visibility of the use of seclusion	Reported to Community & Mental Health Governance Group & annual Trust Board report
			Acute	Seclusion is not used in the acute hospital.	None	None
		136 room in ED	Acute	ED has a 136 suite which can be used by the police for the	Visibility of duration of use of the 136	Reported in annual Trust Board report

				detention and safety of CYP in crisis.		regarding use of Mental Health Act
		Restraint reduction	Tier 4	Routine review of all incidents of restraint or seclusion. CALM training for all staff in Tier inpatient 4 Unit	None	None
			Acute	Parity of esteem programme covers the recording of and reduction in clinical holding and restrictive practice	None	None
		Parity of esteem (post s31 notice)	Acute	Training in mental health awareness in place and launching we can talk programme. Training in clinical holding and restrictive practice in place reported through patient safety strategy board	None	None
		DoLS	All	DoLS training is covered as part of safeguarding and will be moving to liberty protection safeguards	Assurance that real world application of the requirements of DoLS and LPS are understood by all staff	Revised safeguarding training to include
Quality programme	Feedback		Tier 4	Unit is part of the NHSE/I led quality improvement programme for the last 2 years which has included human rights, autism and use of restrictive practices training. The Tier 4 Unit has also successfully partnered with a	None	None Continue with current project

				national project led by Kings College London, under the direction of NHS England to implement the Safewards project. Safewards is a clinical model developed in the UK to promote safer, less coercive practices in mental health care, and to reduce incidents of conflict involving consumers or staff. The model attempts to identify and address the causes of behaviours in mental health settings that may result in harm – such as violence, self-harm or absconding – and to reduce the likelihood of these behaviours occurring". Staff have been working through the 10 Safeward domains and have implemented the majority of them on the unit with some work ongoing work still required in a few areas, the ward has received several fidelity visits from the Safewards leads and received positive feedback from them.	Reported via divisional governance	

				Due to the success of Safewards in the children's setting where it has previously not been utilised the team at Kings College London are keen for our service to write a paper about the Safeward implementation experience		

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	Research and Innovation Committee Terms of Reference
Report of:	Director of Research / Director of Corporate Affairs
Paper Prepared by:	Director of Research

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	To receive and approve the Terms of Reference for the Research and Innovation Committee
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 at present

Alder Hey Children's NHS Foundation Trust

RESEARCH AND INNOVATION COMMITTEE

TERMS OF REFERENCE

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Research and Innovation Committee (the Committee).
Membership	Non-Executive Directors x 3 [one of whom shall be the Chair] Chief Executive Director of Research & Innovation Managing Director of Innovation Director of Research Deputy Chief Executive/Director of Finance Chief Medical Officer Chief Nursing Officer Director of Marketing and Communications Chief Digital and Information Officer Director of Corporate Affairs Academy Director
Attendance	The following would be expected to attend each meeting: Clinical Director of Research Clinical Director of Innovation Deputy Managing Director of Innovation Associate Chief Operating Officer for Research The following would attend, on an occasional basis, as required by the agenda: Divisional Directors Lead Research Nurse Innovation Consultants Other persons by invitation, subject to Chair's approval Secretarial support shall be provided to the Committee to take minutes of the meeting and give appropriate support to the Chair and Committee members.
Quorum	Chair or nominated deputy, one Executive Director, Director of R&I (or delegate)

	Virtual or remote participation in meetings shall count towards the quorum.
Frequency/ Duration	Meetings shall normally take place on a bi-monthly basis and the Committee will meet not less than 5 times a year. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.
Authority	The Committee will operate under the broad aims of overseeing delivery and periodic reviews of the Trust's Research and Innovation Strategic Framework and related activities, to provide assurance to the Board that delivery in these areas supports the Trust's strategic priorities. The Committee has authority on behalf of the Board to: • Guide the development of a cohesive approach to the distinct but interlinked activities of Research and Innovation, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks. • Make decisions rapidly to initiate, prioritise or de-prioritise specific projects and initiatives that fall within the duties set out below, ensuring that an agile, flexible and business-like approach is retained, particularly in connection with commercial opportunities. • Seek and commission external advice as deemed appropriate to the successful delivery of these agendas.
Duties	• Provide robust assurance to the Board on the development and implementation of the Trust's Research and Innovation Strategic Framework, the strategies of the various components of Research and Innovation and their key themes. • Nurture and foster a culture in which Research and Innovation are recognised by all staff as being essential components of improving the futures of children, young people and society • Ensure the delivery of agreed outputs which align to the Trust's vision, including but not limited to: o A sustainable pipeline of innovative technologies, devices and processes o A balanced portfolio of clinical research studies ▪ Each with the greatest potential for • improving access of patients to new avenues in prevention, diagnosis and treatment • translation into clinical practice with positive impact for patients, health services and society • reducing the burden of physical and emotional harm

	• new, data-driven approaches which facilitiate smarter, kinder treatments • Direct new and stronger clinical, academic and commercial partnerships in Research and Innovation which promote the values and aims of the Trust • Review and approve grant opportunities and applications, inward investment opportunities and partnerships which facilitate commercialisation • Understand and oversee the protection of intellectual property element of the Research and Innovation activities, seeking appropriate advice where required • Guide a collaboration with the Trust's Academy and iDigital functions to create a 'campus without walls', which o delivers diagnosis, treatment, care and monitoring in the most appropriate setting for patients and their families o develops the next generation of world-class paediatric researchers and innovators o teaches and trains the Trust's staff in the principles and practice of Research and Innovation using the most efficient, user-oriented processes and pathways • Ensure appropriate commercial acumen and business skills are available to the Trust, wherever necessary. • Ensure effective communications and marketing of Research and Innovation activities and achievements, both internally and externally • Ensure leverage of the Trust's position and optimise clinical, academic and commercial opportunities locally, regionally, nationally and internationally • Review operational and business plans and thereby provide assurance to the Board on the sustainability of Research and Innovation activities • Maintain oversight of the register of company interests ensuring it is in line with relevant legislation and policy • Provide assurance to the Board that the company structure and approach to subsidiary and joint ventures is efficient and compliant with relevant standards and legislation

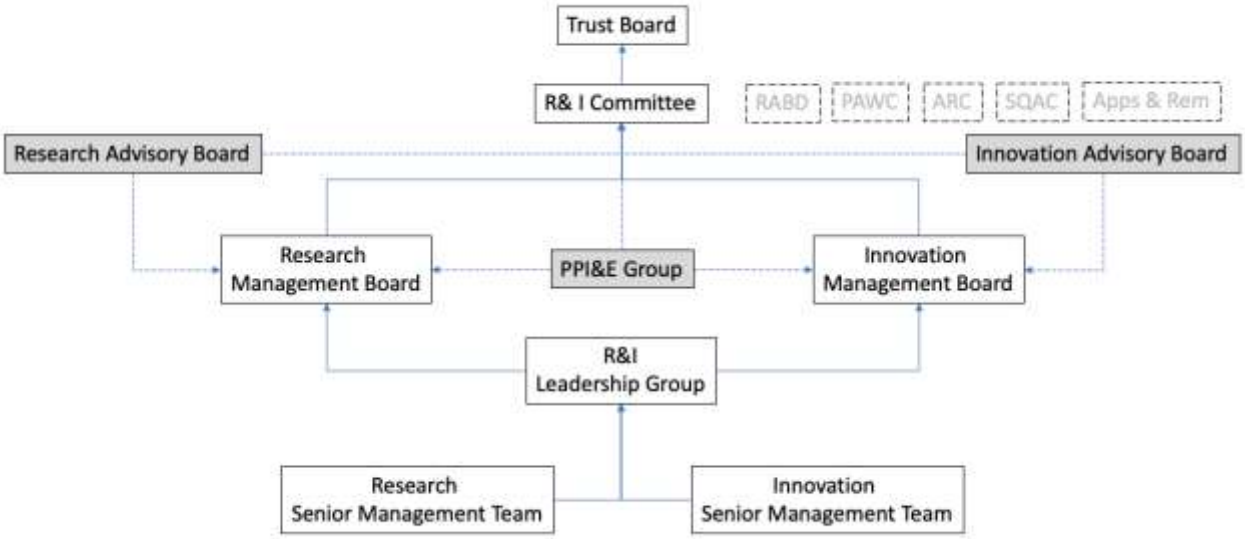
	• Approve investment decisions and ensure due diligence in line with the Trust's Scheme of Delegation • Identify, monitor and control risks relating to the delivery of high-quality Research and Innovation activities. • Ensure that key risks are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate. • Receive, review and provide feedback on o regular reports on performance metrics from subsidiary committees/working groups (see below) o minutes from sub-committees/working groups
Reporting	Minutes of meetings will generally be circulated to members for comment and approval, within 10 working days after Committee meetings. The Committee will ensure that confirmed minutes of its meetings are formally recorded and submitted promptly to the Board of Directors, along with a Chair's report, identifying key areas. Any items of specific concern or which require approval from the Board of Directors will be the subject of a separate report. The Committee will prepare and submit an annual report on its activities to the Board of Directors in June, via Audit Committee in May. Sub committees/working groups reporting to the Committee are set out in the accompanying diagram: • Research Management Board • Innovation Management Board • Research Advisory Board • Innovation Advisory Board • Patient, Parent and Public Involvement and Engagement Group • Research and Innovation Leadership Group • Senior Management Team (Research) • Senior Management Team (Innovation)
Conduct	The Committee will develop a work plan with specific objectives which will be reviewed formally on an annual basis. The committee will also review its performance against these Terms of Reference and its objectives.

	These will provide the basis for reports to the Trust Board of Directors, describing how the Committee has discharged its responsibilities, after six months and thereafter on an annual basis. Agenda and papers for Committee meetings will be distributed not less than 4 working days prior to meetings. Additional papers to be tabled after that only in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.
Other Matters	These Terms of Reference will be reviewed following 6 months of operation and thereafter on an annual basis.

Date approved: October 2022

Review date: April 2023

Proposed new governance structure for Research and Innovation



Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	Sefton Place Collaboration Agreement
Report of:	Director of Strategy and Partnerships
Paper Prepared by:	Sefton Place Partnership

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	This paper provides an update on the development of the Sefton 'Place' collaborative arrangements and seeks approval to sign as a Trust.
Action/Decision Required:	To note ☐ To approve ■
Link to: **1 Trust's Strategic Direction** (A) **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 at present

- **Background**

  Alder Hey have long been a committed partner in Sefton, providing significant range of services in the patch. The Trust has subscribed to previous iterations of collaborative agreements.

  This 'Place' collaboration agreement has been iterated to take account of new system architecture, in line with the implementation of integrated care systems.

  The agreement represents arrangements for Sefton as a 'Place' and builds on the existing integrated governance structures already in situ in Sefton.

- **The Sefton Place Collaboration Agreement**

  The agreement provides an overarching framework for the place-based partnership approach to integrated health, care and wellbeing in Sefton, known as the Sefton Partnership.

  Its development represents a key governance milestone in the 'Place' and work has been undertaken with Hill Dickinson and through the Cheshire and Merseyside Place Based Partnerships working group to understand best practice and develop an outline.

  The arrangements set out are intended to broaden the partnership to include key partners such as Primary Care Networks and further develop the established place-based integrated working arrangements between the partners for the benefit of the Sefton population.

  The collaboration agreement sets out the intention for partners to work together under the governance framework set out to develop the Sefton Partnership. This may potentially in future include requirements in relation to population health outcomes, risk/gain share, financial and contract management requirements, as may be agreed between the partners; developments of this nature will be considered and raised with Trust Board for decision/approval as necessary.

  The agreement is not legally binding and works alongside existing contractual and partnership arrangements for the delivery of care, support, and community services from both the NHS and Council.

  The partners intend to work together under the governance framework set out in this agreement and will regularly review progress together.

- **Recommendation**

  The paper is seeking Board approval to sign up as a partner to the Sefton Place Collaboration Agreement.

Attachments

Annex：Sefton Place Collaboration Agreement

000110

DATE

2022

1. NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

2. SEFTON METROPOLITAN BOROUGH COUNCIL

3. MERSEY CARE NHS FOUNDATION TRUST

4. SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

5. LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

6. ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

7. HEALTHWATCH SEFTON

8. SOUTHPORT AND FORMBY PRIMARY CARE NETWORK

9. SOUTH SEFTON PRIMARY CARE NETWORK

10. SEFTON COUNCIL FOR VOLUNTARY SERVICE

11. ONE VISION HOUSING

COLLABORATION AGREEMENT FOR

SEFTON PARTNERSHIP

No	Date	Version Number	Author
1	October	1	Hill Dickinson
2	June 2022	2	Ellie Moulton, Debbie Fairclough, Stephen Williams, David McCullough
3	July	3	Debbie Fairclough, reflecting feedback from the task and finish group

CONTENTS

Executive summary: collaboration agreement for the Sefton Partnership

This agreement provides an overarching framework for the place-based partnership approach to integrated health, care and wellbeing in Sefton, known as the Sefton Partnership.

The arrangements set out build on the existing integrated governance structures between health and care partners in Sefton. They are intended to broaden the partnership to include key partners such as Primary Care Networks and further develop the established place-based integrated working arrangements between the partners for the benefit of the Sefton population.

This agreement is designed to work alongside existing contractual and partnership arrangements for the delivery of care, support and community services via the NHS and Council to the extent such services are within the scope of the agreement. The agreement is not intended to be legally binding.

The partners intend to work together under the governance framework set out in this agreement to develop the Sefton Partnership and may potentially in future include requirements in relation to population health outcomes, risk/gain share, financial and contract management requirements, as may be agreed between the partners.

The partners will review progress made and the terms of this agreement at six monthly intervals from 1 July 2022 and may agree to vary the agreement to reflect developments. Notwithstanding this, the partners may review and amend the terms of this agreement at any time.

DATE: 2022

This collaboration agreement (the **agreement**) is made between:

1. **NHS CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD**

   CM.partnership@nhs.net

1. **SEFTON METROPOLITAN BOROUGH COUNCIL** of Bootle Town Hall Oriel Road, Bootle, L20 7AE (the "**Council**");

2. **MERSEY CARE NHS FOUNDATION TRUST** of V7 Building, Kings Business Park, Prescot L34 1PJ ("**MCFT**");

3. **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST** of Southport And Formby District General Hospital, Town Lane, Kew, Southport PR8 6PN ("**S&OHT**");

4. **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** of Prescot Street, Liverpool, Merseyside, L7 8XP ("**LUHFT**");

5. **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST** of Eaton Road, Liverpool L12 2AP ("**AHCFT**");

6. **HEALTHWATCH SEFTON** Suite 3B, North Wing, Burlington House, Crosby Road North, Waterloo L22 0LG ("**Healthwatch**").

7. **SOUTHPORT AND FORMBY PRIMARY CARE NETWORK ("Primary Care Networks/ PCNs")** 12 Church Street, Southport, Merseyside, PR9 0QT

8. **SOUTH SEFTON PRIMARY CARE NETWORK ("Primary Care Networks/ PCNs")** G03-G07 Biz Hub, 36 Canal Street, Bootle, L20 8AH

9. **SEFTON COUNCIL FOR VOLUNTARY SERVICE ("CVS")** Suite 3B, 3rd Floor, North Wing, Burlington House, Crosby Road North, Waterloo, L22 0LG

10. **ONE VISION HOUSING** Heysham Road , Bootle , L30 6UR

    together referred to in this agreement as the "**partners**".

The ICB and the Council (in its role as commissioner of social care and public health services) are together referred to in this agreement as the "**commissioners**

MCFT, S&OHT, LUHFT, AHCFT, Healthwatch, Sefton Council for Voluntary service, Primary Care, One Vision Housing and the Council (in its role as provider of social care and locality services, whether directly or through contracting arrangements with third party providers) are together referred to in this agreement as the "**providers**".

Background.

a) The NHS Long Term Plan was published in January 2019 and provided a vision of health and care joined up locally around population needs, the experience of Social Care and Health collectively responding to covid further compounded the need to achieve this. Subsequently on the 11th February 2021 a White Paper was published as a response to the 2020 NHS England Consultation - Integrating care: Next steps to building strong and effective integrated care systems across England **"Health and social care integration: joining up care for people, places and populations"**[1] (the "**White Paper**") it set out the key components of an integrated care system ("**ICS**"). The Bill has since moved through parliament and received Royal Assent in April, which will see it take affect from the 1st July 2022.

b) The Health and Care Act is designed to promote integration of Health and Care System focused on health of the population not patients. It obligates us to operate Health and Care seamlessly without artificial silos. Integrated Care Systems (ICS) will be funded to support Health outcomes in their area and held to account by CQC. ICS's will deliver the best possible care through dynamic partnerships between the NHS and Local Authorities. They will use collective resources to address the most complex heath issues, with enhanced assurance frameworks for Social Care to support improved outcomes and experiences.

c) This agreement sets out the values, principles, and shared ambition of the partners in supporting the further development of place-based health and care provision for the people of Sefton using a population health management approach, building on the progress achieved by the partners to date. The partner organisations under this agreement include HealthWatch Sefton, Primary Care Networks, One Vision Housing and Sefton CVS recognising both the vital role of wider cross-sector partners and the central role primary care will play in moving towards a population health management approach for Sefton.

d) The partners will focus on priority programmes in line with a life-course approach and work towards achieving specific outcomes as per the Health & Wellbeing Strategy and the proposed Marmot "beacon indicators" for Cheshire & Merseyside that are set out in "All Together Fairer". Further priority programmes may be identified by the partners during the term of this agreement as required to further the collaborative work of the partners for the benefit of the population of Sefton.

e) The partnership acknowledge that the Council has a dual role within the Sefton health and care system as both a commissioner of social care and public health services but also as a provider of social care and locality services either through direct delivery or through contracts with third party providers. In its role as commissioner of social care services the Council will work in conjunction with the C&M ICB/ICB and in its role as a

[1] *Health and Social Care Integration: joining up care for people, places and populations* (Health and social care integration: joining up care for people, places and populations)

provider of social care services the Council will work in conjunction with the providers. The Council recognises the need to and will ensure that any potential conflicts of interest arising from its dual role are appropriately identified and managed.

f) This agreement is intended to work alongside:
   a. the services contracts between the C&M ICB and the providers and between the Council and the providers; and
   b. the Section 75 agreement between the C&M ICB and the Council.

INTRODUCTION

The partners have agreed to work together on behalf of the people of Sefton to develop the Sefton Partnership through which to identify and respond to the health and care needs of the Sefton population, and deliver integrated health, support and community care to develop and ultimately deliver improved health and care outcomes for the people of Sefton.

This agreement sets out the key terms that the partners have agreed, including:

the vision of the partners, and key objectives for the development and delivery of integrated services in Sefton;

the key principles that the partners will comply with in working together;

the governance structures underpinning the Sefton Partnership and

A place plan will be developed for 2022/23, which the partners will work together to implement once that has been agreed.

partners agree to work together in good faith and understand that this agreement shall not be legally binding. The partners each enter into this agreement intending to honour all of their respective obligations.

Each of the providers has one or more individual services contracts (or where appropriate combined services contracts) with the C&M ICB or the Council. This agreement will work alongside these services contracts and the Section 75 agreement as appropriate.

Each of the commissioners and the providers agree to work together in a collaborative and integrated way on a Best for Sefton basis and the services contracts set out how the providers provide services to the Population. This agreement is not intended to conflict with or take precedence over the terms of the services contracts unless expressly agreed by the partners in writing.

This agreement is not intended to override or replace the independent statutory and regulatory duties that each partner has, and each partner remains responsible for ensuring that they comply with such duties.

Each partner acknowledges and confirms that as at the date of this agreement, it has obtained all necessary authorisations to enter into this agreement and that its own organisational leadership body has approved the terms of this agreement.

1. THE VISION

1.1 The overarching vision for the partnership as per the borough's Health & Wellbeing

Strategy, and local NHS five year plan Sefton 2gether, is as follows:

A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future.

Our ambitions for Start Well are:

- Education and training will enable every young person to unlock the door to more choices and opportunities
- Every child will achieve the best start in their first 1001 days
- Every child and young person will have a successful transition to adulthood, including young carers, and children with special educational needs and disabilities for whom transition extends to 25 years.

Our ambitions for Live Well are:

- Health, care and wellbeing services across the wider system will work together to support individuals, carers, families, and communities
- The wider system has a strong role in prevention, early intervention, health equity, and integrated care so that access and support is available where needed
- Everyone has a fulfilling role which can support their needs, with opportunities to contribute, learn and progress

Our ambitions for Age Well are:

- Older people will stay active, connected and involved by being part of strong communities in which they are important.
- As people grow older, they will be provided with support, tailored to their needs which respects their dignity and individual preferences, including in relation to caring responsibilities.
- Our communities and the built environment will meet the needs of people as they get older, through age and disability friendly towns, communities, services, housing and transport.

Our All Age ambition is that:

- The places where we live will make it easy to be healthy and happy, support our physical and mental health, with opportunities for better health and wellbeing on our doorstep, where social connections are encouraged across all generations.

2. THE OBJECTIVES

The partners have agreed to work together and to perform their duties under this agreement in order to improve population health and reduce health inequalities across Sefton.

The partners will aim to achieve the following outcomes identified in the Sefton Health & Wellbeing Strategy as well as contribute to the proposed “Marmot beacon indicators” as set out in the All Together Fairer report for Cheshire & Merseyside:

3.1

- Education and training will enable every young person to unlock the door to more choices and opportunities
- Every child will achieve the best start in their first 1001 days
- Every child and young person will have a successful transition to adulthood, including young carers, and children with special educational needs and disabilities for whom transition extends to 25 years.
- Everyone will have a fulfilling role which can support their needs
- The wider system will have a strong role in prevention and early intervention
- Older people will stay active, connected and involved by being part of strong communities in which they are important.
- As people grow older, they will be provided with support, tailored to their needs which respects their dignity and individual preferences, including in relation to caring responsibilities.
- Our communities and the built environment will meet the needs of people as they get older, through age and disability friendly towns, communities, services, housing, and transport.
- The places where we live will make it easy to be healthy and happy, with opportunities for better health and wellbeing on our doorstep

2.2 The partners acknowledge that they will have to make decisions together in order for the Sefton Partnership to work effectively. The partners agree that they will work together and make decisions on a Best for Sefton basis in order to achieve the outcomes.

3. THE PRINCIPLES

3.1 The principles underpin the delivery of the partners’ obligations under this agreement and set out key factors for a successful relationship between the partners.

3.2 The partners agree that the success of the Sefton Partnership will depend on their

ability to effectively co-ordinate and combine their expertise and resources in order to deliver an integrated approach to the planning, provision and use of community assets and services across the partners.

3.3 The partners will work together in good faith and will:

4.3.1 Work together to deliver a single vision through a focused set of priorities to reduce the unacceptable gap in health and wellbeing inequalities

4.3.2 Work to achieve financial sustainability by working to create the conditions to guarantee the most efficient, effective and value for money based use of public resources in Sefton.

4.3.3 Deliver person centred services informed by the voice of experts by experience through commitment to codesign, coproduction and listening at all levels to our owners – the people that need Care and Support.

4.3.4 Commit to acting ethically at all times with the ultimate interest of the citizen held at the heart of what we do. This is to be achieved through openness, honesty, transparency and constructive challenge.

4.3.5 To build on what we learnt during COVID – the power of acting as one, being risk enabled, outcome focused, and solution driven to solve our 'wicked problems'

4.3.6 and Invest in innovative and creative services that bring best practice to Sefton offer digital solution that bring maximum impact and solutions to our citizens

4.3.7 Ensure that all that we do is informed by a population health framework that enables shared, collective data to ensure that residents are getting the best possible care and support – in the right place at the right time

(Together these are the "**principles**").

RESOLVING DISPUTES AND DISAGREEMENTS

The partners agree to adopt a systematic approach to problem resolution which recognises the objectives (section 3) and the principles (section 4) above and which:

seeks solutions without apportioning blame;

is based on mutually beneficial outcomes;

treats providers and the commissioners as equal parties in the dispute resolution process; and

contains a mutual acceptance that adversarial attitudes waste time and money.

If a problem, issue, concern or complaint comes to the attention of a partner in relation to the objectives, principles or any matter in this agreement and is appropriate for resolution between the commissioners and the providers such partner shall notify the other partners and the partners each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion within 20 operational days of such matter being notified.

If any partner receives any formal enquiry, complaint, claim or threat of action from a third party relating to this agreement (including, but not limited to, claims made by a supplier or requests for information made under the FOIA relating to this agreement) the receiving partner will liaise with the Sefton Partnership board as to the contents of any response before a response is issued.

TRANSPARENCY

Subject to compliance with the Law and contractual obligations of confidentiality, the partners will provide to each other all information that is reasonably required in order to deliver the priority programmes and implement the Sefton Place Delivery Plan (once it has been agreed an signed off) in line with the objectives.

OBLIGATIONS AND ROLES OF THE PARTNERS

Each of the partners acknowledges and confirms that:

it remains responsible for performing its obligations in accordance with the service contracts to which it is a party;

it will be separately and solely liable to the relevant counterparty or counterparties under its own services contracts;

it remains responsible for its own compliance with all relevant regulatory requirements and remains accountable to its board/cabinet and all applicable regulatory bodies; and

it will work collaboratively with the other partners to develop the Sefton Partnership approach for the priority programmes and implement the Sefton Partnership place plan.

SEFTON PARTNERSHIP GOVERNANCE

The partners must communicate with each other and all relevant staff in a clear, direct and timely manner. In addition to the partners' own board, cabinet or other relevant committee, which shall remain accountable for the exercise of each of the partners' respective functions, the governance structure for the Sefton Partnership will

comprise: the Sefton Partnership board and any established sub-groups; and the Sefton Health and Wellbeing Board.

It has now been confirmed that substantive delegations to place will not occur during the remainder of 2022/23 therefore the Sefton Partnership board will operate as a collaborative forum and will be responsible for making recommendations on strategic policy matters relevant to the place partnership.

Sefton Partnership board

The board is the forum responsible for:

overseeing the partnership arrangements under this agreement.

reporting to the Health and Wellbeing Board and Cheshire and Merseyside Integrated Care Board on progress against delivering the Health & Wellbeing Strategy for Sefton and supporting the development and implementation of a place delivery plan; and

working with:

national stakeholders (including NHS England and NHS Improvement); and

the Cheshire & Merseyside Integrated Care System

to communicate the views of the partners and updates/progress reports on matters relating to integrated care in Sefton.

The Sefton Partnership board will act in accordance with its terms of reference.

The chair of the partnership will mirror that of the Health and Wellbeing Board and be the Sefton representative on the Cheshire and Merseyside Integrated Care Partnership. The deputy chair of the partnership will be a GP lead clinician from within Sefton. The chairing arrangements shall be reviewed on a bi-annual basis.

Each partner must ensure that its appointed members or attendees of the Sefton Partnership Board (or their appointed deputies/alternatives) attend all of the meetings of the relevant group and participate fully and exercise their rights on a Best for Sefton basis and in accordance with the agreed principles

The partners will communicate with each other clearly, directly and in a timely manner to ensure that the partners (and their representatives) present at the Sefton Partnership board are able to participate in discussions and/or represent their nominating organisations to enable effective and timely consensus recommendations to be made to a relevant board.

The partners will review and develop the governance arrangements for the Sefton Partnership during 2022/23 to strengthen arrangements and create frameworks for potential joint decision-making between the partners, such review to include consideration of developing a joint committee structure between the partners in line with the relevant provisions of the Health and Care Act 2022. This will be subject to approval by the relevant bodies.

Sefton Health and Wellbeing Board

The Sefton Health and Wellbeing Board is a committee of the Council, charged with promoting greater health and social care integration in Sefton. The Health and Wellbeing Board will receive reports from the Sefton Partnership Board as to the development of the partnership arrangements under this agreement and progress against the Health & Wellbeing Strategy.

CONFLICTS OF INTEREST

The partners will:

disclose to each other the full particulars of any real or apparent conflict of interest which arises or may arise in connection with this agreement or the operation of the Sefton Partnership Board, and the committees/forums or groups that operate below immediately upon becoming aware of the conflict of interest whether that conflict concerns the partner, or any person employed or retained by them for or in connection with the performance of this agreement;

not allow themselves to be placed in a position of conflict of interest in regard to any of their rights or obligations under this agreement (without the prior consent of the other partners) before they participate in any decision in respect of that matter; and

CHARGES AND LIABILITIES

The partners will continue to be paid in accordance with the mechanism set out in their respective services contracts.

The partners have not agreed as at the commencement date to share risk or reward. However, the partners will work together in time to develop system financial principles, including the potential development of risk/reward sharing mechanisms.

The partners' respective responsibilities and liabilities in the event that things go wrong with the services will be allocated under their respective services contracts and not this agreement.

CONFIDENTIALITY AND INFORMATION SHARING

Each partner shall keep confidential all confidential information that it receives from the other partners except to the extent that such confidential information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised disclosure by a partner to this agreement.

To the extent that any confidential information is covered or protected by legal privilege, then disclosing such confidential information to any partner or otherwise permitting

disclosure of such confidential information does not constitute a waiver of privilege or of any other rights which a partner may have in respect of such confidential information.

The partners agree to procure, as far as is reasonably practicable, that the terms of this Clause 11 (*Confidentiality and Information Sharing*) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this agreement.

Nothing in this Clause 11 (*Confidentiality and Information Sharing*) will affect any of the partners' regulatory or statutory obligations.

The partners acknowledge that they are each subject to the requirements of the FOIA and will facilitate each other's compliance with their information disclosure requirements, including the submission of requests for information and handling any such requests in a prompt manner and so as to ensure that each partner is able to comply with their statutory obligations.

DURATION AND REVIEW

This agreement shall take effect on the Commencement Date and will continue in full force and effect unless and until terminated in accordance with the terms of this agreement.

The partners will review progress made and the terms of this agreement at six monthly intervals from 1 July 2022 and may agree to vary the agreement to reflect developments. Notwithstanding this, the partners may review and amend the terms of this agreement at any time in accordance with Clause **Error! Reference source not found.** (*Variations)*

VARIATIONS

Any variation to this agreement shall not be effective unless set out in writing and signed by or on behalf of the partners.

This agreement has been entered into on the date stated at the beginning of it.

Signed by [insert]

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

.....

Signed by [insert]

[ ]

for and on behalf of **SEFTON METROPOLITAN BOROUGH COUNCIL**

.....

[ ]

Signed by [insert]

for and on behalf of **MERSEY CARE NHS FOUNDATION TRUST** .....

[ ]

Signed by [insert] .....

for and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST** [ ]

Signed by [insert]

for and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST** .....

[ ]

Signed by [insert]

for and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST** .....

[ ]

Signed by [insert]

for and on behalf of **HEALTHWATCH SEFTON** .....

[ ]

Signed by [insert]

for and on behalf of **[SOUTHPORT & FORMBY PRIMARY CARE PARTNER]** .....

[ ]

Signed by [insert]

for and on behalf of **[SOUTH SEFTON PRIMARY CARE PARTNER]** .....

[ ]

Signed by [insert] .....

for and on behalf of **[SEFTON COUNCIL FOR VOLUNTARY SERVICE]** [ ]

Signed by [insert] .....

for and on behalf of [**ONE VISION HOUSING**] [ ]

SCHEDULE 1

Definitions and interpretation

The following words and phrases have the following meanings:

Agreement	this agreement incorporating the Schedules.
Best for Sefton	the achievement of the Vision and Objectives for the Sefton population on the basis of the principles.
Claims	any claims, actions, demands, fines or proceedings.
Commencement date	the date entered on page one (1) of this agreement.
Confidential information	the provisions of this agreement and all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this agreement.
Dispute	any dispute arising between two or more of the partners in connection with this agreement or their respective rights and obligations under it.
Dispute Resolution Procedure	the procedure set out in section 5
FOIA	the Freedom of Information Act 2000 and any subordinate legislation (as defined in section 84 of the Freedom of Information Act 2000) from time to time together with any guidance and/or codes of practice issued by the Information Commissioner or relevant Government department in relation to such Act.
ICB	Cheshire & Merseyside Integrated Care Board.
Sefton Partnership	The place based arrangement for care and support.
ICS	Integrated Care System.

Insolvency	(as may be applicable to each partner) a partner taking any step or action in connection with its entering administration, provisional liquidation or any composition or arrangement with its creditors (other than in relation to a solvent restructuring), being wound up (whether voluntarily or by order of the court, unless for the purpose of a solvent restructuring), having a receiver appointed to any of its assets or ceasing to carry on business.
Law	a) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; b) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; c) Guidance (as defined in the NHS Standard Contract); d) National Standards (as defined in the NHS Standard Contract); and e) any applicable code.
NHS Standard Contract	the NHS Standard Contract for NHS healthcare services as published by NHS England from time to time.
Objectives	the objectives for the Sefton Partnership set out in Clause 3.
Operational Days	a day other than a Saturday, Sunday or bank holiday in England.
Population	the population of Sefton covered by each of the commissioners.
Principles	the principles for the Sefton Partnership set out in Clause 7.3.
Priority Programmes	the programmes which will set out the key priority areas and populations which are to be the focus of joint working between the partners.
Section 75 agreement	the agreement relating to 2022/23 entered into by the commissioners under section 75 of the National Health service Act 2006 to commission the services listed in the Schedules to that agreement.
Service Users	people within the Sefton population served by the commissioners and who are in receipt of the services.
Services	the services provided, or to be provided, by each Provider to service Users pursuant to its respective services Contract.

Services Contract	a contract entered into by one of the C&M ICB or the Council and a Provider for the provision of services, and references to a services Contract include all or any one of those contracts as the context requires.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Workforce Disability Equality Standard (WDES) Report, 2022**
Report of:	Chief People Officer
Paper Prepared by:	Chief People Officer

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:	

Alder Hey Children's NHS
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Report 2022

Contents

1. Executive Summary

The Workforce Disability Equality Standard (WDES) is a set of specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. It was introduced in 2019 and the WDES allows our organisation to better understand the experiences of disabled staff so that we can support them and make positive changes, creating a more inclusive workforce that feels valued and included. At Alder Hey Children's NHS Foundation Trust, we are committed to improving employee experience for all staff with a disability. We will continue to work hard to monitor all aspects of attraction, retention and recruitment processes making sure that they are equitable and free from prejudice and continue to develop a culture of inclusivity.

There is still additional work to be done to improve the number of staff who declare themselves as disabled. Our ESR data shows that 3.9% of our workforce have declared themselves as disabled. While there are more staff who have declared their status than last year, 27% still have not completed this information.

In the last 12 months, we have seen an improvement in 2 out of the 9 metrics, those being an increase in reporting incidents of bullying, harassment or abuse, and less staff reporting feeling pressured to come to work from their manager when feeling ill which is positive. However, of the other metrics, 5 have seen declines in performance, some marginal and some more marked declines, and one remained static. Those which have seen a decline and where we will need to significantly focus our energies and efforts to improve are:

- The likelihood of being shortlisted from appointment has declined; non-disabled candidates are 1.69 more likely to be appointed compared to disabled staff
- More staff have reported experiencing bullying, harassment or abuse from service users/patients, other staff or their line manager
- Less disabled staff than non-disabled staff report feeling valued by the organisation
- Less staff reporting being supported with reasonable adjustments (down from 80% to 74%)
- Less staff reporting that the organization provides equal opportunities for career progression or promotion.

There was insufficient data to make any interpretation about the numbers of disabled staff entering a formal capability process. There was also no movement in Board reporting in 2021.

In Summer 2022, the Trust launched the new Equality, Diversity and Inclusion Steering Group, picking up the mantle of the excellent foundations laid by the BME Taskforce. Reporting directly into the Trust Board, this group will oversee the development of the action plan associated with the WDES, ensuring the trust's actions are impactful and help make improvements across the whole range of

metrics. Its is evident that there is a lot of work to do to ensure staff with a disability have a better experience at Alder Hey. We started the active engagement of disabled staff with a series of listening events held in late 2021 and 2022, and the launch of the new disability staff network in the Autumn of 2022 aims to work with staff to take this feedback and create and embed positive change.

SUMMARY TABLE			
Indicator	**Trust performance since 2020**		**National comparison from 2021 (England average)**
WDES Indicator 1: Representation	n/a	3.9% report having a disability	3.7% report having a disability
WDES Indicator 2: Likelihood of appointment	Decline	From 1.65 to 1.89	1.11
WDES Indicator 3: Likelihood of capability	Not enough data to interpret	Not enough data to interpret	1.94
WDES Indicator 4: Bullying & harassment: • From patients • From line manager • From other colleagues • Was it reported?	 Decline Decline Decline Improved	 From 22.2% to 23.8% From 12.8% to 14.6% From 17.4% to 21.4% From 51.6% to 53.5%	 31.9% 18.5% 25.6% 47%
WDES Indicator 5: Fairness in career progression	Decline	From 55.8% to 54.9%	78.4%
WDES Indicator 6: Pressure to come into work (presenteeism)	Improved	From 31.1% to 23.4%	32.2%
WDES Indicator 7: Feeling valued	Decline	From 43.5% to 42.6%	32.6%
WDES Indicator 8: Adequate adjustments	Decline	From 80.5% to 74.3%	76.6%
WDES Indicator 9: Staff engagement (score out of 10)	Decline	From 7.4 to 7.2	6.4
WDES Indicator 10: Board membership	No Change	0% report having a disability	3.7% report having a disability

Introduction

This is the 2021 annual WDES Data report. The data for 2021 has been directly compared to data for 2020 providing a clear picture on the indicators that the Trust is performing well in and those indicators that require the Trusts focus in the year ahead. The focus of this report is to present the Trusts performance against the WDES indicators for the past 12 months with a subsequent action plan to improve the experience and opportunities for our disabled staff in the coming year(s).

Data for Indicators 4-9 are taken directly from the staff survey 2021, for which we undertake a full census of all staff in post.

Completeness of data:

A significant number of staff have not self-reported if they have a disability and so the data may not truly reflect the number of employees at Alder Hey who have a disability, however this has decreased from last year. We will continue to communicate to all staff the importance of reporting and updating their personal data via ESR Employee Self Service.

Reliability of comparisons with previous years:

No matters were identified relating to reliability of comparisons with previous year.

Data collection:

Data was collected on 31st March 2022. Total workforce was 4089. 72.9% of colleagues have disclosed information about their disability or long-term condition to the Trust. 3.9% of colleagues have reported that they have a disability or long-term condition, which is an increase of 0.6% from 2020.

INDICATOR 1

Representation of staff with a disability within the organisation compared to non-disabled

Non-Clinical	% Disabled 2021	% Non-Disabled 2021	% Unknown 2021	Clinical	% Disabled 2021	% Non-Disabled 2021	% Unknown 2021
Band 1[1]	0%	100%	0%	**Band 1**	0.0%	0.0%	0.0%
Band 2	3.5%	57.4%	39%	**Band 2**	2.2%	64.1%	33.5%
Band 3	7.8%	67.3%	24.9%	**Band 3**	3.9%	66.5%	29.5%
Band 4	5.1%	66.4%	28.5%	**Band 4**	8.2%	64.1%	27.6%
Band 5	5.4%	79.3%	15.2%	**Band 5**	3.3%	75.1%	21.4%
Band 6	4.5%	76.4%	19.1%	**Band 6**	3.6%	67.1%	29.1%
Band 7	6.3%	76.3%	17.5%	**Band 7**	5.4%	71.2%	23.2%
Band 8a	2.8%	78.9%	18.3%	**Band 8a**	2.7%	60.1%	37.1%
Band 8b	8.8%	70.6%	20.6%	**Band 8b**	0%	72.2%	27.7%
Band 8c	0%	100%	0%	**Band 8c**	0%	83.3%	16.6%
Band 8d	0%	86.7%	13.3%	**Band 8d**	0%	75%	25%
Band 9	0%	100%	0%	**Band 9**	0%	100%	0%
Medical	n/a	n/a	n/a	**Medical**	0.56%	65.1%	34.2%
VSM	0%	76.9%	23.1%	**VSM**	0%	100%	0%

3.9% of colleagues have reported that they have a disability or long-term condition.

[1] Band 1 closed to new entrants

INDICATOR 2

Likelihood of appointment from shortlisting

2020	2021
1.65	1.89

(A figure above 1:00 indicates that Disabled staff are less likely than non-disabled staff to be appointed from shortlisting)

Whilst the numbers of applications from candidates who declare a disability are significantly smaller than those who do not, this result is concerning, especially as it has increased from 1.65 in 2020. The Trust is participating in the national Overhauling Recruitment Programme, with specific focus on the selection sprint; the results from which will influence our development in this area.

INDICATOR 3

Likelihood of entering the capability process

Due to the small numbers of those involved, we are unable to generate a likelihood score for this indicator.

INDICATOR 4

Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: servicer user, managers, other colleagues

From service users and patients:

	2020	2021
Staff with a Disability or Long-Term Condition	**22.2%**	**23.8%**
Staff without a Disability or Long-Term Condition	**17.1%**	**19.2%**

From managers:

	2020	2021
Staff with a Disability or Long-Term Condition	**12.8%**	**14.6%**
Staff without a Disability or Long-Term Condition	**6.6%**	**6.9%**

From other colleagues:

	2020	2021
Staff with a Disability or Long-Term Condition	**17.4%**	**21.4%**
Staff without a Disability or Long-Term Condition	**11.6%**	**10.7%**

1. *it*

They reported it:

	2020	2021
Staff with a Disability or Long-Term Condition	**51.6%**	**53.5%**
Staff without a Disability or Long-Term Condition	**47.9%**	**47.3%**

All three questions about experiencing bullying, harassment or abuse have increased this year, which is of significant concern, although there is an increase in staff reporting such incidents. This will need to be an area of significant focus as part of our response to this report.

INDICATOR 5

Percentage of disabled staff compared to non-disabled staff believing that the organisation provides equal opportunities for career progression or promotion

	2020	2021
Staff with a Disability or Long-Term Condition	**55.8%**	**54.9%**
Staff without a Disability or Long-Term Condition	**65.1%**	**65.2%**

This years' figures show a slight decrease in the number of disabled staff that believe the organisation provides equal opportunities to them for career progression.

INDICATOR 6

Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their managers to come to work, despite not feeling well enough to perform their duties

	2020	2021
Staff with a Disability or Long-Term Condition	**31.1%**	**23.4%**
Staff without a Disability or Long-Term Condition	**18.0%**	**19.5%**

This has decreased significantly, which is a positive step in the right direction.

INDICATOR 7

Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which the organisation values their work

	2020	2021
Staff with a Disability or Long-Term Condition	**43.5%**	**42.6%**
Staff without a Disability or Long-Term Condition	**53.8%**	**50.0%**

2021 data sees a decline in scores from 2020. There is evidently more work to be done for staff with disabilities to ensure they feel as valued as their non-disabled colleagues.

INDICATOR 8

Percentage of disabled staff saying that the organisation has made adequate adjustment(s) to enable them to carry out their work

	2020	**2021**
Staff with a Disability or Long-Term Condition	**80.5%**	**74.3%**

This year's data has seen a significant decrease, and this figure is below the national average of 76.6%. Whilst heartening to know that three-quarters of colleagues feel supported with appropriate adjustments, we need to ensure all colleagues receive the same support.

INDICATOR 9

The staff engagement score for disabled staff, compared to non-disabled staff

The staff engagement score is from 0-10

	2020	2021
Staff with a Disability or Long-Term Condition	7	6.9
Staff without a Disability or Long-Term Condition	7.5	7.4

The staff engagement score is above the national average and has remained larger static over the past 3 years. However, we still need to work towards increasing this score and ensure all staff feel included, valued, and respected.

INDICATOR 10

Board Representation

	Disabled	Non-Disabled	Unknown
Voting Board Members	0%	64.2%	37.7%

The disclosure of disability status is high compared to some other staff groups however we need to encourage all Board members to disclose their information as good practice. We want to develop a board who are representative of our workforce and service users and who can understand, champion, and influence the requirements of our workforce.

Conclusion & Reflection

We have made our first steps in beginning to build a culture of inclusivity and this needs to continue, constantly embedding equality, diversity & inclusion throughout our whole organisational planning. Our newly appointed Equality, Diversity and Inclusion Lead will work closely with the staff networks and the Equality, Diversity and Inclusion Steering Group to collectively build and maintain a positive experience for our patients, carers and our dedicated colleagues.

The Trust embarked on a series of listening events with disabled staff during late 2021 and 2022, and whilst this was a good start., significant work is required to reinstall confident in our disabled staff that we are committed and invested in supporting their career progression and growth whilst they're at Alder Hey. We want our staff to feel valued and respected, implementing more support and equal opportunities for all staff will help strengthen a culture of inclusivity

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Workforce Race Equality Standard (WRES) Report, 2022**
Report of:	Chief People Officer
Paper Prepared by:	Chief People Officer

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:	

Alder Hey Children's NHS
NHS Foundation Trust

Workforce Race Equality Standard (WRES) Report 2022

Contents

Executive Summary

The Workforce Race Equality Standards (WRES) was introduced in 2015 and is now mandatory for all NHS Trusts. Since then, NHS organisations, including Alder Hey, have been collating and analysing their workforce data, holding up a mirror to organisational performance on this agenda and developing action plans to facilitate progress in each metric to improve the experience of black, Asian and minority ethnic colleagues within the Trust.

The Trust has facilitated a number of WRES related activities in the past 12 months, driven by the work of the BME Taskforce which has been in place since 2020 and has focused its efforts on listening and engaging with BME staff, improving diverse communications, zero tolerance approaches and training, and as a result there has been an improvement in 7 out of 9 metrics in 2021/22, compared to 2020/21 data.

Encouragingly, the overall BME population of the Trust has increased by 1% in year to 9%[1] and the Trust Board representation (voting) has increased from 21.4% to 28.6%. successful overseas nursing recruitment has supported this increase in diversity. The Trust has seen a statistically significant improvement in Metric 6, which highlights a decrease in percentage of BME staff reporting that they have experienced harassment, bullying or abuse from other staff, a decrease of 7.4%. However, there is an increase in the percentage of BME staff reporting that they have experienced harassment, bullying or abuse from the public, from 13% to 16.9%. The Trust accepts that it is not tolerable for any staff member to experience bullying and harassment in the workplace and continues to look at how we can reduce these figures.

It is heartening to see progress in Metric 4 (likelihood of BME staff accessing training and CPD), and also in Metric 2 (likelihood of BME applicants being appointed following shortlisting) and we hope these will improve year on year with the development of the education offer for colleagues, and with the Trust's participation in the national Overhauling Recruitment Programme.

In Summer 2022, the Trust launched the new Equality, Diversity and Inclusion Steering Group, picking up the mantle of the excellent foundations laid by the BME Taskforce. Reporting directly into the Trust Board, this group, working with members of the staff network, will oversee the development of the action plan associated with the WRES, ensuring the trust's actions are impactful and help make improvements across the whole range of metrics.

[1] BME population of Liverpool is estimated to be around 11%

SUMMARY TABLE			
Indicator	**Trust performance since 2020**		**National comparison from 2021 (England average)**
WRES Indicator 1: Representation	Improved	From 7.8% to 8.9%	22.4% (NW 13.3%)
WRES Indicator 2: Likelihood of appointment (ratio)	Improved	From 1.07 to 0.91	1.61
WRES Indicator 3: Likelihood of disciplinary action (ratio)	Declined	From 0.43 to 0.91	1.14
WRES Indicator 4: Access to training & CPD (ratio)	Improved	From 1.23 to 0.32	1.14
WRES Indicator 5: Bullying & harassment from the public (staff survey data)	Declined	From 13.4% to 16.9%	28.9%
WRES Indicator 6: Bullying & harassment from staff (staff survey data)	Improved	From 27.5% to 20.1%	28.8%
WRES Indicator 7: Fairness in career progression (staff survey data)	Improved	From 48.4% to 51%	69.2%
WRES Indicator 8: Experience of discrimination (staff survey data)	Improved	From 12.4% to 10.5%	16.7%
WRES Indicator 9: Board voting membership	Improved	From 21.4% to 28.6%	12.6%

Introduction

This is the 2021 annual WRES Data report. The data for 2020/21 has been directly compared to data for 2019/20 providing a clear picture on the indicators that the Trust is performing well in and those indicators that require the Trusts focus in the year ahead. The focus of this report is to present the Trusts performance against the WRES indicators for the past 12 months with a subsequent action plan to improve the experience and opportunities for our BME staff in the coming year(s).

Completeness of data:

There have been no issues identified regarding completeness of data and the current proportion of staff who have self-reported their ethnicity stands at 98.8%. We will continue to communicate to all staff the importance of reporting and updating their personal data in ESR through Employee Self Service.

Reliability of comparisons with previous years:

No matters were identified relating to reliability of comparisons with previous year.

Data Collection:

Data was collected on 31st March 2022, when the workforce comprised 4013 employees. 8.9% reported they were from a black or minority ethnic background. 89.6% reported being from a white background and 1.4% did not state their ethnicity.

INDICATOR 1

Percentage of staff in each of the AFC bands 1-9 and VSM (including executive directors) compared with staff in the overall workforce, by non-clinical and clinical groupings.

Non-Clinical	% BAME 2020	% WHITE 2020	% UNKNOWN 2020	Non-Clinical	% BAME 2021	% WHITE 2021	% UNKNOWN 2021
Band 1 *	6%	94%	0%	Band 1*	0%	100%	0%
Band 2	2%	98%	1%	Band 2	2%	97%	0%
Band 3	4%	95%	1%	Band 3	4%	93%	2%
Band 4	3%	97%	1%	Band 4	4%	96%	0%
Band 5	5%	95%	0%	Band 5	5%	93%	1%
Band 6	7%	93%	0%	Band 6	4%	94%	1%
Band 7	5%	93%	1%	Band 7	3%	98%	0%
Band 8a	6%	89%	5%	Band 8a	6%	90%	4%
Band 8b	1%	96%	0%	Band 8b	9%	88%	3%
Band 8c	0%	92%	8%	Band 8c	0%	100%	0%
Band 8d	0%	100%	0%	Band 8d	6%	88%	6%
Band 9	0%	0%	0%	Band 9	0%	100%	0%
VSM	0%	100%	0%	VSM	0%	100%	0%

Non-Clinical

- Notable improvements in 8b and 8d paybands.
- No significant improvements in any other pay bands, with a reduction in Band 1, Band 6, Band 7

Clinical	% BAME 2020	% WHITE 2020	% UNKNOWN 2020	Clinical	% BAME 2021	% WHITE 2021	% UNKNOWN 2021
Band 2	6%	94%	0%	Band 2	4%	96%	0%
Band 3	1%	98%	0%	Band 3	2%	96%	1%
Band 4	11%	87%	2%	Band 4	7%	88%	4%
Band 5	9%	90%	1%	Band 5	13%	86%	1%
Band 6	6%	94%	0%	Band 6	6%	94%	1%
Band 7	3%	97%	1%	Band 7	3%	96%	1%
Band 8a	5%	93%	2%	Band 8a	3%	95%	1%
Band 8b	0%	100%	0%	Band 8b	3%	97%	0%
Band 8c	0%	100%	0%	Band 8c	0%	100%	0%
Band 8d	0%	100%	0%	Band 8d	25%	75%	0%
Band 9	0%	100%	0%	Band 9	100%	0%	0%

Clinical

- Significant increase in bands 5, 8b, 8d and 9.
- Decreases in the lower bands 2 and 4 and in the more senior 8b.

INDICATOR 2

Likelihood of appointment from shortlisting

White applicants being appointed from shortlisting compared to BME applicants:

2020	2021
1.07	0.90

This has shown positive improvement since 2020; BME candidates were slightly more likely to be appointed from shortlisting than white applicants. Of note, the Trust is participating in the national Overhauling Recruitment Programme, with specific focus on the selection sprint; the results from which will influence our development in this area.

INDICATOR 3

Likelihood of entering the disciplinary process

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff:

2020	2021
0.43	0.91

Whilst this indicator shows no significant increase in the likelihood of BME staff entering into the disciplinary process, it has increased marginally since 2020, and so will be one area for the Trust to retain significant focus on. This remains below the national position.

INDICATOR 4

Access to non-mandatory training & CPD

Relative likelihood of white staff accessing training and CPD compared to BME staff:

2020	2021
1.23	0.32

This indicator has significantly improved since 2020 with more BME colleagues accessing non-mandatory training and development, which is a positive step in the right direction.

INDICATOR 5

Bullying & harassment from the public

2020		2021		2020		2021	
White	18.4%	White	20.7%	BME	13.4%	BME	16.9%

This data demonstrates a slight increase in the percentage of both white and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. There is a renewed and more comprehensive a zero-tolerance policy in place, which supports the Trust's anti-racism stance.

INDICATOR 6

Bullying & harassment from staff

2020		2021		2020		2021	
White	16.2%	White	16.9%	BME	27.5%	BME	20.1%

The Trust is pleased to see a significant decrease in the numbers of BME staff reporting having experienced bullying or harassment from other staff in 2021 and will continue to promote the Zero Tolerance and anti-racism approach launched in 2020 through the auspices of the BME Taskforce.

INDICATOR 7

Fairness in career progression

2020		2021		2020		2021	
White	64.5%	White	63.9%	BME	48.8%	BME	51%

Whilst we have seen a slight positive improvement in responses from BME colleagues, we will continue to aim for no disparity between white and BME staff and aim to improve the overall responses for all colleagues.

INDICATOR 8

Experience of discrimination

2020		2021		2020		2021	
White	4.8%	White	5.6%	BME	12.4%	BME	10.5%

There has been a slight increase in white staff reporting they have personally experienced discrimination at work from managers, team leaders, or other colleagues, although there is still work that needs to be done to eradicate such behaviours. However, there has been a decrease reported by BME staff. Positively, the Trust is below the national average for both staff groups.

INDICATOR 9

Board voting membership

2020			2021		
White	BAME	Not Stated	White	BAME	Not Stated
71.4%	21.4%	7.1%	64.3%	28.6%	7.1%

We continue to work hard to continue to increase our diversity at board level, demonstrated by the increase in diversity in 2021. This is better than the national average of 12.6%. This is significantly higher than the Trust BME representation at 8.9%.

Conclusion & Reflection

This year's WRES report shows improvements in 7 of the 9 metrics, which is a positive move in the right direction and reflective of some of the great work that has taken place to support our BME colleagues across the trust. Nevertheless, the trust must not be complacent and we must continue to strive to eliminate racism and discrimination in all its forms to make Alder Hey a brilliant place to work for all of our colleagues.

We have made our first steps in beginning to build a culture of inclusivity and this needs to continue, constantly embedding equality, diversity & inclusion throughout our whole organisational planning. Our newly appointed Equality, Diversity and Inclusion Lead will work closely with the staff networks to collectively build and maintain a positive experience for our patients, carers and our dedicated colleagues.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 27th October 2022

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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP QUARTERLY PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the Board with a summary of the activities of the FTSU team in the last quarter and to outline the actions planned for the coming six to twelve month period.

2. Recommendation

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

3. Quarter 1 and 2 data

There were cases 8 cases for Q1 and 18 cases for Q2 submitted to the NGO for Q4 of 2021/22. Of these 26 cases, 6 in Q1 are closed and 3 in Q2, in Q2 it should be noted that 8 of those cases remaining open are part of a collective concern, but all have approached the FTSUG independently of each other. Of the total cases raised in Q1 and 2, 4 were done so anonymously.

During Q1, 3 cases related to process/policy, 3 to behaviours and relationships, 1 to Patient safety and Leadership and one relating to detriment. The case relating to detriment has been closed as there was no evidence that the individual had suffered detriment as a result of raising a concern.

During Q2, 5 cases related to process/policy, 12 to behaviours and relationships, 1 to Patient safety and Leadership.

Feedback to the FTSUG from those raising concerns at the point of closing the case, continues to be positive and has identified that that they would use the service again and scored the process highly in terms of satisfaction. Below is a recent response to the question 'would you use the service again and how would you rate the service you received, 5 being great!'

Hi Kerry,

*Yes I agree, and I would 100% give the service a 5**

I am very grateful for your input and support - and I personally feel much more secure knowing you are here should I or any of my colleagues need any advice. In my case, I really didn't know where to turn, and my issue had continued for months with no real answer from anyone I had contacted prior to you. This was having an impact on my wellbeing, and I was looking for other jobs outside of the trust.

4. Lessons Learnt – Case Study

In January 2022 issues were raised by some staff who are part of a small team, these issues were raised through several routes including The Freedom to Speak Up Guardian, Raising Concerns policy and Human Resources and were in relation to:

- Recruitment Activity
- Employee Behaviours
- Processes
- Application of the Trust Values in Practice

In line with the Investigation Policy, an initial fact find was undertaken. Trust Policies that may have been applicable to the situation included:

- Freedom to Speak Up: Raising Concerns Policy
- Investigation Policy
- Disciplinary Policy
- Respect at Work Policy

Considerations and Approach

Due to the alignment to FTSU: Raising Concerns Policy, the next step was to consider the escalation process and ascertain the level of involvement required. As part of this process the following questions were posed:

- What is the highest level of role this issue has been raised with so far?
- What is the potential impact on the service provision?
- What is the potential impact on individuals / the team?

Following the above activity, a group was convened, comprising of Executive lead, managers, HR, FTSUG and SALS/OD, to consider next steps, approach, service impact and employee / patient safety; and subsequently met at intervals to review progress.

It was determined that the most appropriate approach was a Listening Activity due to the alignment to a Just and Fair Culture. This model utilized activity detailed below.

Model

Activity

- Launch meeting
- Individual confidential 1-2-1 listening sessions
- Meeting with leadership team
- Production of report
- Group feedback

Outcomes / Enablers

This approach enabled the following to be achieved:

- Staff remained in work.

- There was no service impact.
- The recruitment process issue was resolved.
- Enhanced leadership capacity in place through the appointment of a new manager, to support the structure already in place.
- Role distinction.
- Behavioural expectations.
- Drivers to support psychological safety are in place

Risks
The following potential risks are highlighted:

- Capacity and Future Sustainability: If this intensive approach was to be utilised across the Trust, capacity within the SALS team could become exhausted. A process for future check-ins and monitoring is required.
- Dependency: There continues to be engagement with the team monthly. If this was to continue it could create an unexpected dependency, which would exacerbate the capacity highlighted above.

Next Steps
The following steps are proposed:

- Review and refresh the Raising Concerns Policy, considering the National Guardians Office (NGO) guidance (complete see below)
- Develop a toolkit – within which clarity and expectation is detailed, as well as tools and techniques.
- Produce a monitoring product to enable quarterly and annual activity.

5. New Speaking Up policy and managers' guidance
Alder Hey have adopted the National Guardians Office recently updated version of the Raising Concerns Policy (previously referred to as Whistleblowing Policy), this has now been through the ratification process. In addition to this policy we have included a Responding to Concerns managers' guide. This has been reviewed by Dr Jo Potier and consideration is being given as to how we can include this in the Strong Foundations programme.

6. Freedom to Speak Up Champions and Deputy Guardian Role
Following on from the 'brainstorming session' which was to evaluate the FTSU service, sustainability and capacity, it was felt that a Deputy FTSUG position was required, this was also in recognition of the limitations placed on the FTSU Champions as a result of the NGO recommendations (not able to carry casework) coupled with increased activity and also provide additional resilience to the team / reduce key person risk on the FTSUG . Consideration by the Board would be appreciated in reviewing the current time provided to the FTSUG as to whether this time could be increased.

7. Learning and Improvement
The Speak Up Listen Up, Follow Up training available to staff, still remains low in terms of uptake, the guidance from the NGO is:

The NGO's guidance on Freedom to Speak Up training states that such training should be treated on a par with mandatory training. It also states that training should be repeated as often as appropriate to ensure that senior leaders have assurance that all workers have the knowledge they need to speak up and respond well. Nearly four in five of respondents (79.5%) said that that speaking up training is available, and over a third (37.2%) said that it is mandatory.

As the uptake remains low, would consideration be given to mandating the Speak Up module as assurance that staff know how to speak up and to who?

Alder Hey Children's NHS Foundation Trust

Kerry Turner
Freedom to Speak Up Guardian
October 2022

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Freedom to Speak Up Review Tool for NHS Trusts and Foundation Trusts – half year update**
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:	National Guardian's Office Strategic Framework 2021
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:	

Freedom to Speak Up review tool for NHS trusts and foundation trusts

September 2021

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**In 6 months** **Partial**	**In 6 months** **Partial/ Ongoing**	1. Appraisals and 360 feedback: Executive PDR documentation has included an assessment against Trust Values for the last five years. The Trust Chair's appraisal is based on an MSF approach. Staff survey includes questions inviting views on senior leaders. 2. Concerns raised: The board receives a thematic report on a quarterly basis from the FTSU Guardian 3. Senior visibility: Senior visibility is a priority across corporate communications. This continued virtually and innovatively throughout COVID, using methods such as Alder Hey all Staff Broadcast. Executive visibility has now been reinstated as part of Brilliant Basics. 4. Corporate Induction: CEO or nominated Executive Director, presents at Corporate Induction, highlighting the importance of the Trust's values, behaviours, and speaking up 5. Values and behaviours:	Triangulation of data with SALS now commenced; considering how Wellbeing Guardian and IR data should best be used to inform the process and assurance via PAWC. Exec team meeting to be used to capture themes from visibility programme as part of BB/leader standard work.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Executives and Non-Executives support the use of the Behavioural Framework, to underpin the Trust's values and the use of them in staff PDR's. The Trust Chair periodically challenges all Board members to reflect on a particular Value at the end of a board meeting. 6. People Plan: the Trust's People Plan includes an objective that 'We will develop a working environment that encourages all staff to 'speak up' and 'listen up' and continue to support the work of our Freedom to Speak Up Guardian and Champions 7. NHS Staff Survey: The annual NHS Staff Survey results of questions related to FTSU are picked up in the Board report and factored into FTSUG's team plans.	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up	p6 Section 1 Section 2 Section 3	Full	Full	1. Executive and Non-Executive Leads: appointments have been made to both positions.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				2. Regular 1:1 meetings: these take place between the Guardian, Executive and Non-Executive Director 3. Reports to Board**:** Quarterly reports are submitted to the Board to ensure clear sighting and accountability, as well as contributing to the Board's own development. The suite of reports includes monitoring of IR cases, each of which has an Executive lead assigned in accordance with Baroness Harding's guidance. 4.Staff Stories**:** Staff stories have been introduced to Board meetings, inviting a member of staff to share an experience of working for Alder Hey - both positive and negative stories are welcomed and learning is taken by board members. 5. Leadership development**:** Leaders are supported and encouraged to continually develop. The Trust's Strong Foundations programme has evaluated very positively among staff at all levels and is the cornerstone of the Trust's leadership development strategy. In addition, the Patient Safety strategy now includes a leadership element.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				6.Bullying and Harassment**:** The NHS Staff Survey results are used to monitor and measure progress. 7. FTSU is widely promoted across the Trust via various methods, with regular sessions on the Trust's Induction programmes. The Trust has an annual Speak Up Safely week each October.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	Partial	Partial	The Trust's People Strategy currently incorporates the speaking up strand. It has previously been agreed that keeping messages simple and minimising the number of overlapping strategies is more accessible for staff.	Board to revisit the need for a separate FTSU strategy.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role • there are regular meetings between the Guardian and key executives as well as the non executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes	p7 Section 1 Section 2 Section 5	Full	Full	1. The Executive team supported the increasing of the FTSU Guardian's dedicated hours. 2. The Guardian attends Regional and National training events and conferences. 3. The Board supported FTSU Leads to receive refresher training, and to train champions, with continuous plans to train more. 4. Regular Coaching and Psychological Support sessions are provided to the Guardian. 5. meetings take place between the Guardian, Exec Director and NED. 6. Open access is provided to relevant Directors when dealing with individual concerns. 7. The Guardian has regular access to Regional and National training events. 8. The Guardian has open access to anonymised patient safety and employee relations data for triangulation purposes.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• the Guardian is enabled to develop external relationships and attend National Guardian related events				9. The Guardian has recently stood down as the Chair of the NW Regional Guardian Network. 10. The Guardian is able to raise issues directly with the relevant HR Business Partner, the Medical Director, Chief Nurse, the HR Director/FTSU Executive Lead and any other relevant Executives. 11. A Deputy Guardian role is currently in development to increase the Guardian's capacity for case work; this will include protected time.	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	Full	Full	1. The Trust has adopted the new national Speaking Up policy six months ahead of the April 2023 timeframe. A supporting Guide for Managers was also approved at the PAW Committee and both will be launched across the organisation as new resources. 2. All policies are reviewed by Staff Side. The FTSUG is also an RCN union rep and therefore attends the Policy Review Group	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inpsection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.	P8 Section 6	Partial	Partial	The NED lead for FTSU commissioned work on triangulation of information, specifically a direct link with the work of the Wellbeing Guardian which has not yet completed. The Trust commissioned modules in Ulysses to enable staff to input concerns in once place.	Wellbeing Guardian report to be incorporated into data triangulation process. In addition, FTSUG working with Patient Safety team to consider a wider data set that links to patient safety strategy workstreams.
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	Full	Full	Comprehensive reports are presented at Board, with attendance from the Guardian on a quarterly basis, which can be evidenced by meeting minutes and papers.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	Partial	Partial	Initial appointments predated guidance/JDs from National Guardians Office, however followed the Trust's fair recruitment process. Future appointments will follow the established process using the published FTSU guidance and example job description.	Recruitment will be reviewed if any change to the guardian arrangements were to occur.
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	Full	Full	Review of data reports and themes are completed quarterly.	Case Reviews, published by NGO, to be included in 1:1s with Executives and NED. Lead: JC
Be open and transparent					
The Trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff	P9	Full	Full	1. Regular reports are submitted to Board, and information shared with CQC and the CCG. 2. Discussions take place with relevant oversight organisation - the National Guardians Office and CQC upon their visits, with attendance at national meetings by Guardian. 3. Discussion within relevant peer networks take place as described above. 4. FTSU content is present within the Trust's annual report.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				5. FTSU discussion takes place at the Public Board. 6. The FTSU Guardian is a member of the EDI taskforce which was established by the Board in 2020.	
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	Partial	Partial	NED lead has a specific objective in relation to FTSU, other roles have this evaluated via Values assessment currently.	Ensure each of the key individuals has a specific focus on speaking up within their PDR.

October 2022

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Board Assurance Framework 2022/23 (September)**
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.

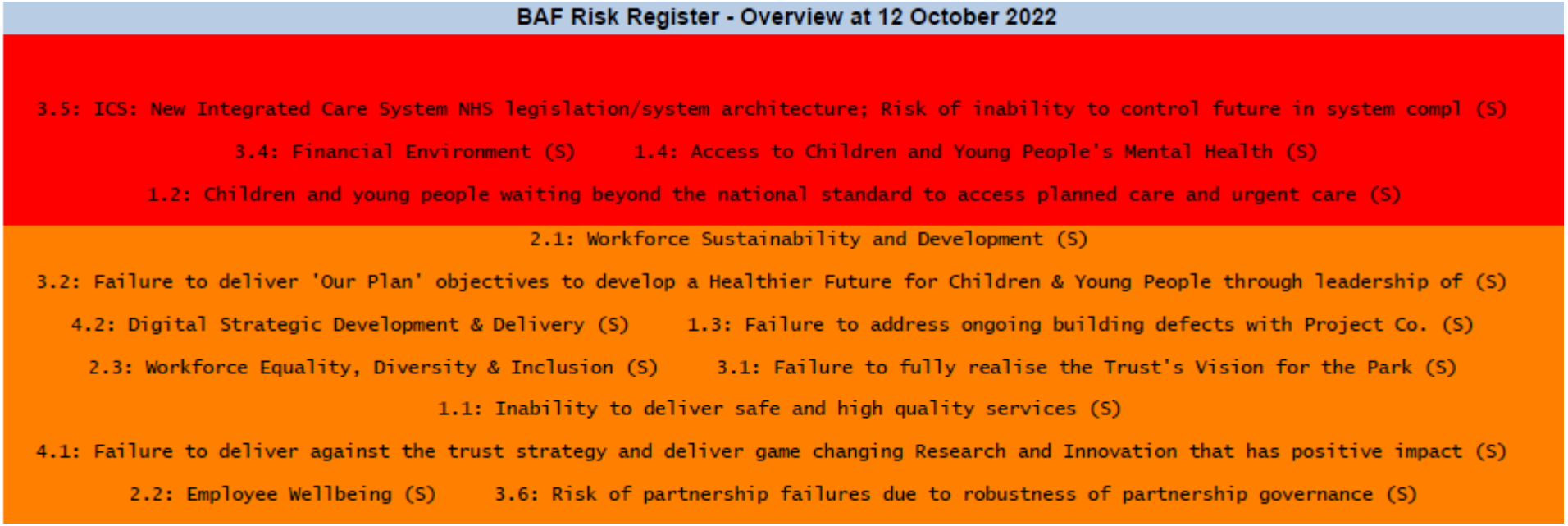
2. Review of the BAF

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	Failure to address building deficits with Project Co.	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 12 October 2022

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



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

Report generated by Ulysses

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

4. Summary of BAF – at 12th October 2022

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	**Failure to address building deficits with Project Co.**	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	3x4	3x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing.**	PAWC	3x3	3x2	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion.**	PAWC	4x3	4x1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park.**	RABD	3x3	3x2	STATIC	STATIC
3.2 DJ	**Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.**	RABD	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment.**	RABD	**4x4**	4x3	STATIC	STATIC
3.5 DJ	**ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment.**	Board	**4x4**	3 x3	STATIC	STATIC
3.6 DJ	**Risk of partnership failures due to robustness of partnership governance.**	RABD	3x3	3x2	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research and Innovation						
4.1 CL	**Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.**	Innovation	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development & Delivery.**	RABD	4x3	4x1	STATIC	STATIC

5. Summary of September 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; controls, actions and evidence reviewed. No change to score in month.

- ***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. Development of CMAST governance and trust board approval noted.

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

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Actions updated. Risks reviewed.

- ***Failure to address building deficits with Project Co. (AB)***
  The weekly meetings between senior management reps from Estates & Project Co reps are ongoing with a view to closing out the remaining defects although the majority have now been resolved. All new defects or issues should be logged on the helpdesk so stakeholders are aware of the issues and progress to date. The two remaining historic defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. These issues where discussed at the liaison committee held in August and the directors from John Laing and Laing O'Rourke are committed to resolving and will be pushed on this for regular updates. Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur. Senior managers from the Trust are still in discussions with Project Co reps regarding current issues and associated commercial aspects although these are mainly newly identified issues rather than historic defects. Chillers are due for completion in January 2023 and the temporary ones will be removed in November once RAMS have been approved.

Internal risks:

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

- ***Inability to deliver safe and high-quality services (NA).***
  this risk has been reviewed and appropriate assurance continues in place. Gaps in assurance are progressing and actions are on track.

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

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

- ***Digital Strategic Development and Delivery (KW).***
  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.
- ***Workforce Sustainability and Development (MS).***
  Risk reviewed - no in month change to risk score. Actions are on track. The focus of availability remains sickness and turnover.

- ***Employee Wellbeing (MS).***
  Risk reviewed following deep dive at People & Wellbeing Committee on 28.9.22. Actions updated as per discussions and progress. 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).***
  No change Oct - full risk deep dive due to being presented to the Risk Management Forum in November which will be updated in BAF risk including refreshed controls and separation of clinical/quality research trials risk from strategic and commercial issues.

- ***Access to Children and Young People's Mental Health (LC)***
  Review of all actions taken place and updates included.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000178

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

Risk	Risk Title	Linked
2229	Risk of being unable to fully coordinate care of major trauma patients which could lead to delays in providing care and treatment, standard care and prolonged stay/inappropriate discharge caused by lack of capacity.	2.1
2233	Failure to meet QST Major Trauma peer review standards, caused by nursing staff not being trained in line with major trauma clinical skills and competencies	1.2
2441	Patients could deteriorate whilst transport services and hospitals agree who is going to undertake retrieval	
2463	Children and Young People will not receive their ASD or ADHD assessment within the agreed timescale (30 weeks as per NICE standard), caused by significant increase in referrals to ASD and ADHD pathways during 2020. Note: Capacity within current pathways is funded to set level by CCGs	1.2
2501	Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments.	1.2 &2.1
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	2.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.2 & 2.1 & 1.4
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	4.2
2332	Challenges to finding a solution to providing a "single service" model for paediatric cardiology may result in delays to patient treatment. This may result in potential harm due to inequitable service provision across the paediatric congenital heart disease operational delivery Network in the North West	
2312	Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.2 & 2.1
2536	The network does not have the financial resources to backfill senior leadership posts to the level needed	2.1
2589	Inability to safely staff Catkin and Community Clinics	2.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.2 & 2.1
2020	Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management.	2.1
2642	Inability to deliver 1-1 care where required on Ward 4B	2.1
2627	Not compliant with national guidance with transferring and transcribing patient records following adoption	
2548	Unable to provide the clinical records in the required time scales – breach of GDPR / Court and police timescales	4.2

000179

BAF Risk

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

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

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

000180

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

000181

BAF Risk

2.1 Workforce Sustainability & Capability

(3x4=12)

Strategic Aim

The best people doing their best work

Related Corporate Risk(s)

Risk	Risk Title	Linked
2100	Risk of inability to provide safe staffing levels.	1.1
2312	Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial, caused by lack of medical cover for Neurosurgical and Craniofacial patients	1.1
2501	Inability to safely staff the waiting list initiative clinics in OPD, caused by COVID 19 pandemic there is now a need to increase OPD clinic capacity to ensure patients are clinically assessed in a timely way and reduce waiting times for appointments.	1.1
2517	"Risk of Children and young people coming to harm whilst waiting for urgent treatment episodes", caused by insufficient resource to meet the urgent demand for treatment (partnership appointments) at Sefton CAMHS.	1.1 & 1.2
2516	Risk of patients not being managed appropriately, caused by lack of ward clerk presence on the wards leading to process failures due to expected daily tasks not being picked up and actioned appropriately, including appointments not being pended or booked correctly and other expected administrative daily ward clerk duties not being actioned appropriately.	1.1
2383	Psychology provision not meeting minimal NHSE Standards. Currently only able to focus on more severe presentations or crisis management for patients. Therefore risk of negative impact on mental health of patients by not being able to provide timely care to avoid exacerbation or progression of presentation	1.1 & 1.2
2536	The network does not have the financial resources to backfill senior leadership posts to the level needed	1.1
2589	Inability to safely staff Catkin and Community Clinics	1.1
2597	There will be inadequate staffing levels of experienced surgically trained neonatal nurses to deliver a safe service on 1C Neonatal. Risk to specifically Neonatal trained staff working outside their scope of experience and training if moved to another speciality. If 4th member of staff is rotating from LWH added pressure on remaining staff on 1C Neonatal	1.1 & 1.2
2020	Cancellation or delay in admissions to Ward 4B due to reduced availability and resources to deliver staff training in invasive and non-invasive ventilation and sleep study management.	1.2
2642	Inability to deliver 1-1 care where required on Ward 4B	1.1

000182

BAF Risk

2.2 Employee Wellbeing

(3x3=9)

Strategic Aim

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

2.3 Workforce Equality, Diversity & Inclusion

(4x3=12)

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000183

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

Strategic Aim: Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk 3.4 Financial Environment (4x4=16)

Related Corporate Risk(s)

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

000184

BAF Risk

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

Strategic Aim

Sustainability through **external partnerships**

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

BAF Risk

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

Related Corporate Risk(s)

Risk	Risk Title	Linked
	NONE	

000185

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
	NONE	

BAF Risk

4.2 Digital Strategic Development and Delivery

(4x3=12)

Related Corporate Risk(s)

Risk	Risk Title	Linked
2548	Unable to provide the clinical records in the required time scales – breach of GDPR / Court and police timescales	1.1
2327	Losing Cardiac data which can impact on the full AH Cardiac service and national submission, caused by database corruption resulting in the database crashing on a regular occurrence	1.1

000186

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2229, 2233, 2441, 2463, 2501, 2516, 2517, 2327, 2332, 2312, 2383, 2536, 2589, 2597, 2627, 2548, 2100, 2642, 2020		
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.
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
Under 'Building Brilliant Basics' programme, the Trust has developed three quality priorities and associated improvement programmes to demonstrate increased quality and safety outcomes	Improvement hub to generate monthly reports to 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.
CQC regulation compliance	Progress against the CQC Action Plan monitoring via Board and sub-committees
monthly review meetings with each division are held with the Medical Director and Chief Nurse to provide assurance relating to the progress of RCA investigations and completion of subsequent action plans.	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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. The Trust will deliver the Parity of esteem work program addressing this issue	31/03/2023	The work continues under the leadership of the ACN for community division. The action owner will be updated to reflect this.
3. SQAC will receive on going monthly updates on this program of work and improvements will be monitored through this process.	31/03/2023	Medication safety is now reporting into Patient Safety Board on a monthly basis. Please see patient safety board progress summary reports for detail. For the year 2021/2022 the reduction in the driver metric of harms reaching the patient was achieved.
1. Continue to monitor KPI's at SQAC and within divisional governance structures.	31/03/2023	Sepsis nurse now in post and is working with trust sepsis lead to develop a targeted improvement plan for this area

Executive Leads Assessment

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

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

Executive Leads Assessment

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

October 2022 - Andrew Mccoll
At end of Sept the number of patients waiting >52weeks has increased to 435. 295 (68%) are in Paediatric Dentistry. There is increased focus on reducing waiting times below 52 weeks for majority of specialties by December. Action plan for Dental includes Insourcing model to commence in November (subject to contract sign off); Spinal Surgery working to sustain <78 week waits.

For urgent care, the "ED at its Best Programme" continues to oversee actions including: Increased low acuity streaming to scheduled GP appointments; Improved staffing resilience; review and relaunch key ED Dept functions (eg Boards Rounds, Huddles, role cards); Utilise Digital solutions to support flow.

September 2022 - No Reviewer Entered
The number of patients waiting over 52 ww has increased further to 379 patients waiting over 52 ww. 276 (73%) of the patients with a long waiting time are in paediatric dentistry. The increase has been driven by a rise in patients waiting for paediatric dentistry and gastroenterology services. Actions are being taken to increase capacity and reduce waiting times in both departments. For dentistry long waiting times are currently projected to reduce to peak in September 2022 and then reduce to 210 by March 2023. Give the difficult in redressing this we are exploring independent sector options.

We have 5 patients waiting over 78 weeks for treatment, we expect this to be zero by Nov 2022. This is well in advance of the national target to reduce waiting times to less than 78 weeks by March 2023.

Emergency Department waiting times improved to 90% in August 2022, associated with a reduction in attendances.

August 2022 - Adam Bateman
At the end of July 2022, there were 343 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment, of which 244 are in paediatric dentistry. This is an increase of 15 patients on the June position, with a rise of 23 patients in dental, and a reduction of 8 long waits in other services. Paediatric dentistry remains the specialty with the greatest waiting list challenge. Additional capacity has been secured in outpatient and theatres which will be phased in from September and October. However, the increase in referrals and volume of long waits means there is a gap in capacity and long waits for inpatient treatment are forecast to increase. We are therefore exploring further solutions including a review of our referrals and independent sector capacity. Our overall recovery performance was strong in July at 114% (as measured by activity) and 107% as measured by value of activity. 102% for new outpatients (a drop on May and below 104%) and 112% for outpatient follow-up (a reduction relative to May). In relation to urgent and emergency care, emergency department standards, Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 76% of patients within 4 hours, a slight drop in performance driven by higher absence levels affecting ED staffing levels and the GP service within ED.

July 2022 - Adam Bateman
At the end of June 2022, there were 331 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment. This is an increase 43 patients. Paediatric dentistry remains the specialty with the greatest waiting list challenge. The Division of Surgery is leading on supporting the department with a weekly meeting to assist with increasing capacity, including securing additional fixed theatre and clinic sessions with the team, and working on supporting a retired colleague to return and increase capacity. We expect this additional capacity to be in place from September 2022. We have modelled backlog clearance and in the good case scenario we project clearance by the end of December 2022. On recovery, provisional data for June indicates strong recovery in elective services at 115% (above the national target), 102% for new outpatients (a drop on May and below 104%) and 112% for outpatient follow-up (a reduction relative to May). In relation to urgent and emergency care, emergency department standards, Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 78% of patients within 4 hours, a third consecutive month of improvement. Through the ED at its best programme we have started a video communication briefing to staff; a move to appointments, rather than waiting, for patients who can be seen by a GP. We are working to open a new proof-of-concept urgent care facility in Q3.

June 2022 - Adam Bateman
For the w/e 29 May 200, there were 288 C&YP on an RTT pathway with a waiting time greater than 52 weeks for treatment. As sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry, a dedicated support plan is now in situ. Recovering services, to in turn reduce waiting times, is one of the 5 operational priorities for 22-23. Provisional data for May indicates recovery of 106% for new outpatients, 120% for outpatient follow-up and 110% for elective activity. Aside from the need to safely reduce follow-up activity, this is really strong performance. In relation to urgent and emergency care, emergency department standards, Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 73.7% of patients within 4 hours, a marginal improvement relative to April. The team are testing changes to managing flow and clinical pathways in the department, including scheduled appointments, for the following day, with our primary care service for low acuity patients. Ahead of winter we are designing two radical changes to the model for specialty assessment and the treatment of minor illness and injury patients.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Failure to address ongoing building defects with Project Co.		
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

Failure to address the ongoing building defects with Project Co resulting in impact to the operational services and running of the hospital and potential contractual dispute.

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

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

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

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

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

August 2022 - Adam Bateman
In the whole the majority of original defects have been resolved and meetings are held weekly with Project Co reps to address ongoing issues as well as identifying new ones. All defects should be logged on the helpdesk so all stakeholders are aware of the issues and progress to date The two main remaining defects (corroded pipework and skylight leaks) are on the risk register and updated monthly with project plans and actions. The issues will also be discussed at the next Liaison Committee to be held on the 16th August. The green roofs have just undergone a full replacement and all associated leaks have been resolved. Monitoring of the roofs is underway to ensure they are in line with the PCP's (project co proposals). In relation to the remaining large scale defects and associated contractual deductions a number of meetings have taken place with senior Trust management and Project Co reps and will continue over the coming weeks or until a suitable agreement is reached in relation to resolving and potential compensation.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Full validation of community mental health waiting list to remove data quality errors and identify any areas of risk. This will support future capacity and demand planning.	30/11/2022	Progress update: validation complete on 2 years and 12 months. Validation currently taking place on over due 6 months follow ups.
Actions for 4 Week Wait National Pilot Programme to continue which includes: -Audits to be completed, including welcome call, DNA audit and referral rejection audit -Scoping for automatic booking of locality mental health appointments to take place -Improvement plan with wider mental health (CAMHS) partnerships to be set following completion of process mapping	30/11/2022	National guidance issued and now changes required to reporting processes nationally and locally - date amended to reflect this
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	31/10/2022	Action date amended due to delays with Meditech
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	Workforce plan A3 completed and shared with Senior Leadership team

Executive Leads Assessment

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

August 2022 - Lisa Cooper

All actions reviewed and updated
July 2022 - Lisa Cooper All actions reviewed and updated

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2312, 2383, 2100, 2501, 2597, 2589, 2516, 2528, 2517, 2535, 2624, 2020		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x4	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. COVID related sickness impacting upon service delivery
7. Increasing turnover rates

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Process in place to monitor sickness absence levels and provide support to staff and managers to manage absence. this includes RTW compliance, training, SALS, OH	30/11/2022	actions continue to be rolled out and monitored. sickness absence managed at local level with HR Advisers.
To identify and target hotspot areas with high turnover rates	31/10/2022	Detailed turnover reports presented to PAWC
3. Development of a methodology to roll-out across the organisation.	01/12/2022	Establishment control project on target
5. Recruitment and Apprenticeship Strategy currently being developed in line with the actions set out in the NHS people plan	01/03/2023	Attraction and Retention Project identified as key project for 22/23

Board Assurance Framework 2022-23

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

1. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of the pandemic and its impacts (PTSD, anxiety and depression rates nationally show significant rise amongst health care staff and suicide rates also rising among healthcare staff; cost of living crisis further increasing pressure for staff and poverty a known determinant of mental ill health).
2. Increase in significant mental health difficulties in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and difficulties in accessing secondary mental health provision in the community in a timely way
3. Rising demand for SALS support and permanent resource no 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 & current rest spaces insufficient to enable staff to rest properly due to IPC restrictions

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	07/11/2022	Progress to be updated at next HWB Steering Group on 1.11.22
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.	07/11/2022	Updated action target date
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	31/10/2022	Training developing well. Target date for completion end October
After Action Review to be coordinated to inform learning from incident. Director of Nursing to ask for member of Governance team to lead the review. Risk management plan in place to ensure member of staff is safe and receiving appropriate interventions.	23/10/2022	No further progress. Will escalate to Chief People Officer again
A clear and consistent, evidence based debriefing pathway to be established enabling staff timely access to support followin traumatic clinical incidents	01/11/2022	MSC research project complete identifying core issues around debriefing for staff at Alder Hey. Core principles agreed by Clinical Psychologists. Task & finish group to be established established comprising reps from SALS and Clinical Health Psychology, Divisional Governance, Trauma coordinator, to agree, operationalise and communicate pathway to the organisation.
Issue escalated from theatres staff via HWB Steering group to exec team. Discussed at CAG and agreed that plan will be developed to remove restrictions with potential priority for theatres and critical care	07/11/2022	Issue raised as part of Employee Wellbeing risk deep dive review and as per report of the HWB Steering Group. Chief Operating Officer present and said this to be actioned as matter of priority with agreement from committee
Increased space to be developed for staff support and staff wellbeing. This includes SALS specific space and also space to be more widely available to staff. Consider also specific HWB budget which departments can use to enhance current wellbeing spaces	01/12/2022	SALS in discussion with development team to consider options for bespoke SALS booth which could be placed on the mezzanine and accessed only for staff support. Proposal for additional staff container based space agreed at execs over summer and to be built over the next 3 months. Plan for utilisation of this space yet to be developed and to involve HWB Steering group

Executive Leads Assessment

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

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

July 2022 - Jo Potier
Risk reviewed and controls amended and updated. Actions reviewed and updated. Unable to close overdue action so escalated to Chief People Officer.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 4x3	Target IxL: 4x1	Trend: STATIC

Assurance Committee: People & Wellbeing Committee

Risk Description

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

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

Gaps in Controls / Assurance

Staff Networks still in development stage, requires further support, resource and input.
Head of EDI vacancy.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Staff Network Chairs to be advertised during August / September	31/10/2022	same as above

Executive Leads Assessment

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

October 2022 - Melissa Swindell
actions updated. risks reviewed

September 2022 - Melissa Swindell
No change to risk score in month. All actions remain on track

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Set up Joint Planning meeting with community	31/12/2022	Awaiting LCC public meeting before organising
Establish an Eaton Road Frontage Review to Prepare Delivery Plan	30/11/2022	Review scope agreed.
Establish temporary office accommodation to house staff within Catkin to allow the building to be demolished.	31/10/2022	Modulars delivered, commissioning nearing completion

Executive Leads Assessment

October 2022 - David Powell
Prior to October Board

September 2022 - David Powell
Prior to September Board

August 2022 - David Powell
Following Campus Review

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

	27.1.22 - Presentation of Beyond programme to HCP Programme Board. ICS CEO in attendance. Programme progress accepted. 8.6.22 - C&M CYP Programme Board minutes (May) and documentation for June meeting attached for assurance of effective progress Sept 22 - Beyond Assurance Group established and reporting to Beyond Board - minutes and agendas attached
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.

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.	31/12/2022	Exec, Trust Board & Governor sessions on 2030 Vision / pop health strategy have all begun (April-May)
6.Develop Operational and Business Model to support International and Private Patients	30/12/2022	International / commercial being built into new 2030 Vision strategy refresh - timeline aligned to Dec 22
1. Developing a stronger understanding of paediatric workforce requirements through the Trust's 2030 Vision refresh work with Strasys - to enable trust and system workforce planning led through HRD	30/12/2022	Workforce analysis core part of Vision 2030 development. Initial analysis undertaken and timeline aligned to Dec 22 (Board agreement to Blueprint scheduled for Oct 22, further shaping with staff, partners and CYP & Families Oct-Dec)

Executive Leads Assessment

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

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

August 2022 - Dani Jones
Risk reviewed; no change to score in month. Evidence and actions reviewed.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

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

Executive Leads Assessment

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.

August 2022 - Ken Jones
Risk reviewed and score maintained at 16 based on the latest financial plan for 22/23, mitigations currently in place and recognition of YTD financial performance for Q1, and CIP delivery to date. Actions have been updated to reflect latest progress.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Trust Board

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Monitoring progress in system developments, continuing to influence along with partners and shaping optimal outcome for C&YP services	15/12/2022	Joint letter to SpecCom re delegation of specialist services to ICSs - Alder Hey & RMCH - sent 29th July 22
2. Children's Hospital Alliance & C&M CMAST Provider Collaborative proposals/assessments under development Financial assessment alongside - including impact of	31/03/2023	As above entry 7.9.22

proposed population need based allocation formula (not yet shared)		

Executive Leads Assessment
October 2022 - Dani Jones Risk reviewed; no change to score in month. Development of CMAST governance and trust board approval noted.
September 2022 - Dani Jones Risk reviewed; no change to score in month. Actions and controls reviewed and evidence updated.
August 2022 - Dani Jones Risk reviewed; no change to score in month. Evidence added, actions and controls reviewed.

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	
Escalation process for risks and issues pertaining to ODNs and Joint Services	
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement)
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)
Governance of Framework to be overseen at Risk Management Forum, and to involve NED's from both parties in any given Partnership	RMF agendas and minutes Presented to RMF inc. Divisional representatives June 22
Quarterly Board Paper reviewing progress and any key risks/issues for escalation from formalized partnerships	Quarterly Board paper - Sept 22 Quarterly Board paper - June 22
Twice-annual ODN oversight report to RABD	May 22 Report attached
MIAA Audit - Partnership Governance	Audit initiation meeting scheduled for 5th October 22

Gaps in Controls / Assurance

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Agreement to pilot Pship Assurance Round approach with LWH and Liverpool Neonatal Partnership. Pack development to be undertaken during March - initial plan with LWH for presentation to LNP Board in April - this has been moved to June (recognising current pressures in team). Learning to be shared and co-design to pack to be incorporated	04/11/2022	LNP PQAR meeting with Non-Exec reps from both Trusts scheduled for October 22
MIAA Audit scheduled for Q2 2022	30/11/2022	Audit initiation meeting scheduled for 5th October 22

Executive Leads Assessment

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

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

August 2022 - Dani Jones
Risk reviewed; no change to score in month. Actions in progress with partners

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: No Risks Linked		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Assurance Committee: Innovation Committee

Risk Description

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

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

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Agree coordinated plan with LCR and other national R&D funders eg UKRI to bring investment into child health innovation	08/11/2023	

Executive Leads Assessment

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

September 2022 - Claire Liddy
no change (SEPT 22)

August 2022 - Claire Liddy
AUG - no significant change

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development & Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 2548, 2327		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x1	Trend: STATIC

Assurance Committee: Resource And Business Development Committee

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Mapping session to be undertaken to ascertain requirements and scope, programme and governance to be established with a multi disciplinary/multi team approach	01/12/2022	Mapping session undertaken. PID in development and programme board to be established
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	01/12/2022	As above
Mobilisation of Y1 of Digital and Data Futures Strategy	31/03/2023	Mobilisation plans in development

Executive Leads Assessment

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

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

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

August 2022 - Kate Warriner
BAF Risk reviewed. Current scores remain in place.
Aldercare programme review has confirmed a re-set of the go live date to 2023, time window to be confirmed. National support requested for additional programme resources.
Mobilisation and programme initiation plans for Digital and Data Futures are in development.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 26th September 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)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Rachel Lea	Deputy Director of Finance	(RL)
	Claire Liddy	Managing Director of Innovation	
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:	Nathan Askew	Chief Nursing Officer	(NA)
	Mark Flannagan	Director of Communications	(MF)
	Cath Kilcoyne	Deputy Director of Business Development	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item: 112	Katie Tootill	Associate Director of Procurement	(KT)
	Jim O'Brien	Capital Project Manager	(JO'B)
	Graeme Dixon	Head of Building services	(GD)

22/23/100 **Apologies:**
John Grinnell Deputy CEO/CFO
John Kelly Non-Executive Director

22/23/101 **Minutes from the meeting held on 22nd August 2022**
The minutes were approved as a true and accurate record.

22/23/102 **Matters Arising and Action log**
Corporate Partnership, Sponsorship Policy and Intranet update would be presented at the October RABD, all other actions had been included on the agenda.

22/23/103 **Declarations of Interest**
There were no declarations of interest.

22/23/104 **Finance Report**
Month 5 Financial Position
M5: An in-month trading deficit of £0.2m in August which is in line with plan. Year to date the Trust is reporting a deficit of £1.2m again in line with the deficit plan as we anticipate CIP schemes to mobilise further in future months.

As requested last month a best, most likely and worst case scenario had been included in the forecast section as well as divisional scenarios. As there were a number of queries raised in relation to actuals verses variance within the Finance report CS/RL agreed to make this clearer going forward.
Action: Finance team

Resolved:
RABD received and noted the M5 Finance report.

22/23/104.1 Safe Waiting List Management Update

Following the last update to RABD June 2022 MC noted that breaches against targets had improved. MC went through the recovery plan for the 5 areas not meeting waiting time targets:

MRI The Radiography service is under review, capacity is currently being maintained via waiting list initiative sessions.

DEXA The new DEXA machine is scheduled for delivery on site the 1st week of October; in the meantime, WHH continue to provide mutual aid.

Endoscopy The portable decontamination unit is now fully functional on site and full service in Endoscopy has been restored.

Respiratory Physiology (Sleep) Procurement delays due to complex governance processes means disappointingly, we do not have a delivery date and/or go live date for the Home Sleep service.

Urodynamics Radiography support for an additional urodynamics list has been secured from September 2022; Urology have reviewed schedules and have allocated additional resource.

The trust forecast recovery against DM01 6 weeks diagnostic target to be achieved by March 2023.

Resolved:

RABD acknowledged the updated position and associated risks. Updates going forward will be received through the new integrated corporate performance report.

22/23/105 2022-23 Interim Update

RL shared a number of slides highlighting challenges for both Alder Hey and Cheshire and Merseyside to meet the 22/23 plan. ICB are aware.

Resolved:

RABD noted the challenging position of 2022-23 Plan with further updates to be received.

22/23/106 Proposed Debt Right Off

The proposed debt write off for September was £14,481.77, this included an overpayment of £7k in 2014. The Chair asked for confirmation if there were any further large debt write offs.

Action: Finance team

A proposal was presented for the finance team to approve non NHS debts below £10k. RABD asked that all debt write off's continue to be presented to RABD and agreed a de minimis level of £500.

Resolved:

RABD APPROVED the September debt write off £14,481.77. RABD agreed a de minimis level of £500 for future debt write offs.

22/23/107 Capital and Cash Update

Capital

Decision is awaited on the £5m capital bid currently lodged with NHSI, 2 further bids have been submitted for Alder care (£2m) and ED Daycase facility (also for £2m).

Cash

Best, most likely and worst case scenarios were presented to RABD.

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

22/23/108 CIP and 2023 risks

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

Resolved:
RABD received and noted the CIP update.

22/23/109 Campus & Park update (starred item – only questions/answers will be noted)

Park/Site Clearance

JO'B highlighted:
Neonatal and Urgent Care development: Cost pressures continue a cost plan options paper is to be presented to Trust Board.

Sunflower House/Catkin: Architectural advisor and specialist experts engaged to review and provide solutions to resolve a number of quality concerns.

Temporary Modular Office (Police Station): Programme delay due to lease agreement for former Police station. Moves held and alternative accommodation agreed with users.

Resolved:
RABD received the Campus and Park update.

22/23/110 AlderC@re Programme

KW highlighted from the report:

- A Go live date for the programme is likely to take place in summer 2023, RABD will continue to be updated.
- October 2022 will be a key month for the programme with the launch of Patient Journeys. These will be a series of walkthroughs of the AlderC@re system, following patients through the system, and allowing users to test processes with real life scenarios.
- A deep dive on benefit realisation will be presented to RABD at a future date.
- Meditech have agreed to provide Alder Hey with additional resources.

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

22/23/111 Energy update

Energy costs have been confirmed for £13m until March 2023. Government discounts were to be confirmed. Plans to agree Energy costs from April 2023 are underway. The Chair asked if internal communications had been circulated on ways staff can cut energy costs, MF advised comms on this would be circulated soon.

Resolved:
RABD noted the agreed Energy cost for the reminder of the financial year.

22/23/112 Q2 Procurement

As of 01st October 2022 all Procurement team members across our four HPL sites will have TUPE transferred into the shared service. All new staff will be going through a two-week on-site induction programme to ensure they are fully supported and have been introduced to key contacts across all of our HPL trusts. New staff are also spending time in clinical areas such as Theatres to build up knowledge, skills, and rapport with colleagues.

In the strategic team out of a possible 11 team members the team have been operating at 60%. There has also been a number of long-term sicknesses across operational Procurement team across the alliance which have been covered by other members within the team.

In recent weeks the Facilities team at AH have concluded an organisational change process, as part of this process it was communicated that the Receipt and Distribution service at AH would transfer into HPL to align with other R and D services across the specialist alliance. CL asked R and D would be using new technologies similar to businesses i.e. Amazon. KT advised that this was being developed and would be included in the Procurement Strategy due to be approved in February 2023.

Resolved:
RABD received the Procurement Quarter 2 report noting the merge of staffing across the four HPL sites.

22/23/113 Procure Partnership Framework Renewal

Resolved:
RABD APPROVED the recommendation to renew the framework hosting agreement with PPFL for a further 4-year period to start from January 2024.

22/23/114 Month 5 Corporate Report

ED department in August was strong, with 90% of patients seen within 4 hours and median clinician wait <60 minutes.

The outcome on a winter virtual ward bid is awaited.

Number of patients waiting plus 52weeks, particularly in Dentistry: extra theatre sessions have been secured from October 2022 to reduce patient waiting times by March 2023.

Resolved:
RABD received and noted the M5 Corporate report.

22/23/115 Communications update

MF highlighted the launch of:
Alder Hey Charity Matalan pyjamas campaign for the 9th year.
Charity campaign for the Neonatal unit.
Resolved:
RABD received and noted the communications paper.

22/23/116 PFI Report

General performance from Mitie was standard in August achieving 97%.

The corroded pipework survey continues. The anticipated side filtration system is still under discussion although no start date has been provided.

Resolved:
RABD received and noted the M5 PFI report.

22/23/117 **Green Plan**
Resolved:
A verbal updated was received noting a detailed paper would be presented in October.

22/23/118 **Board Assurance Framework**
A risk is on Energy increases is to be included on the BAF.

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

22/23/119 **Any Other Business**
No other business was reported.

22/23/120 **Review of Meeting**
The Chair noted challenges with increases to energy.

Date and Time of Next Meeting: Monday 24th October 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 27th October 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	19th October 2022 – Summary 21st September 2022 – Approved Minutes
Report of:	Fiona Beveridge, Non Executive Director, (Chair of Safety Quality Assurance Committee)
Paper Prepared by:	Fiona Beveridge

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Safety Quality Assurance Committee meeting held on 19th October 2022 , along with the approved minutes from the 21st September 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

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

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

None

4. Positive highlights of note

5. Issues for other committees

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 21st September 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	Kerry Byrne	Non-Executive Director	(KB)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	John Grinnell	Deputy Chief Executive	(JG)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Beatrice Larru	Director of Information Prevention & Control	(BL)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Director of HR & OD	(MS)

In attendance:

Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
Julie Creevy	Executive Assistant (Minutes)	(JC)
Julie Grice	Mortality Lead	(JG)
John Kelly	Non Executive Director	(JK)
Natalie Palin	Associate Director of Transformation	(NP)
Jill Preece	Governance Manager	(JP)
Paul Sanderson	Interim Chief Pharmacist	(PS)
Amanda Turton	Head of Nursing	(AT)
Will Weston	Medical Services Director	(WW)
Peter White	Chief Nursing Information Officer	(PW)

22/23/90 Apologies:

Alfie Bass	Interim Chief Medical Officer	(Aba)
Adrian Hughes	Deputy Chief Medical Officer	(AH)
Dani Jones	Director of Strategy	(DJ)
Phil O'Connor	Deputy Director of Nursing	(POC)
Benedetta Pettorini	Divisional Director, Surgery Division	(BP)
Jackie Rooney	Director of Quality & Governance	(JR)
Christopher Talbot	Safety Lead – Surgery Division	(CT)
Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)
Kate Warriner	Chief Digital & Information Officer	(KW)
Dame Jo Williams	Trust Chair	(DJW)

FB welcomed all members and attendees to the Safety and Quality Assurance Committee (SQAC). FB introduced John Kelly, recently appointed Non Executive Director to committee members, John was observing SQAC meeting.

22/23/91 Declarations of Interest

SQAC noted that there were no items to declare.

22/23/92 000216 **Minutes of the previous meeting held on 20th July – Resolved:**
Committee members were content to **APPROVE** the notes of the meeting held on 20th July 2022.

22/23/93 Matters Arising and Action Log
Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/94 Patient Safety Strategy Board update
FB referred to the National Patient Safety Incident Response Framework (PSIRF) link to the short video and urged colleagues to review the video if they had not already done so.

WW presented an overview of Patient Safety Strategy Board update:
Mr Christopher Talbot had been appointed as the new Patient Safety Specialist.
A programme co-ordinator had been recently appointed, with a project Manager at the Trust also providing some support to the programme.

Main area of focus is identifying meaningful data and metrics, with many of the work streams in the programme which are new, and work continues with BI to support this development.

World Patient Safety Day was held on 17th September 2022, which focussed on medication safety.

PSIRF had recently been published, which would result in a significant culture shift, regarding how the Trust responds to incidents in a more inclusive and effective manner. This shift would involve a widespread training programme, and would be worth investment in time and resources to improve safety and learning across the organisation.

FB referred to difficulty with regards to the start of the new work strands, of identifying what BI data and queried what measures would be used. FB also sought clarity regarding whether there is a standard set of principles or questions. WW stated that a number of the workstreams are quite bespoke, however there is national guidance to identify what the organisation should be undertaking. WW stated that there is significant existing data, and that it would be a data driven approach to then look further into the specific detail.

KB referred to the medication safety slide. She noted three years of rapid increases in medication incidents and noted that errors are now on the downward trajectory, and queried whether colleagues understood what the difference was between the present, and in 2017/2018.

WW stated that he was unable to comment on the detail with regards to 2017/2018. WW stated that despite the figures fluctuating from month to month and year to year, the figures are still incredibly low. WW advised that the aim is to undertake benchmarking with other Trusts around the country. Given that the numbers are low and relate to patients who had been harmed the team would like to concentrate on medication incidents whereby patients haven't been armed.

NA provided detail that there had been a positive change in reporting culture since 2017/18. NA stated that the impact of harm is decreasing as the Trust had started to intervene early.

000217 NA referred to the change in profile relating to incidents, and advised that when SQAC receive the Patient Safety Strategy update report at October 2022 SQAC meeting, the report would detail how that shaped and changed over the last five years.

KB referred to the decrease in colleagues who feel that they are able to make a change or recommendation, and queried whether this was being reviewed/addressed NA advised that this is a focus within the programme.

NP commented that this data point had shown a decrease across the board from an NHS provider Trust perspective. NP stated that Alder Hey Children's NHS Foundation Trust are actually comparatively better than other Trusts with regards to this measure. NP stated that she would hope that the efforts that have been put in place over the last 12 months would see improvement in the performance data. NP provided assurance that the Brilliant Basics continue to review and measure this as appropriate.

JG referred to measuring the benefits, and requested that MS and team give some thought about how the committee would receive regular feedback from teams, to ensure that the organisation is not solely relying on annual survey feedback.

JG advised that given the work of the teams involved, and the work of the Brilliant Basics Teams that it felt assuring with appropriate levels of robustness evident within Patient Safety Strategy Board. JG sought assurance that this complicated programme and the interface with other programmes in the organisation was being considered.

NA referred to wider requirements for the organisation in terms of cultural change. A communications plan is in development. NA referred to cultural change which is required across the organisation, of which patient safety is part of this programme, and referred to evolvement of the programme as it develops and matures over the next 12 month period.

JG supported NA comments and queried whether as an Executive Team there is a need to challenge colleagues to think about the upcoming period with regards to how this is aligned and is coherent for all. FB stated that the communication plan and cultural aspects are extremely important and need to be included within the induction process, right the way through to exit interviews, whilst also being included on a day to day basis.

FB thanked WW for update, and for the continued work he, and contributors continue to provide.

FB thanked JG for update and welcomed any further updates as the programme progresses. FB stated that SQAC are assured by the reports provided, and the level of scrutiny Patient Safety is receiving, through Patient Safety Strategy Board and also through the Brilliant basis methodology which is very coherent.

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

Safe

22/23/95 DMO update

000218

NP advised on programmes making success, with good programme management standards, and good levels of stakeholder engagement, with Brilliant basics team ensuring key principles on reviewing data, measuring milestones and ensuring an effective programme assurance at programme and project level.

Current rating overall, for both the Brilliant basics programme and the Safety programme are Green, both of the programmes require updates to their EIA's and QIA's.

The EIA and QIA on the Patient Safety Programme is also at high level and as the work streams are beginning to be implemented that there is a requirement for QIA for each of the workstreams. NP advised on assurance that the milestone are being effectively managed, and from a Brilliant basics perspective, and a patient safety perspective.

JG referred to assurance through sub committees and advised that this would develop and evolve over time and stated that it is important to view as an internal perspective on projects progressing, and any points requiring escalation.

FB stated it would be helpful for SQAC to receive a flowchart detailing the different inputs, FB stated that an offline discussion would be held in terms of the form, frequency and regularity, together with the required detail, in order to develop an appropriate plan.

Resolved: Offline discussion to be held to review, with aim of developing plan.

SQAC received and **NOTED** the DMO update.

Delivery of Outstanding Care

22/23/96 **DIPC Exception Report**

SQAC received and **NOTED** the DIPC exception report.
Resolved: SQAC received and **NOTED** the DIPC exception report.

22/23/97 Assurance ED Assurance Monthly Update

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

22/23/98 Safeguarding Assurance Group Terms of Reference

SQAC received and **NOTED** the Safeguarding Assurance Group Terms of Reference.
Resolved: SQAC received and **NOTED** the Safeguarding Assurance Group Terms of Reference.

22/23/99 Quality Assurance Rounds Themes and risks

PB presented the Quality Assurance Round Themes and risks update, key issues as follows:-

- Identified challenges resonate as in previous Quality Assurance Round Themes and risks reports, with themes particularly regarding people.
- Successes related to feedback from staff regarding improvement in reporting, and similar positive feedback from Friends and Family test responses.
- PB referred to aggregation through the weekly Patient Safety meeting, and particularly the Excellence reports, with regards to the successes which resonate with staff going the extra mile.
- Quality Assurance Round feedback related to the identification that some staff would

benefit from some additional risk management training, this had since been taken by the corporate governance team who are working with individual team members.

KB stated that she would welcome this report being presented to SQAC on a 6 monthly schedule, with the aim of seeing some longer term themes arising, and that the committee members may draw out one or two risks which are broader than the individual teams, with individual teams raising their own risks on their own risk register.

KB stated that it would be helpful to include whether or not there were any longer term themes, and summarising the actions in order to provide information regarding assurance. PB would feedback comments to JR to ensure that these items are included within future reports.

SQAC agreed to the proposal to move from quarterly reporting to 6 monthly reporting and welcomed the Quality Assurance Rounds Themes and risks report at March 2023 meeting.

Resolved: SQAC received and **NOTED** the Quality Assurance Round Themes and risk report and approved the new 6 monthly reporting schedule.

FB thanked PB for presenting the Quality Assurance Round Themes and Risk report on JR behalf.

22/23/100 Mortality Report

JG presented the Mortality Report, key issues as follows:-

- Potential avoidable deaths
  1 case from May 2021, awaiting RCA and further Information, relates to an extremely complex Cardiac case, all treatment options had been explored with the clinical team, patient heading towards palliation. Unfortunately, there was learning identified on an episode of deterioration. The RCA concluded that the outcome was unlikely to change, but that there was learning from this episode of care.

Cardiac arrest.

- Trends – the four monthly mortality review figures are consistent – coping with increased numbers and complexity.
- Diagnostic/recurrent themes are consistent over 2021-22
- Issues related to escalation of unwell cardiac patients overnight with ongoing work to address

Future - Establishing same learning across all of the Divisions; External peer reviewing/input. hoping for a Designated Dr for child death to be appointed for Merseyside over the coming months; and a functioning ME process.

FB thanked JG for informative Mortality Report which detailed a sense of real momentum regarding routines and processes, to ensure that the organisation is well sighted on Mortality, causes and lessons learned.

AB referred to the cardiac case and queried whether any interim assessment is required with regards to the deterioration patient work to establish any gaps or support for these cohort of patients. AB queried whether any cluster analysis had been undertaken.
JG advised that the Divisional Director for Surgery is aware of the current position. AB queried whether this was included on the Risk Register and advised that he would feel more assured to receive a formal analysis from the Divisional Director of Surgery. AB referred to the statistical presentation of the run charts for deaths and queried whether this should be reviewed as a risk adjustment way of presenting the data, and queried whether A Garbett could support JG and HMRG team to provide BI support.

JG advised that she had commenced making changes to the formal of data within the report. JG stated that she had undertaken a discussion with C Jones, and that C Jones was planning on meeting with the Divisional Director to include on the Risk Register.

CC stated that the Divisional Director for Surgery is aware of the issues ,and that C Halfhide, Chair for group is working with the Interim Chief Medical Officer regarding this, the recommendation from the group was to establish a separate working group to review the workforce review - out of hours.

AB highlighted the importance of obtaining the Divisional Director for Surgery's latest assessment.

Resolved: SQAC received and **NOTED** the Mortality Report, SQAC **NOTED** the offer of BI support with regards to the content of the Mortality Report and **NOTED** the request for the Divisional Director for Surgery latest assessment.

22/23/101 Winter Planning report

AB provided SQAC with a detailed overview on Winter Planning and winter preparedness status. AB advised that the Winter Plan is due to be presented to Executive Team on 22.9.22. AB advised on the key goals for the winter which are to provide safe care, keep staff safe, responding effectively to increased demand and acuity and maintaining elective care programme through outpatient and theatres. The Winter Planning updated provided an update on Winter Schemes, Emergency Department Low Acuity Streaming; Virtual Wards and Community Outreach; Capacity and PAU pilot; staffing & Capacity Resilience and Staff Wellbeing.

AB advised that focus on several key themes within the plan relate to some enhancements within ED streaming, with focus on avoiding hospital admission, Enhanced Discharge Pathways through virtual wards, staffing resilience through wellbeing programmes and vaccination and robust escalation plans.

Summary:-

- Dedicated capacity for low acuity patients 80-100 per day
- Avoid unnecessary admission and expedite discharges through the creation of Community Care ANP led virtual wards
- Increase acute inpatient bed capacity by 4% by opening 10 beds to meet increased demand
- Ensure robust escalation plans to support the provision of care for patients in safe staffing models
- Support staffing capacity and resilience by recruiting to additional staffing posts and protecting staff's wellbeing through wellbeing programmes and vaccination for COVID booster and the flu vaccination.
- Approval awaited regarding a bid for funding to secure additional medical cover for the Emergency Department.

AB referred to the actual ward model of care which colleagues are seeking to test out.

FB queried what particular measures the Trust has in place to address the staffing challenges. MS advised that there are good support measures in place and HR team are reviewing what support could be provided due to the impact on staff regarding the cost of living this year, and whether there are any initiatives available to support staff.

MS referred to sickness levels and stated that sickness is currently under 5%, which is positive news in terms of capacity. MS referred to the importance of the staff vaccination

programme with regards to capacity.

NA referred to beds and capacity. Senior Nursing team meet on a monthly basis to fully review the workforce plan and review vacancies. NA advised that there are 60 new starters during September 2022, 33 international nurses who are due to commence prior to December 2022, and also there had been a successful round of interviews had been recently held, with successful appointments for both PICU, NICU & HDU. NA stated that he envisaged by January 2023 that there would be very few vacancies within nursing workforce, and that the Trust run at 2% or less within the nursing workforce. NA clarified that unavailability to work through sickness or maternity leave led to a bigger impact on staffing.

NA alluded to the workforce model, and that the Trust alters the staffing profile, whether that would be on the red, amber, green status to enable as much capacity to remain open as possible. NA expressed thanks to PICU team for ongoing work in addressing their vacancy levels.

JK referred to fuel poverty and the impact on the ability to discharge patients and queried whether this had been considered within the winter plan. AB stated that the modelling hadn't got a specific adjustment for this, however this is a concern. AB stated he was not aware of a specific model that can assist in predicting the impact of this. AB stated that he suspected that safeguarding protocols would be covered, and within elements of community care. JP stated that this issue would need to be considered at the point of discharge in terms of clinical factors, with involvement with the complex discharge team, or with the safeguarding team, and acknowledged the importance of working with Local Authority partners and third sector partners, should colleagues have concerns regarding a patient discharged to an unsuitable home. JP highlighted the importance of staff have really good information on the wards about where they can refer patients for any additional support, should they have concerns. JP stated that a programme of work could be undertaken to ensure staff are fully aware. FB stated that it would be helpful to receive an update in October 2022 SQAC.

Resolved: AB supported an offline discussion to take place with AB & JP

FB thanked AB for Winter Planning update and commended AB and team for the level of innovation that is taking place with regards to the winter plan. FB welcomed SQAC receiving Winter Plan at October 2022 meeting, and also welcomed an update regarding the escalation scenarios at October 2022 meeting.

Resolved: SQAC received and **NOTED** the Winter Plan update, and welcomed the Winter Plan and escalation scenarios update at October 2022 SQAC meeting.

22/23/102 Divisional update on Pressure Ulcer Action Plan

FB advised that during August 2022 the Pressure Ulcer data had been reviewed, and referred to the ongoing levels of pressure ulcers in various different parts of the Trust, and as a result, FB had requested this to be included for discussion. FB welcomed updates from each of the Divisions.

Surgery Division - CC presented the Surgery Divisional Pressure Ulcer Action Plan update, key issues as follows:-

- In the last two year period the Division of Surgery had reported 86 category 2 pressure ulcers, 23 of which were from within the Orthotics Department. In the last six months there have been 10 pressure ulcers for Orthotics and targeted work had been undertaken with the introduction of prophylactic dressings, which has already resulted in improvement.
- According to the data, device related category 2 pressure ulcers have increased: this is due to staff reporting more incidents under the medical device category which was

000222 not reported previously.

The aim for the Division is to reduce the incidence of patients developing a pressure ulcer whilst an inpatient, to reduce Category 2 pressure ulcers and deep tissue injury (DTI).

- The Division would continue to have a zero-tolerance policy for Category 3 & 4 pressure ulcers and introduce the vision of zero - tolerance for all avoidable pressure ulcers. Furthermore, the aim is to reduce hospital acquired skin damage caused by medical device pressure.

Division of Medicine –

- The Division of Medicine have had no grade 3 or 4 pressure ulcers from 2020 to date, therefore, meet the Alder Hey standard of 0% tolerance of categories 3 and 4 pressure ulcers. Given the diversity and complexity of patients within the inpatient wards, this is an area of achievement which the division are very proud.
- Each level 2 is fully reviewed, with increasing focus to ensure wards have a full understanding regarding the products that they can use, working closely with the tissue viability team, to enhance the level of understanding, and how pressure ulcers can be prevented and further reduced.
- Stock levels on three of the wards had been reviewed, to simplify staff to make the correct choices when supporting patients.
- Rapid assessment report had been mandated to obtain a greater understanding for teams to support going forward.

Division of Community & MH –

- Additional training with Physio, given that the Physio team are most likely to see damage first as most of the skin damage evident was under plaster splints and other medical device.
- Division had introduced Prophylactic dressing for those patients at higher risk of skin damage, with the Community Nursing Team working closely with Physio team to modify the mandatory assessment form which is very inpatient focused to make it more usable, with further development required.
- Introduction of ISLA care app for increased capture and communication
- Community & MH Division last had a Category 3 or 4 Pressure Ulcer in July 2019, in August 2022 the Division had no Category 2 Pressure Ulcers.

FB thanked Divisions for update which demonstrated significant learning across all three divisions. FB welcomed PB's comments in terms of aligning the reports and maintaining focus.

PB welcomed the use of the ISLA care app within Community & MH division and queried whether it had been incorporated into relevant policy. PW advised that at present the app is still undergoing trial status and hadn't yet been incorporated into the relevant policy.

NA also expressed his thanks to each of the Divisions and acknowledged the focus and significant amount of work undertaken by each of the Divisions to address Pressure ulcers, and that due to ongoing work to reduce Grade three and 4 pressure ulcers the organisation had seen a year on year decreasing trend.

NA welcomed approach taken by Community & MH Division given the Divisions different needs, NA welcomed potential roll out of ISLA care app to inpatient areas once this is appropriate.

NA suggested that a focus group is required to work on eradicating those non device related pressure sores, and to develop real focussed support for the tissue viability team in terms of devices.

FB welcomed an update at the December 2022 SQAC meeting, incorporating the detail of the discussions across Divisions, details regarding transfer of good practice and development of policy, together with an update on nursing practices.

Resolved: SQAC received and **NOTED** the Pressure Ulcer Action plan and welcomed a further update at December 2022 meeting.
FB thanked all for contributing.

Clinical Governance Effectiveness

22/23/103 NICE Compliance update

KB expressed her disappointment that there are a number of guidelines within the NICE compliance update with minimal or no progress within the baseline assessment, and stated that equally there are a number of actions with minimal, or no progress/action against the action plan, and that momentum appears to have stalled. KB stated that the information detailing how old a number of the guidelines appeared to be missing from the report, KB highlighted the importance of this information being incorporated into the report. KB stated that it does not appear that the level of resourcing or focus is currently correct.

UD stated that the Division of Medicine now have a Director of Governance within the Division of Medicine, with the sole purpose of reviewing NICE guidance and audits, therefore, UD is envisaging improved performance, UD stated that she is hopeful to be able to be provided improved update at next meeting if appropriate.

LC echoed KB comments, and welcomed JR to review the report, LC stated that the report is currently difficult to review and has regular changes. LC referred to the importance of any guidelines being fully triaged initially to determine whether guidelines are relevant for the organisation, or particular divisions, and ensuring any appropriate action required is completed to provide assurance LC stated that she and JP would be happy to work with JR provide any support as appropriate. FB stated that this had to be part of a baseline assessment exercise.

JK expressed concern regarding brilliant basics culture, and that as a Trust the Trust should not tolerate continuation of colleagues not receiving updates as appropriate.
FB stated that SQAC continue to monitor the position to obtain an improved oversight and assurance.

NA expressed his apologies to KB and SQAC with regards to the dates not being included. and confirmed that they would be included for future reports.

FB advised that everybody needs to be part of the conversations to understand the responsibility for chasing information, as much as the responsibility for reporting.

SQAC received and **NOTED** the NICE Compliance update.

Resolved: SQAC received and **NOTED** the NICE Compliance update.
Well Led

22/23/104 Board Assurance Framework

ES referred to the ongoing development of risk appetite and discussions would take

place at Executive Team, ES alluded to the fuel and energy issue and the impact, and how this risk should be included either as a stand-alone risk that straddles the whole organisation, or into the existing strategic risks. With some reflection required regarding the impact of winter, which would be featuring in 1.2, as well as access.

ES alluded to meeting the organisations obligations and requirements regarding collaboration and the impact in terms of reviewing risks and how the Trust respond as part of the system and alluded to the risk appetite.

KB provided her observations and stated that she had reviewed the information differently and on review is happy and confident with regards to review of evidence and assurance regarding controls. KB advised that there are some higher level assurance controls that could be included to further strengthen.

FB welcomed any feedback from JK, JK stated that there are a number of risks that the risk owner is stating that they are unable to address due to external factors which are beyond risk owners' control, and risk ownership.

JK stated that some of the information is very dense, with no numbers and highlighted the need for consistency to enable assurance groups to review more easily.

FB stated that there are different approaches and different papers, and that there is no single correct model for all, and that all read differently, however thought is required on how best to meet the needs of colleagues.

JK stated that the agenda is very time and topic based, and whether there should be something on the agenda stating what actions or recommendations are required to be addressed during the meeting.

FB acknowledged that thought is required in the transition period. FB stated the importance that colleagues do not use the new system developments as an excuse not to progress actions as appropriate.

Resolved: SQAC received and **NOTED** the Board Assurance Framework.

22/23/105 Divisional Report/Quality Metrics update

Community & Mental Health Division – LC provided key issues as follows:-

- Mental Health Pharmacist had been appointed and had commenced in post, with a real focus on prescribing processes and reducing medication errors.
- Deteriorating child workstream had been established within the Division.
- Governance Roadshow is taking place to promote good governance across all services, with focus around data breaches, human error and patient experience.
- Friends and Family scores remain significantly high in the 90%'s for both outpatients, mental health and community services.
- Division have had an increase in complaints in the month of August 2022 with 11 formal complaints, of which three related to Rainbow Sexual Assault Referral Centre, following patient experience feedback a number of significant improvements will be made as a result of feedback. LC stated that she hopes to include at a future Trust Board in the form of a patient story.
- Excellent feedback had been obtained regarding one of the first complaints.
- Sensory project across the Trust is due to come to an end at the end of September 2022, with an update provided to SQAC at the November 2022 meeting.
- Referrals to Neurodevelopmental Services, ASD and ADHD continue to remain significantly higher that what the organisation had been commissioned to provide, with

ongoing work in both those services, and also across the Cheshire and Mersey system with PLACE commissioners with regards to actions required across the whole health and social care economy.
- Division are looking to pilot a new way of working within Speech & Language Therapy team regarding early years to support the increasing number of referrals.
- Mandatory training remains above 95%, together with return to work interviews and PDR compliance.
- Staff turnover rates remain high within the Division, a deep dive had been undertaken and the Division continue to work with workforce and HR colleagues.

Medicine Division – UD provided an update on key issues as follows:-
- Performance against the four hour standard in ED had dramatically improved, currently at 90.2%, this is due to the ongoing work in ED.
- Access challenges remain in relation to RTT and diagnostics.
- Highlight - Radiology is 95% for diagnostics within six weeks.
- Ongoing pressures in Physiology with regards to sleep waiting times, measures in place to review, with target date for achieving all completion of waiting list is envisaged at early 2023.
- Mandatory training - a number of measures had been put in place to improve mandatory training compliance, the Division are currently at 93.48%, with appraisals and revalidation not being signed off where mandatory training is not being completed.
- Short term sickness had reduced within the Division, however long term sickness continues to be high, AT and colleagues are reviewing staffing on 4B and 4C which are the areas of high stress and anxiety to consider any additional support for staff.

Surgery Division – CC provided an update on key issues, as follows:-
- The Division had changed practice for Sepsis monitoring, with the introduction of the new sepsis lead who joins the Division daily to identify any areas of concern and address in real time, any issues that require focus on ward level, which had been extremely positive. Division are working closely with Sepsis Nurse to be less reactive and more proactive.
- Mandatory training is above 90%
- PALS responses to families continues to be 100% for responding within the timeframe
- Division have continued focus on the Risk Register, with specialties being supported to ensure that risks are in date and appropriately managed. Weekly meetings take place with leads and specialties to support with them being 100% compliance from colleagues.
- Activity plan during August 2022 – Division achieved the expectation of 105% against the 104% set for the Division.
- Division have workforce challenges which are currently being reviewed/addressed at specialty level to deliver against plan.

FB thanked Divisions for update and advised on the need for continued oversight regarding staffing turnover. JK alluded to the candidates who had accepted posts and since declined and queried whether the Trust is competing with some form of great grade inflation. UD stated that this was correct and that a listening event within the Division of Medicine had taken place.
Committee **NOTED** the pressures across each of the Divisions.

FB welcomed Divisional updates and thanked colleagues for updates.

Resolved: SQAC received and **NOTED** the Divisional updates and **NOTED** the pressures across each of the Divisions.

22/23/106 Policy Approval

000226

SQAC received and **RATIFIED** the Dissemination and Implementation of National Alerts and Guidance Policy.

KB stated that this policy highlight numerous other alerts and guidelines, and that SQAC do not receive assurance on those guidelines and alerts, and queried whether these other areas require assurance at SQAC.

NA advised that the current system, that when there are high level of compliance that they are noted and monitored through CQSG, and that the NICE guidelines are presented to SQAC as there is a real challenge with NICE guidelines. NA advised that he is happy to bring the others to SQAC if required on an annual basis, however CQSG is currently overseeing. KB stated that she is content with that approach being overseen at CQSG, with the expectation that any issues regarding non-compliance/requiring escalation should be through SQAC as appropriate.

NA advised that a written CQSG key issues monthly report from CQSG would commence from October 2022, and queried whether through a wider governance report should be presented to SQAC on a yearly basis.. NA would discuss offline with JR to ensure appropriate overview for SQAC.

Resolved: Offline discussion to be held with NA & JR

FB thanked NA and WW for update.

Resolved:– SQAC received and **Ratified** the Dissemination and Implementation of National Alerts and Guidance Policy - Policy -RATIFIED.

22/23/107 Any other business

KB referred to the Corporate Risk Register and requested that it would be helpful for Committee to review on a 6 monthly basis, FB advised that discussion would take place in between meetings re timing etc.

22/23/108 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Patient Safety Strategy Board update - identified the need for this to be embedded in the wider culture and for a communications methodology to be developed to support this.
- Quality Assurance Rounds Themes and Risks report received, SQAC agreed to moving to a six-monthly reporting cycle.
- Mortality Report was received, with useful discussion and insight. Assurance received by SQAC with regards to learning in terms of the mortality inquiry process which takes place across the organisation.
- Winter Planning Presentation received detailing the preparations for anticipating and responding to winter pressures, including through service innovation. The report addresses the pressures that the Trust is already experiencing and the increase in demand on services, speaking directly to at least two of SQAC key risks. The need to support staff as an integral part of this plan was recognised.
- Divisional updates on Pressure Ulcers received. The continued determination to proactively manage and reduce pressure ulcers was recognized and significant potential for learning across the divisions recognized. SQAC to receive a summary progress report at the December 2022 meeting.

- NICE Compliance update received. Agreed that action is required to ensure continued oversight and aid improvement. NA would undertake offline discussions to aid this process.
- Divisional updates were received. SQAC noted the pressures across all Divisions. SQAC also noted excellence within the Medicine Division relating to mandatory training, where progress had been aided by a more stringent approach towards signing off PDRs. SQAC received a staff turnover update and noted the need to review the Retention Policy, given wider implications.
- Innovation noted within the Surgery Division with regards to Sepsis review management.
- SQAC noted the outstanding delivery in Surgery of 105% against plan last month.
- Community & Mental Health Division had successfully appointed to the Mental Health Pharmacist role, a significant development which would help to address medication errors.
- SQAC noted the ongoing work regarding the deteriorating child.
- SQAC also noted the Governance Roadshow in CMHD and sensory teamwork
- SQAC noted the ongoing pressures regarding ADHD and Mental Health services demand, together with pressures within Speech & Language Services.
- SQAC agreed to review the Corporate Risk Register at a future SQAC meeting, with offline discussion to take place to agree timeline etc.

21/22/109 Date and Time of Next meeting

FB thanked all for attendance

Next meeting to be held on 19th October 2022 at 9.30 am

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Monday 8th August 2022**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Ms. K. Warriner	Chief Digital and Information Officer	(KW)
In Attendance:	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	Mrs. K. McKeown	Committee Administrator	(KMC)
Observing:	Ms. S. Fletcher	Director of Finance of the Trust's Charity	(SF)
Apologies:	Mr. A. Bass	Acting Chief Medical Officer	(AB)
	Prof. I. Buchan	Associate Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics	(IB)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Ms. A. Lamb	Programme Director for Health Liverpool Innovation	(AL)
	Ms. R. Lea	Acting Director of Finance	(RL)
	Dr. F Marston	Non-Executive Director	(FM)
	Mr. D. Powell	Director of Development	(DP)
	Mrs. L. Shepherd	Chief Executive	(LS)
Item 22/23/24	Ms. V. Furfie	Chief Clinical Information Officer	(VF)

22/23/17 Introductions and Apologies

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

22/23/18 Declarations of Interest

There were none to declare.

22/23/19 Minutes from the Meeting held on the 19th April 2022

Resolved:

The minutes from the meeting that took place on the 19th of April 2022 were agreed as an accurate record of the meeting.

22/23/20 Matters Arising and Action Log

Action 20/21/67.1: *Alderhey@anywhere Discovery Partners Update (Submit a report on*

each of the partnerships once they reach the Heads of Terms stage in order to provide information on the opportunities, financials, commercial opportunities, marketing and IP to enable the Committee to either agree to progress the partnership to the next stage or ask further questions) – It was agreed to remove this action from the log as this information is included in the Commercial and Partnership Agreement log. **ACTION CLOSED**

Action 22/23/06.2: *Q3 Performance Report (Discussion to take place with regard to the regulations, ethics and data management that will be required once the Alder Hey Anywhere Digital Platform is made available for external use)* - It was confirmed that the DPIAA process is sufficient in respect to regulations, ethics and data management and is in progress as part of the programme.
ACTION CLOSED

Action 21/22/26.1: *Commercial Partnerships (further clarity to be included in the report on the materiality level and decision-making process which defines whether an agreement will be submitted to the Innovation Committee or RABD, for approval)* – A draft Standard Operating Procedure (SOP) is to be submitted to the Committee in October to demonstrate a process for providing collective Committee assurance to the Trust Board on commercial partnerships. It was also agreed to discuss the possible adoption of the assurance framework that the Director of Strategy and Partnerships has implemented for wider strategic partnerships. **ACTION TO REMAIN OPEN**

22/23/21 2030 Innovation Strategy: 'Todays Child, Tomorrow's Healthier Adult'.

For completeness, the final version of the Innovation Strategy was submitted to the Committee in its graphic designed format. A number of slides were also shared with the committee which provided information on the pitch deck.

Claire Liddy responded to a number of questions that were raised in respect to the implementation of a marketing strategy, deliverables and impact, the work that needs to take place to bring the deployment phase to life, and the development of the investors pitch.

Following discussion the Chair asked that the pitch deck be circulated to Committee members and that the strategy presentation be shared externally with relevant people.

22/23/21.1 Action: CL

Resolved:
The Innovation Committee received the final version of the Innovation Strategy in its graphic designed format and noted the contents of the pitch deck.

22/23/22 2022/23 Operational Plan.

The Committee received the 2022/23 Operational Plan and was provided with an overview of the approach that is going to be taken to solve real world healthcare problems that children and young people (CYP) face today, create fair access to care and enable a healthier future for all. The Committee was asked to approve the 2022/23 Operational Plan to enable deployment of the deliverables included in the plan.

Following discussion a number of points were made;

- Include revenue information on transparent masks in the KPI section and continue to review this data on a quarterly basis.
- *Monitoring Section* – Expand on the monitoring process, including benefits realisation.
- As the Operational Plan grows have a more preventative focus going forward and set some time aside to agree next year's deliverables. Include a paragraph in the 2022/23 Operational Plan to highlight that this will form part of the next steps process for 2023/24.
- It was felt that a piece of work needs to take place to agree a process in terms of who is responsible for monitoring operational impact along with a reporting structure.

Resolved:
The Innovation Committee approved the 2022/23 Operational plan subject to the comments made by Committee members on monitoring, benefits realisation, next year's deliverables and including a paragraph on the next steps for 2023/23.

22/23/22.1 **Action: CL/EK**

22/23/23 **Innovation Performance Report, Q2**

The Committee was advised that the performance report has been updated to align with the 2022/23 Operational Plan/Innovation Strategy and also includes information on divisional performance. It was confirmed that the performance report will continue to be submitted on a quarterly basis. An overview of the performance report was shared with the Committee which included an update on KPI's, risks and the 2022/23 financial outturn.

A number of actions were agreed following the update:

22/23/23.1 **Action:** Greater detail to be included in future financial outturn updates; YTD figures, variances, breakdown of income lines, cost categories. A phased budget is also required with a revised forecast to include a financial update on revenue for transparent masks. If possible, share the revised forecast with Committee members ahead of October's meeting. **EK**

22/23/23.2 **Action:** Grant funding figures to be included in internal metrics to provide further detail. **EH**

22/23/23.3 **Action:** Additional risk to be included in the next iteration of the performance report regarding the financial sustainability of the Innovation Centre. It was agreed to review the operational risks during October's meeting. **EH/CL**

Resolved:
The Innovation Committee received and noted the quarterly performance update for April 2022 to June 2022.

22/23/24 **Alder Hey Anywhere Digital Platform - Status and Update.**

The Committee received a presentation that provided an update on the Alder Hey Anywhere Digital Platform. The Committee was asked to provide feedback on the product

development/next steps in terms of how the commercialisation of the product should be progressed.

Feedback and challenge was provided by Committee members relating to; learning from previous marketing comms, agreeing the clinical and operational steps for phase 2 of the development, connecting with national work in terms of funding resources, ensuring that due process is followed when progressing international partnerships, reputation and market assessment. Attention was also drawn to the importance of having a brilliant use case to underpin a commercial and branding strategy.

As a result of the feedback the following actions were agreed:

22/23/24.1 **Action:** Compile a business development proposal for further development of the product and submit it to the Innovation Committee during October's meeting; to include information on clinical safety, clinical and operational asks, a specific brand and communications plan (*including a market assessment of competitors and the national landscape*), and product positioning. **CL/EH**

22/23/24.2 **Action:** Live data collection and measurement to be compiled on the clinical and operational uses of the product as part of future partnerships. **CL/EH**

22/23/24.3 **Action:** Brilliant use case to be included in the business case to demonstrate the effectiveness and efficacy of the product, along with metrics for measuring benefits realisation. **CL/EH**

Resolved:
The Innovation Committee received and noted the Alder Hey Anywhere Digital Platform status and update.

Marketing and Communications

The committee discussed lessons learnt from previous communications activity. The Committee agreed an additional action to receive a brand and communications plan for Alder Hey's Innovation strategy during October's committee meeting.

22/23/24.4 **Action:** Submit a brand and communications positioning paper to the Innovation Committee during October's meeting; to include previous lessons learnt from a brand and comms perspective. **MF/CL**

22/23/25 **Commercial and Partnership Agreements Report, Q2.**

The Committee was provided with an overview of the Commercial and Partnership Agreements report for Q2. Attention was drawn to the importance of agreeing a committee reporting and SOP process for partnership agreements once a review of governance has taken place. It was agreed to address this and present a SOP during October's meeting.

22/23/25.1 **Action: CL/EH**

Resolved:
The Innovation Committee received the Q2 update and noted the content of the Commercial Partnership Agreement schedule.

22/23/26 Liverpool City Region

The Committee was advised of the Trust's successful pre-development bid following submission to the Metro Mayor's Liverpool City Region strategic investment fund. Alder Hey received confirmation that the bid had been approved on the 5.8.22 and that the Trust is one of the Liverpool City Region's innovation pipeline projects.

22/23/27 We are Nova – Commercially in Confidence

The Innovation Committee received a report on the status of the position regarding 'We are Nova' following the recent negative press features in the Times Newspaper and receiving a series of Freedom of Information requests. The Committee was advised of the pro-active actions that the Trust has taken, with legal support from Bevan Brittan, to protect the Trust's reputation and brand relating to these business activities.

A discussion took place about the action that relates to the formal notification of a pause to clinical trials. It was pointed out that the Trust can't hold this for perpetuity therefore it was agreed to review this action in order to make a judgement on the overall position and feedback to the Committee on the outcome.

22/23/27.1 Action: JG/CL/EH

Resolved:
The Innovation Committee noted the contents of the status report including the actions taken by the Executive Team and legal representatives.

22/23/28 Board Assurance Framework Update

The Innovation Committee received the Board Assurance Framework (BAF) Report for June 2022. It was reported that a lot of work has taken place to refine risk 1.4 '*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'* and it was felt that in view of the discussions that took place during the meeting the strength of some of the controls may need to be reviewed and tested, particularly around reputation and financial sustainability. The Committee was advised of the importance of keeping risks under review going forward.

Resolved:
The Innovation Committee received and noted the contents of the Board Assurance Framework Report for March 2022.

21/22/29 Any Other Business

There was none to discuss.

21/22/30 Review of Meeting

The Chair thanked everyone for their contributions during the meeting and felt that the agenda had covered some important areas of work. As a result of a number of good discussions actions have been agreed to progress the next steps in terms of business development and strategy deliverables.

Date and Time of the Next Meeting: Monday 10th October 2022, 10:30am-1:30pm, via Teams