Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 29th September 2022, commencing at 11:00am

Liverpool Innovation Park (Room 2 and 3)

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Staff Story (Forest School)							
1.	**22/23/129**	**11:15 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**22/23/130**	**11:16 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**22/23/131**	**11:17 (3 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meetings held on: **28th July 2022.**	**D**	Read enclosure
4.	**22/23/132**	**11:20 (5 mins)**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read enclosure
5.	**22/23/133**	**11:25 (10 mins)**	**Chair/CEO's Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**22/23/134**	**11:35 (40 mins)**	• **IPC** • **Operational Progress Report, Q2 2022/23.** • **Forward look for winter 2022/23.** • **M4 Integrated Performance Report.** • **Developing the New Integrated Performance Report**	B. Larru A. Bateman/ Exec Leads A. Bateman Exec Leads/ Divisional Leads A.Bateman/K. Warriner	To receive an update on the current position To receive an operational progress update for Q2, 2022/23. For information purposes. To receive a report on the Trust's performance for scrutiny and discussion, highlighting any critical issues. To receive and approve the new reporting	**A** **A** **N** **A** **A**	Presentation Read report Read report Read report Read report

Alder Hey Children's NHS Foundation Trust

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Lunch (12:15pm-12:35)							
Strategic Update							
7.	**22/23/135**	**12:35 (5 mins)**	**Liverpool Clinical Services Review.**	L. Shepherd	To receive an update on progress.	**N**	Verbal
8.	**22/23/136**	**12:40 (10 mins)**	**ICS Development Update; including:** • **CMAST Leadership Board Terms of Reference – For a committee of the Board to meet in common with committees of other CMAST trusts.**	D. Jones E. Saunders	To receive an update on the development of ICSs. To approve the CMAST Leadership Board Terms of Reference.	**N/D**	Presentation Read enclosure
9.	**22/23/137**	**12:50 (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							
10.	**22/23/138**	**13:00 (10 mins)**	**Gender Identity Service.**	L. Shepherd	To provide a briefing on the Gender Identity Service.	**N**	Verbal
11.	**22/23/139**	**13:10 (10 mins)**	**Brilliant Basics Update.**	N. Askew	To provide an update on the current position.	**A**	Read report
12.	**22/23/140**	**13:20 (5 mins)**	**Serious Incident Report.**	N. Askew	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
13.	**22/23/141**	**13:25 (5 mins)**	**Nurse Staffing Report.**	N. Askew	To provide an update on the current monthly position.	**A**	Read report
14.	**22/23/142**	**13:30 (5 mins)**	**Complaints and PALS Report, Q1.**	N. Askew	To receive the PALS and Complaints report for Q1.	**A**	Read report

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15.	**22/23/143**	**13:35 (5 mins)**	**Mortality Report, Q1.**	A. Bass	To receive the Mortality Report for Q1.	**A**	Read report
16.	**22/23/144**	**13:40 (10 mins)**	**DIPC Report, Q1.**	B. Larru	To receive the DIPC Report for Q1.	**A**	Presentation
Game Changing Research and Innovation							
17.	**22/23/145**	**13:50 (5 mins)**	**Liverpool Health Partners.**	L. Shepherd/ J. Chester	To receive an update on the current position.	**N**	Read report
Sustainability through External Partnerships							
18.	**22/23/146**	**13:55 (5 mins)**	**North West Paediatric Partnership Board – Chairs Report.**	D. Jones	For information purposed and assurance.	**N**	Read report
19.	**22/23/147**	**14:00 (10 mins)**	**Growing Great Partnerships**	D. Jones	To receive an update.	**A**	Read report
The Best People Doing Their Best Work							
20.	**22/23/148**	**14:10 (10 mins)**	**People Report; including:** • **Wellbeing Guardian: Dashboard**	M. Swindell F. Marston	To receive an update on the current position. To receive an update	**A** **A**	Read report Read report
21.	**22/23/149**	**14:20 (5 mins)**	**Additional Christmas Bank Holiday Proposal.**	L. Shepherd	To approve an additional bank holiday in December for staff.	**D**	Verbal
Strong Foundations (Board Assurance)							
22.	**22/23/150**	**14:25 (10 mins)**	**Alder Care Programme.**	K. Warriner	To provide an update on the current position.	**A**	Read report
23.	**22/23/151**	**14:35 (15 mins)**	**Forward look/Financial Environment; including:** • **Financial Update for M5, 2022/23.**	R. Lea	For information purposes. To provide an update on the current position for Month 5, 2022/23.	**A** **A**	Presentation
24.	**22/23/152**	**14:50 (10 mins)**	**Board Assurance Framework Report; including:** • **Board Assurance**	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** **D**	Read report Read

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			Framework Policy.		To ratify the Board Assurance Framework Policy.		enclosure
25.	**22/23/153**	**15:00 (5 mins)**	**Emergency Preparedness, Resilience and Response Annual Assurance Report (EPRR); including:** • **EPRR core standards assessment.**	N. Askew	To ratify the EPRR Annual Report and the EPRR core standards assessment.	**D**	Read report
26.	**22/23/154**	**15:05 (20 mins)**	**Board Assurance Committees; report by exception:** • **Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 15.9.22.** - **Approved minutes from the meeting held on the 14.722.** • **Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 26.9.22.** - **Approved minutes from the meeting held on the 25.7.22 and the 22.8.22.** • **Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 20.9.22.** - **Approved minutes from the meeting held on the 20.7.22.** • **People and Wellbeing Committee:**	K. Byrne I Quinlan F. Beveridge F. Marston	To escalate any key risks, receive updates and note approved minutes.	**A**	Verbal/ read approved minutes

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
			- **Chair's verbal update from the meeting held on the 28.9.22.** - **Approved minutes from the meeting held on the 3.8.22.** • **Innovation Committee:** - **Chair's verbal update from the meeting that took place on the 8.8.22.** - **Approved minutes from the meeting held on the 19.4.22.**	S. Arora			
Items for information							
27.	**22/23/155**	**15:25 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
28.	**22/23/156**	**15:29 (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 27th October 2022, 9:00am-3:00pm, Liverpool Innovation Park							

REGISTER OF TRUST SEAL
The Trust Seal was not used in September 2022

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M5, 2022/23	R. Lea
IPC Report	B. Larru
Bribery Act 2010 and Trust Anti-Bribery Strategy	K. Byrne

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 28th July 2022 at 11:00am**

via Microsoft Teams

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)
	Mrs. L. Shepherd	Chief Executive	(LS)
	Mrs. M. Swindell	Chief People Officer	(MS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Dr. U. Das	Director of Medicine	(UD)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. D. Jones	Director of Strategy and Partnerships	(DJ)
	Mrs. K. McKeown	Committee Administrator (minutes)	(KMC)
	Mr. D. Powell	Development Director	(DP)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
	Mrs. K. Warriner	Chief Digital and Information Officer	(KW)
Item 22/23/104	Ms. K. Holian	Service Manager, Community Division	(KH)
Item 22/23/104	Ms. C. Lee	Assoc. Chief Operating Officer (acting)	(CL)
Item 22/23/104	Ms. C. Shelley	Assoc. Director of Operational Finance	(CS)
Item 22/23/109	Ms. J. Deeney	Liverpool Neonatal Partnership	(JD)
Item 22/23/109	Ms. J. Minford	Liverpool Neonatal Partnership	(JM)
Item 22/23/109	Ms. M. Passant	Liverpool Neonatal Partnership	(MP)
Item 22/23/109	Dr. A. Bedford-Russell	Liverpool Neonatal Partnership	(ABR)
Item 22/23/112	Ms. C. Shelley	Assoc. Director of Operational Finance	(CS)
Apologies	Prof. M. Beresford	Assoc. Director of the Board	(PMB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Ms. L. Cooper	Director of Community & MH Services	(LC)
	Mr. J. Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Dr. A. Hughes	Deputy Medical Director	(AH)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Mrs. C. Liddy	Managing Director of Innovation	(CL)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mr. I. Quinlan	Vice Chair/Non-Executive Director	(IQ)

22/23/99 Welcome and Apologies

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

22/23/100 Declarations of Interest

There were none to declare.

22/23/101 Minutes of the Previous Meeting

The minutes from the meetings held on the 20th of June 2022 and the 30th of June 2022 were agreed as an accurate record of the meeting.

22/23/102 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 that an update would be provided during September's meeting. **ACTION TO REMAIN OPEN**

Action 22/23/62.1: *Board Self-Certification of Compliance with the Provider Licence (Confirm the timeline for the removal of the Major Trauma service derogation and advise as to whether this matter should be monitored via SQAC)* – The Director of Corporate Affairs, Erica Saunders, is in dialogue with Andy McColl about the timeline for the removal of the Major Trauma service derogation. It was agreed that this matter will be addressed outside of the meeting. **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 September's Trust Board.
ACTION TO REMAIN OPEN

22/23/103 Chair/CEO's Update

The Chair advised of the appointment of two new Non-Executive Directors, Jo Revill and John Kelly, following approval by the Council of Governors on 27th July.

Louise Shepherd reported on the meeting that took place with the Chair of the Cheshire and Mersey Integrated Care System (ICS), Raj Jain, who is focussed on the improvement in the outcomes for children and young people (CYP) in the region and very supportive of what the Trust is doing. A further meeting has been scheduled for September to progress discussions about plans for CYP locally and regionally and to look at working with the ICS to improve the outcomes for CYP.

The Board was informed of the recent visit to Alder Hey by the Chief Executive of the ICS, Graham Urwin. A tour of the hospital took place which highlighted the holistic care that the Trust provides for its patients and what the organisation offers. Graham Urwin met with staff from the Innovation Hub including the clinicians who are driving change and was impressed with the thought that is being given to new models of care and new digital opportunities to improve care.

The Board was informed of the proposal that is being submitted to the Cheshire and Mersey Acute and Specialist Trusts (CMAST) provider collaborative on the 29.7.22 that sets out an approach for driving elective recovery for CYP across Cheshire and Merseyside (C&M). This proposal is also being replicated at North West level. Attention was drawn to the backlog of care for CYP and increasing waiting lists that are becoming a major issue for all trusts. It was felt that it is really important to have a lens on these issues at system level in order to recognise the problems and work together to try and solve them.

Clinical Review of Services in Liverpool – It was confirmed that consultancy firm Carnall Farrar have been appointed to undertake the planned clinical review of services in Liverpool. A meeting has been scheduled for w/c 1.8.22 to look at progressing the review.

Resolved:

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

22/23/104 Operational Issues

Integrated Performance Report Proposal

The Board received a proposal for the development of an integrated performance report which will replace the existing Corporate Report and was advised of the progress that has been made to date with the revised approach.

The vision is for the Trust Board to receive an Integrated Performance Report on a monthly basis that will be data driven with NHSE/I 'Making Data Count' principles applied in line with best practice. It will cut across the five priorities that have been agreed by the Board for 2022/23 and will also cover the Trust's engine rooms and clinical divisions to provide assurance across all domains through to Divisional level.

Support from Board members was requested to help develop the report further from an integrated perspective and to address the concerns about the quantum of metrics that the Board receives. It was pointed out that the Integrated Performance Report will also cover transformation and the impact of some of the Trust's strategic initiatives.

In terms of next steps, work will commence with Board colleagues to design and prototype the Integrated Performance Report in order to submit a full new version of the document to the Board in October 2022. It was reported that the introduction of the Integrated Performance Report will provide a number of benefits in terms of aligning with the Trust's Brilliant Basics work, aligning with national expectations and presenting performance data in a clear and visual way, therefore the Board was asked to approve the proposal to enable it to be progressed.

22/23/104.1 Action: AB/KW

The Board felt that the development of an Integrated Performance Report is a positive step and will help the Trust to move in the right direction. Following discussion, the Board approved the proposal and both Shalni Arora and Kerry Byrne agreed to participate with the development of the new report.

Resolved:
The Board approved the proposal to develop an Integrated Performance Report.

Operational Progress Report, Q1 2022/23

The Board received an Executive Lead update on progress with Q1 priorities as set out within the Operational Plan for 2022/23. An update was provided on the following workstreams:

Recovery;

- The Trust has achieved above the 104% recovery standard for volume of inpatient activity each month with a peak of 115% in June which was driven by Day Case activity. It was also pointed out that the Trust achieved above the 104% measured by value standard in June (105%).
- It was reported that the Trust has achieved the national standard ahead of time to have no patients waiting two years for treatment and provided mutual aid to the Royal Manchester Children's Hospital (RMCH) to help them achieve this standard too.

- The Board was advised of the appointment of seven Consultant Anaesthetists which will drive recovery and enable additional theatre capacity.
- Attention was drawn to the areas of concern that the Trust has; 1. High demand for ADHD/ASD services. 2. Long waits in Paediatric Dentistry. 3. ED performance against the 4 hour national standard. An overview of the actions taking place to address these concerns were shared with the Board.

Safety;

- It was reported that there has been a sustained improvement in mandatory training in Q1 with overall figures back up to 90%. This figure includes some of the really challenged services.
- *Deteriorating Patient* - Due to the number of cardiac arrests remaining stable, the Trust is starting to see a gradual sustained reduction in the number of transfers and unplanned admissions into critical care thus demonstrating that early detection and intervention is starting to take place on the wards.
- It was confirmed that the Patient Safety Strategy Board is now formed, with all safety workstreams coming together to drive forward improvements.
- Attention was drawn to the areas of concern that the Trust has; 1. Compliance with the sepsis 60 minute target in ED. 2. Grade 2 Pressure Ulcers relating mostly to medical devices. An overview of the actions taking place to address these concerns were shared with the Board.

Great Place to Work;

- *Establishment Control Project* – Work is taking place to link the ESR system with the Finance Ledger system to provide baseline data that can be used for future robust planning. It was confirmed that this project is progressing at pace.
- *Great Space to Work Programme* – This project is underway with OD in place to focus on the staff welfare elements of the programme. Throughout this project there will be a focus on achieving a high standard of specification in terms of workplace accommodation for staff from a Campus and off site perspective.
- *Attraction and Retention* – It was confirmed that time to hire metrics are now less than 30 days from conditional offer to unconditional offer.
- Financial wellbeing support has been implemented for staff and the Citizens Advice Bureau are providing fast track support for staff to address issues relating to external factors.
- Attention was drawn to the areas of concern that the Trust has; 1. Lack of progress with the Attraction and Retention project due to resourcing issues. 2. Sickness absence and retention rates increasing across the organisation. 3. Poor take up of the Pulse Check. An overview of the actions taking place to address these concerns were shared with the Board.

Financial Sustainability;

- It was confirmed that the Q1 position was reported in line with the plan control total.
- The Trust has received confirmation of the 2022/23 capital spending limits which allows continuation of the Campus and other capital projects in year.
- New financial dashboards and statements have been launched to budget holders which allows access to real time data in terms of Divisional spend.
- Financial reporting has been accelerated from working day 5 to working day 1 which provides an additional week to view data and address corrective action prior to the following month.

- Positive feedback has been received on national bids for capital funding for both Elective Hub and Eating Disorder Day Case.
- Attention was drawn to the areas of concern that the Trust has; 1. Significant challenge in achieving the control total target. 2. CIP remains a challenge with a £4m gap and no identified opportunity or plans in progress. 3. Inflationary rise across non-pay expenditure. 4. Increase in temporary workforce spend. An overview of the actions taking place to address these concerns were shared with the Board.

Safe Digital Systems;

- The new Digital and Data Futures Strategy has been developed and supported by the Board of Directors.
- The Trust has made good progress during Q1 on a range of projects around connecting digitally with CYP and families; deployment of digital letters, new website and the intranet project. It was confirmed that feedback from families has been positive.
- Progress has been made with the implementation of several system improvements to support safety and transformation including the Islacare platform.
- The main area of concern relates to the Alder Care Programme which has been formally delayed. A review is underway to establish the gaps and requirements for a new go live date which is likely to be in 2023. A reset of the vision, ambition and benefits realisation is underway with Meditech and clinical teams.

M3 Integrated Performance Report

The Divisions of Medicine, Community/Mental Health, Surgery and Clinical Research provided an update on the following domains: Safe, Caring and Responsive as detailed in the Integrated Performance Report for M3. The following points were raised:

Surgery

Two specialities have participated in the new Artificial Intelligence (AI) Was Not Brought (WNB) Pilot and it has been agreed to embed this process across the Division as a result of the positive feedback received in terms of benefits following the conclusion of the pilot.

Medicine

Proactive work is taking place to try and reduce the 52 week waiting list via consultant job planning. Contact has been made with all of the teams in the Division to request their support to help mitigate issues.

It was confirmed that the AI WNB tool has been rolled out to Respiratory, Haematology and Nephrology as a result of the recognised benefits following the pilot, and a request by consultants.

Neurology – It was reported that one of the Trust's consultants who is retiring and returning with a reduced PA commitment has agreed to support some of Neurology's on-calls.

The Board was advised of the increased cost for growth hormone drugs. It was reported that action is taking place to try and alleviate this issue and competitive

price discussions are taking place with pharmaceutical companies. Measures are also being implemented; one of them is to look at preventing wastage.

As a result of an increase in sickness absence rates, the Trust's Chief Nurse, Nathan Askew has been meeting with teams who are affected, with the support of the Division's HR Business Manager. During recent months a number of colleagues with long Covid have returned to work. It was confirmed that the Division is supporting these members of staff.

Community

Continued number of self-harm incidents reported from Tier 4 Unit that relate to one patient – It was confirmed that this patient is being supported by staff on the unit.

Research

The Director of Research and Innovation, John Chester, provided an update on the successes and challenges of the Clinical Research Division. The Board was advised that the Division is committed to contributing to the new Integrated Performance Report, but it was felt that further detail is required in order to gain an overall view of performance within the Division. The following points were highlighted:

- It was reported that the Trust is the best UK leading recruitment site for the 'Stop RSV' trial.
- The Clinical Research Division has commenced its first gene therapy trial for young people with Duchenne muscular dystrophy and has set up a new isolator facility for handling gene therapy agents. The Trust is part of a Multi-Centre Alliance Biomedical Research Centre (BRC) bid with Sheffield, Birmingham and Gt. Ormand Street Hospital and is hoping to receive £0.5m funding if the bid is successful.
- Alder Hey is playing a leading role in the Liverpool Health Partners Academic Health Science Partnership.
- Attention was drawn to the workforce challenges that the Clinical Research Division is experiencing from a clinical leadership and managerial perspective. It was confirmed that the department has recruited an additional analytical consultant to support the department.
- Work is taking place to bring research and innovation closer together in terms of commercial activity, particularly around commercially sponsored clinical trials, as it is felt that a lot can be learnt from the success of the Innovation team. The Division is also looking at a new financial model that is realistic but ambitious.

A discussion took place around the format for reporting the Division's performance metrics and it was felt that it would be more appropriate to include this information in the operational plan. It was suggested combining the operational plans for innovation and research in order to produce a single report that will provide data on key deliverables, metrics and include a forward look.

Louise Shepherd provided positive feedback on the new Integrated Performance Report but drew attention to the importance of incorporating metrics that compare the Trust and using tools like 'Model Hospital' to ensure that the organisation is thinking about the productivity and efficiency of its services and taking action to improve them.

Resolved:

The Board received and noted the Q1 Operational Progress Report, 2022/23 which included updates from each of the Divisions.

22/23/105 ICS Development Update

The Board was provided with an update on the development of the ICS. A number of slides were shared that provided information on the following areas:

- What's new since June?
- ICS Roadmap for integrating Specialist Services.
- Cheshire and Mersey (C&M) governance developments;
  - It was reported that there has been a focus on CMAST Leadership Board governance. The governance group associated with this work have been meeting regularly to consider and refine a 'Working Arrangements' document and the Committees in Common Terms of Reference, with support from Hill Dickinson. Both documents are due for approval at members' Trust Boards in September 2022.

22/23/105.1 Action: ES

  - Issues relating to this area of work include; levels of delegation, involvement of Non-Executive Directors, transparency of decisions and conflicts of interest. It is acknowledged that the collaborative is still in its development stage and therefore working arrangements would be kept under review. A further question relates to the way in which CMAST will work with the other C&M provider collaborative around LD and Mental Health.
  - It was confirmed that the governance group will continue to meet to support CEOs/implementation.

The Chair informed the Board that CMAST has arranged a development session for Non-Executive Directors for the morning of the 2.8.22.

Resolved:
The Board noted the update on the development of the ICS.

22/23/106 Alder Hey in the Park Campus Development Update

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

- *Neonatal and Urgent Care Development* – The Trust is engaging with Morgan Sindall on a weekly basis to look at refining the costs of the construction and to fully understand the pressures. It was confirmed that it will take two to three weeks of work to ensure that a best price is achieved. In addition to this the team are working on an enabling package in order to keep the programme progressing. The Board was advised that work is also taking place to look at maximising the ground floor of the development and optimising income from services.
- *Catkin Centre and Sunflower House Construction* – Progress is being made with the Catkin Centre and options for addressing the exterior of Sunflower House are being discussed. The Trust is in negotiations with Galliford Try about the handover of the Catkin Building prior to the completion of Sunflower House.
- *Park Clearance* - It was confirmed that the Trust has received planning permission for the modular building that will house staff from the old Catkin Building.
- *Step Places* – A meeting is scheduled to take place between the Trust and Step Places on the afternoon of the 28.7.22 to discuss the land buy back deal,

the nursery and staff gym. It was reported that Step Places presented to staff members on the 27.7.22 to provide information on the properties that are to be built on the NE plot.

Resolved
The Board received and noted the Campus Development update.

22/23/107 Digital and Information Technology

The Board was provided with an update on the progress that has been made against the Digital Futures Strategy. The following points were highlighted:

- Attention was drawn to the recent national and regional announcements that were made about the cuts to tech funding to support the national pay award. It was confirmed that capital will not be impacted but there will be cuts to some of the national revenue programmes. There was a clear message from the National Chief Information Officer that frontline digitisation should be supported so that it can continue to progress.
- Interviews have taken place to appoint to the role of Regional Chief Digital and Information Officer. It was confirmed that an appointment has been made.
- The new Digital and Data strategy is complete, having been developed over the last three to six months. It was reported that the delivery of Digital Futures has been incredibly successful for the Trust and has seen some major achievements and benefits, as set out in the refreshed strategy. The new strategy was shared with the Council of Governors on the 13.7.22.
- *Alder Care Programme* – The Board was advised that a formal decision has been made by the Trust to delay the Alder Care Programme due to issues with build progress and functionality. The programme, which is a UK First of Type deployment is currently under review to ascertain the key gaps, improvements and establish a revised go live date.

  It was confirmed that the review has already identified some key learnings, recognising that the move to Meditech Expanse is not an upgrade as had been advised and therefore resourced for. It was also pointed out that there are still high priority functionality issues with Meditech that have no resolution date. An Executive to Executive meeting has been held with Alder Hey and Meditech with a number of key actions and outcomes agreed. A follow up session is due to take place on the 29.7.22

  The Board was informed that the Trust has submitted a request to the national team for resources to support the delay with the programme. Positive discussions have taken place and the Trust's request has been escalated to the regional team for prioritisation. The Trust is awaiting confirmation. Financial negotiations are also taking place with Meditech.

  Monitoring of this risk is conducted via the Resources and Business Development (RABD) Committee with a report submitted on a monthly basis. It was confirmed that the Alder Care Programme has been lodged as one of the Committee's top six risks.
- The iDigital Service is currently undertaking the Level 3 accreditation for Excellence in Informatics as part of the Skills Development Network professional framework. This is highest level that can be undertaken, and it celebrates the profession and workforce. This cuts across the whole of the service; Alder Hey and Liverpool Heart and Chest.

Resolved:
The Board noted the Digital and Information Technology update.

22/23/108 Serious Incident (SI) Report

The Board was provided with oversight of those incidents that are considered as serious following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe from the 1st of June to the 30th June 2022. The following points were highlighted:

- The Trust declared Zero Never Events, and no StEIS reportable incidents that met the SI criteria during June's reporting timeframe (1.6.22-30.6.22).
- It was reported that there has been a concerted effort to close off all investigations carried over from 2021/22, with one outstanding report which is in its final stage of draft (*StEIS reference number: 2021/24660*).
- Action plans are being progressed and it has been agreed to transition those awaiting expanse development into a holding space in order to close the plan whilst maintaining oversight as they go through the programme of development with expanse.
- A recent review of the Trust's Duty of Candour process (CQC Regulation 20) noted a disparity in the number of breaches reported; with 6 Duty of Candour breaches identified. Predominantly, these relate to a delay in the final investigation report not being sent out within 10 days of final sign off. This has been reported to commissioners and CQC and all internal processes with Duty of Candour have been addressed with compliance monitored by the Corporate Governance team.

Resolved:
The Board:
- Noted the content of the SI report.
- Noted the emerging themes for completed SI reports.
- Noted the actions to address open SI overdue action plans.

22/23/109 Liverpool Neonatal Partnership Update

The Board was advised of the two new published drivers for the Liverpool Neonatal Partnership (LNP); **1.** Neonatal GIRFT (*getting it right the first time*) report that was published in 2022 which includes recommendations for practice. **2.** Liverpool Women's Hospital (LWH) external Mortality Review (Birmingham 2020) – It was reported that LWH has been under review in the wake of it being noted that there is an excess in the mortality of babies under 27 weeks gestation. It was confirmed that the content of both reports has added drivers to the programme of work that the LNP is undertaking. It was also pointed out that the British Association of Perinatal Medicine (BAPM) published revised standards in 2021 for providing medical care on units. As a consequence of this a new business plan has been compiled and submitted to the commissioners as additional funding is required for medical staffing. It was confirmed that the LNP are awaiting confirmation of commissioner support and that the business plan is being supported by GIRFT and BAPM Presidents.

A number of slides were shared with the Board to provide an update on the following areas:
- The progress and the challenges of clinical services.
- The progress and challenges in relation to development and strategy.
- Forward look for clinical services.

- Forward look for development and strategy.

It was suggested that it would be beneficial to reflect upon the great work that the LNP has conducted on Ward 1C when submitting a further update to the Board.

Adam Bateman made reference to the difficulties that were experienced when trying to secure a £2m investment for nursing and offered thanks to the teams for their patience during this period. Adam Bateman pointed out that bed capacity will be released in PICU/HDU as more neonates receive care in NICU and felt that that the Trust needs to work closely with the commissioners to attempt to retain that capacity in critical care. Alison Bedford-Russell reiterated Adam Bateman's comments and highlighted the importance of retaining bed capacity in PICU.

Louise Shepherd queried as to whether a discussion could take place regarding research and the ambitions of the LNP. It was confirmed that a meeting has taken place with the Director of Innovation and Research, John Chester, to discuss research intentions, which are very much a part of the LNP's plans, i.e. research on nutrition, infection based research, etc. It was confirmed that both parties are sighted on this area of work. From a research agenda perspective, Shalni Arora advised of the potential intellectual property of the Philips collaboration.

Attention was drawn to the Neonatal Mortality Report and it was queried as to whether this document will be shared with Alder Hey. It was confirmed that the report and action plan will initially be submitted to the LNP Board and from thereon will feed into the Board of Alder Hey and LWH respectively. A discussion took place around some of the recommendations that have been made and it was confirmed that there are some areas of the report that can be addressed quickly while other areas will take longer. Louise Shepherd felt that Alder Hey and the LNP should have a shared voice when responding to issues and therefore from a governance point Alder Hey's Trust Board should be sighted on all reports that impact on neonates. It was agreed to look into this matter further.

In order to offer assurance, Louise Shepherd advised the LNP of the Trust's focus and commitment in progressing the construction of the new Neonatal development.

Resolved:
The Board noted the LNP update.

22/23/110 Medical Revalidation Report

The Board received a report on the 2021/22 Annual Submission to NHS England North West for appraisal, revalidation and medical governance, to provide assurance that the Trust is managing appraisals for clinicians, ensuring that they have access to appropriate resources. Attention was drawn to the following points:

- The Trust is running a separate Medical Director and Responsible Officer programme and will continue to do so for the rest of the year.
- It was confirmed that the L2P appraisal system is now embedded across the Trust. It was reported that the system has a much improved template and package for consultants to conduct their appraisal in a convenient format. The feedback that has been received from consultants has been positive.
- The Trust is planning to be peer reviewed towards the end of the year/early next year. The main focus of the review will be on the quality of appraisals now that L2P has been rolled out across the Trust. It was reported that Alder Hey is looking to make contact with two local trusts who are outstanding in

this area of work to arrange for one of them to conduct the organisation's peer review.

Resolved:
The Board noted the Medical Revalidation Report.

22/23/111 Equality, Diversity and Inclusion Steering Group (EDISG) Update

The Board was advised that the inaugural meeting of the EDISG took place on the 27.7.22. It was felt that attendance at the meeting could have been better, but it was confirmed that progress was made in terms of the group's direction and actions. The Chair of the EDISG, Garth Dallas, thanked the members who attended July's meeting, and Melissa Swindell for the work that took place to ensure that the meeting went ahead.

The EDISG Terms of Reference (ToR) have been approved subject to a further review of the membership composition and scope following feedback from the People and Wellbeing Committee (PAWC). The ToR have been re-circulated to members of the EDISG to enable them to share their views on the breadth of the membership.

It was reported that the chairs of the three staff networks, once appointed, will be allocated one day per month to enable organisation and attendance at network meetings and address the actions that fall out of the meetings. A number of recommendations were also put forward during the meeting by the Chair of the BAME Network; 1. Request approval from the Trust Board for a 'Positive Action Conference' to take place in the Autumn of 2022. 2. Meet with Divisional Managers to discuss EDI and gain their support. 3. Reinstate the monthly newsletter.

Garth Dallas provided an overview of his recent networking activity which included; reaching out to various NHS trusts to gain ideas on establishing networks, linking in with organisations who have high WRES scores, liaising with Liverpool John Moores University (LMJU) to discuss the pipeline at Vice Chancellor level.

The Chair of the Trust Board thanked Garth Dallas for his leadership on this area of work. It was queried as to whether the group will be producing an annual workplan and providing a written update following bi-monthly meetings. Garth Dallas confirmed that this would be produced along with a highlight report following future meetings.

22/23/111.1 Action: GD/MS

Resolved:
The Board noted the EDISG update.

22/23/112 Monthly Financial Update for M3, 2022/23

The Trust reported an in-month surplus of £0.5m with a YTD deficit of £0.7m, which is line with Q1 of the plan. Cash in the bank is £81m.

Key areas to highlight

- *Divisional position;*
  - There is a continued pressure in Medicine with £1m adverse in month (£2m YTD). There are significant issues relating to junior doctors, an unachieved Cost Improvement Programme (CIP) and high-cost hormone drugs.

- Surgery has an improved in month position however there is a £1.2m adverse plan YTD.

- ERF
  - ERF is assumed in line with plan, but the Trust is awaiting the national position. This is a potential risk of £0.2m.
- CIP
  - £0.6m posted in M3 against a target of £1.2m. This is a key risk for the organisation.

2022/23 Plan

- *CIP*
  - The Trust is forecasting to meet £13m of its £17m plan, but a further £4m is yet to be identified.
- Actions underway;
  - There is a weekly focus on 8 sprint areas *(£1.5m of the 4m has been identified*).
  - Discussions are taking place with MIAA re additional resource/support to help generate new ideas and C&M are sharing learning across the patch, again to try and generate ideas.
  - It was pointed out that trusts across the patch are predominantly identifying non-recurrent CIP at this stage in the year rather than recurrent. It was felt that this is a national issue.

The Chair offered thanks to the finance team for driving the Cost Improvement Programme forward and for working with external colleagues to try and find a solution to the issues being experienced. On behalf of the Board, the Chair noted the financial risk to the organisation and acknowledged the work that is being undertaken to address this matter. Louise Shepherd agreed that the Trust is carrying a significant risk but felt that having an intense focus on the organisation's CIP over the next two to three months will pay dividends for the rest of the year.

Resolved:
The Board noted the financial update for M3 and acknowledged the financial risks that the Trust is facing.

22/23/113 Board Assurance Framework Report

The Board was provided with assurance on how strategic risks that threaten the achievement of the Trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 13 principal risks aligned to the Trust's strategic objectives. The following points were highlighted:

- The Board was advised that all risks on the BAF have been scrutinised in month by the respective Assurance Committees.
- It was reported that BAF risks 1.3 *(failure to address building defects with Project Co)* and 3.1 *(failure to fully realise the Trust's vision for the park)* have been updated and now reflect the current position.
- *BAF risk 3.4 (financial environment)* – It was confirmed that a high level risk has been included on the Corporate Risk Register to reflect the in-year position.

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

22/23/114 Board Assurance Committees

Audit and Risk Committee

The approved minutes from the meeting held on the 16.6.22 were submitted to the Board for information and assurance purposes. During the meeting held on the 14.7.22 one of the areas discussed was the work that is going to take place to look at managing risks in Corporate Services. The Committee also ratified the EPRR Policy and associated plans. For continuity purposes it has been agreed that all EPRR documentation requiring approval is to be submitted to the Audit and Risk Committee and an update will be provided to SQAC as required. The Chair of the Audit and Risk Committee advised that the Trust will start to see positive changes in risk processes over the next few months following the appointment of the new Associate Director of Risk and Governance, Jackie Rooney.

RABD

The approved minutes from the meeting held on the 27.6.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 25.7.22 there was a focus on cost pressures, the issue relating to the high cost of hormone drugs, Alder Care and the financial challenges that the Trust is facing. The Committee also received the Green Plan.

SQAC

The approved minutes from the meeting held on the 22.6.22 were submitted to the Board for information and assurance purposes. During the meeting that took place on the 20.7.22 there was a focus on the Safeguarding Review that was initiated by the Trust, and the work that is taking place to improve sepsis compliance.

Louise Shepherd referred to the Safeguarding Review and queried as to whether the outcome of the review should be shared with 'Beyond' as there are a number of important recommendations in the report that appertain to the wider system. Dani Jones agreed to liaise with Lisa Cooper and Nathan Askew regarding this matter.

22/23/114.1 Action: DJ

22/23/115 Any Other Business

There was none to discuss.

22/23/116 Review of the Meeting

The Chair felt that the Board received clear identification of the organisation's risks and the discussions that had taken place during the meeting were relevant and important. The Chair thanked everyone for the work that has been conducted to produce the reports for July's Board.

Date and Time of Next Meeting: Thursday the 29th of September 2022 at 11.00pm at Liverpool Innovation 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 September 2022							
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	Sep-22	**28.7.22** - It was agreed that an update would be provided during September's meeting. **ACTION TO REMAIN OPEN**
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	On track July-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. **ACTION TO REMAIN OPEN**
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	On track Sep-22	
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	On track Sep-22	
Actions for October 2022							
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	Oct-22	**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.
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	On track Oct-22	
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	On track Oct-22	

Status	
Overdue	
On Track	
Closed	

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
28.4.22	22/23/15.1	IPC Update	*PCR Testing for Patients Ahead of Surgery* - Look towards progressing a model, if possible, based on local testing for patients and share this information via the network.	B. Larru	29.9.22	Closed	**19.9.22** - Pre-op testing has now been stopped by NHSE. **ACTION CLOSED**
20.6.22	22/23/62.1	Board Self-Certification of Compliance with the Provider Licence	Confirm the timeline for the removal of the Major Trauma service derogation and advise as to whether this matter should be monitored via SQAC.	E. Saunders	28.7.22	Closed	**28.7.22** - The Director of Corporate Affairs, Erica Saunders, is in dialogue with Andy McColl about the timeline for the removal of the Major Trauma service derogation. It was agreed that this matter will be addressed outside of the meeting. **ACTION CLOSED**
30.6.22	22/23/82.2	Corporate Report	Have a deeper look into referral trends across the Mental Health service to identify the source/drivers behind the surge in referrals.	L. Cooper/ J. Grinnell	29.9.22	Closed	**19.9.22** - This information is to be included in future corporate reports as part of divisional metrics. **ACTION CLOSED**
30.6.22	22/23/86.1	Monthly Financial Update for M2, 2022/23.	Re-instate the reporting process for the Transformation Programme via the organisation's Assurance Committees and Board	J. Grinnell/ N. Palin	29.9.22	Closed	**18.9.22 -** This action has been addressed. **ACTION CLOSED**
28.7.22	22/23/105.1	ICS Development Update	28.7.22 - CMAST Leadership Board - Submit the Committees in Common Terms of Reference to the Trust Board during September's meeting.	E. Saunders	29.9.22	Closed	**18.9.22** - The Committees in Common Terms of Reference have been included on September's Board agenda. **ACTION CLOSED**

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board, Thursday 29 September 2022

Paper Title:	**Operational Update: overview of performance and recovery of services for children & young people**
Report of:	Adam Bateman, Chief Operating Officer
Paper Prepared by:	Adam Bateman, Chief Operating Officer Karl Edwardson, Head of Information Rachel Greer, Associate Chief Operating Officer Chloe Lee, Associate Chief Operating Officer Mark Carmichael, Associate Chief Operating 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:		

1. Introduction

Our *volume* of overall elective recovery performance in August was good at 103% for elective work. The *value* of our 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.

Overall, we are consistently exceeding activity levels compared to 2019 (pre-covid baseline) and we through the course of the year we have driven down the number of patients with a waiting time of greater than 78 weeks. However, we have seen an increase in patients waiting over 52 weeks, with the biggest challenge still in paediatric dentistry. We have undertaken an analysis of our waiting list size which is growing at a very high rate (4% per month). This is a siren call for us to increase capacity in some specialties that have experienced a sharp rise in their waiting list.

On approach to recovery includes the pursuit of opportunities in innovation and transformation to secure improvement in access to care. In outpatients, we have seen a notable increase in the number of patients on a patient-initiated-follow-up pathway. Through a collaboration between innovation and Medicine, we have submitted a national bid to establish a virtual ward at Alder Hey in December 2022, releasing hospital capacity for emergency patients and in turn reducing the risk of elective activity contracting.

In emergency medicine, presentations to the Emergency Department were 112% of pre-Covid levels. In August the percentage of children and young people treated within 4 hrs was improved to 90.2%. s

This paper provides a summary of our analysis and plans in three key areas:

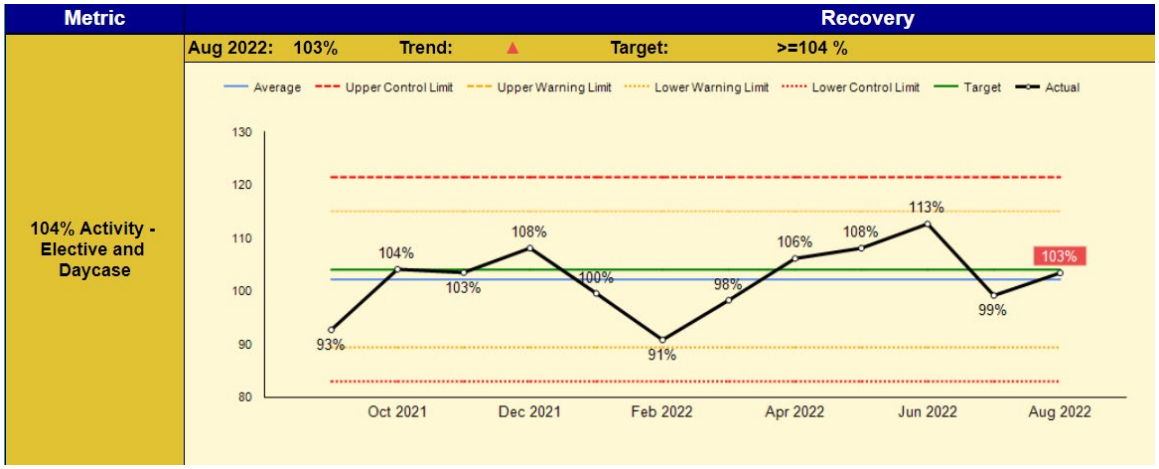
1. Recovery of services, waiting list size and waiting times
2. Timeliness of care in the Emergency Department
3. Diagnostics

2. Recovery of services, waiting times and waiting list size

2.1 Elective recovery

In August the Division of Surgery experienced very high sickness levels in theatres and anaesthesia. In confluence with theatre vacancies, peak annual leave, and junior doctor changeover our theatre sessions performed reduced to 129 per week against a target of 141. This position is improved in September and planned sessions are 6 sessions down on target for the whole month. The Division are offering out additional staffed in week sessions to close the gap against the target.

Despite the staffing challenges described above, we still delivered 103% recovery in Elective and Day Case *volumes*, compared with August 2019 – just under the 104% national standard.



Nationally, an Elective Recovery Fund (ERF) was established to link financial payments to the levels and value of elective activity undertaken. ERF covers the following planned activity: elective inpatient care, day cases, outpatient procedures and outpatient attendances. The value of this elective work is summarised in the table below, by Division and by month. The *value* of our elective recovery did reduce in month 5 down to 96.5%. This was caused by a reduction in recover levels in Surgery caused by the loss of theatre sessions and reduction in complex operations.

Division	M1	M2	M3	M4	M5	YTD Aggregate
Surgery	86.7%	93.6%	98.1%	104.2%	84.1%	**93.2%**
Medicine	123.3%	117.6%	125.6%	117.7%	127.6%	**122.3%**
Community	109.7%	152.0%	127.3%	143.3%	142.8%	**135.6%**
All	**97.9%**	**101.5%**	**106.7%**	**108.8%**	**96.5%**	**102.4%**

2.2 Transformation progress

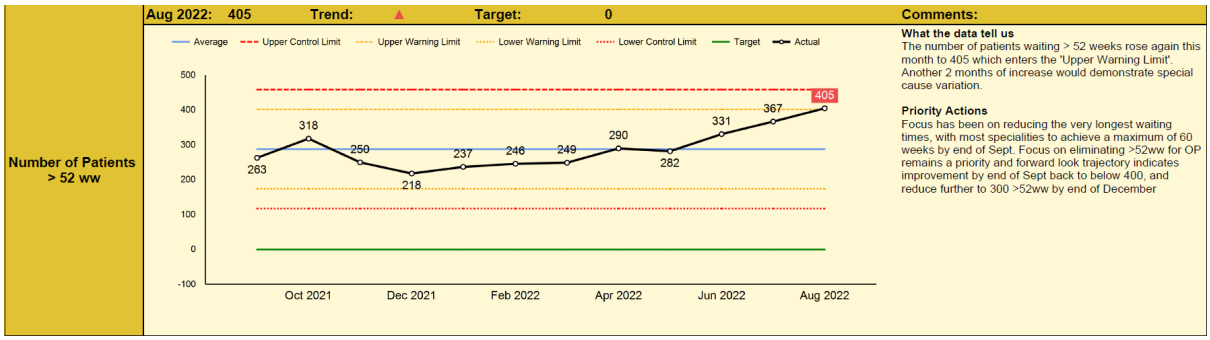
There are three transformation projects within the elective recovery programme. The highlights from August are summarised in the table below:

Area	Highlights
Outpatients	✓ PIFU: 16 specialities live Sept 22 ✓ 968 patients on PIFU pathway ✓ Support for families to attend appointments to go live for 4 specialities on 01.10.2022, patients identified using Was Not Brought Artificial Intelligence system
Elective	✓ 5 orthopaedic IP procedures converted to DC

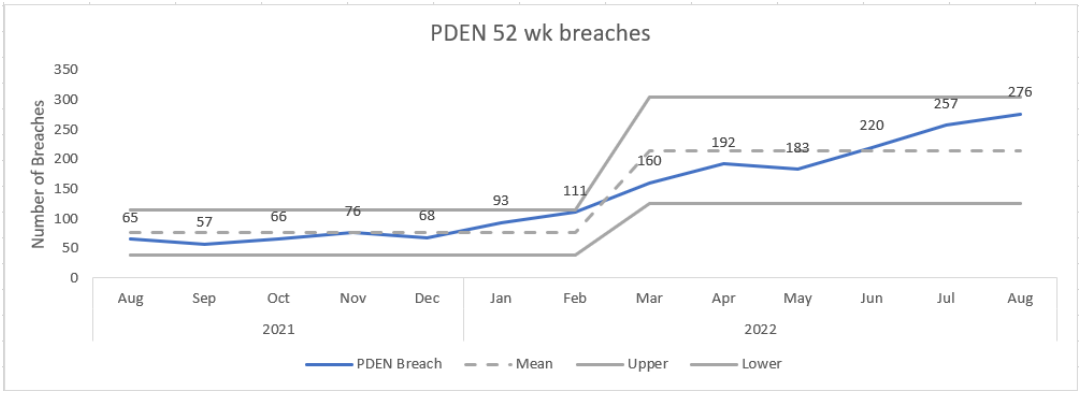
	✓ Paediatric surgery trial to add an additional case to designated lists through Oct 22. ✓ Commencement of Forward Wait trial: Sending of elective inpatients to be accommodated in Forward Wait to improve downtime between cases.
Virtual Ward	✓ Bronchiolitis pathway £260K bid to the Children's Hospital Alliance (funding decision expected 27.09.2022) ✓ Working to establish a respiratory virtual ward for December 2022

2.3 Referral to treatment pathway waiting times

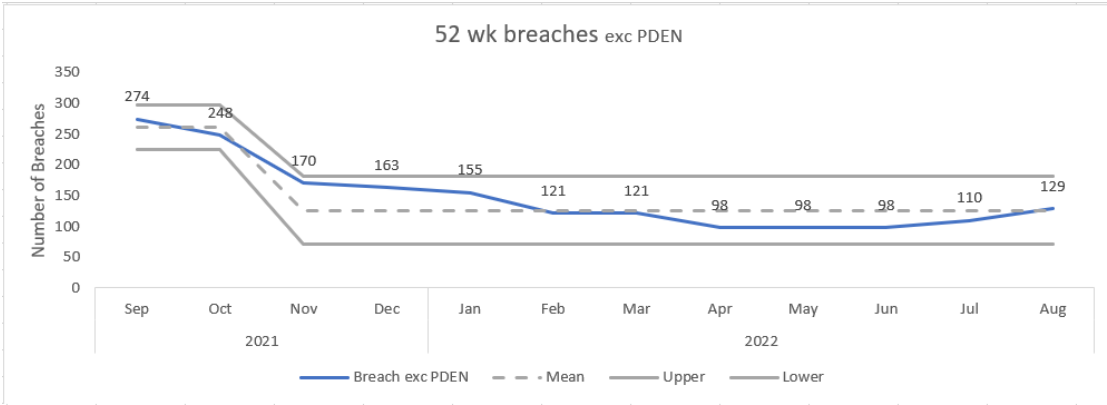
The number of patients waiting over 52 weeks for treatment is increasing.



This increase is being driven by Paediatric Dentistry:



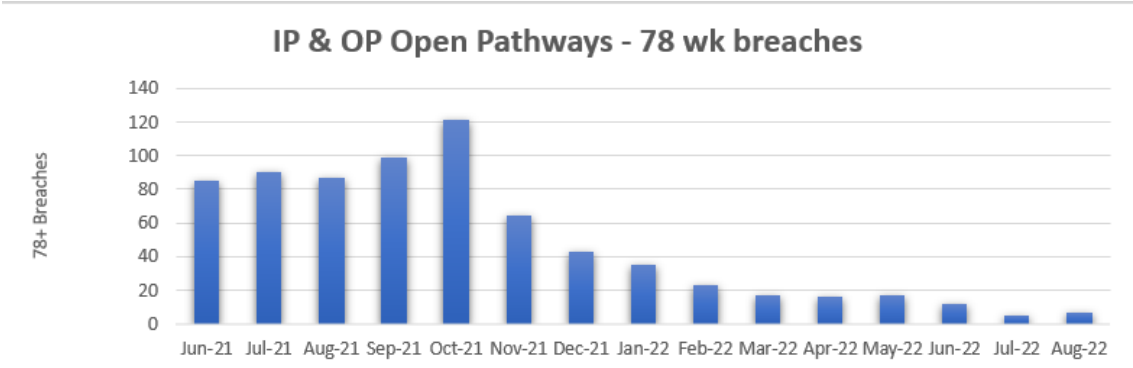
Excluding dentistry, long wait numbers have fallen relative to 2021 and have not been increasing as a trend.



We have undertaken a forward look, and this modelling projects a reduction to 300 52-week waits by December 2022

The Surgical Division has specialty level recovery plans in place to achieve 0 >52 weeks by March 2023, apart from Paediatric Dentistry and Spinal Surgery.

We have focused on reducing the number of patients waiting over 78 weeks for treatment has a clear downward trajectory, as demonstrated in the graph below. We are aiming to have zero patients waiting greater than 78 weeks by the end of October.

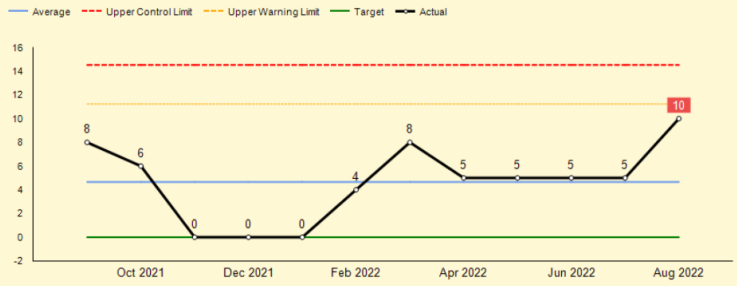


	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
78 wk breaches	85	90	87	99	121	64	43	35	23	17	16	17	12	5	7

2.3 Waiting times for community and mental health services

The number of patients in the CAMHS services waiting over 52 weeks is summarised below. The CAMHs service prioritises urgent access for urgent cases. Nonetheless, there is a real focus on eliminating long wait patients and staff recruitment is expected to suppport no patients in the CAMHS service waiting 52 weeks for treatment by the end of November 2022.

CAMHS 52wk Waiters	Aug 2022: 10	Trend: ▲	Target: 0	Comments:

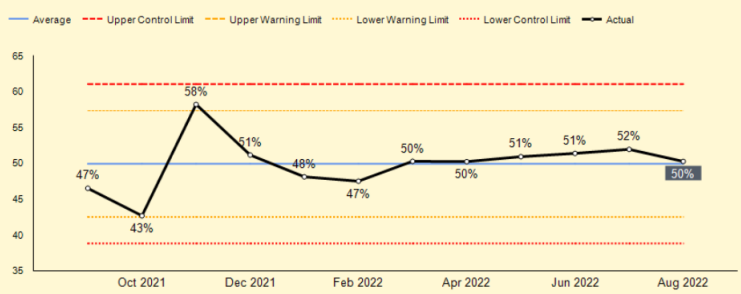


What the data tell us
There has been a significant increase in CAMHS 52 wk waiters this month as indicated in the previous executive scorecard.

Priority Actions
There are x10 52 week breaches at the end of August for specialist mental health services due to a shortfall in routine appointment capacity. This is owing to reduced available clinic capacity and an increased requirement for urgent appointments which has lengthened the routine waiting time. All 10 young people have an appointment booked in September and actions to increase capacity, including recruitment and caseload management, are ongoing.

The Autism Spectrum Disorder pathway has the biggest waiting list challenge in the Community & Mental Health Division.

ASD Incomplete Pathways Waiters within 30wks	Aug 2022: 50%	Trend: ▼	Target not set	Comments:



What the data tell us
The service is maintaining performance of a 50% average over the past 12 months.

Priority Actions
- Focus on long waiters >104 weeks - Recruitment to key posts including psychology - Go live of ND referral platform
- Review of appointment letter process to reduce administrative burden

In response an action plan is in place, as summarised below:

BRILLIANT BASICS

Summary Progress Report: ASD waiting time improvements

NHS Alder Hey Children's NHS Foundation Trust

Problem Statement	• Increase in demand for ASD assessment significantly higher than the capacity available within the service • This means that the process for ASD assessment is exceeding the agreed 30-week maximum waiting time 50% of the time and the number of children and young people waiting over 30 weeks in increasing
Goal for the improvement	• Ensure there is adequate capacity to meet the demand within a reasonable timescale • Agree a new set of metrics aligned with the new demand which is agreed by trust and partner agencies and supported by parent carer forums by 31 August 2022 • Deliver a streamlined and efficient service with no organisational led delays evidenced by reduced incidents

Actions completed

Milestone action completed	Date	Status
Increase in number of MDT appointment slots	August	Completed
Map resources to demand using PtL	August	Completed and ongoing
Communicate and gain agreement to trial digital dictation	August	Completed

Actions planned

Smart Action	Owner	Due date
Commence Digital Dictation training (dates agreed)	AH	15/09/22
Recruitment to Ass Psychology posts	AH	09/09/22
Recruitment via agency for psychology	AH	02/09/22
Revised proposal on max wait times with trajectory	RG/LC	30/09/22
Go live with ND referral platform	KH/VF	01/09/22
Review appointment types/letters to reduce admin burden	AH/I-Digital	TBC
Telephone Team review	KH/AH	30/09/22

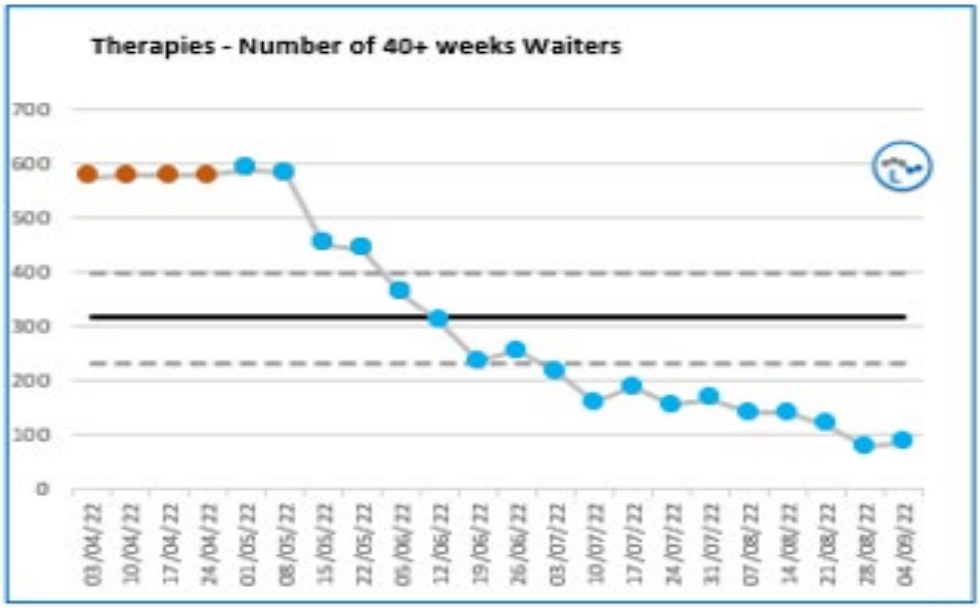
Escalation

- Support to approve revised maximum waiting time trajectory prior to sharing with Executive Team
- Digital team capacity to support improvements in appointment letters **
- Continued risk to achieving agreed maximum waiting times

Version 1.4

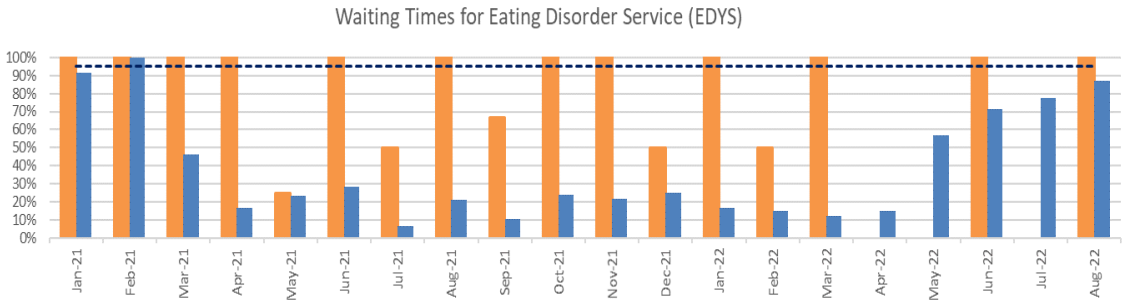
Community Therapies Waiting Times:

There has been a significant reduction in waiting times across community therapy services, however waiting times for community SALT remain a challenge. An improvement plan is in place and work across health and education to pilot a new pathway for early years referrals will commence in October 2022.



Eating Disorder waiting times

Waiting times for the Eating Disorder service have continued to reduce, and assessments are now available within 4 weeks for routine appointments, and 7 days for urgent appointments in line with national waiting time standards.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Urgent EDYS	100%	100%	100%	100%	25%	100%	50%	100%	67%	100%	100%	50%	100%	50%	100%		0%	100%	0%	100%
Routine EDYS	92%	100%	46%	17%	24%	29%	7%	21%	11%	24%	22%	25%	17%	15%	12%	15%	57%	71%	78%	87%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

2.4 Waiting list analysis

In the 6 months from January to June 2022, the RTT waiting list has increased from 19,100 to 23,730 patients. This is an increase of 24% with an additional 4,630 C&YP on the waiting list.

Overall, referrals are up 6% on pre-Covid levels.

All other things being equal, waiting times will increase in the departments with a significant growth in waiting list size and referrals. Significant support and remedial action are required to assess capacity, workforce, and productivity in the departments with the greatest challenge; and then subsequently to take action to enhance it where the data indicates this is necessary.

Aggregate level of referrals in January to June 2022 versus January to June 2019

Year	Total
2019	43,991
2022*	46,680

2022 referral change relative to 2019	6.1%

31 specialties have seen a growth in referrals totalling 6,172 referrals, offset by 18 specialties with a fall in referrals which total 3,483. The net increase is 2,689 (6.1%).

Specialties with the highest rate of growth in referrals

Department/ pathway	Number of Referrals Jan - Jun 2019	Number of Referrals Jan - Jun 2022	Variance	% Change	% Share of Trust growth in referrals
ADHD	320	1,609	1,289	403%[1]	20.88%
Autism Spectrum Disorder	928	2,047	1,119	121%[2]	18.13%
Child and Adolescent	2,069	3,050	981	47%	15.89%
Audiology	2,138	2,567	429	20%	6.95%
Fracture	1,390	1,736	346	25%	5.61%
Psychological Services	464	792	328	71%	5.31%
Respiratory Medicine	767	953	186	24%	3.01%
Paediatric Dentistry	1,087	1,250	163	15%	2.64%
Orthopaedic & Trauma	3,476	3,628	152	4%	2.46%

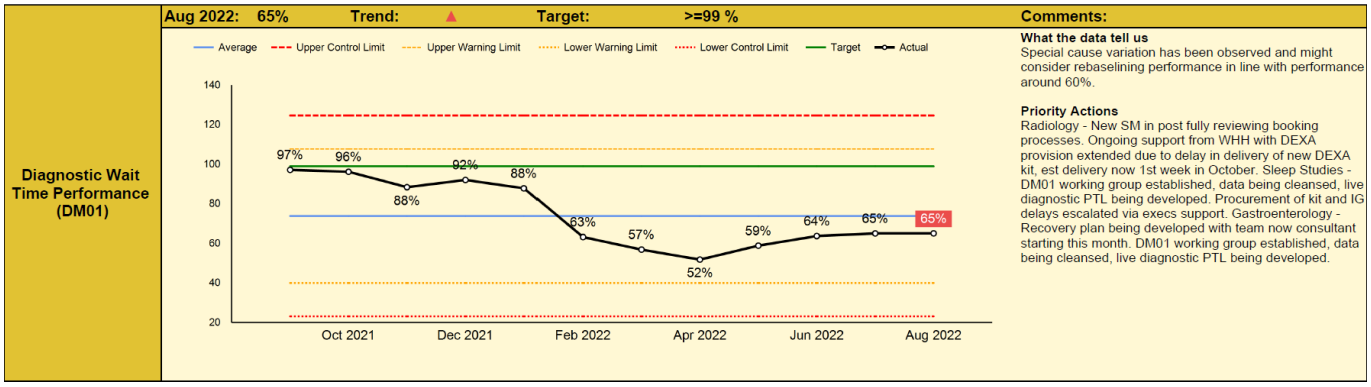
[1] In 2019 a number of referrals for ADHD and ASD came through Community Paediatrics. Therefore, this growth is over-stated as the baseline should be adjusted. Referrals to Community Paediatrics, in the same period, are down by 764. If we assume this reduction is based on the non-receipt of neuro-developmental referrals and put these referrals into the baseline of ASD and ADHD as a 50:50 split, it would mean ADHD referral growth of 989 referrals/ 309%; and ASD referral growth of 737/79%

[2] As per footnote 1.

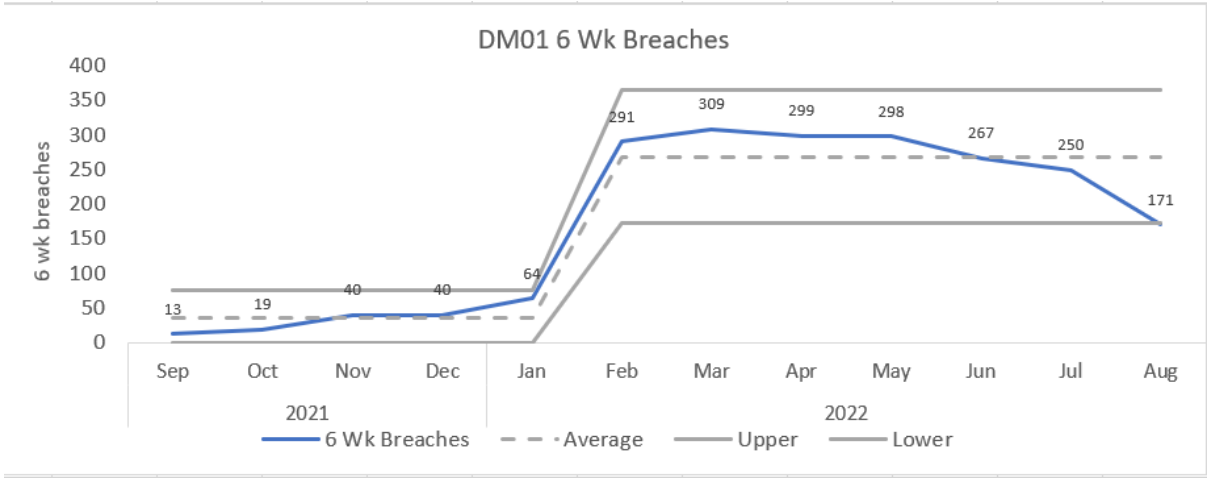
In response to the significant rise in waiting list size and referral growth the following actions will be taken forward:

- To develop the recovery transformation programme to incorporate a key workstream relating to the creation of a 'strategic capacity plan' which integrates productivity-workforce and finance.
- This should be supplemented by 13 department recovery plans.
- Establish Clinical Director ownership and leadership of the departmental recovery plans, with strong operational management ownership too, and support to each team.
- Direct transformational resources in a stratified way – prioritise support to the 13 departments requiring significant recovery and/ or capacity increases due to referral and/ or waiting list growth

3. Access to diagnostics



Whilst the proportion of patients been treated within 6 weeks is static, we have been working through the backlog of patients. We have significantly reduced the total number of patients waiting over six weeks for a diagnostic.

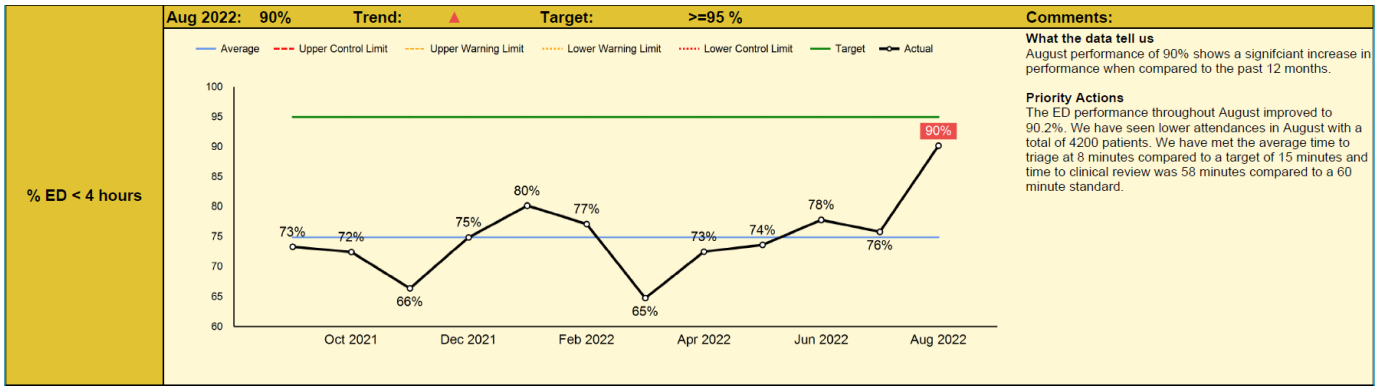


Radiology continues to perform well at 95.86% against the 99% standard. Areas of challenged performance includes:

- Urodynamics: additional capacity will come on-line in September increasing average weekly volume from 4 patients to 7 patients (+75%). The team are on track to hit 100% compliance by January 2023.
- Sleep Studies remains challenged and plans to double capacity through Home Sleep Studies. Equipment will be ordered in September and has delivery lead time of 8 weeks meaning increase in activity will commence in late November.

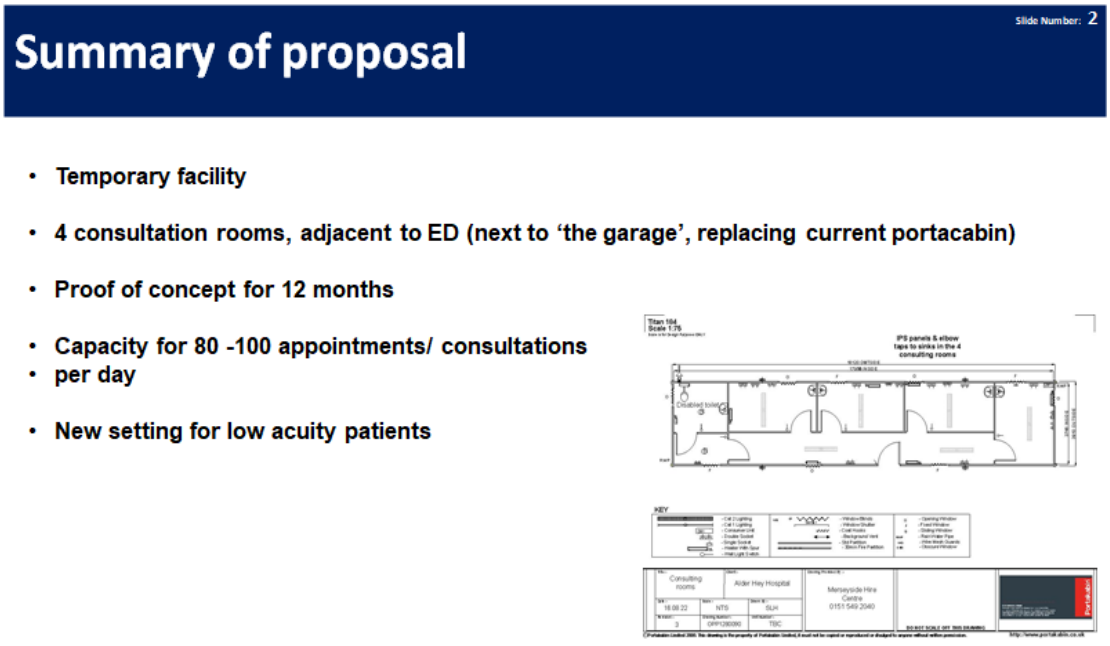
4. Emergency and urgent care admissions and attendances

4.1 Emergency Department attendances to hospital & 4-hour standard



In August, the Department achieved an improvement in complaince with the 4-hour standard. The Department continues to manage time to triage well and in month achieved the time to first clincial review averaging 58 minutes on average against a national target of 60 minutes.

In September, Executive Directors have agreed the development of an urgent care extension to be mobilised for winter. It is summarised below:



Alder Hey Autumn & Winter Emergency Response Plan

September 2022

Version 1

CONTENTS

1. INTRODUCTION

Winter planning is essential to ensure we can safely manage the rise in emergency demand for health care services associated with the increase in prevalence of a range of winter viruses. Our planning scenarios include readiness for potentially higher rates of admission for children and young people experiencing winter viruses, above previous years. Maintaining access to elective services is a key priority too, given the increase in waiting list backlogs.

Seasonal influenza and other respiratory conditions, such as bronchiolitis, disproportionately affect children and young people, adding to the complexity of increased ED presentations and seasonal variations in admissions.

This plan therefore sets out the modelling, escalation framework and capacity interventions that underpin this year's winter plan. This plan is focused on delivering outstanding safe care to C&YP through, and keeping our staff safe, through this period of higher demand.

1.1 Our goals

Our Winter Emergency Response Plan has four clear goals:

- Provide safe care
- Keep staff safe
- Deal effectively with increases and peaks in emergency demand
- Maintain elective care services

1.2 Demand modelling

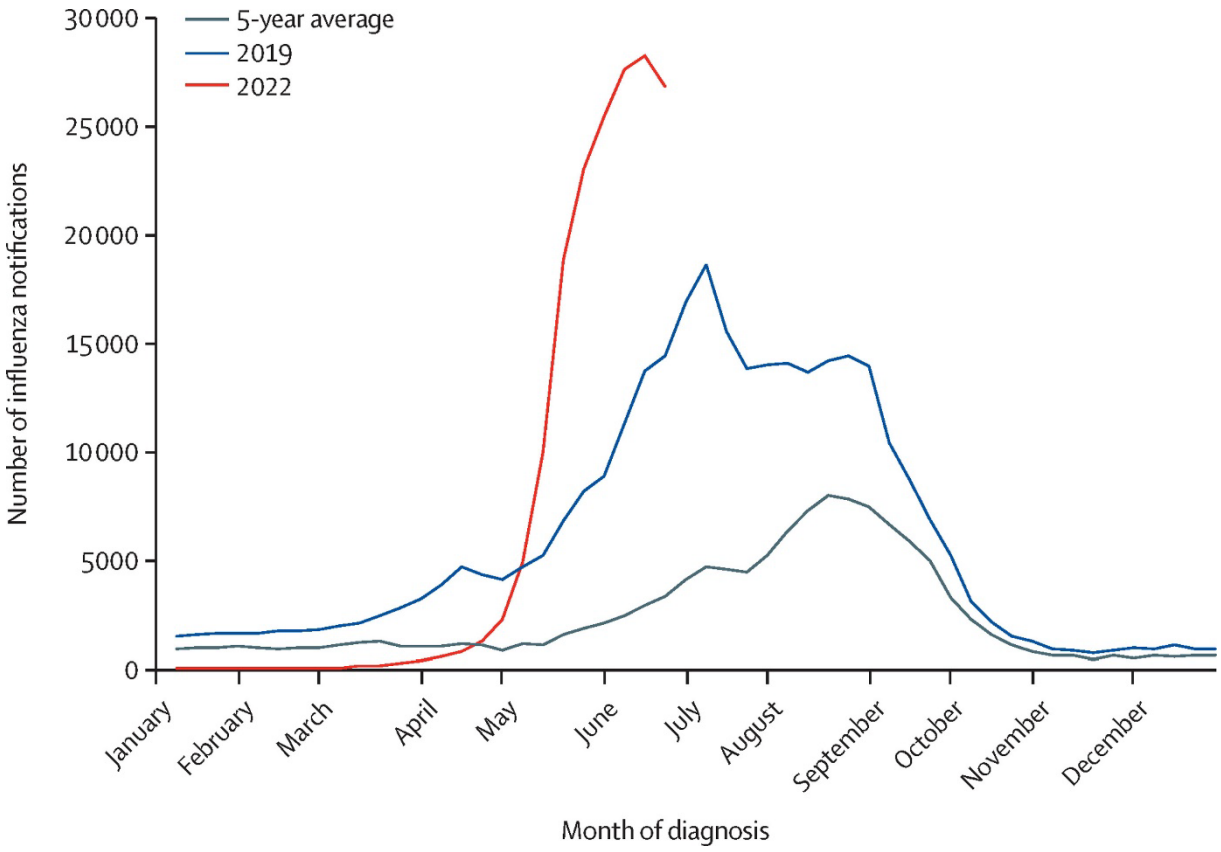
Patient Group	Winter 2019/20 (Oct- Mar)	Winter 2021/22 (Oct-Mar)	Moderate Pressure	Internal Escalation Pressure	Extreme Internal Escalation Pressure	Major Incident Pressure
ED Attendances	30,692	34,261	30,692	32,227	34,375	39,286
Total Emergency admissions (inc RSV, Flu & Covid)	7,453	7,968	7,304	7,528	7,826	8,645
Day case procedures	9873	11,332	8886	8886	4,937-7,405	0-2,468
Elective admissions	2452	2,296	2207	2207	1,226-1,839	0-613

Winter demand scenarios (against 2019-20 baseline)

			Winter 2022-23 demand scenarios			
Patient Group	**Winter 2019/20 (Oct- Mar)**	**Winter 2021/22 (Oct-Mar)**	**Low pressures**	**Moderate pressures**	**Severe pressures**	**Extreme pressures**
Total attendances Oct-March	30,689	34,371	30,689	32,223	34,371	38,295
% relative to 2019-20 baseline		**111.60%**	**100%**	**105%**	**112%**	**125%**
Mean monthly attendances	5,114	5,728	5,114	5370	5728	6382

1.3 Australian Influenza 2022

Australia this year has observed a severe influenza season with an increase in laboratory confirmed influenza from the peak in 2019 to the peak in 2022 of 64%. However, admission numbers year to date from 2022 are slightly lower than 2019.



2. ENHANCED SERVICES FOR WINTER

2.1 Urgent care

One of the key elements of our response to urgent care pressures as a Trust is to provide a dedicated facility for the streaming of suitable lower acuity patients at the Alder Hey site, to ease the pressure on our Emergency Department.

Following the initial phases of the pandemic in 2020, the emergency department at Alder Hey has seen a consistent increase of 12% in attendances compared to 19/20. Although there has been an increase in the patient acuity along with the volume, increase has come from lower acuity patients seeking care for minor ailments that could be assessed and treated in primary care facilities.

For the winter period Alder Hey plans to have an Extended Emergency Department operating on site, adjacent to our Emergency Department. The facility will operate from 8am to 10pm, 7 days a week which supports the period during which we see the highest levels of attendance from the lower acuity patients.

One important aspect of the offer from this element of urgent care services will be that appropriate patients who attend outside of the core operating hours will be offered the option of attending a booked appointment at the facility the following day rather than wait to be seen in the Emergency Department overnight.

We anticipate that between 80-100 patients a day could be streamed into the low acuity facility.

The facility will be staffed with:

- 2 General Practitioner/Advanced Care Practitioners
- 1 ENP
- 1 APNP/Senior Registrar
- 1 HCA to manage care in the waiting room

This will allow the facility to manage attenders from primary care, see and treat conditions, and low acuity secondary care presentations. The facility will operate on an appointment basis to manage demand and ensure a steady flow of patients throughout the operating times. The *Extended Emergency Department will be based adjacent to the Emergency Department to ensure that patients have ease of access both to the facility, and to the services in the main building if needed.

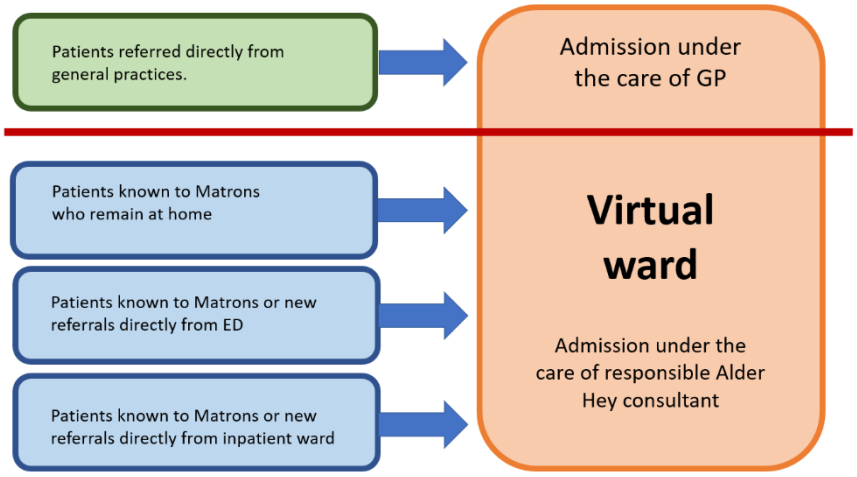
2.2 Virtual ward

Another key element of our plans for this winter period is ensuring that care is delivered as close to home as possible. This ensures that bed spaces at Alder Hey are free for those patients who need them most, and that patients who need care across the healthcare system this winter have it delivered in the most co-ordinated way possible.

There are several elements to this:

- Condition specific virtual ward that link community care teams with specialist teams on Alder Hey site
- Development of hybrid model of care offer through to extend virtual ward offer to other services
- GP referral scheme to Alder Hey Community nursing teams to avoid admission.
- CCNT staffing resilience for complex discharge caseload
- CCNT led community drop-in clinics to support admission/attendance reduction

The model is summarised below:



2.3 Enhanced Complex Discharge Team service

Having successfully received national funding to support discharge planning the following scheme will be in place until April 2023. The scheme supports the expansion of the established Complex Discharge Team. Patients previously supported by the team will receive earlier support, complex elective admissions will be supported and earlier involvement in the patient's stay in hospital. The team has supported a reduction in how long C&YP stay in hospital, and a goal has been set for further reduction in hospital stays of medical stable patients ready for discharge.

2.4 Eating disorder services

Additional health care assistant support will be in place to help care for patients admitted to hospital with an eating disorder. The Health Care Assistants will provide close support to patients, including assistance with feeding.

3. CAPACITY & ESCALATION PLAN

3.1 Trust-wide escalation framework

Measure	Green	Yellow	Amber	Red
Ambulance Handover (mean transfer time in mins)	< 15 mins	15-30 mins	31-60 mins	> 60 mins
Ed attends	160-170	>170	>190	>200
Time to initial assesment within 15 mins (% of patients)	> 95%	80%-95%	50% -79%	< 50%
Mean time to clinical assessment	< 60 minutes	60-90 minutes	90-120 minutes	>120 minutes
Mean time in department	< 4 hours	4-8 hours	8-12 hours	> 12 hours
Patient in ED over 12 hours	No patients at risk of 12 hour wait	Risk of one or more patients in next 2 hours	One or more patients waiting currently over 12 hours with plans in place	One or more patients waiting over 12 hours with no plans to resolve
ED room space occupied	< 80%	80-100%	100%	>100%
Resus occupancy	>1	1	0 but likely to be available in next 2 hours	0 and none available in next 2 hours
DTAs awaiting beds	<=10%	>10%	>20%	>40%
G&A Bed Capacity	<80%	>85%	>90%	>95%
PICU	>= 2 beds	1 bed open with at least one step down identified	1 bed with no step downs / no beds with 1 step down	No beds / No step downs
Staff absence	5- 7.5%	7.5- 10%	10- 17.5%	> 17.5%
Referrals (external admissions)	All have plans to admit	Referral waiting with no plan to admit	More than 1 with no plan to admit	More than 4 with no plan to admit
Outliers (% of inpatients)	<=2	>2-<4	>4<8	>8
Elective work	Proceeding	Under review with potential cancellations	Cancellation of routine electives	Cancellation of urgent electives

3.2 Additional hospital bed capacity

The table below demonstrates the total winter bed capacity including escalation.

Core Capacity	194
Assessment Capacity	12
Escalation bed capacity	10
Total Winter Capacity	**216**

The location of all general and acute beds is noted below:

Ward	Baseline Capacity	Escalation Beds
1c Cardiac Ward	22	
1c Neonatal Ward	9	
3a (General Surgery)	28 Sat & Sun32 Sat-Sun	4 (equates to 1 bed a day)
4a (Neurology/Orthopaedic Surgery)	32	
3c (Specialist Medicine)	28	4
4c (General Medicine)	32	
3b (Cancer Services)	13	2
4b (Complex Medicine)	21	3
Burns Ward	5	
Total bed capacity	**194/190**	**10**

From the 1 December 2022 the additional 10 beds will be staffed and open. An additional 17.34 WTE Registered Nurses are required to staff these beds safely.

Where low staffing availability or high patient acuity affects staffing levels and ratios and capacity requires review, the following process will be followed to request the closure of bed capacity: Opening and Closing of Wards Policy .

3.3 Paediatric intensive care unit and high dependency care

Our priority is to maintain, throughout the winter period, critical care services to children requiring emergency or urgent access. Therefore, our plans are centred on resilient staffing and service arrangements to provide care for paediatric patients and not adult patients. If the situation changes to a worst-case scenario either nationally or regionally, we will work with colleagues in the network and support as needed based on the balance of clinical need across all age ranges.

	Level 3 beds	Level 2 beds	Total
A. Baseline (commissioned)	21	15	36
B. Severe pressure surge	23	18	41
C. Extreme pressure surge	28	20	48

There is physical space in critical care for 43 beds. Therefore, in level 3 'severe pressures' scenario it is possible to flex capacity up to 41 bed spaces (23 ventilated ICU + 18 HDU). This would be dependent on staffing levels with additional support to ensure safe nurse to patient ratios.

In extreme pressure the additional surge beds in reserve would be opened on the Burns Unit and a business continuity plan for Burns would be enacted re-providing the service in a Surgical Ward.

The staffing for the extreme surge beds would need to come from other departments across the trust, therefore there would need to be a reduction in elective activity to facilitate this.

3.4 Staffing Escalation

Daily Safer Staffing meetings take place to review nurse staffing levels and arrangements. Where possible the trust will work to maintaining the nationally recognised levels of nursing care. There may be times when the ideal nursing levels will fall short and then the Safer Staffing chair or out of hours is the 8a ANP for the ACT team who will make decisions to balance the risk across all areas of the organisation.

At times this may lead to working to alternative ratios. The ward mangers and senior nursing team have agreed the minimum staffing requirements which are articulated through a red, amber or green staffing model and describe the skill mix required for each ward. Where an alternative staffing model is in use the nurse in charge of the relevant area will need to make

alterations to how staff work to facilitate safe care for all children and young people. This may involve, for example, the use of task allocation nursing. Core key standards relating to staffing will be maintained as referenced in the Respiratory syncytial virus 2021 preparedness Children's safer nurse staffing framework for inpatient care in acute hospitals (2021) which is supported by relevant professional bodies and trade unions.

The action card in section 8 refers to key actions required as the hospital flows through relevant escalation points. The monitoring of safer staffing is through the safer staffing meeting and is ultimately the responsibility of the Chief Nurse.

If the Trust is escalating through capacity levels staff may be required to change their working commitments to support The Emergency Department or Wards. All options will be considered via the Safer Staffing group; however, considerations would include:

- Staff in educational or training roles returning to patient facing roles
- A suspension of non-urgent meetings for clinical managers
- Requesting support from nurse specialities who are not usually based on the wards

All escalation protocols are included in the Trust Escalation Plan Trust Escalation Plan

4. PATIENT FLOW

A detailed Patient Flow Policy is in place.

The arrangements and routines for the management of patient flow (including transfers from critical care, emergency and elective admissions are managed as follows) are summarised below:

Daily Bed Meetings and Trust Status Report: Bed meetings run at 08:30 hrs, 12:00 hrs and 15:30 hrs. The aim of the daily bed meetings is to establish the predicted admission rates from an emergency and elective perspective and ensure patient flow is maintained by ensuring timely discharges and inter hospital transfers.

The bed meetings are chaired by the Acute Care Team and supported by the Hospital Manager of the Week.

Safer Staffing Huddle: This meeting runs prior to all the bed meetings to review nurse staffing across and agree the staffing models to be deployed. The meeting is chaired by a member of the trust's senior nursing team and attended by a matron from each clinical division. This staffing model confirms the staffing on each ward and advises it is safe to proceed with the established bed numbers for each ward.

Daily Forward Look/Bed Meeting: At the 15:30 Bed Meeting, the next day's staffing, elective demand, and capacity is reviewed. This may mean that actions are required to expedite discharges, prioritise TCI's, and in extreme circumstances reduce elective admissions. These actions and decisions are taken by the Hospital Manager of the Week.

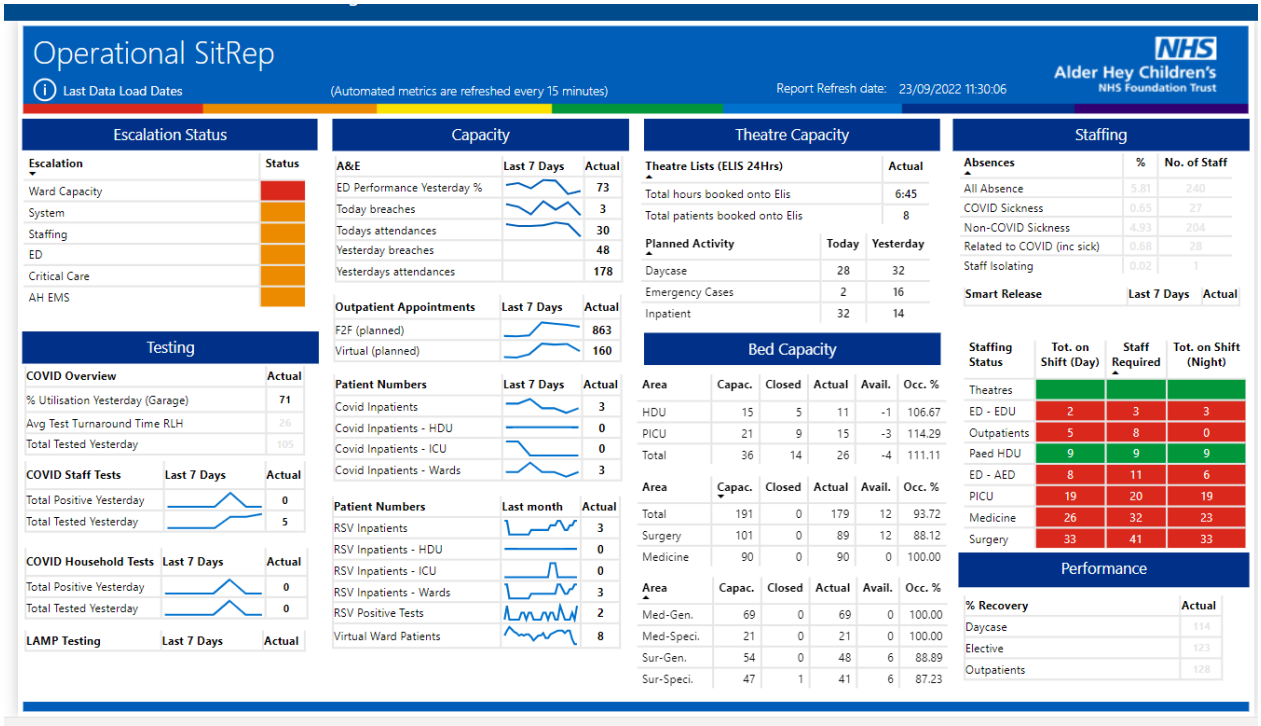
Emergency Department Safety Huddle: This daily meeting is held at 17:15 and is attended by the Senior Clinical Site Coordinator, Acute Care Team, Senior Nurse On Site, Emergency Department Nurse in Charge, the Emergency Department Consultant in Charge, and the Senior Manager On Call when required.

Weekend Planning: Every Friday by midday a detailed weekend plan will be issued by the Patient Flow Team.

Tactical Command: In periods of heightened and sustained levels of escalation the establishment of an operational Tactical Command Room will be deployed. This will run by a Tactical Commander appointed by the Chief Operating Officer.

Data monitoring:

To provide oversight of the Trust's level of escalation a Power BI app is available to capture and present the relevant information:



Management of Outliers: It will be necessary at certain times to admit suitable patients to wards where they would otherwise not be admitted due to bed availability. The Trust has agreed the following principles on the management of outliers:

- Wards will note any outlying patients at the start of each day to be reported at safer staffing meetings and identifying any needing priority for review. It is the responsibility of the ward to notify the clinical team, but Patient Flow should be informed to enable rapid escalation if required.
- Patients placed in an outlying bed will be moved to the ward originally requested at the earliest convenience with each patient being reviewed at the daily bed meetings.
- The plan to outlie, and the timescales for moving to the most appropriate ward will be explained to the patient and family on admission.
- All clinical teams will have an agreed plan to review outlying patients as part of their daily ward round structure.

This is to ensure:

- Optimisation of patient care in the most appropriate clinical setting
- Staff familiarity with specialist medications patients may be on as part of their care
- Efficiency and timeliness of ward rounds for clinical teams

5. STAFF WELLBEING, SUPPORT & ADVICE

5.1 Key Challenges

The NHS People Plan sets out the vision to create a healthy, psychologically safe, improvement-focused, compassionate, inclusive and learning culture to enable the delivery of outstanding care to our children and families. Key to the development and sustainability of such a culture are healthy, well-supported staff who feel safe, connected to each other and valued for their unique role in the delivery of care at Alder Hey.

Prior to the Covid-19 pandemic, NHS staff were reporting extremely high levels of work-related stress (44% in 2019 Staff Survey) and evidence suggests that this figure has risen as a response to the physical, psychological and social impacts of Covid-19 with 45% of staff reporting work related stress in the 2020 survey, rising to 46.8% in 2021 with 35% staff reporting burnout. The 2021 Staff Survey revealed that 54.5 per cent of respondents reported that they had come to work despite not feeling well enough to perform their duties (an 8.1 percentage point increase on 2020).

We have also seen above average levels of staff sickness (with anxiety, stress and depression being the top reported reasons for absence). Opportunities for rest and recovery have also been impacted by the pressures associated with recovery of services coupled with a decrease in public satisfaction with the NHS.

Evidence from previous disasters shows that, in addition to the initial impact, people who work in health and care are at increased risk of developing longer term mental health problems, such as post-traumatic stress disorder (PTSD), depression, anxiety and compassion fatigue. National surveys focused on mental health have shown that 59% of NHS staff are presenting with clinically significant depression, anxiety or PTSD. Estimates of PTSD in the workforce vary from 22%-40% depending on the clinical setting (Greenberg, 2021). This compares to estimates of 7-14% in veteran samples. According to the Office of National Statistics, suicides amongst those in the healthcare industry have increased by at least 20% since the pandemic began.

Figure 1 The psychological and emotional journey through disasters

We know that many of our staff are entering this winter period with depleted reserves and comprised avenues for coping.

Below sets out our current staff support offer and our plans to adapt and develop further to enable staff to cope and recover through the winter period.

5.2 Staff Support at Alder Hey

At Alder Hey, staff have access to a range of support for their health and wellbeing including the Staff Advice & Liaison Service (SALS) (incorporating the Alder Centre staff counselling service), and Occupational Health services, Staff in medical specialties and Critical Care can also access support from Clinical Health Psychology services via Clinical Psychologists embedded in teams.

Through the Covid-19 pandemic, support for staff health and wellbeing has been amongst the top strategic priorities and has led to the rapid development and growth of the Staff Advice and Liaison Service, offering an open door, easy access, rapid response listening service to all staff. The service is an open access support for all staff struggling with any issues related to home or work and also provides early intervention and prevention via psychoeducational events and initiatives across the Trust. It aims to prevent staff difficulties from worsening by addressing issues in the moment and finding the right solution in the right place at the right time.

There is also a focus in SALS on systemic intervention, including team support following debriefs and training, and contribution to the development of a culture which challenges the stigma associated with help seeking in the healthcare and support services. Considerable focus is also given to supporting staff to both transition to and navigate through services, providing a "safety net" of support during what can be extremely difficult journeys and processes.

There have been 5000 contacts to the service between March 2020 and August 2022 (Figure 2). Staff have presented with a wide range of issues and concerns and have been either signposted to appropriate services (with or without ongoing liaison from SALS), given advice and guidance or brief intervention where appropriate. As of August 2022, SALS have seen approximately 30% of the organisation for support.

Feedback gathered has been overwhelmingly positive not only in terms of individual outcomes but also in terms of its impact on the wider organisational view of wellbeing. The service promotes the message "it's OK not be OK" which has been helpful in promoting access to support and in reducing the stigma associated with help seeking and expressed vulnerability in health care professionals. The service has also attracted regional and national interest as a best practice model including funding to undertake research into its efficacy, effectiveness, replicability and scalability to benefit the wider health service and further develop the staff support evidence base.

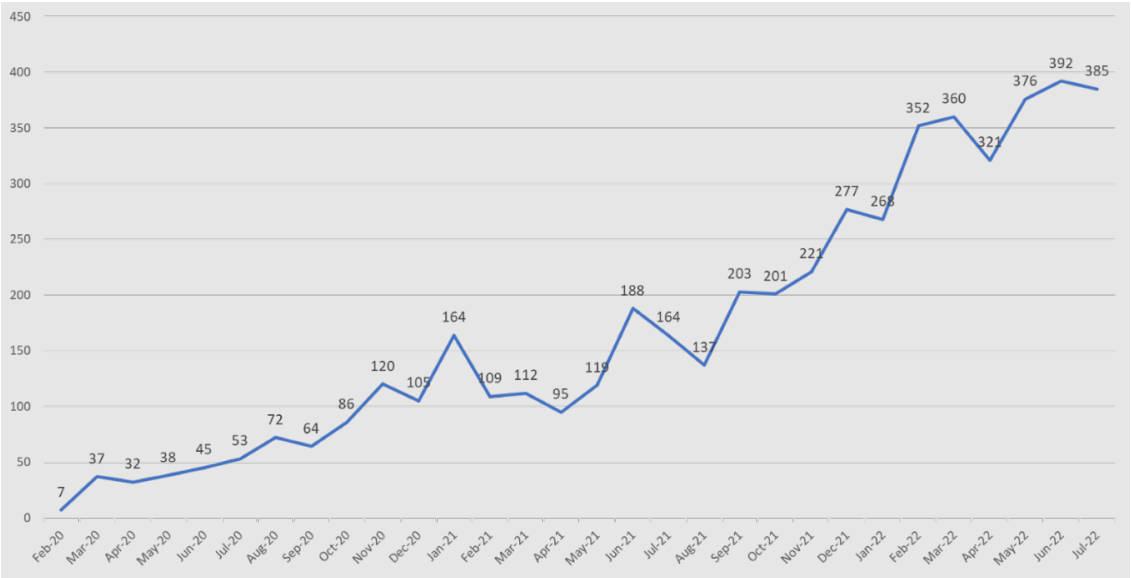


Figure 2 Number of SALS Contacts by month

5.3 An organisational health and wellbeing approach

Our approach to staff support has been and continues to be closely informed by the developing evidence base around what works for whom and in what context. What we know clearly, and what our staff routinely tell us, is that wellbeing interventions alone are not sufficient without interventions that more closely address hygiene factors affecting the daily experience of work and working relationships.

Given the evidence and our learning to date through SALS and other support mechanisms in the organisation, we take an organisational health and wellbeing approach based on the HSE Organisational Health & Wellbeing Framework (see below).

At Alder Hey, we are using this checklist to understand what is most needed for our staff and what key aspects of health and wellbeing support will be needed through the coming

months. Progress against each of the domains is monitored via the bi-monthly Health and Wellbeing Steering Group.

Environment
• Appropriate and accessible rest spaces • Access to appropriate PPE at all times • Accessible water points • Accessible and nutritious food • Accessible toilet and changing facilities • Access to tea and coffee via offer to night staff on the mezzanine • Member of SALS team formally seconded a day a week to ensure that staff wellbeing prioritised in all staff moves via the 'Great Space to Work' project
Managers and leaders
• Wellbeing Guardian role embedded into organisation through chairing the People and Wellbeing Committee and working alongside the SALS and HR/OD function to review and embed the 9 Wellbeing Guardian principles. • Health and Wellbeing conversations promoted and encouraged as part of regular cycle of PDR conversations • Internal general and wellbeing coaching & mentoring offer to all leaders and managers • Strong Foundations leadership programme for all leaders and managers • Support/guidance and help to support Managers and Leaders with undertaking Stress Risk assessments as well as additional accredited training being offered within the organisation • Development of Menopause Policy and education for Managers and Leaders to be able to understand and support those staff experiencing peri menopause and menopause • Financial wellbeing information to support staff collated and available through Share-Point, intranet or via SALS • Partnership work with the Citizens Advice Bureau for any member of staff that works in Alder Hey to be able to access CAB in a targeted streamlined approach • For those teams who were unable to access Staff Survey Results and proceed with Big Conversations, additional temperature check survey being developed to support teams moving forward • Development of training focused on 'recognising and responding to mental health needs in ourselves and others' for all managers accessible via Moodle.
• Fulfilment at Work
• Health & Wellbeing Steering Group active • Improved PDR process • EDI Steering Group developed

• BAME staff network active and Disability network in development
Relationships
• Development of wellbeing champions (SALS Pals) and opportunities to access proactive wellbeing activities and support • Focussed support for teams (dynamics, civility, interpersonal conflict, psychological safety, resilience, reflective spaces, Team Time, team coaching and development, leadership support) • Psychological Safety & Civility training in development to be offered to all staff • Freedom to Speak Up Guardian visible and accessible • OD/SALS offering interventions to teams to support better working together and increased team effectiveness
Improving personal health and wellbeing
• Internal staff support available via Staff Advice and Liaison service with signposting where appropriate to Alder Centre. • Signposting to available HWB offers at local (e.g Occupational Health,), ICS, regional (e.g. Mental Health Hubs) and national level (e.g access to financial support) • Active promotion of Cheshire & Merseyside Resilience Hub • Emotional support that is culturally sensitive and meets the diverse needs of the workforce • Support for targeted groups including monthly menopause support group, listening sessions for staff with seen and unseen disabilities, listening events and resilience training for doctors in training, volunteers' network • Understanding and support available for our staff to respond to current Financial climate via SALS • Access for all Staff to Citizens Advice Bureau via Partnership working with Citizens Advice Bureau • Increased opportunities to improve physical health for staff via Physical Health workstream (reporting to HWB Steering Group) • Offer of wellbeing coaching to staff where indicated as useful to support them working within the Trust
Professional wellbeing support
• Annual leave policy ensures staff have regular time off for rest • Revised induction process for all new staff and learners with HWB conversation offered to all new starters to support overall health and wellbeing and to boost retention • Increased focus on sickness absence and proactive approaches • Staff are encouraged to participate in health and wellbeing training and development opportunities, for individuals and for teams, and given the time to do so • Mental Health awareness training developed to be offered to all leaders and managers via Moodle from September 2022

- Ground TRUTH bulletin in development as mechanism for sharing staff feedback from the ground and to complement other formal feedback mechanisms already in place (e.g. Quarterly People Pulse, Annual Staff Survey)
- Effective and compassionate risk assessments for at risk staff (such as those who are clinically extremely vulnerable)
- Effective and compassionate stress risk assessments and focus on developing internal capacity to deliver these assessments
- Regular whole organisation Schwartz Rounds (once per month) & Team Time established in ED & ICU and more facilitators in training to build capacity to deliver this programme
- Support following distressing incidents/interactions e.g. through debriefs and support from SALS and development of a new debriefing pathway
- Increased focus on staff safety and wellbeing as part of new Patient Safety Strategy
- Development of joint working model with Brilliant Basics to align OD and Quality Improvement work to enhance organisational focus on high performing teams
- Stress Risk Assessment Project evaluating stress risk assessments in practice, alongside the roll out of training across the Trust for managers.

Data insights

- Engaging with staff to understand other support needed – through increased visibility of senior teams, Ground TRUTH debriefs, Quarterly People Pulse feedback and annual Staff Survey
- Focus on improving measurement of impact of HWB interventions via service evaluation and other targeted research projects

6. Vaccinating our Staff

All staff working in the NHS have a personal, moral and professional responsibility to ensure they do all they can to reduce the spread and transmission of respiratory viruses to those who are vulnerable, and to protect themselves from winter viruses through vaccination.

It is of paramount importance to vaccinate those at risk of contracting and spreading flu in order to protect as much of the population as possible and minimise further impact on the NHS and social care.

In 2022-23 there are a range of vaccination activities which will help in the reduction of the spread of viruses.

Key points of the campaign this year:

- All health and social care staff will be offered a 4th COVID vaccination booster starting 19th September 2022 and this will boost immunity against COVID19
- The flu vaccine will be offered to all school age children and young people through the school vaccination programme, opportunistic vaccination will be available in the OPD on site at AH.
- There is a requirement that 100% of AH staff ae offered the flu vaccination. This will also include other members of the workforce, for example students and staff within our partner organisations
- Staf will be able to book their flu vaccine the first two weeks in October, with roving vaccinators in place in November
- Increased numbers of peer vaccinators across the trust
- Live dashboard that will inform the flu steering group of registration status, completion of vaccination and areas of low uptake to be targeted in order to drive focus to the local delivery of the vaccinations
- Divisionally led plans and named leads to support direct and local communications to maximise uptake

7. DEPARTMENTAL ESCALATION PLANS

Departmental escalation plans (including for Paediatric Intensive Care Unit and the Emergency Department) are contained in the Trust Escalation Plan.

Alder Hey Children's
NHS Foundation Trust

Integrated Performance Report August 2022

Alder Hey Children's NHS
NHS Foundation Trust

Contents

000053

How Did We Do?

Executive Summary **Month: August** **Year: 2022**

Alder Hey Children's NHS

Delivery of Outstanding Care

Safe

99% of incidents reported refer to near miss, no harm or minor harm demonstrating a good incident reporting culture in the organisation.

IPC data continues to meet targets with the exception of 2 covid cases which is reflective of the increased prevalence within the community.

Highlight

- No category 3 or 4 pressure ulcers
- No Never Events

Challenges

- Challenge in obtaining the sepsis data; the senior team within the medicine division are working with the sepsis lead to address this.

The Best People Doing their Best Work

Caring

Significant improvement in the ED FFT scores with 92% of families who would recommend the Trust; this is the highest score in ED for a year and is testament to the hard work by the ED team and Division. There has also been an improvement in mental health with 96% of families responding positively. Inpatient feedback remains high at 96%

There has been a significant and sustained improvement in responsiveness to complaints and pals, with complaints responses 100% compliant in month and PALS increased to 82% within 5 days.

Highlight

- Significant improvements in pals and complaints responsiveness.
- Improvement towards target for ED FFT

Challenges

- Families do not always know their planned date of discharge

Delivery of Outstanding Care

Effective

Our ED department in August was strong, with 90% of patients seen within 4 hours and median clinician wait <60 minutes. It should be noted that this co-related to a period with much lower volume of attendances, and underlying pressures still remain while actions from ED Programme Board are being progressed.

Highlight

- Clinical Triage in ED is consistently under 15minutes month on month

Challenges

- Small number of patients still >12 hours in the department (2 in August)

Delivery of Outstanding Care

Responsive

The number of patients waiting >52week for OP & IP care has risen again and now stands at 405. In part this is due to the focus on reducing the very longest waits (>60 weeks). The trajectory for future months shows that >52ww will reduce by end of September, and working towards 300 by end of December (ie 25% reduction over the next 4 months). Paediatric Dentistry remains the most challenged speciality, with 2/3rds of these longest waiters.

Diagnostic waits are stable at 66% compliance against the 6 week standard, but with additional capacity to come online for Urodynamics and Sleep in September this will lead to an upward trajectory in future months.

Highlight

- 100% compliance with Cancer standards

Challenges

- Number of patients waiting >52weeks, particularly in Dentistry

The Best People Doing their Best Work

Well Led

Finance

For the month of August (Month 45), the Trust is reporting a deficit of £0.2m which is in line plan.
For the year to date position, the Trust is reporting a deficit of £1.2m which is in line with the planned position at this stage of the year as we expect CIP schemes to be further progressed later into the financial year.
The main drivers for the YTD position continue to include CIP non-delivery related to earlier months of the year, continued pay and non-pay cost pressures in Junior Doctors, clinical supplies, and drugs, offset in part with slippage in investments. There have also been some non-recurrent benefits supporting the financial position.
Cash in the bank at the end of August was £80.5m.
The overall capital expenditure for the year to date is £2.5m which is slightly ahead of plan, but forecast to be back in line with plan by the end of the financial year.

Sickness

Sickness figures continue to flex across the Trust. As at 6th September the overall figure is 6.25%. The national changes to the COVID scheme are now in place and COVID related absence has reduced to 0.68%, however long COVID remains an area of concern and focus for the Trust.

Staff Turnover

Staff turnover continues to be a concern for the organisation, with some areas and specialist roles being a particular concern and areas of risk for the workforce and for service delivery. These are being supported on a case by case basis by colleagues in HR. As at 6th September turnover is sitting at 13.76%, a slight increase of 0.13% from the previous month. A project to review the exit strategy is underway, which will improve the quality and depth of information available

Highlight

Challenges

- Significant challenge with regards to the CIP requirement in year which is £17m in total
- Significant challenge to achieve the £4.6m control total surplus plan by the end of the financial year particularly with the forecasted pressures associated with energy costs which are expected to rise beyond October
- Achievement of ERF threshold

Game Changing Research and Innovation

Research and Development

New Models of Working

- Appointment of hybrid consultant role with Division of Medicine - Consultant in Paediatric Research and Urgent Care
- Appointment of GP Primary Care Clinician to Clinical Research Facility
- Alder Hey Charity Funding award to trial new working practices for research in ED

Research Activity:

- 178 research studies currently open
- 335 patients recruited to research studies (3353 in 22/23)

Research Assurance:

- GCP training compliance – 94%
- Research SOP compliance – 88%

Highlight

- Continued high level of research participant recruitment

Challenges

- Capacity to setup and deliver new research activity

Alder Hey Children's
NHS Foundation Trust

Part 1 - Executive Scorecard

My Alder Hey 000058
Executive Scorecard

Dashboard refreshed 20 Sep 2022 20:02 (although individual metrics may be older)

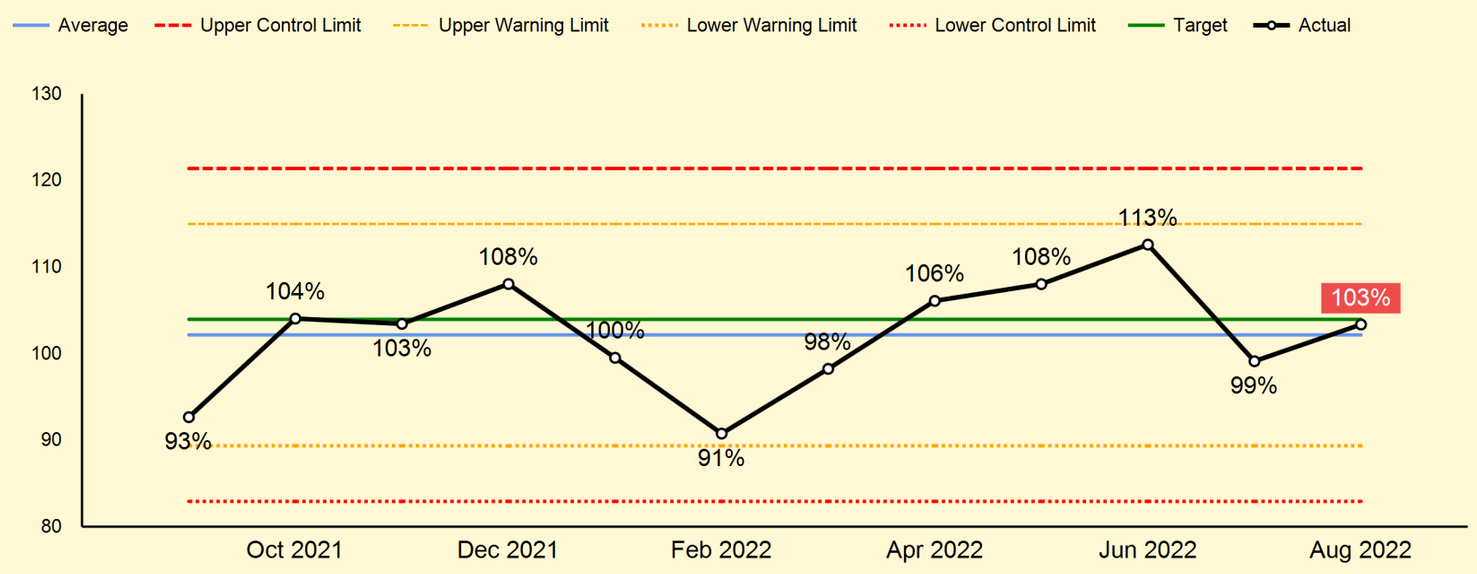
BRILLIANT BASICS

NHS Alder Hey Children NHS Foundation Tru

Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

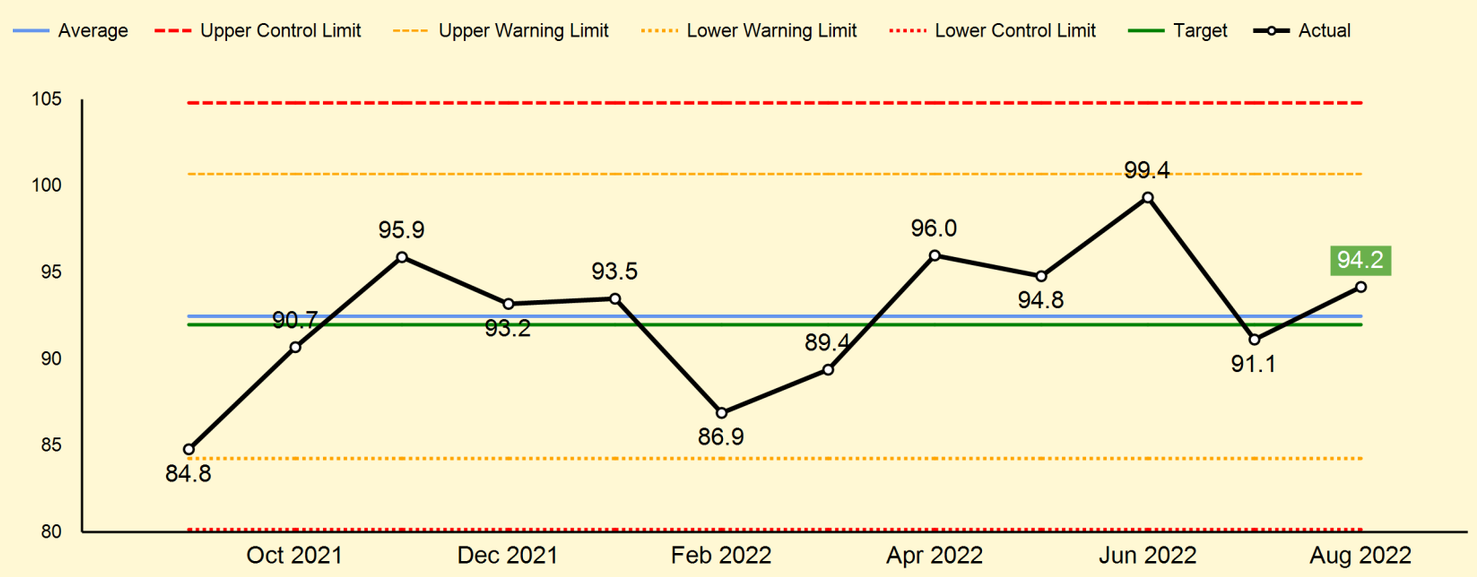
Metric	Recovery			
104% Activity - Elective and Daycase	**Aug 2022: 103%**	**Trend: ▲**	**Target: >=104 %**	**Comments:**



What the data tell us
Performance of 103% is in line with 12 month average but is below the 104% target.

Priority Actions
Continue to focus on delivery of high value specialties (Spinal, Neurosurgery and Cardiac) to achieve ERF. Theatre Improvement Board to deliver productivity benefits with focus on Day Case volume; optimise number of theatre sessions per week to return to >104% in September.

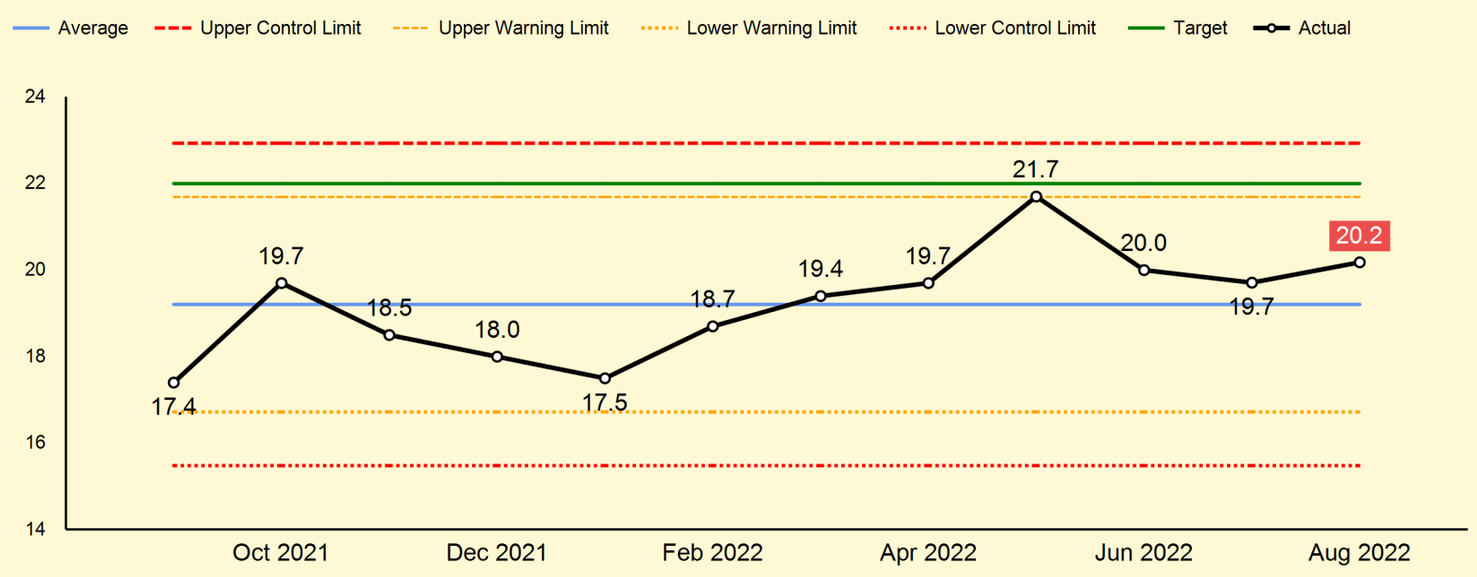
Average Patients per Working Day (DC Spells)	**Aug 2022: 94.2**	**Trend: ▲**	**Target: >=92**	**Comments:**



What the data tell us
August performance of 94.2 is above the target of 92 and exhibits natural variation.

Priority Actions
Theatre Improvement Board to deliver productivity benefits with focus on Day Case volumes, to consistently achieve the target month on month.

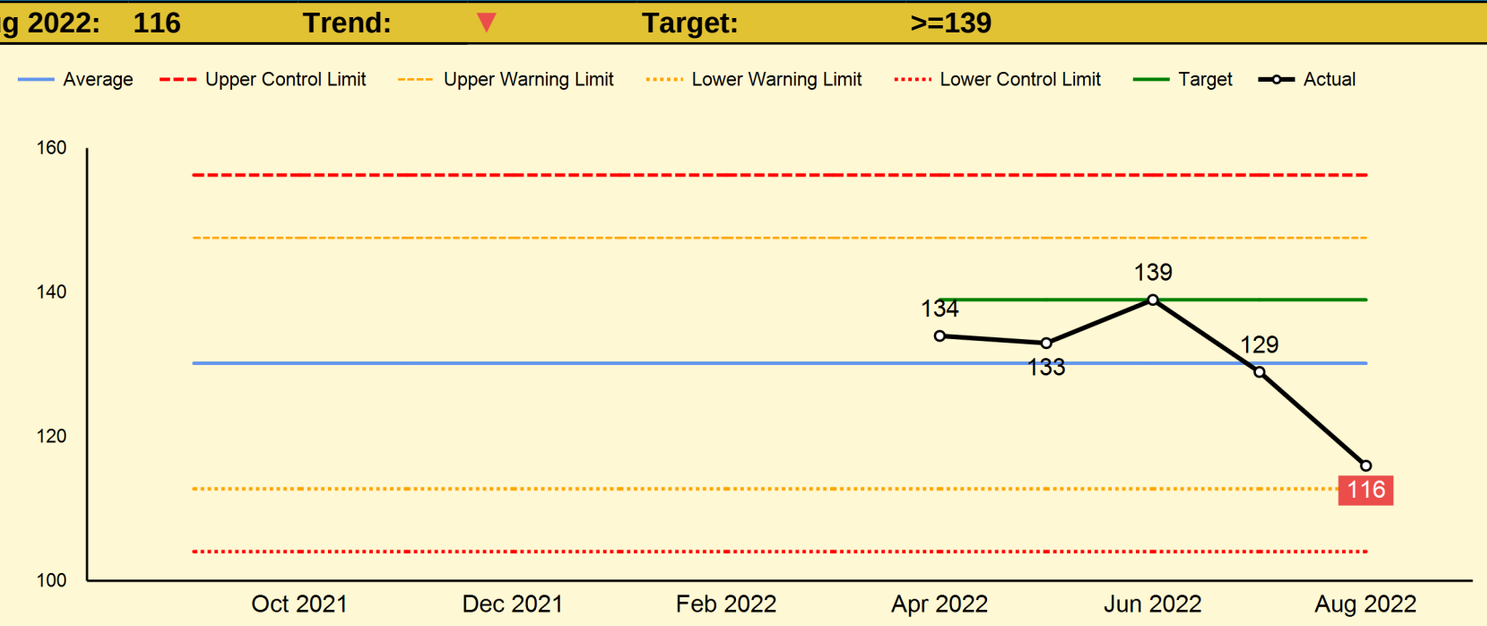
Average patients per working day (Elective Spells)	**Aug 2022: 20.2**	**Trend: ▲**	**Target: >=22**	**Comments:**



What the data tell us
6 points above the average is positive, 1 more point would indicate special cause variation and potential consistent improvement. This shows significant progress towards the target of 22.

Priority Actions
Optimise number of theatre sessions per week to increase volume of Elective patients per working day.

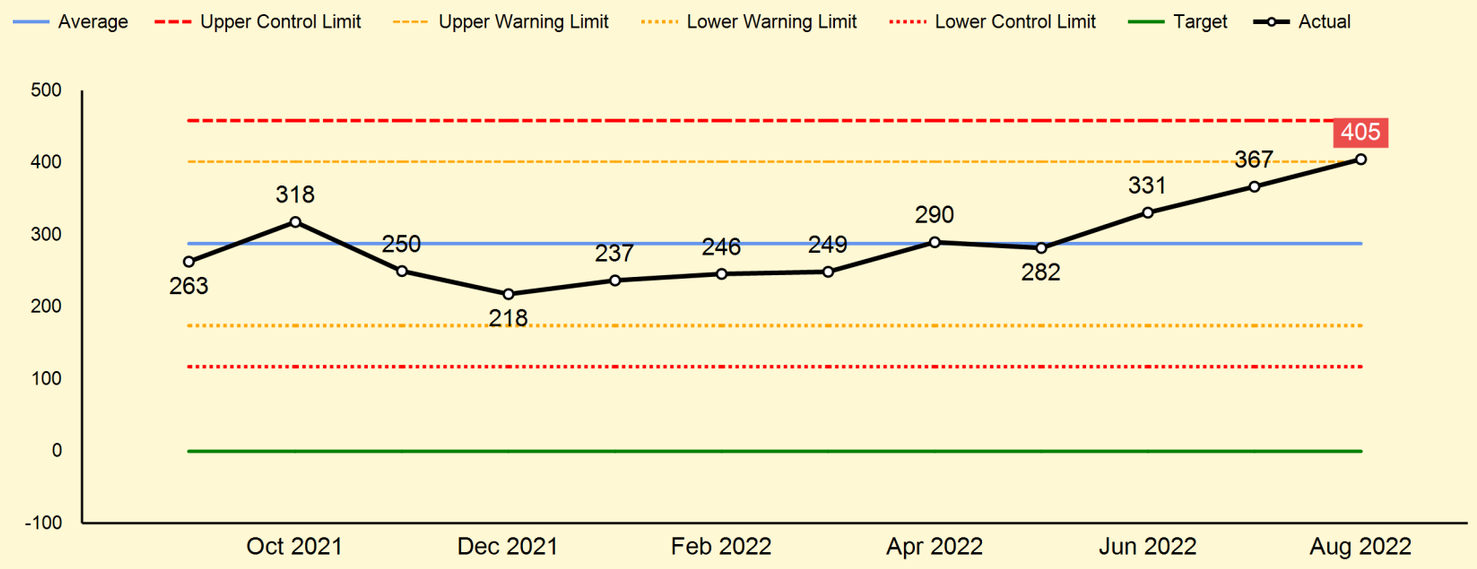
Theatre Sessions per week	**Aug 2022: 116**	**Trend: ▼**	**Target: >=139**	**Comments:**



What the data tell us
There was a significant dip in Theatre sessions per week in August.

Priority Actions
The reduction in sessions against target was largely due to sickness absence in theatres and anaesthetics. A number of theatre sessions were covered using overtime & WLIs however this was challenging due to the time of the year and the reduction in staff who are willing to undertake extra activity at current WLI rates. The division are forecasting a return to full capacity throughout September with plans in place to deliver funded sessions.

Number of Patients > 52 ww	**Aug 2022: 405**	**Trend: ▲**	**Target: 0**	**Comments:**



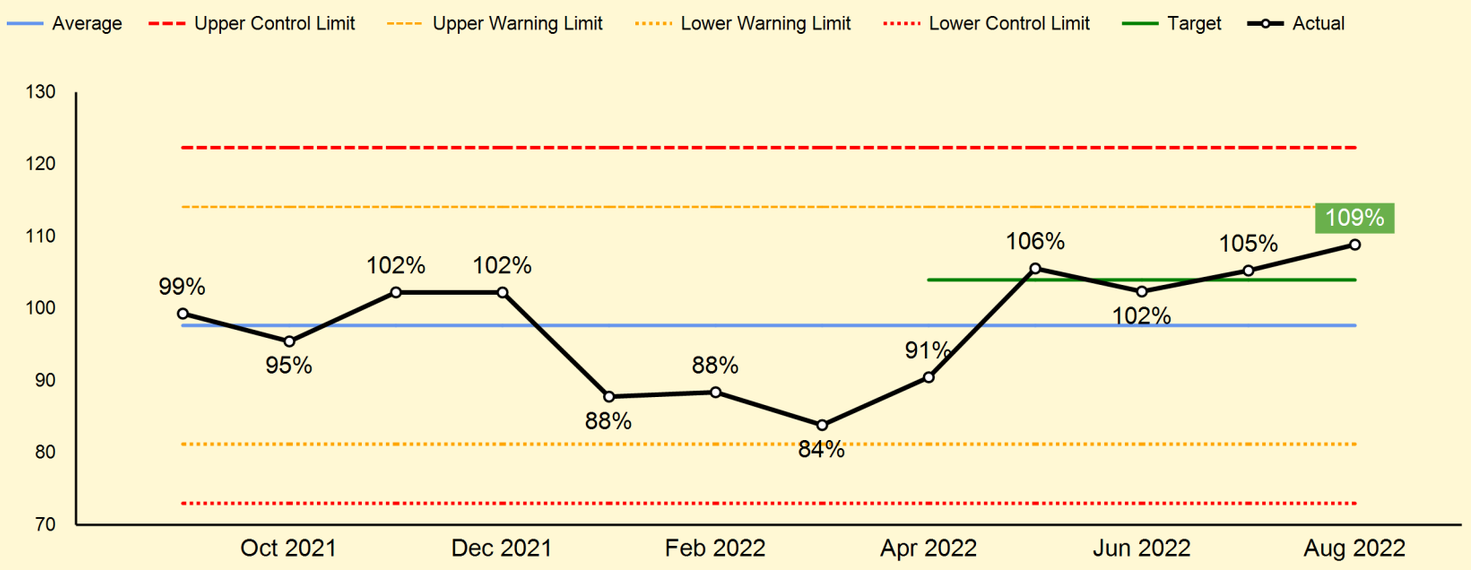
What the data tell us
The number of patients waiting > 52 weeks rose again this month to 405 which enters the 'Upper Warning Limit'. Another 2 months of increase would demonstrate special cause variation.

Priority Actions
Focus has been on reducing the very longest waiting times, with most specialities to achieve a maximum of 60 weeks by end of Sept. Focus on eliminating >52ww for OP remains a priority and forward look trajectory indicates improvement by end of Sept back to below 400, and reduce further to 300 >52ww by end of December

000059

Outpatient New + Outpatient Procedure 104%

Aug 2022: 109% **Trend:** ▲ **Target: >=104 %**



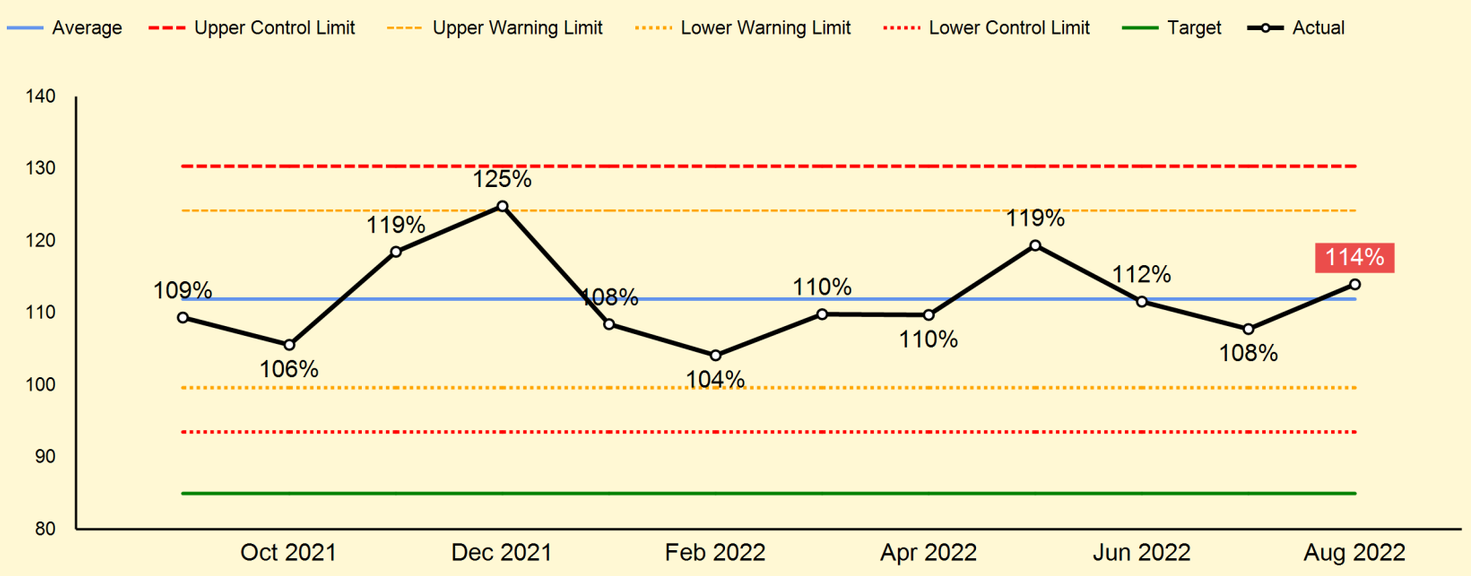
Comments:

What the data tell us
August performance of 109% meets the 104% target, but is consistent with trend and demonstrates natural variation

Priority Actions
WNB BAU process for designated specialities to commence in Oct 22. New Project lead for WNB AI roll out commenced in Sept 22.

Outpatient Follow Up 85%

Aug 2022: 114% **Trend:** ▲ **Target: <=85 %**



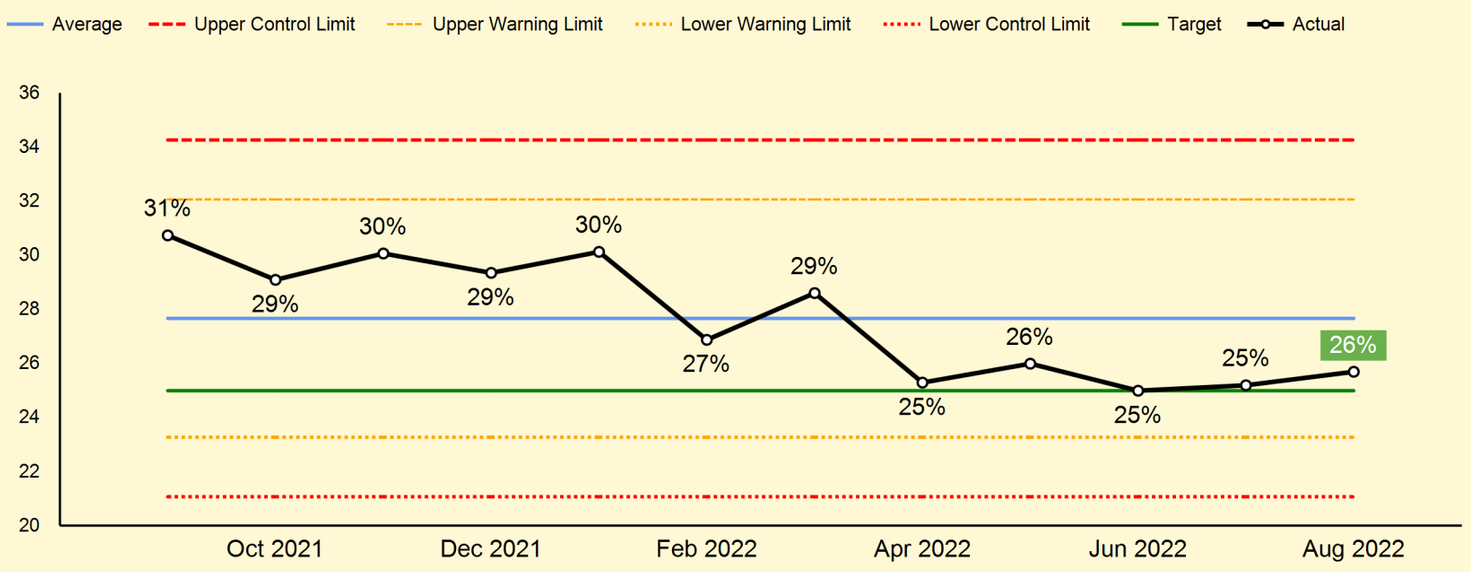
Comments:

What the data tell us
August performance of 114% exhibits natural variation and continues to consistently fail the target of 85%.

Priority Actions
- 16 specialities will be live by end of Sept. - New PIFU dashboard available - Training video to be completed week ending 22 Sept.

Virtual Outpatient 25%

Aug 2022: 26% **Trend:** ▲ **Target: >=25 %**



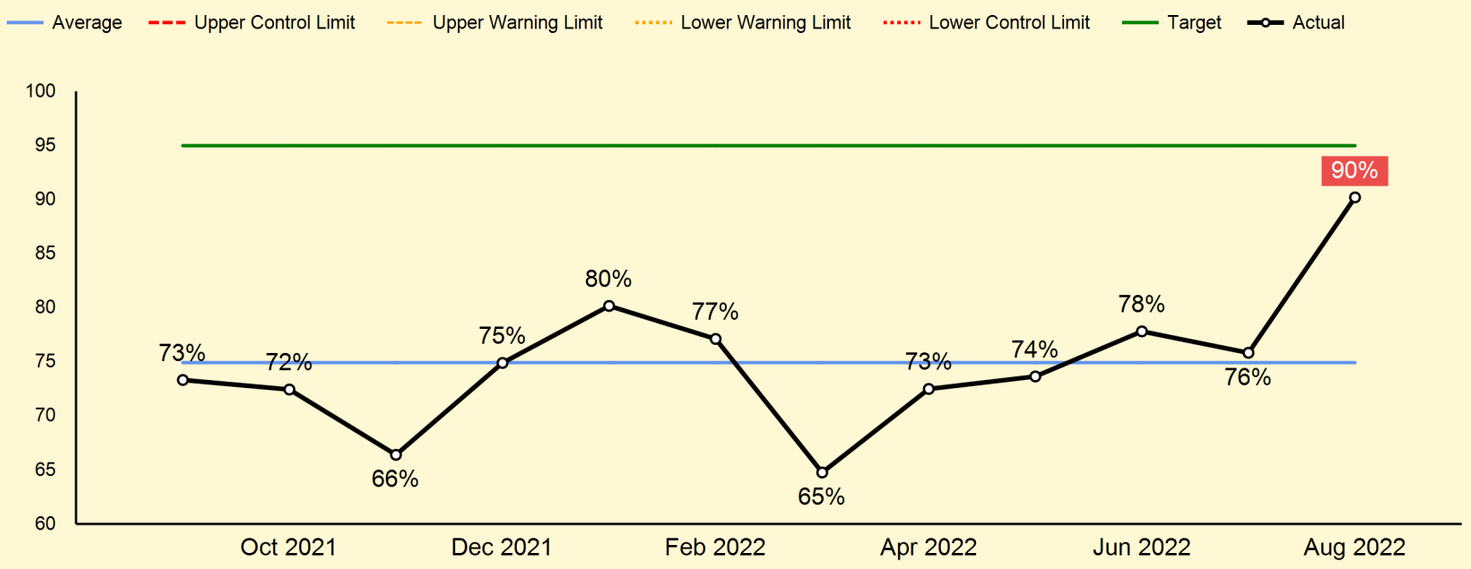
Comments:

What the data tell us
Virtual Outpatients consistently hits the 25% targets as it did in August. Special cause variation was observed in months leading up to the new finacial year showing reduction in performance. Performance now appears to have plateaued around 25%.

Priority Actions
Surgical specialties are not achieving 25% virtual due to standardised pathways post-op. Surgical division is to review bespoke divisional target that would be less than 25% and assess the impact on other divisions to achieve 25% as an organisation.

% ED < 4 hours

Aug 2022: 90% **Trend:** ▲ **Target: >=95 %**



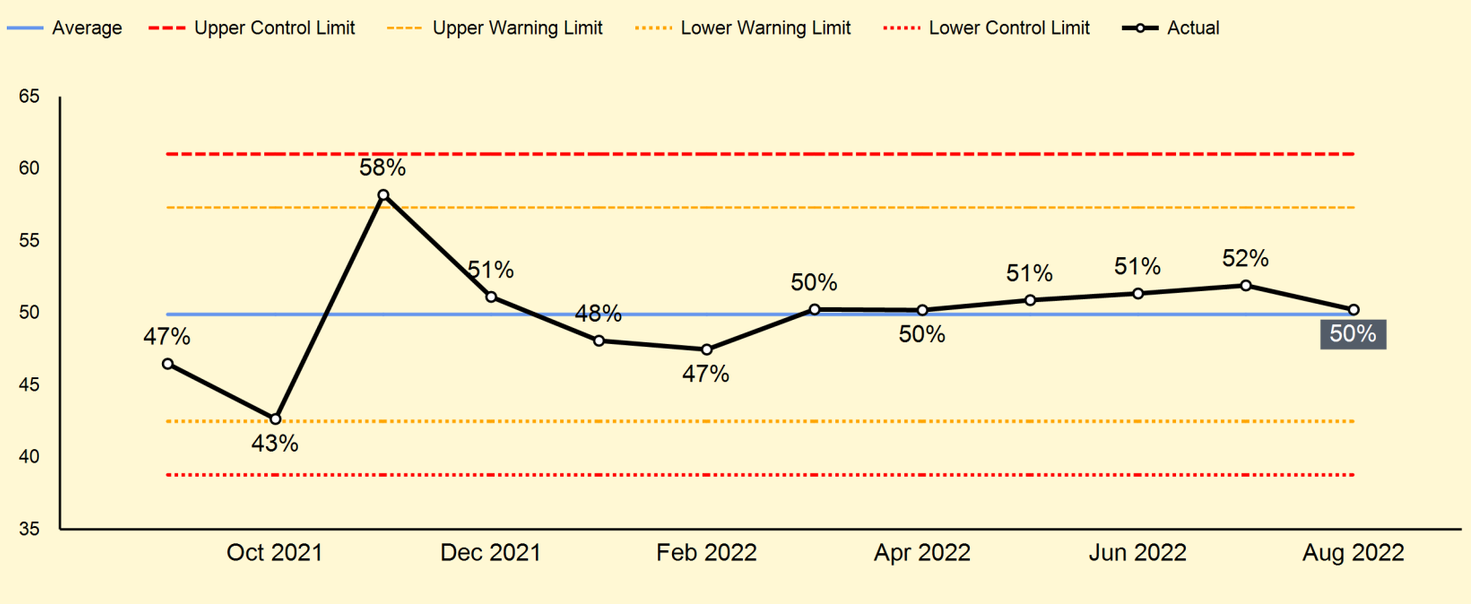
Comments:

What the data tell us
August performance of 90% shows a signifciant increase in performance when compared to the past 12 months.

Priority Actions
The ED performance throughout August improved to 90.2%. We have seen lower attendances in August with a total of 4200 patients. We have met the average time to triage at 8 minutes compared to a target of 15 minutes and time to clinical review was 58 minutes compared to a 60 minute standard.

ASD Incomplete Pathways Waiters within 30wks

Aug 2022: 50% **Trend:** ▼ **Target not set**



Comments:

What the data tell us
The service is maintaining performance of a 50% average over the past 12 months.

Priority Actions
- Focus on long waiters >104 weeks - Recruitment to key posts including psychology - Go live of ND referral platform - Review of appointment letter process to reduce administrative burden

CAMHS 52wk Waiters

Aug 2022: 10 **Trend:** ▲ **Target: 0**

Comments:

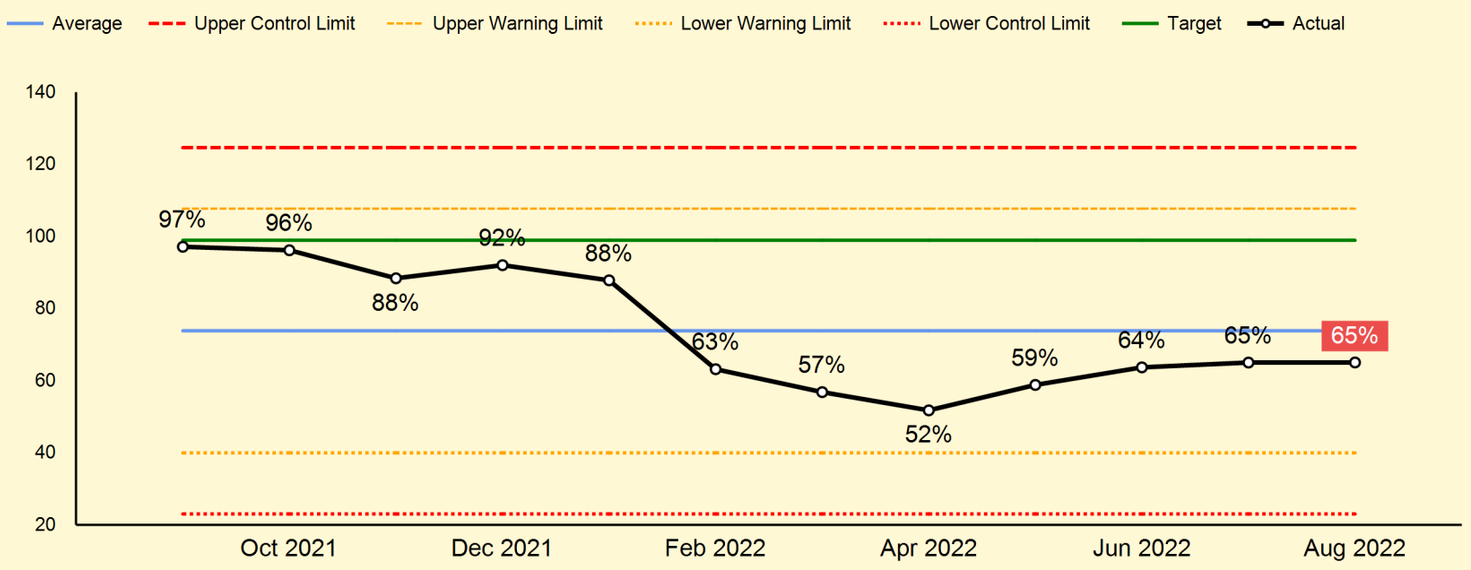
What the data tell us
There has been a significant increase in CAMHS 52 wk waiters this month as indicated in the previous executive scorecard.

Priority Actions
There are x10 52 week breaches at the end of August for specialist mental health services due to a shortfall in routine appointment capacity. This is owing to reduced available clinic capacity and an increased requirement for urgent appointments which has lengthened the routine waiting time. All 10 young people have an appointment booked in September and actions to increase capacity, including recruitment and caseload management, are ongoing.

000060

Diagnostic Wait Time Performance (DM01)

Aug 2022: 65% **Trend: ▲** **Target: >=99 %**



Comments:

What the data tell us
Special cause variation has been observed and might consider rebaselining performance in line with performance around 60%.

Priority Actions
Radiology - New SM in post fully reviewing booking processes. Ongoing support from WHH with DEXA provision extended due to delay in delivery of new DEXA kit, est delivery now 1st week in October. Sleep Studies - DM01 working group established, data being cleansed, live diagnostic PTL being developed. Procurement of kit and IG delays escalated via execs support. Gastroenterology - Recovery plan being developed with team now consultant starting this month. DM01 working group established, data being cleansed, live diagnostic PTL being developed.

My Alder Hey 000061
Executive Scorecard

Dashboard refreshed 20 Sep 2022 20:02 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children NHS Foundation Tru

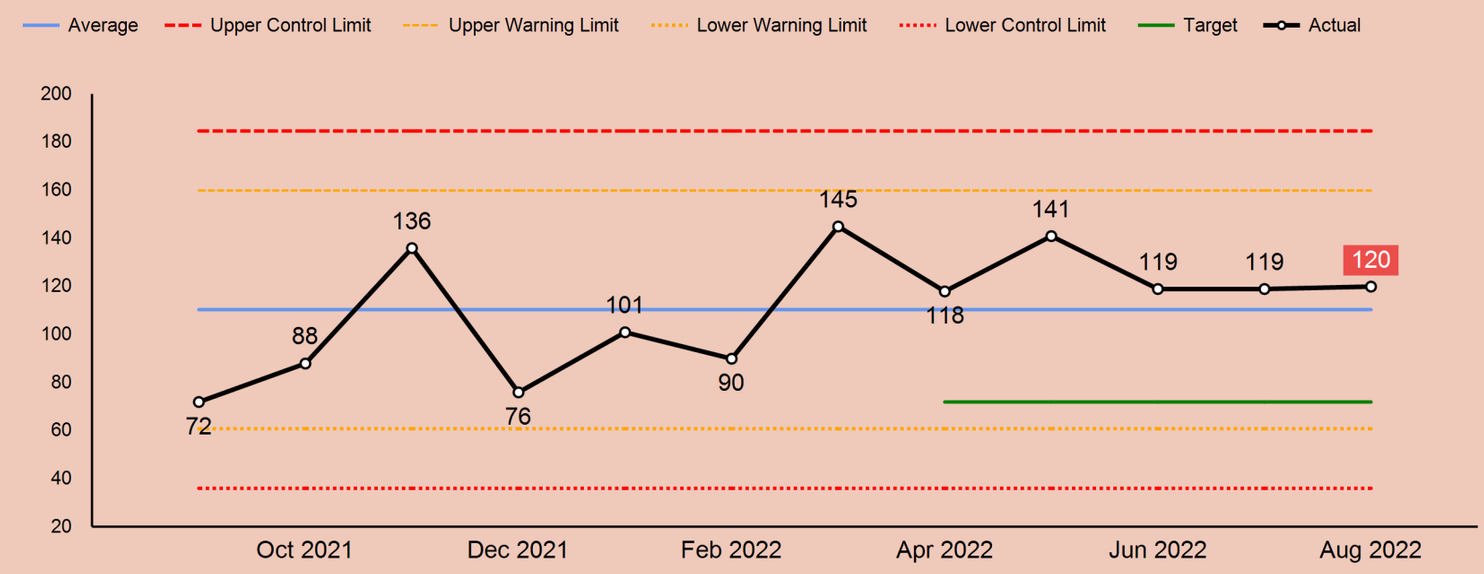
Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

Metric	Outstanding Safety

25% Reduction in Harms

Aug 2022: 120 **Trend:** ▲ **Target: <=72**



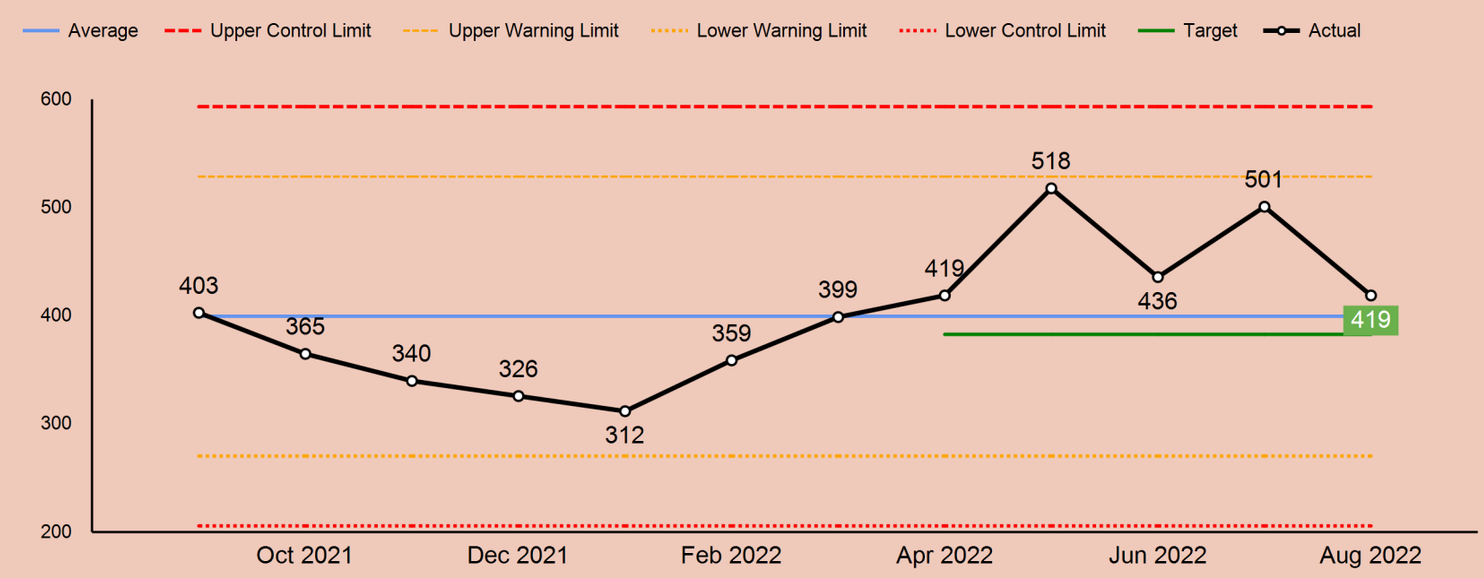
Comments:

What the data tell us
In August there were 119 incidents of minor harm and above. Special cause variation was observed between March-May (2 out of 3 consecutive points near the outer third limits) and another month above the average would highlight more special cause variation (7 or more points above or below the average). This is looking like an increased trend of incidents with minor harm and above.

Priority Actions
The Trust has started work in transitioning over to the new national Patient Safety Incident Response Framework. This will include how we manage incidents, share learning and help us to reduce harms

Incidents rated "No Harm & Near Miss"

Aug 2022: 419 **Trend:** ▼ **Target: >=383**



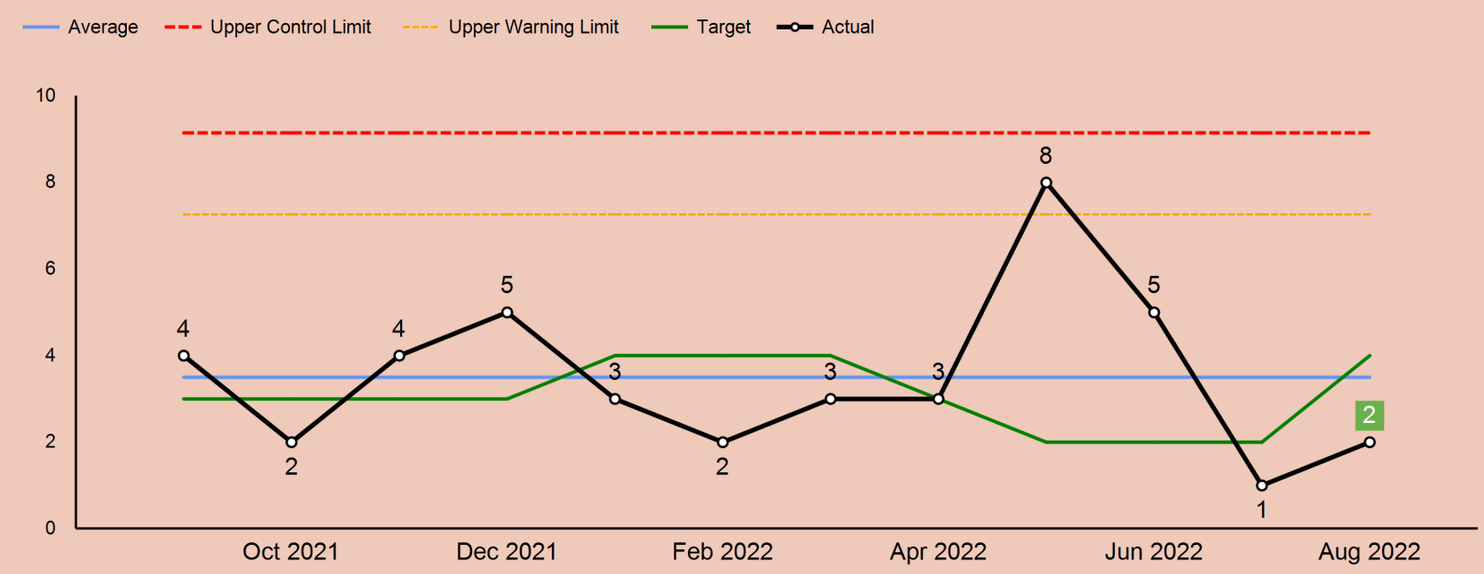
Comments:

What the data tell us
Special cause variation was observed in May-July (2 out of 3 consecutive points near the outer third limits) which indicates an increase to number of incidents recorded in line with the target.

Priority Actions
Reporting continues at the weekly safety meeting where the details of significant incidents continue to be discussed.

Medications with minor harm or above Incidents

Aug 2022: 2 **Trend:** ▲ **Target: <=4**



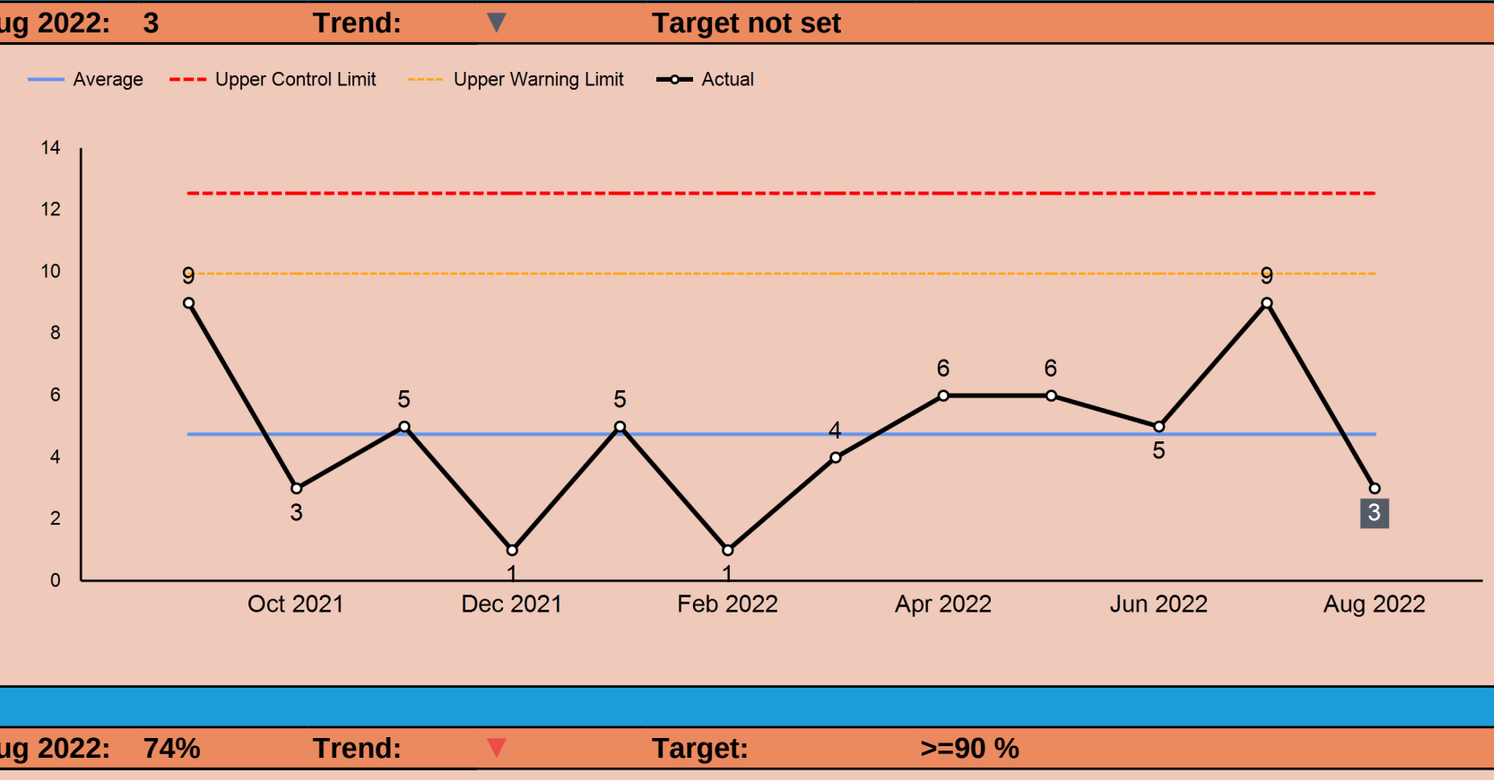
Comments:

What the data tell us
We continue to see a trend of low numbers each month. August showed 2 incidents which is in line with the target.

Priority Actions
As part of the quality improvement project a new medication incident dashboard has been developed with BI support. Having live and detailed data readily available helps us to better understand and improve our medication error performance.

Pressure Ulcers G2-4

Aug 2022: 3 **Trend:** ▼ **Target not set**



Comments:

What the data tell us
We continue to see a trend of low numbers each month. August showed 3 pressure ulcers which continues to demonstrate natural variation.

Priority Actions
We await the findings of the device related grade 2 pressure ulcers

Sepsis < 60 mins (ED only)

Aug 2022: 74% **Trend:** ▼ **Target: >=90 %**

Comments:

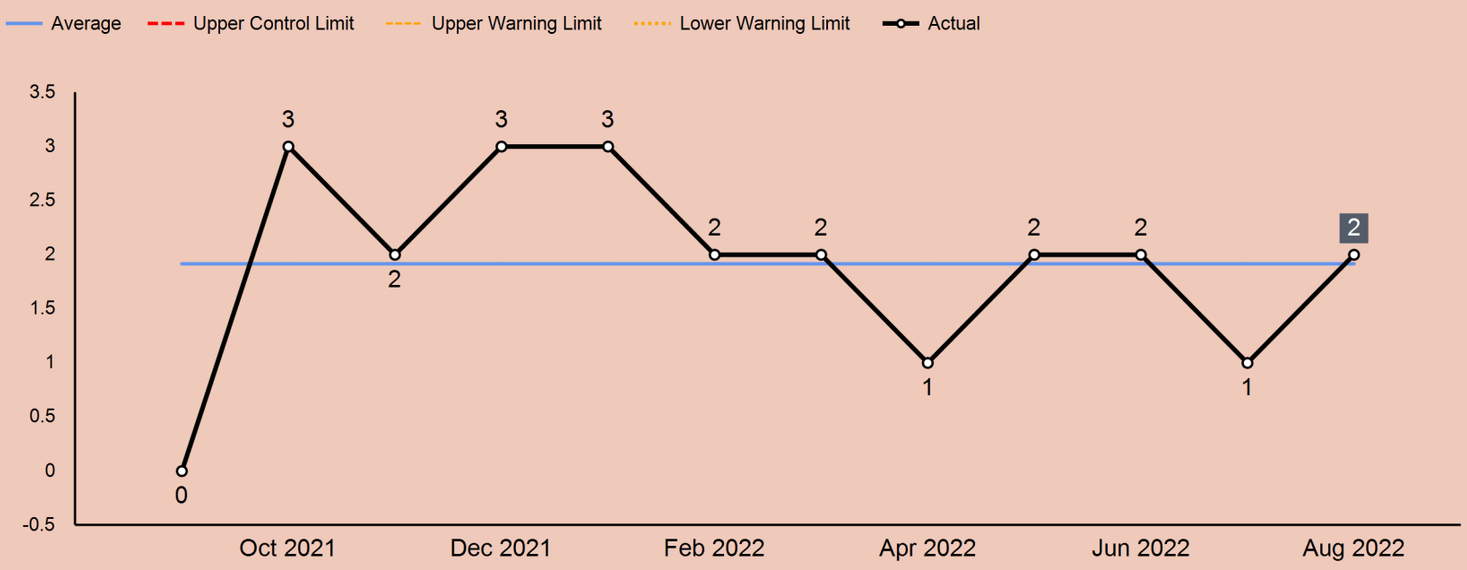
What the data tell us
Performance in August of 74% is below the 90% target, and demonstrates natural variation.

Priority Actions
Further work is required by the Divisions, BI and the Sepsis nurse to ensure in patient sepsis data is available for reporting

000062

Cardiac Arrests

Aug 2022: 2 **Trend:** ▲ **Target not set**



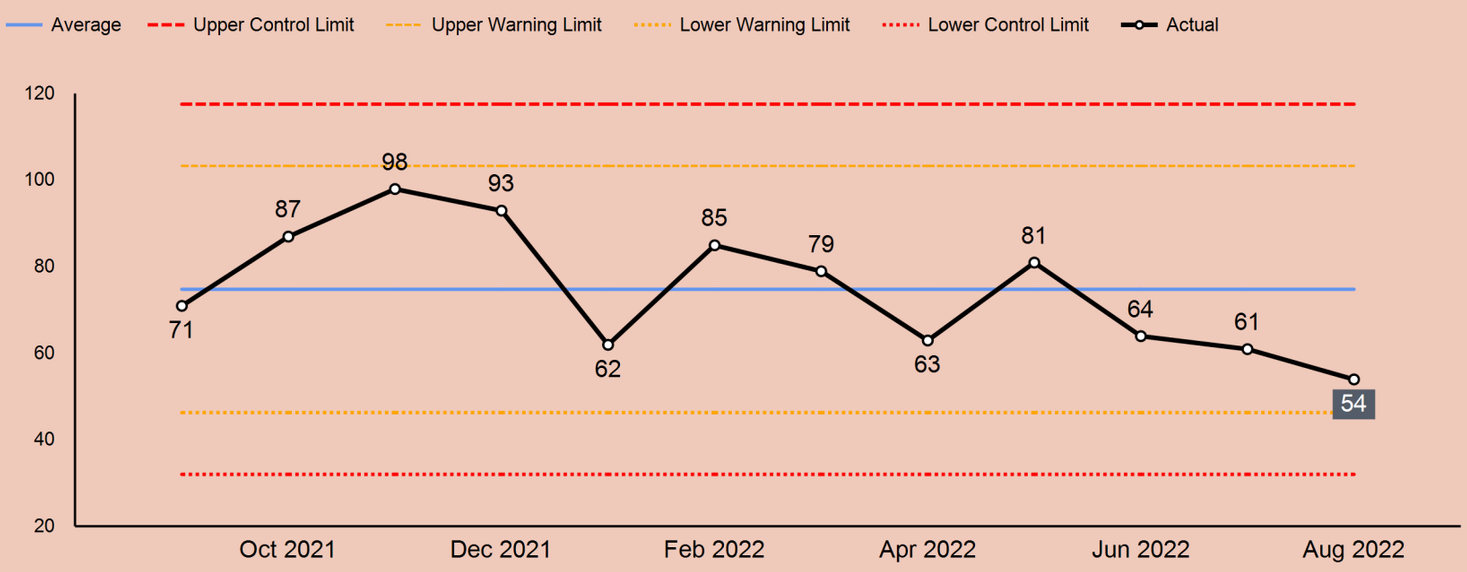
Comments:

What the data tell us
Low numbers each month, demonstrating natural variation.

Priority Actions
No actions required

Unplanned Admission to HDU/PICU

Aug 2022: 54 **Trend:** ▼ **Target not set**



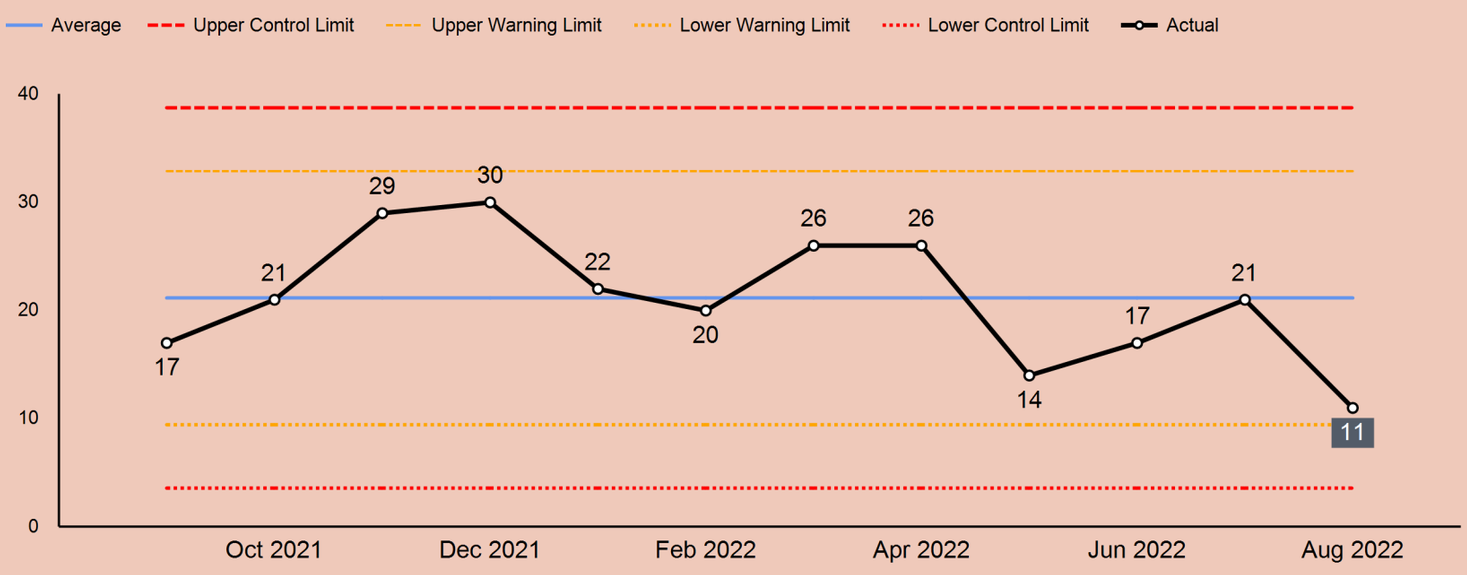
Comments:

What the data tell us

Priority Actions
The deteriorating patient steering group continues to meet to address staff awareness/ training and the wider implications of the deteriorating patient pathway

Step Downs out of CC out of hours (7pm-7am)

Aug 2022: 11 **Trend:** ▼ **Target not set**



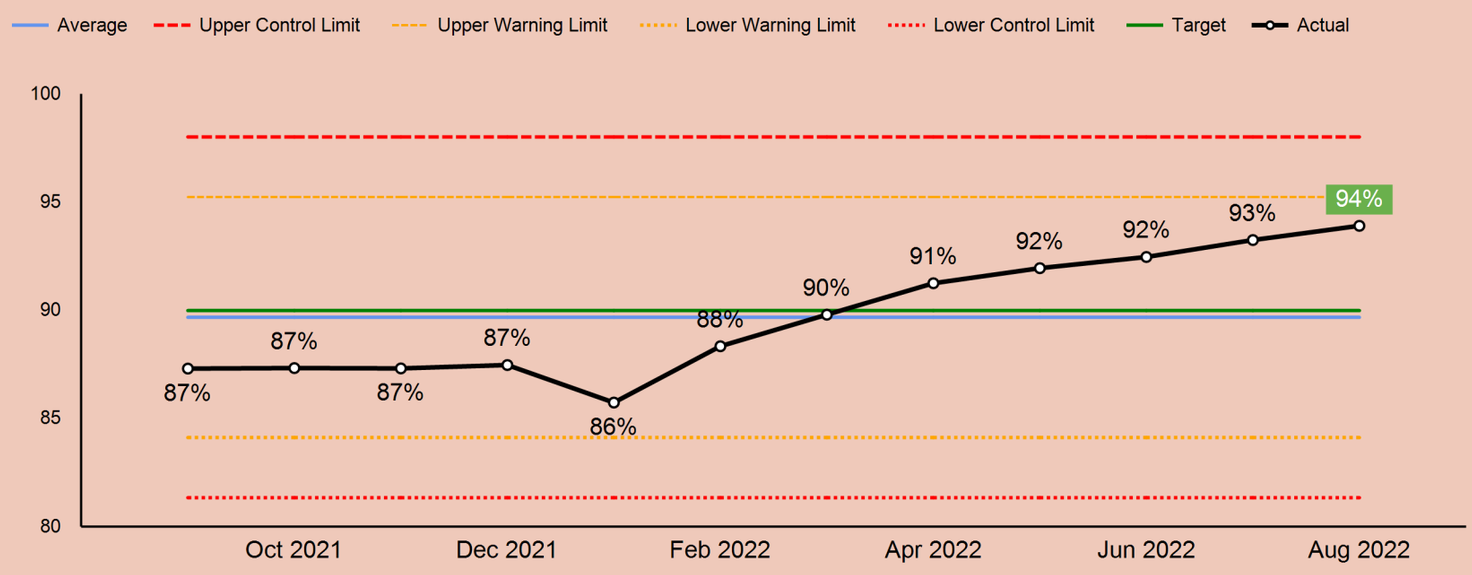
Comments:

What the data tell us
August had 11 step downs out of CC out of hours, this is below the average for the last 12 months and demonstrates natural variation.

Priority Actions
No actions required

% Mandatory Training Compliance

Aug 2022: 94% **Trend:** ▲ **Target:** **>=90 %**



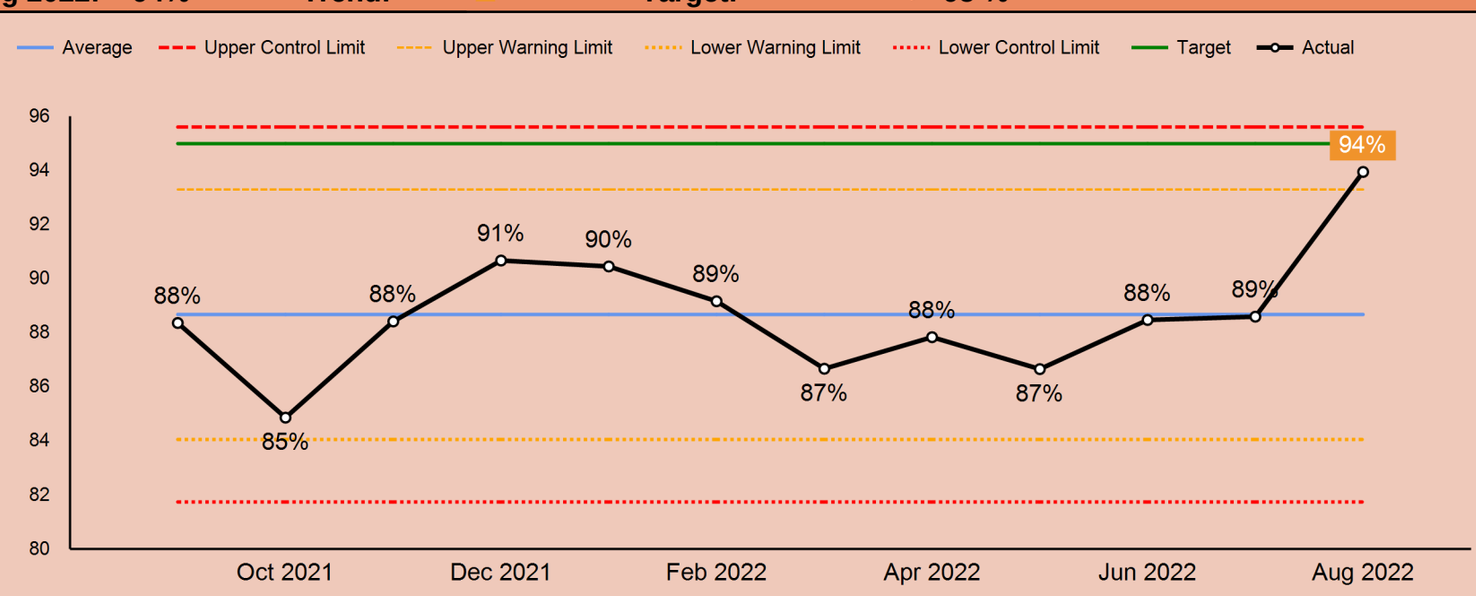
Comments:

What the data tell us
Special cause variation has been observed (6 points in a row with an increasing trend). This demonstrates an improvement against the previous average and has a result has hit the 90% target for the past 6 months.

Priority Actions
A real push by the Divisional teams has seen us continue to achieve well above the 90% target for mandatory training

FFT % Recommend Trust

Aug 2022: 94% **Trend:** ▲ **Target:** **>=95 %**



Comments:

What the data tell us
There is a significant increase in FFT % within August to 94%. This still exhibits natural variation within the current system and is below the 95% target.

Priority Actions
There continues to be a real focus on the FFT agenda in ED culminating in an improved performance.

% Compliants response within 25 working days

Aug 2022: 100% **Trend:** — **Target not set**

Comments:

What the data tell us
The current average is 70%. 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

Priority Actions
The Divisional and corporate teams have improved complaint and PALS processes, resulting in much improved response times and achievement of targets.

My Alder Hey 000063
Executive Scorecard

Dashboard refreshed 20 Sep 2022 20:02 (although individual metrics may be older)

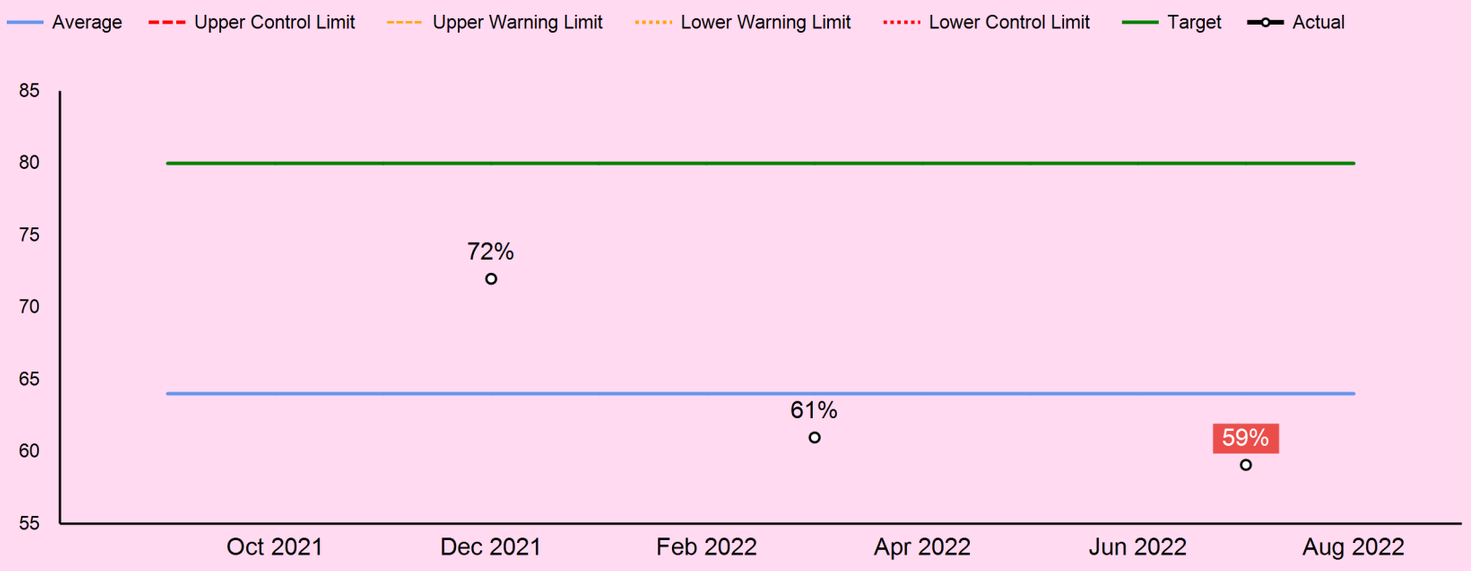
BRILLIANT BASICS

NHS Alder Hey Children NHS Foundation Tru

Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

Metric	Great Place to Work
> 80% of staff recommend as a place to work	**Jul 2022: 59% Trend: ▼ Target: >=80 %**

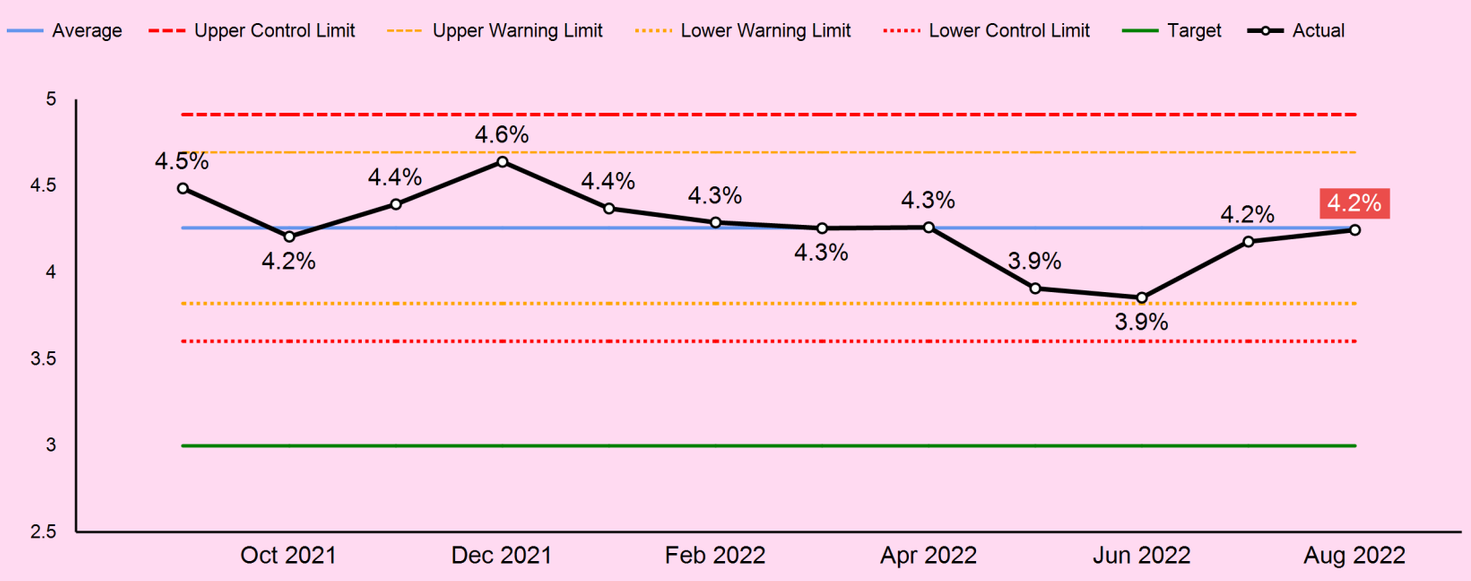


Comments:

What the data tell us
Only 3 data points, so difficult to analyse data given the frequency of the survey (quarterly). The underlying position will become clearer after subsequent pulse checks are completed. However, the latest data point of 59% is below the target of >75%. Next Data point is expected from the full staff survey around Nov/Dec

Priority Actions
The 2022 national staff survey launches on 20th September and will be open for responses until 25th November with communications planned to support and encourage completion

Metric	
Long Term Sickness	**Aug 2022: 4.2% Trend: ▲ Target: <=3 %**

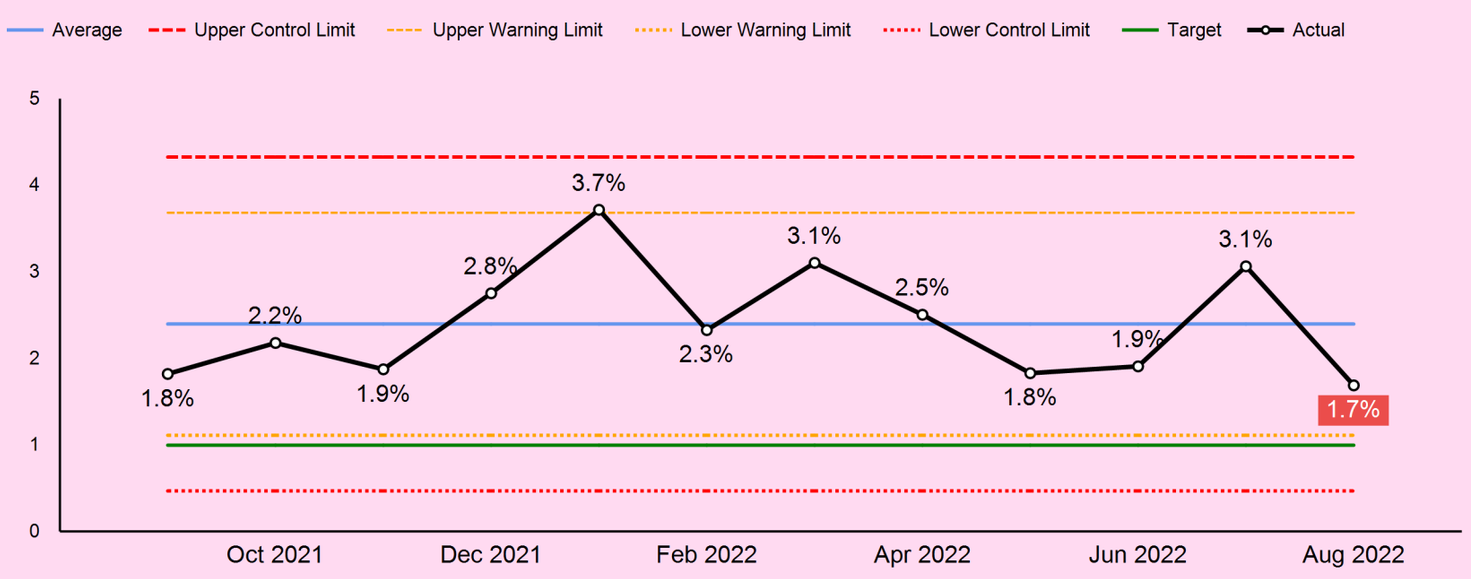


Comments:

What the data tell us
August 2022 (4.1%) whilst demonstrates natural variation in relation to the 12 month average.

Priority Actions
Support for sickness continues, with interventions remain in place, with these including: • Early invention accessing OH, to remain in and support return to work. • Regular surgeries for managers continue, as does monitoring on a case by case basis. • HR colleagues attend hotspot areas on a regular basis e.g. wards; developing action plans as needed. • Stress Risk Assessment Training is taking place across the business. • Organisational support through SALS, and the Alder Centre continues. In addition, the sickness absence manager training has received positive feedback and has been well attended from managers across the Trust. Training dates are in place for the rest of the year.

Metric	
Short Term Sickness	**Aug 2022: 1.7% Trend: ▼ Target: <=1 %**

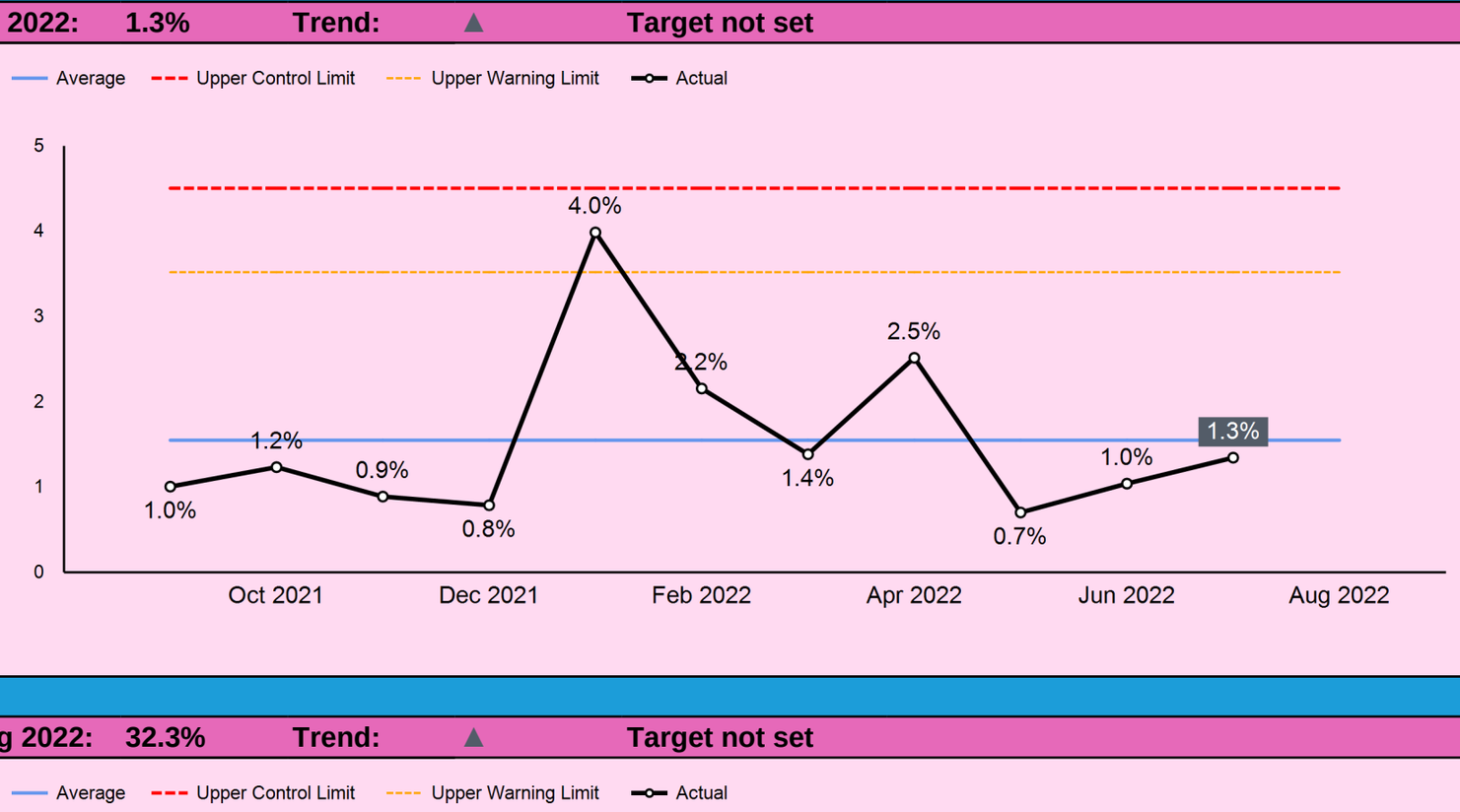


Comments:

What the data tell us
August 2022 (1.8%) demonstrates natural variation in relation to the 12 month average. The target figure of 1% is at the lower control limit over the past 12 months so significant improvement work would need to be done to achieve this target in any individual month.

Priority Actions
See above and below

Metric	
Absence COVID Related	**Jul 2022: 1.3% Trend: ▲ Target not set**

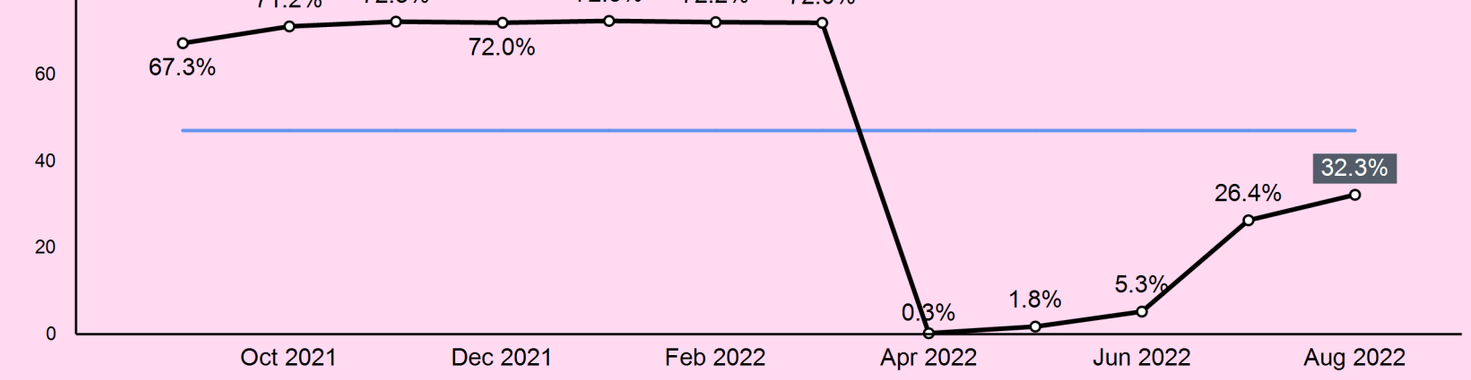


Comments:

What the data tell us
Peak in January was above Upper Warning Limit, reflecting the Omicron surge. Figures in 2022 have not yet returned to the 2021 average.

Priority Actions
Following a change in national guidance, Covid-19 are now being paid in line with the terms and conditions. Those off with long Covid-19 were contacted ahead of this change; though Covid related absence has reduced in month, long Covid-19 remains an area of focus and concern.

Metric	
% PDR Compliance YTD	**Aug 2022: 32.3% Trend: ▲ Target not set**



Comments:

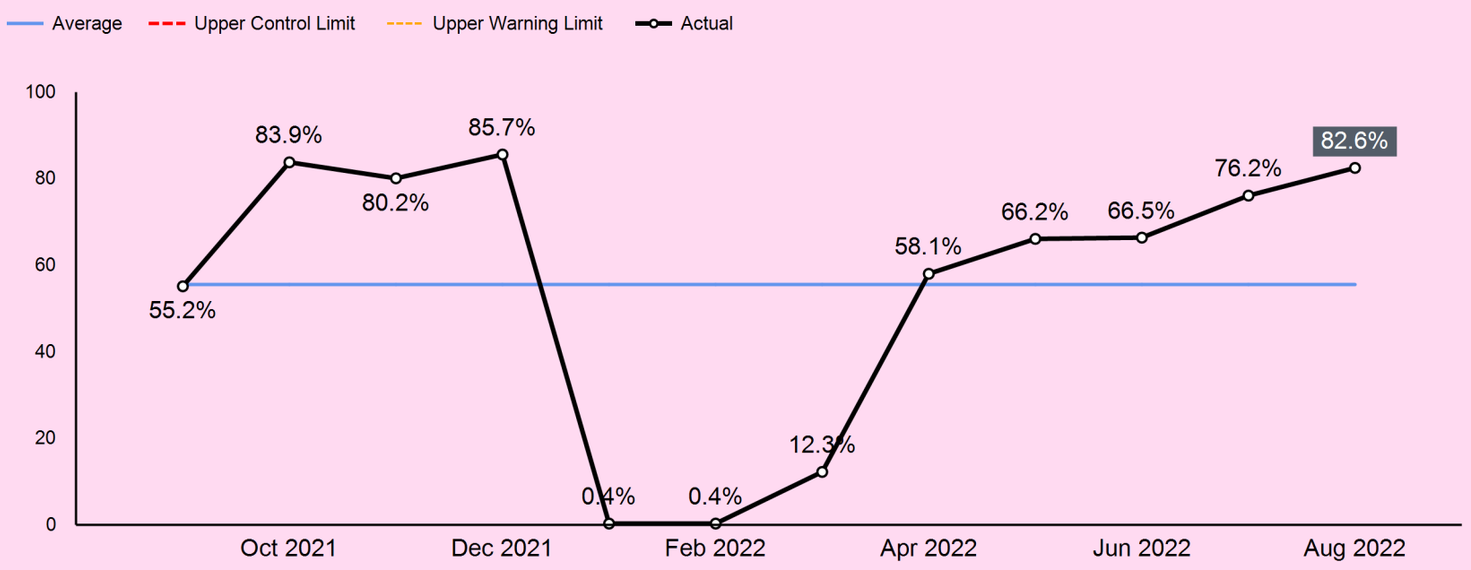
What the data tell us
PDR compliance in 2021/22 did not achieve the 90% target. In April, PDR Compliance has reset due to the opening of the PDR window. We would expect to see increase over the coming months, with target for all senior posts to have PDR completed by end of July 2022. The remaining PDRs need to be finalised before the end of March 2023 and we can expect an increase month on month to hit this target.

Priority Actions
PDR completion remains high on the agenda, with focus now moving to the band 2-6s.

000064

% Medical Appraisals YTD

Aug 2022: 82.6% **Trend:** ▲ **Target not set**



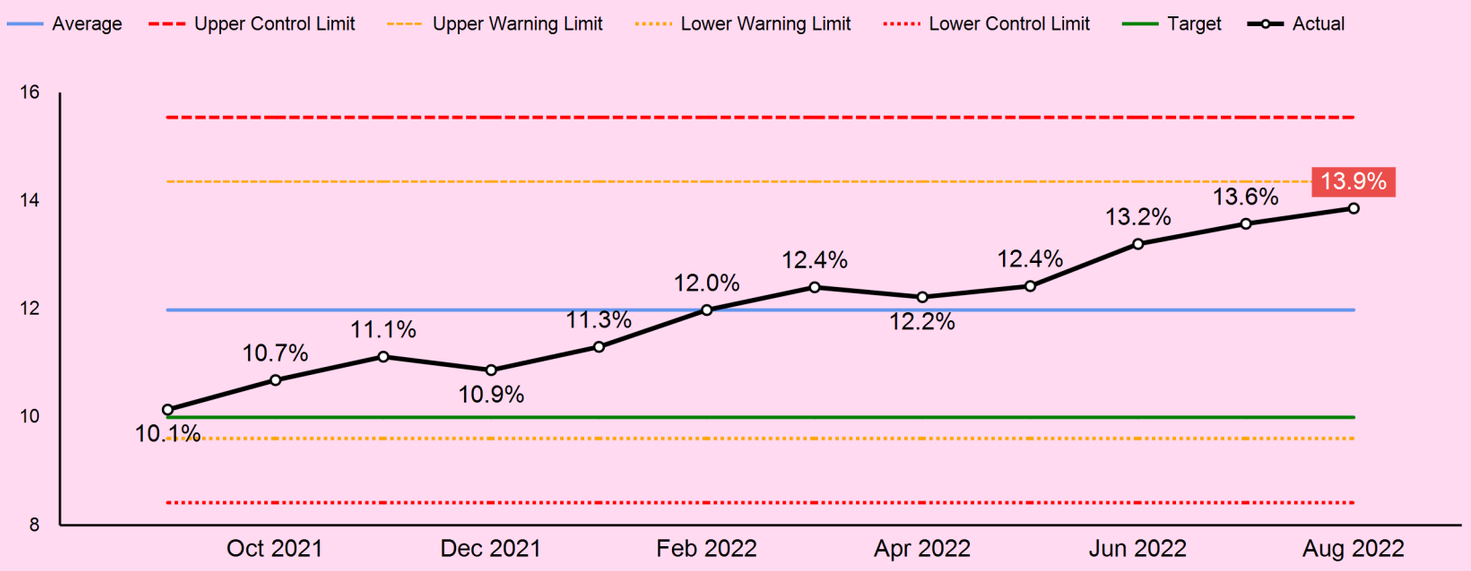
Comments:

What the data tell us
Window for Medical appraisals opened in January, and current performance shows steady rise. The new process is for each Consultant to get an appraisal in their birth month so these data will need to be adjusted to reflect this.

Priority Actions
Medical appraisal completion continues to be monitored and supported through medical education, with a clear view on the numbers to be completed each month.

% Staff Turnover

Aug 2022: 13.9% **Trend:** ▲ **Target:** **<=10 %**



Comments:

What the data tell us
Not only is the average above the 10% target but the past 7 months show values consistently over the average - therefore special cause variation has been observed. This indicates statistically over a sustained period of time that there is an increase in Staff leaving the organisation.

Priority Actions
In addition to the specific focus through PAWC, quarterly turnover deep dive reports are now presented at each of the Divisional Boards to support review and action.

My Alder Hey 000065
Executive Scorecard

Dashboard refreshed 20 Sep 2022 20:02 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children NHS Foundation Tru

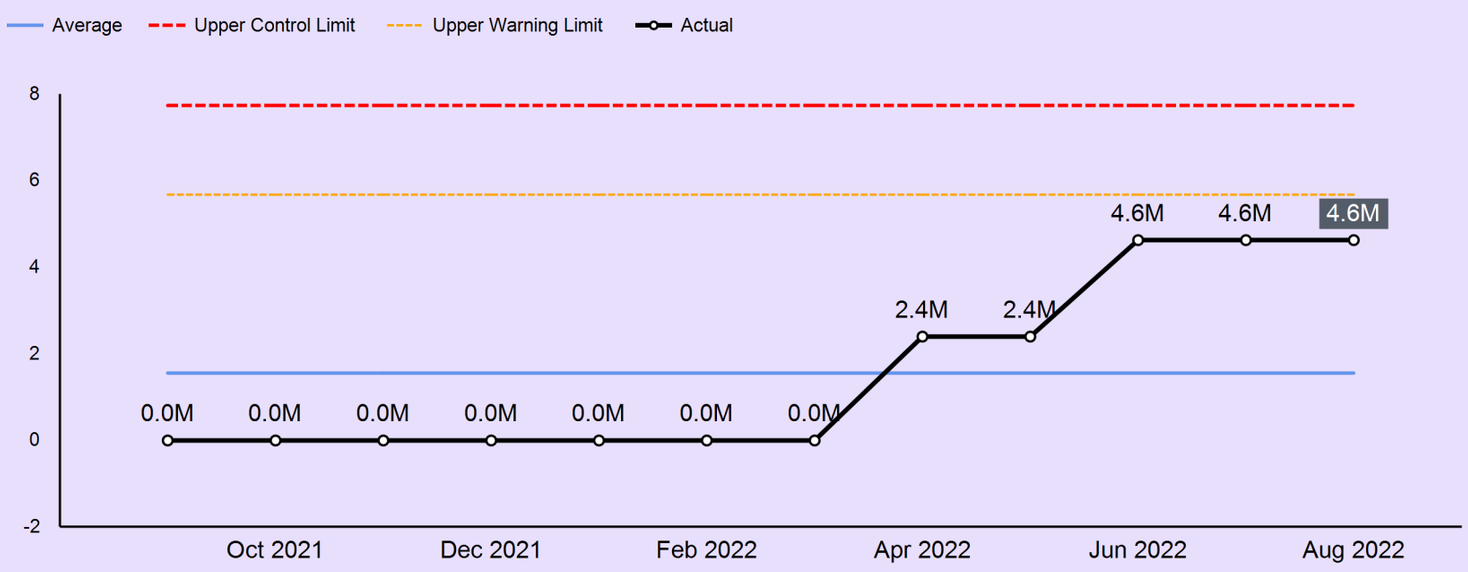
Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

Metric	Financial Sustainability

I&E Control Total

Aug 2022: 4.6M **Trend:** — **Target not set**



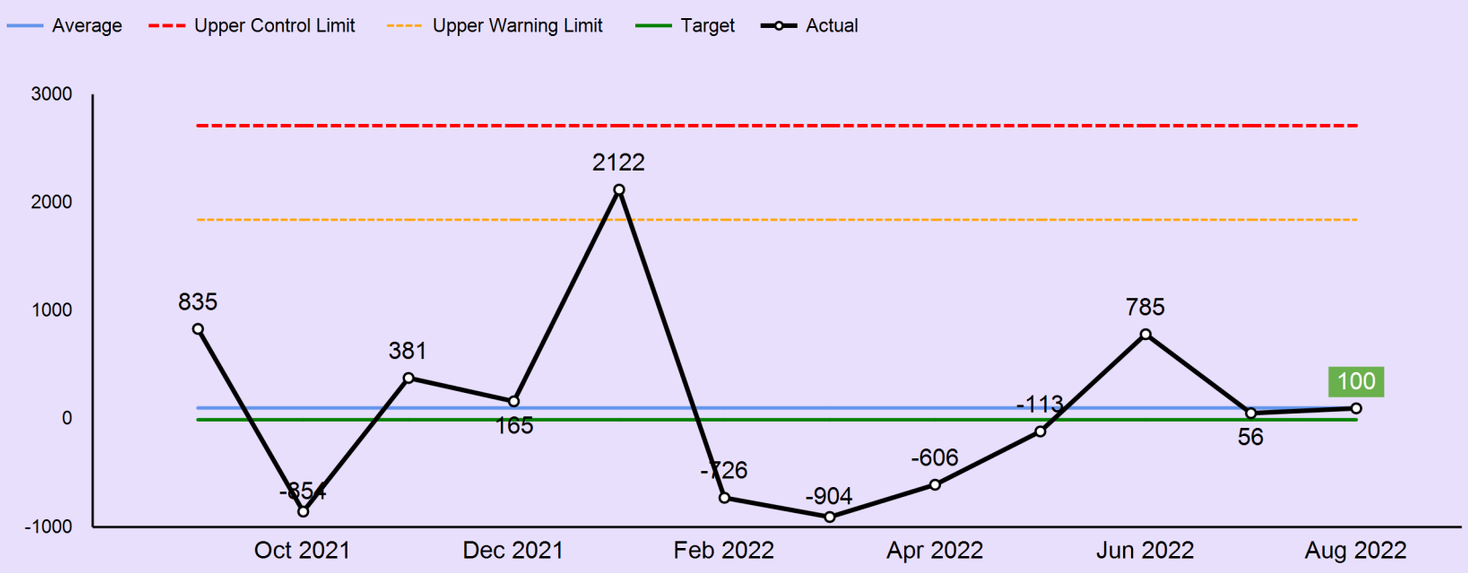
Comments:

What the data tell us
The Trust is reporting a planned position at this stage in the year which is a £4.6m surplus as reported to Cheshire & Mersey ICB. There are however significant risks in achieving this position including CIP progress and spend control mechanisms in particular increase in energy costs which are outside the control of the Trust.

Priority Actions
Continue with deep dives and finance reviews supporting cost control and reduction where possible. Green taskforce group now set up to assess waste reduction in energy usage.

I&E vs Plan (YTD - £000s)

Aug 2022: 100 **Trend:** ▲ **Target:** >=-5%



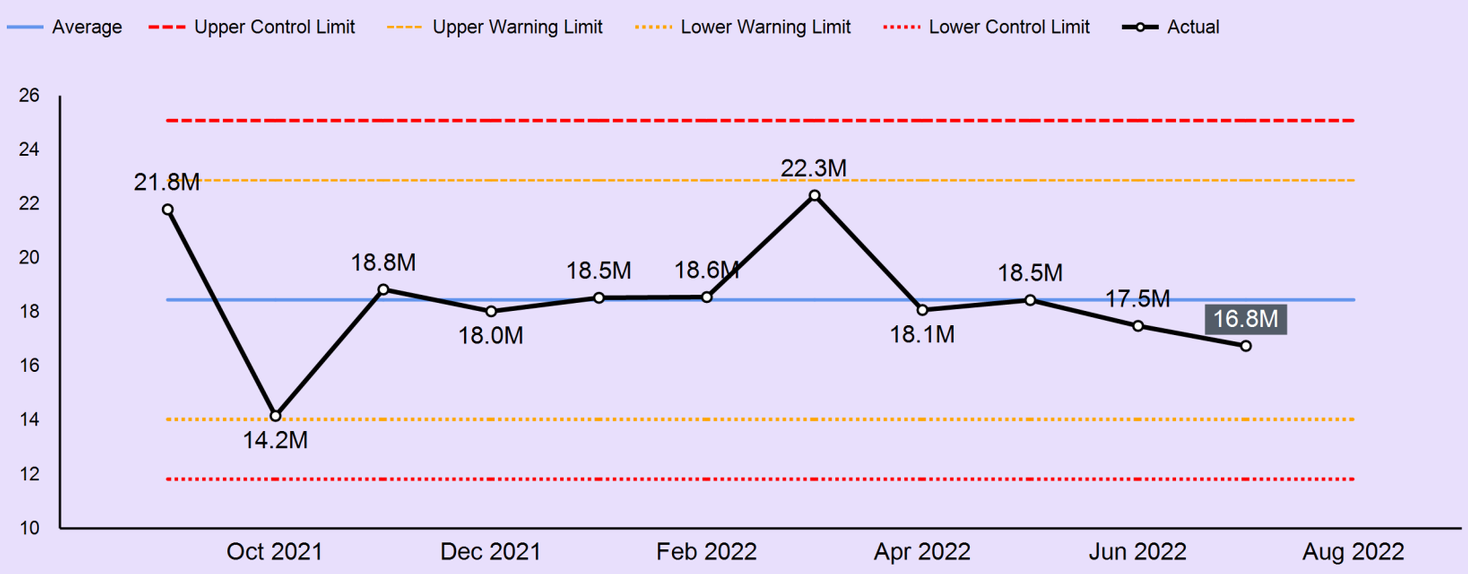
Comments:

What the data tell us
Continue with deep dives and finance reviews supporting cost control and reduction where possible. Green taskforce group now set up to assess waste reduction in energy usage. Main drivers for the ytd position includes CIP non-delivery and continued pay and non-pay cost pressures including Junior Doctors, clinical supplies and drugs, offset in part with slippage in investments. There are also a number of non recurrent benefits supporting the position.

Priority Actions
Continue with deep dives and finance reviews supporting cost control and reduction where possible

Expenditure Run Rate (Pay)

Jul 2022: 16.8M **Trend:** ▼ **Target not set**



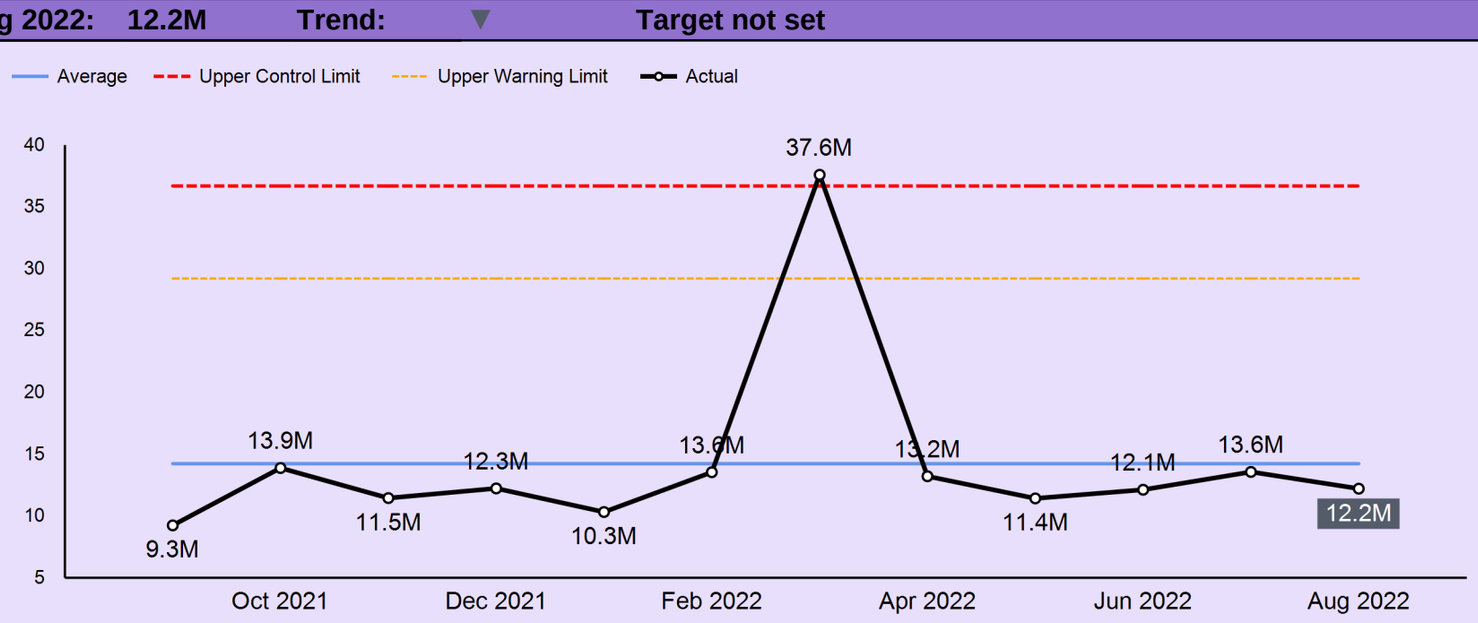
Comments:

What the data tell us
Run rate for pay in August is £17.7m which is higher than the previous month but in line with plan in month. We have seen a number of non recurrent benefits in the position including review of prior year commitments no longer required as well as existing vacancies across a number of divisions. Year to date, pay is showing a favourable to plan position of £0.5m.

Priority Actions
Focus on Agency controls as directed by NHSEI as part of the Workforce CIP Sprint

Expenditure Run Rate (Non Pay)

Aug 2022: 12.2M **Trend:** ▼ **Target not set**



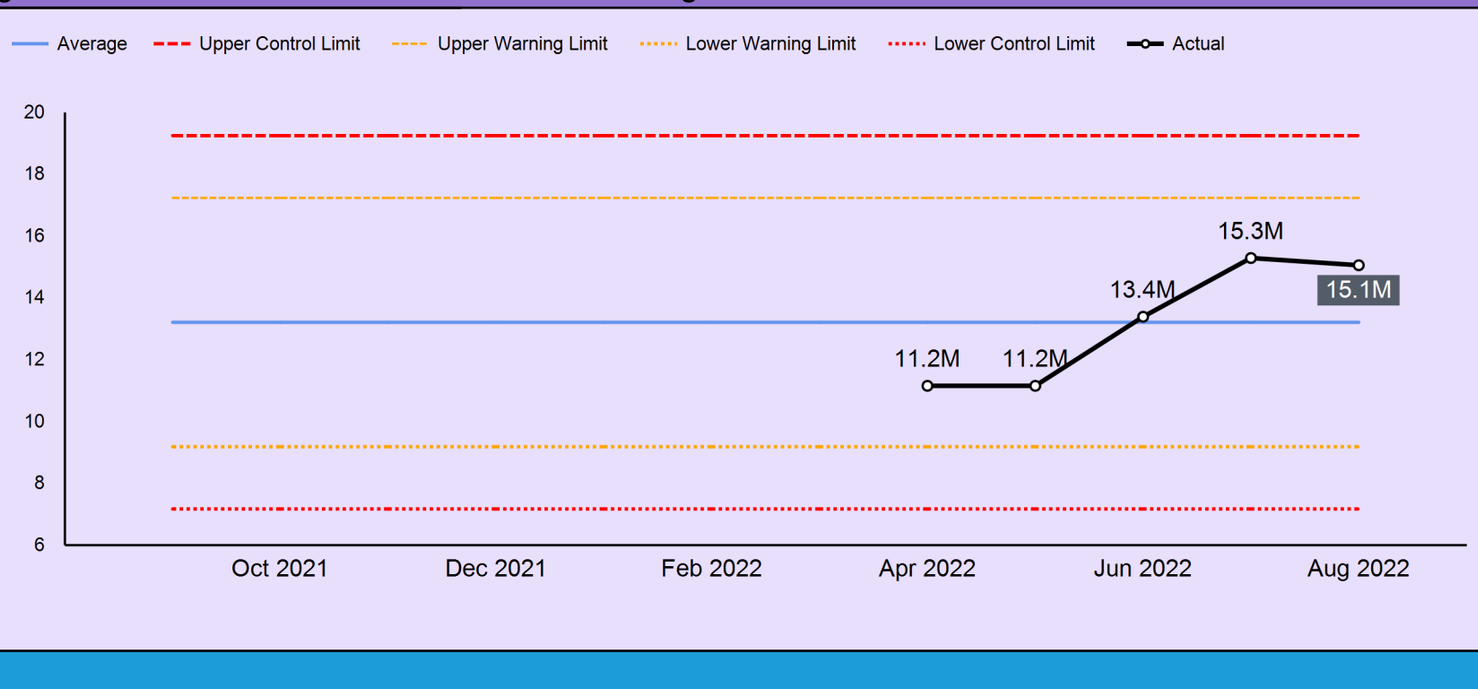
Comments:

What the data tell us
Run rate for non-pay in August is £12.2m which is lower than last month by £1.3m and adverse to plan by £0.1m. Year to date, Non Pay is showing an adverse to plan position of £3.0m of which £2.1m is largely offset with income. The remainder is associated with CIP non delivery and non pay pressures including clinical supplies and drugs costs which have moved from a pass through reimbursement to a fixed contract regardless of activity volumes.

Priority Actions
As above - continue with deep dives and finance reviews supporting cost control and reduction where possible

CIP Forecast

Aug 2022: 15.1M **Trend:** ▼ **Target not set**



Comments:

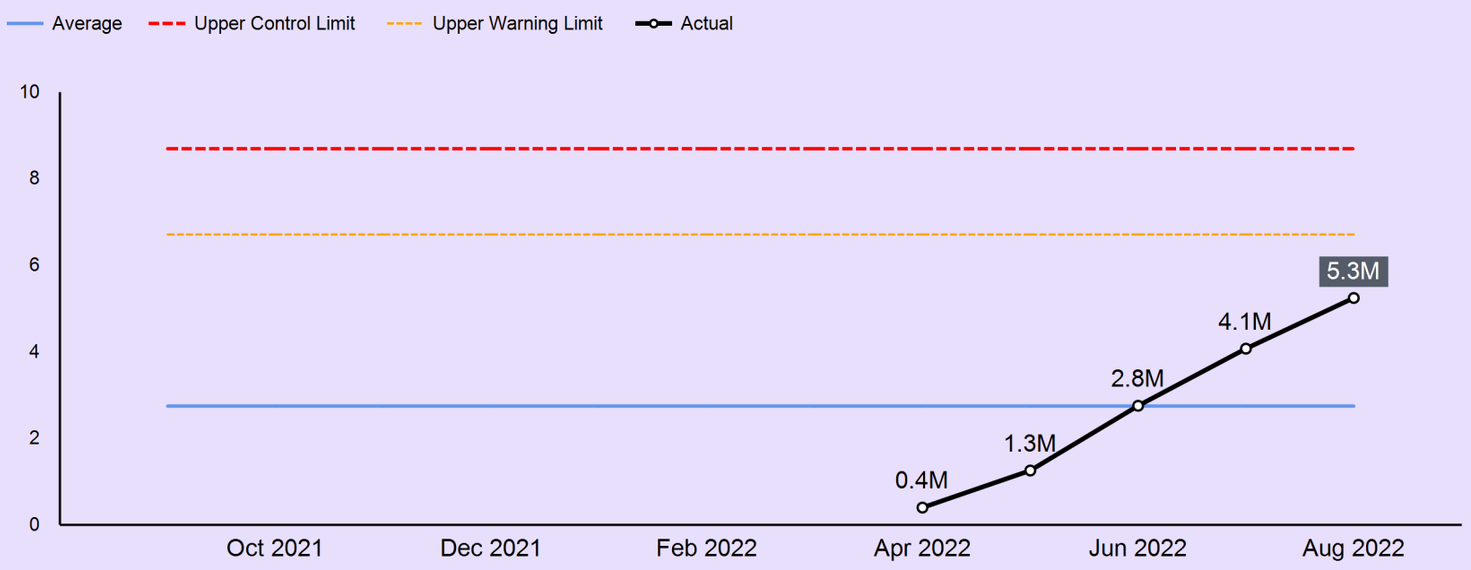
What the data tell us
The Trust is forecasting to deliver £15m savings. This is consistent when compared to month 4. However there still remains a gap of £2.0m to achieve the £17.3m target.

Priority Actions
Divisions continue to progress schemes and report progress each month at SDG via finance Activity sessions. Sprint areas report progress to relevant SDG “Sprint Huddle”

000066

CIP Delivered (YTD)

Aug 2022: 5.3M **Trend:** ▲ **Target not set**



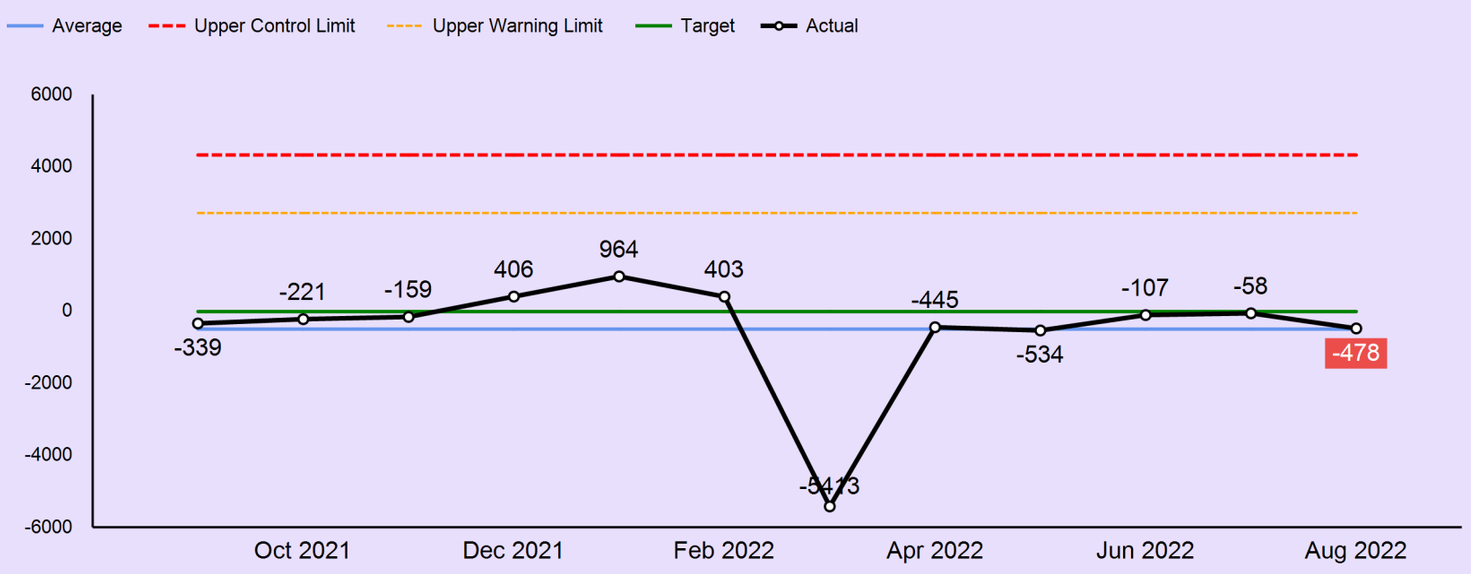
Comments:

What the data tell us
CIP Delivered year to date is £5.3m against a ytd plan of £5.8m resulting in a shortfall to plan of £0.5m

Priority Actions
Divisions continue to progress schemes and report progress each month at SDG via finance Activity sessions. Sprint areas report progress to relevant SDG "Sprint Huddle"

Capital Plan (vs CDEL) £000s

Aug 2022: -478 **Trend:** ▲ **Target: >=-5%**



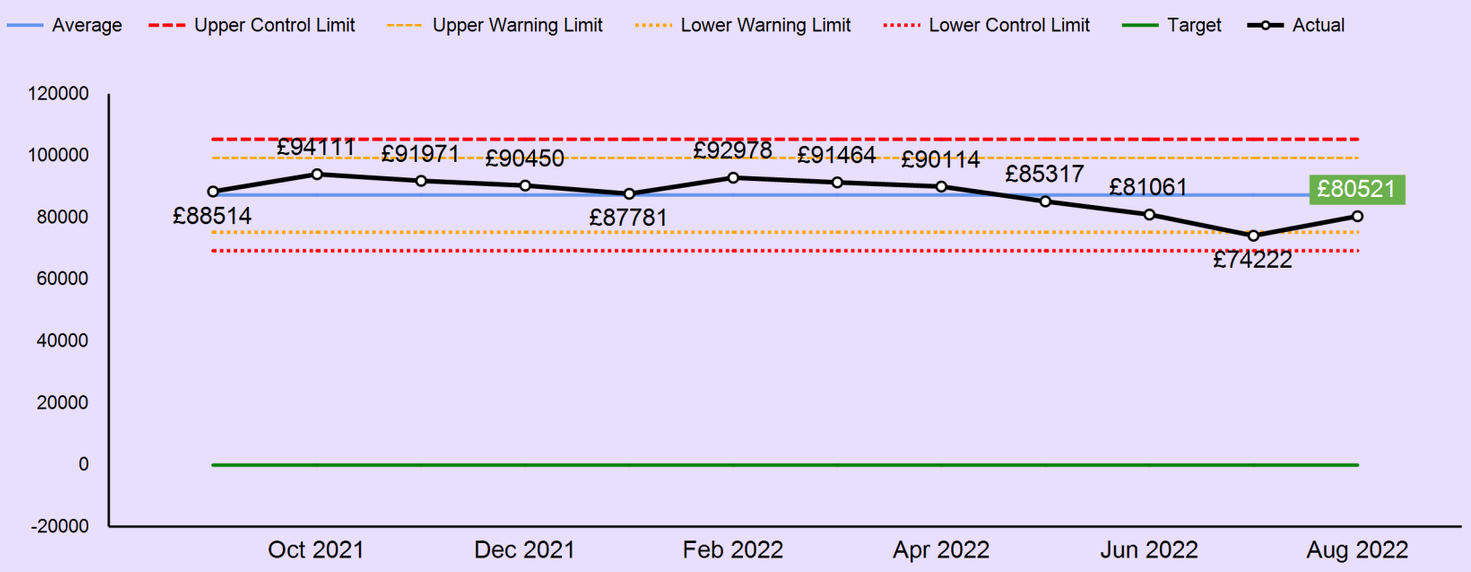
Comments:

What the data tell us
Capital spend YTD is £2.5m which is slightly ahead of plan but is forecast in line with plan by the end of the financial year

Priority Actions
Continue to monitor spend in line with plan and CDEL limits

Cash £000s

Aug 2022: £80521 **Trend:** ▲ **Target: >=-5%**



Comments:

What the data tell us
Trust remains at a healthy cash balance

Priority Actions
No Action Required

My Alder Hey 000067
Executive Scorecard

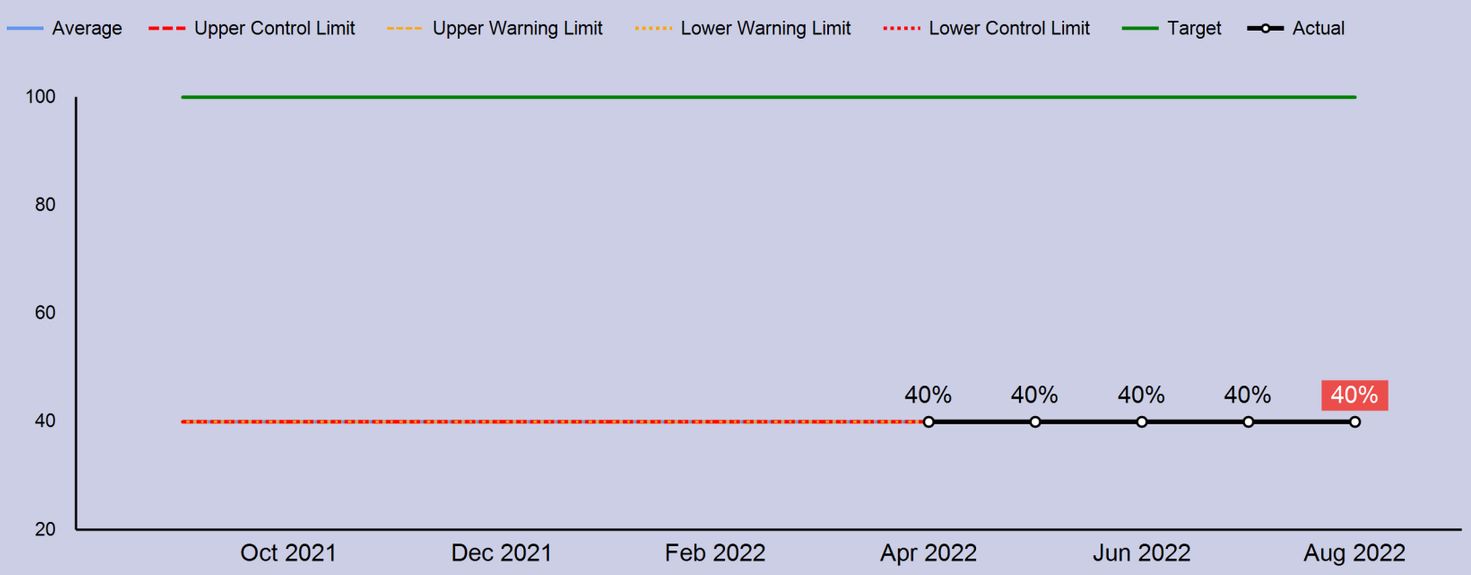
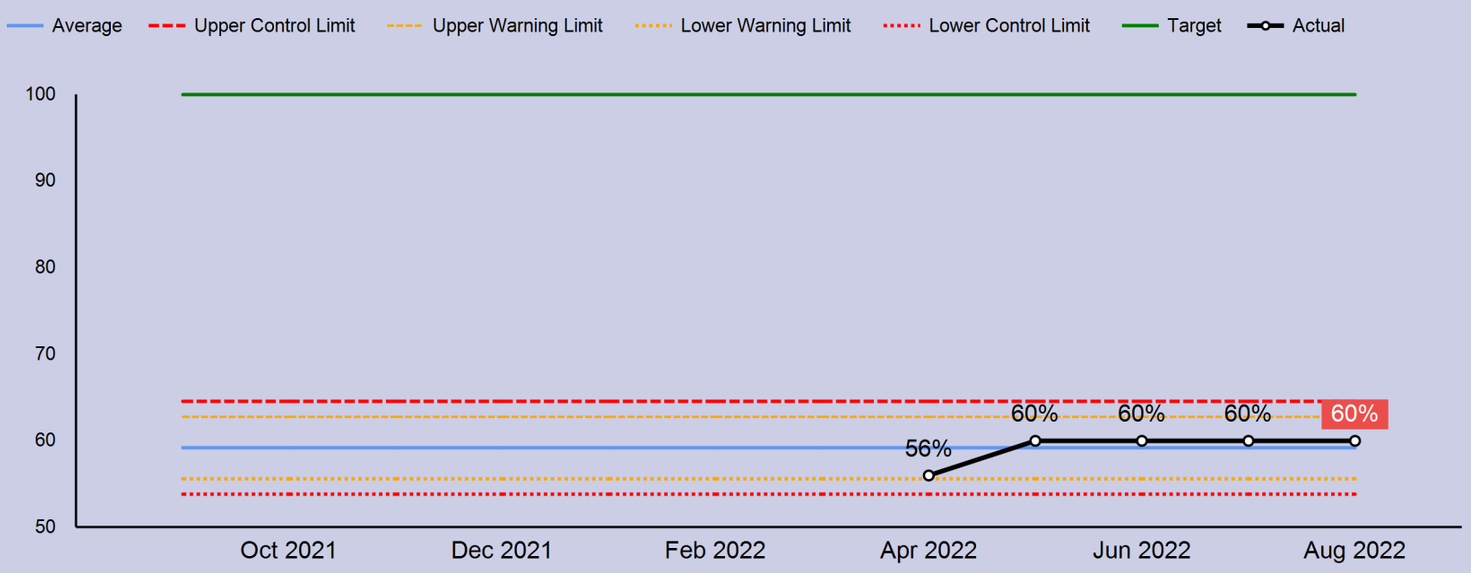
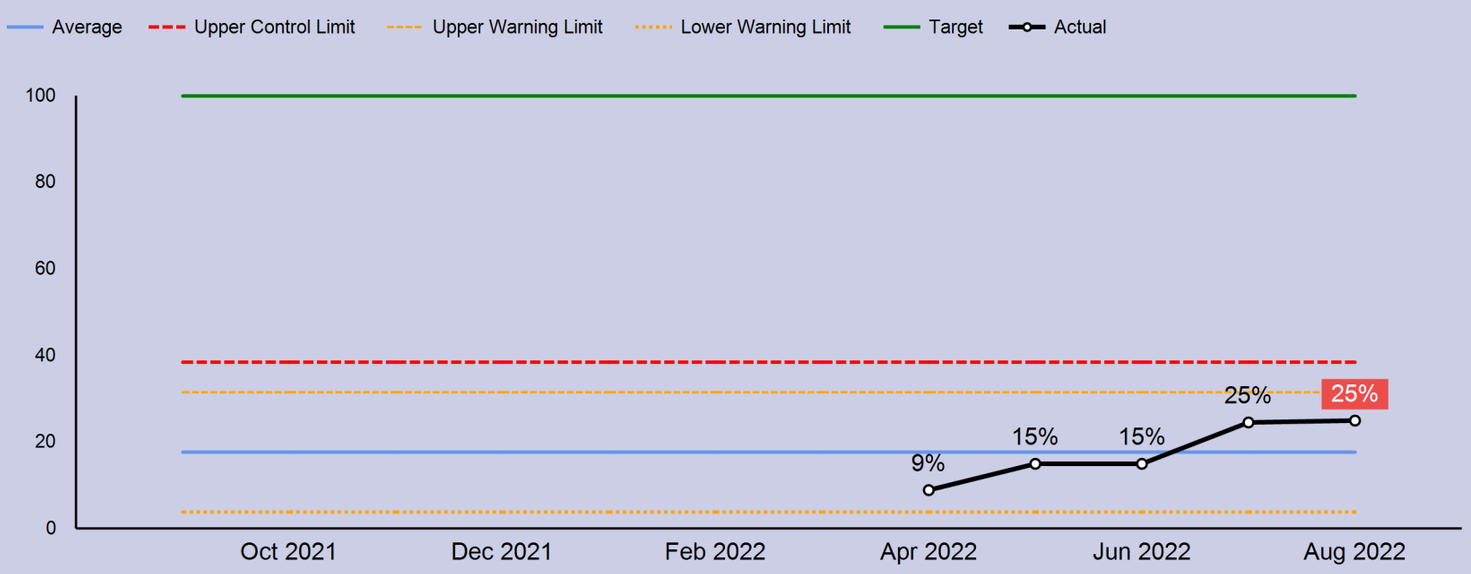
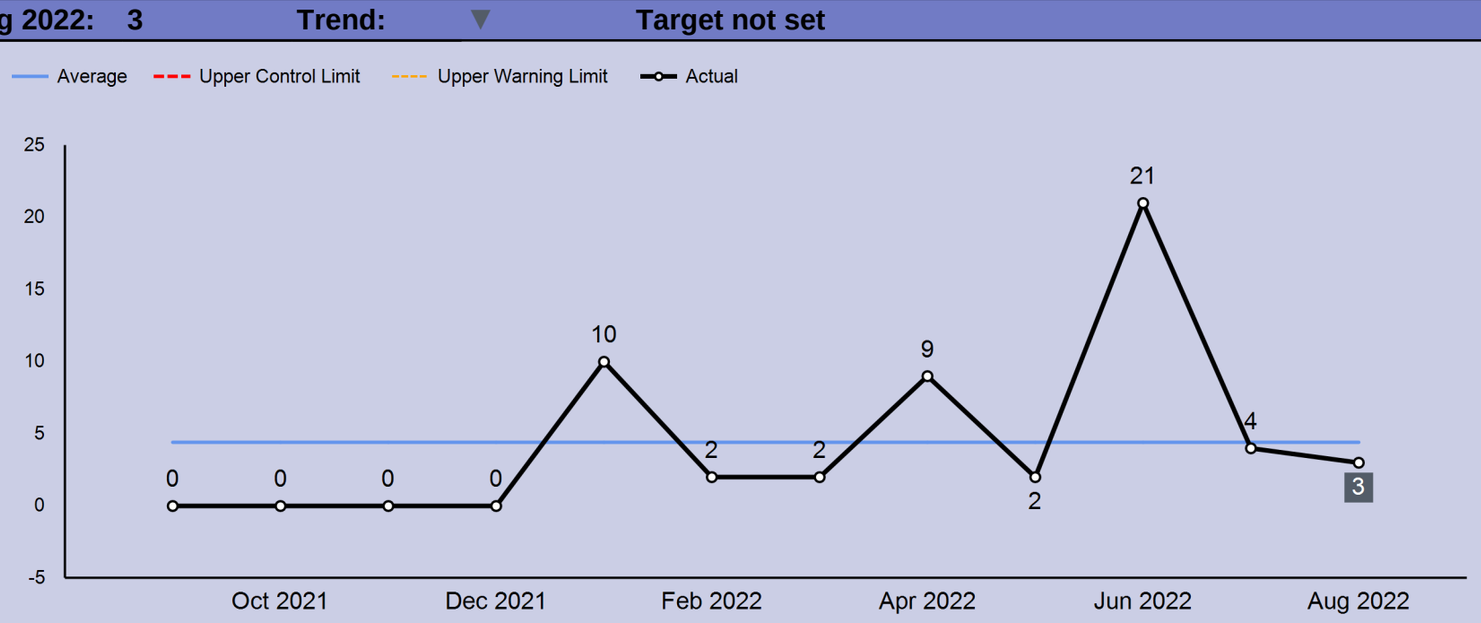
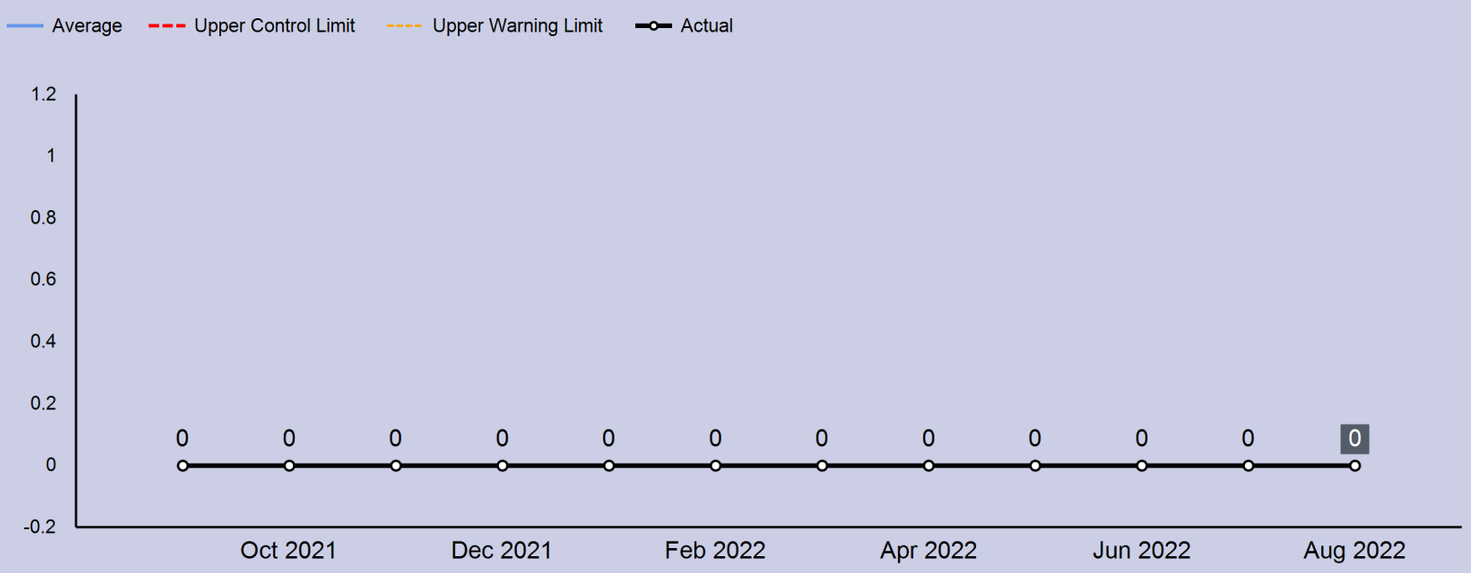
Dashboard refreshed 21 Sep 2022 09:07 (although individual metrics may be older)

BRILLIANT BASICS

NHS Alder Hey Children NHS Foundation Tru

Home > Detailed Scorecard

Please click on the word 'Home' to navigate back to the summary page

Metric	Safe Systems
100% safety compliance	**Aug 2022: 40% Trend: — Target: 100 %**  **Comments:** **What the data tell us** Programme is currently undergoing a programme review following a number of issues resulting in a delay to the go live confirmed. Some performance trajectories will be re-baselined during this review period. Within the programme, the clinical team have identified a number of key 'patient safety criteria' which must be met prior to go live to achieve a safe and successful implementation. There are currently 40% of the solutions signed off and approved. This is behind the predicted trajectory for the end of June due to awaiting solutions from Meditech and complexity of sign off for these criteria. Escalated to the AlderC@re Board as part of the gateway review process and the wider AlderC@re programme is now in review to replan based on these exceptions. **Priority Actions** Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint
% system build completion	**Aug 2022: 60% Trend: — Target: 100 %**  **Comments:** **What the data tell us** Within the new system the majority of the modules need fully rebuilding and this section will aim to track and monitor build progress by Meditech and the System Development Team. Overall there is 60% of the system now built. **Priority Actions** Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint
% specialty sign off	**Aug 2022: 25% Trend: ▲ Target: 100 %**  **Comments:** **What the data tell us** As part of the programme, each specialty will need to review and approve any of their bespoke specialty documentation. This area is part of the programme review recovery plan and currently at 25% completion. **Priority Actions** Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint
Number of staff involved in prototype testing	**Aug 2022: 3 Trend: ▼ Target not set**  **Comments:** **What the data tell us** A key programme objective is to engage users and involve them in the testing of the new system. Users have been invited to test the current prototypes to help get a feel for how the new system will function and ensure it meets their needs. A total of 50 staff have now been involved in prototype testing. **Priority Actions** Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint
Number of staff trained in Alder Care	**Aug 2022: 0 Trend: — Target not set**  **Comments:** **What the data tell us** Training for users will commence once build is complete at the latest 12 weeks before go live. **Priority Actions** Completion of Aldercare programme review, confirmation of revised deployment date and clarity of the programme vision and ambition supporting outstanding care within Alder Hey and a national blueprint

Alder Hey Children's
NHS Foundation Trust

Part 2 - Dashboard of Metrics

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG	Comments Available
Proportion of Near Miss, No Harm & Minor Harm	99.8%	100.0%	99.6%	98.8%	100.0%	99.5%	99.6%	99.8%	99.6%	100.0%	100.0%	99.7%	99.8%		>=99 % N/A <99 %	✔
Clinical Incidents resulting in Near Miss	61	91	89	65	76	73	79	89	99	111	75	119	98		No Threshold	
Clinical Incidents resulting in No Harm	300	312	276	275	250	239	280	310	320	407	361	382	321		No Threshold	
Clinical Incidents resulting in minor, non permanent harm	88	72	86	134	76	99	88	143	116	141	117	117	118		No Threshold	
Clinical Incidents resulting in moderate, semi permanent harm	1	0	1	1	0	2	1	1	2	0	0	1	1		No Threshold	
Clinical Incidents resulting in severe, permanent harm	0	0	1	1	0	0	1	0	0	0	0	0	0		0 N/A >0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Medication errors resulting in harm	6	4	2	4	5	3	2	3	3	8	5	1	2		<=4 N/A >4	✔
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0	✔
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Sepsis: Patients treated for Sepsis within 60 Minutes - A&E	90.2%	76.6%	85.9%	85.7%	77.4%	78.0%	83.7%	95.1%	79.6%	86.8%	77.8%	78.3%	74.3%		>=90 % N/A <90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	86.4%	81.1%	87.0%	82.9%	75.9%								94.3%		>=90 % N/A <90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - C.difficile	0	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Hospital Acquired Organisms - MSSA	0	0	1	3	1	0	0	1	1	0	0	1	0		No Threshold	

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	92.3%	88.4%	84.9%	88.4%	90.7%	90.5%	89.2%	86.7%	87.8%	86.7%	88.5%	88.6%	94.0%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	79.6%	64.3%	61.1%	64.2%	71.7%	74.4%	69.5%	59.3%	60.3%	59.6%	73.4%	68.7%	92.1%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	96.2%	92.7%	93.4%	93.6%	95.8%	96.2%	90.5%	94.4%	100.0%	92.4%	90.6%	86.4%	91.1%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	91.4%	92.9%	94.2%	92.1%	92.4%	92.7%	93.9%	95.7%	96.5%	95.3%	97.6%	95.7%	96.2%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	95.8%	96.3%	90.6%	96.4%	100.0%	96.2%	95.5%	94.1%	96.4%	100.0%	90.9%	76.0%	96.4%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	95.4%	94.7%	91.8%	94.2%	95.9%	94.7%	94.1%	93.3%	93.9%	93.3%	91.7%	93.9%	94.3%		>=95 % >=90 % <90 %	✔
Complaints	12	13	13	14	9	16	20	19	15	15	16	11	21		No Threshold	
PALS	88	148	136	141	106	101	135	136	102	148	164	133	150		No Threshold	

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG	Comments Available
% Readmissions to PICU within 48 hrs	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%								No Threshold	✔
ED: 95% Treated within 4 Hours	87.7%	73.3%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%	77.8%	75.9%	90.2%		>=95 % N/A <95 %	✔
ED: Patients In Department >12 Hours	0	14	47	46	26	11	23	70	19	10	23	8	2		0 N/A >0	✔
ED: Median Time to Triage (Mins)	10	14	17	17	13	10	12	20	12	14	11	11	8		<=15 N/A >15	✔
ED: Median Time to Clinical Assessment (Mins)	76	100	108	129	87	83	102	125	106	104	101	109	58		<=60 N/A >60	✔
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	12	32	23	56	23	22	16	23	21	22	26	20	26		<=19 N/A >19	✔
28 Day Breaches	8	5	11	12	25	7	3	9	10	9	8	8	10		0 N/A >0	✔
Clinic Letters Completed within 10 Days	60.5%	64.7%	60.7%	67.9%	55.1%	70.3%	63.4%	66.4%	58.5%	62.6%	65.0%	55.2%	60.2%		>=95 % N/A <95 %	✔

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	96.2%	97.5%	95.8%	99.1%	92.6%	96.1%	93.0%	95.3%	95.7%	97.8%	98.8%	96.3%	97.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	97.8%	96.8%	97.6%	99.1%	96.6%	98.1%	96.7%	97.8%	99.3%	97.8%	98.2%	98.7%	98.2%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	93.0%	95.5%	93.3%	87.2%	71.1%	72.3%	67.6%	66.1%	66.4%	66.9%	85.3%	69.9%	73.4%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	96.2%	96.8%	98.8%	98.3%	97.3%	98.1%	97.1%	98.7%	97.1%	98.9%	97.6%	99.3%	98.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	77.4%	75.2%	78.8%	79.5%	78.5%	71.4%	80.9%	87.3%	78.7%	78.6%	82.1%	83.9%	81.4%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	87.6%	89.2%	92.7%	95.7%	89.9%	91.7%	91.9%	93.0%	95.3%	90.8%	90.5%	90.3%	92.0%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	71.1%	66.5%	62.1%	63.2%	64.2%	62.0%	61.5%	61.3%	60.1%	61.8%	59.2%	56.9%	58.2%		>=92 % >=90 % <90 %	✔
Waiting List Size	13,286	13,092	18,495	18,976	19,127	19,098	19,731	20,612	21,894	22,885	23,735	24,156	24,494		No Threshold	
Waiting Greater than 52 weeks - Incomplete Pathways	195	263	318	250	218	237	246	249	290	282	331	367	405		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	94.7%	97.2%	96.3%	88.5%	92.1%	87.9%	63.3%	56.9%	51.9%	58.9%	63.8%	65.1%	65.1%		>=99 % N/A <99 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100 % N/A <100 %	✔
PFI: PPM%	99.0%	99.0%	97.0%	99.0%	99.0%	96.0%	92.0%	99.0%	98.0%	99.0%	97.0%	99.0%	97.0%		>=98 % N/A <98 %	✔

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG	Comments Available
Control Total In Month Variance (£'000s)	-51	835	-854	381	165	2,122	-726	-904	-606	-113	785	56	100		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	234	-339	-221	-159	406	964	403	-5,413	-445	-534	-107	-58	-478		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	82,121	88,514	94,111	91,971	90,450	87,781	92,978	91,464	90,114	85,317	81,061	74,222	80,521		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	-1,713	2,766	-2,610	149	1,474	1,047	273	27,774	1,210	204	322	571	160		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	71	-2,466	2,477	676	-16	6	9	-7,579	-121	406	-585	1,059	44		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	1,591	534	-720	-443	-1,293	1,068	-1,008	-21,099	-1,694	-723	1,049	-1,574	-104		>=-5% >=-20% <-20%	✔
PDR	65.0%	67.3%	71.2%	72.3%	72.0%	72.5%	72.2%	72.0%	0.3%	1.8%	5.3%	26.4%	32.3%		No Threshold	
Medical Appraisal	70.8%	55.2%	83.9%	80.2%	85.7%	0.4%	0.4%	12.3%	58.1%	66.2%	66.5%	76.2%	82.6%		No Threshold	
Mandatory Training	87.4%	87.3%	87.3%	87.3%	87.5%	85.7%	88.4%	89.8%	91.3%	92.0%	92.5%	93.3%	93.9%		>=90 % >=80 % <80 %	✔
Sickness	6.5%	6.3%	6.4%	6.3%	7.4%	8.1%	6.6%	7.4%	6.8%	5.7%	5.8%	7.2%	5.9%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	1.6%	1.8%	2.2%	1.9%	2.8%	3.7%	2.3%	3.1%	2.5%	1.8%	1.9%	3.1%	1.7%		<=1 % N/A >1 %	✔
Long Term Sickness	4.9%	4.5%	4.2%	4.4%	4.6%	4.4%	4.3%	4.3%	4.3%	3.9%	3.9%	4.2%	4.2%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	1,096	1,367	1,137	1,592	1,523	1,387	1,620	2,080	1,570	1,375	1,172	1,403	1,188		No Threshold	
Staff Turnover	9.7%	10.1%	10.7%	11.1%	10.9%	11.3%	12.0%	12.4%	12.2%	12.4%	13.2%	13.6%	13.9%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	92.2%	94.5%	91.6%	87.7%	84.5%	81.3%	84.0%	81.7%	83.7%	86.4%	85.1%	83.4%	72.7%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	100.0%	97.7%	100.0%	95.4%	97.8%	98.9%	100.0%	100.0%	97.5%	97.0%	99.0%	99.0%	99.1%		>=85 % N/A <85 %	✔

Game Changing Research & Innovation

000074

R&D

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	125	132	139	142	145	148	150	153	154	148	143	147	142		>=130	>=111	<111	✔
Number of Open Studies - Commercial	38	40	43	44	42	43	44	38	40	39	35	36	36		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	3	7	7	4	1	3	0	3	3	1	0	1	1		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	0	2	3	3	0	3	0	0	1	1	0	1	0		>=1	N/A	<1	✔
Number of patients recruited	1,060	983	931	1,038	816	978	937	1,157	917	944	565	592	335		>=100	>=86	<86	✔

Alder Hey Children's NHS Foundation Trust

Part 3 - Divisional Performance

Medicine Division

SAFE	There were no areas of concern in month	**Highlight** • Whilst not visible in the scorecard the Division is reporting 100% compliance with the 60-minute standard for the treatment of sepsis in month. **Challenges** •
CARING	Increase in PALS in month noted, no specific issues noted	**Highlight** • **Challenges** •
EFFECTIVE	Notable improvement in ED performance in month	**Highlight** • ED performance against 4-hour standard at 90.2% in month • ED time to clinician within the 60-minute standard in month. **Challenges** • Theatre utilisation has improved in month but is falling short of target; review continues with Surgery of list allocation and utilisation • Decline in WNB rates over the last 2 months, concern this relates to external factors affecting families ability to attend faced to face appointments; WNB AI toll continues to be rolled out at speciality level.
RESPONSIVE	Access challenges remain in relation to RTT and Diagnostics	**Highlight** ▪ Radiology achieving above 95% for diagnostics within 6 weeks, considerable improvement in last 3 months **Challenges** ▪ Physiology and Endoscopy diagnostic waiting times remain, recovery plans in place with a target recovery date of March 2023 across all services. ▪ RTT challenges remain from a 52 week perspective in Gastroenterology and Dermatology; new Gastroenterology Consultant commenced in September and recovery plan in action to reduce waits in the service; Dermatology staffing challenges identified and business case to improve sustained improvement in development.

WELL LED	Mandatory Training Compliance remains compliant	**Highlight** • **Challenges** • Long term sickness absence rates across the Division remain high, with high levels of absence in relation to stress/anxiety; all cases being managed effectively • Turnover analysis underway to understand reasons for staff leaving, this will be cross referenced with the outputs from the Staff Big Conversations to develop a long term workforce retention plan.

Medicine 000078

SAFE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	28	33	39	24	49	32	40	35	44	45	29	38	37		No Threshold
Clinical Incidents resulting in No Harm	101	133	93	87	100	104	105	91	108	102	116	123	117		No Threshold
Clinical Incidents resulting in minor, non permanent harm	17	12	28	25	18	19	14	14	17	27	27	17	18		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	0	0	0	0	0	1	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	2	3	1	0	1	1	0	0	1	2	0	0	1		No Threshold
Medication Errors (Incidents)	20	35	24	20	30	28	18	20	31	29	21	31	39		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	2	1	6	7	4	1	4	2	0	4	5	0	1		No Threshold
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	75.0%	85.7%	91.3%	83.3%	83.3%								100.0%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	1	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	3	3	4	2	1	0	1	3	7	7	4	4	6		No Threshold
Hospital Acquired Organisms - MSSA	0	0	1	1	0	0	0	0	1	0	0	1	0		No Threshold
Cleanliness Scores	98.7%	98.8%	99.4%	98.5%	98.4%	99.2%	98.8%	99.4%	99.7%	99.4%	98.5%	99.7%	99.2%		No Threshold

CARING

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Complaints	4	3	5	7	2	5	5	4	6	7	8	5	4		No Threshold
PALS	26	49	50	45	42	35	50	53	34	45	45	34	50		No Threshold

EFFECTIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Referrals Received (Total)	1,999	2,561	2,743	2,828	3,182	3,057	2,658	3,449	2,568	2,477	2,428	2,666	2,389		No Threshold
ED: 95% Treated within 4 Hours	87.7%	73.3%	72.5%	66.4%	74.9%	80.2%	77.1%	64.8%	72.5%	73.7%	77.8%	75.9%	90.2%		>=95 % N/A <95 %
ED: Patients In Department >12 Hours	0	14	47	46	26	11	23	70	19	10	23	8	2		0 N/A >0
ED: Median Time to Triage (Mins)	10	14	17	17	13	10	12	20	12	14	11	11	8		No Threshold
ED: Median Time to Clinical Assessment (Mins)	76	100	108	129	87	83	102	125	106	104	101	109	58		No Threshold
ED: Percentage Left without being seen	4.3%	9.1%	9.5%	8.7%	6.1%	4.0%	5.9%	10.6%	7.6%	7.8%	5.4%	6.5%	1.5%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	0	1	0	1	4	0	1	1	0	1	1	1	0		0 N/A >0
ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	0	1	0	0	3	0	0	0	0	0	0	0	0		0 N/A >0
ED: Re-attendance within 7 days of original attendance (%)	9.7%	8.4%	9.2%	9.6%	9.9%	9.1%	8.8%	9.5%	9.4%	8.4%	8.9%	9.2%	9.1%		No Threshold
ED: Number of patients spending >12 hours from decision to admit to admission	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised	72.2%	78.5%	76.6%	76.7%	73.7%	70.8%	74.9%	79.2%	78.3%	82.7%	75.8%	77.6%	82.1%		>=90 % >=80 % <80 %

Medicine 000079

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
On the day Elective Cancelled Operations for Non Clinical Reasons	3	2	3	5	0	4	0	5	9	0	2	2	1		No Threshold
28 Day Breaches	0	1	1	2	2	0	0	2	1	6	1	1	2		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	42	30	43	45	40	33	37	26	36	27	15	10	12		No Threshold
OP Appointments Cancelled by Hospital %	14.9%	13.9%	15.3%	12.5%	12.4%	12.7%	13.6%	13.2%	15.3%	15.8%	13.4%	13.0%	11.4%		<=5 % N/A >10 %
Was Not Brought Rate	10.7%	9.2%	9.1%	8.8%	8.8%	8.6%	7.8%	8.0%	9.0%	8.6%	9.7%	9.1%	10.4%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	10.9%	8.6%	9.3%	8.6%	8.7%	10.4%	7.3%	9.0%	8.8%	8.4%	9.1%	10.5%	11.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	10.8%	9.4%	9.1%	8.9%	8.8%	8.3%	7.9%	7.8%	9.0%	8.7%	9.8%	8.5%	10.1%		<=14 % <=16 % >16 %
Coding average comorbidities	5.58	5.50	5.68	5.57	5.49	5.51	5.41	5.55	5.73	5.70	5.53	5.49	5.74		No Threshold

RESPONSIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	100.0%	92.7%	88.7%	100.0%	92.5%	93.3%	92.1%	93.4%	92.2%	98.0%	98.0%	94.4%	97.9%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	97.9%	92.7%	94.3%	100.0%	98.1%	98.7%	97.0%	95.9%	98.0%	96.0%	96.0%	99.1%	97.9%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	91.5%	92.7%	86.8%	89.7%	58.5%	57.3%	58.4%	53.7%	51.0%	55.0%	62.0%	66.4%	64.2%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	87.2%	90.2%	100.0%	94.9%	96.2%	97.3%	95.0%	97.5%	95.1%	98.7%	96.0%	100.0%	100.0%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	72.3%	75.6%	73.6%	84.6%	73.6%	58.7%	80.2%	89.3%	80.4%	79.2%	82.0%	86.0%	77.9%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	74.5%	85.4%	86.8%	97.4%	92.5%	92.0%	92.1%	96.7%	95.1%	90.6%	90.0%	89.7%	90.5%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	83.3%	77.5%	65.4%	65.9%	67.4%	64.1%	63.4%	62.8%	61.5%	62.0%	59.6%	56.7%	64.7%		>=92 % >=90 % <90 %
Waiting List Size	3,507	3,565	5,605	5,842	5,943	5,955	6,136	6,411	6,922	7,266	7,445	7,617	7,559		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	7	13	23	10	15	5	2	2	5	8	10	27	32		0 N/A >0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	96.4%	95.2%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks	94.4%	97.1%	96.4%	88.7%	92.3%	88.5%	66.7%	59.6%	55.2%	62.0%	69.5%	67.7%	68.0%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	100.0%	100.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	91.9%	89.8%	89.8%	90.0%	88.2%	89.8%	90.4%	88.9%	89.9%	90.2%	91.4%	90.6%	90.1%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	100.0%	96.0%	91.0%	98.0%	94.0%	100.0%	99.0%	99.0%	97.0%	96.0%	93.0%	98.0%	99.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	93.0%	79.0%	73.0%	81.0%	84.0%	93.0%	82.0%	89.0%	83.0%	80.0%	84.0%	83.0%	86.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	61.0%	57.0%	51.0%	66.0%	54.0%	72.0%	64.0%	67.0%	61.0%	62.0%	71.0%	69.0%	72.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	83.1%	86.7%	100.0%	84.5%	90.2%	74.8%	72.5%	77.1%	73.2%	84.1%	96.0%	94.1%	94.8%		>=99 % N/A <99 %
Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	91.7%	100.0%	97.1%	94.3%	93.6%	89.7%	93.5%	91.2%	87.1%	95.7%	97.3%	97.1%	100.0%		>=99 % N/A <99 %
Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	100.0%	100.0%	98.0%	98.7%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.9%		>=99 % N/A <99 %

WELL LED

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-58	253	-127	-199	87	144	-261	-344	-343	-653	-1,032	760	-250		No Threshold

Medicine 000080

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Income In Month Variance (£'000s)	-490	201	-184	1,138	829	-308	135	273	1,294	638	16	649	316		No Threshold
Pay In Month Variance (£'000s)	47	121	-35	15	70	-96	-218	-376	-151	-160	-234	476	145		No Threshold
AvP: IP - Non-Elective	694	826	1,008	956	860	892	913	902	-32	-5	12	35	-80		>=0 N/A <0
AvP: IP Elective vs Plan	134	112	125	125	95	120	136	165	7	9	14	11	13		>=0 N/A <0
AvP: OP New	1,214.00	1,628.00	1,601.00	1,804.00	1,205.00	1,323.00	1,277.00	1,520.00	-154.87	221.49	283.98	176.03	331.12		>=0 N/A <0
AvP: OP FollowUp	5,179.00	6,032.00	5,375.00	6,066.00	4,864.00	5,625.00	5,238.00	6,319.00	1,208.18	1,406.02	1,411.02	643.73	1,116.32		>=0 N/A <0
AvP: Daycase Activity vs Plan	1,139	1,276	1,276	1,377	1,167	1,203	1,231	1,472	239	310	345	100	194		>=0 N/A <0
AvP: Outpatient Activity vs Plan	7,386	8,672	8,047	9,043	7,103	7,866	7,487	9,012	872	1,532	1,382	444	999		>=0 N/A <0
PDR	61.7%	65.8%	72.8%	74.0%	73.7%	74.5%	74.2%	74.0%	0.0%	1.6%	4.0%	16.3%	25.2%		No Threshold
Medical Appraisal	75.9%	52.2%	81.8%	75.7%	80.3%	0.0%	0.0%	10.2%	46.5%	58.9%	59.4%	74.1%	77.8%		No Threshold
Mandatory Training	86.9%	87.0%	86.1%	86.6%	86.7%	85.9%	87.0%	88.9%	90.2%	91.5%	91.9%	92.8%	93.5%		>=90 % >=80 % <80 %
Sickness	7.1%	6.3%	6.5%	7.4%	9.3%	9.8%	8.1%	9.0%	8.5%	6.8%	7.0%	8.3%	7.2%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.9%	1.8%	2.3%	2.2%	3.6%	4.5%	2.9%	4.1%	3.3%	2.0%	2.1%	3.3%	2.2%		<=1 % N/A >1 %
Long Term Sickness	5.2%	4.5%	4.3%	5.2%	5.8%	5.3%	5.2%	4.9%	5.2%	4.8%	4.9%	5.0%	5.0%		<=3 % N/A >3 %
Temporary Spend ('000s)	263	292	311	373	370	452	495	614	484	508	383	473	230		No Threshold
Staff Turnover	8.2%	9.2%	9.4%	9.5%	9.7%	11.0%	11.9%	12.6%	12.6%	13.4%	14.0%	14.9%	14.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	90.6%	95.0%	83.8%	83.7%	79.3%	75.2%	77.0%	81.3%	76.3%	78.2%	78.7%	79.0%	79.1%		>=90 % >=80 % <90 %

Surgery Division

SAFE	• In month reduction in clinical incidents resulting in minor, non-permanent harm. • Continue to see a positive recording culture for clinical incidents resulting in no harm.	**Highlight** • Continued trend of 0 pressure ulcers. • Continued trend of 0 never events for over 12 months. **Challenges** • In month increase in medication errors.
CARING	• Increase in month for PALS and formal complaints- continued improvement work underway in the division to better inform patients of expected waiting times.	**Highlight** • 100% of PALS and complaints consistently responded to within given timeframes. **Challenges**
EFFECTIVE	• August saw a reduction in referrals compared to previous months which is likely due to the time period. • Main areas of challenge in August for theatre utilisation were Cardiac Surgery (due to the increase in NEL cases), Gynaecology, Orthopaedics and Paediatric Surgery. A significant number of short notice theatre changes were made in August due to unprecedented volume of sickness within theatres which affected overall utilisation. This is not expected to continue into September. • WNB initiatives to focus on specialities with highest volume/rate. Community sites to be reviewed in September in order to increase number of overbookings to offset WNB rate, particularly Community Ophthalmology.	**Highlight** • Continued trend of 0 readmissions to PICU within 48 hours for 5th month. • Hospital initiated clinic cancellations reduced for 3rd consecutive month. **Challenges** • Theatre utilisation decreased to 86.1% in August. • WNB rate although reduced in month is still higher than target.
RESPONSIVE	• RTT position decreased in August which was in line with the divisional trajectory. This is predominantly within Paediatric Dentistry and Spinal Surgery. The Dental and therefore divisional position is projected to improve from Mid-October with additional capacity. There is still a risk in achieving RTT compliance as the additional capacity will address patients waiting > 52 weeks in the first instance- this figure will start to decrease. The division are on track to have 0 > 52 weeks in other specialties by October. • Division wide trajectories are being completed by October to analyse required OP and IP capacity to bring specialities in line with 18 weeks & to manage potential growth.	**Highlight** • Diagnostic compliance improved for the 2nd consecutive month which is predominantly a result of the improvement work within Urology to improve the Urodynamics compliance. This is set to fall within 6 weeks by January 2023. **Challenges** • RTT open pathways decreased further in August & patients waiting > 52 weeks grew to 370. • Patients knowing their expected date of discharge remains below target for 2nd consecutive month, to be reviewed by divisional matrons. • Waiting list size grew again for the 12th consecutive month, emphasising the importance of the demand and capacity work underway within the division.
	• August was a challenging month financially and the	**Highlight**

WELL LED	division were £425k off control total and did not achieve ERF. This was predominantly due to a significant reduction in theatre activity as a result of a high volume of sickness within theatres. This is not expected to continue, and September is projecting to hit weekly targets. The division has reviewed the impact of lost activity and will look to factor into the recovery plan. There is however a risk due to the reduced number of WLI sessions we will be able to run whilst the BMA rate card is under review.	• Mandatory training compliance was above target for the 5th consecutive month which is a result of a focus by all management teams. • Sickness rates decreased in month although the short-term sickness in August was focused in theatres and so had a significant impact on elective activity. **Challenges** • August control total in month was –425 • Temporary spend remains a challenge due to a number of workforce issues. WLI spend is reducing in focused areas but work is ongoing to reduce this further and a review against 19/20 spend is underway.

Surgery 000083

SAFE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	24	42	33	33	21	24	21	34	36	39	27	51	28		No Threshold
Clinical Incidents resulting in No Harm	114	107	103	119	117	79	114	132	111	144	137	157	126		No Threshold
Clinical Incidents resulting in minor, non permanent harm	49	39	43	80	40	40	43	42	45	61	52	71	62		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	1	0	1	1	0	2	1	1	1	0	0	1	1		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	1	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	3	1	1	3	4	1	2	2	1	6	4	0	1		No Threshold
Medication Errors (Incidents)	28	26	20	28	29	21	21	26	26	39	27	23	40		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	1	0	0	0	0	0	0	0		0 N/A >0
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	100.0%	75.0%	82.6%	82.4%	75.0%								75.0%		>=90 % N/A <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	0	2	1	0	0	1	0	0	0	0	0		No Threshold
Cleanliness Scores	98.2%	98.6%	98.5%	97.4%	99.3%	98.7%	98.7%	99.1%	98.5%	99.5%	99.2%	99.4%	99.3%		No Threshold

CARING

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Complaints	4	6	4	5	4	4	10	10	8	5	6	1	6		No Threshold
PALS	25	29	29	42	33	28	45	43	32	59	55	45	48		No Threshold

EFFECTIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	2	0	0	0	1	1	1	0	0	0	0	0	0		No Threshold
% Readmissions to PICU within 48 hrs	2.7%	0.0%	0.0%	0.0%	1.3%	1.7%	1.1%								No Threshold
Referrals Received (Total)	3,251	3,959	3,618	4,019	3,178	3,392	3,696	4,315	3,441	4,286	3,986	3,559	3,448		No Threshold
Theatre Utilisation - % of Session Utilised	81.3%	83.8%	86.7%	79.4%	81.5%	77.5%	86.0%	88.6%	87.5%	96.8%	106.8%	89.2%	85.7%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	9	30	20	51	23	18	16	18	12	22	24	18	25		No Threshold
28 Day Breaches	8	4	10	10	23	7	3	7	9	3	7	7	8		0 N/A >0
Hospital Initiated Clinic Cancellations < 6 weeks notice	74	54	78	43	51	48	34	50	39	28	44	36	32		No Threshold
OP Appointments Cancelled by Hospital %	11.3%	11.3%	10.5%	8.8%	10.5%	12.8%	12.4%	13.7%	14.4%	12.1%	11.3%	10.9%	11.0%		<=5 % <=10 % >10 %
Was Not Brought Rate	10.1%	8.6%	7.8%	8.3%	9.1%	9.3%	8.2%	7.9%	9.3%	8.8%	9.1%	9.8%	9.4%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	12.0%	9.9%	9.3%	10.2%	10.6%	11.0%	9.7%	8.6%	11.7%	9.9%	10.1%	11.1%	10.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	9.5%	8.1%	7.3%	7.6%	8.6%	8.6%	7.6%	7.7%	8.5%	8.4%	8.7%	9.3%	8.8%		<=14 % <=16 % >16 %
Coding average comorbidities	4.57	4.51	4.50	4.28	4.51	4.57	4.65	4.59	4.47	4.52	4.42	4.32	4.47		No Threshold
CCAD Cases	19	23	29	24	33	20	22	27	29	26	30	29			No Threshold

Surgery 000084

RESPONSIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
IP Survey: % Received information enabling choices about their care	95.0%	99.1%	99.1%	98.7%	92.7%	97.7%	93.6%	96.4%	97.7%	97.6%	99.2%	97.4%	97.8%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	97.8%	98.3%	99.1%	98.7%	95.8%	97.7%	96.5%	99.0%	100.0%	99.0%	99.2%	98.4%	98.3%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	93.5%	96.6%	96.4%	85.9%	78.1%	80.9%	73.1%	73.8%	75.4%	75.2%	97.0%	71.9%	78.2%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	99.3%	99.1%	98.2%	100.0%	97.9%	98.5%	98.2%	99.5%	98.3%	99.0%	98.3%	99.0%	97.8%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	79.1%	75.0%	81.2%	76.9%	81.2%	78.6%	81.3%	86.2%	77.7%	78.1%	82.2%	82.8%	83.2%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	92.1%	90.5%	95.5%	94.9%	88.5%	91.6%	91.8%	90.8%	95.4%	91.0%	90.7%	90.6%	92.7%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	67.4%	63.8%	61.7%	63.1%	63.5%	61.9%	61.5%	61.9%	61.0%	62.7%	59.8%	57.8%	56.0%		>=92 % >=90 % <90 %
Waiting List Size	8,632	8,319	11,360	11,505	11,621	11,567	11,949	12,413	13,085	13,640	14,220	14,422	14,766		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	186	249	294	239	202	231	244	246	282	265	314	336	370		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	88.9%	80.0%	83.3%	66.7%	32.5%	35.4%	29.6%	38.3%	23.9%	33.9%	43.1%		>=99 % N/A <99 %

WELL LED

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-5	-137	-349	-598	-657	-130	-232	-581	-603	-353	-271	-43	-425		No Threshold
Income In Month Variance (£'000s)	28	-144	-43	68	59	-16	23	131	10	10	115	63	51		No Threshold
Pay In Month Variance (£'000s)	-64	-158	-82	-452	-331	-85	-358	-196	-218	5	-256	15	-206		No Threshold
AvP: IP - Non-Elective	386	421	371	411	404	386	385	452	6	-15	-70	-67	-76		>=0 N/A <0
AvP: IP Elective vs Plan	243	270	288	278	247	213	237	281	-17	-19	-34	-23	-37		>=0 N/A <0
AvP: OP New	2,170.00	2,824.00	2,451.00	2,479.00	1,958.00	2,053.00	1,925.00	2,350.00	-565.43	-241.53	-136.79	-160.24	-90.42		>=0 N/A <0
AvP: OP FollowUp	5,725.00	6,664.00	7,095.00	8,281.00	5,911.00	6,136.00	6,273.00	7,680.00	722.52	860.91	98.68	-652.62	-375.36		>=0 N/A <0
AvP: Daycase Activity vs Plan	622	710	732	837	696	672	611	720	-22	-51	4	-78	-42		>=0 N/A <0
AvP: Outpatient Activity vs Plan	9,329	11,089	11,076	12,583	9,231	9,382	9,511	11,322	220	748	-10	-1,019	-665		>=0 N/A <0
PDR	52.8%	54.2%	60.0%	61.6%	60.9%	61.4%	61.3%	61.1%	0.3%	0.5%	0.6%	31.9%	32.8%		No Threshold
Medical Appraisal	66.7%	59.5%	87.0%	89.3%	91.0%	0.8%	0.8%	14.4%	71.2%	80.6%	76.7%	78.7%	85.5%		No Threshold
Mandatory Training	88.4%	88.9%	88.4%	87.4%	87.6%	87.0%	88.5%	89.4%	91.1%	90.9%	91.8%	92.7%	93.6%		>=90 % >=80 % <80 %
Sickness	6.2%	6.4%	6.0%	5.6%	7.2%	8.3%	6.0%	7.0%	6.3%	5.4%	5.6%	7.0%	5.5%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	1.7%	2.3%	2.5%	1.9%	3.2%	4.5%	2.6%	3.4%	2.8%	2.2%	2.5%	3.6%	1.8%		<=1 % N/A >1 %
Long Term Sickness	4.5%	4.1%	3.5%	3.8%	4.0%	3.8%	3.4%	3.6%	3.5%	3.2%	3.1%	3.4%	3.7%		<=3 % N/A >3 %
Temporary Spend ('000s)	469	532	363	631	535	474	535	824	621	341	482	595	586		No Threshold
Staff Turnover	10.2%	10.4%	11.2%	11.4%	11.3%	11.8%	12.1%	12.3%	12.0%	11.2%	11.3%	11.2%	11.6%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	92.5%	94.1%	94.8%	89.0%	87.0%	83.4%	86.6%	80.5%	86.8%	90.4%	87.5%	84.5%	63.6%		>=90 % >=80 % <90 %

Community & Mental Health Division

SAFE	CAMHS Pharmacist commenced in post in July – focus on reducing medication errors. Established deteriorating patient workstream following a number of incidents	**Highlight** • Zero moderate, severe harms or deaths recorded in July and August 2022 • Zero grade 3 or 4 pressure ulcers **Challenges** • High number of incidents relating to interpreter services leading to "failed" or incomplete appointments
CARING	Established Divisional patient experience sub-group "Governance Roadshow" to promote good governance focus on data breach/human error and patient experience (5 rights of appointments) Deep Dive on Rainbow/SARC complaints to understand if any themes or improvement opportunities by 30 September 2022	**Highlight** • 91% FFT Scores for Community in August • 96% FFT Scores for Mental Health in August • 94% FFT Scores for Outpatients in August • 43 compliments received • 16 Excellence reports **Challenges** • 3 formal complaints received in July • 11 formal complaints received in August (3 Rainbow; 3 Dev Paeds; 3 CAMHS; 2 ADHD/ASD) • 47 PALS enquiries in July • 41 PALS enquiries in August
EFFECTIVE	ISANSY monitors now in use within Community Nursing Service & will form part of the approach to developing the Virtual Ward at Alder Hey. WNB predictor tool – rolled out in Comm Paeds since start August and a plan to extend pilot to Community Mental Health Services planned (September) Focussed action required on HCA H&W clinics to improve attendance rates CAMHS Paired Outcome Scores to be area of focus with aim of achieving minimum 50% (end 2022/23) & long-term target of 90% achievement	**Highlight** • Sensory project update - internal group underway to share learning and embed processes across Trust including training, audit and toys! • Additional funding approved for second year of Liverpool 'Autism in Schools' Project to embed training and develop young people's recourse pack • Successful bids to HEE for additional CAMHS training posts in Liverpool and Sefton to support growth in workforce **Challenges** • WNB rates in Division above 10% except for ASD which is below 6% • Clinic letter sign off within 7 days of activity is 74.65% at the end of August
RESPONSIVE	ASD Improvement A3 developed with actions agreed and monitored via Divisional Board monthly.	**Highlight** • Reduction in longest waiting patients across all services. No over 52 weeks in SALT by 31 August • OP activity compared to 2019 - 154% August and 123% YTD

	SALT team to pilot new way of working within early years to support early assessment and intervention. Project commissioned by Health and Local Authority and monitored via SEND board. To commence October 2022	• Virtual OP activity above 40% consistently within Division **Challenges** • ASD and ADHD waiting time above agreed 30-week KPI • CAMHS waiting times higher than locally agreed KPIs • High WNB rate in Community – highest numbers of WBN are in community HCA clinics which are required to support prescribing processes. •
WELL LED	PDR compliance for all staff following focus on Band 7 and above staff is an area of priority for division	**Highlight** • Mandatory Training remains above 90% • Return to Work meetings remain at above 90% • At the end of August there are no Risk on Risk Register overdue for review **Challenges** • Sickness absence remains over target with an increase in month. HR team to continue to work closely with managers and staff to support and encourage a swift return to work. • Turnover remains high at **14.52%** and a challenge for the Division - top reasons for leaving are; Promotion, End of FTC, Work Life Balance, Relocation and Retirement.

Community 000087

SAFE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	4	8	4	2	4	13	14	10	12	18	12	18	24		No Threshold
Clinical Incidents resulting in No Harm	65	49	63	56	29	40	51	65	88	146	70	56	44		No Threshold
Clinical Incidents resulting in minor, non permanent harm	10	14	8	9	4	7	17	65	39	44	19	13	10		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)	8	12	18	13	5	6	5	16	5	4	6	4	6		No Threshold
Pressure Ulcers (Category 3)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores	86.8%				98.6%	98.5%	98.2%	97.3%	100.0%	100.0%			100.0%		No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Complaints	3	4	2	2	3	7	4	4	1	3	2	4	11		No Threshold
PALS	34	63	51	48	25	31	31	35	29	37	50	39	40		No Threshold

EFFECTIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Referrals Received (Total)	729	1,022	1,119	1,236	1,064	1,148	1,157	1,414	898	1,353	1,178	957	806		No Threshold
Hospital Initiated Clinic Cancellations < 6 weeks notice	22	17	25	41	17	12	8	13	2	0	11	16	6		No Threshold
OP Appointments Cancelled by Hospital %	15.0%	12.2%	17.0%	9.8%	13.9%	13.7%	14.0%	17.0%	14.1%	11.2%	15.7%	12.2%	11.6%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	12.1%	16.0%	17.6%	17.0%	16.5%	16.3%	12.0%	10.9%	16.3%	10.7%	15.1%	16.6%	18.7%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	16.1%	13.8%	13.4%	14.0%	13.1%	12.3%	13.2%	11.8%	14.8%	14.5%	14.9%	18.5%	19.3%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	14.2%	21.6%	17.6%	17.9%	19.9%	18.8%	10.6%	13.8%	16.3%	11.5%	14.6%	12.0%	15.8%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	24.4%	24.0%	20.1%	19.1%	15.7%	15.8%	14.8%	14.5%	17.6%	13.0%	17.9%	24.1%	26.1%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	19.6%	12.6%	16.0%	20.9%	17.4%	18.2%	16.1%	13.3%	22.6%	13.5%	19.3%	25.1%	26.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	15.2%	10.9%	12.0%	13.8%	14.0%	12.4%	13.8%	12.3%	15.1%	16.6%	15.9%	18.1%	17.9%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	99.5%	101.4%	122.6%	103.8%	91.2%	100.5%	128.6%	128.6%	128.6%	124.9%	114.3%	114.3%	113.4%		No Threshold
CAMHS: Tier 4 DJU Bed Days	185	184	236	210	198	219	252	279	270	270	240	248	247		No Threshold
CYP1 - Number of Referrals	0	0	17	30	112	175	140	186	106	135	157	61	83		No Threshold
CYP1 - Number of Referrals Accepted	0	0	16	13	44	77	49	77	48	54	46	24	28		No Threshold
CYP1 - Number of visitors to the site			1,114	1,302	990	1,224	1,234	1,808	1,063	1,626	1,329	1,151	931		No Threshold
Coding average comorbidities	8.00			4.50	7.00	3.50			15.00	2.00	2.00		3.50		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

Community 000088

RESPONSIVE

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		1		1		4									No Threshold
CAMHS: Referrals Received	297	476	526	568	434	537	484	622	350	567	490	366	302		No Threshold
CAMHS: Referrals Accepted By The Service	141	234	302	307	220	277	233	317	171	277	229	173	157		No Threshold
CAMHS: % Referrals Accepted By The Service	47.5%	49.2%	57.4%	54.0%	50.7%	51.6%	48.1%	51.0%	48.9%	48.9%	46.7%	47.3%	52.0%		No Threshold
RTT: Open Pathway: % Waiting within 18 Weeks	61.2%	52.8%	53.3%	54.5%	56.9%	55.0%	54.1%	52.0%	49.7%	54.3%	53.0%	51.4%	50.8%		>=92 % >=90 % <90 %
Waiting List Size	1,147	1,208	1,530	1,629	1,563	1,576	1,646	1,788	1,887	1,979	2,070	2,117	2,169		No Threshold
Waiting Greater than 52 weeks - Incomplete Pathways	2	1	1	1	1	1	0	1	3	9	7	4	3		0 N/A >0
CAMHS: Crisis / Duty Call Activity	367	675	563	766	629	687	619	751	652	800	665	549	596		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks	68.3%	63.8%	63.9%	68.2%	68.7%	67.7%	67.2%	70.6%	69.2%	69.6%	64.9%	56.9%	53.0%		>=92 % >=90 % <88 %
ASD: Completed Pathways	242	65	73	136	89	112	95	59	66	72	68	80	69		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	5.0%	9.2%	6.8%	20.6%	20.2%	24.1%	10.5%	3.4%	9.1%	19.4%	5.9%	3.8%	11.6%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)			23.8%	21.7%	25.0%	16.7%	15.0%	12.5%	15.0%	57.1%	71.4%	77.8%	81.2%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)			100.0%	100.0%	50.0%	100.0%	50.0%	100.0%		0.0%	100.0%	0.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals	144	143	165	168	177	150	140	157	134	165	171	172	135		No Threshold
CCNS: Number of Contacts	809	736	931	959	951	740	823	904	800	928	914	876	732		No Threshold

WELL LED

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	250	540	16	60	185	346	-77	93	36	297	160	453	261		No Threshold
Income In Month Variance (£'000s)	75	118	-78	59	118	-112	-106	78	53	0	20	78	43		No Threshold
Pay In Month Variance (£'000s)	167	15	142	319	-9	248	228	-112	17	90	204	252	203		No Threshold
AvP: OP New	518.00	586.00	593.00	661.00	533.00	543.00	592.00	672.00	125.00	364.00	137.00	194.00	327.00		>=0 N/A <0
AvP: OP FollowUp	3,069.00	3,804.00	3,423.00	4,157.00	3,414.00	3,758.00	3,599.00	4,091.00	1,160.00	1,569.00	1,265.00	1,322.00	1,444.00		>=0 N/A <0
AvP: Outpatient Activity vs Plan	3,587	4,391	4,016	4,824	3,961	4,314	4,203	4,782	1,293	1,938	1,406	1,521	1,792		>=0 N/A <0
PDR	78.8%	81.0%	80.9%	83.4%	83.6%	83.0%	82.5%	82.6%	0.0%	1.6%	8.2%	28.7%	37.2%		No Threshold
Medical Appraisal	68.0%	48.0%	80.0%	60.0%	84.6%	0.0%	0.0%	8.6%	40.0%	33.3%	50.0%	72.2%	88.9%		No Threshold
Mandatory Training	91.9%	91.4%	91.6%	91.5%	91.1%	91.5%	92.4%	93.3%	94.4%	95.3%	95.0%	95.4%	95.7%		>=90 % >=80 % <80 %
Temporary Spend ('000s)	127	168	192	166	273	168	278	493	202	254	153	198	192		No Threshold
Safer Staffing (Shift Fill Rate)	98.9%	96.3%	108.0%	98.2%	96.8%	99.1%	99.1%	99.4%	96.9%	96.9%	98.5%	96.8%	108.4%		>=90 % >=80 % <90 %

Research Division

SAFE	• Divisional Mandatory training demonstrates good compliance at 94% overall for month. • All Incidents reported onto Ulysses system and thematic reviews conducted periodically. • Quarterly incident bulletin shared with team. • Trust metrics discussed at monthly 121's with staff to encourage compliance. • PDRs complete for band 7 and above	**Highlight** • Mandatory Training > 90% • GCP training 86% • SOP compliance 79% (dropped due to SOP review window) • ANTT compliance 100% • CRD ICP compliant 97.6% **Challenges** • X 1 incidents reported in month • Low staffing levels at times and CRF ward working in amber model.
CARING	• R&D metrics for PALS and complaints are recorded separately from corporate data (action completed) • 0 complaints received • Patient centred follow up care for patients on clinical trials. • Patient feedback used to improve quality of patient care and experience • Extra ordinary team brief to cover proposed R&I strategy.	**Highlight** • X 0 Complaints or PALS concerns • Patient and family story shared on website. • PRES link and paper versions given to all families to capture feedback • Actively seeking patient research stories to share (supported by comms team) • Staff engagement sessions ongoing **Challenges** • More work to do on local patient internal audits • Low numbers of electronic survey questionnaires from patients on system. • Compliments to be added to Ulysses as standard practice. • Staff morale and queries about internal review.
EFFECTIVE	• Continue with portfolio review with a number of meetings held with key PIs to review portfolios. • Clinicians encourage children and young people to make informed decisions about participating in studies. • Research skills training continues with new induction plan in progress for new starters. • Systems and processes are being reviewed as part of effective and efficient ways of working • 2 quality rounds hosted to explore research awareness in clinical staff and also RSV studies.	**Highlight** • Stop RSV trial. Leading recruitment site and continuing through summer months as rates remain high • Formally selected as site for large flagship RSV vaccine study and preparing to open in autumn. **Challenges** • CRD working with local system partners to improve research participation.
RESPONSIVE	• Coordinated and partnership working with local providers to offer joint training programmes. • Key working groups established for improvement plans in line with annual plan.	**Highlight** • Agile working continues to support flexibility for staff • Collaborative working with external partners continues • Archiving improvement project continues. **Challenges** • Response to NIHR portfolio review is slow due to complicated process and negotiations with PIs.
		Highlight

WELL LED	• LTS numbers have reduced with successful RTW for some staff members. • Internal staff survey results have been collated and shared • Monthly team briefs continue and each team have weekly huddles to report RAG rating on work pressures/concerns.	• Division supporting staff with Flexible working (hybrid model) • CRD engaging staff with SALS • Monthly team brief meetings continue- with plan for more F2F meetings. **Challenges** • Correct model for future working to be established • Recruitment and retention being monitored carefully due to increase in leavers- 19.4 for August. • F2F exit interviews continue with leavers with key questions focussed on retention

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	Developing the New Integrated Performance Report
Report of:	Chief Digital and Information Officer & Chief Operating Officer
Paper Prepared by:	Associate Chief Operating Officer

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

Developing the New Integrated Performance Report

1.0 Introduction

This paper provides the Trust Board with an update on the development of the new Integrated Performance Report (IPR).

The scope of this piece of work is limited to the IPR for Trust Board. Once this has been completed we will commence work on developing reports for Sub-Committees and Divisional reports for Performance Reviews, but these are outside of scope of this initial project.

2.0 Governance Arrangements

A paper was taken to Executive team meeting (21 July) and Trust Board (28 July) to describe the proposed approach and set scope. This proposal is consistent with the Brilliant Basics approach adopted in the Trust and the national "Making Data Count" principles.

An Executive Design Group has provided oversight with fortnightly meetings, and a Delivery Group has met weekly to implement actions, review progress, and ensure delivery remain on track against agreed milestones and timetable.

These groups have comprised of the following members:

Role	Name	Executive Design Group	Delivery Group
Deputy CEO	John Grinnell	Yes	
Chief Operating Officer	Adam Bateman	Yes	
Chief Digital and Information Officer	Kate Warriner	Yes	
Associate COO	Andrew McColl	Yes	Yes
Associate Director of Data and Analytics	Alex Garbett	Yes	Yes
Head of Analytics	Karl Edwardson	Yes	Yes
Insight Analyst	Karen Bailey		Yes

3.0 Stakeholder Engagement

A key part of using the Brilliant Basics approach is to ensure we listen and are informed by all appropriate stakeholders.

In addition to the Board Development Day on 12 April (with part of this session repeated on 01 September), the following stakeholders have been consulted individually through this process. This has mostly been through specific meetings, or in some cases by email correspondence:

Role	Name	Date
Chief Nursing Officer & AHP / HCP Lead	Nathan Askew	18 Aug / 01 Sep
Chief Operating Officer	Adam Bateman	19 Aug
Chief Digital and Information Officer	Kate Warriner	26 Aug
Chief People Officer	Melissa Swindell	30 Aug
Director of Corporate Affairs	Erica Saunders	01 Sep / 02 Sep
Deputy Director of Finance	Rachel Lea	02 Sep / 05 Sep
Non-Exec Directors	Kerry Byrne, Shalni Arora	06 Sep
Community & Mental Health Division	Lisa Cooper, Rachel Greer, Kate Holian	06 Sep
Division of Medicine	Mark Carmichael	01 Sep
Division of Surgical Care	Chloe Lee	08 Sep
Clinical Research Division	Jason Taylor, Sabrina Brown	26 Aug / 02 Sep
Estates & Facilities	Lachlan Stark	13 Sep

4.0 Summary of Improvements

The new IPR will include the following improvements:

- Reduction in overall length so the report is more manageable, with main report now 15-18 pages, plus 2 pages per Division (previous format was up to 60 pages in total)
- Overall reduction in volume of metrics, helping to focus on what matters
- Use of “watch / drive” metrics to differentiate priorities
- Use of SPC charts, with up to 24 months of data to give greater insight and show performance trajectory more clearly (removing RAG rating)
- Structured sections of narrative to succinctly celebrate successes, highlight areas of concern and focus on actions.
- More metrics for Research, improving parity and consistency with the other clinical divisions
- Divisions have much more succinct performance summary for Trust Board (with additional details to be reported at Executive led Performance Reviews)
- Corrected previous omissions of Risk Management, Digital, Corporate Services, and Estates & Facilities, making the new report more comprehensive and genuinely an ***integrated*** performance report.

The following table quantifies these changes with regard to number of metrics.

Number of Metrics	Old Corporate Report	New IPR	Comments
Safe	17	14	2 Drive + 12 Watch to differentiate priorities
Caring	8	6	2 Drive + 4 Watch to differentiate priorities
Effective	9	7	1 Drive + 6 Watch to differentiate priorities
Responsive	15	10	3 Drive + 7 Watch to differentiate priorities
Well Led	16	20	Differentiate between Workforce, Finance, with Risk and Digital metrics added to correct previous omission
Total	**65**	**57**	Initial reduction from 65 to 52 metrics (20% reduction) Plus 5 new metrics for Risk (2) and Digital (3) = total 57.
Community & Mental Health	57	41	28% Reduction in number of metrics
Medicine	81	39	52% reduction
Surgery	60	34	43% reduction
Research	5	25	Increase in metrics – to improve parity and consistency with the other clinical divisions
Corporate Services	0	12 + tbc	Pending meeting with Estates / Facilities

5.0 Prototype of the new IPR:
An extract from the new design, covering two CQC domains and one Divisional Performance Summary are included in the Appendix.

These are not completely final versions and the Delivery Group are still working on refining some minor details, however it does show the proposed structure, format, visual presentation and “look and feel” of the proposed IPR.

6.0 Complete List of Metrics in IPR

Following the stakeholder engagement each metric has been reviewed, giving consideration to relevance and prioritisation ("drive / watch") for the Trust Board. The full list of metrics which will be included as content for Main Report (with "Drive and Watch" metrics) and the Divisional Summaries is included in the Appendix.

It is proposed that, once approved, these metrics will remain consistent for the remainder of 2022/23 reporting, with a "window" to make changes in March/April 2023, aligned to annual planning, new national guidance and the Trust strategy refresh, with opportunity to include metrics on strategic areas (eg Health Inequalities, Green etc) for 2023/24. This will be managed through a formal process with robust governance and executive approval for changes.

7.0 Monthly timetable for Producing IPR

The following timetable is proposed for production of the IPR on a Monthly basis

Working Day	Task	Who
1-4	Populate report with most recent month data, checking the quality and accuracy of data.	KE
5-6	Technical Analysis / Insight comments completed for Drive metrics, and identify any special cause variation (inc watch metrics) for inclusion in Executive narratives.	AG / AM
7-8	Executive directors and Divisional Directors (or delegates) complete narrative sections and actions for Drive metrics. *If delegated, this requires Executive sign off by end of working day 8.*	Executive Directors
9	Consolidate each narrative section in full report.	KE
10	Nominated executive signs off full report.	KW / AB
11	Report available for circulation to the Executive Team, for their collective review prior to inclusion in Trust Board papers.	

8.0 Recommendations

It is recommended that the Trust Board approve:

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

The Delivery Group will then be able to complete the full report for all CQC domains and Divisions, with a technical review of each metric ensuring data parameters and definitions are set correctly. The final report design available the Executive Design Group by Friday 30th September, which will enable production of the IPR to commence from 3rd October for circulation to Trust Board in line with the agreed timetable.

Following completion of this design project for the Integrated Performance Report and production for October Trust Board, we will commence a second phase to roll out consistent approach to reporting for:

a) Sub-Committees of the Trust Board
b) Divisional Performance Reviews – this will be an extension of the Divisional Summaries included in the IPR.

It is requested that the Trust Board support this second phase by allowing some time at each sub-committee in October to engage with committee members, discuss and define scope of Sub-Committee reports.

APPENDICES

- **Prototype of the new IPR,** covering two CQC Domains and one Divisional Performance Summary

- **Complete List of Metrics in IPR,** showing content for Main Report (with “Drive and Watch” metrics) and Divisional Summaries

- **Metrics removed from previous Corporate Report**

Integrated Performance Report | August 2022

Alder Hey Children's NHS Foundation Trust

Outstanding Safety

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

Highlights:

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Areas of Concern:

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Forward Look (with actions)

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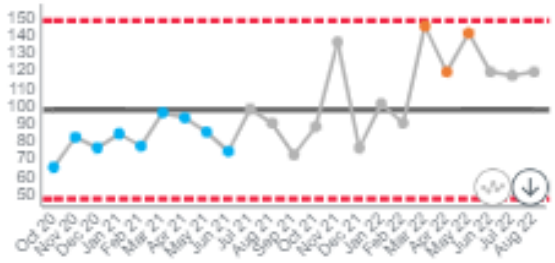
Number of Incidents rated Minor Harm and above



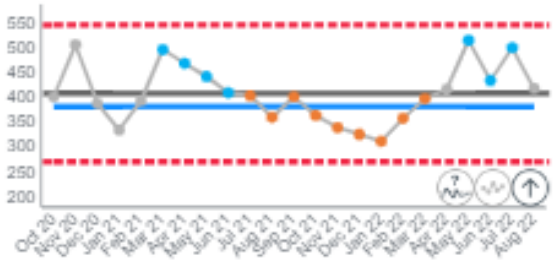
Technical Analysis:

Safe Technical Analysis (479)

Actions:

Safe Actions (479)

Number of Incidents rated No Harm and Near Miss



Technical Analysis:

Safe Technical Analysis (3876)

Actions:

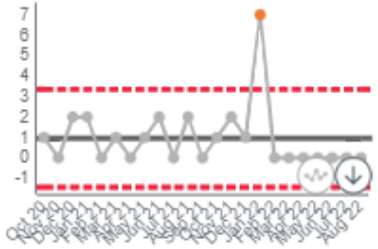
Safe Actions (3876)

Outstanding Safety - Metric Summary

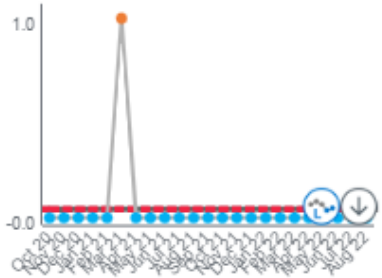
Metric Name	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	August 2022	119		96.21		
Number of Incidents rated No Harm and Near Miss	August 2022	420	383	408.21		
Number of Serious Incidents (Steis reported)	August 2022	0		0.96		
Number of Never Events	August 2022	0		0.04		
Sespis % Patients receiving antibiotic within 60 mins for ED	August 2022	74	90	83.66		
Sespis % Patients receiving antibiotic within 60 mins for Inpatients	December 2021	76	90	84.95		
Number of Medication Errors resulting in harm (minor harm and above)	August 2022	2	2	3.79		
Pressure Ulcers G2-4	August 2022	3		4.33		
Use of physical restrictive intervention (MH Tier 4)	August 2022	11		15.47		
Number of Unplanned Admissions to Critical Care (HDU/PICU)	July 2022	61		70.19		
Safe Staffing: Care Hours per patient per Day (Inpatient Wards)	July 2022	13		10.76		
Hospital Acquired Organisms - MRSA (BSI)	August 2022	0		0.00		
Hospital Acquired Organisms - (difficile)	August 2022	0		0.17		
Hospital Acquired Organisms - MSSA	August 2022	0		0.71		

Outstanding Safety - Watch Metrics

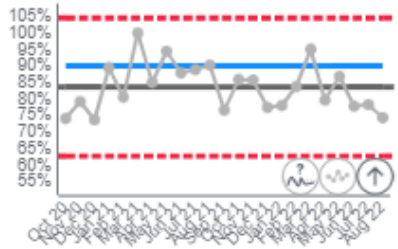
Number of Serious Incidents (Steis reported)



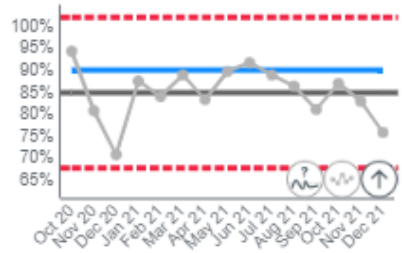
Number of Never Events



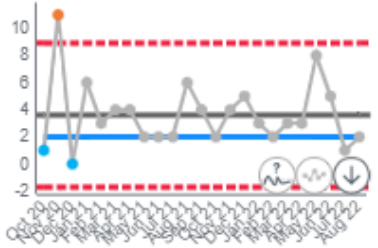
Sespis % Patients receiving antibiotic within 60 mins for ED



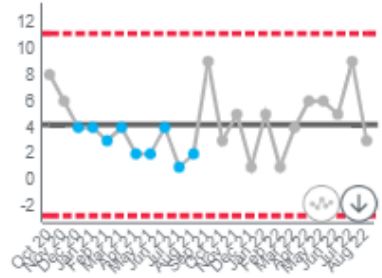
Sespis % Patients receiving antibiotic within 60 mins for Inpatients



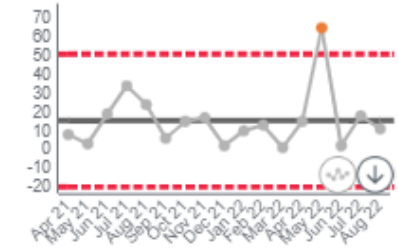
Number of Medication Errors resulting in harm (minor harm and above)



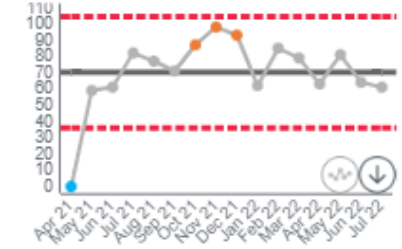
Pressure Ulcers G2-4



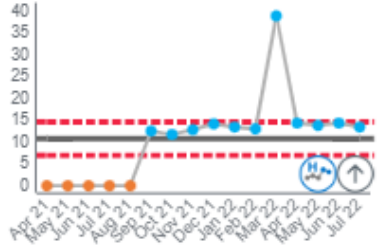
Use of physical restrictive intervention (MH Tier 4)



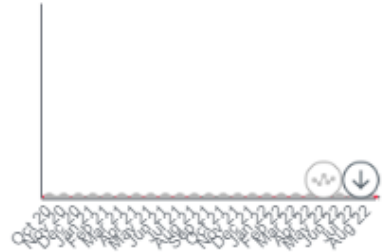
Number of Unplanned Admissions to Critical Care (HDU/PICU)



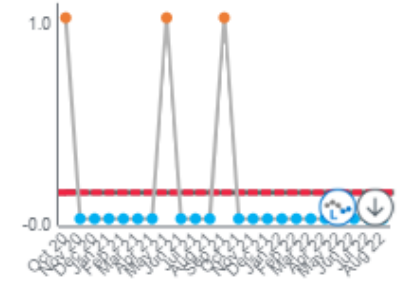
Safe Staffing: Care Hours per patient per Day (Inpatient Wards)



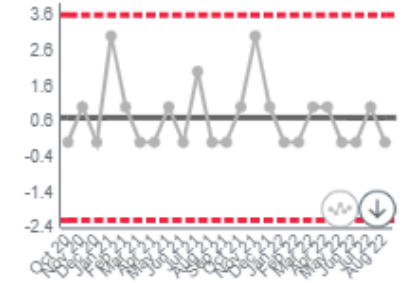
Hospital Acquired Organisms - MRSA (BSI)



Hospital Acquired Organisms - (difficile)



Hospital Acquired Organisms - MSSA



Integrated Performance Report | August 2022

Alder Hey Children's NHS Foundation Trust

Caring

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

Highlights:

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Areas of Concern:

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Forward Look (with actions)

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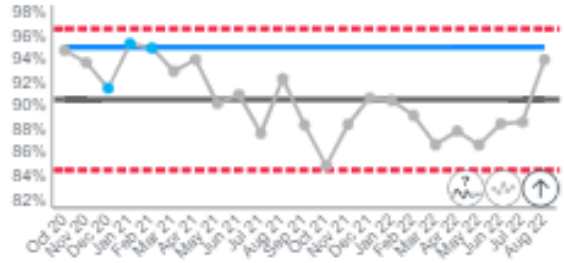
F&F Test - % Recommend the Trust



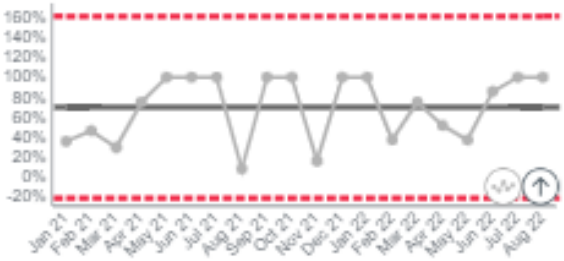
Technical Analysis:

Caring Technical Analysis (496)

Actions:

Caring Actions (496)

% Complaints Responded to within 25 working days



Technical Analysis:

Caring Technical Analysis (2829)

Actions:

Caring Actions (2829)

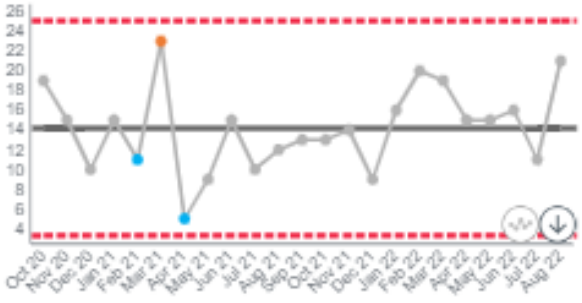
Integrated Performance Report | August 2022

NHS
Alder Hey Children's
NHS Foundation Trust

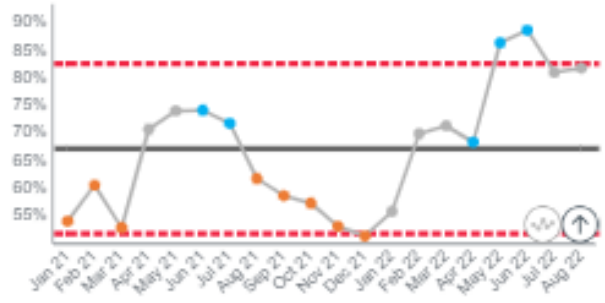
Caring - Metric Summary

Metric Name	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	August 2022	94	95	90.54		
% Complaints Responded to within 25 working days	August 2022	100		69.72		
Number of formal complaints received	August 2022	21		14.04		
% PALS Resolved within 5 Days	August 2022	82		67.08		
Number of PALS contacts	August 2022	150		114.83		
F&F ED - % Recommend the Trust	August 2022	92	95	76.37		

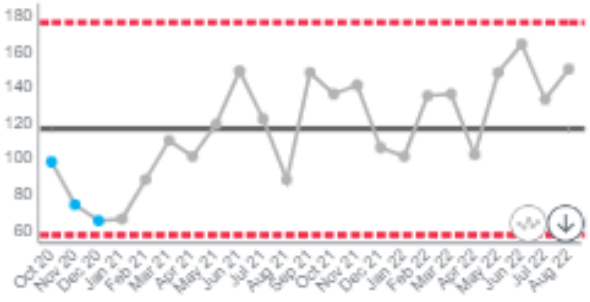
Number of formal complaints received



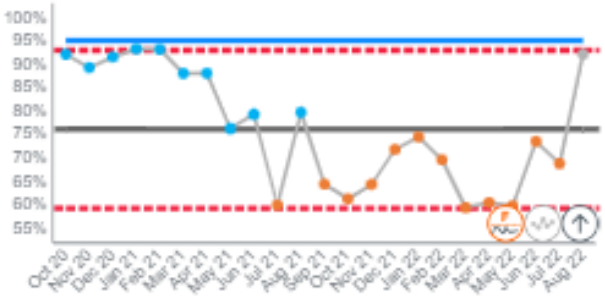
% PALS Resolved within 5 Days



Number of PALS contacts



F&F ED - % Recommend the Trust



Integrated Performance Report | August 2022

NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Medicine

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

Highlights:

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Areas of Concern:

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Forward Look (with actions)

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Safe

Metric Name	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	August 2022	119		96.21		
Number of Incidents rated No Harm and Near Miss	August 2022	420	383	408.21		
Sespis % Patients receiving antibiotic within 60 mins for ED	August 2022	74	90	83.66		
Sespis % Patients receiving antibiotic within 60 mins for Inpatients	December 2021	76	90	84.95		
Safe Staffing: Care Hours per patient per Day (Inpatient Wards)	July 2022	13		10.76		

Caring

Metric Name	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	August 2022	94	95	90.54		
% Complaints Responded to within 25 working days	August 2022	100		69.72		
Number of formal complaints received	August 2022	21		14.04		
% PALS Resolved within 5 Days	August 2022	82		67.08		
Number of PALS contacts	August 2022	150		114.83		
F&F ED - % Recommend the Trust	August 2022	92	95	76.37		

Integrated Performance Report | August 2022

NHS
Alder Hey Children's
NHS Foundation Trust

Divisional Performance Summary - Medicine

Responsive

Metric Name	Date	Value	Target	Mean	Variation	Assurance
Hospital Acquired Organisms - (difficile)	August 2022	0		0.17		
Hospital Acquired Organisms - MRSA (BSI)	August 2022	0		0.00		
Safe Staffing: Care Hours per patient per Day (Inpatient Wards)	July 2022	13		10.76		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	December 2021	76	90	84.95		
Sepsis % Patients receiving antibiotic within 60 mins for ED	August 2022	74	90	83.66		
Number of Incidents rated No Harm and Near Miss	August 2022	420	383	408.21		
Number of Incidents rated Minor Harm and above	August 2022	119		96.21		

Effective

Metric Name	Date	Value	Target	Mean	Variation	Assurance
F&F Test - % Recommend the Trust	August 2022	94	95	90.54		
% Complaints Responded to within 25 working days	August 2022	100		69.72		
Number of formal complaints received	August 2022	21		14.04		
% PALS Resolved within 5 Days	August 2022	82		67.08		
Number of PALS contacts	August 2022	150		114.83		
F&F ED - % Recommend the Trust	August 2022	92	95	76.37		

Well Led

Metric Name	Date	Value	Target	Mean	Variation	Assurance
Number of Incidents rated Minor Harm and above	August 2022	119		96.21		
Number of Incidents rated No Harm and Near Miss	August 2022	420	383	408.21		
Sepsis % Patients receiving antibiotic within 60 mins for ED	August 2022	74	90	83.66		
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients	December 2021	76	90	84.95		
Safe Staffing: Care Hours per patient per Day (Inpatient Wards)	July 2022	13		10.76		
Hospital Acquired Organisms - MRSA (BSI)	August 2022	0		0.00		
Hospital Acquired Organisms - (difficile)	August 2022	0		0.17		

Icon Definitions

Variation	Assurance	Description
		Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or deteriorating performance. This process is not capable. It will FAIL the target without process redesign.
		Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. However despite deterioration the process is capable and will consistently PASS the target.
		Special cause of a concerning nature where the measure is significantly HIGHER. This occurs where there is higher pressure in the process or worse performance. This process will not consistently hit or miss the target. This occurs when target lies between process limits.
		Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.
		Special cause of a concerning nature where the measure is significantly LOWER. However the process is capable and will consistently PASS the target.
		Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.
		Common cause variation, no significant change. This process is capable and will consistently PASS the target.
		Common cause variation, no significant change. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.
		Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.
		Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).
		Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.
		Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.
		Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target. (This occurs when target lies between process limits).

Complete List of Metrics in IPR

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Safe	Number of Incidents rated Minor Harm and Above	Change currency to "Harms per 1,000 bed days"	<72 pcm	Drive	Yes	Yes	Yes	Yes	
Safe	Number of Incidents rated No Harm and Near Miss	Change currency to "Harms per 1,000 bed days"	>380 pcm	Drive	Yes	Yes	Yes	Yes	
Safe	Number of Serious Incidents (Steis reported)	Change currency to "Days since…"	0 (nil)	Watch					
Safe	Number of Never Events	Change currency to "Days since…"	0 (nil)	Watch					
Safe	Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients		>= 90%	Watch		Yes	Yes		
Safe	Sepsis: % Patients receiving antibiotic within 60 mins for ED		>= 90%	Watch		Yes			
Safe	Number of Medication Errors rated Minor harm and above		<= 4	Watch					
Safe	Pressure Ulcers G2-4		<= 5	Watch					
Safe	Use of physical restrictive intervention (MH Tier 4)	New Metric	<= 20	Watch	Yes				
Safe	Number of Unplanned Admissions to Critical Care (HDU/PICU)	Def'n - Only internal transfers from wards to HDU/PICU.	<= 30	Watch					
Safe	Safe Staffing: Care Hours per patient per Day (Inpatient Wards)		>= 10	Watch	Yes	Yes	Yes	Develop Equivalent	
Safe	Hospital Acquired Organisms - MRSA (BSI)	Change currency to "Days since…"	0 (nil)	Watch					
Safe	Hospital Acquired Organisms - C.difficile	Change currency to "Days since…"	0 (nil)	Watch					
Safe	Hospital Acquired Organisms – MSSA	Change currency to "Days since…"	0 (nil)	Watch					

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Caring	F&F Test - % Recommend the Trust	Excluding ED (as this is separate Watch metric)	>= 95%	Drive	Yes	Yes	Yes	Develop Equivalent	
Caring	% Complaints Responded to within 25 working days	Def'n – only include those complaints with due date in reporting month	100%	Drive	Yes	Yes	Yes		
Caring	Number of formal complaints received	Divisions need target to be split	<= 20	Watch	Yes	Yes	Yes	Yes	
Caring	% PALS Resolved within 5 Days	Def'n – only include those PALS with due date in reporting month	>= 90%	Watch	Yes	Yes	Yes		
Caring	Number of PALS contacts	Divisions need target to be split	<= 150	Watch	Yes	Yes	Yes	Yes	
Caring	F&F ED - % Recommend the Trust		>= 95%	Watch		Yes			

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Effective	ED: % treated within 4 Hours		>= 95%	Drive		Yes			
Effective	Number of Cancelled Operations (on day of admission for a non-clinical reason)		<= 20pcm	Watch			Yes		
Effective	Number of Patients cancelled on the day of surgery who are not re-booked within 28 Days		0 (nil)	Watch			Yes		
Effective	Number of Super Stranded Patients (21 days)	Divisions need target to be split	<= 30	Watch		Yes	Yes		
Effective	% Virtual Outpatients (national standard 25%)		>= 25%	Watch	Yes	Yes	Yes		
Effective	% Was Not Brought Rate (All OP: New and FU)		<= 10%	Watch	Yes	Yes	Yes		
Effective	% of Clinical Letters completed within 10 Days	Def'n – dictated, transcribed and signed off by clinician	>= 95%	Watch	Yes	Yes	Yes		

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Responsive	% Recovery for DC & Elec Activity Volume (national standard of 104%)		>= 104%	Drive		Yes	Yes		
Responsive	Number of RTT Patients waiting >52weeks (Incomplete pathways, OP&IP combined)		0 (nil)	Drive	Yes	Yes	Yes		
Responsive	Diagnostics: % Completed Within 6 Weeks of referral		>= 99%	Drive		Yes	Yes		
Responsive	RTT Open Pathway: % Waiting within 18 Weeks (OP & IP Combined)		>= 92%	Watch	Yes	Yes	Yes		
Responsive	Cancer Standards	Include all nationally mandated cancer standards	100%	Watch		Yes			
Responsive	% Recovery for OP New & OPPROC Activity Volume (national standard of 104%)		>= 104%	Watch	Yes	Yes	Yes		
Responsive	% OPFU Activity Volume (national standard reduce volume to 85%)		<= 85%	Watch	Yes	Yes	Yes		

Responsive	Number of Patients Recruited into Research Studies		>= 500					Yes	
Responsive	Number of Active (Open) Studies - Academic		>= 130					Yes	
Responsive	Number of Active (Open) Studies - Commercial		>= 30					Yes	
Responsive	Number of New Studies - Academic		>= 3					Yes	
Responsive	Number of New Studies - Commercial		>= 1					Yes	
Responsive	Number of Grants Submitted	CRD to ensure data available						Yes	
Responsive	Number of Grants Awarded	CRD to ensure data available						Yes	

Responsive	CAMHS: Number of Patients waiting >52weeks	Consistent with RTT reporting	0 (nil)		Yes				
Responsive	CAMHS: First Partnership - % Waiting within 18 weeks	Consistent with RTT reporting	>= 92%		Yes				
Responsive	CAMHS: Paired Outcome Scores				Yes				
Responsive	CAMHS: Crisis / Duty Call Activity	No target – report for variation but not assurance	n/a		Yes				
Responsive	EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)		>= 95%		Yes				
Responsive	EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)		>= 95%		Yes				
Responsive	ASD: % Incomplete Pathways within >52wks				Yes				
Responsive	ASD: % Referral to triage within 12 weeks		100%		Yes				
Responsive	ADHD: % Incomplete Pathways within >52wks				Yes				
Responsive	ADHD: % Referral to triage within 12 weeks		100%		Yes				
Responsive	IHA: Number IHAs not complete within 20 days of starting in care	Need to resolve issues regarding Data Quality / manual processes	0 (nil)		Yes				
Responsive	IHA: % complete within 15 days of referral to Alder Hey	Need to resolve issues regarding Data Quality / manual processes	100%		Yes				

Well Led – Workforce

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Well Led	% Staff who recommended Alder Hey as a place to work		>= 80%	Drive	Yes (if available)	Yes (if available)	Yes (if available)	Yes (if available)	Yes (if available)
Well Led	Staff Turnover		<= 10%	Drive	Yes	Yes	Yes	Yes	Yes
Well Led	Sickness Absence (Total)		<= 5%	Drive					
Well Led	Short Term Sickness	Now includes Covid related absence, with new target at 2%	<= 2%	Watch	Yes	Yes	Yes	Yes	Yes
Well Led	Long Term Sickness		<= 3%	Watch	Yes	Yes	Yes	Yes	Yes
Well Led	Mandatory Training		>= 90%	Watch	Yes	Yes	Yes	Yes	Yes
Well Led	% PDRs completed since April	Target is 90% by March, but with trajectory over the year	>= 90%	Watch	Yes	Yes	Yes	Yes	Yes
Well Led	Medical Appraisal	Appraisal within rolling 12 months	100%	Watch	Yes	Yes	Yes		

Well Led – Financial Sustainability

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Well Led	Revenue Position (Year End Forecast)			Drive	Yes	Yes	Yes	Yes	Yes
Well Led	CIP Position (Year End Forecast)			Drive	Yes	Yes	Yes	Yes	Yes
Well Led	Run Rate for expenditure on energy			Drive					
Well Led	Revenue Position (variance to date)			Watch	Yes	Yes	Yes	Yes	Yes
Well Led	CIP Position (delivered to date)			Watch	Yes	Yes	Yes	Yes	Yes
Well Led	Capital			Watch					
Well Led	Cash	Consider changing to Liquidity (Days)		Watch					

Well Led – Risk Management

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Well Led	Total Number of risks scored 15 and above (on last day of the month)	No target – report for variation but not assurance	n/a	Drive	Yes	Yes	Yes	Yes	Yes
Well Led	% Risks within review date (on last day of the month)	Def'n - % of all risks within review date (not just those 15+)	>= 95%	Drive	Yes	Yes	Yes	Yes	Yes

Well Led – Safe Digital Systems

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Well Led	100% Safety Compliance	Trajectory towards 100% to be agreed	100%	Drive					
Well Led	Alder Care - % System Build Completion	Trajectory towards 100% to be agreed	100%	Drive					
Well Led	Alder Care - % Specialty Sign Off	Trajectory towards 100% to be agreed	100%	Drive					

Well Led – Environment (Estates and Facilities).

CQC Domain	Metric	Notes	Target	Main Report	C &MH	Medicine	Surgery	Research	Corporate
Well Led	To be included for 2023/24	For example, Building safety, Water Safety, Fire Safety Compliance, Cleanliness							Yes
Well Led									Yes
Well Led									Yes
Well Led									Yes

Metrics removed from previous Corporate Report

CQC Domain	Name of Metric	Reason for Removing from IPR
SAFE	Clinical Incidents resulting in minor, non-permanent harm	Consolidated within "Minor Harm and Above"
SAFE	Total no of incidents resulting in moderate harm	Consolidated within "Minor Harm and Above"
SAFE	Total no of incidents resulting in major harm	Consolidated within "Minor Harm and Above"
SAFE	Total no of incidents resulting in death / catastrophic	Consolidated within "Minor Harm and Above"
SAFE	Clinical Incidents resulting in Near Miss	Consolidated within "Near Miss & No Harm"
SAFE	Clinical Incidents resulting in No Harm	Consolidated within "Near Miss & No Harm"
SAFE	Proportion of Near Miss, No Harm & Minor Harm	Remove - Duplication
SAFE	No Harm whilst waiting > 52 weeks on waiting list	Remove - report by Exception
SAFE	Number of children that have experienced avoidable factors causing death - Internal	Remove - report by Exception
SAFE	Pressure Ulcers (Category 3)	Consolidated within "Pressure Ulcers Category 2-4"
SAFE	Pressure Ulcers (Category 4)	Consolidated within "Pressure Ulcers Category 2-4"
SAFE	Medication Errors (Incidents)	Report at Sub-Committee level (SQAC)
SAFE	Cardiac Arrests	Report at Sub-Committee level (SQAC)
SAFE	Step Downs out of CC out of hours	Report at Sub-Committee level (SQAC)
SAFE	%Consent before day of surgery	Report at Sub-Committee level (SQAC)
SAFE	Cleanliness Scores	Replace in Estates and Facilities Summary
SAFE	CCNS: Advanced Care Plan for children with life limiting condition	Report at Divisional PRM
SAFE	CCNS: Supported early discharges from hospital care	Report at Divisional level
SAFE	CCNS: Prescriptions	Report at Divisional level
CARING	F&F Inpatients - % Recommend the Trust	Report at Sub-Committee level (SQAC)
CARING	F&F Outpatients - % Recommend the Trust	Report at Sub-Committee level (SQAC)
CARING	F&F Mental Health - % Recommend the Trust	Report at Sub-Committee level (SQAC)
CARING	F&F Community - % Recommend the Trust	Report at Sub-Committee level (SQAC)
EFFECTIVE	ED: Percentage Patients Left without being seen	Report at Sub-Committee level (SQAC)
EFFECTIVE	ED: Re-attendance within 7 days of original attendance (%)	Report at Sub-Committee level (SQAC)
EFFECTIVE	ED: All handovers between ambulance and A & E - Waiting more than 30 minutes	Report at Sub-Committee level (R&BD)
EFFECTIVE	ED: All handovers between ambulance and A & E - Waiting more than 60 minutes	Remove - Duplication
EFFECTIVE	ED: Number of patients spending >12 hours from decision to admit to admission	Remove - Duplication
EFFECTIVE	Coding average comorbidities	Report at Sub-Committee level (R&BD)
EFFECTIVE	Theatre Utilisation - % of Session Utilised	Report at Sub-Committee level (R&BD)
EFFECTIVE	No of children readmitted to PICU within 48hrs of discharge	Report at Sub-Committee level (SQAC)
EFFECTIVE	% of children readmitted to PICU within 48hrs of discharge	Remove - Duplication
EFFECTIVE	Referrals Received (Total)	Remove - Externally driven
EFFECTIVE	OP Appointments Cancelled by Hospital %	Report at Sub-Committee level (R&BD)
EFFECTIVE	Hospital Initiated Clinic Cancellations < 6 weeks notice	Report at Sub-Committee level (R&BD)
EFFECTIVE	Was Not Brought Rate (New Appts)	Consolidated within single WNB Metric
EFFECTIVE	Was Not Brought Rate (Follow up Appts)	Consolidated within single WNB Metric

EFFECTIVE	Was Not Brought Rate (New Appts) - Community Paediatrics	Consolidated within single WNB Metric
EFFECTIVE	Was Not Brought Rate (Follow up Appts) - Community Paediatrics	Consolidated within single WNB Metric
EFFECTIVE	CAMHS: % CHOICE Was Not Brought Rate	Consolidated within single WNB Metric
EFFECTIVE	CAMHS: % All Other Was Not Brought Rate	Consolidated within single WNB Metric
EFFECTIVE	CAMHS: Tier 4 DJU % Bed Occupancy At Midday	Report at Divisional PRM
EFFECTIVE	CAMHS: Tier 4 DJU Bed Days	Report at Divisional PRM
EFFECTIVE	CAMHS: % Patient Active Caseloads With 2 Or More Contacts	Report at Divisional PRM
EFFECTIVE	CCNS: Number of commissioned packages	Report at Divisional PRM
EFFECTIVE	CCAD Cases	Report at Divisional PRM
RESPONSIVE	Waiting List Size	Report at Sub-Committee level (R&BD)
RESPONSIVE	Waiting List Size	Remove - Duplication
RESPONSIVE	Waiting Times - 40 weeks and above	Remove - Duplication
RESPONSIVE	Average patients per Session (DC)	Remove - Duplication
RESPONSIVE	Average patients per Session (Elective)	Remove - Duplication
RESPONSIVE	Average Patients per Working Day (DC)	Report at Sub-Committee level (R&BD)
RESPONSIVE	Average patients per Working Day (Elective)	Report at Sub-Committee level (R&BD)
RESPONSIVE	Theatre Sessions per week	Report at Sub-Committee level (R&BD)
RESPONSIVE	IP Survey: % Received information enabling choices about their care	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Treated with respect	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Know their planned date of discharge	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Know who is in charge of their care	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Patients involved in play and learning	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Patients involved in Play	Report at Sub-Committee level (SQAC)
RESPONSIVE	IP Survey: % Patients involved in Learning	Report at Sub-Committee level (SQAC)
RESPONSIVE	PFI: PPM%	Replace in Estates and Facilities Summary
RESPONSIVE	Imaging - % Report Turnaround times GP referrals < 24 hrs	Report at Divisional PRM
RESPONSIVE	Imaging - % Reporting Turnaround Times - ED	Report at Divisional PRM
RESPONSIVE	Imaging - % Reporting Turnaround Times - Inpatients	Report at Divisional PRM
RESPONSIVE	Imaging - % Reporting Turnaround Times - Outpatients	Report at Divisional PRM
RESPONSIVE	Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks	Report at Divisional PRM
RESPONSIVE	Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks	Report at Divisional PRM
RESPONSIVE	Imaging - Waiting Times - Plain Film % under 24 hours	Report at Divisional PRM
RESPONSIVE	Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks	Report at Divisional PRM
RESPONSIVE	Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	Report at Divisional PRM
RESPONSIVE	Pathology - % Turnaround times for urgent requests < 1 hr	Report at Divisional PRM
RESPONSIVE	Pathology - % Turnaround times for non-urgent requests < 24hrs	Report at Divisional PRM
RESPONSIVE	ASD: Completed Pathways	Report at Divisional PRM
RESPONSIVE	CAMHS: Tier 4 Admissions To DJU	Report at Divisional PRM
RESPONSIVE	CAMHS: Referrals Accepted By The Service	Report at Divisional PRM

RESPONSIVE	CAMHS: % Referrals Accepted By The Service	Report at Divisional PRM
RESPONSIVE	CAMHS: Total Number of Referral Received to Service per Month	Report at Divisional PRM
RESPONSIVE	CCNS: Number of Referrals	Report at Divisional PRM
RESPONSIVE	CCNS: Number of Contacts	Report at Divisional PRM
WELL LED	Absence COVID Related	Consolidated within Short Term Sickness
WELL LED	Payroll Accuracy	Report at Sub-Committee level (P&WB)
WELL LED	Temporary Spend ('000s)	Report at Sub-Committee level (P&WB / R&BD)
WELL LED	Income - £m (Variance)	Report at Sub-Committee level (R&BD)
WELL LED	Pay In Month Variance (£'000s)	Report at Sub-Committee level (R&BD)
WELL LED	Expenditure Run Rate Pay	Report at Sub-Committee level (R&BD)
WELL LED	Expenditure Run Rate Non Pay	Report at Sub-Committee level (R&BD)
WELL LED	NHSI - Governance Concern	Remove - report by Exception
WELL LED	Safer Staffing	Replace with "Care Hours per Patient per Day"
WELL LED	Number of Staff involved in testing	Remove – Defer to 2023
WELL LED	Number of Staff trained in Alder Care	Remove – Defer to 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common
Report of:	Director of Corporate Affairs
Paper Prepared by:	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	This paper provides an update on the actions in respect of continued approach to collaborative working through the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative.
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

1. Executive Summary

The Cheshire and Merseyside Acute and Specialist Trust provider alliance has brought trusts together to establish priorities aligned to the triple aim. C&M Trust leaders have been working together to explore collaborative potential, develop ways of working and define priorities over the last year. Through the Leadership Board it had been determined that the arrangements for CMAST will be formalised through a joint working agreement and the establishment of a Committee in Common by each Trust. Board members have continued to be kept informed of the work of CMAST and the emerging governance arrangements.

The Trust has a duty to collaborate and to be part of one or more provider collaboratives. Trust approval of the attached Joint Working Agreement and Committee in Common Terms of Reference is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

The paper is seeking Board approval of the CMAST Joint Working Agreement and Committee in Common Terms of Reference.

2. Background

Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon wider and existing local collaborative strengths, such as the Cancer Alliance.

In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures and now, also require all providers to be part of a collaborative. Furthermore such a policy imperative is seen as a way to ensure all providers support the delivery of the *triple aim* through:

- Aligning priorities,
- Supporting establishment of the ICS with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

Cheshire and Merseyside Trust leaders have been working together to explore collaborative potential, develop ways of working and defining priorities over the last year. This work has included working with Hill Dickinson and Mike Farrar and has involved both Chief Executives and Chairs.

In addition to the triple aim priorities, CMAST has identified a number of complimentary, key functions, that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system, and
- Creating an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

3. CMAST Governance Arrangements

Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB it has been proposed by CMAST members and is now advocated that CMAST's ways of working should be embedded through a Joint Working Agreement. Such an approach provides a means to document the progress made within

Cheshire and Merseyside, and provides an opportunity for Boards to demonstrate a shared commitment to the vision, priorities and programmes of work that they have identified and initiated, both internally and externally.

It is also proposed that CMAST more formally establish its governance to provide a route for shared and formalised decision making as and when required. This decision-making framework aims to underpin existing ways of working and provide a framework to build from, as necessary, to fulfil either the need, potential or ambition of CMAST Boards. The proposed approach is for Trusts to establish a Committee in Common, now enabled through the NHS Health and Care Act 2022.

The full documents are provided as separate attachments, with a summary provided below.

- **Joint Working Agreement**

  The Joint working Agreement:

  - Covers: vision; function; priorities and work programme.
  - Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making.
  - Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach.

- **Committee in Common - Terms of Reference**

  The Terms of reference:

  - Sets out the C&M response, as proposed by Chairs and Chief Executives to the Provider Leadership Board collaborative approach.
  - Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance.
  - Sets aims and objectives of Committee in Common.
  - Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement.
  - Confirms the quorum.
  - Annex A establishes potential activities delegated to the Committee in Common when in scope of the work as set in the Joint Working Agreement.

  To note: NWAS is proposed as a participant of the meeting rather than as a member.

  The documentation provides outputs that represent the culmination of a period of engagement and development with Cheshire and Merseyside Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of Cheshire and Merseyside's preferred way of operating.

  The document delivers both a foundation and framework for CMAST development, decision making and support for its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the remit of CMAST develops and the ask of the system expands, varies or diminishes. Examples of decision making have been developed to help Boards understand how the documents will work in practice.

4. Conclusion

The Trust has a duty to collaborate and to be part of one or more provider collaboratives. Alder Hey continues to work collaboratively through CMAST and also a range of well-established networks, in addition to a number of joint posts, services and mutual aid.

Trust approval of the Joint Working Agreement and Committee in Common Terms of Reference is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

5. Recommendations

The Board is asked to

i. Approve the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board

ii. Approve the establishment of a Committee in Common with Terms of Reference as proposed

iii. To adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals.

Attachments

(a) CMAST Joint Working Agreement
(b) CMAST Leadership Board Alder Hey Committee in Common Terms of Reference

HILL DICKINSON

Draft No: 1 - 6
Date of Draft: 5 September 2022

Dated 29th September 2022

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST

(2) LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

(3) SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST

(4) WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST

(5) WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST

(6) THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST

(7) LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST

(8) THE WALTON CENTRE NHS FOUNDATION TRUST

(9) LIVERPOOL WOMEN'S NHS FOUNDATION TRUST

(10) ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST

(11) EAST CHESHIRE NHS TRUST

(12) ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST

(13) MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST

and

(14) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	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;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT,

	Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust, Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including: ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.

2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.

Key functions

2.3 The key functions of CMAST are to:

2.3.1 Deliver the CMAST vision;

2.3.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.3.3 Align priorities across the member Trusts,

2.3.4 Support establishment of ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.3.5 Direct operational resources across Trust members to improve service provision;

2.3.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.3.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.4 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

2.4.1 Reduce health inequalities;

2.4.2 Improve access to services and health outcomes;

2.4.3 Stabilise fragile services;

2.4.4 Improve pathways;

2.4.5 Support the wellbeing of staff and develop more robust workforce plans; and

2.4.6 Achieve financial sustainability.

2.5 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.6 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

2.6.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.6.2 Cancer Alliance delivery and enablement – subject to the request of the Alliance;

2.6.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.6.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.6.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.6.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.6.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, 104 week wait delivery; and

2.6.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.7 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution) in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will ensure that each CMAST programme should have a Chair sponsor

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998)

and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of CMAST across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and their relevant information officers) , this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests

on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;

- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;

- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and

- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.6 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.6.1 terminate the Agreement;

10.6.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.6.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

12.2 The expression "counterpart" shall include any executed copy of this Agreement transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the St Helens and Knowsley Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 15 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 16 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

Alder Hey Children's NHS Foundation Trust

V 5-2 September 2022

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

CMAST LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Alder Hey Children's NHS Foundation Trust	Alder Hey Children's NHS Foundation Trust of Eaton Road, Liverpool, L12 2AP;
Alder Hey Children's NHS Foundation Trust CiC	the committee established by Alder Hey Children's NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the Alder Hey Children's NHS Foundation Trust CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of

	Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The Alder Hey Children's NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on 29th September 2022 and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the Alder Hey Children's NHS Foundation Trust CiC

2.1 The aims and objectives of the Alder Hey Children's NHS Foundation Trust CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the Alder Hey Children's NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The Alder Hey Children's NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the

Alder Hey Children's NHS Foundation Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Alder Hey Children's NHS Foundation Trust CiC.

3.2 The Alder Hey Children's NHS Foundation Trust CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The Alder Hey Children's NHS Foundation Trust CiC is a committee of Alder Hey Children's NHS Foundation Trust's board of directors and therefore can only make decisions binding Alder Hey Children's NHS Foundation Trust. None of the Trusts other than Alder Hey Children's NHS Foundation Trust can be bound by a decision taken by Alder Hey Children's NHS Foundation Trust CiC.

3.4 The Alder Hey Children's NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Alder Hey Children's NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in Alder Hey Children's NHS Foundation Trust's Constitution.

4.2 Alder Hey Children's NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Alder Hey Children's NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by Alder Hey Children's NHS Foundation Trust's Board or Council of Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of Alder Hey Children's NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Alder Hey Children's NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to Alder Hey Children's NHS Foundation Trust's Board for inclusion on the private agenda of Alder Hey Children's NHS Foundation Trust's next Board meeting in order that Alder Hey Children's NHS

Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Alder Hey Children's NHS Foundation Trust CiC shall send the minutes of Alder Hey Children's NHS Foundation Trust CiC meetings to Alder Hey Children's NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of Alder Hey Children's NHS Foundation Trust's Board meeting.

6.3 Alder Hey Children's NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by Alder Hey Children's NHS Foundation Trust's Board for inclusion on the agenda of Alder Hey Children's NHS Foundation Trust's Board meeting.

7 Membership

7.1 The Alder Hey Children's NHS Foundation Trust CiC shall be constituted of directors of Alder Hey Children's NHS Foundation Trust. Namely the Alder Hey Children's NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Alder Hey Children's NHS Foundation Trust CiC Member shall nominate a deputy to attend Alder Hey Children's NHS Foundation Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for Alder Hey Children's NHS Foundation Trust's Chief Executive shall be an Executive Director of Alder Hey Children's NHS Foundation Trust.

7.4 In the absence of the Alder Hey Children's NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend Alder Hey Children's NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of Alder Hey Children's NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a Alder Hey Children's NHS Foundation Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of Alder Hey Children's NHS Foundation Trust CiC. The Alder Hey Children's

NHS Foundation Trust's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – as set out in the CMAST Agreement under clause 4) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of Alder Hey Children's NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of Alder Hey Children's NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3 inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of Alder Hey Children's NHS Foundation Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, Alder Hey Children's NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Alder Hey Children's NHS Foundation Trust CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Alder Hey Children's NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Alder Hey Children's NHS Foundation Trust CiC shall be confidential to the Alder Hey Children's NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of Alder Hey Children's NHS Foundation Trust's Board.

10 Quorum and Voting

10.1 Members of the Alder Hey Children's NHS Foundation Trust CiC have a responsibility for the operation of the Alder Hey Children's NHS Foundation Trust CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Alder Hey Children's NHS Foundation Trust CiC shall have one vote. The Alder Hey Children's NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the Alder Hey Children's NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in Alder Hey Children's NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in Alder Hey Children's NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Alder Hey Children's NHS Foundation Trust CiC.

11.2 All Members of the Alder Hey Children's NHS Foundation Trust CiC shall declare any new interest at the beginning of any Alder Hey Children's NHS Foundation Trust CiC meeting and at any point during a Alder Hey Children's NHS Foundation Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 Alder Hey Children's NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, Alder Hey Children's NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend Alder Hey Children's NHS Foundation Trust CiC meetings (in person) and fully participate in all Alder Hey Children's NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Alder Hey Children's NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Alder Hey Children's NHS Foundation Trust CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each Alder Hey Children's NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Alder Hey Children's NHS Foundation Trust CiC meeting.

13.2 The agenda for the Alder Hey Children's NHS Foundation Trust CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to Alder Hey Children's NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Alder Hey Children's NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Alder Hey Children's NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Alder Hey Children's NHS Foundation Trust CiC meeting with a view to Alder Hey Children's NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by Alder Hey Children's NHS Foundation Trust's Board). Any proposals discussed at the Alder Hey Children's NHS Foundation Trust CiC meeting outside of these parameters would come back before Alder Hey Children's NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to Alder Hey Children's NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Alder Hey Children's NHS Foundation Trust CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;

	Decisions delegated to Alder Hey Children's NHS Foundation Trust CiC
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements;

	Decisions delegated to Alder Hey Children's NHS Foundation Trust CiC
	e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: 29th September 2022

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Thursday, 29th September 2022

Paper Title:	**Campus Development Monthly Update**
Report of:	**Development Director**
Paper Prepared by:	Associate Development Director (Acting) Jim O'Brien

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:	Nil	

Campus Development report on the Programme for Delivery

September 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 3 in Quarter 2 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	Programme and Cost Pressure Substantial cost increases expected due to market inflation, availability of labour and / or materials	Working closely with contractor to finalise and agree position in preparation for presentation to Board
Sunflower House / Catkin	Programme delay; HO 30th September 2022 Quality issues	Weekly route to HO meetings held. Meetings held with GT Construction and Commercial Directors to review performance and delivery. Take over of Catkin element achieved, police station accepted. Architectural advisor and specialist experts engaged to review and provide solutions. Proposal being drawn up to conclude.
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, modulars projects, IP2 and Histo projects and their programmes.	Programme reviews held weekly to keep on top of all 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 (Alder Centre)								
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. Working through cost and programme with contractor in preparation for presentation to the Board. Finalising contractor selection and 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. Working closely with contractor to finalise and agree, challenging work package costs, VE and design. Continue working with Project Co to mitigate impact.

Catkin Centre and Sunflower House Construction

Current status	Risks/issues	Actions
Completion date delayed until 30th September 2022. Accepted takeover of Catkin element and now commissioning this element of the build. Agreed take over for Police station element, works inspected and accepted by Merseyside Police. Planning the signature of the lease and their occupation. Working towards the HO date and applying pressure to close out works and seek approval to accept.	Further programme delays. Quality issues being experienced on site.	Weekly route to HO meetings held. Meetings held with GT Construction and Commercial Directors to review performance and delivery. Architectural advisor and specialist experts engaged to review and provide solutions. Early warnings under the contract issued and correspondence issues to close out issue.

Modular Office Buildings

Current status	Risks/issues	Actions
LOR and Portakabin engaged to provide both modular solutions. Larger unit by Alder Centre being provided by LOR; layouts agreed and signed off and programme agreed. Construction almost complete on site, awaiting final utility connection to HO building and begin commissioning and occupation. Smaller unit in Police Station car park being provided by Portakabin; layouts agreed and signed off and programme agreed. Project on hold due to police station lease not in a position to sign; for takeover of the former police station.	Programme delay, police station modular	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 2 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. MUGA works commenced.	MUGA lighting	MUGA lighting utility connection being provided by LCC, working closely to ensure this is provided in time.

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Landscaping completed for Phase 2 with number of paths started. Phase 3 started within existing Springfield park. 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.

Medical Photography / Orthotics

Current status	Risks/Issues	Actions/next steps
Project complete	None	None

Innovation Park 2

Current status	Risks/Issues	Actions/next steps
Works progressing well on site. HO date of 15th October 2022	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 29th September 2022.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	Brilliant Basics – Programme Delivery Assurance Report
Report of:	Nathan Askew, Chief Nursing Officer and AHP/HCP Lead
Paper Prepared by:	Natalie Palin, Associate Director of Transformation, Andy McColl, Associate Chief Operating Officer

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	• Brilliant Basics Delivery Plan (26th May 2022) • Brilliant Basics Programme Update – (30th Sept 2021) • Leader Standard Work - Supporting Performance and Improvement (24TH Feb 2022)
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	N/A resource requirements for 2022/23 are within the existing budget provision.

1. Introduction

The purpose of this paper is to provide the trust board with assurance on progress against the Brilliant Basics (BB) delivery plan 2022-25. BB is our trust approach to improving quality, safety, and effectiveness. The delivery plan details the systems of control, which support the achievement of the intended benefits. The BB programme (Sept 22) has been rated green for Programme Management Standards and progress is on track against key milestones.

2. Background

The Brilliant Basics delivery plan was approved in May 22, with quarterly monitoring provided to trust board. Brilliant Basics is our vehicle for improvement and support our journey towards **'outstanding'**. Building on the long history in Alder Hey to continually improve and enhance outcomes for children and young people. Over the last 2 years we have worked with KMPG and Point of Care (POC) to create a model, that reflects best practice and embeds children and young people's involvement. The driving principles of the approach are detailed in diagram 1.

Diagram 1: Brilliant Basics Improvement Principles

Table 1 – provides details of the key programme workstreams and Executive Sponsor(s).

Table 1: BB Workstreams and Executive Sponsor

Workstreams	Executive Sponsor	Chief Nurse and AHP/HCP Lead
Leading for Improvement	Deputy Chief Executive / Director of Finance	
Learning for Improvement	Chief People Officer	
Delivering Improvement	Chief Operating Officer	
Enabling activities	Children and Young people's involvement, measurement, communication	

3. Assessment

Programme Assurance

Table 2: Assurance Table

Project Title	OVERALL PROJECT GOVERNANCE RATING	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged (CYP, Staff)	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY RATING	Targets / benefits defined/on track	Milestone plan is defined	QI APPROACH EMBEDDED RATING	Generation of change ideas with those closest to the problem	PDSA cycles documented	Measurement for improvement	Learning	OVERALL FINANCIAL DELIVERY RATING
Brilliant Basics		●	●	●	●	●	●		●	●		●	●	●	●	NA

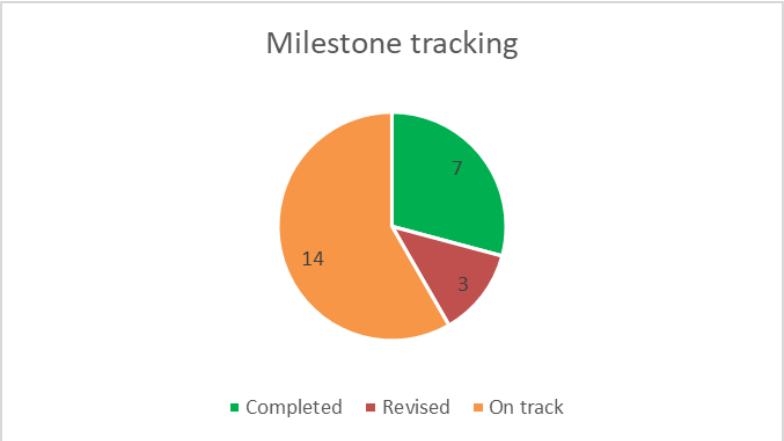
BB has been rated green against the trusts Programme Management Standards. Each workstream has a set of key milestones and progress is reviewed by the SRO and oversight is reported to strategic executives. Engagement by workstream sponsors (representatives) is consistent at the programme group and risk are reviewed and updated on a regular basis.

The programme regularly encourages feedback from external stakeholders (not in the core delivery group), to provide assurance around the effectiveness of actions. The programme has a set of target measures, which are tracked and monitored.

Milestones

The overall programme milestones are monitored at a programme and workstream level. The diagram below, details that no milestones are overdue, 7 have been completed and 14 are on track. Year to date three milestones have been revised, with approval by the SRO. Table 3, details some of the key milestone highlights April to Sept 22.

Diagram 2: Milestone tracking



April to Sept 22 Milestone highlights

Appendix 1 contains the BB Summary Progress report, which provides details of the overall programme measures and progress. The below table (3) provides a highlight of key successes achieved year to date.

Table 3: BB Workstreams Highlights Year to Date

Workstreams	Highlights – Year to Date
Leading for Improvement	• **First trust in the country** to implement Daily Safety meetings. • **New Executive Standard Work** implemented, embedding improvement behaviours and BB principles. • Exceutive standards reviewed and maintained. • Executive 'Go Look and See' visibility programme continues. • BB 'focus on what matters' and standardised reporting being used at the Patient Safety Strategy Board.
Learning for Improvement	• **6 Teams coached** in Brilliant Basic – providing skills, knowldege and confidence in applying the approach. • **65 managers** and matrons trained in BB, making sure our leaders support staff to make changes. • 10 teams, self-nominated to be coached in future cohorts. • **Celebration event** for cohorts 2 & 3
Delivering Improvement	• **Operational Plan 22/23** – designed and developed utilizing BB approaches, to focus on measurement, involvement and problem solving. • **Initiation and Delivery of ED @ Its Best** – improvement programme, (following extensive staff engagement); using BB approach, alongside Organisational Development. With a combination of on the shop floor coaching around 'Huddles and Board round' to project actions to support volumes and flow. • **Performance Review Meetings** – utilizing the BB tools, thinking and approach; allowing targeted action for areas requiring improvement
Enabling activities	
Children and Young people's involvement	• **Youth Engagement Lead Role** recruited to August 2022, enabling the creation of the Involvement and Childs Rights team. To further enhance Children and Young people's involvement and voice in improvement.
Communication	• Brilliant Basics – **focused month in May** focusing on staff experiences of working in a BB way and the impact! • **Positive** feedback and **national interest and engagement** in twitter content

Areas of focus – Sept to Dec 2022

Children and Young People's involvement: A core development for the 22/23 plan was to enhance children's and young people's involvement in improvement, alongside the Rights of

the Child. The investment in a team who will have a dual focus around improvement and rights through the lens of children's involvement, will undoubtable enhance healthcare experience. This team will support both the coaching for participation and improvement, supporting staff to build confidence and capabilities.

Learning for improvement: An exciting milestone scheduled for completion in Dec 22, is the development of a suite of online learning materials. This will expand the breadth of learning opportunities and cater for individual learning styles and preferences. Currently the predominant learning and coaching approach is constrained by the resource of the Quality Hub Team. The BB online bite size resources will enable self-directed learning and provide open access to all. This will support those early adopters to start embedding BB tools and techniques into their team.

Review: In accordance with the delivery plan an evaluation and programme review is scheduled for November 22. This review involving multiple stakeholders, will aim to develop the 23/24 objectives, based on organisational need, learning and good practice. In support of continuing to challenge ourselves to make BB '*the way that we do things at Alder Hey*.'

4. Conclusion

Programme assurance has rated the BB project delivery approach as green. This level of assurance indicates that the systems of control are effectively managing milestone delivery. It is however recognized that BB is more than a set of delivery actions, it's a multi-year cultural change, reliant on new habits and behaviours, hence the benefit of tools and coaching to embed new ways of working.

The planned areas of focus for Sept – Dec 22, will enhance children's and young people's involvement, which will further embed systematic methods for involvement and staff capability building.

4. Recommendations

a. To note the progress to date and key areas of focus for Sept to Dec 2022

Appendices'

- Appendix 1: BB Summary Progress Report
- Links: Case studies https://youtu.be/aGUWDkoxl3Y

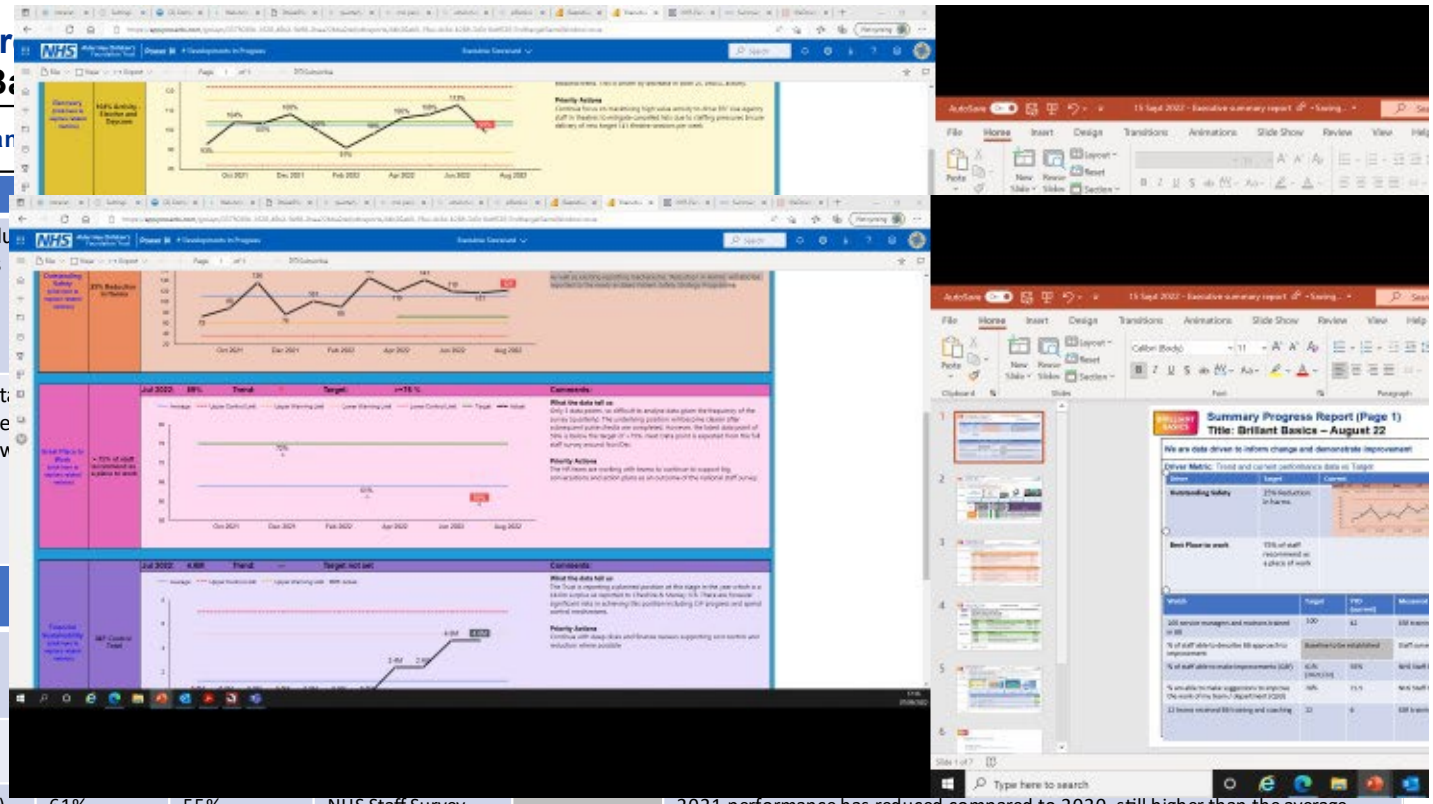
Appendix 1: Summary Progress Report BB

BRILLIANT BASICS

Summary Progr
Title: Brillant Ba

We are data driven to inform chan

Driver	Target
Outstanding Safety	25% Redu in harms
Best Place to work	75% of st recomme place of v

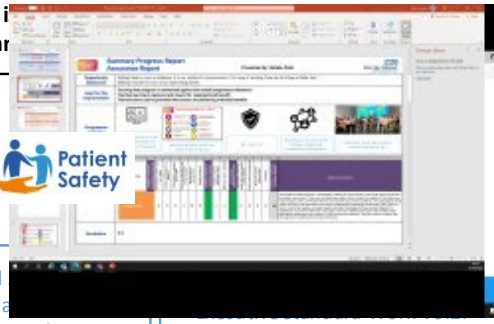


Watch					
100 service managers and matrons trained in BB					
% of staff able to describe BB approach to improvement					
% of staff able to make improvements (Q3f)	61% (2021/22)	55%	NHS Staff Survey		2021 performance has reduced compared to 2020, still higher than the average, and better than worst performing. Best in comparison group 61%
% am able to make suggestions to improve the work of my team / department (Q3d)	78%	71.5	NHS Staff Survey		2021 performance has reduced in comparison with 2021, still higher than average.
12 teams received BB training and coaching	12	6	Local training register	On track	Wave 5 starting 14th September with **5** teams signed up. **10** teams in the pipeline for readiness assessments. ED team receiving agile coaching on BB tools as part of ED@itsbest project.

Summary Progress Report
Assurance Report

Presented by: Natalie Palin

Alder Hey Children's NHS Foundation Trust

Opportunity Statement	Brilliant Basics is not an initiative, it is our vehicle for improvement, it's a way of working ' *how we do things at Alder Hey*' . Making it easier for each of us make things better.
Goal for the improvement	**Ensuring that progress is maintained against the overall programme milestones** **That key learning i** **That assurance ca**
Programme overview	   BB – Standard utilised in the Pa Strategy Board Next review in Dec 22 August nmenced for ights and Involvement Staff members Celebration event with previous cohorts from wave 2 & 3
Assurance Rating	
Escalation	N/A

Summary Progress Report
Leading for Improvement

Presented by: John Grinnell

Alder Hey Children's NHS Foundation Trust

Opportunity Statement	Brilliant Basics is not an initiative, it's a way of working '*how we do things at Alder Hey*'. Making it easier for each of us make things better.
Goal for the improvement	**Small changes, big improvements, healthier Futures.** • Making sure our leaders support you to make changes. Training you to have the skills, knowledge, and confidence you need. Nothing is too small, or large that cannot be changed

Actions completed

Workstreams	Smart Action	Owner
Leading	Divisional Performance reviews used BB approach- generally positive with some feedback for further improvement	A Bateman
Leading	Exec team formally reviewed Standard work- largely positive feedback	A McColl
Leading	Formal support from KPMG ended (review of progress and next steps)	A McColl
Leading	Daily Safety Briefing continuing well	J Grinnell
Leading	Corporate Services Collaborative still forming- still needs real focus to ensure this is effective	E Saunders

Actions planned

Workstreams	Smart Action	Owner	Due date
Leading	• Completion of the BB Handbook	N Palin / A McColl	August 2022
Leading	• Deputy Standard Work and Leadership Behaviours - Evaluation	N Palin	Sept 2022
Leading	• Develop and mature the "Corporate Services Collaborative"	E Saunders	Sept 2022
Leading	• Revise approach for Executive Coaching (1 -1 and/or Team Coaching)	M Swindell	Aug 2022
Leading	• Commence NED Development Programme	E Saunders	Sept 2022
Leading	• Cascade leadership behaviours / standard work from Exec team into Divisions	J Grinnell	Sept 2022

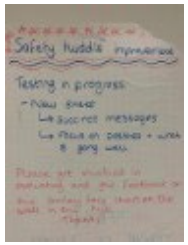
Escalation	Exec team to clarify and agree the approach to Executive Coaching

Version 1.4

Summary Progress Report
Learning for Improvement

Presented by: Melissa Swindell

Alder Hey Children's NHS Foundation Trust

Opportunity Statement	Brilliant Basics is not an initiative, it is our vehicle for improvement, it's a way of working '*how we do things at Alder Hey*' Making it easier for each of us make things better.
Goal for the improvement	**Small changes, big improvements, healthier Futures.** Making sure our leaders support you to make changes. Training you to have the skills, knowledge, and confidence you need. Nothing is too small, or large that cannot be changed
Actions completed	 Consistently high evaluation of all sessions Quality tea drop in sessions running once per month  BB knowledge and skill building facilitating team away days  BB coaching in ED at its best project 
Actions planned	See table below
Escalation	None in this reporting period

Workstreams	Smart Action	Owner	Due date
Learning	Develop and deliver the integrated improvement model	Melissa Swindell	October 2022
Learning	BB bite-sized learning resources produced	Melissa Swindell	December 2022
Learning	BB online learning established on Moodle	Melissa Swindell	December 2022

Version 1.4

Summary Progress Report
Delivering Improvement

Presented by: Adam Bateman

Alder Hey Children's NHS Foundation Trust

Opportunity Statement	Brilliant Basics is not an initiative, it is our vehicle for improvement, it's a way of working. *'how we do things at Alder Hey'* Making it easier for each of us make things better.
Goal for the improvement	**Small changes, big improvements, healthier Futures.** • Making sure our leaders support you to make changes. Training to give you the skills, knowledge, and confidence you need. Nothing is too small, or large that cannot be changed. **(Standard comms)**
Actions completed	 Executive Score – card developed, metrics agreed.  Operational Plan – Developed and approved  Divisional Performance Reviews in standardised reporting framework  ED at Its Best – Integrated OD / BB improvement approach commenced  Board approval for new Integrated Board Report – reflecting good practice
Actions planned	See table below
Escalation	NA

Workstreams	Smart Action	Owner	Due date
Performance data	Completion of the new Integrated Performance Report	AM / AG	27/09/2022
Performance data	Development of Divisional performance	AM / AG	30/11/2022
Delivering improvement	**Step Change** • Effective reporting process 'framework' for assurance and performance against benefits and milestones	AB / NP	31/03/2023

Version 1.4

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

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

Alder Hey Children's NHS
NHS Foundation Trust

1. Purpose

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

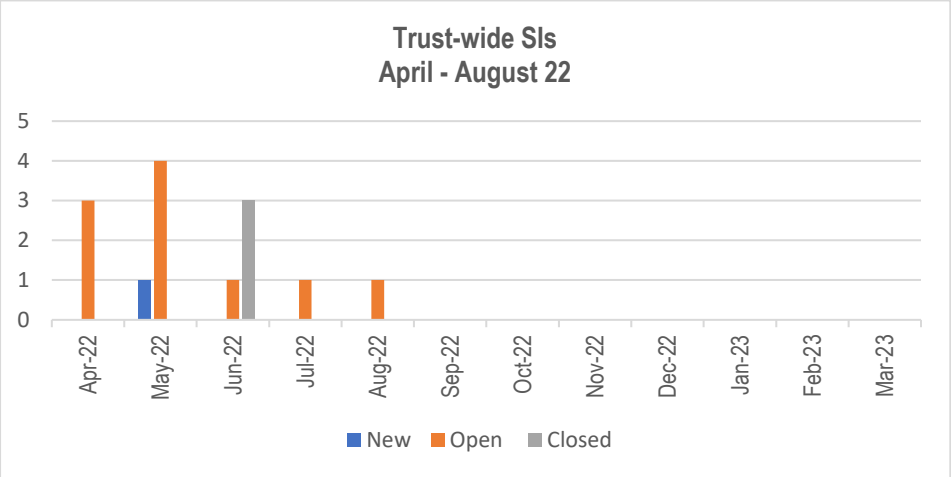
3. Local context

3.1 Never Events

The Trust declared **Zero** Never Events during the reporting period (1st July – 31st August 2022).

3.2. Serious Incidences

Graph 1 Trust-wide StEIS reported SI status August 2022



3.2.1 Declared Serious Incidences

The Trust declared no StEIS reportable incidents that met the SI criteria during the reporting timeframe (1st July – 31st August 2022).

3.2.2 Open Serious Incidences

There is **1** SI open and overdue during the reporting period, 1st July – 31st August 2022 as outlined in table 1 below:

Table 1 Open SIs June 2022

StEIS reference	Date reported	Division	Incident	Summary
2021/24660	25/11/2021	Surgery	Near miss reported for potential for learning	Refer to appendix 1 for detail

3.2.3 Serious incident reports

3.2.4 SI action plans

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

12 SI action plans are overdue their expected completion date, of which:

6 SI action plans have been completed and, pending corporate review, are to be sent to commissioners for closure.

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	0 Action plan to be reviewed in divisional meeting 29th September to confirm all actions completed and pending corporate review to be 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 All actions completed - action plan pending corporate review	19/12/2020

					to be sent to commissioners for closure.	
2020/608	08/01/2020	09/01/2020	Medicine	Misdiagnosis of tumour	0 All actions completed - action plan pending corporate review to be sent to commissioners for closure.	30/06/2021
2020/19349	08/10/2020	12/10/2020	Medicine	Inappropriate clearance of C-Spine	0 Completed action plan closed by ICB 07/09/2022.	30/06/2021
2020/12954	09/07/2020	10/07/2020	Corporate Services	Incorrect settings on port-a-count machine resulting in staff being incorrectly passed on an FFP3 mask	0 All actions completed - action plan pending corporate review to be 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 – to be reviewed and updated 29/09/2022.	30/04/2022
2021/12203	27/05/2021	10/06/2021	Medicine	Deteriorating patient requiring transfer to HDU	12 2 actions outstanding – to be completed end of September.	01/06/2022
2021/20934	06/10/2021	12/10/2021	Surgery	Potential harm due to delayed follow up	8 5 actions outstanding.	30/06/2022

2020/23828	11/12/2020	18/12/2020	Corporate Services	Waiting list data quality issues with 52 week waits	0 All actions completed – action plan to be sent to commissioners for closure.	30/06/2022
2021/25961	15/12/2021	21/12/2021	Medicine	Patient relapsed during receipt of active leukaemia treatment	11 5 actions outstanding. Action plan extension to be requested from commissioners.	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. Action plan extension to be requested from commissioners.	31/07/2022
2022/1581	18/01/2022	24/01/2022	Surgery	Category 4 Pressure Ulcer	0 All actions completed - action plan pending corporate review to be sent to commissioners for closure.	31/08/2022

3.3 Internal level 2 RCA Investigations

The Trust declared **Zero** internal level 2 RCA investigations during the reporting timeframe 1st July – 31st August 2022.

Duty of candour

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

2 Duty of Candour responses were required and completed within expected timeframes during the reporting period.

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.

The RCA methodology seeks to identify the causal factors associated with each event and action plans are developed to address these factors.

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.

5 local SI action plans were confirmed closed by commissioners during the reporting timeframe.

0 SI investigation reports were concluded and submitted to commissioners during the reporting period 1st July – 31st August 2022.

5. Next steps

- Ongoing review of open SIs with overdue actions plans is underway by divisions as a matter of priority.
- Support continues to be offered from the corporate governance team to support divisions with the timely completion of action plans.
- Ongoing monitoring of SI action plan completion internally via CQSG.
- Maintaining effective collaboration between the corporate governance team and divisions.

6. Recommendations

The Trust Board is asked to:

- Note the content of the report
- Note actions to address open SI overdue action plans

Alder Hey Children's NHS
NHS Foundation Trust

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 - reported as per protocol (as Near Miss).	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 August 2022: RCA drafted and with lead investigator.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS
29th September 2022

Paper Title:	**Monthly Nurse Staffing Report**
Report of:	**Nathan Askew, Chief Nursing Officer**
Paper Prepared by:	Cathy Wardell, Associate Chief Nurse, Medicine.

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ■
Background Papers and/or supporting information:	The current monthly safe staffing indicator included in the board report will move to the attached reporting template, with the metric moving from fill rate to care hours per patient per day (CHPPD) The guidance regarding reporting nurse staffing levels was updated in 2021 and Alder Hey have been working on development of the data set and presentation of this data, with the report now ready for inclusion in the monthly board report. This paper provides an overview of the changes and an introduction to board members on the future style of reporting Care hours per patient day (CHPPD): guidance for all inpatient trusts (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:	BI resource for automating this process is already allocated

Associated risk (s)	The Trust will need to move to this reporting method to maintain compliance with NHSE reporting requirements.

1. Introduction

This paper provides the Trust board with an overview of the changes to reporting nurse staffing levels to be complaint with the reporting requirements of NHSE in relation to the updated guidance on Care hours per patient day (CHPPD).

2. Background

Historically the Trust have been required to publish safe nursing staffing levels in terms of an overall % metric of fill rate for inpatient nursing shifts. This is a crude metric, aggregated at trust level, based on 100% of nurses being deployed to care for 100% occupancy of beds.

The current method of reporting does not reflect the contribution to overall care needs of Health care Support Workers (HCSW) or include any adjustment for reduced occupancy.

The limitation of % compliance measures have been recognised nationally and therefore there is a requirement to move to CHPPD which allows for an average of hours of care received by each patient in a 24 hour period, with the ability to compare this through a benchmarking process with wards providing similar care nationally.

The report contains balancing measures which help to provide further assurance on safe levels of nurse staffing. An overview of the elements of the report are detailed below.

In line with NHSE requirements the Trust return safe staffing report to NHSE monthly. Due to data validation prior to publication by NHSE and the model hospital the safe staffing data will be 2 months behind (reporting June data in August). To mitigate this Alder Hey will publish the previous month daily staffing model data by day and night shift to provide a level of immediate assurance to the board on our nurse staffing levels.

3. Outline of the new report

Fill rates

The previous % fill rate against planned deployment of staff is included at the left side of the report. This is split by day and night shifts and by registered nursing staff and HCSW. The ideal staffing level is calculated on the assumption of 100% occupancy of the ward and an average level of dependency.

CHPPD

The number of hours of care available is calculated by length of shift multiplied by the number of registered nurses and HCSW available over the month. Each day the midnight census of the wards is captured to calculate the total number of patients

who received care in a month. The hours of care available are divided by the number of patients to give the average CHPPD.

It is noted that many wards will provide care to more patients in a day time than are present at the midnight census, however the national requirement is set on the basis of the midnight census.

The model hospital provides a national average of all patients in a similar care environment to allow for comparison of the hours of care received by children and young people at Alder Hey.

Many factors affect the number of nurses on a shift which contribute to the total care hours per day across the different units in England. These include acuity, complexity, environmental (number of single rooms) and the number of patients requiring 1:1 care for physical or mental health needs.

HR data

The report contains an overview of the monthly figures relating to vacancy, turnover and sickness at ward level, all of which provide indications for lower levels of fill rate or potential lower CHPPD.

Balancing safety metrics

A range of safety balancing measures are included which would flag and highlight wards of concern. All measures have been linked to indicating issues with quality of care, seeing a direct coloration by increasing incidents or lower patient experience associated with lower staffing levels.

Medication incidents

A direct coloration is seen when staffing levels are low, workload for nursing staff increases resulting in increased medication error rates. This metric is the total errors (prescribing, dispensing and administration) and not reflective of harm reaching the patient.

Staffing incidents

NHS England have developed a list of red flags for staffing which should be recorded and appropriate action taken. These are displayed as a balancing measure.

FFT, Pals and Complaints

As a combined measure of patient experience and satisfaction are included as a balancing measure. An increase in pals and complaints with a decrease in FFT scores would indicate a poor patient experience.

A narrative is provided to give context for lower levels of CHPPD or fill rate bringing together key highlights from the report

% of safe staffing shifts

As explained the reporting of safe staffing is delayed by two months due to data quality, processing and publication delays within the national system. Therefore, Alder Hey will publish our safe staffing data generated by the daily safe staffing meeting.

Alder Hey nursing deployment models rate each shifts as red, green, amber or yellow based on the ratio of staff to patients in each ward area, generating an overall staffing level colour for the trust. The chart included demonstrates a continuing shift of increasing green and yellow shifts with reducing amber and red, giving assurance on our compliance with safe staffing models of care.

4. Conclusion

The board are asked to note the contents of this report which will form part of the board pack for information moving forwards.

Reference
More information on CHPPD can be found:
https://www.england.nhs.uk/wp-content/uploads/2021/03/B0473-care-hours-per-patient-day-chppd-guidance-for-all-inpatient-trusts-updated-march-2021.pdf

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Safe Staffing & Patient Quality Indicator Report
June 2022

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	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		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	15.18	-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	32.59	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	32.59	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	13.22	-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	18.23	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	9.73	-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	8.01	-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	8.89	-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	9.73	-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	11.48	-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	8.47	-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.

On the medical wards, 3B and 4B had a low fill rate of Registered Nurses due to a high vacancy rate. Wards 3B, 3C and 4B also have continued high levels of sickness. A full overview of absence is taking place with Ward managers, HR, Matrons and Heads of Nursing to ensure we are managing cases in line with policy timeframes, occupational health referrals are in place and welfare meetings conducted.

In addition, all seconded posts on 4B have been reviewed and staff brought back to the wards where appropriate to support the establishment. The matron has also been reviewing the 121 risk assessments for HCA cover to ensure patient safety and will review incidents each morning and escalate any issues.

On the surgical wards 3A and 4A, prioritise HCA cover for patients requiring a 121 as per the risk assessment.

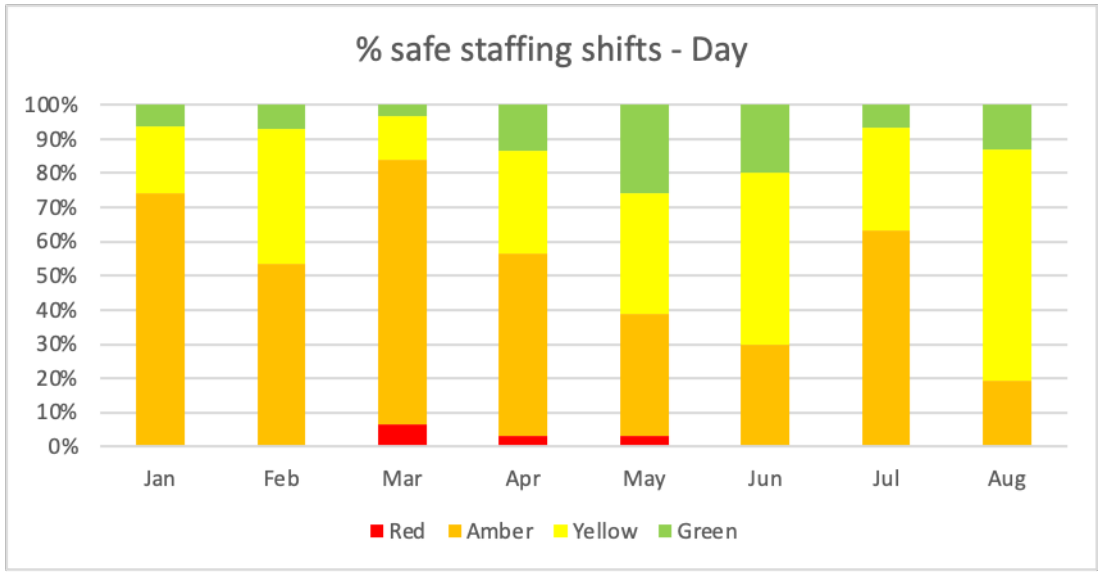
HDU and ICU had a low fill rate of Registered Nurses due to a high vacancy rate. The 8.45 FTE over establishment on ICU for unqualified vacancies, includes the international nurses awaiting a PIN.

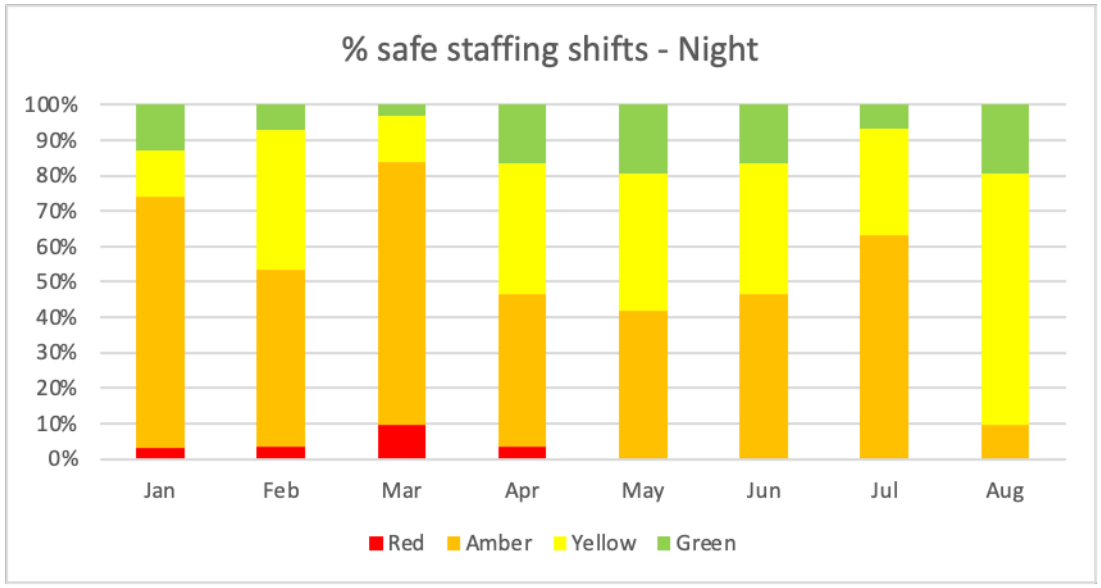
ICU had 17 medication incidents which is a reduction of 9 from May, with no incidents requiring escalation.

The wards are now supported by safe staffing in hours and by SNOS out of hours to ensure all staffing concerns are escalated and then decisions can be made based on overall hospital acuity and patient risk factors. During this period reported, staff moves were not recorded on ERoster.

Safe staffing ragged mainly yellow staffing days during both day and nights shifts in August (see below), which is a reduction of mainly amber days during July.

Friends and Family test showed 8 wards scored 100%.


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


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

Alder Hey Children's NHS Foundation Trust

Trust Board
29th September 2022

Paper Title:	**Quarter 1 2022/23 Complaints, PALS and Compliments report**
Executive Lead:	Nathan Askew Chief Nurse
Paper Prepared by:	Pauline Brown Director of Nursing
Paper Presented by:	Pauline Brown Director of Nursing

Purpose of Paper:	The purpose of this paper is to provide Trust Board with an update and assurance on the performance against complaints and PALS targets in Q1 2022/23, a thematic analysis of the top reasons for complaints and PALS, action taken because of concerns raised, and achievements in Q1 2022/23.
Summary and/or supporting information:	47 formal complaints received in Q1 with 1 subsequently withdrawn therefore 46 in total; this is a decrease compared to Q4 2021/21 (55). The top reason for formal complaints received in Q1 continues to be treatment and procedures, and perceived communication failure. 100% compliance with the 3 working day acknowledgement standard was achieved in Q1. Compliance with the 25 working day response time was 83% in April, 51% in May and 71% in June (average 68%) demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern. 5 second stage complaints were received in Q1 2022/23 No new referrals to the Parliamentary & Health Service Ombudsman during this period; one PHSO investigation in the Surgical division (received April 2019) has now concluded, and one in Medicine (received February 2021) has also concluded. Actions have been taken as advised by PHSO. There were 437 informal PALS concerns raised in Q1 2022/23; this is a significant increase following a spike in May and June. The main themes continue to relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff There has been significant improvement in responding to and resolving informal PALS concerns within 5 working days with an

	average of 85% compliance. Most notably the Surgical Division achieved 100% compliance responding to PALS concerns. This has a direct positive impact on families who raise a concern. Significant progress has been made during Q1 in regards to processes and systems to support effective management of complaints and concerns, including revised Complaints and Concerns Policy (RM6), a new PALS process implemented, bespoke risk assessment training for Divisions, a Quality Ward Round to ascertain the views of children, young people, families and staff, the development of online feedback, and the completion of all actions identified in the MIAA complaint review action plan. 102 compliments are recorded centrally in Ulysses
Financial Implications	None
Key Risks Associated	Reputational risk associated with not meeting the quality priorities and the Trust targets.
Quality Implications	Poor patient experience due to not meeting the required time frame for response and resolution and not having staff appropriately trained to locally resolve issues in their ward / department / service
Link To: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Delivery of outstanding care** **The best people doing their best work** Sustainability through external partnerships Game-changing research and innovation Strong Foundations
Resource Impact:	Yes
Action/Decision Required:	Trust Board are asked to note and approve the content of this report

1. Introduction

The Trust is committed to ensuring all our children, young people and their families receive the highest quality of care. However, where care and treatment does not meet the standard of care our service users expect, the Trust has a duty to listen to their concerns, investigate them fully, and provide a full, appropriate, and compassionate response. Compliments, concerns, and complaints are an important measure of the quality of care we deliver and are used to learn and further improve our services.

The aim of the report is to provide assurance that the Trust is responding to the concerns raised by children, young people, and their families in line with Trust procedures, Department of Health legislation and standards expected by the Parliamentary and Health Service Ombudsman (PHSO); identifying and analysing themes that the Trust needs to address to make service improvements; and to highlight action taken.

This report provides an overview of formal complaints and informal PALS concerns received and completed between April to June 2022 (Q1).

2. Formal Complaints

2.1 Number of formal complaints received Q1 2022/23

47 formal complaints were received in Q1 of which 1 was subsequently withdrawn from the Medical Division resulting in a total of 46. This is a slight decrease compared to the previous quarter (Q4 2021/22) where 55 formal complaints were received of which 4 were subsequently withdrawn resulting in a total of 51. Of note, Community and Mental Health Division have seen a significant decrease as demonstrated in Figure 1.

Figure 1 shows a comparison of this quarter and the previous quarter (does not include withdrawn complaints); Figure 2 shows the breakdown of complaints received by Divisional services in Q1; Figure 3 shows the complaints received by month (does not include withdrawn complaints) over a rolling 12 month period.

Figure 1: Number of formal complaints in Q1 2022/23 compared to previous quarter

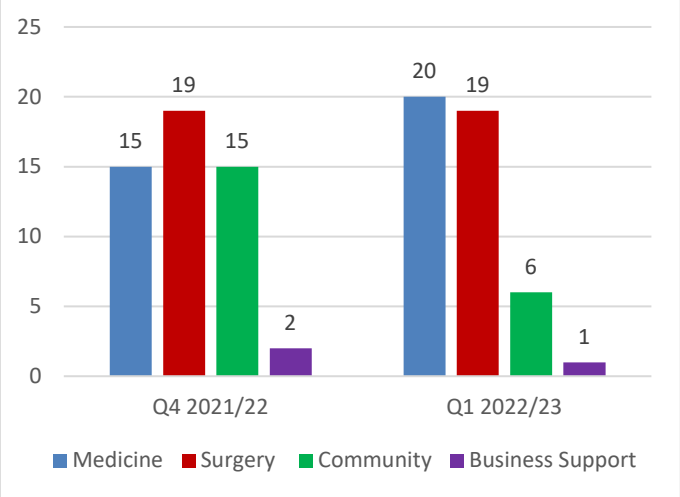


Figure 2: Number of formal complaints by Divisional services Q1 2022/23

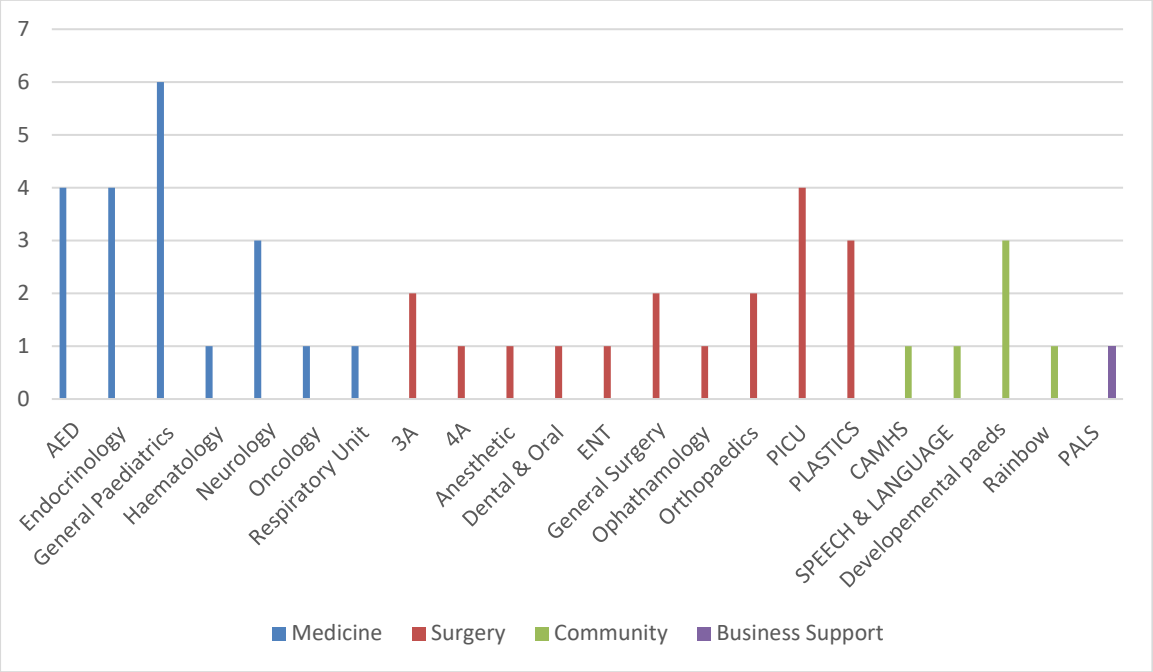
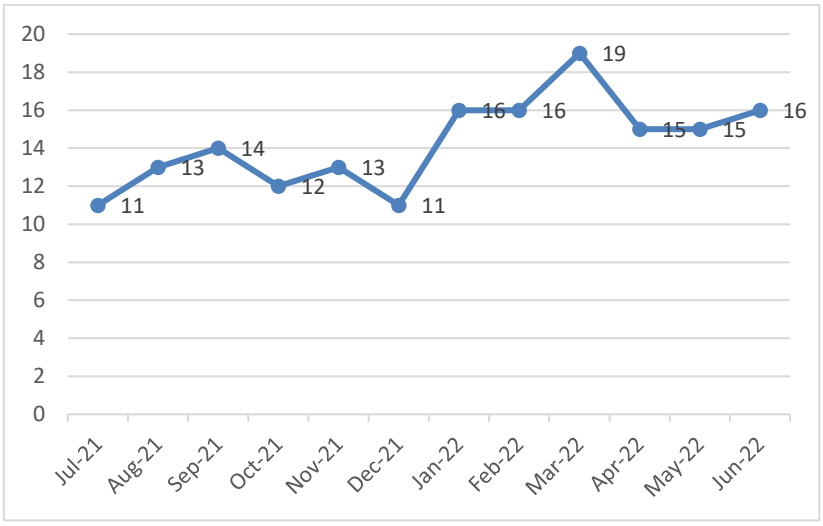


Figure 3: Number of formal complaints rolling 12 months

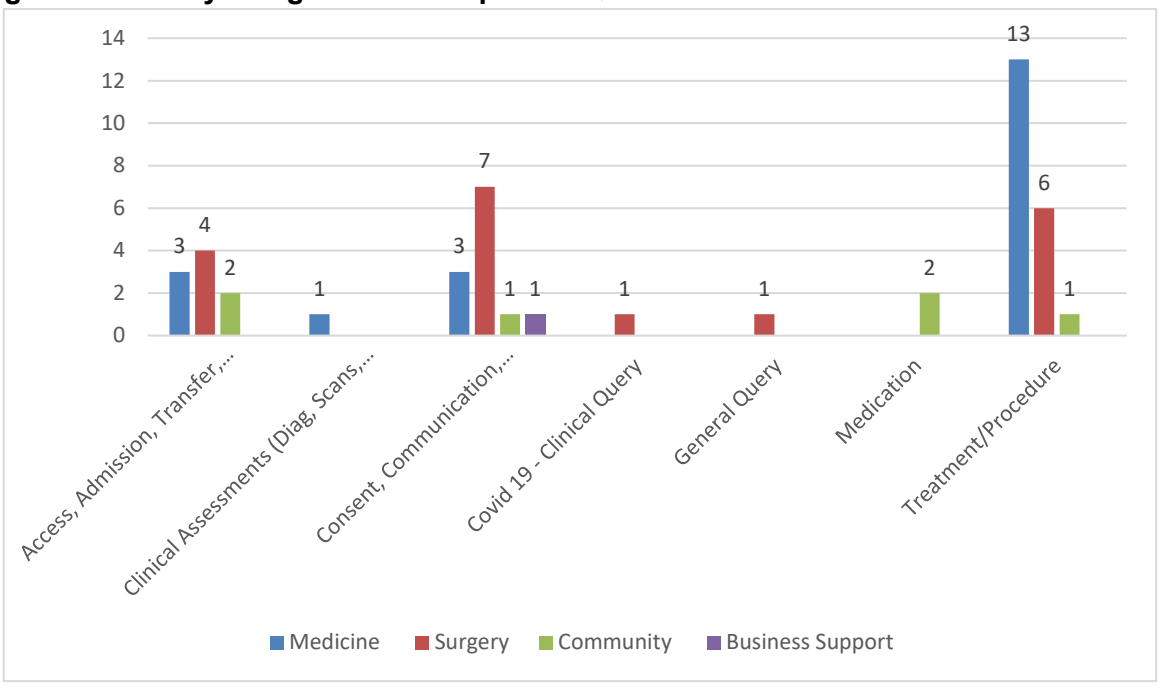


2.2 Complaints received by category Q1 2022/23

Complaints are categorised by subject as set in the Trust Ulysses complaints system. A complainant may raise several issues that the Trust must respond to, and all concerns expressed by families are categorised within the record, however the primary issue is used within this report to monitor key trends.

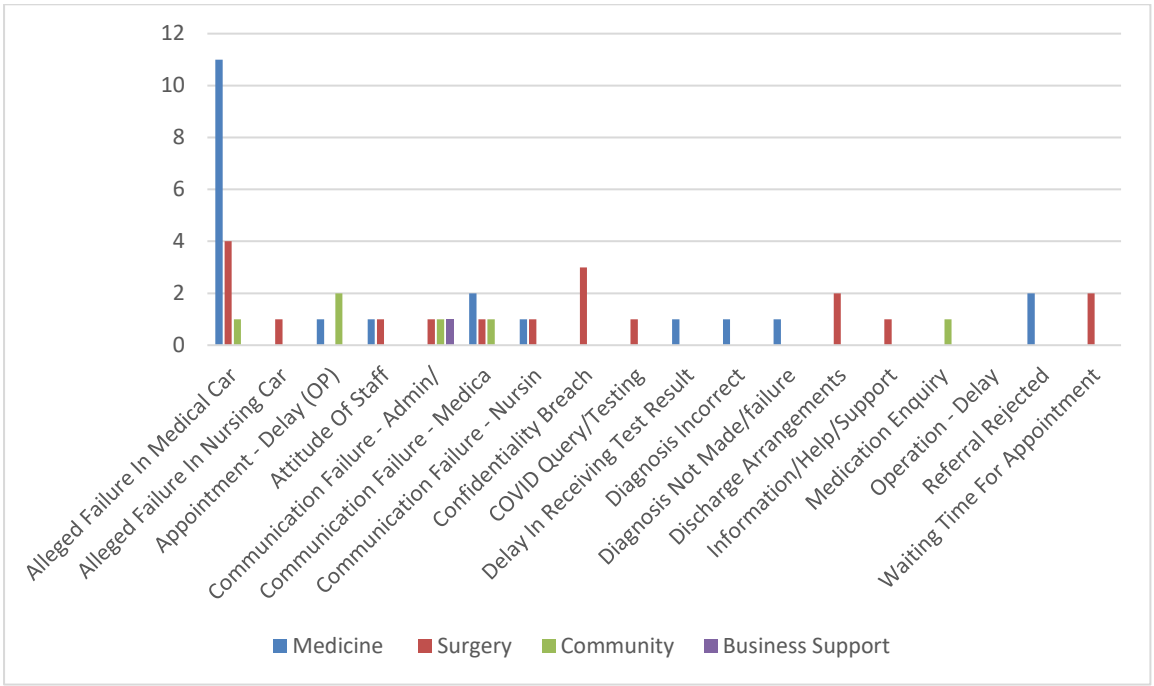
Figure 4 demonstrates that the main theme in this quarter continues to be in relation to treatment and procedure with a total of 20 complaints (43%) in Q1.

Figure 4: Primary categories of complaints Q1 2022/23



Sub-category identification provides further detail regarding the primary issues raised by families. Figure 5 demonstrates the main theme within the treatment and procedure category is in relation to alleged failure in medical care accounting for 16 of 20 complaints in this category and 34% of the overall 46 complaints received.

Figure 5: Subcategories of complaints Q1 2022/23



2.3 Trust performance against Key Performance Indicators (KPI)

2.3.1 National context

Current national guidance has set out that Trusts must continue to comply with NHS Complaints Regulations, however, acknowledge that in some settings it may take longer to respond to a complaint and consider it currently permissible for this to go beyond the usual six month maximum time period. However, organisations should opt to operate as usual regarding the management of complaints if they are able to do so. The Trust continues to aspire to responding to complaints in line with RM6 Complaints and Concerns policy.

2.3.2 Compliance with 3-day acknowledgement Q1 2022/23

The NHS Complaints Guidance sets out that complaints should be formally acknowledged within 3 working days; which reflected in the Trust policy. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwatch Advocacy. The Complaints Officer may also telephone the complainant to discuss their concern further.

In Q1, 100% (47 of 47) of the formal complaints received were acknowledged within 3 working days, with 40 (85%) being acknowledged on the same day demonstrating consistently high standard. Figure 6 and Table 1 shows performance with this KPI over a rolling 12 months which demonstrates the journey of improvement

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

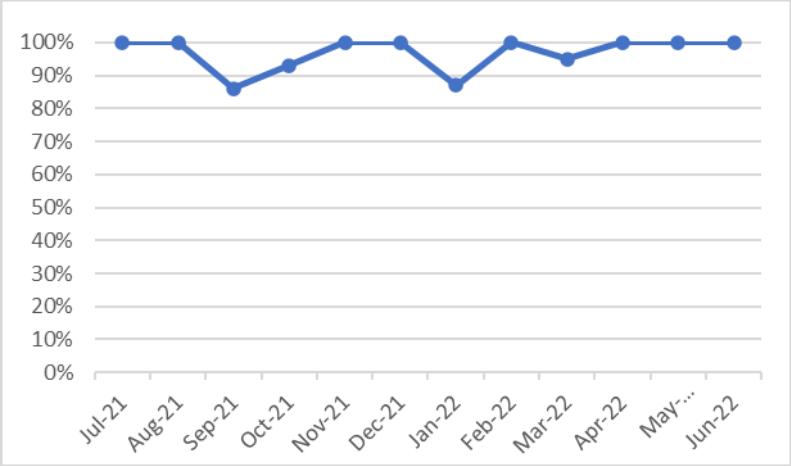


Table 1: Compliance with 3-day acknowledgement for a rolling 12 months				
Reporting period		Total complaints received	Total number acknowledged within 3 working days	% number acknowledged within 3 working days
Q2 21/22	July	11	11	100%
	Aug	14	14	100%
	Sept	14	12	86%
Q3 21/22	Oct	14	13	93%
	Nov	14	14	100%
	Dec	11	11	100%
Q4 21/22	Jan	16	15	87%
	Feb	19	19	100%
	March	20	19	95%
Q1 22/23	Apr	15	15	100%
	May	15	15	100%
	June	17	17	100%

2.3.3 Complaints responded to and closed in Q1 2022/23

A total of 45 complaints were responded to and closed in Q1 (not inclusive of complaints closed due to withdrawn) of which 26 were received during Q1 and 19 were received in Q4 2021/22.

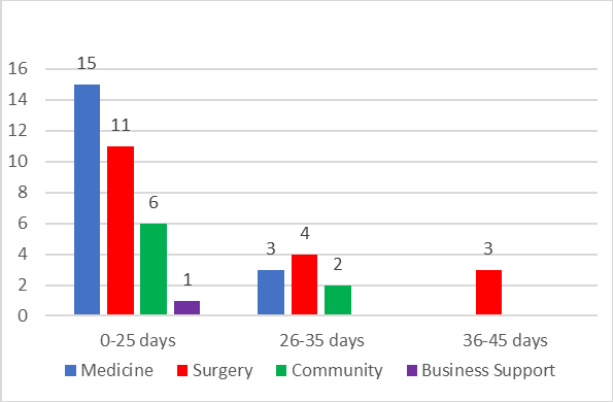
2.3.4 Compliance with 25-day response

Whilst the NHS Complaints Guidance states that there is no set timeframe to respond to a formal complaint, as this is dependent on the nature of the complaint, the Trust has set an internal timeframe in the Complaints and Concerns policy to respond to formal complaints within 25 working days. Where a complaint is complex and / or multi organisational, this is discussed with the complainant to negotiate an extended timeframe with them and agree a new date for response. A meeting with appropriate Trust representatives is also offered as this can lead to a successful resolution of the concerns raised.

Of the 45 complaints responded to in Q1, 33 were responded to within 25-days as demonstrated in Figure 7 which is a sustained improvement with this KPI.

Of the 20 complaints that remain open and under investigation (all received within Q1), 17 were within the 25 day timeframe at 1st July 2022 and 3 were overdue.

Figure 7: Compliance with 25-day response – complaints responded to in Q1



Improving the time to respond to families in a timely manner is a continued Trust and Divisional priority. The journey of improvement within Divisions in the past 6 months, can be identified by the significant shift to the left in the response times illustrated in Table 2 below, with Medicine Division achieving 83% compliance (15 of 18); Surgery Division achieving 61% compliance (11 of 18), and Community achieving 75% compliance (6 of 8).

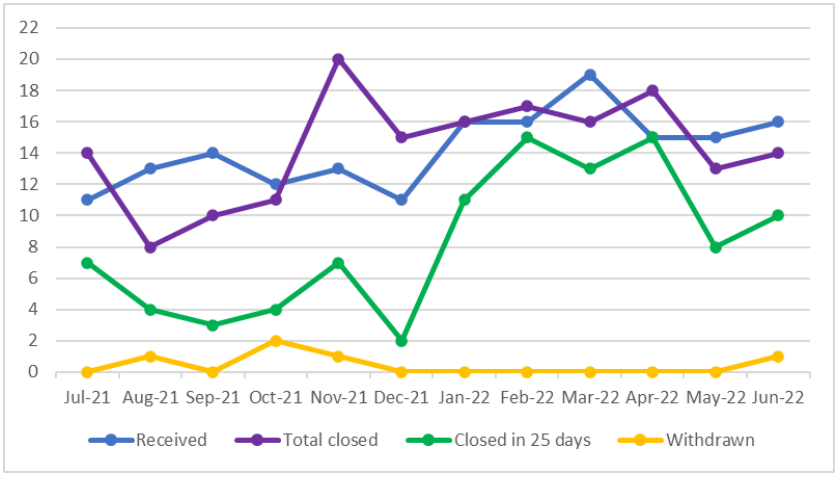
Table 2: Compliance with 25-day response for a rolling 12 months

Number of complaints responded to in 2021/22 by Quarter by Division (does not include withdrawn)			Days								
			0-25	26-35	36-45	46-55	56-65	66-75	76-85	86-95	96 -121
Q2 21/22	Medicine	14	2	5	3	2	2				
	Surgery	12	3	2	3	2			2		
	Community	7	5	1		1					
	Business Support	4	3								1
Q3 21/22	Medicine	15	3	8	3						1
	Surgery	13	9	3	1						
	Community	7	4	3							
	Business Support	1	1								
Q4 21/22	Medicine	10	9	1							
	Surgery	10	9	1							
	Community	11	11								
	Business Support	1	1								
Q1 22/23	Medicine	18	15	3							
	Surgery	18	11	4	3						
	Community	8	6	2							
	Business Support	1	1								

As complaints are often not received and responded to within the same month or quarter of the year, Figure 8 shows the number of complaints received in month, the total number closed in month and the number responded to within 25-days. The graph also shows the number of complaints withdrawn.

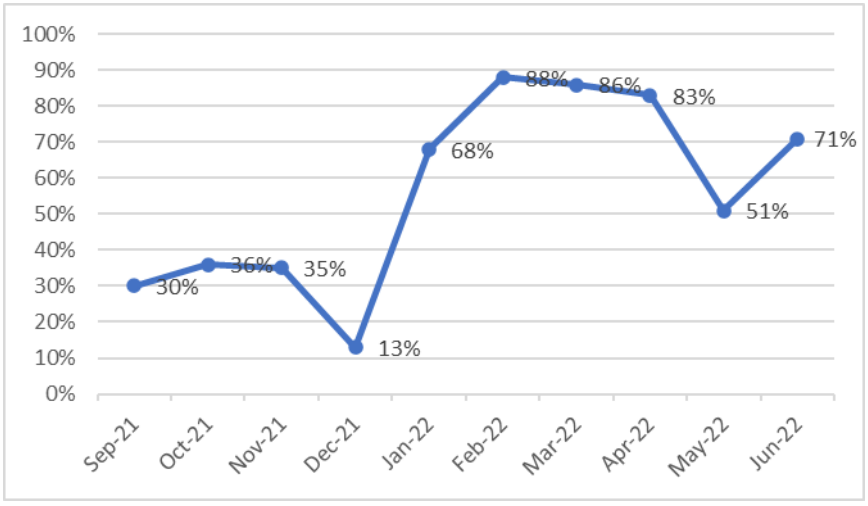
Figure 9 shows the percentage compliance with the KPI by month for a rolling 12 months, overall demonstrating the continued journey of improvement. In Q1 compliance was high in April 83% and June 71% but decreased to 51% in May (mean 68% for Q1) demonstrating the need for a continued focus

Figure 8: Comparison of complaint number with 25-day response for a rolling 12 months



NB: Withdrawn complaints are not included in the 'received', 'total closed', or 'closed in 25 days' figures and only depicted in the 'withdrawn' figure

Figure 9: Percentage of complaints closed within 25-day response rolling 12 months



2.3.5 Number of open and closed formal complaints by month

Table 4 shows there were 47 formal complaints opened in Q1 2022/23 of which 1 was subsequently withdrawn resulting in 46 new complaints in 2022/23, 46 closed, 22 open investigations of which 20 are first stage and 2 have progressed to second stage. Complaints that are received in a month may not be responded to until the next month in line with the 25-day response timeframe.

Table 4: Formal Complaints received 2022/23													Cumulative to date
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	
Received	15	15	17										**47**
Withdrawn and closed			1										**1**
New complaints (adjusted from withdrawn)	15	15	16										**46**
Open (first stage)	3	2	19										**24**
Investigated, responded to and closed	18	13	14										**45**
Re-opened (Second stage)	1	1	3										**5**

2.3.6 National complaint reporting: KO41a return

The Trust is mandated to submit data nationally regarding the status, categories and outcome of complaints on a quarterly basis to NHS Digital using the Hospital and Community Health Services Complaints Collection (KO41a) tool.

The information obtained from the KO41a collection monitors written complaints received by the NHS. It also supports the commitment given in equity and excellence to improve the patient experience by listening to the public voice.

For assurance, Q1 was submitted in line with the NHS Digital schedule.

2.4 Outcome of the complaint

2.4.1 Complaints upheld

The outcome of each complaint response is reviewed and assigned by the Chief Nurse or deputy. In Q1 11 (24%) of complaints were not upheld; 21 (46%) were partially upheld, and 14 (30%) were fully upheld. A complaint will be partially upheld if any one concern raised is upheld irrespective of whether the majority of concerns in a complaint are not upheld. This is a significant marker of an open, transparent and learning organisation. Figures 10 shows the outcome of complaints closed in Q1 by Division; Figure 11 shows the outcomes for the trust overall on a rolling quarterly basis. This demonstrates that the majority of complaints investigated and responded to are consistently fully or partially upheld.

Figure 10: Outcome of 46 complaints closed in Q1 2022/23

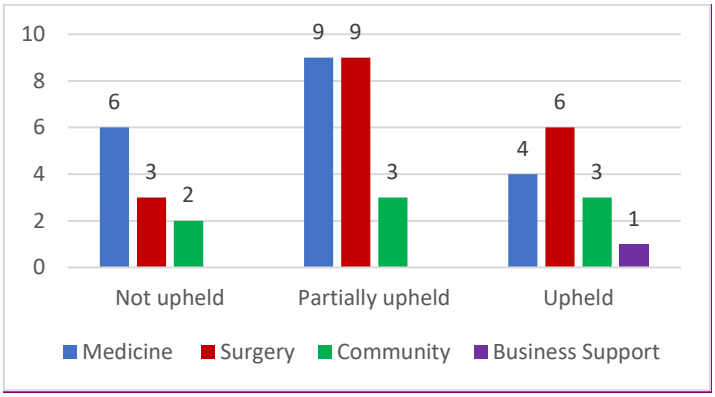
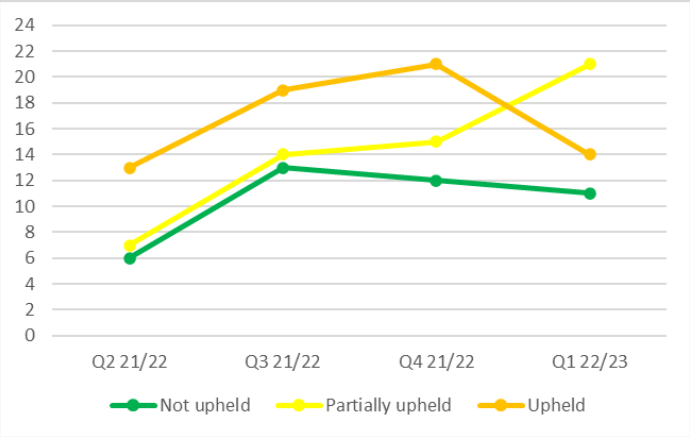


Figure 11: Outcome of complaints closed by rolling quarter



2.4.2 Second stage complaints

Second stage complaints are a rich source of valuable data and a key indicator of our performance. They can be triangulated to inform the Trust of how satisfied our families are with the quality of our response, and as an early indicator of families who may seek further resolution through the Parliamentary & Health Service Ombudsman. Second stage complaints are monitored on a monthly basis as a key performance indicator.

The initial response letter advises the complainant that, should they be dissatisfied with any part of the initial complaint response, or require further assistance, they should contact the Trust within 25 working days in order that the Trust can try to resolve any outstanding concerns.

In Q1, 5 families informed us that they were not satisfied with the outcome of their initial complaint response: 1 received in Q3 21/22 and responded to in Q4 21/22; 2 received in Q4 21/22 and responded to in Q1 22/23; 2 received and responded to in Q1 22/23. Three relate to Surgery Division and two relate to Medical Division.

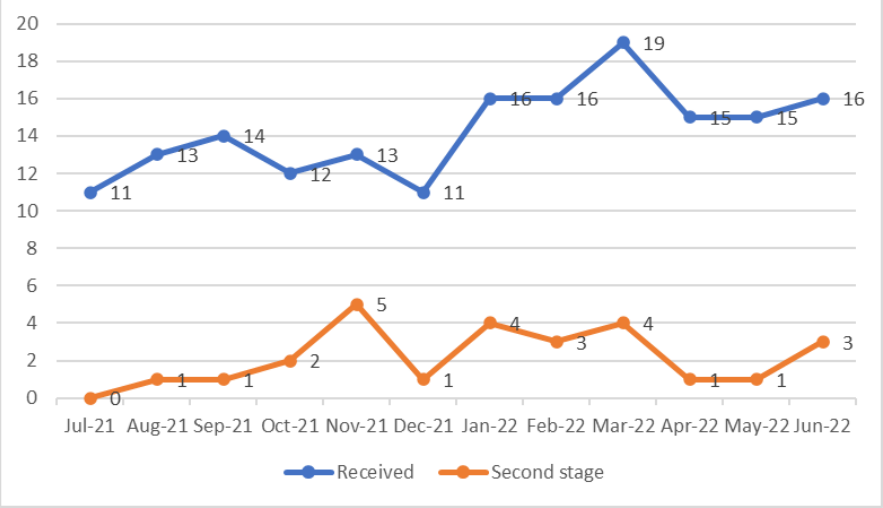
Families have been dissatisfied either because they felt the response did not answer their questions fully or because they disagreed with our response.

100% (5) were acknowledged within 3 working days. One complaint has been subsequently resolved and closed within 26 working days. Of the remaining 4 open investigations, 3 were within the 25 day response time as at 1st July 2022 and 1 had exceeded the timescale.

This is an overall high level of satisfaction with the quality and content of the initial complaint response, however there is a need to continue to monitor and review the reasons why families remain dissatisfied to ensure our investigations, responses and actions are appropriate and of the highest standard for our families.

As second stage complaints may not necessarily fall within the same Quarter, they cannot be displayed in accurate percentage terms by Quarter. However, Figure 12 shows the comparison of monthly initial complaints and monthly second stage complaints received for a rolling 12 months

Figure 12: Comparison of initial formal complaints responses with complaints re-opened at second stage for a rolling 12 months



2.5 Referrals to Parliamentary & Health Service Ombudsman (PHSO)

There were no new referrals to the Parliamentary & Health Service Ombudsman during this period. One PHSO investigation in the Surgical division (received April 2019) has now concluded, and one in Medicine (received February 2021) has also concluded. Actions have been taken as advised by PHSO.

2.6 Actions and learning from complaints

It is essential that where things go wrong the Trust takes action to remedy any issues. Complaint response letters inform the individual complainant what action has or will be taken, and the Division monitor the actions through to completion. As a result of a finding and recommendation in the MIAA review in December 2021, Complaints Officers now include a clear breakdown of all actions in the response letter to the complainant and all Divisions use the same template to ensure a consistent high quality approach.

Complaint Officers log actions and learning within Ulysses however the system requires significant development to enable actions to be pulled into an action log which can be

monitored and tracked to completion; currently this requires manual input which is resource and labour intensive. It is expected hat the new risk management system will facilitate this requirement.

Formal complaints are reviewed at the monthly Divisional Integrated Governance meetings to ensure senior divisional oversight of the current trends, to enable learning, to enable identification of specific areas of concern and any strategic actions, and ensure actions are fully disseminated, implemented and reviewed. Updates are shared by the Divisions at the Clinical Quality steering Group (CQSG) each month to ensure Trust wide learning.

Examples of improvements made to services as a result of concerns raised are:

Medical Division:

Concern: Clinical letter accuracy
Action: Ensure accurate information is documented in clinic letters and remind staff to always be professional

Concern: Missed Discharge in medication
Action: Incident form submitted in relation to missed discharge medications. Incident has been added onto the ward safety huddle to ensure all take home medications are checked by two registered nurses to ensure dosage is correct before patient is discharged. In complex patients with many medications there may need to be added pharmacy input in checking all take home medications.

Surgical Division:

Concern: COVID testing, communication failure for nursing and discharge arrangements.
Action: Cleft palate information board to be made for parents and staff reference. Cleft palate teaching sessions added to the agenda for ward nurse teaching. Practice education team to contact staff to signpost to DMS and reiterate importance of providing written information for parents in discharge

Concern: Poor communication
Action: Staff reminded to double check information before listing patients. Staff to discuss the importance of keeping the babies and children warm prior to surgery and to offer a warm blanket. SAL to place signs in all patient cubicles asking parents to notify staff if they require a blanket to keep their child warm. Blanket warmer to be ordered.

Community:

Concern: Complaint regarding lack of communication regarding referral and appointment
Action: To ensure that information on a patient's current status with the department is checked and communicated effectively to parents/carers. All administration staff to be reminded regarding the principles of customer care. The triage process within the Community SaLT Service to be reviewed and circulated to the Speech and Language Therapist to reduce the risk of children not being prioritised upon re-referral. A recovery plan is in place for the Community SaLT Service to reduce the length of waiting times. A process to review children's

referral in the Community SaLT Service when they have waited over the standard 18 weeks has been trialled and is to be implemented

Concern: Lack of support from Community Speech and Language Therapy service.
Action: Therapists will be provided with additional training to further develop their knowledge and skills with regards to working with children and young people with Downs Syndrome. The clinical pathway for working with children and young people with Down's Syndrome will be reviewed, and parents / carers will be consulted with as part of this review. Therapists will be asked to discuss all planned discharges with their supervisor prior to raising a discharge with the family and nursery / school to ensure that it is clinically appropriate.

2.7 Achievements in Q1

2.7.1 Quality Ward Round

Building on the engagement session with the CYP Forum in March 2022, a Quality Ward Round was undertaken in May to gauge the views of children, young people, their families and the staff to further understand what information they would like, to understand how staff manage local concerns and to ascertain what information is available on the wards.

Key learning points included:

- Parents/carers/CYP felt able to raise concerns/issues and problems with the staff on the ward/department and they would prefer to speak to the staff on the ward.
- Parents/carers/CYP feel that if issues were not resolved or the same issue keeps happening, if they did not receive an apology or felt that they haven't been listened to may lead them to consider raising a complaint.
- 70% of parents/carers/CYP felt that they had not seen any information on the ward/department advising them how to raise a complaint or concern.
- 91% or parents/carers/CYP feel that their child has the same right to complain as they do. Staff also feel that the child / young person has the right to complain or raise concerns.
- Staff were able to describe the steps they would take if a parent/carer/CYP shared concerns including listening, an apology and trying to resolve the issues locally.
- 95% of staff said they would document concerns raised of these 59% would record it in the patients Meditech record. 62% of staff were not aware that local complaints/concerns should be recorded in Ulysses.
- 71% of staff confirmed that they have received information about themes and learning from complaints/concerns at either a safety huddle or team meeting.
- 83% of staff think that further training in managing concerns would help them in their role.

Actions as a result of the Quality Ward Round include:

- Develop a QR code to enable CYP to raise an issue; this supports the feedback from the CYP Forum
- Devise a Training Needs Analysis and develop training for staff in local resolution
- Local concerns are not routinely recorded in Ulysses therefore raise awareness through training and as part of launch of new risk management system

Report, presentation and Microsoft form question sets available as Appendix 1

2.7.2 Complaints and Concerns Policy (RM6)

The new Complaints and Concerns Policy (RM6) was approved and ratified through CQSG and SCAC in June 2022. Whilst the fundamental elements of the policy have not changed, it has been completely re-written to provide clear guidance, structure and process throughout, to clearly define roles and responsibilities, and to improve the flow of the policy to assist staff to promptly identify relevant guidance

It has been updated to reflect:

- The United Nations Convention on the Rights of the Child
- The NICE guidance on the right of children and young people to complain (NG204)
- The updated NHS Complaints Guidance (2021)
- The learning from Healthwatch report (2020)
- GDPR
- To address the MIAA findings

The policy has been significantly strengthened in regard to:

- The rights of children and young people to raise concerns
- The importance of the first contact resolution principle for concerns raised at local level
- Supporting staff involved in complaints
- Supporting complainants including concerns for their health and wellbeing
- The importance of learning lessons, disseminating the learning, taking appropriate action and making improvements, and monitoring actions to completion
- The purpose and importance of the initial risk assessment process
- The management of complaints deemed to be complex including Coroner's Inquests
- Management of withdrawn complaints
- Process for extending timeframes
- Management of complaints via the complaints module in the Ulysses electronic risk management system
- Template letters for consistent approach to responses

2.7.3 Online feedback

In line with the MIAA report published in January 2022, an opportunity for complainants to share feedback regarding their experience of the management and response to their complaint has been implemented and is available on the Trust website. The template response letter has been updated and provides all complainants with a QR code and a link to the feedback form. Going forward, responses will be reported on quarterly.

2.7.4 Risk Assessment training

Risk assessment training was arranged and delivered in April for Complaints and PALS Officers and Divisional Governance leads. The training included generic risk assessment training and bespoke training to assess the risk of formal complaints and identify actions that may be required to address the emerging risks. The importance and process for risk assessing complaints has been addressed in the new Complaints and Concerns Policy.

2.7.5 MIAA action plan complete

The MIAA conducted an audit of complaint management during Q3, and a report was received by the Trust Audit and Research Committee in January 2022. The Trust received limited assurance and 11 recommendations were been made relating to two high risks, 6 medium risks and 3 low risks. The two high risks were in regard to identification, recording and sharing of lessons learned: and monitoring actions from complaints. A comprehensive action plan to address the recommendations was devised and all actions have now been completed. The action plan is available as Appendix 2.

2.8 Healthwatch

Healthwatch Liverpool and Healthwatch Sefton are key members of the Patient Experience Group and feedback any issues or concerns raised by children, young people and families. Concerns are also fed back in real time to the Patient Experience lead. Numbers are small and concerns are usually anonymous; there is a process to triangulate any concerns with concerns received by the Trust both by theme and if the complainant shares their name the Trust is able to respond either directly to the individual or through Healthwatch. No issues have been raised in Q1.

2.9 Ockenden report: Governance of complaints

In March 2022, the Department of Health and Social Care published the Ockenden report; the outcome of an independent review of the maternity services provided by another Trust. In relation to complaints, it was reported that responses were not empathetic and were not delivered in the time frames of the Trust complaint policy. Complaint response letters included inaccurate information, justifying actions and cases where explanations laid blame on the family themselves for the particular outcome. Staff were lacking in formal training for responding to complaints.

An action plan has been devised of which 4 relate to complaint management. Three of the recommendations and actions have been assessed as fully compliant or have been completed as per Appendix 3. The outstanding action will be taken forward by the Patient Experience Group and overseen by SQAC.

3. PALS informal concerns

3.1 Number of informal PALS concerns received Q1 2022/23

There were 437 informal concerns received during Q1, an increase of 56 (382) reported in Q4 2021/22 with a significantly high number of 183 recorded in June 2022 as shown in Figure 13.

Figure 13: Number of PALS concerns by rolling 12 months

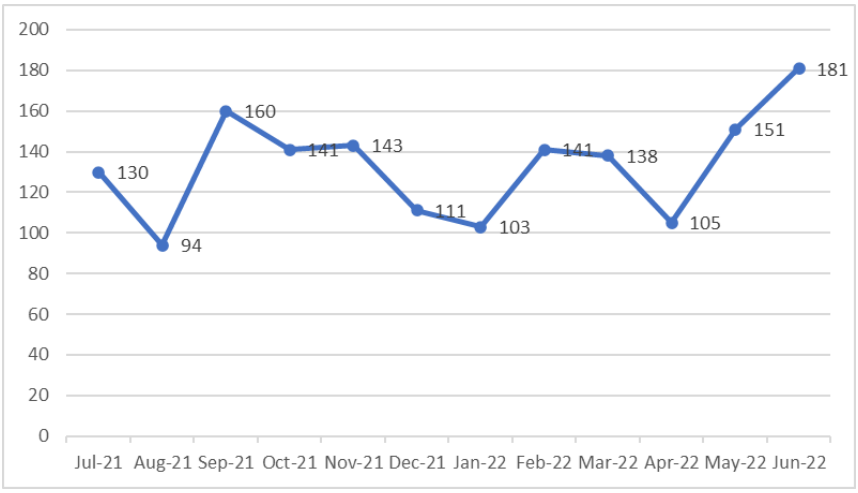


Figure 14 shows a compaitive breakdown of informal PALS concerns by Division for this quarter and last quarter. Figure 15 shows the highest number of informal concerns raised by services in the Divisions; this enables Divisions to identify areas that potentially need additional support or deep dive.

Figure 14: comparative number of informal PALS concerns by Division Q4 2021/22 and Q1 2022/23

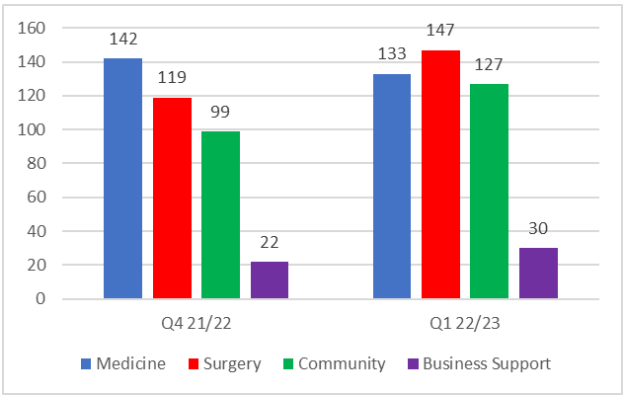
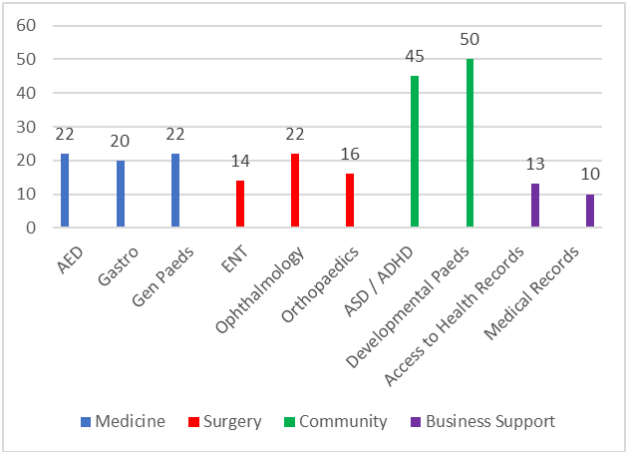


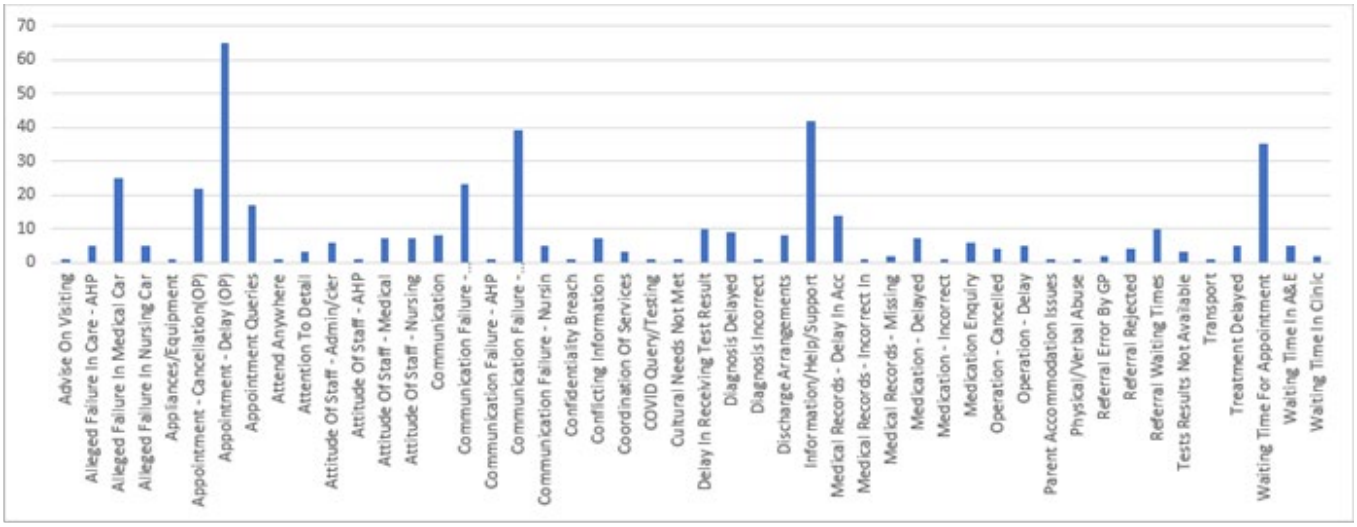
Figure 15: Services by Division with highest number of informal PALS concerns raised



3.2 Informal PALS concerns received by category Q1 2022/23

All informal PALS concerns are categorised by subject using the same system as formal complaints, which assists with data analysis and monitoring. The main issues raised within Q1 relate to appointment delays and waiting times for appointments, and perceived communication failure by medical staff as shown in Figure 16. The category of Information / Help / Support, which also received a majority number, is under review.

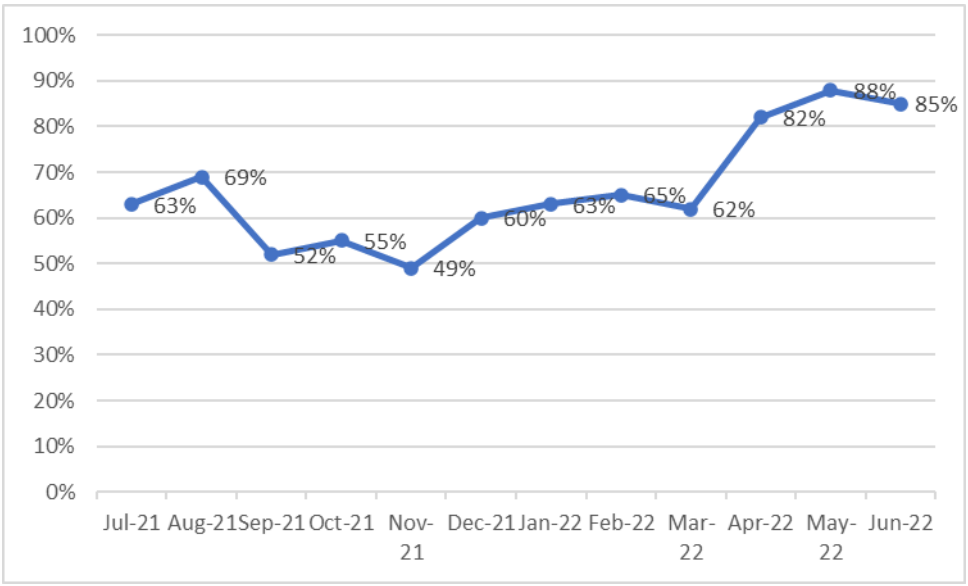
Figure 16: Category of informal PALS concerns Q1 2022/23



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

The timeframe to resolve PALS concerns is 5 working days. There has been significant progress with this KPI throughout Q1 as demonstrated in Figure 17 which shows compliance between 82% to 88% (mean 85% for Q1).

Figure 17: Percentage compliance with the 5-day PALS response rolling 12 months



Of particular recognition is the achievement of 100% compliance throughout Q1 by the Surgical Division as demonstrated in Figure 18 and Table 5. The whole team, including nursing, medical, operational, risk and governance, complaints and PALS, and Patient Experience, have worked together collaboratively to ensure patients and families have received a timely and supportive resolution to their concerns, and understand that the most important factor in the management of PALS concerns is to assist our families.

Figure 18: Percentage compliance by Division Q1 2022/23

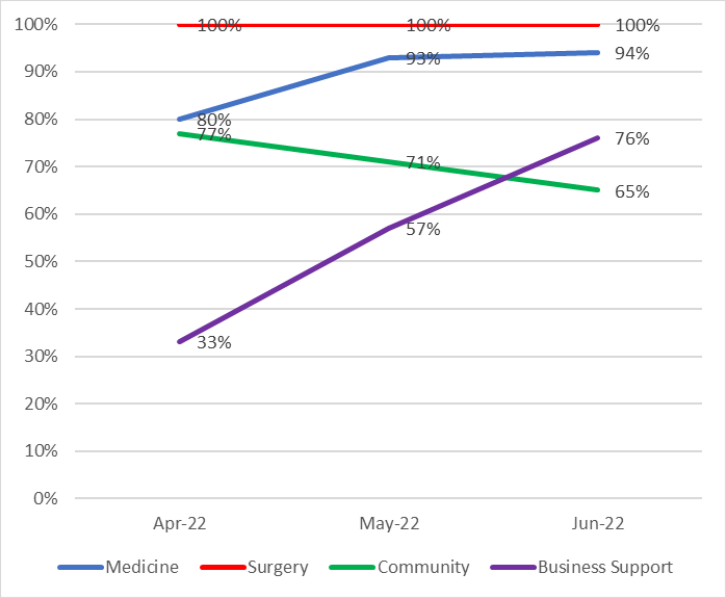


Table 5: Compliance with 5-day response to PALS concerns			
PALS	**Received Q1 2021/22**	**5-day response**	**Overdue and ongoing**
Medicine	133	120 (90%)	13 (10%)
Surgery	147	147 (100%)	0 (0%)
Community	127	89 (70%)	38 (30%)
Business Support	30	19 (63%)	11 (37%)
Total	**437**	**375 (85%)**	**62 (15%)**

A new PALS process was agreed in April 2022 at a workshop and is included in the revised Complaints and Concerns Policy. The process includes clear roles and responsibilities including ensuring that informal concerns raised regarding Business Support services are managed in the same way as the Divisions to provide appropriate support and oversight and improve compliance to ensure families receive a timely response.

Divisions have also implemented local monitoring of both formal complaints and informal PALS concerns with weekly review by the PALS & Complaints Officers and Risk & Governance Leads and weekly escalation to the appropriate Associate Chief Nurse as required.

4. Compliments in Q1

Compliments are an equally important measure of the quality of care, treatment and service the Trust delivers, providing powerful and valuable feedback and demonstrating that a family feel compelled to share this with us by taking precious time to share what has been good about their experience. This feedback also provides important balance with concerns raised.

There is currently limited information recorded in the central Ulysses system regarding compliments although it must be noted that the Community Division continue to input the majority of compliments as shown in Figure 19 below. It is acknowledged that the Trust receives many more compliments which have not been centrally recorded and Divisions are encouraged to submit. During the Quality Ward Round, ward staff advised that they do not record compliments received on their ward due to time constraints. However most of the wards displayed thank you cards received from grateful families. Examples of compliments can be found in Appendix 4.

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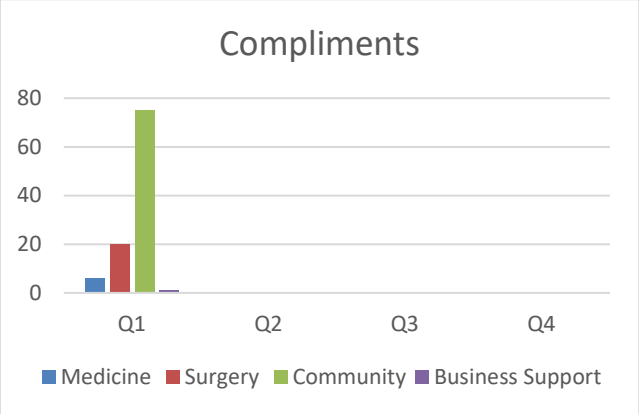
Figure 19: Compliments recorded in Ulysses in Q1



5. Conclusion

This report provides assurance to Trust Board of the continuing improvements in responding to the concerns raised by children, young people, and their families. Significant progress has been made during Q1 in regards to processes and systems to support effective management of concerns, including revised Complaints and Concerns Policy (RM6), a new PALS process implemented, bespoke risk assessment training for staff Complaints Officers and Divisional Governance leads, a Quality Ward Round to ascertain the views of children, young people, families and staff, the development of online feedback, and the completion of all actions identified in the MIAA action plan.

There has been continued improvement across KPI's, including 100% compliance with acknowledging formal complaints within 3 working days, and the highest reported compliance with responding and resolving informal PALS concerns within 5 working days with an average of 85% compliance. Most notably the Surgical Division achieved 100% compliance responding to PALS concerns. This has a direct positive impact on families who raise a concern. Not all formal complaints were responded to within 25 working days, with a decreased performance in May meaning the average compliance in Q1 was 68%

demonstrating the requirement for continued focus, action and commitment to ensure families receive a timely response to their concern.

Appendix 1: Quality Ward Round

Quality Round Report - Local mana

Appendix 2: MIAA action plan (complete)

MIAA Complaint audit action plan Dec

Appendix 3: Ockenden action plan (related to complaints management)

Ockenden action plan May 2022 SQAC upda

Appendix 4: Examples of compliments Q1 2022/23

Medicine Division

AED*: 'Patient and family centred care'*

AED: '*outstanding professionalism and care Dr X was doing a locum in ED he normally works for the medical consultants'*

Surgery Division

1C Cardiac: "*Thank you so much for coming to see me when I'm on the ward. We always have lots of fun together when we play with toys and get messy. You are amazing"*

Surgical Day Care Unit: *"Still to this day when x (child's name) is due for a check-up at Alder Hey he asks if he's seeing Dr x. He was so young when you were treating him, but he remembers you. You took such good care of x (and me) for over 3 years, and we cannot thank you enough for every check-up, visit, medication review. Thank you for always listening to my concerns, thank you for always making x feel safe. You are the angel of Alder Hey"*

Cardiac Surgery: "x (Consultant's name), for giving our daughter, x, a chance at life. You are spoken about almost daily in our house and we are eternally grateful for your gifts!"

Community Division

School Mental Health Support*: "There are no words to tell you just what you've done for me, things I never thought where possible, someone I never thought I would be. You showed me I could do it, you helped me to be brave, but mostly it was your encouragement, and the kind*

words that you gave. I will never forget you, and everything you've done, to us, you are so special thanks for helping me and my mum."

"Thanks you so much for everything you have done for me and x, words cannot describe how much your kindness, help and support have changed our lives for the better. Lots of luck for your future career, any child who receives your support will be a lucky child."

"To x, thank you for taking care of me and helping me get over my fears. You have made a huge impact in my life."

Integrated Children's Community:
"Thank you so much for all of your help and support with x we really appreciate it all!

Community Physiotherapy & Occupational therapy: *"I'm very pleased to say that x is walking well, running, jumping, and talking a lot - basically doing everything you would expect a child of her age! Something I believed we would achieve, and we have?? We are very proud of her. We made it clear we wanted to do all we could early doors and found out that it was possible to have weekly physio sessions with x from 2.5 months old which I believe really helped us to get to where we are today. We worked hard to make sure that we were encouraging her to move in the ways that she should be for her age every step of the way and having someone to tell us what to do was incredibly helpful. As first-time parents we wouldn't have had a clue so we are very grateful for all the help that we have been given from Alder Hey and hope more hospitals in the UK can offer the same early intervention for HIE babies as we are very fortunate to live where we do to get the level of care that we've had, and the results speak for themselves"*

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

Section two is the Quarter 1 Mortality report which includes a review of statistical analysis in PICU, followed by more detailed analysis of the place of death, teams involved and specifics about expected vs observed deaths.

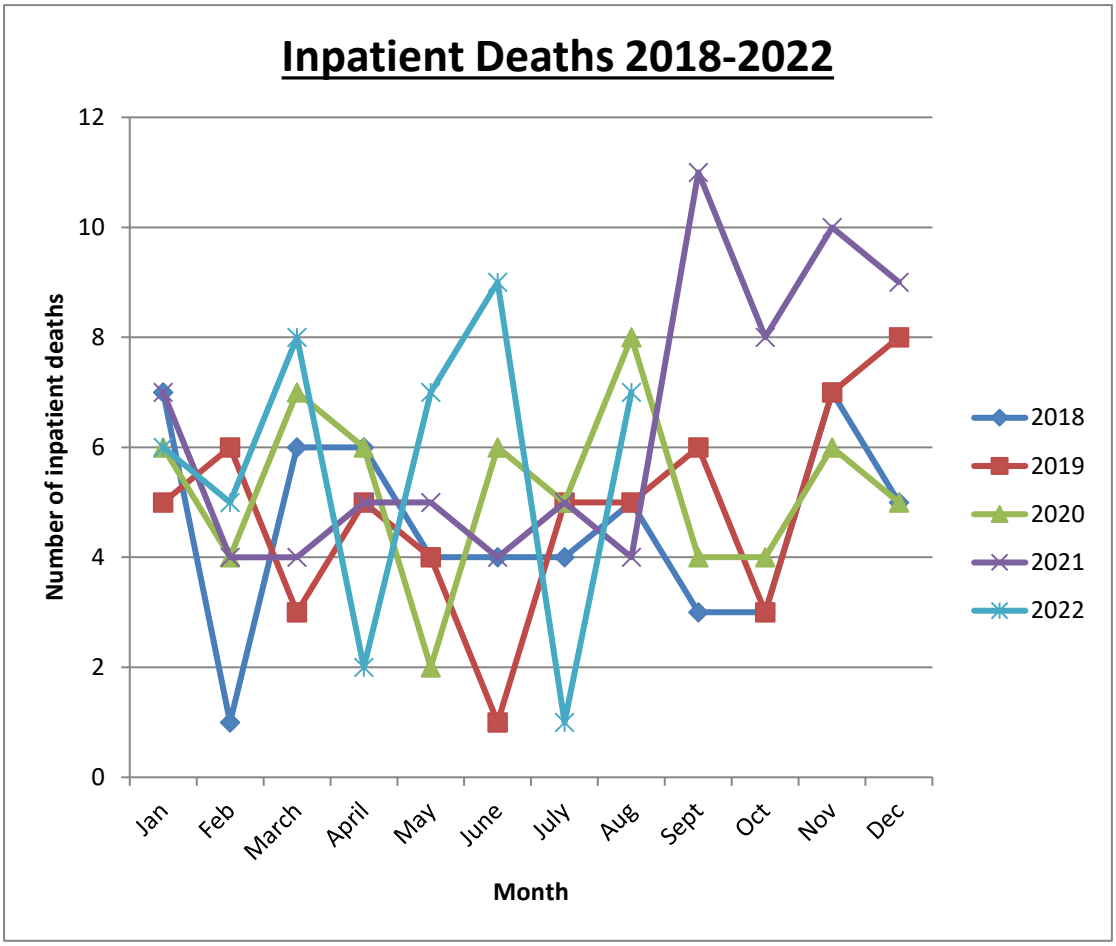
Section 1: Report from the Hospital Mortality Review Group (HMRG)

The percentage of cases being reviewed within the 4-month target is consistent due to the group increasing meeting frequency and duration when the need has arisen.
Looking at the 5-year figures, there is an increase in case numbers in 2021 but significantly there had been changes in the way that the data is recorded. These figures used to cover patients that had died in the hospital but not the Emergency Department deaths. These can be children /YP where unfortunately nothing can be done, and resuscitation may have been stopped soon after assessment by a senior clinician. The decision was made to include these so that all deaths in Alder Hey are reviewed by the same process receiving the same scrutiny and ensuring the family's voice can always be heard.

In 2022, the figures seem to be returning to more usual levels although there have been increases in all childhood illnesses following COVID lockdowns and the relaxation of all isolation measures. The summer months have seen children presenting with illnesses that traditionally we would only see in winter /spring. As life returns to normality this should return to the traditional patterns in the future.
However, there have been several trauma deaths over the last year which have been shocking and the Trust has had to cope with the outcomes of violent crime that as a paediatric trust we have been relatively protected from previously. As an organisation, we must ensure that we learn as much as possible from these tragic cases to improve our trauma care going forward so we are as prepared as possible.

Inpatients Deaths 2018 -2022

Month	2018	2019	2020	2021	2022
Jan	7	5	6	7	6
Feb	1	6	4	4	5
March	6	3	7	4	8
April	6	5	6	5	2
May	4	4	2	5	7
June	4	1	6	4	9
July	4	5	5	5	1
Aug	5	5	8	4	7
Sept	3	6	4	11	
Oct	3	3	4	8	
Nov	7	7	6	10	
Dec	5	8	5	9	
Total	55	58	63	76	45



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

1) One of the most significant changes will be the introduction of the Medical Examiner (ME) process. This was due to be a legal requirement for all acute Trusts by April 2022 but has been delayed to next year. There are several reasons for the ME legislation – 'enabling families to have a voice', improving accuracy of death certificates and ensuring every death is reviewed. Since we are a Paediatric Trust and, our mortality numbers are significantly less than our adult peers we are already able to scrutinize all deaths. The death certificates are completed by senior clinicians and in a very timely manner.
   In addition, if there are any concerns regarding a child death, the case follows the coronial process. Lastly, we are very fortunate in having the Snowdrop team who support and engage with families, so we have contact and are currently working on formalizing the feedback we receive. The main challenge for AHCH introducing the ME process is ensuring that it doesn't slow down the current process and impact negatively on the families. The plan currently is for AHCH to be covered by the medical examiner team at LUHFT. There is work beginning now to start establishing a process so that it will be in place when it is a legal requirement.

2) A concerning and recurrent issue is the escalation of unwell cardiac patients overnight as their deterioration is not as easy to assess using the existing PEWS tool and it is a very precarious patient group. It is therefore vital that any change is identified in a timely manner and the correct treatment initiated and escalated if no improvement. The Trust is aware of these issues and work is being undertaken re escalation processes out of hours so that a senior with the required cardiac expertise is contacted immediately. The problem is complex to solve and a number of groups are working on it including the 'deteriorating patient group'.

3) RCA's continue to be problematic to the HMRG process due to the considerable time period for the RCA's to be completed and released. This has a huge impact on both the staff involved as well and the families' concerned. There have been changes made with more recent RCA's but it is vital that the older ones are resolved so that the family and staff can start to move forward. It is also essential that the family are prepared by the Snowdrop team for when they are going to receive the RCA and the clinicians who have been involved in the care (often for extended periods) have sight of the RCA's involving their patients.

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

Current Performance of HMRG

Due to the timing of this report, there are 2 sets of figures to be reviewed, the completion of the 2021 figures and the 2022 deaths to September. Included are the 2 summary tables and the more detailed breakdown for both sets of figures

Summary of 2021 deaths

Number of deaths (Jan. 2021 – Dec. 2021)	76
Number of deaths reviewed	76
Departmental/Service Group mortality reviews within 2 months (standard)	71/76 (93%)
HMRG Primary Reviews within 4 months (standard)	53/67 (79%)
HMRG Primary Reviews within 6 months	45/49 (92%)

Summary of 2022 Deaths

Number of deaths (Jan. 2022 – Sept. 2022)	45
Number of deaths reviewed	18
Departmental/Service Group mortality reviews within 2 months (standard)	36/38 (95%)
HMRG Primary Reviews within 4 months (standard)	17/21 (86%)
HMRG Primary Reviews within 6 months	10/11 (91%)

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

Several of the current cases are very complex for a variety of reasons and often require multiple discussions so entailing a considerable amount of time but this is vital to ensure that the correct conclusions and learning is achieved. The

meetings are once a month and held on TEAMS enabling more people to attend including the DGH clinicians involved if they wish.

Outcomes of the HMRG process 2021

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2-month timescale	HMRG Reviews within 4-month timescale	HMRG Reviews within 6-month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review/ AAR	Learning Disability
							Internal	External		
Jan	7	6	6	5	5	1			1	1
Feb	4	4	4	2	3	2		2	1	3
Mar	4	4	3	2	4	1			1	
Apr	5	5	4	4	5	2			1	2
May	5	5	5	5	5	1	1		2	
Jun	4	4	4	1	4	3			1	1
Jul	5	5	4	5	5	2				3
Aug	4	4	4	3	4	2				2
Sept	11	10	11	10	10	3			1	2
Oct	8	8	8	7	8	4			1	
Nov	10	3	9	9	10	3			1	1
Dec	9	3	9	7	9	4				

Outcomes of the HMRG process 2022

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

Potentially Avoidable Deaths

There has been one avoidable death in this entire reporting period. This was an extremely difficult case involving a child with a very complex medical condition who had been an inpatient at Alder Hey for a considerable time. All potential treatment options had been explored and indeed discussions were being redirected to palliation. This child had been critical on a few occasions previously and had received optimal care to ensure the best outcome.
Unfortunately, when the child died there were aspects of care that could have been improved upon and were highlighted in the RCA that was undertaken. It is sad because prior to that the care provided had been excellent and the outcome was inevitable but the care on that night could have been improved. So as an organisation, it is vital that we acknowledge this and learn as much as we can from it. A considerable amount of learning came out of the RCA and the Trust is working hard to ensure there is no reoccurrence although some of the issues will take time to resolve
In addition, there is still an outstanding RCA on a traumatic death that was STEIS reported so as a group we have not been able to rediscuss.

Learning disabilities

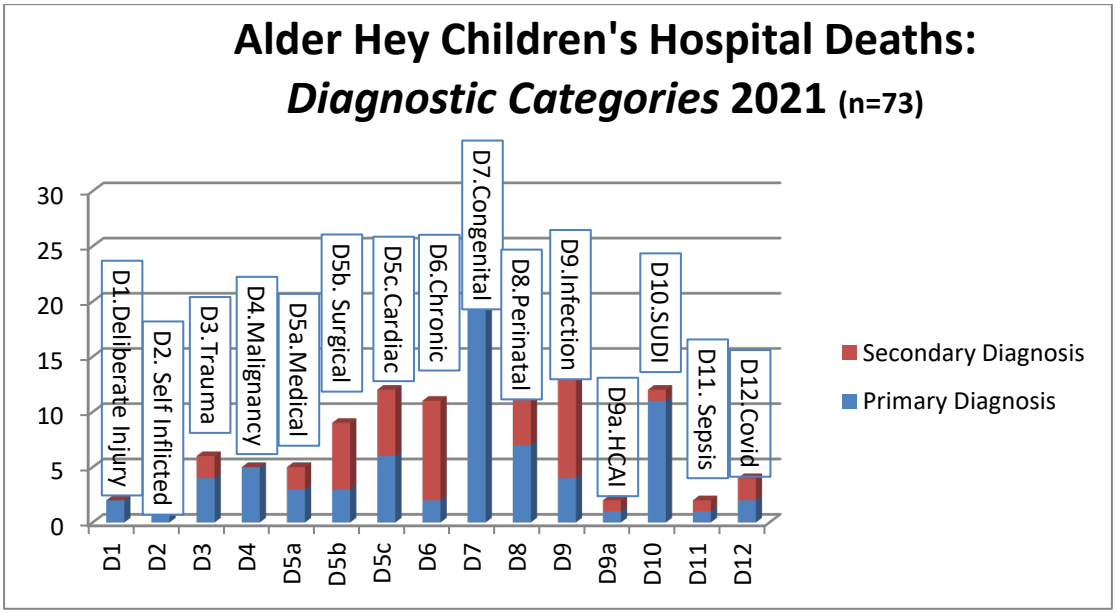
The output table of the mortality process records any children/YP that were identified as having learning disabilities. Out of the 76 cases reviewed in 2021, 15 (20%) were identified as having learning disabilities. In 2022, there have been 7 (16%) deaths of children /YP with learning disabilities from the 45 cases so far. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.
In the 'Mortality Report Output table', we record all the children/YP that have learning disabilities, regardless of age, whereas the LeDeR requirement is for cases where they are over the age of 4 years. The reason we record all ages is to check there is no trend /issues in patients with learning disabilities which can occur at any age not just over 4. There have been no concerns identified at this time.

Family

The Snowdrop (bereavement team) at Alder Hey provide an exceptional service, supporting the family for a considerable time after a patient has passed

away (if wanted). There is ongoing work between HMRG, the palliative care team and the bereavement team to improve the feedback that the group receives from families, to continue to improve the care we provide.
The Operational Bereavement group has restarted, and this should help in consistency of the bereavement process across the Trust. The Snowdrop team will be involved in the discussion about the introduction of the ME process to minimise the impact on the families.

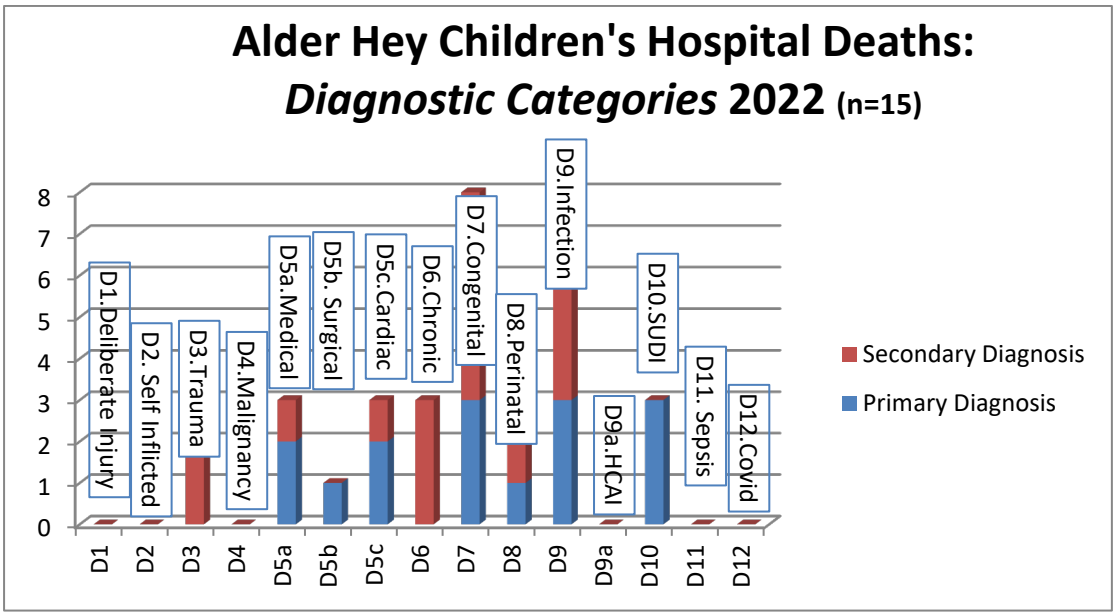
Primary Diagnostic Categories



Diagnostic /Disease Categories (based on CEMACH categories - ref Arch Dis Child 2011; 96:922-6 + 927-31)

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

The cases reviewed in 2021 show that the highest diagnostic code is children with underlying congenital conditions (29%). These are often the most complex cases with several issues that need to be identified, monitored, and treated. These include the congenital cardiac cases which can be incredibly challenging and involve high risk procedures due to the nature of the underlying anatomy.
The next most common category (15%) is the sudden unexpected /unexplained deaths of infants /children (SUDI's /SUDIC's), which would correspond to the increased numbers of deaths recorded as this previously may not have been in the figures. However, there have been more SUDI/SUDIC's than usual and it will be interesting to see whether the CDOP (Child Death Overview Panel) identifies any cause for this. There have been more child protection cases which have presented during and just after lockdowns.



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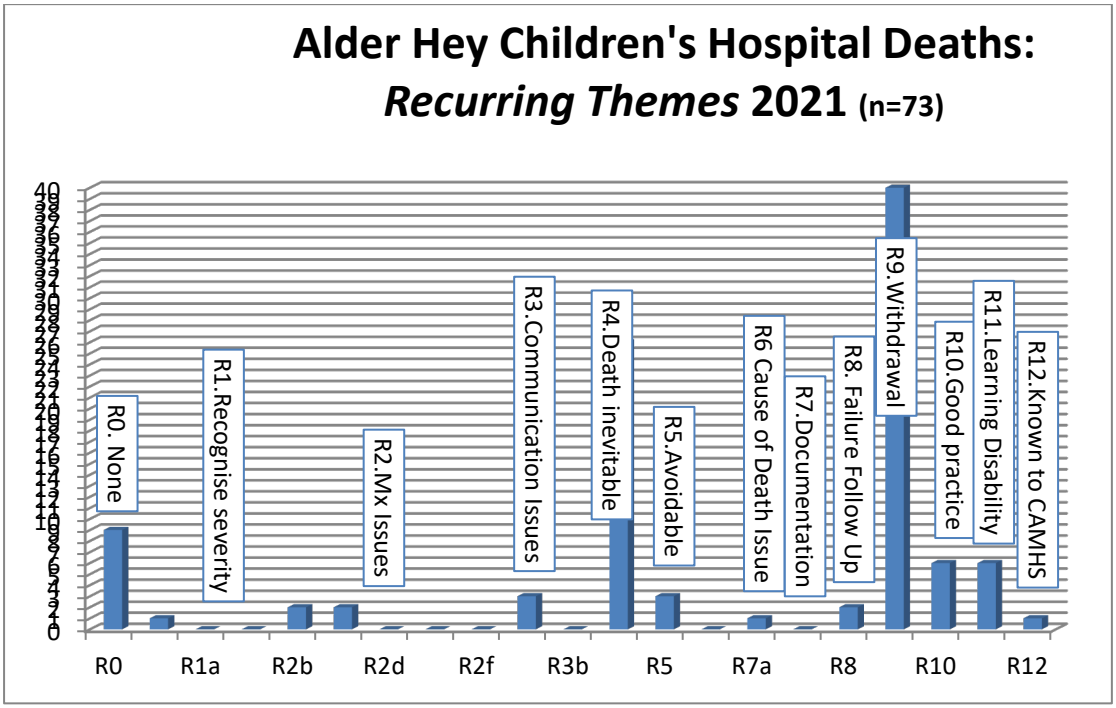
D10	Sudden unexplained, unexpected death/SUDI/SUDC - excludes SUDE (D5)
D11	Sepsis

For the 2022 cases, there are only 15 cases that have been reviewed and the coding completed although other cases have been discussed but further information is required such as PM's or coroner's inquest. Of these cases , due to such low numbers there are a number of categories that have the same number – 3 (20 %) each – Congenital anomalies , infection and sudden unexplained /unexpected.

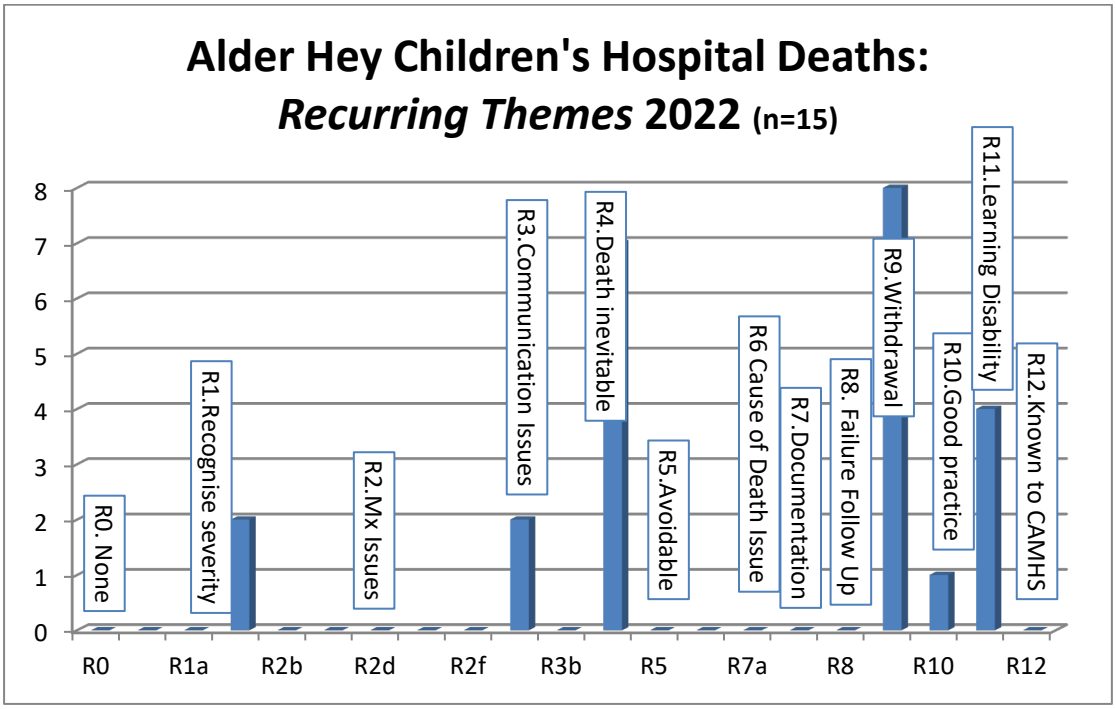
There were no Hospital acquired or sepsis deaths which is reassuring. The trends will become clearer as more cases are completed

Recurrent Themes



R0	No RT	
R1	Recognise Severity	R1a Failure to ask for Senior/Consultant review
R2.	Mx Issues	R2a Before Arrival
		R2b Delay in transfer
		R2c In Alder Hey
		R2d Delay in supporting services or accessing supporting services
		R2e Difference of Opinion re: Rx - Patients & families
		R2f Difference of Opinion re: Rx - Clinical teams
R3.	Communication	R3a Patients & families
		R3b Clinical teams
R4	Death Inevitable	
R5	Avoidable	R5a Alder Hey
		R5b Medical
		R5c External
R6	Cause(s) of Death Issue	R6a incomplete or inaccurate MCCD
		R6b Should have had post-mortem
		R6c Not agreed
		R6d Failure to discuss with HM Coroner
R7	Documentation	R7a Recording
		R7b Filing
R8	Failure of Follow Up	
R9	Withdrawal	
R10	Good Practice	
R11	Learning Disabilities	
R12	Known to CAMHS	

The main recurrent code for 2021 was withdrawal of care (55 % of cases), which demonstrates that the intensive care team are working with families to ensure that no child /young person suffers unnecessarily when all treatment options are explored but are not suitable.
Death was concluded to be inevitable in 35%, regardless of the care and expertise that was provided in AHCH. This category also includes the cases where death was inevitable with hindsight. The reason these cases were included were that it has no reflection on the care AHCH provides and several children are transferred for investigations which then indicate conditions which are palliative.



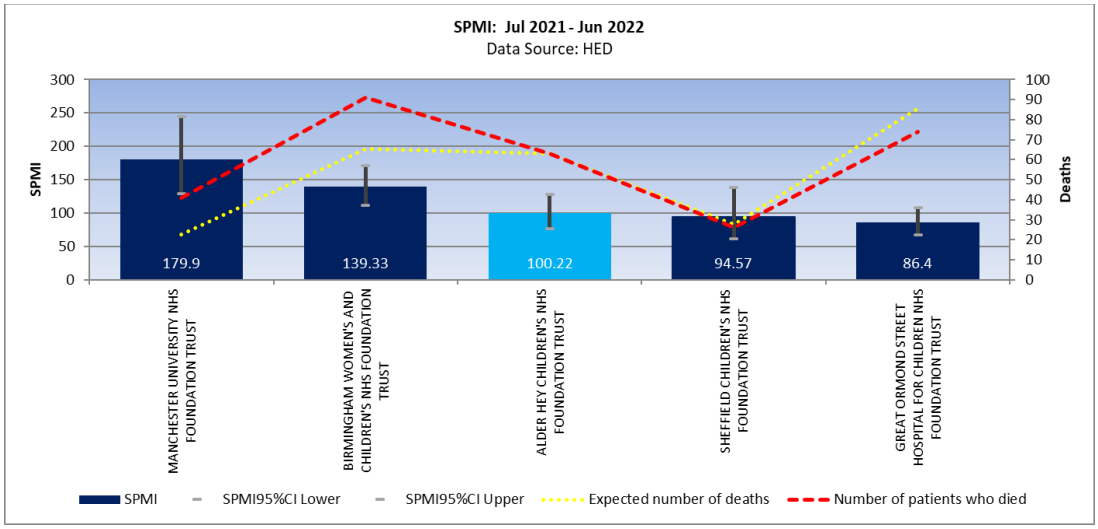
For the recurrent themes of 2022 there are the same limitations as were highlighted with the diagnostic codes. There are only 15 cases that have been closed – 53% had withdrawal of care and 47% death was inevitable so the same pattern as demonstrated by the 2021 recurrent themes with the same explanation.

Section 2: Quarter 1 Mortality Report: April 2022 – June 2022

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

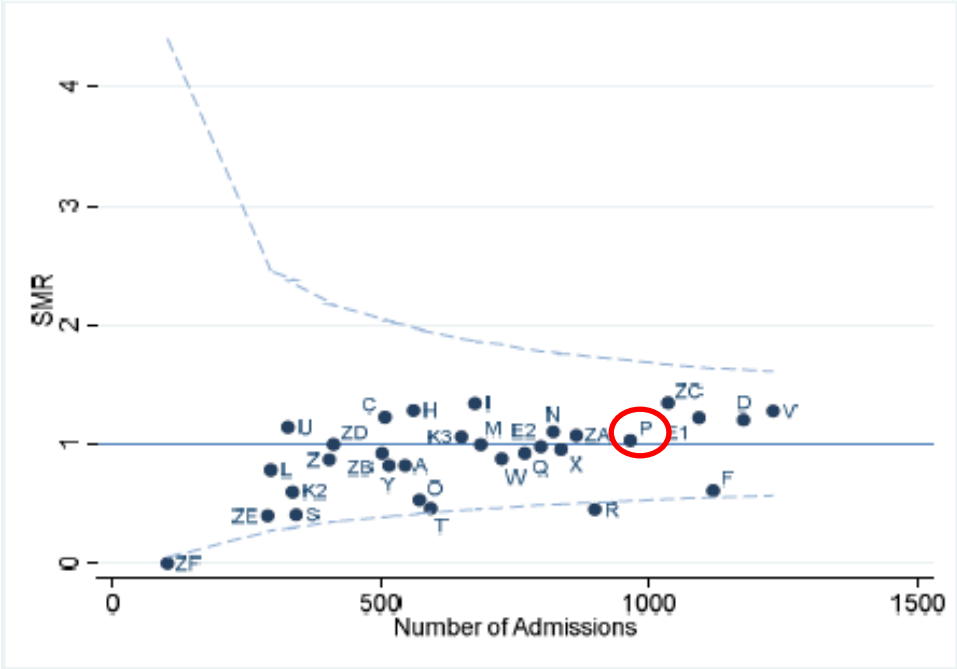
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates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



The chart shows that Alder Hey has performance of 63 deaths against 62.9 expected deaths. This shows that the mortality figure is as expected with the workload that the Trust undertakes. In preceding reports, the number of deaths were higher due to the impact of COVID, decreasing the workload and undertaking higher risk cases and this was a comparable situation to our peers. Now the workload has returned to pre COVID times and so the figure has returned to the expected levels.

-PICU

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

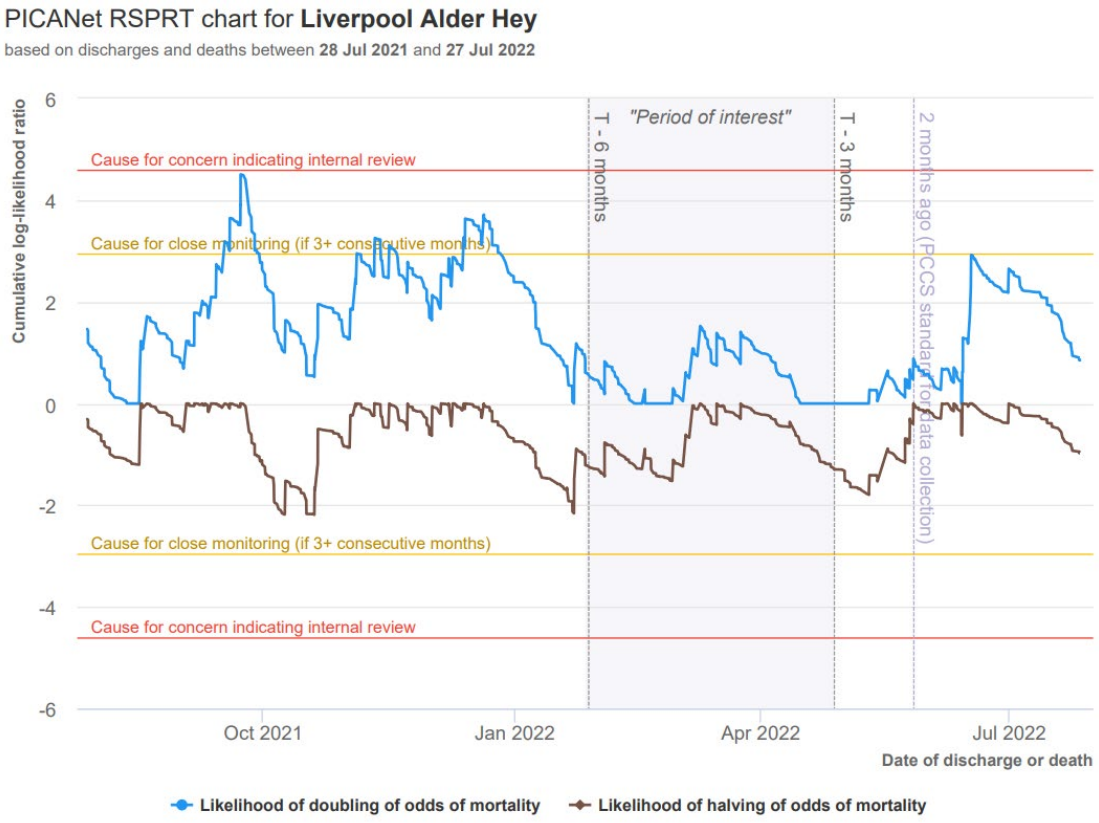


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

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

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

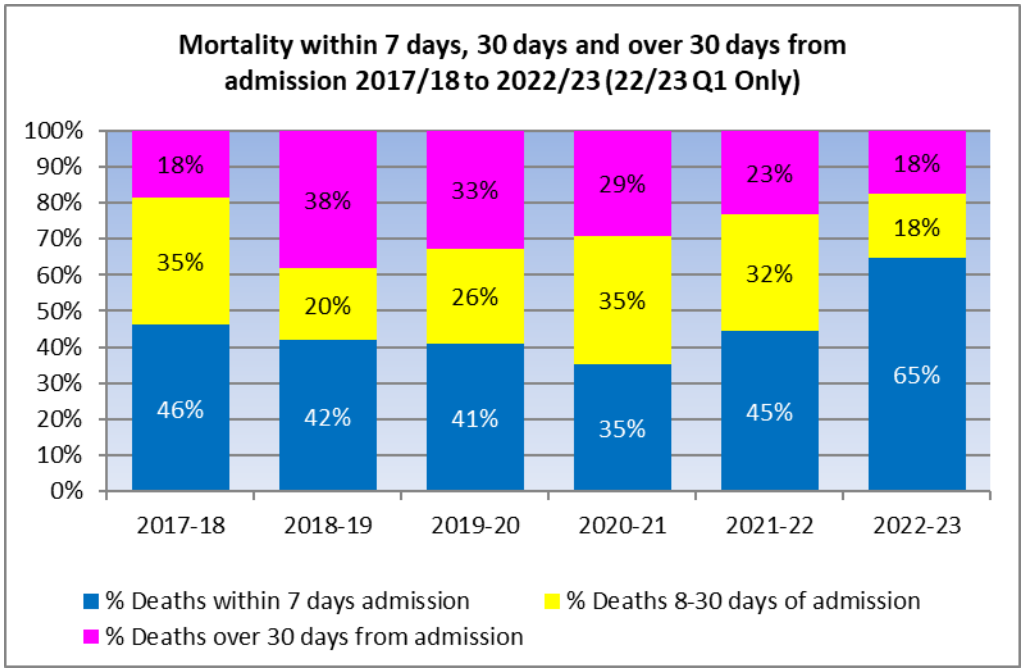


The most recent available RSPRT chart runs until the end of July 2022. Over the last 6 months we continue to operate in the 'safe zone'. The PICU Team reviews all cases and no issues have been highlighted

Real time monitoring of mortality

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April 2022 – June 2022) 65% occurred within 7 days of admission, 18% occurred within 8-30 days from admission, and 18% deaths occurred over 30 days from admission.

Conclusion

HMRG is providing effective and comprehensive reviews in a timely manner, and the 4-month target is running at an acceptable level in view of the workload and the complexity of the cases.

Concerning issues such as escalation issues relating to cardiac patients overnight and the delays in the RCA's being released are being addressed. The first steps of introducing of the ME process at AHCH will be made in the next few steps and then the practicalities of making it work.

References

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

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

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

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Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	Update on Liverpool Health Partners (LHP) Organisational Change
Report of:	Chief Executive
Paper Prepared by:	LHP CEO Host LHP Interim Change Programme Director

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Background Papers and/or supporting information:	This paper provides an update on the actions in respect of continued approach to collaborative working through the Liverpool Health Partners, specifically the proposed restructuring and associated organisational change.
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:	

1. Executive Summary

This paper summaries the LHP Organisational Change Process and the implications for all partners arising from the changes.

2. Background

Liverpool Health Partners is a partnership of 12 academic, research and NHS members.

The Partners are:

- Liverpool University Hospitals NHS FT (LUH)
- Alder Hey Children's NHS FT (AHC)
- Liverpool Heart and Chest Hospital NHS FT (LHCH)
- Clatterbridge Cancer Centre NHS FT (CCC)
- Mersey Care NHS FT (MC)
- Liverpool Women's Hospital NHS FT (LWH)
- The Walton Centre NHS FT (WC)
- University of Liverpool (UoL)
- Liverpool John Moores University (LJMU)
- Liverpool School of Tropical Medicine (LSTM)
- Edgehill University (EHU)
- NHS Cheshire and Merseyside (C&M NHS)

LHP is hosted by LHCH and subject to LHCH policies and procedures. There are currently circa 50 members of staff working either on a full or part time basis for LHP although a number of these are employed by partner organisations and seconded to the research programmes or the SPARK service.

The Partners have agreed a need to refocus the purpose, priorities and structure of LHP and to enter a transitional period that is expected to take 6-9 months to agree a new operational structure to meet future business needs. This has resulted in a significant organisational change process that commenced at the beginning of August 2022.

LHP will continue to function as an entity during the transitional period and it is not anticipated that there will be a detrimental effect on existing research of new opportunities as work will continue through each organisation's research function and the SPARK joint research office.

3. Current Position

i) Executive and Central Support

Partners agreed at their meeting on 27th July that although they are still undecided about the future service model, they are clear that the current infrastructure is no longer fit for purpose. Therefore, the roles of the CEO, the Executive and the Central Support function will not be required from the 30th September resulting in a number of staff being placed at risk of redundancy. 0.5WTE of a Band 7 Communications role will be retained for 12 months to manage internal and external stakeholder communications during the transition period.

Suitable alternative employment is being sought for each member of affected staff from across partner organisations as well as the CRN and the Innovation Agency. If

alternatives are not secured by 30th September, individuals will be served notice of redundancy and will either work their notice period if there is suitable work to be done or be paid Pay in Lieu of Notice (PILON). The number of compulsory redundancies is expected to be in single figures.

The Chair of LHP has voluntarily agreed to step down at the end of October 2022.

ii) Single Point of Access to Research and Knowledge (SPARK)

The SPARK service is being retained in its current form pending the outcome of a review into its purpose and practice which is expected to conclude at the end of November 2022. Therefore, these staff have been excluded from the Organisational Change process and their overall leadership and management has been temporarily moved to the NW Clinical Research Network under the leadership of Chris Smith, COO for 6 months from 1st October 2022.

iii) Research Programmes

Members were asked to review the effectiveness of the 6 research programmes of work that were supported by LHP and to decide whether to continue or cease the work. The Starting Well, Neuro/Mental Health and CVD programmes are to continue but they will in future be led and funded directly by relevant Trusts and HEIs and the accompanying staff will be TUPEd to the programme lead Trust wef 1st October 2022.

The Cancer, Infection and Living Well programmes are to be discontinued in their current form and associated staff will return to their substantive positions. It is not anticipated that there will be any redundancies due to staff churn.

4. Financial Implications

LHP is currently financed via a 3 tier contribution model that reflects the size of partner organisations. Based on the detailed cost analysis presented to partners at their meeting on 27th July it is expected that redundancy and notice costs will be met through existing financial reserves leaving a surplus of circa £45k to the end of September. Partners have agreed to pay, on an equal share basis, the additional sum of £32.25k each to cover residual costs for the remaining 6 months of the 2022/23 financial year. The value of the current financial model will be reviewed as part of the transitional process and recommendations made about future funding for 2023/24 onwards.

5. Governance

LHCH has agreed to continue as host until 31st March 2023 whilst a new host is sought. Louise Shepherd has been appointed as the SRO to lead LHP through the transition period and LHP will continue to meet monthly to agree the future direction and infrastructure required.

6. Recommendation

The Board is asked to note the workforce and financial implications of the LHP organisational change process and the decision to scale down operational functions whilst the future direction is decided.

Paper Title	North West Paediatric Partnership Board (NWPPB) Chair's Report
Report of:	Joint NWPPB Chairs: Louise Shepherd (CEO Alder Hey) & Stephen Dickson (CEO RMCH)
Paper Prepared by:	Jenny Dalzell, Associate Director of Strategy and Partnerships, Alder Hey Children's NHS FT Adam Hebden, Associate Director of Strategy, RMCH

Purpose of Paper:	Decision **Assurance** **X** Information Regulation
Action/Decision Required:	To note **X** To approve
Date:	6th September 2022

1. Introduction

The North West Paediatric Partnership Board (NWPPB) drives joint oversight of the North West Operational Delivery Networks (ODNs) and outlines the overarching commitment of Alder Hey and Royal Manchester Children's Hospital (RMCH) to collaborative delivery of specific specialist and tertiary paediatric services for the North West where mutually agreed.

The Board meets quarterly and with the backdrop of Covid, has met 3 times since April 21. This has ensured each organisation has fulfilled their roles as ODN hosts and provided ODN assurance.

As we emerged from the pandemic, our March 22 meeting refreshed its working arrangements in recognition of the growth of partnership working between Alder Hey and RMCH. Meeting agendas were refreshed to ensure an Exec to Exec check in for issues of urgent escalation followed by representation from joint services and clinical networks. This provides the Board with robust programme governance on progress and issues for escalation. Terms of Reference have been amended to reflect this and were approved in March 22. In July 22, the Board received updates in the new format which provided assurance against each programme of work.

Collaborative working and mutual aid has been further enhanced during and since the pandemic, ensuring equitable access to services for children and young people supporting local secondary care providers/district general hospitals, delivering joint commitments across the North West and securing critical care and surgery capacity.

2. NWPPB Positive Highlights of Note

During the last 12 months the NWPPB has overseen a great deal of partnership working, some key highlights include

- Full implementation of the new joint North West Tier 3 Obesity service running across the two hubs (Alder Hey and RMCH) with a spoke in Preston. The North West have been praised by the central and regional teams for the unique collaborative approach taken in set up and delivery of the service.

- The Paediatric Critical Care, Surgery in Children, Long Term Ventilation ODN, in addition to mobilising as a new Network, has supported both the transformation and recovery agendas, most recently ring leading the Surge Plan for the region.

- A joint scoping business case for a potential single Paediatric Cardiology Service across Alder Hey and RMCH has been completed and submitted to Specialist Commissioners. The commitment and collaboration from clinical, managerial, and executive teams at both institutions has accelerated progress over the last 12 months surpassing previous efforts.

3. Agenda Items Received / Discussed / Approved at NWPPB 3 November 2021

Introduction - Of note, this was a shortened meeting to maintain Board rhythm whilst being mindful of current ongoing Covid pressures.

Neonatal - The ODN leads the Neonatal Critical Care Review (NCCR) – a major transformation programme to drive service change, develop neonatal capacity, redesign and expand neonatal

critical care services to further enhance safety, effectiveness and the experience of families, improve neonatal capacity and triage within expert maternity and neonatal centres, develop the expert neonatal workforce and enhance the care of families through care coordination and investment in improved parental accommodation. The NWPPB recognised that this ODN is the closest to structural change; all details would be fed through the Neonatal ODN Board, and oversight of NCCR into the Specialist Commissioning Women and Children's programme board.

Paediatric Critical Care, Surgery in Children, Long Term Ventilation (PIC/SiC/LTV) ODN - The ODN covers specialised services falling into two groups: 'episodic' care (PCC and SiC) and 'longer term care' (LTV). The geographical areas of the patient pathway often flow across several interdependencies provided within tertiary, secondary and community services supported by multidisciplinary professionals from health, local authority and third sector providers. The ODN focuses on coordinating these pathways between providers to ensure consistent, equitable access to specialist resources and expertise. Appointment to key roles were reported to be underway, alongside development of the work plan. There was a recognition by the NWPPB that that connections with transformation and recovery agendas should be made to ensure opportunities for future development are met.

All-Age CHD ODN - Two key strategic pieces of work were outlined, namely the development of a single PTL across the region to ensure patients wait safely and achieve equitable access, and delivery of a future single paediatric CHD service for the NW.

Major Trauma – Clinical roles were formalised. A proposal was approved to establish a formal ODN Board with an independent Chair (following the Neonatal model).

4. Agenda Items Received / Discussed / Approved at the NWPPB 9 March 2022

Cancer ODN – RMCH and Alder Hey jointly host the new ODN, with funding and employment sitting within RMCH. RMCH provided an update on the mobilisation of the Cancer ODN; this is a short life project with a planned scope that will conclude once the Cancer ODN workforce is recruited in post and the work plan is being progressed. There has been excellent engagement with clinicians and cancer alliances and a progressive view on how they work together to form a single board for the region.

PCC/SiC/LTV ODN - Discussion regarding the importance of linking social care into future engagement sessions, to help speed up the discharge for LTV patients. The Network Director confirmed that the Oversight Group has looked at flow and will pick up this workstream in future meetings.

Neonatal ODN – Priority work is being undertaken to support implementation of the Ockenden recommendations with network units, and a report would be tabled at a future NWPPB, as well as through the Local Maternity Systems (LMS). The NWPPB recognised the existing national and regional delays in moving forward with the NCCR recommendations and advocated for the importance of moving forward to drive security for staff and sustainability for neonatal services in the region.

Governance - The NWPPB recognised the increased partnership working across the two organisations and the need for an appropriate reporting and governance mechanism to reflect and promote this. The Board were supportive of the new structure and remit for the NWPPB and approved the refreshed Terms of Reference.

5. Agenda Items Received / Discussed / Approved at NWPPB 18 July 2022

All-Age CHD ODN – Commissioners have requested development of a single patient treatment list (PTL) across NW CHD services to support enhanced and equitable access to services across the geography. A clinical engagement session is scheduled for September 22 to scope the benefits and risk associated with this.

North West Transport Service (NWTS) - A case is in development seeking an additional NWTS team to meet fluctuations in acute demand and to meet unmet specialist transport needs in the NW region (NWTS is only commissioned for L3 transfers into PICUs). This additionality would improve team resilience and is supported by both RMCH and Alder Hey.

Major Trauma - Trauma units and local emergency hospital's trauma services have been peer reviewed across Greater Manchester. Trauma Audit and Research Network (TARN) data shows continuing quality across the Network. The NW Network leads both the National Trauma and National MT Rehabilitation Networks for Children.

North West Paediatric Tuberculosis Managed Clinical Network (MCN) – Aim to deliver a network of services that will be fully integrated across all areas of the NW and North Wales, supporting young people and their families who are assessed for or diagnosed with TB infection or disease. This helps standardise care across the region and empowers families and health professionals, to work together to ensure the best possible outcomes for our children. Models to screen refugees from Afghanistan have been shared and training given to support new assessment diagnostics. The Network has fed into the national team at NHSE/I to amend policy and reduce radiological exposure to children-this also significantly reduces the operational burden of screening children.

6. Areas to Highlight

Within the new commissioning landscape, there are risks and opportunities relating to the delegation of Specialised Commissioning into ICSs from April 2023. Through our existing collaborative working arrangements for children and young people across the North West, the region is well placed to continue as the specialist CYP footprint going forward. The preferred position is that all specialised paediatric services should be commissioned at a multi-ICS (or national) level. Devolving commissioning to a local level may result in fragmentation, dilution of scarce resource, loss of CYP involvement and/or affect service viability. Alder Hey and RMCH jointly supported this perspective in a return to NHSE/I specialist commissioners in August 22, recommending engagement for clinical and financial assessment of the proposed transition, and offering support in this.

7. Issues for Other Committees

No risks or issues for escalation to other committees. All ODNs and joint work areas are operating within tolerance on agreed workplans, finance, resources and risks/issues.

8. Recommendations

It is recommended that each Trust Board receives this report as assurance and notes the progress within the North West Paediatric Partnership.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

September 2022

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

Purpose of Paper:	Decision **Assurance X** **Information X** Regulation
Background Papers and/or supporting information:	Link to BAF Risk 3.6 – risk of partnership failures due to robustness of partnership governance.
Action/Decision Required:	To note **X** To approve
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships X** Game-changing **research and innovation** **Strong Foundations**
Resource Impact:	N/A

Growing Great Partnerships

1. Introduction

The purpose of this quarterly report is to provide the Board of Directors with an update and assurance of progress and risk management within the Trust's established health and care partnerships. This quarter the report will focus in on:

- North West Cardiology/Cardiac - Liverpool ACHD partnership, the North West Congenital Heart Disease Network (the All-Age CHD Operational Delivery Network (ODN)) and the emergent NW Paediatric Cardiology approach
- Cheshire & Merseyside (C&M) – "Beyond" Children & Young People (CYP) Transformation - hosted by Alder Hey
- Liverpool Place - Alder Hey partnership with Liverpool City Council Public Health (LCC PH).

2. Links to Strategic Objective & Scope

Alder Hey has long recognised that to achieve our vision of '*a healthier future for children and young people*' we must work in partnership, recognising that no individual organisation addresses the full range of patient pathways for any given child or young person. This paper provides assurance against the Trust's strategic objective of *growing great partnerships*.

As agreed in the June 22 Trust Board meeting, this paper will provide a quarterly update on core partnerships between the Trust and health and care system partners, on a rotational basis, to assure the Board that the Trust is fulfilling its role robustly and that associated risks are adequately managed.

3. Established Partnerships – Assurance / Update

NW Cardiology/Cardiac

Established partnership	Executive Lead	Purpose	Partners	Established	Governance/ Reporting Arrangements	Risks / Issues for Escalation to Trust Board
Liverpool ACHD P'ship	Alf Bass	Joint delivery of Level 1 adult congenital heart disease service	Liverpool Heart & Chest FT (LHCH) Liverpool University Hospitals FT Liverpool Women's FT	2018 – revised MOU Sept 2020	External – Liverpool ACHD Partnership Board (quarterly) Internal – Division of Surgery	1 residual risk of 12 re: historical adult Manchester patient backlog – held on LHCH risk register & routinely reviewed by partners at ACHD Board.
NW Congenital Heart Disease Network (All-Age CHD ODN)	Dani Jones	To support provision of high-quality care for CHD patients across NW, NWales & IoMan, in line with the requirements of the NHSE standards.	All NW Tier 1, 2 & 3 cardiology & cardiac services, plus Isle of Man and North Wales	2019	NW Paediatric Partnership Board (Quarterly – Paediatrics only) NW Adult CHD Partnership Board (Quarterly – Adults only) NW NHSE Specialist Commissioning -Quarterly ODN report to RABD re assurance of hosting accountabilities	The ODN reports on a range of strategic risks pertaining to access and equity of care across the NW, waiting times etc. These are routinely scrutinised by the NW ODN Board, inc. NHSE/I Specialist Commissioners, and escalated to the North West Paediatric Partnership Board as appropriate. The NW CHD ODN will be invited to Alder Hey's Risk Management Forum in Autumn 22 for a deep dive as the ODN is hosted at the Trust.

Liverpool ACHD partnership (serving the North West, Isle of Man, North Wales)

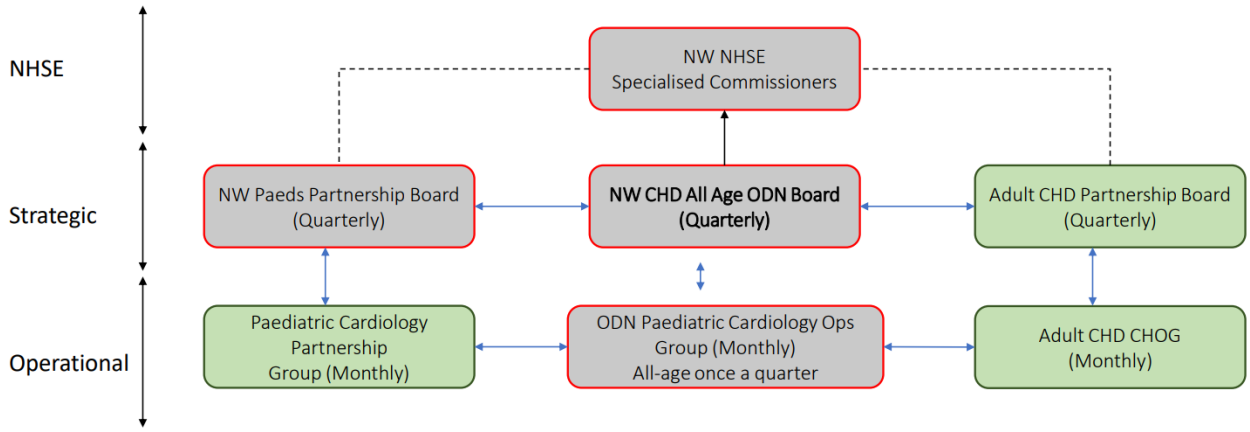
The North West has a partnership of four trusts delivering level 1 ACHD services with one trust (MFT) delivering the level 2 service with the support of the Liverpool Partnership. A similar arrangement exists for paediatric CHD services with (AHFT) providing the level 1 service and outreaching to level 2 and other District General Hospital sites in the North West. To ensure robust, safe and sustainable services which meet national standards, the Liverpool partnership has an agreed collaborative service delivery model and established a memorandum of understanding to underpin the arrangements for effective working. Governance is provided through:

- The Liverpool ACHD Partnership Board: (Chaired by LHCH Medical Director, Alder Hey represented by Chief Medical Officer) monitors a suite of clinical, operational, financial and workforce key performance indicators in addition to performance against the national ACHD standards and service specification. There is also a NW Partnership Oversight forum – these meet alternately so that there is a high-level forum every 3 months, enabling any more urgent issues to be picked up as they arise.

- The Congenital Heart Disease Operational Group (CHOG): (Chaired by LHCH Adult Cardiology lead, Alder Hey represented by Surgical Divisional management) receives all relevant information about the service to include operational performance, clinical governance, finance and activity. Clear governance responsibilities are in place with the integrated governance (CHOG) meeting occurring monthly and reporting to the partnership board.

North West Congenital Heart Disease Network (the all-age ODN)

The ODN is hosted at Alder Hey and supports the provision of high-quality care for CHD patients across the North West, North Wales & the Isle of Man, in line with the requirements of the NHS England standards. The ODN is focused on ensuring a high quality, fit for purpose capable network, providing strategic direction for cardiac services, ensuring seamless care across the region and equity of access and egress to services in a timely manner, with the aim of providing high quality care as close to home as possible. The CHD ODN has a thriving patient and public participation group and puts the patient at the heart of all CHD services. The ODN delivers education, training, and support across the patch to provide assurances that service standards are being met. There is a robust and clear clinical governance framework to support quality improvements in care that benefit patients regionally. The ODN also leads on development of digital systems that enable the sharing of clinical information between regional providers in a timely manner, as well as driving informatics, outcome data and innovation as tools for service improvement. Close working with CHD ODN and NSHE Specialist Commissioners is ongoing to shape the approach to a single patient tracking list (PTL) for adults and children across North-West to ensure safe waiting of all CYP and adults as well as to support transition into adult services.



To mitigate ongoing challenges in delivering services outside of Alder Hey, and to support increasing demand and greater equity of care across the North West, Alder Hey are working with Royal Manchester Children's Hospital (RMCH) on the proposed development of a NW single service approach for cardiology – clearly a medium to long term solution. The two trusts have brought teams together, have established a NW Paediatric Cardiology Partnership group (reporting into the NW Paediatric Partnership Board - including an update at the July 22 meeting) and a joint business case requesting financial support to implement a scoping team to progress was submitted to NW Specialist Commissioners by Alder Hey and RMCH in August 22.

Operationally, and to support safe waiting, all hosted ODN risks are managed via monthly monitoring and as a requirement for all CHD Networks, a data return to NHS England providing the latest information on -

1. Total number of patients on PTL (Patient Treatment List - inclusive of new referrals and follow up patients)
2. Total Number of NEW referrals
    - Overdue an appt by >3months
    - Overdue an appt by > 6 months
    - Overdue an appt by >12 months
3. Total number of F/U patients

Overdue an appt by > 3 months
Overdue an appt by > 6 months
Overdue an appt by > 12 months

4. New referrals
   Total number of new referrals received each month
5. DNA
   Overall (new and F/U) DNA rate %

In addition, the Network continues to discharge its duties through collaboration, education and patient engagement.

Supported by Commissioners, and as outlined above, there is complete agreement from all Level 1 & 2 providers to enable a single PTL across the Network. This will –

- Ensure patient safety and reduce clinical risk
- Provide High quality accurate data
- Permit effective and dynamic capacity and demand planning
- Facilitate a comprehensive equitable service provided across the region

Alder Hey has also provided mutual aid to RMCH in the form of staff (nursing and sonography).

A deep dive of all ODN hosted risks will be undertaken during Autumn 22 at Alder Hey's Risk Management Forum.

"Beyond" C&M CYP Transformation

"Beyond" is focussed on a population health approach, with a "shift left" in delivery towards early intervention and prevention as a vehicle for transforming the delivery of services that support children.

Beyond is led by a Programme Director and supported by a small programme management team, all hosted at Alder Hey within the Strategy and Partnerships team.

Established partnership	Exec Lead	Purpose	Partners	Estab-lished	Governance/ Reporting Arrangements	Risks / Issues for Escalation to Trust Board
"Beyond" C&M CYP	Dani Jones	Improving CYP outcomes across the C&M system	C&M ICS – all partners	April 2021	External - C&M ICS Programme Board, NHSE/I NW Region Internal – 2 x per year Trust Board update	No new risks over 12 since June Board update. Mitigations ongoing through Beyond Board.

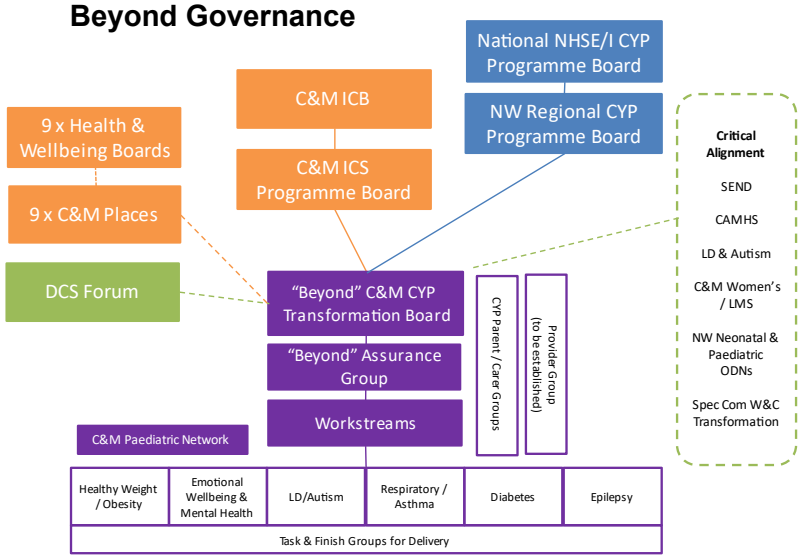
The Beyond Board meets quarterly, is chaired by a Local Authority CEO (St Helens). The Beyond SRO is Alder Hey's CEO and the Beyond Exec lead (Alder Hey Director of Strategy & Partnerships) are both represented at the Board.

The Beyond SRO and Exec lead provide the programme assurance back into Alder Hey Trust Board, through a twice annual deep dive and these quarterly reports.

The programme has six priority themes for CYP in C&M, all connected with an overarching theme of 'Starting Well': Emotional wellbeing and mental health integration, healthy weight & obesity, respiratory diseases/asthma, learning disabilities and difficulties & Autism, Epilepsy and Diabetes.

Significant progress has been made in programme set up, establishment of workstreams and multi-agency, widespread C&M leadership resource is now in situ. Partnership working is also underway with the Marmot team (Institute of Health Equity) and key C&M partners.

Beyond Governance



Recent successes include two successful Expressions of Interest from C&M trusts to support transition in diabetes to adult service, appointment of C&M clinical leads for Diabetes and Epilepsy. Beyond is leading integrated models of mental health and wellbeing (such as the Gateway CAMHS approach), adopting and spreading innovative new models of care such as the Parent Champion approach for respiratory support in Children's Centres (developed in Liverpool, spread through Beyond funding into 4 additional 'Places' in C&M), and funding received for the recruitment of a C&M-wide Asthma Practitioner.

The "Beyond" programme is invited to November's Alder Hey Trust Board for the next deep dive.

Alder Hey partnership with Liverpool City Council Public Health (LCC PH)

In October 2019, Alder Hey Board endorsed the establishment of Alder Hey & Liverpool City Council Public Health (LCC PH) partnership (led by Alder Hey's Director of Strategy & Partnerships and LCC PH's Public Health Consultant lead for Children.

In June 2021 a joint senior Public Health Practitioner was appointed 50/50 across the two organisations (Band 8B, fixed term). In Dec 21, Trust Board endorsed the establishment of the Establishment of Health Inequalities & Prevention (HIP) Steering Group, which provides Public Health governance within Alder Hey.

Established partnership	Exec Lead	Purpose	Partners	Estab-lished	Governance/ Reporting Arrangements	Risks / Issues for Escalation to Trust Board
Alder Hey & Public Health Liverpool	Dani Jones	Delivery of a shared work plan via joint practitioner resource	LCC Public Health	May 21	Internal – Health Inequalities & Prevention Steering group → Safety & Quality Committee	None for escalation.

This AH & LCC PH partnership has now enabled a successful pitch for 'Contain Management Outbreak Funding (COMF) funding to flow to Alder Hey (£955k, 12 months non-recurrent).

COMF is LCC funding to achieve Liverpool's coronavirus recovery plan, with specific responses to outcomes directly impacted by pandemic. The 7 priority outcomes for COMF that LCC and Alder Hey have committed to working on are –

- ✓ The application of specialist paediatric expertise within prevention programmes
- ✓ Building public health and community capacity and skills
- ✓ Enhancing protective factors (e.g., good mental health, physical activity, leisure, access to green spaces, access to healthy food, breastfeeding, developing skills, enhancing parenting, forming positive relationships)
- ✓ Reduction in key modifiable risk factors (e.g., poor mental health, problems with finances, employment, relationships, exposure to food with high calorific and low nutritional value)
- ✓ Collaborative working between organisations to meet needs holistically and for whole families
- ✓ Increased volunteering opportunities and community participation
- ✓ Enhancing accessibility for families facing additional barriers, particularly families who are materially disadvantaged, from Back and Minority Ethnic Background and families of children with SEND.

The funding has just been received (Sept 22) and programme and project set up is underway. Alder Hey will now work to achieve progress against these outcomes through 2 routes:

1) Internal Alder Hey 'prevention in pathways' x 3 projects – all have been scoped with Alder Hey clinical teams and leads – Mini Mouth Care Matters, a restrictive food intake pilot and development of a Health Inequalities survey and toolkit.
2) The Healthy Weight programme (led by Alder Hey in partnership with LCC PH team, and clinically led by Alder Hey's Obesity Lead Consultant) will focus on working in partnership with the voluntary, community and social enterprise (VCSE) sector to deliver on the 7 outcomes via running a £500k mini grant scheme with VCSE partners and evaluating progress of successful bids throughout the 12 months.

Progress, impact, and outcomes will be reported into both Liverpool City Council Public Health team and Alder Hey's HIP Steering Group, the latter providing the implementation oversight within Alder Hey (with financial report into RABD).

4. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	**Highlight report – People Plan**
Report of:	**Chief People Officer**
Paper Prepared by:	Melissa Swindell

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** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	
Associated risk (s)	BAF risk 2.1, 2.2, 2.3

1. Introduction

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

2. People Metrics

The key area of focus this month continues to be staff availability; turnover has increased Trust wide in month and analysis has been undertaken to identify and plan with the areas with highest turnover. Sickness absence remains above target, however by mid September, sickness had reduced to below 5%, an encouraging position.

Time to hire continues its strong position, with an average of 30 days. PDR's for senior colleagues is looking strong, and work is underway to ensure all staff receive their PDR by the end of March '23.

Are We Well Led?
People Section: HR Metrics

Trustwide
Workforce Headcount: 4189

	KPI	Target	June 22	Jul 22	Aug 22
Absence	Sickness Absence (in month %)	4%	5.72%	7.48%	6.13%
	Short Term Sickness Absence (in month %)	1%	2.50%	3.39%	2.18%
	Long Term Sickness Absence (in month %)	3%	3.22%	4.09%	3.95%
	Return to Work Completion (in month %)	100%	65.11%	67.03%	71.66%
Turnover	Staff Turnover (rolling 12m %)	10%	13.10%	13.82%	14.61%
	Leavers (Headcount)	-	57	47	72
	Time to Hire (pre-employment checks)	30 days	30	30	30
Diversity	Proportion of BAME Staff in Workforce (in month%)	-	9.79%	9.86%	9.85%
Pay Accuracy & Spend	Pay Accuracy (%)	99.5%	99.39%	99.32%	99.34%
	Value of Overpayments (£)	-	£32,388.64	£85,410.19	£39,809.93
Training & Appraisal	Mandatory Training (in month)	90%	92.48%	93.26%	93.92%
	PDR band 7+ (from 01/04/2022)	90% (by end of July 22)	18.56%	57.63%	77.98%
	PDR all AFC (from 01/08/2022)	90% (by end of March 23)	5.29%	26.39%	32.29%
	Medical Appraisal (from 01/04/2022)	90% (by end of March 23)	66.46%	76.17%	82.57%

3. Staff Survey

The annual Staff Survey launched on 20th September 2022 and will be open for responses until the 25th November 2022. Significant changes were made to the Survey last year to align with the People Promise from the 2020/21 national People Plan which sets out what we can expect from each other and our leaders to make the NHS the best place to work and stay well. Although there have been some minor changes to the survey this year, they have not been significant and so we are able this year to compare our results against the 2021 Survey. Completion rates are monitored on a weekly basis and will be reported to the Board and People and Wellbeing Committee.

4. Financial Wellbeing

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

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

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

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

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

5. Pensions

As a result of the recent national pay deal, some salary levels in pay bands 3,5 and 8a were pushed into a higher pensions contribution bracket between April-Sept 22. For those staff in bands 3 and 5 who were impacted by this, this meant that any backpay they were expecting has been used to pay any pension contribution arrears. For staff in bands 8a who were affected, their back pay was not enough to cover the pension contribution arrears, leaving them with salary deficit from the previous month. The Trust has acted upon national guidance to support these staff, which has been to offer an advance for the shortfall, and allow staff to pay this back over a 6 month period. This has been escalated nationally as a significant issue for those staff affected, and this scenario must be avoided in the future.

NHS Pensions contributions will change on 1st October 2022, and all scheme members have been written to by NHS Pensions to inform them of the changes. The Trust has also shared communications with staff on this subject.

We will be providing pensions information sessions in the Autumn to help colleagues understand more about their pensions.

6. Industrial Relations Climate

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

The RCN will be balloting their members for industrial action between 6th October 2022 and 7th November 2022. UNITE the Union ballot for industrial action has now closed and we expect Unison's ballot to open in late October 2022. We understand that consultation about industrial action is underway in a number of other smaller trade unions.

The BMA will ballot junior doctor members in England for industrial action if the Government does not commit to full restoration of junior doctors' pay to levels equivalent to 2008/09 by the end of September 2022.

The risk of industrial action is now a standalone risk on the Trust Risk Register and will be monitored closely once the outcome of the ballots are known and the intentions of the unions are clear.

7. Partnership Working

The Trust has successfully entered into the final stages of negotiation with local staffside colleagues to update the Partnership Agreement, a document which outlines the principles of how the Trust and the Trade Unions will work in partnership together and the facility time that will be supported to enable effective partnership working. The aim will be to conclude this process and have the agreement signed by both Trust and staffside leads by November 2022.

Melissa Swindell
Chief People Officer
September 2022

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 29th September 2022

Paper Title:	**Wellbeing Guardian: Dashboard**
Report of:	**Wellbeing Guardian**
Paper Prepared by:	Fiona Marston. Jeanette Chamberlain, Jo Potier and Sarah Robertson

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Paper presented to the Board on 29th July 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:	None

1. Introduction

This paper is a follow up as proposed in the presentation to the Board by the Wellbeing Guardian on 29th July 2021, providing an action plan for approval by the Board

2. Background

The Wellbeing Guardian WBG) is a Non-Executive Director who:

There are nine Board principles supported by the WBG and the recommended approach to implementation is:

Phase 1: Health and wellbeing has limited coverage at board level

- Undertake NHS Health and Wellbeing Diagnostic to assess current health and wellbeing performance and identify priority activities (Principle 1)
- Identify a wellbeing guardian
- Agree the priority actions to be included in the wellbeing guardian role description and how the nine principles will be phased in

Phase 2: Principles of wellbeing guardian role are largely embedded

- Wellbeing guardian role is established and functioning well within the board.
- Most of the nine principles are routinely evidenced at board meetings, including reference to supporting equality and inclusion in the workplace.
- A holistic health and wellbeing strategy is in place (either standalone or as part of a wider people strategy) and being delivered.
- Staff experience measures indicate a compassionate culture is in place or being created.

Phase 3: Health and wellbeing is routinely considered and included in board activity

- All board members routinely consider the holistic health and wellbeing of our NHS people in their strategic and operational plans and performance reporting
- The board regularly hears feedback, including in the form of staff stories
- All nine principles are being delivered
- The NHS Health and Wellbeing Diagnostic Tool dashboard is green

Alder Hey's appointed WBG (Fiona Marston) is working with SALS, Organisational Development and HR to advance the implementation. The Board was advised at the July 2021 meeting that the NHS Health & Wellbeing Diagnostic had been completed for Alder Hey and the Board formally approved the priority actions and the move to Phase 2 of implementation.

The Wellbeing Steering Group has created a Dashboard to summarise the action plan for the nine principles supported by the WBG, which will be presented to the Board at its meeting on 29th September 2022. The Dashboard shows that the action plan has been implemented and good progress has been made to implement the nine principles of the Wellbeing Guardian.

PAWC will be reviewing the Dashboard at its meeting on Wednesday 28th September 2022, with the aim of approving the completion of Phase 2 and progression to Phase 3 of implementation of the nine principles of the Well Being Guardian

The Board is asked to:

(i) Note the actions planned described in the Dashboard
(ii) Subject to formal approval by PAWC, ratify the decision that Phase 2 has been completed and confirm progression to Phase 3 of implementation of the nine principles of the Well Being Guardian

Proposal for the Trust to award an additional day of annual leave

on

Friday 23rd December 2022

Introduction

The Trust has awarded an additional days' holiday to all colleagues employed by Alder Hey in recent years in recognition of the hard work and dedication of every member of staff. Last year (2021/22), being an exceptional year due to the COVID pandemic and the outstanding effort made by all colleagues to support the organisation through the crisis, two wellbeing days were awarded to staff, one to be taken (where possible) on Christmas Eve, and the other day was to be agreed with individual line managers for a day of their choosing.

This offer of support has always been very well received by staff across the Trust, demonstrating our continued recognition of, and commitment to, the wellbeing of our employees.

Proposal

It is proposed that for 2022/2023, we continue this offer of support by awarding one additional days leave to staff as a wellbeing day, to acknowledge and thank staff for their hard work, and to provide an additional day of rest and recuperation in what we know will be a busy and challenging winter period.

The proposal this year will be for this to be taken by colleagues, where possible, on **Friday 23rd December 2022.** This change of date from previous years is due to Christmas Eve falling on a Saturday. (This day can be taken on an alternative day for colleagues who need to provide services to our children and young people on this day, or for those who don't celebrate Christmas)

Whilst the additional holiday is always well received, it does always generate a series of questions and in keeping with previous years, if awarded, a full suite of FAQ's will be provided to managers and staff by the HR team.

Recommendation

For the Board to consider the proposal and support the awarding of an additional days leave for all colleagues directly employed by Alder Hey.

Melissa Swindell
Chief People Officer
September 2022

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	AlderC@re Programme Update
Report of:	Position on the deployment of Meditech Expanse under the AlderC@re Programme
Paper Prepared by:	Jason Bradley, AlderC@re Programme Director Kate Warriner, Chief Digital and Information Officer

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

1. Executive Summary

This paper provides an update on the AlderC@re Programme which is deploying an updated Electronic Patient Record (EPR) from MEDITECH. The deployment date for AlderC@re Phase One was set for October 2022 but at a review point in May 2022 it became clear that system development, by both the Trust and MEDITECH, was not on schedule. On review with the Trust Executive Team it was agreed to defer deployment into 2023.

A full review of the programme has been completed, and a revised plan, developed in conjunction with MEDITECH, has been received by the AlderC@re Programme Board and reported to the Executive Team and Resources and Business Development Committee (RABD). The revised programme plan has indicated a provisional timetable for go live in summer 2023. This plan is being refined as the programme progresses, with the next revision to be presented to the AlderC@re Board in October 2022.

The programme review identified key lessons learned, recognising that the move to MEDITECH Expanse is not an upgrade of the current EPR, it is akin to a new EPR deployment requiring a significant rebuild, and is a UK “first of type”.

The benefits of the AlderC@re programme are clear in providing a much more modern, easier to use EPR for staff, ultimately supporting improved experience, safety and outcomes. The new system will provide a more enhanced joined up and integrated record for our staff to care for our children and young people.

A great user experience is at the heart of the advantages of the new system. The look and feel of the system for staff is significantly more intuitive and easier to navigate than the current system. The programme, through strong clinical leadership, has addressed a number of long standing challenges with the current system. These include making some key clinical items of significant importance much more prominent in the patient record and aiming to reduce the amount of admin burden and ‘clicks’ for staff.

National digital colleagues are appraised of the current position with regards to the programme and have provided support particularly in terms of supplier and functionality management and a UK focus on resolving any issues.

October 2022 is a key month for user engagement with the launch of Patient Journeys across the Trust. The sessions are due to be delivered alongside availability of a ‘simulation hub’, a physical location for engaging with the system and programme team; a test system, for users to explore the system independently; and proactive AlderC@re communications and engagement to promote the programme.

The Board of Directors is asked to note the latest position with the planning for AlderC@re deployment and the revised go live timescale in 2023.

2. Background

The AlderC@re Programme is overseeing the deployment of a new version of the MEDITECH EPR (Electronic Patient Record) referred to as AlderC@re within the Trust, with the MEDITECH Expanse 2.1 version to be delivered in the first phase. A plan was in place to deploy AlderC@re in October 2022 but due to failing designated gateway criteria in June 2022, a programme review was established to include development of a revised deployment plan. Since June 2022, a new programme team has been in place to review the programme, to provide ongoing programme management, and validation of what has been completed thus far.

The initial review identified some key lessons learned, recognising that the move to MEDITECH Expanse is not just an upgrade but a new deployment, requires a significant rebuild, and is a UK “first of type”. The need for refined governance and additional resources were identified, alongside more robust management of high priority issues in conjunction with MEDITECH. Additional project

and programme management resource is in place, including business analyst and change management resource.

The review confirmed that October 2022 was not viable, with subsequent agreement from the Trust Executive Team to defer to 2023, and the full review has now completed with a revised programme plan developed.

3. Programme Plan

The first version of a revised programme plan presents a provisional timetable for go live in summer 2023. This plan is being refined as the programme progresses, with the next revision to be presented to the AlderC@re Board in October 2022.

A deep dive on the programme plan with senior Trust and MEDITECH sponsors took place in August 2022. This took the executive members and programme team through the detailed programme plan. The plan will be reviewed by NHS Digital as part of the programme external assurance process, and project governance will be aligned with Trust assurance mechanisms. An updated Project Initiation Document (PID) will be presented to the Programme Board for review and approval.

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. The ambition is to provide ten journeys with staff, enhancing the socialisation of the programme, and will identify any remaining functionality, process, or configuration issues.

MEDITECH are working with customers to establish a national group for Trusts deploying Expanse. This will include looking at lessons learned, NHS requirements and prioritisation, and the approach to nursing solutions.

4. Benefits

In addition to the overarching benefits narrative noted above, a Statement of Planned Benefits is in place for the programme. This provides a level of detail within the programme identifying key expected benefits. A first review of the Statement Of Planned Benefits has been completed during June to August 2022. This involved reviewing existing programme material, meeting with programme team members and Meditech colleagues. The number of benefits/disbenefits logged has increased from 50 to 135 (of which 7 are awaiting further information). The key themes are '**Improve user experience'** (33 benefits logged), '**Improve Safety** (32), '**Improve Data Quality**' (11) and '**Reduce admin time**' (50). Most of the benefits are logged as "qualitative", with two cash releasing benefits identified.

Further work will be progressed as the programme develops with a recognition that the return on investment from an EPR is multifactorial across a range of domains.

Key outcomes include reduced clicks, easier access to information, user friendly interface with customisation options, specialty specific information, improved alerts / notifications, safe waiting list, reduced risk ratings, and increased electronic documentation such as WHO checklists.

Discussions are also taking place with MEDITECH on the potential to provide functionality to support enhanced nursing processes in phase 1, with further opportunities to be assessed in future phases.

Next steps will include reviewing the updated benefits with project managers and the clinical informatics (CXIO) team, reviewing further information from MEDITECH, and working with the communications and engagement leads to develop key messages for benefits, including "top 10" benefits for target audiences.

5. Communications, Training, and Engagement

The communications, training and engagement work has been focussed on recruiting champions and running prototyping session that show elements of the system to users. This is now moving into a second phased based on the Patient Journeys, and more targeted sessions with individual departments.

Computer carts are on order that will enable a more mobile approach to engagement, and a “now versus the future” video is being prepared to show improvements in the new system side by side with the current system. Meetings will be held with Divisional General Managers to identify best ways to cascade information within each division and confirm governance of sign off structure.

An AlderC@re strapline has been developed: ‘A safe and easy to use EPR’.

6. Risks

Risks continue to be progressed with regards to priority development items awaiting delivery from MEDITECH, especially those that currently have no confirmed delivery date. These include the final developments required for electronic prescribing (EPMA). A gateway process will take place as part of the revised programme plan in November 2022 that will provide the next decision point for assessing whether sufficient progress has been made to recommend moving to the next phase of the programme.

Retention and recruitment of resources is a key risk, alongside aligning AlderC@re with the developing plans to deploy a new theatre system.

Lessons learned from other Trust EPR programmes will be taken into account, for example where issues have occurred with ability to complete national reporting successfully, and where programmes have been delayed due to issues with system interfaces.

A revised resource profile has been developed. This along with the wider programme position and risks have been shared with Integrated Care System, regional and national colleagues who have indicated support given the first of type nature of the programme.

7. Summary and Conclusion

The review of the AlderC@re Programme has now concluded and a revised programme plan has been presented to the AlderC@re Board with a provisional timeline for summer 2023. Detailed work to review the benefits profile has started, with significant progress made.

There continue to be significant risks that need to be mitigated, with the immediate challenge for MEDITECH of concluding the work to resolve all priority 1 development issues, and for the Trust to progress the system build.

The Trust Board is asked to note the latest position with the planning for AlderC@re deployment in 2023.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	**Board Assurance Framework 2022/23 (August)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Monthly BAF Reports
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

000258

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.

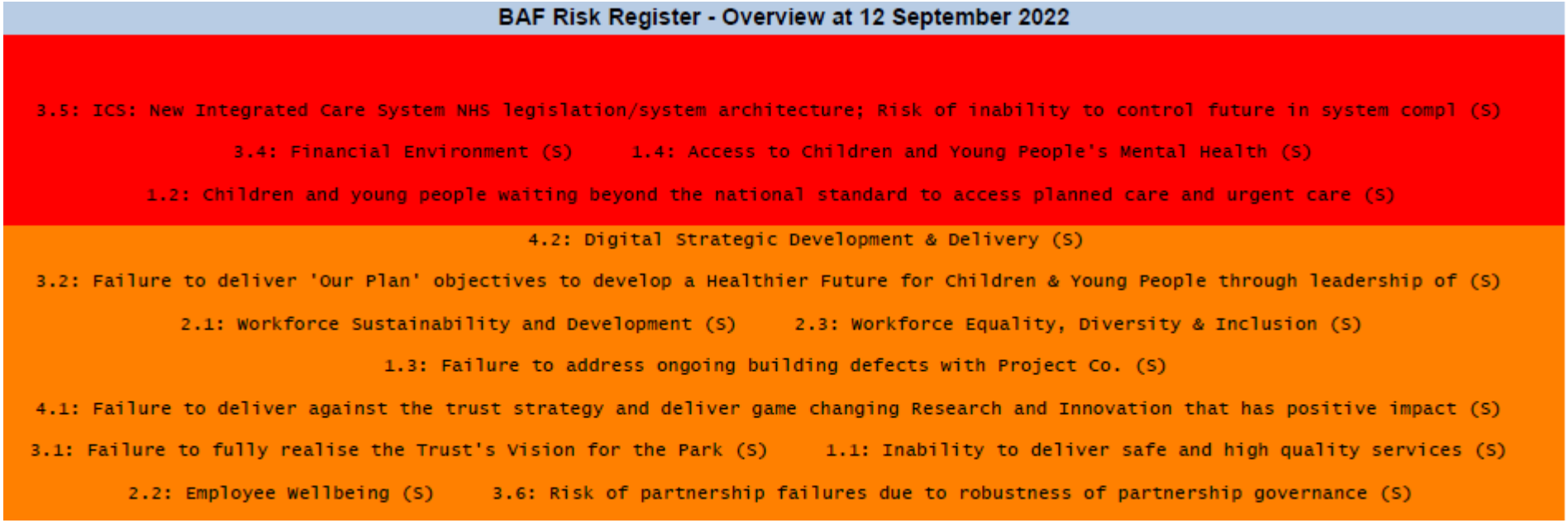
2. Review of the BAF

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 12th September 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 September 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	3x2	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 August updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in date. Actions and controls reviewed and evidence updated.

- ***ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment (DJ).***
  Risk reviewed; no change to score in month. Actions and controls reviewed and evidence updated.

- ***Risk of partnership failures due to robustness of partnership governance (DJ).***
  Risk reviewed; no change to score in month. Controls, actions and evidence reviewed.

- ***Workforce Equality, Diversity & Inclusion (MS).***
  No change to risk score in month. All actions remain on track

- ***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.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  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.

- ***Inability to deliver safe and high-quality services (NA).***
  This risk has been reviewed and updates provided on the current gaps in control. The other controls remain in place and are effectively mitigating this risk.

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

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

- ***Digital Strategic Development and Delivery (KW).***
  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.

- ***Workforce Sustainability and Development (MS).***
  No change to risk score in month. All actions remain on track

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

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

- ***Access to Children and Young People's Mental Health (LC)***
  All actions reviewed and updated. Action relating to job plans completed and closed.

Erica Saunders
Director of Corporate Affairs

Links between high scored risks & BAF

000263

BAF Risk

1.1

Inability to deliver
safe and high-quality services

(3x3=9)

Strategic Aim

Delivery of **outstanding care**

Related Corporate Risk(s)

(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. * (linked to 2.1)

(2230) Risk of ten-fold medication errors resulting in serious harm to patients caused by prescribing, administration, dispensing and documentation processes subject to human or process errors

(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

(2441) Patients could deteriorate whilst transport services and hospitals agree who is going to undertake the retrieval caused by UNHM and Alder Hey are served by two different transport services (KIDS & NWTS) meaning neither will transport non-time critical patients between trusts. Paediatric surgery and Neurosurgery deliver a substantial part of University Hospitals of North Midlands (UHNM) surgical work, this includes on call and out of hours.

(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 * (Linked to 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. *(Linked to 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.* (Linked to 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.* (linked to 1.2 & 2.1)

(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

(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 (Linked to 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 (Linked to 1.2 & 2.1)

(2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 2.1)

(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 1.2)

(2570) Inadequate provision of inherited cardiac conditions (ICC) service for Children within the North West.

(2589) Inability to safely staff Catkin and Community Clinics (Linked to 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

(2326) Delayed diagnosis and treatment for children and young people (Linked to 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. (Linked to 2.1)

(2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 2.1)

(2564) There is a risk of delayed diagnosis and the inability to monitor ophthalmic , oncology and neurological conditions. there is a risk to life and of permanent harm to vision.

(2650) Unable to reprocess endoscopes .Delay in treatment due to list/procedure cancellations. Endoscopes not available for emergency procedures.

(2643) Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)

(2642) Inability to deliver 1-1 care where required

(2652) unregulated device (for intussusception emergencies) could fail leading the patient to need surgery

(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

(2664) Risk that anaesthetist unable to attend ED for patients with unstable airway

(2684) Unable to deliver high quality elective paediatric haematology service

(2654) Children will not receive the quality of care that they require to effectively manage their condition resulting in poorer outcomes.

000264

BAF Risk	Strategic Aim	Related Corporate Risk(s)
1.2 Children and young people waiting beyond the national standard to access planned care and urgent care (3x5=15)	Delivery of **outstanding care**	(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 (linked to 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 (linked to 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 (linked to 1.1) (2517) Risk of Children & 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 (linked to 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 (Linked to 1.1 and 2.1) (2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) service (Linked to 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. (Linked to 1.1 & 2.1) (2326) Delayed diagnosis and treatment for children and young people (Linked to 2.1)

000265

BAF Risk	Strategic Aim	Related Corporate Risk(s)
1.3 Failure to address ongoing building defects with Project Co. (4x3=12)	Delivery of **outstanding care**	None
1.4 Access to Children and Young People's Mental Health (3x5=15)		(2497) Breaching waiting time standards in the Eating Disorder Service (EDYS) (2517) Children and young people come to harm whilst waiting for urgent treatment episodes. (2643) Children and young people will not receive their ASD assessment within the agreed timescale (30 weeks Trust standard)

BAF Risk	Strategic Aim	Related Corporate Risk(s)
2.1 Workforce Sustainability & Capability (3x4=12)	**The best people** doing their best work	(2100) Risk of inability to provide safe staffing levels.(Linked to 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(Linked to 1.1) (2340) Risk in the amount of training delivered will suffer due to the inability of resuscitation staff providing it, equally with holding the cardia arrest bleep, caused by insufficient staff in resuscitation team. (linked to 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. (linked to 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. (linked to 1.1) (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. (linked to 1.1) (2497) Delayed diagnosis and treatment for children and young people", caused by lack of clinical capacity and increase in the number of referrals being made to the EDYS service * (linked to 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 (Linked to 1.1) (2536) The network does not have the financial resources to backfill senior leadership posts to the level needed (Linked to 1.1) (2589) Inability to safely staff Catkin and Community Clinics (Linked to 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 (Linked to 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. (Linked to 1.2) (2617) The inability to recruit nurses in a timely manner to allow for training and education in time for us to open the new neonatal unit in November 2023 (Linked to 1.2) (2642) Inability to deliver 1-1 care where required

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BAF Risk	Strategic Aim	Related Corporate Risk(s)
2.2 Employee Wellbeing (3x3=9)	**The best people** doing their best work	None
2.3 Workforce Equality, Diversity & Inclusion (4x3=12)	**The best people** doing their best work	None

BAF Risk	Strategic Aim	Related Corporate Risk(s)
3.1 Failure to fully realise the Trust's vision for the Park (3x3=9)	Sustainability through **external partnerships**	None
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)		None
3.4 Financial Environment (4x4=16)		(2663) Failure to deliver the 2022/23 control total set by Cheshire & Mersey ICS (2637) The Greener Project may not achieve the predicted £1 million savings target linked to energy
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)		None
3.6 Risk of partnership failures due to robustness of partnership governance (3x3=9)		None

BAF Risk	Strategic Aim	Related Corporate Risk(s)
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)	Game-changing **research and innovation**	None
4.2 Digital Strategic Development and Delivery (4x3=12)		None

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: 2383, 2332, 2441, 2461, 2265, 2427, 2384, 2233, 2312, 2229, 2332, 2383, 2536, 2578, 2100, 2501, 2597, 2415, 2020, 2617, 2589, 2516, 2535, 2528, 2326, 2326, 2497, 2664, 2548, 2514, 2340, 2570, 2230, 2246, 2410		
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

Board Assurance Framework 2022-23

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

Board Assurance Framework 2022-23

NHS 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, 2578, 2501, 2501, 2597, 1902, 2463, 2535, 2528, 2326, 2497, 2517, 2246, 2410		
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	23/09/2022	Recruited into Locum Specialty Dentist posts 2 XWTE. Expected start date(s) Sept 2022 Recruited into 0.2 WTE Specialist Dentist post - expected start date Oct 2022 Dental Nurse interviews to take place 6th Sept 2022 Discussions with insourcing company commenced

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.

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.

May 2022 - Adam Bateman
The current number of C&YP waiting over 52 weeks for treatment is 275. Over the past two months the number has plateaued. Sixty per cent of the total number of long wait patients are concentrated in the specialty of paediatric dentistry. A specialty recovery plan to address this is being finalised by the 6 May 2022. We also have a Trust wide plan to recover services to 104% this year.

Our Emergency Department dealt with a 9.8% increase in attendances relative to 2019. We treated 72.4% of patients within 4 hours, an improvement relative to March (driven largely by a return from absent of a number of staff). Through the annual plan process we have agreed a significant increase in investment to increase staffing levels, and to establish capacity in a primary care stream. We also have a staff development and improvement programme in place - ED at its best.

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

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.

July 2022 - Rachel Lea
Risk reviewed following discussion at RABD. Controls, assurances and actions updated. Exec Lead changed from David Powell to Adam Bateman

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: 2497, 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.	30/09/2022	All children and young people reported to be waiting >2 years overdue have been validated.
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	30/09/2022	Automatic booking of EDYS appointments in place. Process mapping sessions with Aqua completed and summary report expected.
Improvement required in completion and recording of Routine Outcome Measures. ROMS app to be launched which is expected deliver this improvement.	30/09/2022	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

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, 2536, 2578, 2100, 2501, 2597, 2020, 2617, 1902, 2589, 2516, 2624, 2535, 2528, 2497, 2497, 2517, 2340, 2246		
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

L&D team monitoring compliance on a weekly basis. Separate actions plans in place to support those f2f topics which dipped during the pandemci, incl resus and MH.	30/09/2022	mandatory training progressing well, Trust now above 90%

Executive Leads Assessment
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
July 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 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 support employee health and wellbeing and address mental health which can impact upon operational performance and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
The People Plan Implementation	Monthly Board reports
NHSE Organisational Health and Wellbeing framework implemented	HWB Steering Group ToRs
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
Reward and Recognition Group relaunched after being on hold during the peak of the pandemic	Reward and Recognition Meetings established; reports to Wellbeing 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 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

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 this pandemic
2. Increase in mental health crises in healthcare staff due to personal and service related impacts of the Covid 19 pandemic and corresponding decrease in availability of emergency mental health provision
3. Increase in self-reported rates of burnout as assessed via 2021 Staff Survey and consistent with national picture for NHS staff

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

Business case in development and now awaiting opportunity to present at appropriate forum whilst SALS also seeking external funding sources and opportunities for income generation to assist with current cost pressures.	30/09/2022	Business Case under review
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.	30/09/2022	Still awaiting report. No progress.
Agree a develop a SALS Pals (HWB champion) model across the organisation & implement model	30/09/2022	Progress to be reported at next 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
Recruitment process for new Head of EDI	31/08/2022	Recruitment process commenced
Staff Network Chairs to be advertised during August / September	30/09/2022	Action commenced 1 August 2022

Executive Leads Assessment

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

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 with revised timescales. Target risk rating amended

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	30/09/2022	Informal proposal made to FSP
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.	10/10/2022	Modulars ordered and delivery dates agreed. Planning approved for former police station modular, planning for three storey modular expected on the 21st July 2022

Executive Leads Assessment

September 2022 - David Powell
Prior to September Board

August 2022 - David Powell
Following Campus Review

June 2022 - David Powell
Following Campus Review Session

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 Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under implementation	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

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.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Strong Foundations	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 2637, 2663		
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	30/09/2022	LTFM work delayed due to ongoing requirements of the 22/23 business planning and system requirements.
2. Five Year capital plan	30/09/2022	22/23 Capital plan approved based on current CDEL allocation. Awaiting confirmation of outcome of bids for any further allocation. Work underway with C&M regarding allocations for 23/24 and 24/25.

Executive Leads Assessment

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.

July 2022 - Rachel Lea
A new risk has been added to the corporate risk register regarding the financial risk to the 22/23 plan. Relevant actions have been moved over and progress updated on both risks. No change to risk score on this.

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 C&M Provider Collaboratives x 2 - to ensure CYP voice high on agenda	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
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)
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 proposed population need based allocation formula (not yet shared)	31/03/2023	As above entry 7.9.22

Executive Leads Assessment

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.

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

Board Assurance Framework 2022-23

Alder Hey Children's NHS Foundation Trust

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

Assurance Committee: Resource And Business Development Committee

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
NW NorCESS Escalation Plan - approved through NW Paediatric Partnership Board and adopted by the NorCESS service group	
Escalation process for risks and issues pertaining to ODNs and Joint Services	
Partnership Quality Assurance Framework	P'ship Quality Assurance Framework in development. Initial review with Alder Hey Execs (MD, Chief Nurse, Corp Gov Exec) complete; awaiting comments then further work with partners to identify pilot area. Update to Risk Management Forum Nov / Jan (dependent on partner engagement)
Identification of 'pilot' partner to co-design the Framework	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 - June 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	31/10/2022	Agreement from both Alder Hey and LWH to identify 2 NEDs for PQAR complete. NED's identified. Date under scheduling.
MIAA Audit scheduled for Q2 2022	31/10/2022	Draft TOR for audit currently under agreement

Executive Leads Assessment

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

July 2022 - Dani Jones
Risk Reviewed; no change to score in month but progress with actions, controls and evidence.

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: 2624		
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

September 2022 - Claire Liddy
no change (SEPT 22)

August 2022 - Claire Liddy
AUG - no significant change

July 2022 - Claire Liddy
July - no 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: 2265, 2235		
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

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.

July 2022 - Kate Warriner
BAF Risk reviewed. Current scores remain in place. Aldercare programme currently in exception, formal review underway. Review has confirmed that October 22 go live is not viable, work in progress to establish revised go live date and associated required resources. Resourcing challenges are improving with recruitment of some key vacancies in some services. Mobilisation plans for Digital and Data Futures is in development.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	Board Assurance Framework Policy RM58 (V6)
Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs / Governance Manager

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	All changes highlighted in yellow for ease and referenced on page 2 of the Policy
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 Foundation Trust

RM58 – BOARD ASSURANCE FRAMEWORK POLICY

Version:	6
Name of ratifying committee:	Board of Directors
Date ratified:	29/09/2022
Name of originator/author:	Director of Corporate Affairs
Name of approval committee:	Audit and Risk Committee
Date approved:	15/09/2022
Executive Sponsor:	Director of Corporate Affairs
Key search words:	Assurance, Risk, BAF, RM58
Date issued:	September 2022
Review date:	September 2025

Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
6	September 2022	Director of Corporate Affairs	Current	
5	September 2019	Director of Corporate Affairs	Archived	
4	February 2018	Director of Corporate Affairs	Archived	
3	September 2016	Director of Corporate Affairs	Archived	
2	July 2015	Director of Corporate Affairs	Archived	
1	July 2014	Director of Corporate Affairs	Archived	

Record of changes made to Board Assurance Framework Policy – Version 6			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
Throughout	Throughout	- All references to Integrated Governance Committee replaced with Risk Management Forum. - All references to Workforce & OD Committee replaced with People and Wellbeing Committee - All references to Clinical Quality Assurance Committee replaced with Safety and Quality Assurance Committee - All references to Audit Committee replaced with Audit and Risk Committee	Updated to reflect new committee structure since v5 of the policy
3.3	5	Updated to reflect new Risk Management Forum arrangements	Ne reporting structure
Throughout	Throughout	References to Corporate functions replaced with business unit functions	Point of consistency
App A 1.6	11	Updated to reflect risk grading on risk management system	

Contents

1 Introduction

A Board Assurance Framework (hereafter referred to as the BAF) must be driven by the objectives of the organisation. Therefore it follows that clear strategic and operational objectives need to be identified before an effective system of internal control can be established. Without clear objectives, the Trust would be unable to identify and evaluate the risks that threaten the achievement of its goals and design and operate a system of internal control to manage those risks. The corporate objectives for the Trust are determined by the Board of Directors, based on organisational, local and national priorities, stated in the Trust's operational plan and other related documents. The BAF enables the Board to demonstrate that it has been properly informed about the totality of its risks and is able to sign the Annual Governance Statement required annually by NHS Improvement.

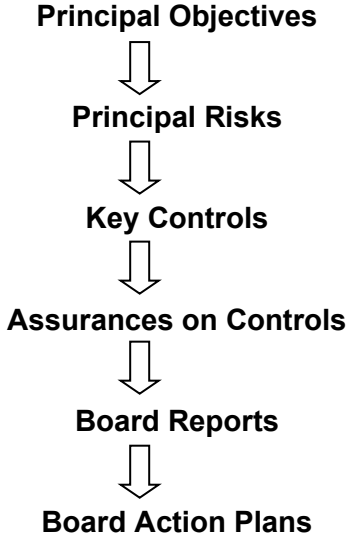
The BAF must be a dynamic tool to enable the Board to assure itself that all significant strategic risks are being managed effectively. The elements involved in this assurance process are:

- The BAF must be reviewed and updated with progress towards closing the identified risks and associated gaps in control and/or assurance at least quarterly.
- Independent scrutiny must take place to ensure that these updates are valid.
- Both of these processes must also consider whether new risks have arisen with the potential to jeopardise the achievement of the Trust's principal strategic objectives.

2 Purpose of Policy

The purpose of this policy is to set out the key structures, systems and processes by which the Board of Directors is assured, via the BAF and the underpinning risk registers that the Trust's strategic and operational objectives are being achieved through the effective management of the strategic and operational risks. See Fig.1 below.

The Board Assurance Framework



3 Duties and Responsibilities

3.1 Board of Directors

- It is the duty of Board members to ensure that they monitor the Trust's significant risks as detailed in the corporate risk register and that those corporate risks link into the high level risks on the BAF, that relate to specific strategic objectives and the associated controls and assurances in line with the work plan. In particular, the Board should focus upon progress by exception of action plans to address gaps in control and assurance.
- The Board should ensure that all systems, processes and procedures required for the BAF function effectively, including where elements have been delegated to Committees.

3.2 Board Committees

- The overall role of the Board's committees is to carry out the detailed work of assurance on behalf of the Board. They report recommendations to the Board. The Board Committee's core role and responsibilities is to:
  - Scrutinise reports on the relevant risks to that Committee's remit from the BAF and the corporate risk register; the delivery of the Annual Plan and compliance with CQC Standards.
  - Contribute to the development of the Annual Planning cycle and ensure that this plan reflects stakeholder requirements.
  - Give the Board confidence that the systems, policies and people they have put in place to deliver the Annual Plan are operating in compliance with CQC Standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
  - ~~Recommend to the Board the level of assurance required, the source of assurance required and how the reporting of assurances will be managed and coordinated.~~
  - Provide the Board with the evidence required of the effectiveness of controls in order to be able to sign the Annual Governance Statement and maintain unconditional registration with the CQC.
  - Scrutinise reports and evidence of assurances provided by clinicians, managers, Trust committees and independent assurers on the status of the Trust's internal controls.
  - Ensure that unacceptable levels of assurance and risks are reported to the Trust Board for their consideration.

3.3 Risk Management Forum

- The Risk Management Forum oversees the design and effective operation of the risk management process across the Trust including the management of the production of the BAF.
- The Forum provides the Board with assurance that a comprehensive corporate risk register is in place derived from the Executives' view of the major risks to the Trust and the risks being escalated from Divisions and business support functions.

- The Forum oversees the integration of clinical, organisational and financial risk management systems across the Trust with that of corporate business planning.
- It is authorised to take remedial action to resolve weaknesses and incorporate best practice.

3.4 Divisions and Business Unit Functions

- All Divisions and Business Unit Functions should ~~complete and~~ report to the Risk Management Forum on their specific accountabilities and responsibilities as defined in the work plans.

3.5 Director of Corporate Affairs

- The Director of Corporate Affairs will facilitate the process for updating the BAF.
- The Director of Corporate Affairs will ensure the Board of Directors is provided with an updated BAF every month.
- The Director of Corporate Affairs will ensure that timely risk modelling is undertaken for all new identified or emerging risks.

3.6 Executive Directors

- Each risk identified on the BAF will have an Executive Director owner who holds accountability for updating entries in the Assurance Framework against that risk i.e. associated controls, actual assurances (reports etc), action plans and impact/likelihood score.
- Once all updates from risk owners have been received, the Executive Lead will sign off the refreshed BAF.
- The Executive Directors ~~with responsibility for staff groups in each~~ will be accountable for the proactive timely and accurate review and update of all risks owned by their Divisions / business unit function. ~~corporate service.~~ This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them. It is also an opportunity to identify any emerging new risks for assessment and inclusion in the corporate risk register.

3.7 Non-executive Directors

- It is the role of all Non-Executive Directors to contribute to Board and Committee discussions and make constructive challenges.
- They should identify issues, either through Committee activities or at the Board itself, of which the Audit and Risk Committee will undertake a more detailed review.

3.8 Associate Chief Operating Officers / Heads of Business Unit Functions, Project and Programme Managers

- Associate Chief Operating Officers, business support function Heads of Departments, Project and Programme Managers are accountable for the

complete and accurate review and update of all risks owned by their Divisions/ service/ programme. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them.

- They are also accountable for identifying any emerging new risks for assessment and escalation to the corporate risk register.

3.9 All Staff

- To contribute to the identification of risk through active participation in the risk assessment and incident reporting processes by ensuring they comply with their responsibilities identified in the risk assessment and incident reporting policies.
- To follow all relevant safety precautions in line with the Trust's Incident policy.
- Must keep all mandatory training up to date as ~~through attendance and updating~~ identified in the Trust's training needs analysis.

4 Process for Maintaining the Board Assurance Framework

4.1 The BAF is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals.

4.2 The BAF contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

4.3 Risks are scored using a 5x5 matrix of impact and likelihood. This 5x5 matrix, in which scores for impact or consequence of the risk is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating.

4.4 The BAF is maintained by the Director of Corporate Affairs. The information recorded on the Framework includes:

- Description of the risk
- Current risk score
- Control measures in place
- Evidence of current assurances
- Gaps in controls/ assurances
- Target risk rating
- Actions required to achieve the target risk rating – the appetite for the specific risk.

4.5 The Board of Directors has delegated responsibility of monitoring risks and assurances to the Risk Management Forum (RMF), which will oversee the design and effective operation of the risk management process across the Trust including the management of the Corporate Risk Register and Board Assurance Framework. The RMF will provide the Audit and Risk Committee with a bi-monthly assurance report on the outcome of the meeting including an

updated BAF, a summary of the corporate risk register and any key issues arising from the meeting. The full BAF and corporate risk register will also be produced to inform Board Committees including Safety and Quality Assurance Committee, the Resources and Business Development Committee, Innovation Committee and People and Wellbeing Committee of the latest position on their related risks.

4.6 The Audit and Risk Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

5 Process for the Local Management of Risk (which reflects the organisation wide Risk Management Strategy)

- ~~Each Clinical Division and Corporate Business Unit Function will refresh their risk register on an annual basis as per the Trust's Risk Management Strategy.~~
- The locally identified risks, derived from completing the risk assessment tool, will be utilised to inform the departmental risk registers. Divisional Associate COOs/Heads of ~~Corporate~~ Business Unit Functions are responsible for ensuring that actions are put in place to mitigate identified risks.
- The ways in which risk can be escalated from Ward and department level to Divisions and corporate levels is outlined in the Risk Management Strategy.
- Divisions/~~Corporate~~ Business Unit Functions will provide exception reports to the Risk Management Forum in line with its work plan.

6 Monitoring Compliance with the Processes

As stipulated within this policy, the Trust will keep the BAF under review via the Risk Management Forum and monthly reports to Board of Directors and its Committees.

- The reports will be presented by the Director of Corporate Affairs to the Board of Directors and its assurance committees.
- An annual audit of the corporate risk register/ Assurance Framework will form part of the internal audit programme, to support the Annual Governance Statement.
- The purpose of this annual audit is to monitor the systems and processes of the approved organisation-wide risk register.
- The Trust's BAF will be monitored to assess compliance with the key performance indicators.
- The audit process will assess whether: -
  - Responsibilities are clearly agreed and recorded and there is evidence to support objectives which are clearly linked to the Trust's operational plan or other strategic documentation.
  - Risks are clearly linked to objectives, their priority (impact/likelihood) has been determined and they have been attributed to a lead.
  - Risks are assessed and new/amended risks are considered and included where appropriate.

- Controls effectively manage the risk, there is evidence that the controls are in place and that there is adequate management of controls.
- Controls relied upon are sufficient to manage the risk i.e. expected assurances have been received and provide sufficient information to efficiently manage the risk.
- Positive assurance evidence is collated and uploaded onto performance accelerator and signed off by the accountable Executive Director.
- Where gaps in control/assurance have been identified, appropriate actions plans have been agreed to address these and are monitored consistently in line with policy standards.
- Board reports, Risk Management Forum minutes, Resources and Business Development Committee minutes, Safety and Quality Assurance Committee minutes, Innovation Committee, People and Wellbeing Committee minutes and Audit Committee minutes provide evidence that the Assurance Framework has been effectively discussed and considered and progress/ action has been taken to address areas raised following the audit.
- The Risk Management Forum and Audit and Risk Committee monitor reports ensuring that recommendations/actions are implemented where monitoring has identified deficiencies. This is to ensure that lessons have been learned and agreed changes in practice made.

7 Further Information

Equality Analysis *(hyperlink)*

References

- The Healthy NHS Board
- Taking it on Trust
- Board Assurance Frameworks – A Simple Rules Guide for the NHS
- CQC Standards
- ~~NHSI Single~~ NHS system Oversight Framework ~~updated November 2017~~
- NHSI Annual Reporting Manual

Associated Documentation

This policy should be read in accordance with the Trust Risk Management Strategy.

Appendix A

1. Definitions

1.1 Assurance

Confidence based on sufficient evidence, that internal controls including policies, procedures, practices and organisational structures are in place and operating effectively ensuring the strategic objectives are being achieved.

1.2 Key Elements Assurance Framework

- An Assurance Framework (BAF) is a simple but comprehensive method for:
  - The management of the principal risks to meeting the organisation's objectives.
  - Providing evidence for the Annual Governance Statement. Guidance on what should be included within the Statement is provided within Monitor's Annual Reporting Manual each year.

1.3 Principal Objectives

- Principal Objectives are statements of the crucial measurable results which the organisation must achieve in order to achieve its overall goals in line with its strategic aims.
- Clinical Divisions and ~~Corporate~~ business unit functions must align their objectives with the principal objectives in order to ensure that their activities contribute to the achievement of the Trust's principal objectives.
- The BAF must specify the Director who is accountable to the Board for delivering the Principal Objectives of the corporate plan.
- The Principal Objectives must be stated in terms which are:

Specific
Measurable
Achievable
Realistic
Time-based

1.4 Risk Registers

- Risk registers are held at Ward /Departmental level, Divisional level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register). The principal risks associated with each strategic objective must be identified on the BAF.
- The risk rating tool (5x5 matrix) enables staff to consider the potential harm that would be caused if a hazard or threat was realised and how likely this is to happen. The two factors of likelihood and impact/consequence are used to establish the level of risk; this will assist staff in deciding which risks take priority and highlight areas which need rapid attention.
- The Divisional/Department/Business Support Function level risk register must reflect the proactive annual risk assessments undertaken and

reactive risks identified through incident reporting etc. including demonstrating action taken against these risks at least monthly.

- Each Division/Department/Business Support function has responsibility to review their own risks and to inform the Risk Management Forum of actions completed to reduce or eliminate the identified risk.
- The Division /Department/Business Support Function risk assessments will contribute to the formulation of the high level Trust Corporate Risk Register along with other forms of risk identification. This will ensure that the risk registers are consistent and that meaningful decisions on the prioritisation and treatment of risks can be made.
- Risk Registers will be kept at Business Support Functions, Divisional and Department/Ward levels within the Trust.
- At Board level the corporate risk register will include risks to the achievement of Principal Objectives together with risks escalated from business support functions, Divisions and Department/Ward levels.

1.5 Principal Risks

- Factors which potentially threaten the achievement of the principal objectives are called principal risks and need to be identified. They should be stated as "If x happens then y will be the consequence".
- Using risk profiling the principal risks to achieving the principal objective are identified and summarised on the BAF together with a score of their likelihood and potential impact.

1.6 Risk Profiling

Risk Profiling is a process that involves the identification and assessment of all risks encountered by an organisation, enabling the identification of high-risk issues, facilitating the management and prioritisation of such risks.

- Risk profiling gives a risk a 'Likelihood score' of:

  1 = rare - do not expect this to happen.
  2 = unlikely - most probably will not happen.
  3 = ~~occasionally~~ possible - 50:50 chance of occurring.
  4 = likely - most probably will happen.
  5 = almost certain - confident that this will happen.

- Risk profiling gives an impact/consequence score of

  1 = Negligible. Almost non - no obvious harm. Insignificant cost increase / schedule slippage
  2 = minor - no permanent harm (recovery within month). Less than 5% over local budget / schedule slippage.
  3 = moderate - semi-permanent harm (recovery takes longer than 1 month but no more than 1 year) and/or adverse publicity for the Trust. More than 10% over local budget / schedule slippage.
  4 = major - permanent harm not resulting in death or severe disability to a person or persons. Start of a national investigation into the Trust. Disruption of key Trust services which significantly hinder the Trust in meeting its responsibilities. Less than 5% over Trust budget.

5 = catastrophic - death or permanent severe disability to a person or persons and/or significant loss of reputation for the Trust and/or loss of key Trust services which prevent the Trust meeting its responsibilities. More than 10% over Trust budget.

Note: Harm in all the above includes damage to the organisation, its finances, its reputation, its business, its patients, staff or visitors.

1.7 Identification of Risks

Potential principal risks to the achievement of the Trust's objectives are identified in two ways: the 'top down' proactive (risk assessment) identification of risks that directly affect the Trust's achievement of its principal objectives, combined with the 'bottom up' assessment of the most significant risks within the business support, programme and Clinical Risk Registers~~. which in turn originated in Clinical Business Units, programme and Business Support Function Risk Registers.~~

1.8 Controls and Assurance

- Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives; they should make a risk less likely to happen, or reduce its effect if it does happen.
- The Assurance Framework requires the Trust to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
- The Assurance Framework summarises how the Board knows that the controls it has in place are effectively managing the principal risks together with references to documentary evidence that the assurances are working effectively.
- There are two groups of assurances on controls:
  - Internal Assurance
  - Independent Assurance
- Internal assurance is provided by the following Committees:
  - Audit and Risk Committee
  - Safety and Quality Assurance Committee
  - Resources and Business Development Committee
  - Risk Management Forum
  - People and Wellbeing Committee
  - Health and Safety Committee
  - ~~Clinical Systems Informatics Project Group~~
  - ~~Information Governance Committee~~
- The purpose of the committees is to carry out an analysis of assurances received, identify any key gaps in the assurance mechanisms and provide an evaluation of the effectiveness of these mechanisms to inform the relevant strategic objectives on the Assurance Framework.
- The Board of Directors then receive summary reports from these committees together with Audit and Risk Committee reports and makes a

final judgement on the level of assurances received and any actions required to ensure delivery of the Trust's objectives and obligations.

- Independent assurance is provided by:
  - Audit and Risk Committee
  - Internal Audit and External Auditors
  - Care Quality Commission
  - Health and Safety Executive
  - NHS Improvement

1.9 Key Controls

- Key controls are the means by which the risk's impact or likelihood may be reduced together with references to documentary evidence of the existence and effectiveness of that control mechanism. Risk control is achieved by reducing the likelihood of the risk, reducing the impact of the risk and/or transferring the risk. The risk controls are also identified through a risk profiling process and summarised on the Assurance Framework as are any gaps in risk control.

- The Board of Directors and all other Trust staff ~~grade risks~~ must use the same ~~tool~~ grading matrix contained within the risk management system.

1.10 Gap in control and assurance

- A gap in control is deemed to exist where adequate controls are not in place, or where collectively they are not effective. A failure to put in place sufficient effective policies, procedures, practices of organisational structures to manage risks and achieve objectives.
- A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective. In other words a failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed is operating effectively.
- Wherever gaps in control or assurance are identified, action plans must be clearly defined, monitored consistently for improvement and allocated to appropriate lead Directors.

1.11 Controls Performance Reports and Associated Action Plans

- Performance reports e.g. audit reports provide strong evidence of the effectiveness of control activities and should identify necessary improvements where controls are lacking. It therefore follows that performance reports generate valuable information for the Assurance Framework and that there is a clear need for performance reporting and the Assurance Framework to be strongly linked.
- Where there is deficits identified in performance action plans must be formulated and consistently monitored to ensure compliance with performance standards (strategic objectives).

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

Paper Title:	2022-23 Alder Hey Children's NHS Foundation Trust Emergency Preparedness Resilience and Response Annual Assurance and Core Standards Self-Assessment
Report of:	Chief Nursing Officer & AHP/HCP Lead (Accountable Emergency Officer)
Paper Prepared by:	Jacob Gray – Emergency Preparedness, Resilience & Response Manager

Purpose of Paper:	Decision ☐ Assurance ■ Information ■ Regulation ■
Background Papers and/or supporting information:	Alder Hey Children's EPRR Annual Core Standards.
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:	

1. Introduction

This report is to provide a required annual assurance report to the Board of Directors on the current position of the Alder Hey Children's NHS Foundation Emergency Preparedness Resilience and Response (EPRR) portfolio. It also provides assurance for the Trusts self-assessment against the NHS England Core Standards for EPRR for the period of 2022 – 2023 period. It is to inform the Board that the Trust, following a self-assessment has rated itself as 'substantially compliant'.

2. Background

The Civil Contingencies Act 2004, Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, NHS Act 2006, and Health and Care Act 2022 underpin EPRR within Health. Additionally, the NHS Standard Contract Service Conditions (SC30) requires providers of NHS-funded services to comply with the NHS EPRR Framework and other NHS England Guidance.

The minimum requirements that Acute Providers must meet are outlined in the NHS England Core Standards for Emergency Preparedness, Resilience and Response. In line with national requirements the Trust is required to provide an annual assurance of compliance against these Core Standards.

3. Conclusion

For the 2022 – 2023 there are 64 standards the Trust is required to assess itself on. From the Trusts self-assessment; 59 of the standards have been declared as 'fully compliant' and 5 standards 'partially compliant'. This provides the Trust with 92% compliance and an overall assessment of 'substantially compliant'.

In addition, each year there is a 'deep dive' that is conducted to gain additional assurance into a specific area, this however does 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 full statement of compliance can be found in Appendix A with the action plan for partially compliant standards found in Appendix B.

4. Recommendation

The Alder Hey Children's NHS Foundation Trust Board of Directors is requested to note the annual EPRR assurance report and approve the self-assessment assurance rating of 'substantial compliance' in line with the NHS England EPRR core standards for 2022 – 2023.

Annual Assurance Report

1. EPRR Governance

The Trusts new EPRR Policy; replacing the previous Major Incident Policy and Business Continuity Policy sets out the expected framework and duties on how EPRR will be coordinated and conducted within the Trust. The refocused Policy has created a renewal of representatives from across the Trust to represent their Specialism and/or Division at the EPG to make the development of EPRR process across the Trust more cohesive and creates a better understanding in areas that can be developed through EPRR arrangements.

A new EPRR Manager was appointed to the Trust in February 2022 and reports to the Deputy Director of Nursing with regular informal reporting to the Director of Nursing and Chief Nursing Officer (Accountable Emergency Officer).

The Trusts Director of Nursing Chairs the Emergency Preparedness Group (EPG) in which all EPRR matters are coordinated through. The EPG reviews and assesses EPRR related risks, received updates from the Trusts supports the creation and updating of incident plans.

2. EPRR Training and Exercising

The Emergency Preparedness Group has recently approved a new Training Needs Analysis (TNA) for EPRR as a standalone document, this was previously contained within the Trusts Major Incident Policy. The new TNA sets out the approach in which on call and supporting mechanisms during incidents require training against an annual schedule. It also outlines the Trusts exercise requirements.

It is acknowledged within the Trusts EPRR Annual Core Standards for 2022 – 2023 that the Trust is partially compliant against not currently having a formal training and exercising programme suitably in place. The action against this can be found in Appendix B. it is also acknowledged that even though the Trust is currently without a formal programme in place it has been carrying out training and exercising during 2022; with examples listed below.

The Trusts overall percentage for EPRR Mandatory Training as of August 2022 is 95.46%. This has been a steady improvement since the last report to Board where the EPRR Mandatory Training was below 87.99%.

a. On Call Executive (Internal Strategic)

All Executives on the on call team have attended and participated in the Trusts internal Strategic On Call EPRR Training to support them in their role as the Trusts Strategic Commander during local incidents. There has also been a significant training resource made available through NHS England

to support Strategic Commanders through Principles of Health Command Course dates that has seen significant enrolment from our Executives.

b. On Call Senior Manager (Internal Tactical)

9 sessions of internal Tactical On Call EPRR Training have been scheduled during the 2022 period. With 7 commenced and completed, and 2 sessions outstanding. NHS England's additional support for Tactical Commanders through the Principles of Health Command Course has also been widely booked on to by the Senior Managers who are showing a dedicated and encouraging approach to improving their skills and knowledge as the Trusts Tactical Commanders. As of writing the Senior Manager compliance against attendance and enrolment on to courses is currently at 90%.

c. Loggist Training

2 sessions of Loggist Training have been scheduled for November 2022, enrolment onto the courses expects the Trusts Loggist capability to increase from 22 to approximately 35.

d. Business Continuity Workshop

A business continuity workshop was scheduled in May 2022 and participated by business continuity plan authors from the Division of Medicine, this proved useful for the authors and additional workshops will be included into the Trusts Training and Exercising programme to support cross Divisional working.

e. HCID – Exercise

The Trust is currently reviewing its Infection Prevention Control (IPC) approach to High Consequence Infectious Diseases (HCID) risk by establishing a specific HCID plan to support a suitable and robust response. To support this process Exercise Princeps – HCID was conducted in June 2022. The subsequent debrief identified 12 recommendations that would need to be applied before the HCID plan is approved and ratified with an additional live exercise to further test the plan, at time of writing there are only currently 4 recommendations still open.

f. Communications Cascade

The Trusts Switchboard conducted its 6 monthly cascade in April 2022, this supports the trusts requirements test its emergency contacts arrangements and update individuals and phone numbers on a regular basis. It also offers the opportunity to support Switchboard operators in their confidence and competence when being requested to activate their manual cascade. During the latter part of 2022 and into 2023 the Trust is to go live with an automated incident cascade system to reduce the risk of delayed notification when alerting cascade recipients or an incident. The next scheduled communications cascade is in October 2022.

3. Significant incidents in the last 12 months

The Trust has dealt with a number of incidents through the 2022 period; below are the significant incidents that have been recorded and reported through the EPG.

a. Water Loss – Dewi Jones Unit

As a result of a burst water main in July 2022 an area in which the Dewi Jones Unit (DJU) is located was impacted by a loss in water, this resulted in the arrangements of bottled water and large water containers to be delivered to the DJU over a weekend to support basic drinking and hygiene needs of patients and staff. Multiple recommendations in the debrief that followed on from the incident related to provision of external contract suppliers, escalation processes, and availability of local business continuity plans resulted in an action plan that the Community Division is progressing with and providing the EPG with a bi-monthly update trough the groups Divisional reporting governance arrangements.

b. Endoscopy Unit – Contamination

In April 2022 as a result of an unknown source of contamination impacting the safe service delivery of the Endoscopy Unit, local business continuity plans were enacted within the Division to support the Trusts Endoscopy provisions. This worked well and highlighted the necessity of having up to date and suitable business continuity plans. The business continuity incident was subsequently stood down after a prolonged period of time with the Trust establishing a temporary Endoscopy Unit on site until works are completed to solve the contamination issue.

c. CT Scanner –Downtime

In July 2022 the Imaging Department had a scheduled downtime of its CT Scanner, the business continuity arrangements of such downtime and to support the Trusts arrangements as a Major Trauma Centre with a requirement to deliver imaging resource 24/7 is to use its Gamma Camera as an interim measure. Upon activation of the Gamma Camera a fault was discovered that wasn't displayed the evening before when tested for the scheduled downtime. The resulting debrief and learning highlighted additional business continuity requirements to be in place in the event of CT and Gamma Camera loss including the exploitation into an additional CT Scanner to support the Trusts overall resilience as a Major Trauma Centre. An action plan monitored by the Trusts Lead Radiographer is reported on bi-monthly to the EPG for assurance.

d. Heatwave

During July and August 2022, the North West region along with much of England experienced significantly higher temperatures than previously

recorded with 36°C recorded around the Liverpool area. The Trusts Heatwave Plan at the time was going through its re-ratification process and was applied to the first Heatwave without a designated command and control team to coordinate the response to the heatwave. It was found in the debrief that had a command and control structure been in place the coordination of resources and communications with trust staff would have been more effective and had a more positive impact.

A number of additional issues were encountered across the Trusts estate including the discipline of keeping the main hospital windows closed to support its cooling system and numbers of air cooling units available to support essential and supporting areas.

Learning was captured and immediately applied to the response of second heatwave to ensure a command, control, and coordination cell was in place for the 2 day period in and out of hours. This resulted in a much better approach to the heatwave and supported the Trust through actionable decision making and provided the Strategic Commander with a greater level of assurance on the Trusts position in relation to the incident.

4. Plans for 2023 – 2024

As a part of the action plan listed in Appendix B of this document the Trust through the EPG will establish a formal Training and Exercising programme for the 2023 – 2024 period to support all areas of the organisation against their expectations as a part of any EPRR response to incidents.

In the interim of a formal Training and Exercise programme being established the Trust will undertake the following exercises to contribute to the Trusts overall resilience to disruptive events:

- Black Start – Ensuring the Trust services continue during external power failure.
- Cyber Attack – Supporting a coordinated approach of on call and IM&T in the event of a cyber incident impacting the Trust.
- Communications Cascade – To support switchboard operator competence and confidence and to update the cascade database in the event of a major incident being declared.

5. Policies, Plans, and Procedures

The Trust has library of incident response plans under the EPRR umbrella, they include:

- EPRR Policy
- On Call Manager Policy

- Major Incident Plan
- Critical Incident Plan
- Business Continuity Plan
- CBRN HazMat Plan
- Evacuation Plan
- Heatwave Plan
- Cold Weather Plan
- Fuel Shortages Plan
- Lockdown Plan
- Bomb Threats and Suspicious Packages Plan
- Pandemic Plan

6. EPRR Risk Assessment

The Trust has 1 EPRR recorded risk identified on its risk register. This is to be reviewed to incorporate risks associated with the local and national risk register and internal risks highlighted within the organisation relating to disruption, pandemic disease, utilities failure, etc.

This is to ensure the EPG has a prominent oversight of risks relating to the Trusts overall preparedness arrangements to external factors that cannot be prevented but can be prepared against.

7. Conclusion

The above report on assurance identifies and highlights a great progression in the Trusts EPRR arrangements over the previous 12 months, it creates opportunities for continuous learning and development for the remainder of 2022 leading into the 2023 – 2024 period. It reaffirms the committed approach the Trust has to its EPRR requirements.

Appendix A

Cheshire and Merseyside Local Health Resilience Partnership (LHRP) Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

Alder Hey Children's NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

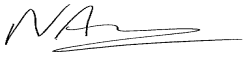
Where areas require further action, Alder Hey Children's NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Substantial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer



21/09/2022

Date signed

29/09/2022	29/09/2022	07/07/2023
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix B

Domain	Standard Name	Standard Detail	Partial Compliance Evidence & Rationale	AHCH FT Action to be taken	Lead	Timescale
Duty to Maintain Plans	Evacuation and Shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Evacuation Plan (Currently in working cycle after previous exercise).	Actions and ongoing work relating to previous exercise ongoing with internal task and finish group to support update of Evacuation plan.	EPRR Manager.	31st May 2023.
Training and Exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Training delivered against EPRR TNA and in accordance with EPRR Policy, Section 4.6 point 5, 9. Section 4.10, point 7. Section 5.1.	CPD records for all Commanders need standardising and issuing to commanders for personal CPD recording.	EPRR Manager / Education and Training Team.	28th February 2023.
	EPRR Exercising and Testing Programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Programme for 2021 -2022 concluded March 2022. Evidence of 6 monthly communications tests available. Evidence of exercise Princeps - HCID available. Evidence of exercise Black Start available. Requirement to create 23/24 training and exercising programme. Black Start Exercise scheduled for end of summer 2022. Cyber Security Exercise scheduled for winter 2022.	Creation of formal training and exercising programme aligned to EPRR Policy and TNA.	EPRR Manager.	31st January 2023.
	Responder Training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in	Maintained training records of all on-calls available.	CPD records for all Commanders need standardising and issuing to commanders for personal CPD recording.	EPRR Manager / Education and Training Team	28th February 2023.

		accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role				
Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Scope and objectives of the Trusts BCMS not clearly defined or documented within the EPRR Policy or Business Continuity Plan. Much of the work required to satisfy the standard currently being undertaken on an informal basis.	Formal BCMS to be established to support and coordinate BC programme	EPRR Manager	31st May 2023.

Domain	Standard Name	Standard Detail	Partial Compliance Evidence & Rationale	AHCH FT Action to be taken	Lead	Timescale
Evacuation and Shelter	Up to Date Plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	Plan in place tested August 2021 prior to October 2021 update.	Plan to be reviewed and updated to incorporate any additional requirements outlined in the NHS England Evacuation and Shelter Guidance v3 October 21.	EPRR Manager / Fire Officer	31st May 2023.
	Patient Movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.	Local evacuation plans in place for areas, ward departments.	Elaboration required on section 9.9 within evacuation plan and additional work required at next evacuation exercise.	EPRR Manager / Fire Officer.	31st October 2023.
	Patient Transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.	Previous exercises ended at patient transportation to on-site evacuation points. - highlighted learning captured in Exercise Jupiter.	Ongoing work relating to Exercise Jupiter relating to onward transportation and transfer	EPRR Manager / Deputy Nursing Director	31st May 2023.
	Patient Receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	Focus on evacuation and not on receiving patients, on declaration of incident from partner organisation Trust would initiate incident response plans to assess and produce capacity to support network pressures as required.	Evacuation plan designed to facilitate evacuation, less on the receiving patients. Requirements around shelter and receiving of patients requires review and include into next version of plan.	EPRR Manager / ACT Lead	31st May 2023.
	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.	The scope and requirements around community evacuation are not included within the current plan, however community is included in working group to support next plan version.	Review and inclusion of community evacuation risks and partner agencies	EPRR Manager / Communities AHP Lead	31st May 2023.

	Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.	Not formally included within current version of the plan.	Elaboration required on staff redeployment to support partner organisations, inclusion of potential support available.	EPRR Manager / Deputy Director of Nursing	31st May 2023.
	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	Not formally included within current version of the plan.	To be reviewed and included in next version of evacuation plan	EPRR Manager	31st May 2023.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 29th September 2022

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

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the Audit and Risk Committee meeting that was held on the 15th September 2022, along with the approved minutes from the Audit and Risk Committee meeting that was held on the 14th July 2022.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

The Audit & Risk Committee (ARC) is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its Terms of Reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Board Assurance Framework Policy
- Board Assurance Framework
- Update from the Risk Management Forum (RMF) including the Corporate Risk Register and Trust Risk Register Report
- Presentation on Risk Management within the Medicine Division
- Internal Audit Progress Report
- Advisory report commissioned by the Chief Digital & Information Officer (CDIO) "IT Hardware Assets Review" following the theft of a number of iPads in 2021
- Internal Audit Follow Up Report
- Terms of Reference for "Improving NHS Financial Sustainability" an audit mandated by NHSE
- Request for an internal audit of Junior Doctors governance process from the Deputy Director of Finance (DDoF)
- Clinical Audit Trust Audit Programme
- Presentation from the DDoF on the third party assurance report on the ELFS payroll service
- Emergency Planning Resilience and Response (EPRR) documents:
  - EPPR Core Standards Assessment
  - Cold Weather Plan
  - Critical Incident Plan
- Process for identifying the disposal of nil value fixed assets
- Progress against actions identified in the ARC self-assessment
- Liverpool Health Procurement proposal for raising and approving waivers

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

The Board is asked to note the Memo from the Anti-Fraud Fraud Specialist relating to the Bribery Act 2010 and the Trust Anti-Bribery Strategy.

4. Positive highlights of note

The Committee noted that the positive outcome of the audit of Consent (substantial assurance); this area was subject to a number of actions in the most recent CQC visit.

The Committee was pleased to note the high % completion of mandatory training for both Conflicts of Interest and Fraud Awareness (>95%).

The Committee noted the assessment by the EPRR Manager against the EPRR Core Standards of “substantially compliant” along with an action plan to address the areas which are not fully compliant.

The Committee was pleased to receive the advisory report commissioned by the CDIO “IT Hardware Assets Review” following the theft of a number of iPads in 2021. Whilst ARC does not usually receive such reports it requested to see this one due to the weaknesses internal controls leading to the theft. The CDIO will present an update on the agreed actions to the November ARC meeting and internal audit will report on the implementation of actions until complete.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS Foundation Trust

Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 14th July 2022**

Via Microsoft Teams

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
In Attendance:	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Ken Jones	Associate Finance Director	(KJ)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Ms E Saunders	Director of Corporate Affairs	(ES)
Item 22/23/50	Mr. J. Gray	Emergency Preparedness, Resilience and Response Manager	(JGRAY)
Apologies:	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Ms. J. Preece	Governance Manager	(JP)

22/23/43 Introductions and Apologies

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

22/23/44 Declarations of Interest

There were none to declare.

22/23/45 Minutes from the Meeting held on the 16th June 2022

Resolved:
The minutes from the meeting that took place on the 16.6.22 were agreed as an accurate record of the meeting.

22/23/46 Matters Arising and Action Log

Action 22/23/13.1: *Internal Audit Follow Up Report (Project Management Review - RL to liaise with the Development Team to see if the overdue recommendations can be implemented within the next three months with an update to be provided to the June meeting)* **–** An update will be provided during September's meeting. **ACTION TO REMAIN OPEN**

Action 22/23/36/1: *External Audit Year End Report on the Trust's Accounts for 2021/22 (Audit Differences - Provide assurance to the Board on each of the identified audit differences via the compilation of a briefing note)* – Assurance was provided to the Board during June's Trust Board meeting therefore it was agreed to close this action.
ACTION CLOSED

22/23/40.1: *Company Representatives Policy (Amend the narrative in the Quality Impact Assessment to reflect that the Audit and Risk Committee will be approving the Company Representative Policy)* – The narrative in the Quality Impact Assessment has been amended to reflect that the Audit and Risk Committee approved the Company Representative Policy. **ACTION CLOSED**

21/22/87.1: *Trust Risk Register Analysis (Conduct a piece of work to confirm that the information being reported in terms of zero/low risks by a number of areas across the Trust is correct. Divisional Leads to provide an update during January's Audit and Risk Committee*) – It was confirmed that relevant information appertaining to this action will be included in September's Trust Risk Management report. **ACTION TO REMAIN OPEN**

21/22/87.2: *Trust Risk Register Analysis (look at a governance reporting structure for the risks of services that sit under the remit of an Executive Lead rather than within a Division)* – A Corporate Services Collaborative has been established to look at providing metrics for performance monitoring that can be reviewed collectively and to conduct group work on CIP contributions. The inaugural meeting took place on the 12.7.22 and the group, which consists of the Heads of Corporate Services, has agreed three initial priorities. The Collaborative will be held to account in the same way as the Divisions and a performance review has been scheduled for the 9.9.22 with the Executive Team.

In terms of an approach going forward, the Collaborative has agreed to view priorities/hotspots via a risk lens as the risk profiles are very different across the Trust owing to the variety of services and budgets that sit under the Corporate umbrella. The Risk Management Forum will also conduct a deep dive into identified risks.

The Chair queried the process for feeding back to the Committee on this area of work. It was agreed to provide an update during September's meeting on the outcome of the Corporate Services Performance Review along with regular updates following Corporate Services Collaborative meetings. **ACTION TO REMAIN OPEN**

Action 21/22/89.1: *Update on Risk Management Process within the Division of Surgery (During the next Risk Management Forum discuss the possibility of implementing a set of best practice standards Trust wide in order to have a standard approach for risk management)* – It was felt that this action will be addressed as a result of the work that the new Associate Director of Nursing and Governance, Jackie Rooney, is conducting with the Divisions. It was agreed that an update will be provided in September.
ACTION TO REMAIN OPEN

Action 22/23/32.1: *Minutes from the Previous Meeting (share the outcome of the advisory work that was conducted by MIAA on the incident relating to the stolen iPads and report on the recommendations via the follow-up process)* – It was agreed that the Chair will contact MIAA to ask for the outcome of the advisory work to be circulated to Committee members forthwith. **ACTION TO REMAIN OPEN**

22/23/47 Board Assurance Framework (BAF) Report

The Audit and Risk Committee received an overview of the BAF as at the 31.5.22. The following points were highlighted:

- The Committee was advised that the risks on the BAF have been scrutinised by the respective Assurance Committees.
- It was reported that BAF risks 1.3 *(failure to address building defects with Project Co)* and 3.1 *(failure to fully realise the Trust's vision for the park)* have been updated and now reflect the current position. It was confirmed that risk 3.1 has been reassigned to the Chief Operating Officer, Adam Bateman and a number of the actions relating to risk 1.3 are to be re-assigned to the Senior Capital Project Manager, Jim O'Brien.
- *BAF risk 3.4 (financial environment)* – Work has commenced to include risks on the Corporate Risk Register to describe the in-year operational financial risks.
- A new risk has been incorporated on the BAF which relates to access to children's and young people's mental health (BAF risk 1.4).

John Grinnell referred to BAF risk 1.2 *(children and young people waiting beyond the national standard to access planned care and urgent care)* and queried as to whether the Trust should review the risk profile on a regular basis to see if the situation is improving/deteriorating. It was pointed out that the current issue on access remains the same but it's about the organisation starting to anticipate future risk and looking at how it is conveyed, for example, the Trust is seeing early signals that demand has surged significantly in eleven specialities and waiting lists have grown by 20%. As a result of this figures will be available at a later date which will underline the period of time that patients are waiting for key services. It was agreed that this is an area of work that will need to be progressed accordingly.

The Chair drew attention to the references relating to eating disorders in BAF risk 1.2 *(Children and young people waiting beyond the national standard to access planned care and urgent care)* that may need to be removed. It was also pointed out that the report needs updating as it is not aligned with the number of gaps that the Trust is identifying versus the actions that have been identified to address these gaps.

The Chair queried the progress that has been made with Project Co in terms of the ongoing building defects and asked as to whether a meeting has been scheduled with Project Co, to include a small number of NEDs, to discuss three main areas of concern. The Committee was advised that some of the remedial/maintenance work has been completed but the more complex issues will take longer to address. The Trust is expecting a formal proposal on the latest position from Project Co mid-August and a meeting is to be scheduled for September.

Resolved:
The Audit and Risk Committee received and noted the BAF update as at the 31.5.22.

22/23/48 Risk Management Forum (RMF) Update; including Corporate Risk Register

The Committee received an overview of the RMF that took place on the 20.6.22. The following points were highlighted:

- It was reported that June's meeting was well attended and had a high level of engagement, with risk owners providing an update on their respective risk/s .
- The Director of Strategy and Partnerships, Dani Jones, presented the work that is being undertaken to develop a Partnership Governance Framework for the Trust.

Forum members were advised of the risks that appertain to BAF risk 3.6 (*risk of partnership failures due to the robustness of partnership governance)* and the proposed measures that are to be implemented to reduce risk.

- John Grinnell thanked Erica Saunders for progressing the RMF in his absence and felt that for continuity purposes it would be beneficial for the Director of Corporate Affairs to continue in the role of the Chair of the RMF.

The Chair queried as to whether the housekeeping of risks on the risk register has been addressed, as suggested during March's RMF. It was confirmed that Jackie Rooney is liaising with the Divisions re this matter and a piece of work is taking place to ascertain as to whether there are any additional risks that need to be included on the risk register.

Corporate Risk Register

The Committee received the Corporate Risk Register (CRR) for the period from the 1.4.22 to the 31.5.22. The following points were highlighted:

- It was reported that there are a total of 25 high risks open on the CRR with five themes identified; people, access to services, major trauma, governance and medicines management.
- Three high risks have been reviewed and reduced; **1902** (*Reduced availability of ED Consultants on shift to oversee the safety of the service, including the department's response to Major Trauma cases)*, **2246** (*The 24 hour on-call Specialist Palliative Care medical advice and symptom management at end of life cannot be delivered)* , **2410** *(Risk of long waits in ED department*) and will be monitored as moderate risks going forward. Risk **2365** (*The department will not be able to provide the diagnostic support for clinical specialities across the Trust)* has been transferred from the CRR to divisional oversight
- The Committee was advised that a lengthy discussion took place on the high risks during June's RMF with good engagement, challenge and assurance in terms of evidence. A piece of work is to take place on the likelihood/description of risks as there are a large number of mitigations/actions in place and yet the risks remain static.

Resolved:
The Audit and Risk Committee noted the update from the RMF meeting that took place on the 20.6.22, and the contents of the Corporate Risk Register.

22/23/49 Trust Risk Management Report

The Audit and Risk Committee received the Trust Risk Register Report for the period from the 1.4.22 to the 31.5.22 in order to scrutinise the effectiveness of risk management in the Trust. The Committee was advised that the assurance presented in this report is a direct reflection of evidence available on the electronic Ulysses risk management system. The following points were highlighted:

- 19 additional risks have been added to the Trust's Risk Register during the reporting period, with 65% of risks remaining in the moderate category. There are 26 long standing high moderate risks that have a current score of 12 and have been on the register for twelve months or more, with all bar one having been

reviewed. It was reported that the Medical Division have the most risks at this point in time.

- The Committee was advised of the top five risk categories; clinical risk (29%), staffing (90%), IT (7%), governance and finance (7%). 14 risks were closed in the reporting period compared to 42 in the previous reporting period, of which, it was felt that further understanding of this is required. It was reported that the discrepancy in the closed risk element of the report relates to a previous piece of work that was conducted to update/tidy the risk register.
- There were 5 increased risk scores compared to 7 in the last reporting period and 4 decreased risk scores in the current reporting period.
- There are areas of concern noted in the report; **1.** an increase of risks with an overdue date in comparison to the previous reporting period for the Division of Surgery, Division of Medicine, the Academy and the Change Programme. **2.** A static position in month for risks with no agreed actions for the Division of Medicine, the Academy, Facilities and the Change Programme. **3.** There was an increase of 12 risks from 7 risks without a risk rating.
- In terms of next steps, the l Divisional Risk & Governance Leads are actively reviewing open risks with an overdue review date, risks without an action plan or risk score, and a data cleanse of risk registers is ongoing across Divisions with the support from the Corporate Governance team.

The Committee was advised that work has commenced on the 26 long standing high moderate risks, of which, one has been closed and is in the process of being updated on the Ulysses system. During the next two months the Corporate Governance team is going to support the Divisions to review their risks to ensure they are described appropriately and have a SMART Action Plan.

Risk validation meetings are taking place with the Divisions/Services and a challenge has been put forward to Medicines Management about reducing the risk ranking of the ten-fold medication errors due to the large number of mitigations in place and the likelihood of any risk happening. It was confirmed that a discussion has taken place between the Divisional Leads and Pharmacy Services to progress this.

There is to be a focus on identifying risks that haven't been included on the risk register but are known to be there, via the use and triangulation of evidence/findings from other sources. The Corporate Governance Team are also going to review the reporting timeframe for feeding data from the RMF into the Audit and Risk Committee to ensure that the information is as current and timely as possible in order to provide the required assurance to the Committee.

The Chair informed the Committee that she felt assured by the update provided and the work that is taking place to create a step change in terms of managing the Trust's Risk Register. The Chair suggested that a trend be included in future reports to show the progress that is being made with the 25 long standing high moderate risks rather than including detailed information in an appendix.

22/23/49.1 **Action: JR**

Resolved:
The Audit and Risk Committee received and noted the Trust Risk Management Report.

22/23/50 Emergency Preparedness, Resilience and Response (EPRR) Policy

The Emergency Preparedness, Resilience and Response Manager, Jacob Gray, submitted the EPRR Policy and plans to the Committee, drawing attention to the updates/high level changes that have been made to the respective documents; Escalation Plan, Heatwave Escalation Plan, Hazardous Materials, Chemicals, Biological, Radiological, Nuclear and Explosives Incident Management Plan, Business Continuity Plan and Local Business Continuity Plan Template all of which have been approved by the Emergency Preparedness Group.

Moving forward, EPRR will report into the Clinical Quality Steering Group (CQSG) who will produce a report on the outcome of the EPRR Core Standards Assessment and produce an annual assurance report which will be submitted to the Safety and Quality Assurance Committee (SQAC) (This was subsequently agreed to be reported to ARC rather than SQAC – see below).

The Chair drew attention to the length of the EPRR documents and queried the ease in which staff members are able to access information to carry out relevant actions at short notice. It was reported that this area of work is tested via Business Continuity Plan exercises, it was also pointed out that work is taking place to create an additional generic Incident Response Plan to support the slimmed down version of the next iteration of the Major Incident Plan, the Major Business Continuity Plan and the Critical Incident Plan. It was confirmed that the new generic plan will be able to be applied to all EPRR plans and help reduce documents.

The Chair informed the Committee of her remit as the NED lead for EPRR and advised that, for continuity purposes, it has been agreed that the EPRR Annual Assurance Report will be submitted to the Audit and Risk Committee for ratification, rather than SQAC.

Following discussion it was agreed that on the basis that the documents submitted are well established, have been updated in line with current guidance and have received approval from two additional committees, the Audit and Risk Committee are able to ratify the EPRR Policy and plans.

Resolved
The Audit and Risk Committee received and ratified the:

- EPRR Policy.
- Escalation Plan.
- Heatwave Escalation Plan.
- HazMat CBRNE Incident Management Plan.
- Business Continuity Plan.
- Local Business Continuity Plan Template.

22/23/51 Any Other Business

Liverpool Health Procurement Proposal

The Trust has received a proposal from Liverpool Health Procurement for the implementation of a standardised tender waiver process across the collaborative. It was agreed to include this item on September's Audit and Risk Committee agenda and share

the documentation, which the Trust has just received, with the Chair and Garth Dallas ahead of September's meeting.

22/23/51.1 **Action: KJ**

Auditor's Annual Report for Year Ended the 31.3.22

The Committee received the auditor's Annual Report for year ended the 31.3.22 and the issue of audit opinion on the Trust's financial statements for 2021/22. A brief overview of sections 4, 6,7 and 8 was provided, and it was confirmed that Ernst and Young have issued an unqualified opinion on the Trust's accounts. From a Value for Money (VFM) perspective, the auditors confirmed that the Trust has adequate VFM arrangements in place and that there were no matters to report by exception.

Erica Saunders thanked Hassan Rohimun and his team for sharing the outcome of the audit prior to the Trust laying its Annual Report and Accounts before Parliament on the 8.7.22. In addition to this, the Chair asked that her thanks be relayed to the Trust's finance team too.

Resolved:
The Audit and Risk Committee received the auditor's Annual Report for year ended the 31.3.22 and the issue of audit opinion on the Trust's financial statements for 2021/22.

2**2/23/52** **Meeting Review**

It was felt that the Committee had a good discussion on risk during the meeting and were advised of the plans that the new Associate Director of Nursing and Governance, Jackie Rooney, has to progress this area of work trust wide.

Date and Time of the Next Meeting: Thursday 15th September 2022, 2:00pm-5:00pm, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 25th July 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	Dame Jo Williams	Non-Executive Director	(JW)
	Adam Bateman	Chief Operating Officer	(AB)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Rachel Lea	Deputy Director of Finance	(RL)
In attendance:			
	Mark Flannagan	Director of Communications	(MF)
	Ian Gilbertson	Assistant Chief Digital and Information Officer	
	Ken Jones	Associate Director Financial Control & Assurance	(KJ)
	Jim O'Brien	Capital Project Manager	(JO'B)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Clare Shelley	Associate Director Operational Finance	(CS)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:			
	Catherine Kilcoyne	Deputy Director of Business Development	(CK)
	Alex Pitman	Green Programme Director	

22/23/63 Apologies:

Shalni Arora	Non-Executive Director	(SA
Nathan Askew	Chief Nursing Officer	(NA)
Graeme Dixon	Head of Building services	
John Grinnell	Director of Finance	(JG)
Melissa Swindell	Director of HR & OD	(MS)
Kate Warriner	Chief Digital & Information Officer	(KW)

22/23/64 Minutes from the meeting held on 27th June 2022
The minutes were approved as a true and accurate record.

22/23/65 Matters Arising and Action log
The Chair noted all actions for this month are included as an agenda item.

22/23/66 Declarations of Interest
There were no declarations of interest.

22/23/67 Finance Report
Month 3 Financial Position
Year to date the Trust is reporting a deficit of £0.7m which is in line with plan for Q1 as we anticipate CIP schemes to mobilise further after Q1.

Internally, the Trust would not be achieving the Elective Recovery Funding threshold due to EL value of activity compared to 19/20 (not count of activity) and Outpatient Follow Up reduction targets not being met. However, the instruction from NHSEI on ERF is to report to plan until the national position is known.

Non-pay variance to plan mainly relates to an increase and a change of paying for certain drugs in blocks. This is currently under review. There is also a separate review into understanding movements in drug costs over the last 3 years. Further analysis has also taken place with regards to the increase in medical supplies. DJW queried if the drug cost increase was due to inflation noting details would be shared following the review. AB asked if drug costs would be reviewed across the divisions.

Resolved:
RABD received and noted the M3 Finance report.

22/23/68 **2022-23 Plan**
Resolved:
RABD noted the challenging position of 2022-23 Plan with further updates to be received.

22/23/69 **Capital and Cash Update**
A draft refresh of the 5 year capital plan has been completed based upon a Hybrid of the 2022/23 plan and the internal capital plan approved by RABD in January for the years 2023/24 and beyond, whilst CDEL confirmations have not been confirmed for these years, significant pressures on CDEL is likely to remain from 23/24 onwards.

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

22/23/70 **CIP and 2023 risks**
A slide on progress to date was received. Work continues on identifying savings for the 8 sprint areas to support CIP.

Resolved:
RABD received and noted the CIP update.

22/23/71 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
JO'B highlighted:

A review into the increased costs in relation to the Neonatal project has commenced. A paper will be presented at the July Trust Board.

Weekly meetings are in place in relation to performance and delivery of the Sunflower House/Catkin project.

Resolved:
RABD received the Campus and Park update.

22/23/72 **Alder Care**
Following the Alder Care programme turning red on the Board Assurance Framework the programme has now been officially delayed. To cause minimal disruption AC would not be introduced in the winter months so a new date is to be agreed in spring 2023.

The Chair asked for the programme to be included within the Benefit realisation programme.

The Chair queried if a response has been received in relation to Meditech providing additional support, it was noted discussions were ongoing.

Resolved:
RABD noted the continued challenges around Alder Care. RABD will receive further monthly updates.

22/23/73 **Business Development**
The second opinion service is due to be launched on 1st August 2022.

AB asked for future reports to include a tracker against international revenue and support required from Alder Hey.

Resolved:
RABD noted and received the Business Development update.

22/23/74 **Month 3 Corporate Report**
Additional theatre sessions are being sourced for dentistry to provide support in reducing waiting times.

Resolved:
RABD received and noted the M3 Corporate report.

22/23/75 **Communications update**
BBC breakfast will be presenting from the Steven Gerrard garden tomorrow morning to reveal the amount raised for the Alder Hey Charity following a drum-athon from the BBC Weather presenter.

MF agreed to present an update to RABD on the Alder Hey Intranet.
Action: MF

Resolved:
RABD received and noted the communications paper.

22/23/76 **PFI Report**
Resolved:
RABD received and noted the M3 PFI report.

22/23/77 **Energy Contracts**
Resolved:
AP updated RABD on the expected 8.8% increase to energy costs for Alder Hey in October when the current contract comes to an end. RABD noted the steps in place including support from Energy brokers.

22/23/78 **Board Assurance Framework**
ES noted recent changes in escalated risks. RABD discussed risks in relation to Business Development. RL asked for future BD reports to include a tracker on the number of consultations and specialities.
Action: CK

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

22/23/79 **Any Other Business**
Ken Jones, MIAA Secondment
RL noted Ken Jones would be starting a secondment with MIAA tomorrow and wished him well.

22/23/80 **Review of Meeting**
The Chair noted challenges with cost pressures, two main concerns with increases are energy and a hormone drug that has changed to a block payment.

RABD agreed to ask for Board support to review energy costs in line with the green plan.

Date and Time of Next Meeting: Monday 22nd August 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 22nd August 2022 at 13:30, via Teams

Present:	Ian Quinlan	Non-Executive Director (Chair)	(IQ)
	John Grinnell	Director of Finance	(JG)
	Dani Jones	Director of Strategy and Partnerships	(DJ)
	Rachel Lea	Deputy Director of Finance	(RL)
	Claire Liddy	Managing Director of Innovation	
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance:			
	Mark Flannagan	Director of Communications	(MF)
	Cath Kilcoyne	Deputy Director of Business Development	
	Andy McColl	Associate Chief Operating Officer, Performance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
Agenda item:	Alex Pitman	Green Programme Director	

22/23/80 Apologies:

Adam Bateman	Chief Operating Officer	(AB)
Shalni Arora	Non-Executive Director	(SA
Nathan Askew	Chief Nursing Officer	(NA)
Graeme Dixon	Head of Building services	
Jim O'Brien	Capital Project Manager	(JO'B)
Clare Shelley	Associate Director Operational Finance	(CS)
Melissa Swindell	Director of HR & OD	(MS)

The Chair noted the meeting was not quorate, it was noted there were no items for approval.

22/23/81 Minutes from the meeting held on 25th July 2022
The minutes were approved as a true and accurate record.

22/23/82 Matters Arising and Action log
The Chair noted there were no actions for this meeting.

22/23/83 Declarations of Interest
There were no declarations of interest.

22/23/84 Finance Report
Month 4 Financial Position
RL reported an in-month trading deficit of £0.2m in July which is slightly ahead of plan. Year to date the Trust is reporting a deficit of £0.9m again largely in line with the deficit plan as we anticipate CIP schemes to mobilise further in future months.

The main drivers for the year-to-date position continue to be CIP non-delivery from earlier months of the year, continued pay and non-pay cost pressures including Junior Doctor pressures, clinical supplies, offset in part with slippage in investments and vacancies. The Chair asked for an update on the agency cap for the September RABD.
Action: RL/CS

A discussion was held on the best and worst case scenario scale by division, it was agreed this would be presented at the September RABD.
Action: RL/CS

Resolved:
RABD received and noted the M4 Finance report.

22/23/85 **2022-23 Plan**
Resolved:
RABD noted the challenging position of 2022-23 Plan with further updates to be received.

22/23/86 **Capital and Cash Update**
Capital
The Capital Programme was approved by the ICS with CDEL confirmed at £8.9m, Charity funding was also confirmed at £3m, YTD progress is maintained in line with these assumptions.

Five bids are currently lodged with NHSI, the outcome of these bids is awaited.

Cash
High-Level 5 year cash forecast was noted, significant system uncertainty remains from 2023/24 and beyond to predict accurately.

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

22/23/87 **CIP and 2023 risks**
CIP was achieved in full this 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.

CL queried an outstanding payment from Higher Education Institute partner, the finance team are continuing to work with the HEI partner to resolve this matter updates will continue to be received within the Finance report.

Resolved:
RABD received and noted the CIP update.

22/23/88 **Campus & Park update (starred item – only questions/answers will be noted)**
Park/Site Clearance
RL highlighted:
Neonatal and Urgent Care development: Cost pressures continue a cost plan is due to be presented at the September RABD.

Sunflower House/Catkin: daily meetings are being held to resolve a number of quality concerns.

Resolved:
RABD received the Campus and Park update.

22/23/89 **Alder Care**
KW highlighted from the report:

Meetings were ongoing with the Meditech team to assess the feasibility of bringing Version 2.2 into scope for delivery, recognising that priority will be given to safe deployment within planned timescales.

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.

22/23/90 **Digital Futures**
KW highlighted from the report:

Alder Hey's Digital Futures Strategy, which was launched in 2019 will be formally closed down in August. This will then pave the way for the launch of refreshed strategy entitled - 'Digital and Data Futures'.

The launch of the strategy will be facilitated by the establishment of 4 Programmes of work based around themes. Each Programme will have its own set of deliverables, established governance and will report into Digital Oversight Collaborative and Resource and Business Development committee respectively.

Resolved:
RABD noted and received the Business Development update.

22/23/91 **Innovation and Commercial Activity**
CL highlighted from the report:
There has been £15k worth of commercial income received to end July and 4 collaboration agreements in negotiation related to ongoing funded projects.

A Commercial income 5-year business plan and financial model was approved by RABD in January 2022 as part of the Innovation Strategy production.

Resolved:
RABD supported the refresh to Commercial Partnership governance that has been requested by innovation Committee.

22/23/92 **Month 4 Corporate Report**
AMc highlighted:
ED performance remains challenged with 4 hour performance at 76% in July. AMc noted low staffing levels for this month.

Median time to triage in July was 11 minutes which is positive against 15 minute target.
Resolved:
RABD received and noted the M4 Corporate report.

22/23/93 **Communications update**
Communications helped to launch an international innovative service which will enable clinicians from across the globe to access world-leading medical professionals at Alder Hey for a second opinion.

MF noted the launch of the charity appeal to support the new Neonatal Unit.

Resolved:
RABD received and noted the communications paper.

22/23/94 **PFI Report**
Resolved:

RABD received and noted the M4 PFI report.

22/23/95 **Green Plan**

Energy

AP reported on the ongoing discussions with an Energy Broker to agree contract from October 2022 onwards.

Resolved:

RABD received and noted progress to date against the Green Plan.

22/23/96 **Benefit Realisation**

Resolved:

RABD received and noted the BR report.

22/23/97 **Board Assurance Framework**

Resolved:

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

22/23/98 **Any Other Business**

No other business was reported.

22/23/99 **Review of Meeting**

The Chair noted challenges with increases to energy.

Date and Time of Next Meeting: Monday 26th September 2022, 1330, via Teams.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

29th September 2022

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	21st September 2022 – Summary 20th July 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 21st September 2022, along with the approved minutes from the 20th July 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 received. A good discussion was held, which 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 was received detailing the preparations for anticiating 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. SQAC 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 team work
- 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.

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 20th July 2022
Via Microsoft Teams

Present:	Fiona Beveridge	Non-Executive Director) -SQAC Chair	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Alfie Bass	Interim Chief Medical Officer	(Aba)
	Lisa Cooper	Director – Community & Mental Health Division	(LC)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Kerry Byrne	Non-Executive Director	(KB)
	Marianne Hamer	Director of Allied Health Professionals (AHP's)	(MH)
	Christine Hill	Pathology Manager, Safety Lead	(CH)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Melissa Swindell	Director of HR & OD	(MS)
	Dame Jo Williams	Trust Chair	(DJW)
	Jackie Rooney	Director of Quality & Governance	(JR)

In attendance:

	Carolyn Cowperthwaite	Acting Associate Chief Nurse, Division of Surgery	(CC)
	Julie Creevy	Executive Assistant (Minutes)	(JC)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jill Preece	Governance Manager	
22/23/78	David Porter	Consultant Infection & Immunology Consultant/ Sepsis Lead	(DP)
22/23/80	Rachel Greer	Associate Chief Operating Officer, Community & Mental Health Division	(RG)
	David Reilly	Associate Director of Digital Systems (IM&T)	(DR)

22/23/70 Apologies:

Adam Bateman	Chief Operating Officer	(AB)
Pauline Brown	Director of Nursing	(PB)
John Grinnell	Deputy Chief Executive	(JG)
Dani Jones	Director of Strategy	(DJ)
Beatrice Larru	Consultant, Infectious Diseases	(BL)
Phil O'Connor	Deputy Director of Nursing	(POC)
Erica Saunders	Director of Corporate Affairs	(ES)
Christopher Talbot	Safety Lead – Surgery Division	(CT)
Cathy Wardell	Associate Chief Nurse, Division of Medicine	(CW)
Kate Warriner	Chief Digital & Information Officer	(KW)

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

22/23/71 Declarations of Interest
SQAC noted that there were no items to declare.

22/23/72 Minutes of the previous meeting held on 18th May 2022 – Resolved:
Subject to Jackie Rooney, Director of Quality & Governance being added to the list of colleagues present at the last meeting, the Committee members were content to

000339 **APPROVE** the notes of the meeting held on 22nd June 2022.

22/23/73 Matters Arising and Action Log

Action Log – action log was received and updated.

Quality Improvement Progress Reports

22/23/74 Overview of reporting process from Patient Safety Board

Aba presented an overview of Patient Safety Strategy Board. The Patient Safety Strategy focusses primarily on moving patient safety away from concentrating on the investigation, to the learning from investigations, and proactively preventing incidents.

. The Patient Safety Strategy is a 3-5 year plan, although there are some issues that would be resolved earlier, i.e., the Medical Examiner and Patient Safety Specialist roles. There are 19 workstreams within the Patient Safety Strategy Board, Aba proposed that a report is provided to SQAC that details an overview of the progress made, and would be displayed in a diagram format.

Aba referred to the clinical workstreams and proposed that the intention is to provide a brief easy to read 2 page summary detailing progress and challenges to SQAC, Aba welcomed any comments with regards to the proposal.

Progress included the advertising of Patient Safety Specialist, with some interest received to date; this individual would assist in progressing the Patient Safety Strategy and would draw out themes, allow triangulation of intelligence from PALS, complaints and litigation to enable widespread learning across the organisation.

ABA passed on his personal thanks to Will Weston, Medical Services Director and Nicki Murdock, previous Medical Director who had undertaken significant work with Nathan Askew in establishing and supporting the introduction of Patient Safety Strategy Board.

FB stated that the report was commendable in terms of the clarity regarding the scope of the work, the responsibilities and the intended reporting mechanisms.

FB requested clarity regarding Safety 1 and Safety 2, NA advised that Safety 1 refers to learning retrospectively through investigation and encompasses the new PSIRF which moves from routine RCA for incidents to a more thematic review of the organisations top areas for concern, driven by data.
Safety 2 refers to focussing on what works well, and how this could be applied to other areas. NA stated that these are significant pieces of work that are particularly culturally focussed.
NA stated that the Trust is really committed to this change. FB referred to the cultural shift with regards to not undertaking a root cause analysis every time. NA advised that the national learning had shown that once the rapid review had been undertaken that the majority of the learning for the individual case becomes evident.

DJW welcomed the significant progress made to date and stated that the clarity of accountability is extremely helpful for the whole organisation.

JR advised that the Trust would also be using the Health Safety Investigation Branch Reports which would be shared through CQSG and Patient Safety Board. JR is meeting with one of the earlier adopter sites from Lancashire on 22nd July 2022, in the absence of any feedback from the centre, JR would provide feedback through to the Patient Safety Strategy Board.

000340 **Resolved** SQAC received and **NOTED** the Overview of Reporting Process for Patient Safety Strategy Board.

Resolved: SQAC RATIFIED the Patient Safety Strategy Board Terms of Reference.

Safe

22/23/75 DIPC Exception Report

SQAC received and **NOTED** the DIPC exception report. NA provided an update on the winter vaccination programme and confirmed that the Trust had received confirmation of the flu and covid booster vaccination during the Autumn/Winter period for staff. NA advised that the Trust had also been requested to lead on Covid booster vaccinations for the relevant at risk Children & Young People, which would result in increased workload. NA advised that the Trust is also looking at how the organisation could assist with the 'Catch up' for childhood immunisation programme, with regards to the ask from the Integrated Care Board, this is currently being explored.

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NA highlighted a risk with regards to the Pandemic Team, given that the Pandemic Team are currently only funded until September 2022, with the hope that the team would be disbanded, however, given the levels of Covid cases within the population, that the Pandemic Team may need to be extended and potentially increased over the upcoming winter period. NA advised that a further update would be provided within future DIPC updates.

FB expressed concerns regarding Alder Hey Childhood immunisation support request, and highlighted the need to ensure primary care wrap around support given the workload and resources involved.

KB referred to table 1 within the DIPC report and stated that this was currently displaying as on trajectory, however there are currently 9 cases of BSI within first 3 month period, given that the full year target is 19, and that this data display did not clearly flag a potential problem.
NA advised that he liaise offline with BL in order to provide feedback and advised that it would be timely to review the DIPC data which is presented to SQAC.

Resolved: NA to provide feedback to BL to ensure a review of DIPC data, and a review of how the data is presented to SQAC.

DJW queried whether colleagues had received any feedback or updates in terms of the whole system from the ICB with regards to emergency work and how it is being dealt with. ABa advised that within the Cheshire & Mersey ICB that colleagues are looking to the Trust for a solution, Alder Hey are working with Mersey Care and Primary Care regarding how to deliver Emergency care locally in the first instance, and if this is successful this could be rolled out across the ICB's, however there had been no formal update with regards to Children and Young People.

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

22/23/76 Assurance ED Activity Monthly Activity Update

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

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

22/23/77 Quarter 1 Mental Health Attendances at ED

LC presented the Quarter 1 Mental Health Attendances at ED report, key issues are detailed in the report – notably:

- On average 85% of Children & Young People who present with a mental health need at ED are referred to crisis care services.
- From the trend of attendances at the Trusts Emergency Department with mental health presentations and referrals to crisis Care. From 1st April 2021 – 31st March 2022, there had been 841 children and young people presenting with mental health needs, of which 706 were supported by the Crisis Care Service.
- For the reporting period Quarter 1, 58 (25%) of children and young people were admitted to an acute inpatient ward, which is higher than the previous quarter (19%), this was attributable to the number of Children & Young People who presented with an eating disorder that required medical admission to an acute ward.
- Of the children and young people seen in the Emergency Department with a mental health presentation in Quarter 1, 63% are open, or have previously been known to Alder Hey Specialist Mental Health Services. This is an increase compared to the previous quarter (56%).

KB referred to the 63% of children and young people that are previously known to Alder Hey in the Mental Health Services. KB was keen to understand if there was any benchmarking data - i.e., a % of people who present and are undergoing treatment at present at ED, and if there isn't whether this should be reviewed, as ideally the Trust should be looking to reduce that number of Children and Young People who are known to the Trust and present to ED.
LC advised that those children presenting at ED are usually brought into ED by police, ambulance, family members or relatives, and those patients usually present in a mental health crisis.

KB questioned whether the data could be tracked and reviewed, and requested if the data could be split to show the data identifying those patients undergoing ongoing current support, versus previously known. LC advised that she liaise with colleagues to request whether future reports could include this detail for inclusion within the next Quarterly report.

DJW referred to 63% of children and young people that are previously known to Alder Hey and alluded to the pressures on those teams who are supporting the individual children and young people. She questioned whether there are any gaps within the team, and queried whether there were appropriate resources. LC stated that this could be explored further given the continued increases in attendances.

Resolved: SQAC received and **NOTED** the Quarter 1 Mental Health Attendances at ED update and welcomed further reflections in the future Quarterly report regarding those children known to mental health services.

22/23/78 Sepsis Monitoring Plan/Update

NA presented the Sepsis Monitoring Plan, and expressed his personal thanks to David Porter for his support with regards to the Sepsis report. NA advised that over several months that Sepsis performance had been monitored against sepsis target. SQAC recognised the challenges regarding staffing and recruitment, and that these issues were being addressed. NA advised that the Sepsis focus had been reset and highlighted the importance of focus for plans for improvement going forward. NA highlighted that Sepsis aligns within the Deteriorating Patient workstream and is part of the Patient Safety Strategy, with the need to realign how, when and where Sepsis reports, ensuring SQAC have oversight.
NA stated that there is a clear plan of improvement. NA advised that the Medicine Division host the Sepsis as a workstream on behalf of the entire Trust.
NA proposed that SQAC receive a detailed Sepsis update plan/report at September 2022 meeting, with SQAC receiving quarterly Sepsis updates thereafter, this

Approach was welcomed and supported by SQAC.
FB thanked NA & DP for the extremely clear roadmap and timeline, and advised that SQAC understood the necessity for the Sepsis reset. FB welcomed any questions or comments from SQAC.
DJW expressed her thanks to NA & DP for the Sepsis monitoring plan update and queried whether the Patient Safety Strategy Group would receive monthly monitoring Sepsis updates, with SQAC receiving fewer regular updates.
DJW referred to Sepsis resources and queried whether the current resources were sufficient to enable appropriate wrap around support.
DP referred to the frequency of Sepsis reporting, and stated that he is happy to report to Patient Safety Strategy Group monthly if required until further stabilisation. DP referred to workforce and stated that currently there is adequate resource allocated. DP stated that other Paediatric Trusts do not have a dedicated Paediatric Sepsis nursing post, and that this post should be a co-ordinating role to provide oversight and is a role linking numerous streams of work.

FB referred to the Patient Safety Strategy Board and stated that the strategy aspects of sepsis would be dealt with within Patient Safety Strategy Board and SQAC would receive assurance regarding performance. FB welcomed Quarterly reporting to SQAC, and advised that SQAC would expect to receive an exception report for any unforeseen issues that required urgent review/oversight by SQAC.
NA advised that a monthly Sepsis update is included on the Patient Safety Strategy Board agenda in order to ensure appropriate monitoring and scrutiny.
FB thanked UD, DP & NA for continued support.

Resolved: SQAC received and **NOTED** the Sepsis Monitoring Plan/update, SQAC to receive quarterly Sepsis updates.

22/23/79 CCG Review of Trust's Safeguarding

LC presented the CCG Review of Trust's Safeguarding Report.
The Action plan would be monitored through the divisional board and on a quarterly basis via the Contract and Quality Review meeting (CQRM), and the quarterly safeguarding business meeting with the Designated nurses Safeguarding Children to allow progress to be monitored.

LC advised that there is a development session with the team scheduled to take place on 21st July 2022 to review the actions and a Safeguarding Assurance Group would be established. The Safeguarding Assurance Group would report into SQAC Quarterly detailing Safeguarding issues, training, education and policies and procedures, performance and activity with the finer detail currently being reviewed. LC and Associate Director of Safeguarding are the leads for the Action Plan.
Summary of key findings and recommendations had been fully reviewed by the Director Community & Mental Health Services and Associate Director for Safeguarding Children & Statutory Services who commenced in post in May 2022 and are detailed in the report.

LC advised that from her perspective the report is extremely accurate and that she is pleased to address actions required for continued improvement. LC advised that the Associate Director of Safeguarding and Statutory Services had recently commenced in post and is making a significant difference in terms of governance. LC alluded to other key appointments made to come online from now until August 2022 – including a Named Nurse for Children in Care which is a role that the Trust haven't had previously, and there will be a New Nurse for Children and Safeguarding who is due to commence in a couple of weeks.

SQAC welcomed a quarterly Safeguarding update detailing on progress against action

and assurance regarding service as part of the revised safeguarding assurance report.
000343

FB thanked LC for comprehensive update, SQAC acknowledged that there is further work to do, and welcomed quarterly updates, FB referred to the training element and advised that this would also be applicable for People & Wellbeing Committee.
KB stated that this was an outstanding report, which detailed a number of actions relevant for the wider Cheshire & Mersey System and stated that this was positive.
KB drew the attention of LC to the free form feedback in the report and requested assurance that this was also being incorporated into the action plan.
LC referred to the feedback received from the wider staff across the organisation regarding the perception of the team would be scrutinised and reviewed in detail; LC anticipated that additional issues may become evident, and that the service is ripe for change.

DJW congratulated LC for commissioning the Trust Safeguarding Review and referred to learning regarding leadership style and any relevant learning for the organisation.

LC advised that the Safeguarding arrangements within the ICB and at Place are under review at present, LC stated her preference in that the ICB review what the Safeguarding arrangement are, reviews its Statutory requirements and review what organisations are delivering.

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LC is keen for Alder Hey to influence the system regarding the Safeguarding arrangements across the wider system

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DJW alluded to NED role and support LC advised that offline discussion would be required with DJW regards to a request for support for NED to be Co-Chair of the Safeguarding Assurance Group in order to provide scrutiny.

NA echoed LC comments, and referred to the culture and having the designated roles within the organisation and referred to the importance of external scrutiny. NA referred to challenges or improvements in terms of ICB statutory duty to ensure that services are being commissioned as appropriate.

FB thanked LC for the comprehensive report, and progress made to date, and acknowledged the longevity in terms of the long term work required, SQAC agreed that engagement with key stakeholder is vital, together with the engagement across the whole Trust.

Resolved: SQAC received and **NOTED** the CCG Review of Trust's Safeguarding Report, SQAC to receive Quarterly update at September 2022 together with the Terms of Reference.

22/23/80 Safe Waiting List full action plan

RG presented the Safe Waiting List full action plan; key issues as follows:-

- RG advised that there are presently two open action plans relating to Safe Waiting List Management
- Acton plan 1 relating to the Level 2 Comprehensive Root Cause Analysis: waiting list management 52 weeks – number of completed actions – 14 of the 19 actions had been completed, 1 action is ongoing, and 4 of the 19 actions are overdue. Of the 4 actions overdue and still open, they each relate to the development of systems for EXPANSE.
- Action plan 2 relating to the Level 2 Comprehensive Root Cause Analysis - Urology outpatient incidents – aggregated review – 3 of the 8 actions had been completed, 4 actions are on trajectory and 1 action is overdue. The action that is overdue relates to a separate piece of work that has been commissioned in relation to the way in which patients are categorise on the Trust's waiting lists.

- Assurance – NHS Digital have increased the data quality score for the data waiting list which provided external assurance.

FB thanked RG for the comprehensive update which provided good assurance, and External assurance.
NA stated that there are a number of action plans across the organisation that relate to EXPANSE, resulting in actions not being able to be completed or being delayed until the implementation of expanse. NA stated it would be helpful to give some thought as to whether these actions could be included within a separate forum/action plan, NA welcomed feedback from JR.
JR advised that discussion had recently been held with KB & ES and at ARC and to wherever possible to review risks, especially the long standing risks with an aim to closing those risks and transferring to a new category, this is currently work in progress.
KB stated that she is liaising closely with JR in terms of ongoing housekeeping of risks.
NA agreed with KB's comments with regards to risks on the Risk Register and the importance of not losing the actions from RCA's, NA advised that thought is required on managing this from a governance perspective ensuring oversight.

NA advised that he discuss this further with JR on 22nd July 2022 to enable an appropriate solution.

FB stated that whilst the risk is still live and there are mitigations or a watching brief that is required to be maintained as the final solution is not in place, it is important to keep relatively close to where the risks sits until a satisfactory solution is place.

Resolved: SQAC received and **NOTED** the Safe Waiting List full action plan.
NA to liaise with JR to enable appropriate solution.

22/23/81 Transition Update

NA presented the Transition update.
NA advised that the report does not relate to those highly complex Children and Young People who require Transition.

Current review of processes had identified that all services have a Transition process in place, led by the Clinical Nurse Specialists, that support the transition of young people.
The Associate Chief Nurses had developed a reporting template that would provide greater visibility to the progress of transition within each speciality service line. There are a vast number of young people who will have definite care and be transitioned back to GP as no ongoing care is required. There are a small number of services where transition arrangements are not in place, e.g., there is no current spinal services for patients 18 years and over, and therefore these patients would remain under the care of Alder Hey.

NA advised that it is the intention to present a report to SQAC in the future detailing those Children & Young People transitioned or discharged to GP. The Transition process would provide real clarity on the stage of Transition for Children & Young People who are 14 and above.

NA referred to the challenge in terms of no routine method of capture and recording of data at present, - with a useful form on Meditech, which would be used as part of the process, the form required revision. NA advised that some of the actions in the plan have longevity, however, with experience regarding the necessary changes that the allotted time would be required. NA advised that there had been a commitment from the Divisions that by September 2022 that a stock take will be completed, against waiting lists at a service level, ensuring detailed information is captured on the reporting template.

NA advised that this is a manual process, and therefore the team are not able to produce monthly updates to SQAC.

NA passed on his personal thanks to the Divisions for ongoing support and for taking full ownership of the process going forward.

FB requested clarity from NA regarding whether the report would be shared at September or October 2022 SQAC, NA advised that the report would be presented to October 2022 SQAC.

FB stated that it was a clearly articulated plan. SQAC acknowledged the need for the longer timeframes required as in reality to capture all patients it would take a full cycle of appointments. With the aim of receiving some intelligence with monitoring and a BI process. NA anticipated that once there is a clear system fully established, this would demonstrate An appropriate programme. NA stated that he anticipated that the need for formal transition is much smaller that colleagues currently anticipate.

NA expressed his personal thanks to the Divisions for ongoing support and ownership to enable progress.

Resolved SQAC received and **NOTED** the Transition Update Report and welcomed a further quarterly Transition Update at the October 2022 meeting.

22/23/82 CQSG Key Issues Report

NA provided CQSG key issues report.
NA advised that the CQSG meeting had taken place on 12th July 2022, the meeting had been positive. NA commended the corporate and divisional teams for ongoing collaboration, with richer discussions taking place at CQSG.

- CQSG had continued to focus on Audit and NICE guidelines.
- CQSG had approved numerous policies.
- NA stated that there were no significant issues to escalate to SQAC.

KB stated that a similar approach had been taken at Audit & Risk Committee with a number of items being delegated to Risk Management Forum, this approach had worked well and ARC would receive a report from Risk Management forum.

NA advised that he welcome this approach for the September SQAC meeting, and that he would discuss offline with JR on 22nd July 2022.

Resolved: Offline discussion to take place with NA & JR on 22nd July 2022.

SQAC received and **NOTED** the CQSG verbal update. SQAC welcomed update regarding NICE at September 2022 meeting.

Resolved: SQAC received and **NOTED** the CQSG Key issues update.

Clinical Governance Effectiveness

22/23/83 Confidential Enquiries Report

JR presented the Confidential Enquiries Report key issues:

- The Trust had participated in 3 National Confidential Enquiries and 1 national service improvement programme during the reporting period – April 2021 – March 2022. Participation in the Confidential Enquiries had been reported on the Trusts Quality Account for 2021-2022.

- The last published Perinatal Mortality report was in 2019 with several recommendations noted, Alder Hey's Bereavement Policy has been updated in line with the recommendations from Snowdrop Bereavement Team.
- Suicide in Children 2021 report was shared across the Community & Mental Health Division with no specific actions for the Trust noted from the report, this had been shared at Divisional Level, the Associate Chief Nurse from Community & Mental Health Division is leading on Parity of Esteem work for the Trust and is currently reviewing and updating the Policy for Suicide and Self-Harm and any guidance, any learning from this Confidential Enquiry would be incorporated into the revised Policy

SQAC **NOTED** that the long term ventilation team had participated in a long term ventilation study, with the report being published in 2020, due to the pressures of COVID not all of the recommendations had been actioned, governance team are working with the long term ventilation team to review progress against the recommendations, long term ventilation team are also using the local ODN to plan and standardise care across the three integrated care systems across the Northwest

Next Steps-there is a new NCEPOD Confidential Enquiry on Testicular Torsion is currently in development. This has been added to the Trust Audit Plan for 2022-2023. It will be assigned to the relevant Division when it goes live.

Alder Hey Clinical lead (Dr Gavin Clearly) currently supporting NCEPOD with development of aims and methodology for Juvenile Idiopathic Arthritis NCEPOD study.

Support would commence across all divisions to improve the completion of any associated action plans resulting from Confidential Enquiries in line with agreed timeframes and compliance.

Resolved: SQAC received and **NOTED** the Confidential Enquiries Report, SQAC **NOTED** the actions to improve assurance and compliance and agreed to the level of assurance provided, SQAC agreed the level of reporting.

JR advised that the report had been shared at CQSG, report was well received, CQSG felt it was an annual report, with any updates by exception to CQSG and SQAC.

FB thanked JR for informative report, and stated that the report is extremely narrative focussed, and advised that the reporting mechanisms required clarity and tracking with regards to anticipated route detailing who is taking responsibility. JR would ensure that this is included in future reports.

Well, Led

22/23/84 Board Assurance Framework

SQAC received and **NOTED** the Board Assurance Framework.

Resolved: SQAC received and **NOTED** the Board Assurance Framework.

22/23/85 Divisional Report/Quality Metrics update

Community & Mental Health Division – LC provided key issues as follows:-

- LC referred to learning from incidents regarding patient identifiable information being sent to an external account, this forms a trust wide approach with a number of incidents reported, reminding staff how to share patient information in an appropriate manner.

- Challenges within the Division regards 1 young person who is an in-patient on Tier 4 inpatient unit, during month of May 2022 there were 76 incidents reported regarding self-harm, this had reduced in June 2022 to 27 and is part of the presentation for this young patient.
- 104% elective recovery target had been achieved.
- Was Not Brought rates remains high, and remained challenging, the division are using the predictor tool in both mental health services and in paediatrics which are the two highest areas of referrals to identify those children and young people who are likely to not attend, to enable the division to work closely with Children and Young People/families to provide support.
- Mandatory Training remained above 95%
- Return to work interviews are over 91%
- PDR compliance rates are currently 49%, LC has received assurances that all staff Band 7 and above would have a PDR booked by the end of July 2022, as this is being performance managed individually with service leads.

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

- Recovery – Divisional goal was 104%, with the division achieving this goal, as additional capacity for general paediatrics had been established.
- Was Not Brought tool,-division had aimed to below 8%, unfortunately this had increased.
- Mandatory Training – across the division is currently 92%, division continue to address non-compliance.
- Sickness absence – UD referred to long covid and stated that it would be helpful to review long covid on a Trust wide basis in order to have a unified process and policy, division currently have 2 staff members currently away with long covid.
- PDR compliance - 281 staff at band 7 are required to undertake PDR's by 30th July 2022, this is being followed up within the division.
- Achieving CIP targets had been a challenge for the division, ongoing work taking place to address, Divisional leads are meeting with services to identify areas for CIP.

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

- Division are on trajectory for elective activity, this remains a challenge for the division, the division had been tasked to over perform this year, with no plans to reduce any elective work, even during the winter surge, division acknowledge the significant challenge.
- PDR focus is ongoing, CC is positive that all Band 7/8 will have completed completed a PDR by 30th July 2022.
- Sepsis remains a challenge within the division, which is being monitored on a daily basis within the division, the division are looking to move from reviewing cases retrospectively to being more proactive. Proactive discussion take place frequently with KH, Sepsis Nurse to enable discussion on Sepsis patients, ensuring a proactive plan is in place for such patients within the division
- PALS – 100% compliance in response to PALS, with the division ensuring personal contact with parents and families with excellent feedback from families during times of distress. The division aim to continue personal contact with families going forward to provide that personal support to families.
- Audit remains a challenge for the division, division aim to meet with audit leads, and have a new forum - Audit and learning group which allows each audit lead to present and provide additional proactive support to ensure that learning is translated across the Trust.

  FB welcomed reflections over time regarding personal contact with families with regards to feedback generated.

000348 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.

Responsive

22/23/86 Policy Approval

SQAC received and **RATIFIED** the Interpreter, Translation and Accessible Information Policy

Resolved:– Interpreter, Translation and Accessible Information Policy -RATIFIED.

22/23/87 Any other business

None

22/23/88 Review the key assurances and highlight to report to the Board

Positive updates were received regarding: -

- Overview of reporting process from Patient Safety Strategy Board was received which outlined how the Patient Safety Strategy Board would operate, and detailed assurance would be provided to SQAC.
  SQAC RATIFIED the Patient Safety Strategy Board Terms of Reference.
- Assurance ED Activity Monthly update received
- DIPC Exception report was received, SQAC received an update regarding vaccination demand and the impact on Alder Hey, in addition to receiving an update regarding the demand regarding childhood immunisation support, and the direction of travel.
- SQAC received Quarter 1 Mental Health Attendances update, good discussion was held, issues raised regarding pressures within the team, and whether the organisation could learn more by focusing on some of the known patients who present to ED.
- Safe Waiting List update was received, which highlighted good progress made to date.
- Transition Update was received, which highlighted good progress made to date.
- Sepsis Monitoring Plan update was received which highlighted good progress to date.
- CCG Review of Trusts Safeguarding Report was received, SQAC acknowledged that this was an excellent report, SQAC noted the commencement of a lengthy and detailed piece of work to improve the organisation position and also to ensure greater clarity and connectivity across the ICS.
- Interpreter, Translation and Accessible Information Policy was received and RATIFIED.

21/22/89 Date and Time of Next meeting

FB thanked all for attendance and advised that there is no plan to meet on 17th August 2022. FB stated that there would be a circulation of reports during August 2022 and urged SQAC to review the circulated reports and to raise any questions as appropriate, any questions raised would be responded to as appropriate, and should a meeting need to be convened for any urgent issue this would be convened if appropriate.

Next meeting to be held on 21st September 2022 at 9.30 am

Alder Hey Children's NHS Foundation Trust

People and Wellbeing Committee
Confirmed Minutes of the last meeting held on
Via Microsoft Teams

Present:	Fiona Marston	Non-Executive Director (Chair)
	Melissa Swindell	Chief People Officer
	Adam Bateman	Chief Operating Officer
	Nathan Askew	Chief Nurse
	Erica Saunders	Director of Corporate Affairs
In attendance:	Kathryn Allsopp	Head of Operational HR
	Pauline Brown	Director of Nursing
	Clare Shelley	Associate Director of Operational Finance
	Jill Preece	Governance Manager
	Natalie Palin	Head of Transformation
	Katherine Birch	Director of the Alder Hey Academy
	Sarah Marshall	HR Business Partner, Community & Mental Health
	Fiona Beveridge	Non-Executive Director
	Jacqui Lyons-Killey	Associate Chief Nurse – Research
	Chloe Lee	Interim Associate COO - Surgery
	Neil Davies	HR Business Partner
	Kerry Turner	Trust FTSU Lead
	Rachel Greer	ACOO – Community & Mental Health
	Tracey Jordan	Executive Assistant (Minutes)
Apologies:	Dot Brannigan	Governor
	Sharon Owen	Deputy Chief People Officer
	Mark Flannagan	Director of Communications & Marketing
	Jason Taylor	Acting Associate COO – Research
	Maria Salcedo	HRBP – Surgery
	Jacqui Pointon	Associate Chief Nurse
	Maisie StJohn	Service Manager
	Jeanette Chamberlain	Staff Advice & Liaison Service Manager
	Ian Quinlan	Non-Executive Director
	Adrian Hughes	Deputy Medical Director
	Jo Potier	Associate Director of Organisational Development
	Gill Foden	HR Manager
	Julie Worthington	Clinical Systems Facilitator
	Alfie Bass	Acting Chief Medical Officer
	John Chester	Director of Research & Innovation
	Urmi Das	Director, Division of Medicine
	Lisa Cooper	Director of Community & Mental Health Services
	Claire Liddy	Managing Director, Innovation
	Rachel Hanger	Associate Chief Nurse - Surgery
	Cath Wardell	Associate Chief Nurse – Medicine
	Ayo Barley	Head of Equality, Diversity & Inclusion
	Mark Carmichael	Associate COO – Medicine
	Phil O'Connor	Deputy Director of Nursing
	Alfie Bass	Consultant Orthopaedic Surgeon

Alder Hey Children's NHS Foundation Trust

22/23/047 Declarations of Interest

Fiona Marston – (LSTM) Liverpool School of Tropical Medicine

Introductions

22/23/048 Minutes of the previous meeting held on 29th June 2022

The minutes of the last meeting were approved as an accurate record.

22/23/049 Matters Arising and Action Log

No matters arising. Action log was updated accordingly.

22/23/050 Progress Against the Internal Communications Plan

Deferred to the next meeting

22/23/051 Freedom to Speak Up

KT summarised the cases brought through FTSU for 2021/22 which were presented to Board in June 2022. This will be presented each quarter going forward to this Committee and annually the Board.

It was noted cases continue to rise following Quarter 4 opposed to the slight decrease in quarter 1 and there has been a slight increase in quarter 2. KT highlighted to the Committee that SALS continues to show improvement within Alder Hey. KT noted the numbers tend to fluctuate to some degree due to access to SALS – and confirmed all data is reviewed accordingly and displayed within the report.

In terms of the national staff survey results relating to speaking up, the trust is performing well, however we would like to continue to improve. Our FTSU Champions are a great cohort of staff who report into the monthly FTSU meetings and continue to work to make staff feel safe.

ES advised the committee that a new national FTSU policy has just been launched, and the expectation is that every NHS organisation will adopt this policy by April 2023. The intention is to introduce the local changes to the trust sooner by bringing it to this committee for approval at the next meeting. Following attendance at a recent webinar with the NGO & NHS England, the expectation is that Trust's will adopt this as a template alongside the new national policy. There is also a refection tool that will replace the current self-assessment document that was produced for the board based on a range of principles how far each organisation has embedded the principles of speaking up. It was noted that, to date, the trust have 16 champions, after starting with 27, and we will continue to work on this.

FM asked for reassurance around the rise in the SALS figures with the exception that some are in relation to Freedom to Speak Up as the numbers are increasing. MS commented, advising we need to look at the resource we currently have in SALS and

explained at the moment there is a mixture of permanent and temporary resource. MS confirmed conversations are taking place around improving in making sure we maintain the service going forward with the possibility of presenting a business case to the organisation.

FM took reflection on the points raised by KT & MS and what resources can be created and maintained with plans to anticipate a further rise in numbers. KT spoke around ideas of how we can promote routes of escalation and suggested to work on directing staff to speak with HR colleagues by making this a positive route. MS commented advising there is a variety of HR Managers / Business Partners that staff can raise concerns to but will come down to who staff feel comfortable contacting.

22/23/052 Flowers - Update

ND presented the report in relation to the requirements under the Bear/Flower legal challenges and outcomes, which ensures staff are paid in accordance with Agenda for Change Terms and Condition in relation to their annual leave and holiday pay.

ND shared with the committee the next steps, and that we were working with finance colleagues to conclude. MS formally thanked ND for his continued work around this project.

The committee noted the report and acknowledged the next steps in the process.

22/23/053 Nurse Workforce Report

PB informed the committee that the report has been circulated to all Executives / Non-Executives following the last Board Meeting.

Recruitment: Figures across the two years have been maintained and hold a really good position. Following on from the last financial year, we were able to recruit into some new and senior posts – new Director of AHPs, Marianne Hamer, has started in post and a further two Nursing Information Officers, including Peter White, and a new Associate Nurse for Advanced Practice.

PB advised vacancy rates had been below 2% in the previous financial year and highlighted there are still significant staffing pressures in year to date which are generally associated with staff availability which effected the months of November through to January. The team are nationally mandated to report on staffing levels with 90% considered acceptable for those months. During this period there were occasions when the rate dipped which estimated between 80% - 85%, but this was negated through invoking staffing levels around the amber & red categories which presented a clear escalation policy in line with the National Guidelines. PB highlighted multiple organisations who have also experienced some difficulties in relation to the same situation.

Leavers: rate had increased last year. The team continue to explore reasons for staff leaving by conducting exit interviews with HR and looking into "other" reasons.

The team have undertaken this year's round of establishment reviews and will address any gaps. Further work has been conducted in relation to the RCN standards as part of the establishment reviews. PB highlighted for noting, the RCN standards have come through within the Ockenden report this year. There are several recommendations

within the report about Staffing & Workforce – there is a comprehensive action plan in place around this and each of the actions has been assigned to a working group, which is then assigned to this Committee for oversight. PB advised that she will provide further detail on a more subsequent meeting with the relevant information applicable to PAWC and submit on a separate report.

Key achievements within the year includes the role of Pastoral Support Educator, a role specifically designed to support our overseas nurse cohort. PB highlighted other elements of support which started in May; a Senior Nurse / AHP out of hours role which conducts 4 hours through Monday - Friday and weekends designed to support the "out of hours" Team to support the Nurses on shift. This has been running for the last 3 months which is proving successful. We continue working with our newly qualified Nurses to ensure staff are supported and there is a new preceptorship and rotation programme – PB confirmed more information will follow.

PB highlighted there is a very robust workforce group chaired by NA which meets monthly and there is a comprehensive action plan currently being worked through and will be brought back in the new year for further update. It was noted that one of the main focuses from this meeting is reducing our use of temporary staffing due to the NHSP staffing usage being high and the teams are looking for ways to reduce.

PB noted there is a change in our Acuity Tool which will be moving to the Shelford Safer Nursing Care tool for children & young people.

NA commented that the trust achieved all of the one-year goals which is reflected in the report and discussed the team are very ambitious in line of the stretch targets. FM asked how the teams are linking in with EDI strategy due to an experience earlier this year where we did try to implement a process to attract more BAME applicants, but we weren't able to attract the numbers. PB advised there are several routes of entry which includes the registered nurse apprenticeship programme as well as the Nurse Associate. It was further discussed that work has been completed around processes in relation to this to help encourage all individuals to apply but there is a strict educational critera to meet in order to enter that programme.

PB highlighted the trust have the Alder Hey Nursing and Healthcare Support Worker workforce plan in place which is a 5 year plan with its main focus on compliance with regulation, education and training through all different routes. The team are currently looking at the scope of advanced and clinical academic careers through a Workforce Group chaired via NA which meets monthly.

NA expressed some concern around returning to the recruitment episode regarding our non-Caucasian workforce and shared with the committee that BAME staff within nursing has increased from 2% to 8% in the last year. AN advised that the committee is committed to this. FM asked going forward, it would be good for the committee to have sight on updates. MS confirmed this data is monitored yearly through the Workforce Race Equality Scheme Report which gets published each year. MS also highlighted this is a part of the metrics in the BAME Task Force and will continue to be as part of the EDI Steering Group going forward.

Team continued to discuss at length.

FM / NA expressed this report was well collated and formally thanked PB & Team for the work conducted around this.

22/23/054 Corporate Report Metrics (June 2022)

- **Community & Mental Health Division:**

RG presented the community and mental health division metrics highlighting the below key points by exception:

PDR compliance at the end of June was 20% for all band 7 and above staff. RG discussed that the plan to have all B7s appraised by end of July 2022 has not reached the target for various reasons, and she confirmed the team are working hard to achieve. There still some outstanding data to be inputted into the system and those areas will be followed up to highlight any gaps. RG noted, since June the figures have improved.

Mandatory Training remains 90%, which is positive. Division continues to experience challenges in some areas due to sickness and advised there has been improvement seen for those who are off on long term sick which has reduced as of June to just under 3%. Some of the remaining challenges are around staff turnover and the impact that has, including ability to recruit. RG noted that some of the challenges within the division which are different to others is due to a lot of fixed term appointments relating to projects. RG confirmed there is deep dive planned around turnover which should improve the division overall position.

ES highlighted to the Committee a newly formed Corporate Services Collaborative Group Meeting has taken place, with the next one due next week. This was set up partially in response to the previous committee discussion about corporate services, and its aim is to provide more insight and details. ES advised this enables and presents the opportunity to think more creatively about models of how we as a trust do things and with the plan to see and report back assurance.

- **Medicine Division:**

Deferred to next month due to no representation at this month's committee.

- **Research Division:**

Deferred to next month due to no representation at this month's committee.

- **Surgery Division:**

Deferred to next month due to no representation at this month's committee

- **Trust Metrics:**

MS: The latest data from PDRs has reached the 50% mark for B7 and above with the plan to look at the minimum 90% by the end of July.

Mandatory Training is looking good at present. MS noted that the L&D Team have done a significant amount of work working with the divisions, particularly around those topics that have been a struggle to deliver during COVID as they were practical based training.

The Trust is starting to see a decline in COVID sickness absence rates. Return to work compliance is 65%, and this is being closely monitored. MS advised there is continued work being carried out in in relation to turnover which has increased by 3% within the last two years. The team are now reporting detailed data on turnover at the PAW Committee. Divisions present detailed turnover information within their Performance Reviews - this meeting highlights hotspot areas of where they know there is a higher turnover and teams are working on plans for future positions and outcome.

22/23/055 Board Assurance Framework – August 2022

ES discussed there is some good pieces of assurance in relation to the strategic risks that has recently emerged. It was highlighted Mandatory Training remains high due to gaps. ES highlighted 3 risks that are of concern and advised there is a plan in place to conduct a deep dive on those that are within People & Wellbeing to identify where the gaps are. ES discussed in terms of the overall wellbeing of staff opposed to the position of speaking up and rising concerns as set out in the policy needs initial focus – this will be looked at in more detail with KT/MS over the next run of meetings to ensure this is valuable assurance for the board.

ES advised updates are made through the risk management forum in terms of some of the corporate risks

22/23/056 JCNC

Approved minutes following the last JCNC Meeting to be presented at the next meeting.

22/23/057 Any Other Business

None.

22/23/058 Review of Meeting

22/23/059 Date and Time of Next meeting
Wednesday 28th September 2022 at 2pm

Alder Hey Children's NHS Foundation Trust

Innovation Committee

Confirmed Minutes of the meeting held on **Tuesday 19th April 2022**

Via Microsoft Teams

Present:	Mrs. S. Arora	Non-Executive Director (Chair)	(SA)
	Mr. I. Hennessey	Clinical Director of Innovation	(IH)
	Mrs. C Liddy	Managing Director of Innovation	(CL)
	Mr. I. Quinlan	Non-Executive Director	(IQ)
	Mrs. L. Shepherd	Chief Executive	(LS)
In Attendance:	Prof. I. Buchan	Associate Pro Vice Chancellor for Innovation and Chair of Public Health and Clinical Informatics	(IB)
	Mr. J. Corner	Digital Salford (External Advisor)	(JC)
	Dr. J. Chester	Director of Research and Innovation	(JC)
	Mr. M. D'Abbadie	MSIF (External Advisor)	(MDA)
	Mr. M. Flannagan	Director of Communications	(MF)
	Mrs. E. Hughes	Deputy Managing Director of Innovation	(EH)
	Mrs. K. McKeown	Committee Administrator	(KMC)
	Mrs. K. Warriner	Chief Information Officer	(KW)
Observing:	Ms. F. Ashcroft	CEO of the Trust's Charity	(FA)
Apologies:	Mr. A. Bass	Acting Chief Medical Officer	(AB)
	Mr. J. Grinnell	Director of Finance/Deputy CEO	(JG)
	Ms. E. Kirkpatrick	Finance Manager	(EK)
	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)
	Ms. E. Saunders	Director of Corporate Affairs	(ES)
Item 22/23/08	Mr. I Sinha	Consultant in Respiratory	(IS)
Item 22/23/09	Mr. S. Hosny	Innovation Consultant	(SH)
Item 22/23/10	Mr. S. Hosny	Innovation Consultant	(SH)

22/23/01 Introductions and Apologies

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

22/23/02 Declarations of Interest

There were none to declared.

22/23/03 Minutes from the Meeting held on the 7th February 2022

Resolved:

The minutes from the meeting that took place on the 7th of February 2022 were agreed as an accurate record of the meeting.

22/23/04 Matters Arising and Action Log

Action 21/22/24.1: *Business Development/Strategic Partnerships Update*– The Phillips proposal related to a loan agreement for equipment for the Neonatal Unit. It was confirmed that this action has been addressed and the kit is now on site. In terms of the intellectual property(IP) position, it was reported that a patent review has been conducted and the outcome is to be submitted to John Chester and Fiona Marston.
ACTION TO REMAIN OPEN

Action 21/22/41.1: *Draft Intellectual Property Policy (Refine the draft Intellectual Property Policy based on the comments made during the meeting and submit a further version of the policy during the next Committee meeting)* – The Draft IP Policy has subsequently been approved. **ACTION CLOSED**

Action 21/22/53.2: *Draft Innovation Strategy (establish a small working group to finalise the strategy. Group to include JC/FM/SA/MF/CL/EH)* – It was confirmed that a small group came together to finalise the Innovation Strategy. **ACTION CLOSED**

22/23/05 Draft 2022/23 Innovation Operational Plan.

The Committee was provided with an overview of the Trust's draft Innovation Operational Plan for 2022/23. It was reported that the strategy's vision, mission and strategic objectives have been mapped across to form a twelve month operational plan, in accordance with the NHS Operational Planning Guidance for 2022/23. The Trust's main innovation approach will be to unleash innovation culture and talent in Alder Hey to help solve real world problems that exist in the Trust. In addition to this, when commercial opportunities arise the Trust will look to monetise them. Attention was drawn to the following activities in the plan;

- Products and solutions that are to be prioritised in 2022/23
  - Any Where Platform.
  - Version 2 of CIP Mental Health as One Project.
  - Lab to Life.
  - Intelligence Automation Abilities.
- Intensive measurement approach with lagging and leading metrics to be used to show progress and measure impact over time.

A discussion took place around the timeline and process for providing an update on the activities of the Innovation Operational Plan to the Committee. It was agreed to update the current performance report to include the sections of the Operational Plan that are being monitored, and report on a quarterly basis.

22/23/5.1 Action: EH/CL/SA

Marc D'Abbadie queried as to whether the Trust has any plans to engage with Liver Labs in terms of the funding that is available to seed and pump prime health tech innovation projects. It was confirmed that the organisation is liaising with Liver Labs about two of the Trust's projects.

Louise Shepherd felt that digital and research should be linked in rather than having a stand-alone plan, key partners need to be drawn out and clarity is required around Alder

Hey's overall role in the City's eco system. Attention was drawn to the importance of describing this information in the Innovation Operational Plan and joining it up.

Mark Flannagan queried as to whether the Innovation Operational Plan can be approved prior to the Innovation Strategy being approved. The Chair advised that the strategy has been approved in principle and there aren't going to be any changes that will affect the plan therefore it was agreed to approve the Innovation Operational Plan. It was confirmed that the Committee will review the plan on a quarterly basis and in the event there are any changes to the strategy the plan will be amended accordingly.

It was requested that the plan be a rolling one to accommodate the fast pace of innovation and also that a timeline chart be included to highlight the overlaying and integration of activities.

22/23/5.2 **Action: CL**

Resolved:
The Innovation Committee approved the 2022/23 Innovation Operational Plan and agreed to review it on a quarterly basis to ensure it remains aligned with the Innovation Strategy.

22/23/06 **Q3 Performance Report**

The Committee was provided with an update on performance for the period from January 2022 to March 2022. The following information was also shared:

- Branding and reputation;
  - Claire Liddy, Emma Hughes, Louise Shepherd, Enitan Carrol and Shalni Arora were awarded the title of Northern Power's Innovation Woman of 2022.
  - The Committee was advised that Claire Liddy is a Board member of the Liverpool City Region (LCR) Innovation Board.
- Partnership and Business Developments in Q4.
- Funding bids submitted in Q4.

Iain Buchan provided feedback on the AlderHey Anywhere platform and the Lab to Life data collection programme and specifically on some of the intellectual property risks.

Claire Liddy invited Iain Buchan to meet with the Trust's senior Data Scientist and Clinical Lead for AI to discuss the organisation's thinking around ethics, regulation and the open source nature of sharing AIs with other organisations. Iain Buchan suggested that the Trust conduct a brief presentation to the North West Clinical Prediction Group as they have a lot of experience in deriving models from data, validating them and handcrafting improvements. Iain Buchan agreed to liaise with the group on behalf of the Trust.

22/23/6.1 **Action: CL/IB**

The Chair queried as to whether this is something that the organisation needs to think about from a Digital Strategy perspective at a wider Trust level as thought needs to be given to regulations, ethics and data management once the platform is made available for external use. It was suggested that a conversation take place with Kate Warriner and the Digital Team to discuss this matter further.

22/23/6.2 **Action: CL/KW**

Resolved:
The Innovation Committee noted the Q4 Performance Report.

22/23/07 Innovation Management Accounts

The Committee received an overview of the Innovation Management Accounts for Month 12. A number of slides were shared which provided information on the following areas:

- 2021/22 provisional revenue/capital outturn.
- 2022/23 provisional revenue budget by month.
- 2022/23 provisional capital budget.
- Industry investment on a twelve month rolling basis.
- Impact measurement.
- *Next steps* - It was reported that during the next meeting an update will be provided on the profit and loss statement for the Innovation team, the capital position and impact reporting on a project basis.

Following the update a number of points were raised; **1**. If possible, have a process in place to audit savings and contributions to ensure they are only counted once. **2**. Find a way to benchmark savings. **3**. Look towards balancing the commercial impact against the spread of innovations which is about improvement in health for children and young people. **4**. Try to quantify benefits/outcomes taking into account the Trust's assumptions on commercial revenue. **5**. Having a challenging target will create additional pressure on quantifying outcomes.

Iain Buchan advised the Committee of the work that is taking place in Liverpool on mental health via the Office for Life Sciences. NHSEI, partners and industry, and felt that there are lots of opportunities for Alder Hey in terms of the long-term child and adolescent mental health interest and the immediate data intensive aspects that reach out to children and families in ways that have to be core business. Louise Shepherd reported that the Trust is keen to be a part of this endeavour that is taking place in Liverpool but pointed out that further detail is required in terms of Alder Hey's role and how it accesses the various bids. Ian Buchan concurred to be the Trust's link person in order to keep the Trust abreast of the opportunities that are taking place in Liverpool and it was agreed to discuss this matter further outside of the meeting.

22/23/7.1 Action: LS/IB

Resolved:
The Innovation Committee received and noted the Innovation Management Accounts for M12.

22/23/08 Lab to Life Child Health Data Centre – Strategic Overview.

Claire Liddy introduced the Lab to Life Data Centre presentation. It was pointed out that this concept is in its early stage and is part of the deployment of the Innovation Strategy. A number of slides were submitted to the Committee which provided information on the following areas:

- The problem statement.
- Vision and expected outputs.
- Strategic theme for 2022/24: The Right To Breathe.

- Cutting edge data science and Artificial Intelligence (AI) to drive change: From Lab to Life, From Epidemiology to Empowerment.
- Year 1 projects for addressing the 'Right to Breath.
- Dedicated unit to attract external investment.

The Committee was advised that the model that the Trust is trying to produce is about putting data into action to create interventions so that a repeatable model can be created and taken to other regions both in the UK and potentially across the globe.

Iain Buchan pointed out that are a lot of opportunities for consolidation and agility but drew attention to the importance of closing the gap between data and action without being distracted by building a parallel infrastructure. It was felt that it is important to use what is already there, for example, focus on the actions that haven't been taken after such a long time of describing the problem, and move from describing inequalities to programming equity.

Ian Sinha agreed with Iain Buchan's comments and advised that the application of data in clinic is an area that needs to be bridged. It was agreed that it would be beneficial to have a conversation about consolidation, exploiting assets that are already there and joining them together.

22/23/8.1 **Action: CL/IS/IB**

The Chair asked as to whether the Trust should review this project in terms of the next steps to look at advancing it sooner. Kate Warriner felt that Lab to Life would be a practical example of a good use case that would provide tangible evidence about children's health and would link in with the recent discussions that have been taking place with ICS colleagues. It was agreed to discuss this matter further.

22/23/8.2 **Action: IS/CL/KW**

The Chair thanked Ian Sinha for his presentation.

Resolved:
The Committee noted the contents of the Lab to Life Child Health Data Centre presentation.

22/23/09 **Draft Intellectual Property Policy**

The Committee received version 6 of the draft Intellectual Property Policy for approval. It was reported that the following amendments have been made to the policy following feedback from Committee members:

- A cover sheet has been included at the front of the policy to encourage staff to share their ideas with the Innovation Centre so that they can be progressed where possible.
- The text in the document has been reduced where appropriate and all duplications have been removed.
- The various forms of intellectual property have been defined for completeness.

It was pointed out that the policy is looking to incentivise people whilst retaining an element of control over the final product. All innovations will be reviewed by the Innovation Evaluation Panel on a case by case basis to establish what the likely contribution will be and approve the sharing of revenue/upside.

Attention was drawn to the importance of approving the document as the Trust is presently operating without a formal IP Policy. The Chair raised a query about the governance process for approving/monitoring the policy with it being a Trust wide document. Following discussion, it was agreed to submit the policy to the Resources and Business Development Committee in the first instance to look at whether there are other aspects of the Trust's operations that need to be considered prior to submitting it to the Trust Board. In terms of monitoring the policy, it was agreed that the Director of Finance will be the Executive Lead.

Resolved:
The Chair advised that following the amendments to the policy, as highlighted during the meeting, the document will be circulated to the Committee for a final review and approval. It was also agreed to submit the amended version of the policy to RABD in May for ratification.

22/23/9.1 **Action: SH**
22/23/9.2 **Action: SH**

22/23/10 **Commercial and Partnership Agreements Report, Q4**
Resolved:
The Innovation Committee received and noted the quarterly update and the contents of the Commercial Partnership Agreement schedule.

22/23/11 **Top Risks/Key Priority Areas for 2022/23 relating to the development of innovation initiatives.**
Resolved:
It was agreed to defer this item to the next committee meeting.

22/23/12 **Board Assurance Framework Update**
Resolved:
The Innovation Committee received and noted the contents of the Board Assurance Framework Report for March 2022.

22/23/13 **Innovation Committee Annual Report – 2021/22.**
The 2021/22 Innovation Committee Annual Report was approved subject to any comments received from Committee members by the 22.4.22.

22/23/14 **Innovation Committee Terms of Reference**
Resolved:
The Innovation Committee Terms of Reference were approved subject to any comments received from Committee members by the 22.4.22.

21/22/15 **Any Other Business**

There was none to discuss.

21/22/16 **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.

John Chester drew attention to the importance of Committee members receiving papers in a timely manner to enable full scrutiny of reports ahead of the meeting.

Date and Time of the Next Meeting: Monday 8th August 2022, 1:00pm-4:00pm, via Teams