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Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Thursday 6th July 2023, commencing at 11:15am

Lecture Theatre 4, Institute in the Park

AGENDA

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
STAFF STORY (11:15am-11:30am)							
1.	**23/24/75**	**11:30 (1 min)**	**Apologies.**	Chair	To note apologies.	**N**	For noting
2.	**23/24/76**	**11:31 (1 min)**	**Declarations of Interest.**	All	Board members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**23/24/77**	**11:32 (2 min)**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **8th June 2023.**	**D**	Read enclosure
4.	**23/24/78**	**11:34 (1 mins)**	**Matters Arising and Action Log; including:** • **Liverpool Trusts Joint Committee Terms of Reference (approved version).**	Chair E. Saunders	To discuss any matters arising from previous meetings and provide updates and review where appropriate. To receive the final approved version of the Terms of Reference.	**A** **N**	Read enclosure Read enclosure
5.	**23/24/79**	**11:35 (10 mins)**	**Chair/CEO's Update:** • **Trust Strategy Board Update.**	Chair/ L. Shepherd	To provide an update on key issues and discuss any queries from information items.	**N**	Verbal
Operational Issues							
6.	**23/24/80**	**11:45 (50 mins)**	• **M2 Overview.** • **M3 Flash Report.** • **Integrated Performance Report for M2, 2023/24.** • **Finance Update for M2, 2023/24.**	Executives/ Divisions	To receive the Trust's Integrated Performance Report for scrutiny and discussion**,** highlighting any critical issues. To receive an update on the current M2 position.	**A** **A**	Read report/ slides Presentation

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
7.	**23/24/81**	**12:35 (10 mins)**	**Alder Hey in the Park Campus Development Update.**	J. Halloran	To receive an update on key outstanding issues/risks and plans for mitigation.	**A**	Read report
8.	**23/24/82**	**12:45 (5 mins)**	**Resources and Business Development Committee:** - **Chair's verbal update from the meeting held on the 26.6.23.** - **Approved minute from the meeting held on the 22.5.23.**	J. Kelly	To escalate any key risks, receive updates and note the approved minutes from the 22.5.23.	**A**	Read enclosure
Lunch (12:50pm-13:10pm)							
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
9.	**23/24/83**	**13:10 (10 mins)**	**Use of Restrictive Physical Interventions Annual Report 2022/2023**	L. Cooper	For information and assurance purposes.	**N**	Read report
10.	**23/24/84**	**13:20 (10 mins)**	**DIPC Report, Q4.**	B. Larru	To receive the DIPC report for Q4.	**A**	Read report
11.	**23/24/85**	**13:30 (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
12.	**23/24/86**	**13:35 (5 mins)**	**Safety and Quality Assurance Committee:** - **Chair's Highlight Report from the meeting held on the 21.6.23** - **Approved minutes from the meeting held on the 17.5.23.**	F. Beveridge	To escalate any key risks, receive updates and note the approved minutes from the 17.5.23.	**A**	Read enclosure
The Best People Doing Their Best Work							

Alder Hey Children's NHS Foundation Trust

No.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
13.	**23/24/87**	**13:40 (10 mins)**	**People Plan Highlight Report; including:** • **EDI Update.**	S. Owen	To receive an update.	**A**	Read report
Strong Foundations (Board Assurance)							
14.	**23/24/88**	**13:50 (5 mins)**	**Revised Constitution.**	E. Saunders	To receive and approve the revised version of the Trust's Constitution.	**D**	Read report
15.	**23/24/89**	**13:55 (5 mins)**	**Board Assurance Framework Report.**	E. Saunders	To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed.	**A**	Read report
16.	**23/24/90**	**14:00 (5 mins)**	**Audit and Risk Committee:** - **Chair's Highlight Report from the meeting held on the 22.6.23** - **Approved minutes from the meeting held on the 20.4.23.**	K. Byrne	To escalate any key risks, receive updates and note the approved minutes from the 20.4.23.	**A**	Read enclosure *(to follow)*
Items for information							
17.	**23/24/91**	**14:05 (4 mins)**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
18.	**23/24/92**	**14:09 (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 7th September 2023, 11:00am, Lecture Theatre 3, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust seal wasn't used in June 2023

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Financial Metrics, M2, 2023/24	R. Lea
Trust's Constitution	E. Saunders

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Thursday 8th June 2023 at 9:00am**
At Liverpool Innovation Park

Present:	Dame Jo Williams	Chair/Non-Executive Director	(DJW)
	Mrs. S. Arora	Non-Executive Director	(SA)
	Mr. N. Askew	Chief Nurse	(NA)
	Mr. A. Bass	Chief Medical Officer	(ABASS)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof. F. Beveridge	Non-Executive Director	(FB)
	Mrs. K. Byrne	Non-Executive Director	(KB)
	Mr. G. Dallas	Non-Executive Director	(GD)
	Mr. J. Grinnell	Chief Financial Officer/Deputy CEO	(JG)
	Dr. F. Marston	Non-Executive Director	(FM)
	Ms. J. Revill	Non-Executive Director	(JR)
	Mrs. L. Shepherd	Chief Executive Officer	(LS)
In Attendance	Dr. J. Chester	Director of Research and Innovation	(JC)
	Ms. L. Cooper	Director of Community and MH Services	(LC)
	Dr. U. Das	Director of Medicine	(UD)
`	Mr. M. Flannagan	Director of Communications and Marketing	(MF)
	Mrs. D. Jones	Director of Strategyand 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)
Observing	Mr. P. Sanderson	Interim Chief Pharmacist	(PS)
Item 23/24/44	Ms. J. Deeney	Liverpool Neonatal Partnership	(JD)
Item 23/24/44	Ms. A. Bedford Russell	Liverpool Neonatal Partnership	(ABR)
Item 23.24.57	Ms. N. Palin	Assoc. Director of Transformation	(NP)
Apologies	Mr. J. Kelly	Non-Executive Director	(JK)
	Mrs. R. Lea	Deputy Director of Finance	(RL)
	Ms. B. Pettorini	Director of Surgery	(BP)
	Mrs. M. Swindell	Chief People Officer	(MS)

Patient Story

The Chair welcomed Lewis and his mum Monica who had been invited to attend June's Trust Board to talk about the sensory environment work that has been done, in association with Alder Hey, from a patient's perspective and a parent's perspective. Donna from Liverpool Parent Carers also attended Board to share feedback on behalf of other families involved in this work.

A number of slides were submitted to the Board which provided an overview of the sensory environment project and what was achieved as a result of this work. It was pointed out that parents' voices were heard as a result of working in co-production at the Focus Group that was established as part of the project.

Both Monica and Donna informed the Board that without the support and dedication from the team at Alder Hey who listened to parents, carers, children and young people, the project wouldn't be as successful as it is.

Lewis shared a poem that he wrote which gave an account of how he felt when having to attend Alder Hey for an appointment and how the noises, smells and visuals affect him from the moment he steps into the building until sometimes days later after his appointment has taken place.

Monica informed the Board that Lewis was diagnosed with sensory processing disorder in 2016 and pointed out that as parent of a child with this disorder the sensory journey begins the second a notification of an appointment is received. Monica explained the process that she goes through to reduce Lewis's sensory distress and explained how tiring mentally and emotionally a trip to Alder Hey is for both of them. This is why the sensory project is so important to so many children and young people who come to Alder Hey.

The Chair thanked Lewis, Monica and Donna for providing an insight into the sensory work that is taking place at Alder Hey and wished them all the very best for the future.

23/24/36 Welcome and Apologies

The chair welcomed everyone to the meeting and noted the apologies received. The Chair extended a welcome to the Trust's Interim Chief Pharmacist, Paul Sanderson who was observing June's Trust Board.

23/24/37 Declarations of Interest

There were none to declare.

23/24/38 Minutes of the previous meeting held on Thursday 4th May 2023
Resolved:
The minutes from the meeting held on the 4th May were agreed as an accurate record of the meeting.

23/24/39 Matters Arising and Action Log

Matter Arising

There were none to discuss.

Action Log

Action 23/24/09.3: *Operational issues (The Trust conducted a great deal of work to create a surgical space for dental care in a Hub and subsequently care for CYP was denied. The Chair agreed to raise this matter with the Integrated Care Board (ICB) –* This issue was raised at the last ICB meeting and the Trust has been advised that this matter is under review. It was confirmed that a visit to the Hub has been scheduled to discuss as to what can be progressed. **ACTION CLOSED**

23/24/40 Chair's and CEO's Update

The Chair advised of the Cheshire and Merseyside (C&M) Chairs meeting that took place on the 7.6.23 with the Chair of the Integrated Care Board, Raj Jain. It was reported that there was a focus on the acute and LDMHC collaborative working together which the ICB is supportive of.

Discussions are also taking place about the way the system is developing and how the financial fallout is effecting organisations in terms of managing money, collaboration and how they operate. The ICB recognise that it's a challenge for all. It was reported that NHSE have asked for Strategic Recovery Plans to be submitted by September 2023 but it was pointed out that activity figures are high and the funding will not be enough to address the issues being experienced. A conversation has taken place with the CEO and Medical Director of C&M about taking a strategic four stage approach to understand the rudiments of the problems, the drivers behind costs, and the options for longer term sustainability.

Attention was drawn to the importance of the system coming together to address the C&M issue. From a Board perspective it will be necessary to remain sighted on this significant strategic issue and position children and young people (CYP) to ensure resources for CYP remain together as a whole.

The Chair informed the Board that a meeting is to be scheduled with the North Regional Director at NHSE, Richard Barker to ensure the region is sighted on the work that the Trust is undertaking and to understand that the needs of CYP must not be overlooked. It was pointed out that it is necessary for the Trust to be proactive in terms of being advocates for CYP.

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

23/24/41 Vision 2030 Strategy Update

The Board was provided with assurance and oversight on the progress against the 2030 Strategy mobilisation plan. The mobilisation plan details the key milestones that will support a rapid implementation. It was reported that the overall position for the mobilisation plan is on track and progress has been sustained across all milestones. Attention was drawn to the following points:

- The Trust's approach to the establishment and remit of CYPF areas of need has progressed. It was pointed out that the effective mobilisation of the CYPF areas of need will be essential for ensuring that Alder Hey organises itself around CYPF requirements and delivers the level of change that children and families have advised that they want to see by 2030. This is a new area of focus and lays out the work that is being conducted on the mobilisation of the organisation's strategic initiatives.
- Work is taking place to develop an economic model which will be shared with the Trust Board in due course, and a suite of strategic initiatives are to be submitted during the inaugural meeting of the Strategy Board on the 6.7.23.

A conversation took place about Non-Executive Director (NED) involvement in terms of promoting the 2030 strategy and it was agreed to have a discussion facilitated by Louise Shepherd and John Grinnell to enable NEDs to publicise the strategy autonomously.

23/24/41.1 Action: LS/JG

Feedback was provided following engagement with staff and CYP and it was felt that there is genuine optimism and lots of energy/ideas about the 2030 Strategy.

Resolved:
The Board noted the progress that has been made to date in the mobilisation of the Trust's 2030 Strategy.

23/24/42 Developing a CYP Strategy for Cheshire and Merseyside.

A presentation was submitted to the Board which provided an overview of the work that is taking place to develop a CYP system and strategy for C&M. A number of slides were shared which delivered the following information:

- An explanation of the emergent of the C&M CYP System.
- CYP Sub-Committee;
  - C&M have agreed to establish a CYP Sub-Committee.
  - This will provide single oversight of CYP across C&M.
  - The Sub-Committee is to be established in Q2.
  - The CYP Sub-Committee will need to drive the CYP Strategy going forward.
- CYP System priorities;
  - Health Care Partnership Board Strategy.
  - C&M Joint 5 Year Forward Plan.
  - NHS LTP
- Proposal for the C&M Health Delivery Network and the reasons for the need of this network.
- CYP Health Delivery Network;
  - Will be accountable to the ICB CYP Board.
  - CMAST – *Diagnostics, elective, workforce, Urgent Care.*
  - LDMHC – *Access to Crisis Care, EDYS, SALT, ASD, ADHD.*
  - C&M-wide response to key drivers.
  - Best practice clinical pathways.
  - Spread and adopt new models of care and innovation.
  - Brings CYP health together to tackle growing challenges.
- Recommendations and Next Steps;
  - Board to note the developing shape of the CYP system.
  - Board to note the proposal for the Health Delivery Network.
  - Board to note alignment with the Strategy 2030 direction

Louise Shepherd and Dani Jones responded to a number of questions that were raised about the Place Delegation approach, having a common method for ASD/ADHD access/waiting times, whether there is an opportunity for the adoption of the work that has been conducted by the Trust to develop a strategy for CYP, and if there are other regions that have a CYP Strategy and Board that are in an advanced stage.

Paul Sanderson made reference to the funding for the national community of medicine and highlighted the importance of connecting with the ICB and other leads nationally regarding this matter. It was agreed to discuss this further outside of the meeting.

23/24/42.2 Action: DJ

The Chair thanked the Director of Partnership and Strategy, Dani Jones for the presentation and acknowledged that the timing is appropriate in terms of developing and progressing the Health Delivery Network.

Resolved:
The Board noted:

- The developing shape of the CYP system.
- The proposal for the Health Delivery Network.
- The alignment with the Strategy 2030 direction.

23/24/43 Draft Terms of Reference (ToR) - Liverpool Trusts Joint Committee (LTJC).

The Board received the draft Terms of Reference for the Liverpool Trusts Joint Committee for approval.

The Liverpool Clinical Services Review (LCSR) was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. The ToR set out the six recommendations from the LCSR that will form the scope of the work for the LTJC.

It was reported that the ICB has asked that the respective trusts come together to form the LTJC, which will be Chaired by David Flory, to tackle the recommendations following the conclusion of the review. The majority of the work will be addressed by the Royal Liverpool Hospital, Liverpool University Hospital NHS FT (LUFT) and other acute trusts. The Board was advised that the recommendations for the Liverpool Women's Hospital are being dealt with via an alternative board.

The Board was asked to agree the ToR in their present format but it was pointed out that in the event of any further changes a final version of the document will be submitted for approval at the next meeting.

Resolved:
The Board approved the Terms of Reference for the Liverpool Trusts Joint Committee.

23/24/44 Liverpool Neonatal Partnership (LNP) Update

The Board was provided with an overview of the risks, issues and achievements of the Liverpool Neonatal Partnership for the last six month period. Attention was drawn to the following areas:

- There have been seven key risks/issues within the LNP over the last few months. Some of these have been addressed and are in an implementation phase, while others require ongoing collaboration with teams on both sites to achieve an outcome.
- Commissioners have agreed to release funding for the next phase of staffing, which will include; consultant posts (3.5 wte), ANNPs, Matron, Band 7 and 6 nurses and AHP recruitment. An overview of staff recruitment was provided, as detailed in the report.
- The recruitment of Allied Health Professionals (AHP) has been successful and it was pointed out that the qualified speciality rate at Alder Hey is now 60%. These posts were funded by Ockendon.
- The clinical care model on 1C Neo has been developed further over the last six months, with consultants now present seven days a week. 8am-8pm, Monday to Friday and 8am-5pm, Saturday and Sunday. There will be a further increase in weekend cover with the appointment of consultants later this year. As a result of this there is capability to augment patient flow.
- The risk relating to staffing levels has been reduced from a rating of 16 to 12. This reflects the work completed around recruitment and training, and the

implementation of the escalation pathways for 1C Neo for the movement of staff. It was pointed out that the achievement on 1C is due to the input from staff.

- The LNP is working with the Chief Operating Officer, Adam Bateman and the Development team to progress the delivery of the new Neonatal Centre. Work is also taking place with support teams at Alder Hey to develop pathways collaboratively.
- The LNP is working with partners to develop clarity of data and a robust reporting system to support activity figures/data submission.
- Work is taking place to develop a clinical care model on 1C Neo. It was reported that this is an evolving model which is improving care on 1C Neo.
- The LNP team has been awarded runner up for 'Team of the Year' at the Neonatal Nurse of the Year Awards and have achieved the Green Family Integrated Care accreditation across the LNP.
- The Board was advised that Alder Hey is a breastfeeding pilot site for UNICEF. It was pointed out that breastfeeding upon discharge is above average at the Trust due to the work conducted by the organisation's nurses.

A discussion took place about strengthening relationships with colleagues on the Wirral from a partnership perspective.

On behalf of the Board the Chair thanked the LNP team for their leadership and the progress that has been made.

Resolved:
The Board noted the LNP update.

23/24/45 Integrated Performance Report, M1

Operational Issues

The Board received an update on the progress that has been made on the Trust's 2023/24 operational priorities, as detailed in the slide; **1.** Delivery of the Patient Safety Strategy. **2.** Increase people availability and wellbeing. **3.** Advance the clinical research portfolio and innovation pipeline. **4.** Handover Springfield Park to the community. **5.** Improve access to care and reduce waiting times. **6.** Financial sustainability. **7.** Safely deploy the Alder Care Programme.

It was felt that the update was extraordinary and the work that is taking place around paediatrics will put Alder Hey in a position to be a national leader. In terms of the Trust's virtual offer of urgent and emergency care it was felt that Alder Hey should receive some national recognition for the work that has been conducted.

The Board received the Integrated Performance Report (IPR) for Month 1. An update was provided on the following areas of the IPR:

- Outstanding Safety - *Safe;*
  - There has been a continued improvement in ED sepsis and a continued reduction in pressure ulcers following the work underway relating to medical devices. 90% of staff have completed level 1 patient safety training. It was confirmed that work will continue to improve compliance.

- Outstanding Safety - *Caring;*
  - There has been a continued sustained improvement in timely responses to PALS and formal complaints.
  - Friends and Family Test feedback is static as 92%. Work will continue with ED to progress this area.
  - *Nurse Workforce* – There has been an increase in green day/night shifts during the month. Attention was drawn to the month on month improvement.

- Well Led – *Risk Management*

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

- Well Led – Safe Digital System – *Digital*

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

Community and Mental Health Division

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

The Chair referred to the high Was Not Brought (WNB) rate across some areas of the Division; Community Mental Health services/ADHD service and queried as to whether this issue could be looked at via a deprivation/inequalities lens to see if there is a pattern around social circumstance. It was reported that improvement work is taking place to look at why patients attend some appointments and yet not others. Reference was also made to the WNB work that is being conducted by the Children's Hospital Alliance associated with deprivation. It was pointed out that deprivation is one of the factors of high WNB rates which is evidenced in the algorithms. Adam Bateman advised of the piece of work that is taking place to contact patients who are most at risk.

Division of Medicine

- It was reported that ED are looking to develop a virtual offer going forward.

Division of Surgery

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

Corporate

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

Resolved:
The Board received and noted the content of the IPR for Month 1.

Initial Flash Report.
Resolved:
The Board received and noted the Flash Report for May 2023.

Finance Report for M1, 2023/24

A number of slides were shared with the Board to provide the following information:

- The Trust reported a deficit of £0.5m which was in line with the planned position for April. The financial plan submitted to NHSEI on the 4th of May requires Alder Hey to achieve a surplus of £12.3m during 2023/24. This also requires delivery of a recurrent £17.7m CIP Target. Cash balance for April remained high at £83.2m.
- It was reported that there may be some recognition of industrial action in terms of funding.
- *Cost Improvement Programme (CIP);*
  - One of the key risks for the Trust is the CIP programme with £0.6m posted in M2 against a target of £1.2m. The overall gap in year is £11m.
  - A number of actions are underway to address CIP risks and Divisional finance panel meetings are to be scheduled for areas not reporting to plan and will be subject to a quarterly business review at RABD.

Resolved:
The Board noted the finance report for M1, 2022/23.

23/24/46 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* – Due to increased costs there has been a delay to the unit opening. It was confirmed that a further programme workshop has been planned to address the issues. The outcome of the workshop will be reported via RABD.
- *Sunflower House* – It was confirmed that the replacement of pipework has been completed in Sunflower House and is in progress within the Catkin Building. Water test results will continue to be monitored.
- *Park Reinstatement* – It was reported that the asbestos found in the old Catkin Building has since been removed and the programme to demolish the building has recommenced. The Board was advised that a forum for the local community took place two weeks ago with Liverpool City Council and Alder Hey in attendance. It was felt that the meeting was positive and thought is being given to scheduling monthly sessions to discuss important items as a group.

It was pointed out that the delay in the opening of the Catkin car park is creating issues for parents. David Powell agreed to look into this matter and provide an update accordingly.

23/24/46.1 Action: DP

A query was raised about the timescale for the opening of the Neonatal and Urgent Care Development. David Powell advised that confirmation will be provided once the Neonatal Workshop has taken place on the 8.6.23.

Resolved
The Board received and noted the Campus Development update provided on the 8.6.23.

23/24/47 Resources and Business Development Committee (RABD)

The approved minutes from the meeting held on the 24.4.23 were submitted to the Board for information and assurance purposes. During May's meeting the Committee had an in depth discussion on the Neonatal development.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 24.4.23.

23/24/48 Mental Health Act Annual Report for 2022/23.

The Board received the 2022/23 Mental Health Act Annual Report and was provided with assurance in respect to the activity in relation to use of the Mental Health Act (1983 & 2007) (MHA) for the reporting period from the 1.4.22 to the 31.3.23. Attention was drawn to the following points:

- During the 2022/23 reporting period, the Trust had 17 children and young people (CYP) detained under a section of the Mental Health Act. This is an increase compared to 2021/2022 when 12 CYP were detained under a section of the Mental Health Act. This is due to an increase of CYP with an eating disorder requiring detention to a Paediatric Ward for refeeding as part of their overall treatment plan. The Board was also advised of the increase in annual detentions under Section 136 of the Mental Health Act.
- Applications for Deprivation of Liberty Order Safeguards (DoLS) increased in 2022/23 to 15 compared to 14 in 2021/22.
- Mental Health Act Training compliance is at 93% for Ward 4C and 92% for ED.
- The Trust has commissioned an independent Mental Health Advocacy Service for CYP on a Paediatric Ward. For the reporting period there were 5 CYP referred for advocacy support from the Trust's Tier 4 Children's Inpatient Unit and 10 CYP referred from Ward 4C. The Advocacy Service has also provided training to Ward 4C staff on the role of advocacy and will continue to provide this on a quarterly basis.

The Chair pointed out that the report reflects a real change across the Trust.

Resolved:
The Board received and noted the content of the Mental Health Act Annual Report for 2022/23.

23/24/49 Brilliant Basics (BB) Update.

The Board received oversight of the Brilliant Basics (BB) Delivery Plan for 2023/2024 and details of the key milestones that will support the development of a culture of continuous improvement. The following points were highlighted:

- 80% of milestones are on track, 3 (20%) milestones have been rated amber and have mitigating actions in place to address the issues.
- It was reported that the Programme governance assurance is rated green in all areas and there are no risks or issues to raise to the Board.

- The Board was advised that the BB principles and approach is to be embedded into the governance structures which will support the delivery of the 2030 Vision and the Trust's strategic initiatives.
- The SharePoint site is ready to be activated and will continue to be refined based on evidence.

A query was raised as to whether there is a methodology in place to test how teams are feeling following the implementation of the BB Delivery Plan. It was reported that a piece of work is taking place in terms of liaising with teams to see what improvements have been sustained and embedded into practice. Further detail will be provided in due course.

Resolved:
The Board noted the Brilliant Basics update.

23/24/50 Serious Incident (SI) Report

The Board was provided with oversight of incidents that are considered as serious following the guidance from the NHS England Serious Incident Framework (March 2015), and associated learning for the reporting timeframe from the 1.4.23 to the 30.4.23. The following points were highlighted:

- Zero Never Events were declared during the reporting period.
- The Trust declared one StEIS incident during the reporting period; reference number 2023/7350. The Board was advised that a clinical discretion resulted in a decision to treat the respective patient with oral antibiotics for periorbital cellulitis rather than orbital cellulitis. Following the initial review it was felt that the wording in the Emergency Department (ED) handbook should be re-assessed to see where further clarity can be provided, as well as ensuring that all pathways in the handbook are readily available on all computers in the Urgent Treatment Centre (UTC) and staff are aware of how to access them.
- One SI action plan remains open but is within the expected date of completion, and one SI action plan has been completed and closed.
- Three initial Duty of Candour responses were required and completed within expected deadlines during the reporting period. It was confirmed that the Trust is fully compliant with Duty of Candour.

The Chair queried as to whether the utilisation of UTC brings with it an increased risk for Alder Hey. It was reported that a blended model is in place for the running of UTC which the Trust governs.

Resolved:
The Board received the Serious Incident report for the period from the 1.4.23 to the 30.4.23.

23/24/51 Nurse Staffing Report – 2022/23.

The Board received the Nursing Workforce Report for 2022/23 which provided assurance that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff. Attention was drawn to the following highlights:

- It was reported that the 2021-2025 Nursing and Health Care Support Worker Workforce Plan continues to be implemented and is on track.
- In the 2022/23 financial year 153.2 WTE Band 5 Registered Nurses were recruited via local, national and international campaigns. The Board was advised that this the highest number of front line nursing staff recruited since reporting in this format commenced in 2016.
- In year, nursing vacancy rates are below 2%, which is significantly lower than the national average of 10% as reported by NHSE. As of the 31.3.23, the Trust had 13.56 WTE Band 5 vacancies which are mainly aligned with PICU and Ward 4C. Staffing pressures are therefore largely due to staff availability to work due to sickness absence and maternity leave, rather than vacancies.
- The Trust received a national Pastoral Support Quality Award from Health Education England (HEE) for the outstanding support and processes in place to support international recruits. It was pointed out that only three trusts in England have achieved this prestigious accolade.
- A further successful bid has been awarded to Alder Hey by NHSE/I to continue to support the funding of the Trust's International Nursing Workforce Strategy for a further twelve months.

Reference was made to risk 2050 in Appendix 10 of the report and it was pointed out that this forecast is a small gap at the present time but the Trust may see a huge increase in dual careers/part time working from younger staff members going forward. A discussion took place about a possible opportunity for the Trust to develop an internal clinical academic structure to enable staff members to study and gain qualifications that will enable them to apply for alternative roles within the organisation.

Fiona Beveridge felt that a focussed piece of work should take place to understand how staff feel about their work life and what it is they would like to do in terms of progression. Lisa Cooper advised that a number of staff members including acute hospital colleagues have applied for roles in mental health.

Fiona Marston referred to the impact on countries as a result of international recruitment and queried as to whether there will be any changes to this area of employment from an Alder Hey perspective. It was confirmed that the Trust is in full compliance with the UK code/respective countries' code but there will be a reduction in this area of recruitment going forward. It was pointed out that international nurses are very experienced and bring great diversity but there is a need to shift reliance on oversees recruits. In overall terms the Trust's aim should be to enable nurses to gain further experience and return to their home country to use their skills.

Resolved:
The Board noted the contents of the Nurse Staffing Report for 2022/23.

23/24/52 PALS and Complaints Report, Q4.

The Board was provided with an update on performance against complaints and PALS targets in Q4. Attention was drawn to the following points:

- A further focus is required on some areas of compliance.
- There has been a vast improvement in the quality of complaint responses as a result of improvement work that has been taking place. The Trust has also seen a reduction in second stage complaints.

- The Board was advised that a review of the legibility of the report is to take place to ensure it is more readable.

The Chair queried as to whether the Trust could address complaints via a different approach rather than a traditional one going forward. It was pointed out the Trust has to adhere to regulatory compliance but work is taking place around local resolution and improving experiences.

Resolved:
The Board received and noted the PALS and Complaints Report for Q4.

23/24/53 Mortality Report, Q4

The Board received the Mortality Report for Q4 and was advised that there have been no potentially avoidable deaths during this reporting period and when reviewing all deaths there are no concerning trends.

Alder Hey has appointed two paediatric medical examiners (ME) to join the LHUFT ME team, with one already in post and the second due to commence imminently. It was reported that the Trust will spend the next year refining the ME post.

It was confirmed that information has been uploaded onto In-Phase and will be part of the information gathered via the new Patient Safety Incident and Risk Framework (PSIRF).

Resolved:
The Board received and noted the Mortality Report for Q4.

23/24/54 Safety and Quality Assurance Committee (SQAC)

The approved minutes from the meeting held on the 19.4.23 were submitted to the Board for information and assurance purposes. During May's meeting there was a focus on NICE guidelines from an assurance perspective. It was reported that after a number of months of requesting an improvement in compliance there has been an increase. A deep dive is to take place into the few areas that still need addressing but the Committee is more assured that when new guidelines arrive that they will be actioned.

The Board was advised that the Committee has moved into a new architecture for governance which will change the way reports will look and be delivered.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 19.4.23

23/24/55 People Plan Highlight Report including; EDI Update

The Board was provided with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during April and May 2023.

The Chief Medical Officer, Alfie Bass advised that planning is taking place for the third round of strike action by junior doctors. During this period the Trust will flex the system to maintain access to care for more services than previously. It was reported that the BMA has announced dates for consultant strike action and a further three days of strike action will be taken by junior doctors in July. It was pointed out that the strike action is having a profound impact on the Trust's ability to address waiting lists.

The Chief Nurse Nathan Askew advised on the outcome of the RCN and Radiography ballot and pointed out that some members have agreed to a pay deal but there are still a number of groups that are continuing to take strike action.

EDI

The Board received an overview of the key strategic and operational issues impacting the organisation in relation to Equality, Diversity and Inclusion (ED&I) during March/ April 2023. The following points were highlighted:

- It was reported that the Zero Tolerance Policy has been launched. Attention was drawn to the importance of raising the profile of the policy across the organisation and ensuring that it links into the Trust's Sickness Absence Policy.
- The Board was advised that the launch of the Reasonable Adjustments Policy was a huge success with staff members attending the day to learn more about the policy. The Trust also promoted the launch of the 'Disability and Long Term Conditions' staff network which was well received.
- Staff network chairs/deputy chairs are going to take part in the Employee Network Leadership programme delivered by Radius Training. The programme will provide information about how to run an effective staff network and influence change. In terms of the Armed Forces Network, training will be provided once a Chair has been appointed.
- It is the 75th Windrush anniversary on the 22.6.23 and it was reported that the Windrush flag is to be flown over Liverpool Town Hall. It was felt that it is important for Alder Hey to be involved in future commemorative Windrush events going forward.
- The Chair of the Race, Ethnicity and Cultural Heritage (REACH) Group is looking to have the inaugural meeting in July, but it is felt that all three groups should be launched together to raise awareness and inform staff of how they can be part of the work that is taking place around EDI.
- It was confirmed that EDI will link into the overall 2030 strategy.

Resolved:
The Board noted:

- The contents of the People Plan Highlight Report.
- The update on EDI.

23/24/56 People and Wellbeing Committee

The approved minutes from the meeting held on the 29.3.23 were submitted to the Board for information and assurance purposes. During May's meeting the Committee received a report on staff turnover which highlighted the reasons for the increase in the turnover position and the interventions that are taking place to improve the position/ increase staff availability.

Attention was also drawn to the outcome of the Equality Delivery System review that was shared with the Committee. It was found that patient access had improved and there were no areas underdeveloped. The Committee also received the Apprenticeship Policy which was discussed in depth.

Resolved:
The Board noted the update and the approved minutes from the meeting held on the 29.3.23.

23/24/57 Transformation Programme Update

The Board received an update on the Transformation Programme for Q1. It was reported that the Delivery Management Office (DMO) resource has now pivoted towards the mobilisation of the 2030 Strategy Programme and is currently managing the transitioning towards a single transformational programme for 2030. Attention was drawn to the following delivery and assurance results for Q1:

- Brilliant Basics is rated at green for governance and delivery.
- Workforce planning has been rated as amber for governance and delivery due to evidence not being available to provide assurance to demonstrate on-going management of risks and delivery progress.
- *Governance* – The remaining four programmes have been rated amber meaning that evidence was not available at the time of assessment; *Patient Safety, Alder Care, Genomics and Greener*. The Board was advised that the management of Alder Care risks is significantly high therefore there are no concerns, but all other remedial actions have been escalated to Senior Responsible Officers for their respective programme.
- It was confirmed that the DMO will be supporting the delivery of the 2030 Strategy deployment.

Kerry Byrne commended Natalie Palin for the work that has been conducted to provide the Board/Committees with a lot more assurance on the Transformation Programme.

Resolved:
The Board noted the Q1 update and approved the proposed improvements to the Governance and Assurance Framework, as detailed in section 4 of the report.

23/24/58 Board Assurance Framework Report (BAF)

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

- It was reported that the new In-Phase Risk Management System has gone live.
- The Board was advised that a BAF development session has been scheduled to take place on the 6.7.23 to look at associated risks to delivery of the 2030 strategy and think about how risks are described and assessed in this new context.

Resolved:
The Board received and noted the contents of the Board Assurance Framework report for April 2023.

23/24/59 Any Other Business

There was none to discuss.

23/24/60 Review of the Meeting

The Chair felt that the Board covered a large number of topics during June's meeting and is moving in the right direction from a strategic perspective. The Chair advised Board members not to underestimate the challenges in terms of money, strike action, higher expectations, and thanked everyone for their contributions throughout the duration of the meeting.

Date and Time of Next Meeting: Thursday the 6th July. 9:00am, LT4, Institute in the Park.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for July 2023							
4.5.23	23/24/09.2	Operational Issues	Exec Team to challenge itself to find solutions for access, performance, turnover and finances in terms of the complex issues that the Trust is experiencing, whilst ensuring there is the right oversight at Assurance Committee/Board level. Initial thoughts to be shared on this matter during June's Trust Board.	J. Grinnell	8.6.23	July-23	**1.7.23** - An update will be provided during July's Trust Board. **ACTION TO REMAIN OPEN**
4.5.23	23/24/21.1	Board Assurance Framework Report	A piece of work is to take place on the risks that fall out of the 2030 Strategy.	E. Saunders	6.7.23	On track July-23	
4.5.23	23/24/21.2	Board Assurance Framework Report	Meeting to take place between Melissa Swindell, Garth Dallas and Angie Ditchfield to discuss EDI risks from a CRR/BAF perspective.	M. Swindell	8.6.23	July-23	**1.7.23** - An update will be provided during July's Trust Board. **ACTION TO REMAIN OPEN**
8.6.23	23/24/41.1	Vision 2030 Strategy Update	Discussion facilitated by Louise Shepherd and John Grinnell to take place to enable NEDs to publicise the strategy autonomously.	J. Grinnell/ L. Shepherd	6.7.23	On track July-23	
8.6.23	23/24/41.2	Developing a CYP Strategy for Cheshire and Merseyside	Meeting to take place with Paul Sanderson re his reference to funding for the national community of medicine to discuss the importance of connecting with the ICB and other leads nationally regarding this matter.	D. Jones	6.7.23	On track July-23	
8.6.23	23/24/46.1	Alder Hey in the Park Campus Development Update	Look into the issues that are causing a delay to the opening of the Catkin car park and provide an update.	D. Powell	6.7.23	On track July-23	
Actions for September 2023							
27.10.22	22/23/176.1	Research and Innovation Committee Terms of Reference	*Alignment to RABD ToR* - RABD ToR to be submitted to the Board with the proposed amendments for alignment, following approval of the R&I TOR.	R. Lea	26.1.23	Sept-23	**19.1.23** - This item has been deferred to February's Trust Board. 29.3.23 - This item has been deferred to May's Board. **27.4.23 -** This item has been deferred to June's Board. **3.6.23 -** The ToR will be submitted to the Board in September once they have been reviewed by RABD. **ACTION TO REMAIN OPEN**
27.10.22	22/23/182.2	Board Assurance Framework Report	Look at presenting the monthly trend in section four of the Board Assurance Framework Report in a more dynamic/meaningful way.	E. Saunders	15.12.22	Jun-23	**15.12.22** - A piece of benchmarking work is taking place to ascertain a response to this request, this includes looking at the new risk management system to understand what it can produce in terms of a trend report. **29.3.23** - This action is linked to new risk system and is unchanged pending the go live of Inphase in April. **27.4.23** - The new risk system is due to go live on the 10.5.23 therefore an update will be provided in June. 1.7.23 - This action has been deferred until September **ACTION TO REMAIN OPEN**
Actions for October 2023							
27.10.22	22/23/185.1	Review of Meeting	Invite a black member of staff to present to the Board during 'Black History Month'.	K. McKeown	26.10.23	On track Oct-23	

Status	
Overdue	
On Track	
Closed	

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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Closed Actions							
24.11.22	22/23/198.1	Integrated Performance Report - Divisional Performance Update	*Division of Medicine* - Invite the Histopathology Team to April's meeting to provide an update on the work that is being undertaken by the team (post mortems and placenta work for North Wales/support for Birmingham Children's hospital, etc.)	M. Carmichael/ K. McKeown	27.4.23	Closed	29.3.23 - The Histopathology Team are to be invited to July's meeting. **1.7.23** - A member of the Histopathology has been invited to July's meeting to share detail on the teams work. **ACTION CLOSED**
30.3.23	22/23/310.1	Vision 2030 Strategy Update	*ICS Update* - For clarity purposes, provide an overview of the various bodies detailed in the ICS updates to see 1. How they interlink. 2.The impact that have they on CYP. 3. How they determine the Trust's influence.	D. Jones	30.3.23	Closed	**8.6.23** - A presentation was provided duiring June's meeting that addressed tis action. **ACTION CLOSED**
4.5.23	23/24/09.3	Operational Issues	The Trust conducted a great deal of work to create a surgical space for dental care in a Hub and subsequently care for CYP was denied. The Chair agreed to raise this matter with the ICB.	Dame Jo Williams	6.7.23	Closed	**8.6.23** - This issue was raised at the last ICB meeting and the Trust has been advised that this matter is under review. It was confirmed that a visit to the Hub has been scheduled to discuss as to what can be progressed. **ACTION CLOSED**

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	**Liverpool Trusts Joint Committee Terms of Reference – approved version**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	**Liverpool Trusts Company Secretaries**

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	• Liverpool Clinical services Review • One Liverpool Plan **Note**: a summary set of minutes will be produced on behalf of the LTJC that will allow member NHS provider trusts to share them with their Public Boards and Council of Governors.
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

Liverpool Trusts Joint Committee

Terms of Reference

Version	DRAFT 1.5
Implementation Date	16/06/2023
Review Date	December 2023
Approved By	Trust boards
Approval Date	[ ]

REVISIONS

Date	Reason for Change	Author
2 May 2023	Version 1.0 – first draft	HD
2 May 2023	Version 1.1 – second draft	HD
3 May 2023	Version 1.2 – third draft (to align with Sub-Committee TORs)	HD
3 May 2023	Version 1.3 – fourth draft	HD
12 June 2023	Version 1.4 – fifth draft – feedback from LTJC member trusts	DS
16 June 2023	Version 1.5 – comments from LTJC meeting/Approved	DS

1	Name	**Liverpool Trusts Joint Committee (LTJC)**
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); "**Chair**" means the chair of the LTJC; "**C&M MHLDC**" means the Cheshire and Merseyside Mental Health, Learning Disability & Community Collaborative; "**CMAST**" means the Cheshire and Merseyside Acute and Specialist Trusts Collaborative; "**Delegation**" means the terms of any delegation to the LTJC including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 2 and "Delegated" shall be construed accordingly;

		"**ICB**" means the NHS Cheshire and Merseyside Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated; "**LCSR**" means the Liverpool Clinical Services Review "**LCSR Recommendations**" means the six recommendations from the Liverpool Clinical Services Review which come within the scope of the LTJC, as set out in paragraph 4; "**LTJC**" means the Liverpool Trusts Joint Committee; "**LTJC Sub-Committees**" means the three sub-committees of the LTJC, being • LUHFT and TWCFT (Aintree site) • CCC and LUHFT (Royal Liverpool site) • LHCH and LUHFT (Broadgreen site) "**Member**" refers to a member of the LTJC listed in paragraph 7; "**Purpose**" the purpose of the LTJC as set out in paragraph 3; "**Trusts**" are Alder Hey Children's NHS Foundation Trust (**AHFT**); Liverpool Heart and Chest NHS Foundation Trust (**LHCH**); Liverpool University Hospital NHS Foundation Trust (**LUHFT**); Liverpool Women's NHS Foundation Trust (**LWFT**); Mersey Care NHS Foundation Trust (**MCFT**); The Clatterbridge Cancer Centre NHS Foundation Trust (**CCC)**; and The Walton Centre NHS Foundation Trust (**TWCFT**); and "**Work Plan**" means the rolling plan of work to be carried out by the LTJC over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference. All references to legislation are to that legislation as updated from time to time.
3	Purpose	The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. A diagram setting out the various governance groups and organisations involved in overseeing and implementing the recommendations from the LCSR is set out at Appendix 1. Through delivering its Work Plan (via the LTJC Sub-Committees), the LTJC will be responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six LCSR Recommendations within the scope of LTJC.

		The six LCSR Recommendations within the scope of the LTJC are as follows: • R3 - Improving outcomes and access to emergency care using existing co-adjacencies • R5 - Providing timely access to high-quality elective care through existing estates/assets • R7 - Combining expertise in clinical support services to provide consistent services (Liverpool) • R9 - Attracting and retaining talent in Health and Social Care within Liverpool City Region • R11 - Integrating digital systems to improve care delivery • R12 - Making best use of resources to secure financial sustainability for all organisations in Liverpool. Should the LTJC identify further opportunities to improve clinical services in Liverpool through collaboration, these additional workstreams will be agreed to and overseen by the LTJC as part of the Work Plan. The following principles will inform the work of the LTJC in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that clinicians are at the forefront of the development of the envisaged approach on each site, with appropriate clinical leadership from each organisation to oversee the work and facilitate involvement from the clinical community • Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Place systems, CMAST, NHS Commissioning: Specialist Services, and the C&M MHLDC • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the LTJC to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation.

		• Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders • Ensure no detriment to patients within a wider geography to Liverpool.
4	Scope	The LTJC shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The LTJC may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the LTJC's Purpose. The LTJC shall hold to account the LTJC Sub-Committees which shall be responsible for delivering elements of the Work Plan and associated priorities through delegations from the LTJC and reporting back to the LTJC, as set out in their respective terms of reference.
5	Status and legal basis	The LTJC is established by the Trusts as a joint committee pursuant to sections 65Z5 and 65Z6 of the 2006 Act in respect of those functions within its scope which are formally delegated by the Trusts to the LTJC in accordance with paragraph 6 below. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the 2006 Act. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Trusts must have regard to the guidance published by NHS England in March 2023 (and any subsequent/replacement guidance) about the exercise of these powers.
6	Decision-Making	• Decision-making by each Trust Chief Executive Member of the LTJC The Chief Executive of each Trust sits on the LTJC. Where a Chief Executive has delegated authority from their Trust to take decisions, they are able to take decisions on behalf of their Trust while sitting on the LTJC. Other members of the LTJC cannot require a Chief Executive to exercise their delegated authority in a particular way. The Trusts will work towards having consistency in the levels of delegated authority held by each of the Chief Executives when sitting on the LTJC. Where the Chief Executive does not have delegated authority from their Trust to

		take a decision which the Trusts wish to take in the LTJC (outside of the formal delegations to the LTJC) then that decision will need to be referred back to the relevant Trust board for determination unless it has been delegated to the LTJC as outlined below. • Decision-making by the LTJC as a joint committee The Trusts may formally delegate decision-making to the LTJC in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. Where functions of the Trusts have been delegated, the LTJC acts as a joint committee of the relevant Trusts. The LTJC shall make decisions by consensus of all Members, with the Chair and Chief Executive Members from each Trust seeking to make consensus decisions on behalf of their own Trust. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration.
7	Accountability	The LTJC is accountable to each Trust board.
8	Reporting arrangements	The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust's Council of Governors and that feedback from their Trust is fed through to the LTJC. The LTJC shall submit a summary of the minutes from the LTJC Chair to each Trust board meeting in public. The LTJC shall ensure that the work of the LTJC Sub-Committees is reflected in its own minutes. The LTJC shall provide regular reports on its work to the ICB. The LTJC shall provide an annual report to the Trusts and the ICB.
9	Membership	The Members of the LTJC are: • Chair of AHFT • Chief Executive of AHFT • Chair of LHCH • Chief Executive of LHCH • Chair of LWFT • Chief Executive of LWFT • Chair of LUHFT • Chief Executive of LUHFT • Chair of MCFT • Chief Executive of MCFT • Chair of CCC • Chief Executive of CCC

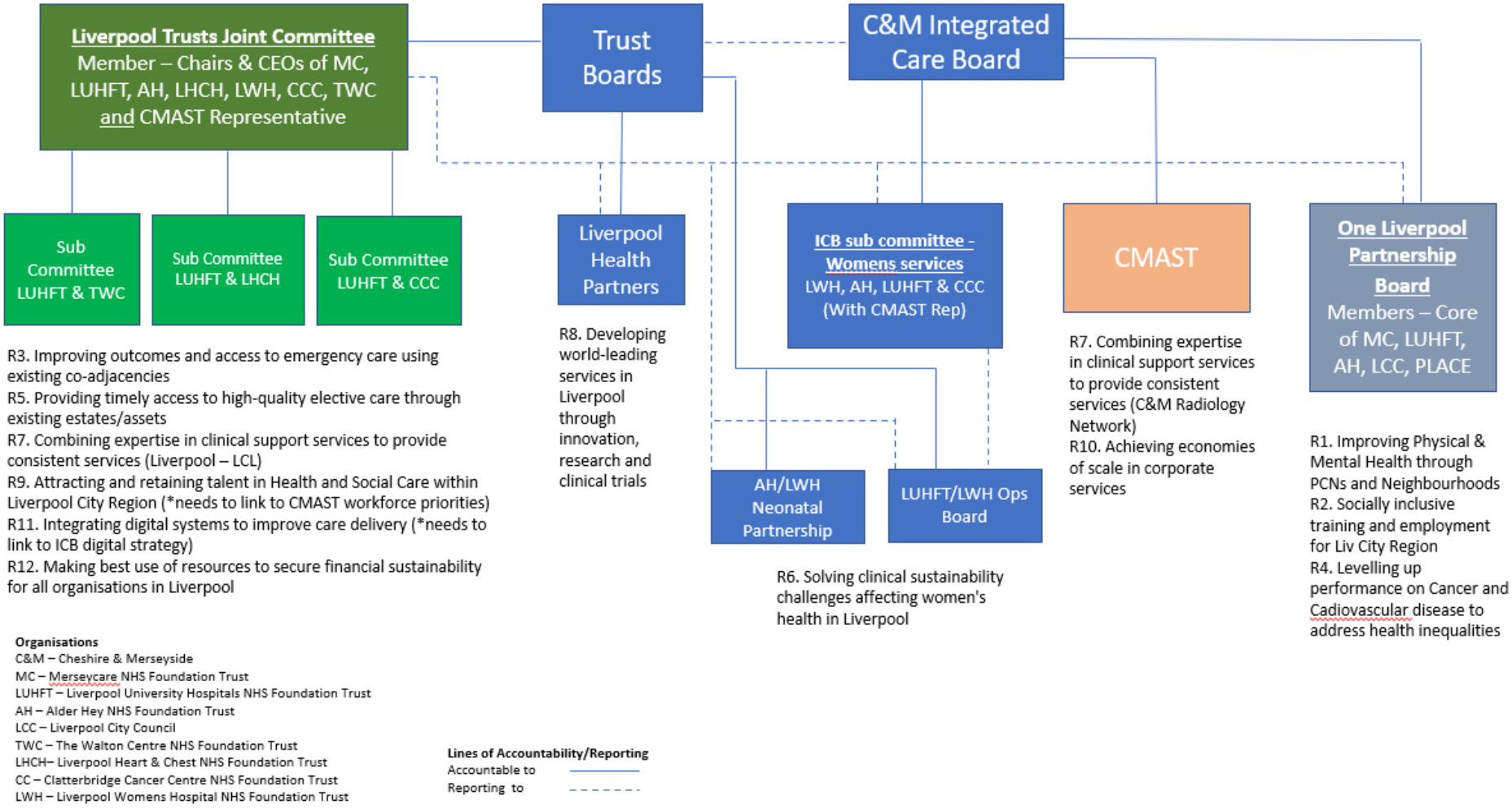
		• Chair of TWCFT • Chief Executive of TWCFT Decisions are taken by the Members as set out in paragraph 6 above.
10	Attendees	The Chair of the LTJC may invite such attendees to LTJC meetings to provide information or be involved in discussion as the Chair considers appropriate. The following shall be invited to attend every meeting of the LTJC: • Representative from CMAST A representative from C&M MH&CC may also where appropriate to the agenda be invited to attend meetings of the LTJC. The Trusts agree to make any of their officers who are involved in delivery of the Work Plan available to attend the LTJC as requested.
11	Deputies	With the permission of the Chair, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary. The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.
12	Chair	The first Chair of LTJC (the "**Chair**") shall be the Chair of LUHFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. Meetings of the LTJC will be run by the Chair. The decision of the Chair on any point regarding the conduct of the LTJC shall be final. The first Deputy Chair of LTJC shall be the Chair of LWFT who will remain in this position unless otherwise agreed by a majority of the remaining Members. If the Chair is not in attendance, then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, one Member from each Trust, or their authorised deputy, must be in attendance for the LTJC to be quorate. If any Member of the LTJC has been disqualified from participating on an item

		in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The LTJC will meet at least monthly in private. Additional meetings may take place as required by giving not less than 14 calendar days' notice in writing to all Members. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	Support to the LTJC	The Lead Officer for the LTJC is the Director of Corporate Affairs of LUHFT and is responsible for managing LTJC agendas and all governance arrangements

		for the Work Plan. The LTJC will be provided support by LUHFT. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer; • Sending out agendas and supporting papers to Members at least five working days before the meeting. • Liaising with attendees invited to LTJC meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any LTJC meeting. • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval. • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions. • Publicising LTJC meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The LTJC is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of a Trust. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the LTJC. The LTJC is authorised to commission any reports or surveys it deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The LTJC is authorised to obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary provided it ensures that full funding is available to meet the associated costs.

		The LTJC is authorised to create sub-committees or working groups as are necessary to achieve its Purpose. The LTJC is accountable for the work of any such group. The LTJC may delegate decision-making to the LTJC Sub-Committees in relation to particular projects or workstreams. Such delegations will be in accordance with the guidance given by NHS England and will be appended to the relevant Sub-Committee Terms of Reference.
18	Conduct of the LTJC	Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity. Members of the LTJC will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. The LTJC shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the LTJC to the Trusts and the ICB Board.
19	Amendments	These Terms of Reference may only be amended by resolution of each of the Trust boards. Any amendments shall only take effect upon all Trust boards agreeing the change to the Terms of Reference or on such date as all Trust boards agree, whichever is the later.
20	Review date	These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the Terms of Reference will be required to be approved by all Trust boards.

APPENDIX 1 – LIVERPOOL CLINICAL SERVICES REVIEW GOVERNANCE ORGANOGRAM



APPENDIX 2 – TEMPLATE DELEGATION

[To be determined]

Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

Flash Report -June 2023

Strategic Goals	Operational Objectives	Key Metrics	Target	Actual for June
Unrivalled Experience	Deliver our Patient Safety Strategy	Number of Incidents rated Moderate Harm and above	0	**1**
		Number of Serious Incidents (Steis reported)	0	**0**
		Number of Never Events	0	**0**
		Number of Hospital Acquired Organisms - MRSA, C.difficile, MSSA	0	**1 (MSSA)**
		FFT - % Recommending Trust	> 95%	**93%**
Supporting our Colleagues	Increase people Availability and Wellbeing	Staff Turnover	*<13%*	***13.6%***
Collaborating for CYP	Handover Springfield Park to the community	Return Springfield Park to Liverpool City Council	By Nov 2023	**On Track**
Smartest ways of Working	Improve Access to Care and Reduce Waiting Times	ED: % treated within 4 Hours	> 76%	***85.5%***
		Number of RTT Patients waiting >65weeks	0	**191**
		Number of ASD & ADHD Patients waiting >65weeks	0	**1,343**
		Elective Recovery (Vol)	> 100%	**111%**
		Diagnostic Performance	> 90%	**92.6%**
	Financial sustainability	Revenue position – Year End forecast	12.3m	**£12.3m**
	Safely Deploy Alder C@re	Alder C@re deployed	By Sept 2023	**On Track with risks**

Alder Hey Children's NHS Foundation Trust

Operational Plan Progress Summary

Published 4 July 2023

Strategic Goals	2023-24 Operational Priorities	Progress in June 2023	Areas of challenge
Unrivalled Care and Experience	**1. Deliver our Patient Safety Strategy**	• Plans in place for new born screening, pilot with NHSE as first children's trust • Parity of esteem redefined with 4 clear workstreams • Programme risks reviewed and updated	• Business case for PSI team • Some outstanding aspects of assurance, progress continues • Some challenges with reporting from InPhase following deployment
Supporting our Colleagues	**2. Increase people availability and wellbeing**	• Strategy Workshops undertaken and initial PID completed • Strong Foundations 23/24 dates published	• Recruitment timeline will impact upon delivery of plan and potential cost savings • Resource requirement discussions ongoing
Pioneering Breakthroughs	**3. Advance our clinical research portfolio and innovation pipeline**	• £3.3M award from NIHR to fund MRI scanner, additional equipment and associated building work • Agreements signed for 2 x commercial research projects – joint contract value > £250K • First UK recruit to CRESCENT study (exploring better ways to stop epileptic seizures sooner) at NIHR Alder Hey CRF	• National decline in commercial research activity • Finalising 23-24 R&I Financial Plan • Development of the research strategy
Collaborating for CYP	**4. Handover Springfield Park to our community**	• Old Catkin building has been demolished, and partial possession provided to Park contractor to make a start on the infant & junior playground • Pathway connection into Springfield Park is open • Seeded areas growing nicely • Created access for a new area for Forest School, outdoor sessions now taking place	• LCC to complete lighting connection to MUGA in July • Continued removal of excavated materials from the NE plot • Clearance of the site completed to enable Park contractor to complete drainage, soiling and seeding before end September
Smartest ways of Working	**5. Improve access to care and reduce waiting times**	• Sustained improvement in Emergency Department (ED) performance: 85% seen in 4hrs in June • Further improvement in access to diagnostic tests: 92% undertaken within 6 weeks in June	• Impact of junior doctor industrial action • Growing number of patients waiting >52 weeks in ENT. Discussions with the LNC around rate of pay and volumes of weekend work, scheduled for July. Investment case for in-sourcing submitted to RABD.

		• High levels of elective recovery: 111% in June 2023	• Significant waiting times in neuro-developmental pathways (>65wks). Pathway workshop scheduled and and investment case is with commissioners
Smartest ways of Working	**6. Financial sustainability**	• Reporting an in-month deficit of £0.5m in June (M3) and £1.5m deficit year to date (Q1). This is in line with the plan. • Industrial action is impacting on delivery of activity and incurring additional costs with a risk to the plan in Q2. • Financial assessment underway on strategic initiatives to quantify savings. • Improved CIP identified to 58% in year.	• New expenditure controls released from C&M which all trusts must implement. • IYE CIP improvement however risk on recurrent with less than 30% identified. • Ongoing initial action, risk to delivery of plan in Q2.
Smartest ways of Working	**7. Safely deploy Alder C@re**	• Training ready to start 03/07/2023 • Number of Priority 1 issues reduced from 12 to 5 • Core build now at 96% • Detailed cutover plans in development	• Increase in booking for training required (48%) • Reporting workstream in exception with recovery options in progress

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

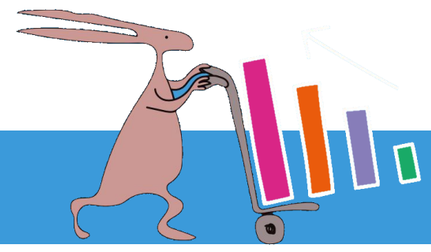
Paper Title:	**Integrated Performance Report (May 2023)**
Report of:	**Executive Leads/Divisional Leads**
Paper Prepared by:	Deputy Head of Information

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

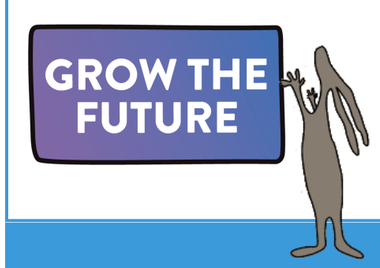
NHS
Alder Hey Children's
NHS Foundation Trust

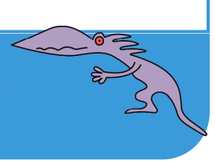
Integrated Performance Report

Published: June 2023



Contents





Alder Hey Children's NHS Foundation Trust

Icon Definitions

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

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

XmR chart

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

Process limits

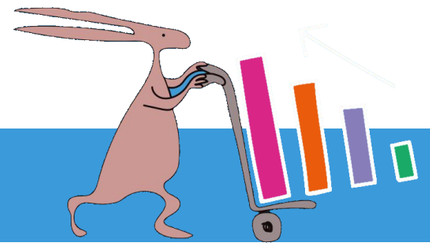
In a stable process, over 99% of data points are expected to lie between the process limits. For reporting, the upper and lower process limit values are usually given as the range of expected values going forward.

Special cause variation & common cause variation

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

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

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



IPR Summary

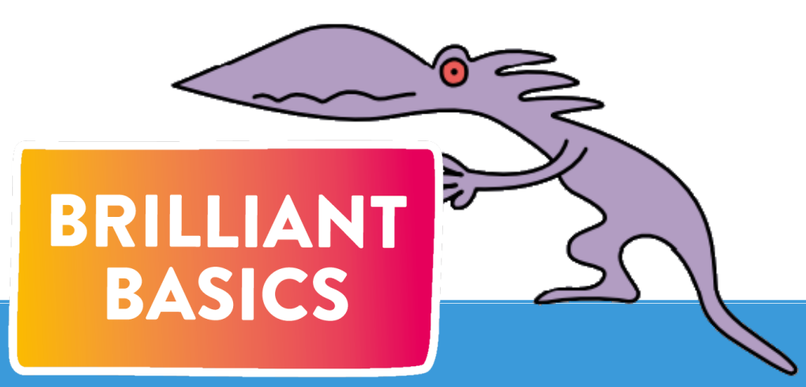
The matrix below provides a summary of performance metrics presented in the Integrated Performance Report. The matrix highlights headlines from the IPR against the Assurance and Variation icons.

		Assurance		
		Achieving Target	Inconsistently Achieving Target	Not Achieving Target
Variation	Special Cause - Improvement	Cancer 2 week referrals demonstrates performance is consistently achieving target with an improving trend	Level 1 patient safety training, PALS resolved within 5 days and ED Sepsis are inconsistently achieving target with an improving trend	Medical Appraisals, Diagnostics, Recovery for Outpatient New & Procedures and AlderCare metrics, are not achieving targets but demonstrating improvement
	Common Cause	Cancer and Overall Financial position metrics are consistently achieving targets	Level of Harm, IP Sepsis, Recovery and ED performance, WNB metrics are inconsistently achieving target and are yet to evidence statistical improvement	F&F recommend the trust & ED, Theatre Utilisation, Clinic Letters completed, Medical Appraisal and LTS are not achieving targets and are yet to evidence statistical improvement
	Special Cause - Concern		Serious Incidents	>65 Wk waits (RTT & ASD/ADHD), Staff Turnover, CAMHS >52 week waits and Oral Health wait metrics are not achieving targets with a declining trend

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

- 11.8% of our metrics are consistently achieving target
- 54.9% of our metrics are inconsistently achieving target
- We are not achieving the target for 33.3% of our metrics but experiencing improvement in 6 of these metrics.

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



Unrivalled Experience - Safety

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

Highlights:

• Decrease in the number of pressure ulcers and zero Category 3 or Category 4 pressure ulcers • Zero hospital acquired infections reported • 95% of inpatients received antibiotics within 60 minutes in line with the sepsis pathway • Over 90% of staff have attended Level 1 Patient Safety training

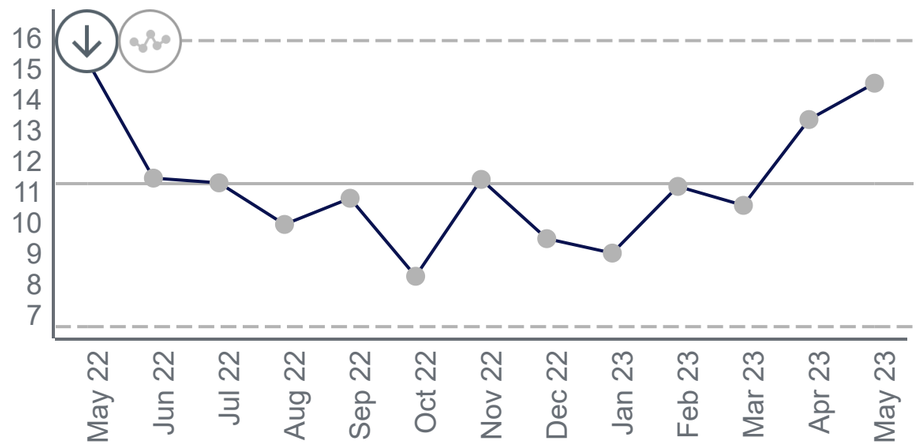
Areas of Concern:

• One serious incident reported; all regulatory requirements met inclusive of Duty of Candour, 72 hour rapid review and submission to Steis. Level 2 RCA commenced • Time to admister antibiotics in ED for sepsis

Forward Look (with actions)

• Targeted work is underway to improve antibiotic administration time for sepsis in ED: • Immediate implementation of the missed sepsis pathway review so that team can learn from individual incidents. The review will be undertaken by senior ED clinician rather than the sepsis nurse to facilitate ownership of the actions identified in the reviews • Refresh to improve documentation for example what time IV access is sited to enable accurate timeline in reviews • Several CQUINs agreed for 2023/24 which relate to safety metrics which will be monitored through Divisional Governance structures and SQAC: Pressure ulcer & Phvsical restrictive intervention

Incidents of harm per 1,000 bed days (rated Minor harm and above)



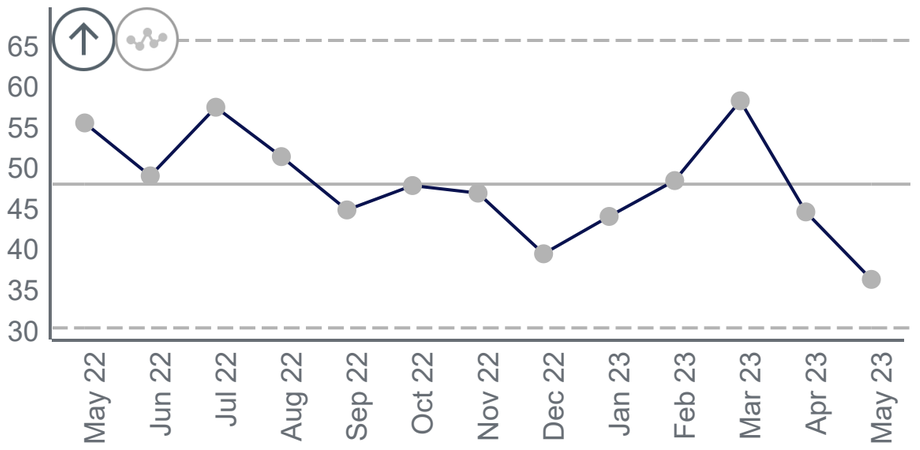
Technical Analysis:

Common cause variation has been observed with a 12 month average of 11 incidents per 1000 bed days. InPhase for incident reporting launched 2nd May 2023, rates currently assessed on Physical Harm only.

Actions:

The Trust continues to encourage incident reporting and an open and transparent approach. High attendance at the weekly Patient Safety Meeting. Implementation of PSIRF continues

Number of Incidents rated No Harm and Near Miss per 1,000 bed days



Technical Analysis:

Common cause variation has been observed with a 12 month average of 48 incidents per 1000 bed days. InPhase for incident reporting launched 2nd May 2023, rates currently assessed on Physical Harm only. Reduction of incidents occurred with 315 incidents in May compared to 363 in April and 503 in March.

Actions:

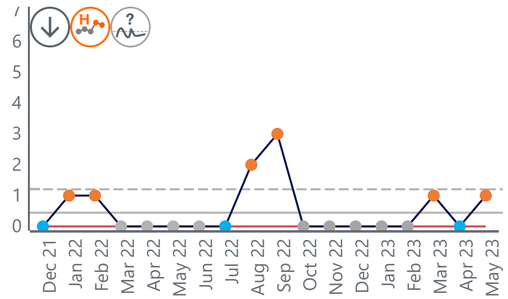
The Trust continues to encourage incident reporting and an open and transparent approach. High attendance at the weekly Patient Safety Meeting. Implementation of PSIRF continues

Integrated Performance Report | June 2023

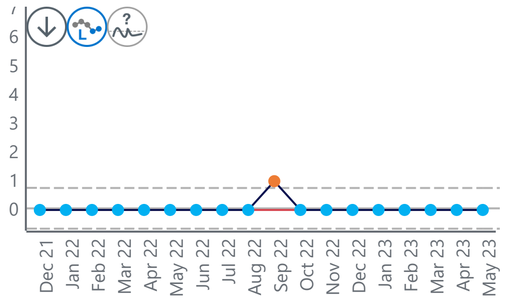
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Safety - Watch Metrics

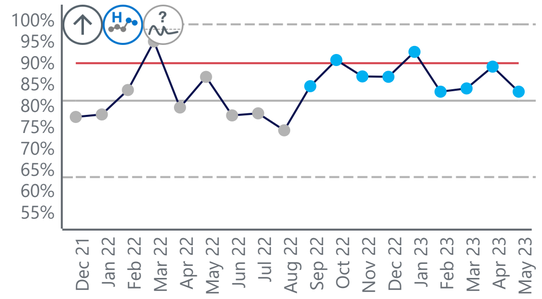
Number of Serious Incidents (Steis reported)



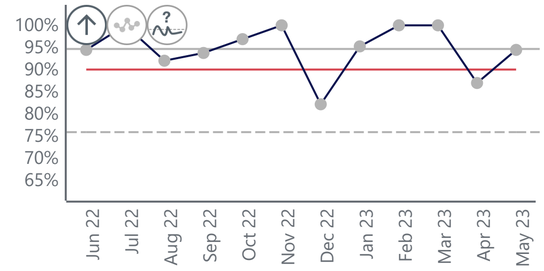
Number of Never Events



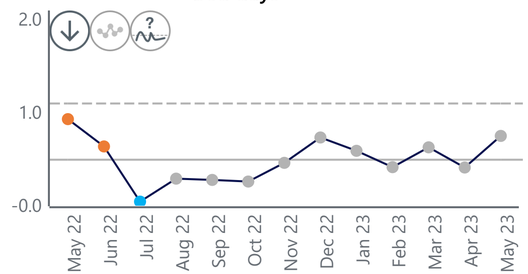
Sepsis % Patients receiving antibiotic within 60 mins for ED



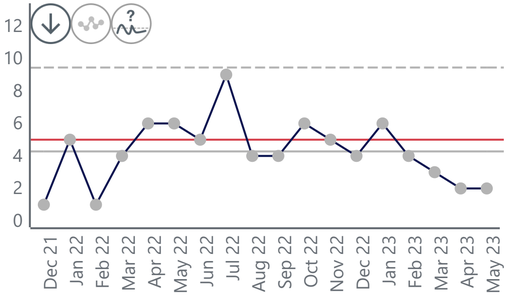
Sepsis % Patients receiving antibiotic within 60 mins for Inpatients



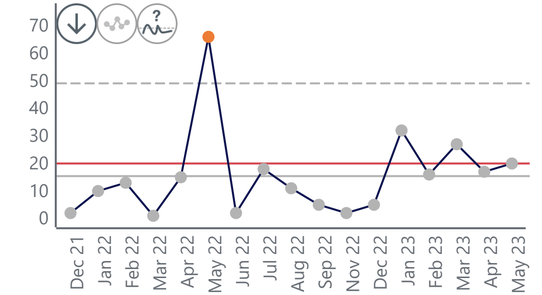
Medication Errors rated Minor harm and above per 1,000 bed days



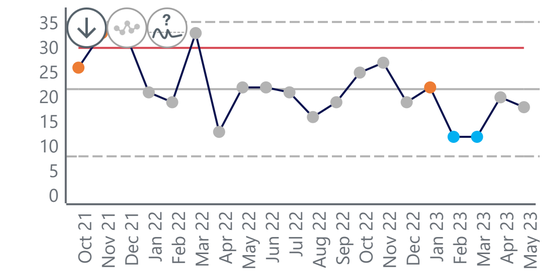
Pressure Ulcers G2-4



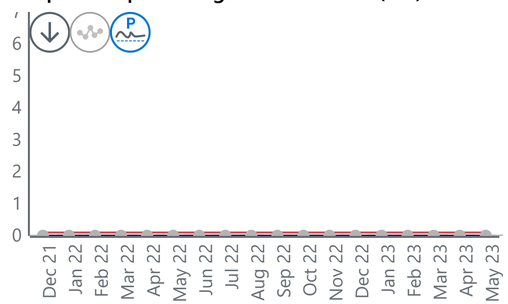
Use of physical restrictive intervention



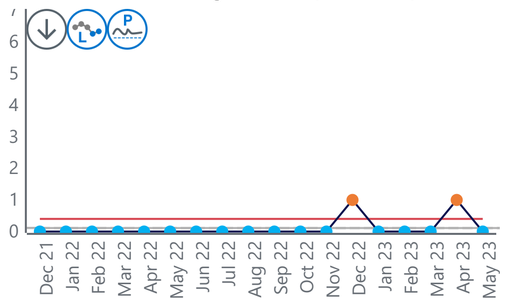
Number of patients deteriorating from an inpatient bed admitted to Critical Care (HDU/ICU)



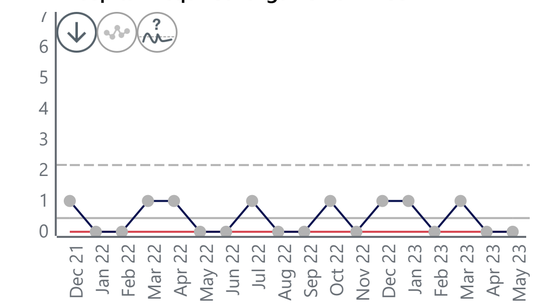
Hospital Acquired Organisms - MRSA (BSI)



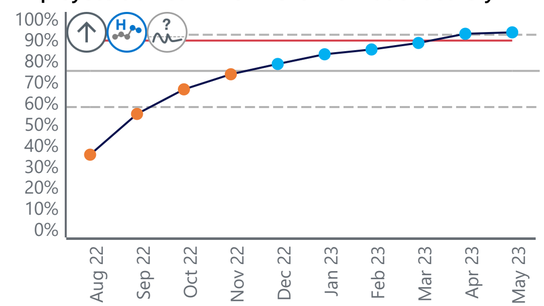
Hospital Acquired Organisms - (C.Difficile)



Hospital Acquired Organisms - MSSA



Employees trained in new Level 1 of Patient Safety



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Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring

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

Highlights:

Clear journey of improvement in responding to PALS and complaints in a timely manner and to support early resolution

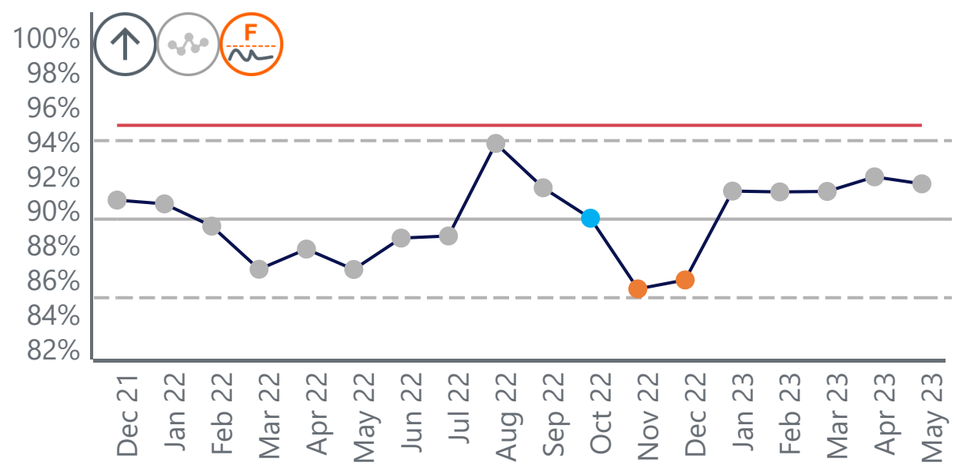
Areas of Concern:

Continued high number of PALS concerns; staff encouraged to locally resolve issues

Forward Look (with actions)

Revamp of the PALS office and space outside to encourage children, young people and visitors to access for any help and support and signposting they need

F&F Test - % Recommend the Trust



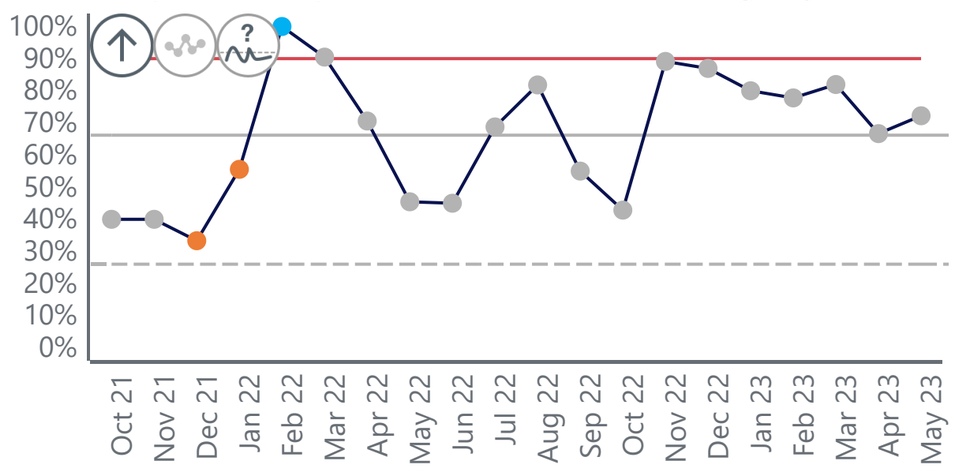
Technical Analysis:

Consistently not achieving the 95% target, but has had 5 months in a row above the average which, if continues would demonstrate special cause variation.

Actions:

Ambitious Patient Experience strategy in development

% Complaints Responded to within 25 working days



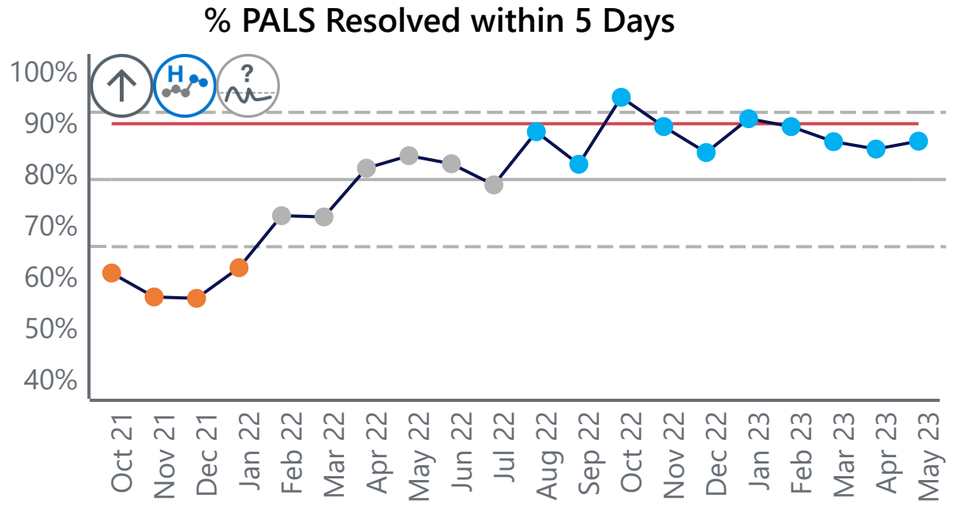
Technical Analysis:

Inconsistently achieving the 90% target with an average of 66% which shows significant fluctuation from month to month. InPhase for complaints reporting launched May 2023.

Actions:

Continued improved response times; Year End Complaints report widely shared which details local information for local Divisional action to aid identification of areas for improvement

% PALS Resolved within 5 Days



Technical Analysis:

Inconsistently achieving the 90% target but has demonstrated special cause variation of an improving trend. InPhase for PALs reporting launched May 2023.

Actions:

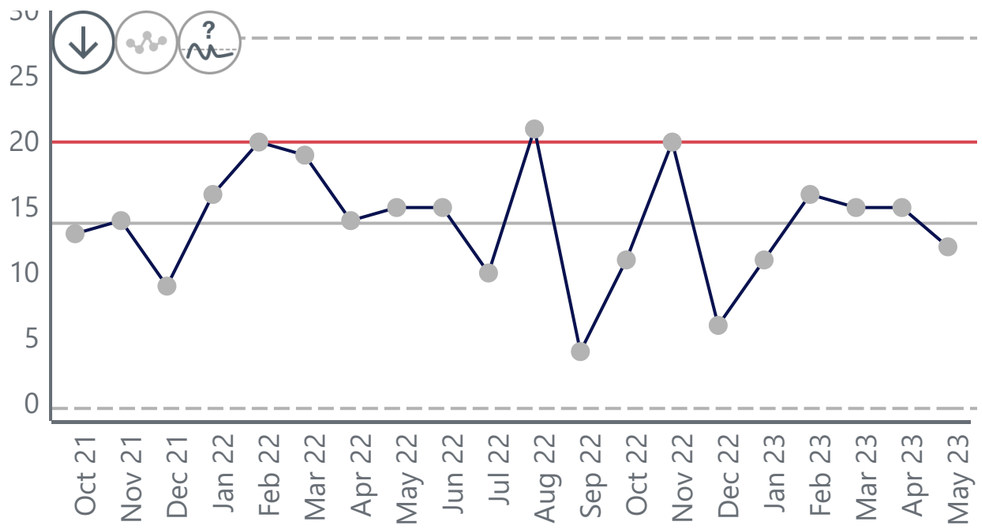
Continued improved response times; Year End Complaints report widely shared which details local information for local Divisional action to aid identification of areas for improvement. Continued emphasis on local resolution at the first point of contact to avoid esclalation to a PALS concern

Integrated Performance Report | June 2023

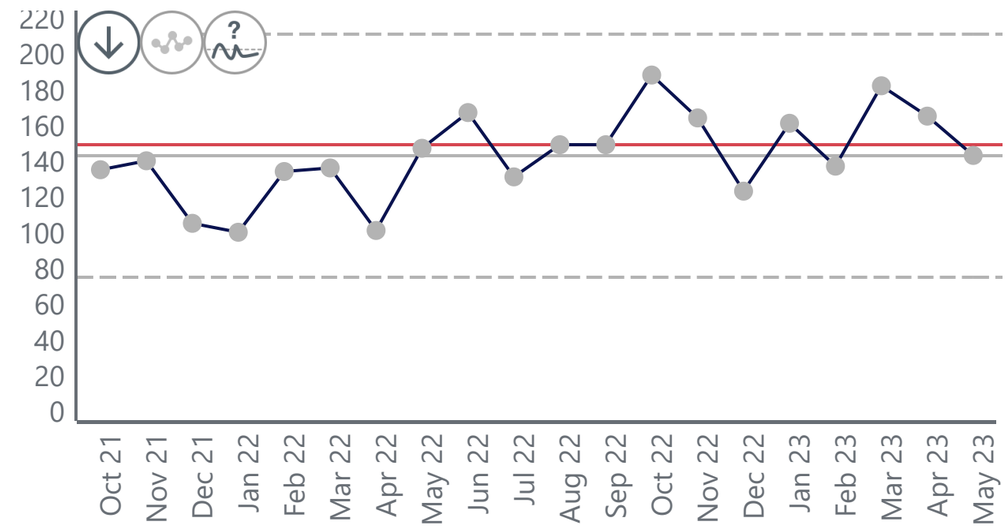
Alder Hey Children's NHS Foundation Trust

Unrivalled Experience - Caring - Watch Metrics

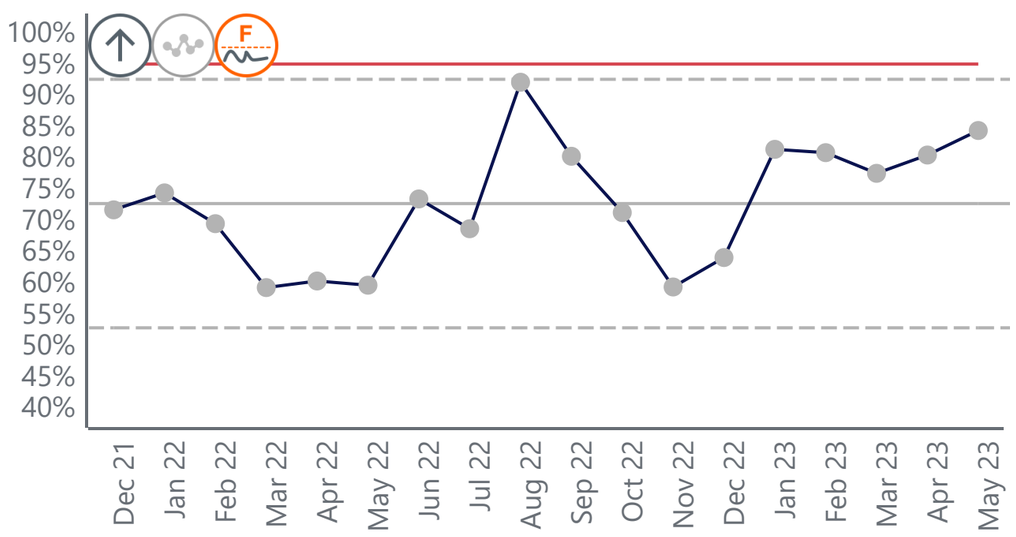
Number of formal complaints received



Number of PALS contacts



F&F ED - % Recommend the Trust



Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services: Effective

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• ED Performance >76% national standard for 5 consecutive months • Les than 20 Cancelled Operations in each of Apr and May (although currently showing normal cause variation) • Theatre Utilisation at 78% is a positive indicator, reaching the statistical upper limit

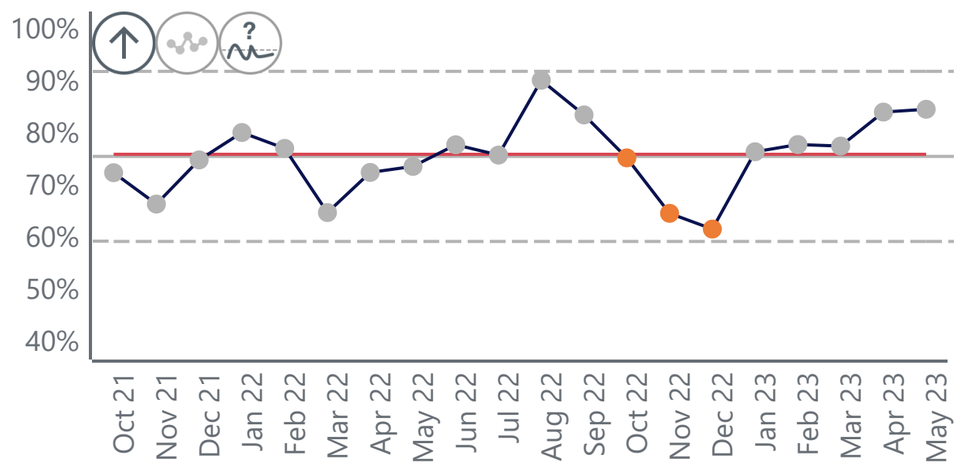
Areas of Concern:

• WNB rate still above 8% (although 5 consecutive points below the mean is a positive indicator) • Clinical Letters sign off remains at 66% (although 6 consecutive points above mean is a positive indicator) • Long Stay patients (>21 days LOS) consistently above target with impact on flow

Forward Look (with actions)

• Urgent Care: PAU Pilot scheduled for late summer along with an enhanced virtual urgent care offer to include virtual consultations • WNB rate: focus at specialty level using AI tool with associated interventions, and additional project in ADHD & Comm Paeds to deliver changes to appointment times • Clinical Letters: Divisions continue focus on sign off for those letters with longest waiting times

ED: % treated within 4 Hours



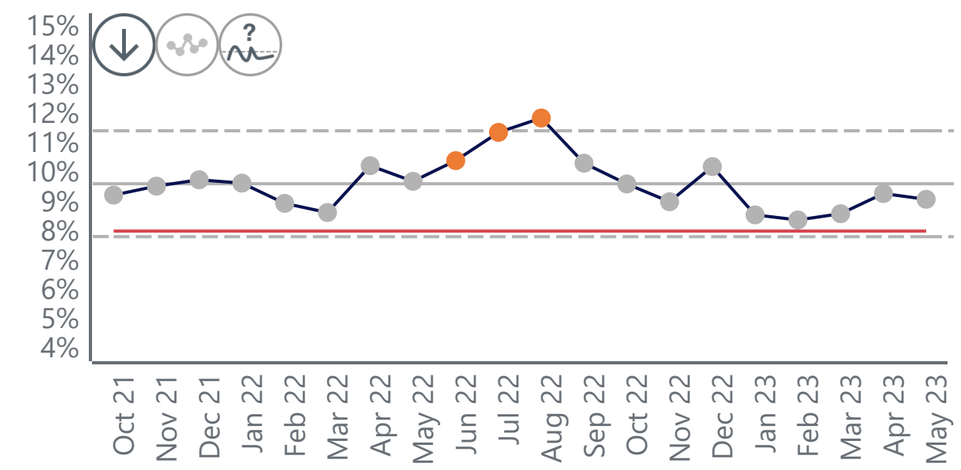
Technical Analysis:

Inconsistently achieve the new national target of 76%, common cause variation has been observed but the Trust has achieved the target for the past 5 months.

Actions:

Monitor current actions to sustain performance above national target. PAU Pilot scheduled for late summer along with an enhanced virtual urgent care offer to include virtual consultations.

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



Technical Analysis:

WNB rates demonstrates common cause variation. Previous 5 months have been below the average which if continued would demonstrate special cause variation

Actions:

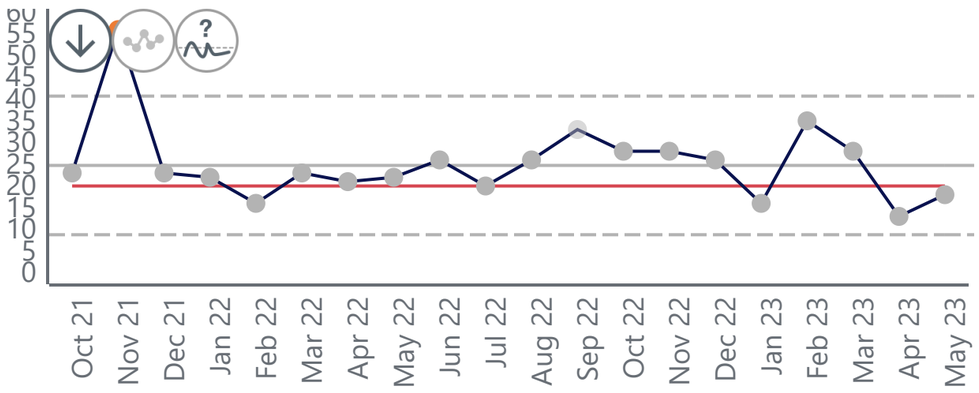
Surgery Division focussing on 5 specialities, with AI app and personal phone calls (patient having a >70% chance of WNB). 'Opt in opt out' pilot to commence in June in Community Ophthalmology Service. ADHD & Community Paediatrics to deliver changes in the models of specific appointment times, expected benefits from July

Integrated Performance Report | June 2023

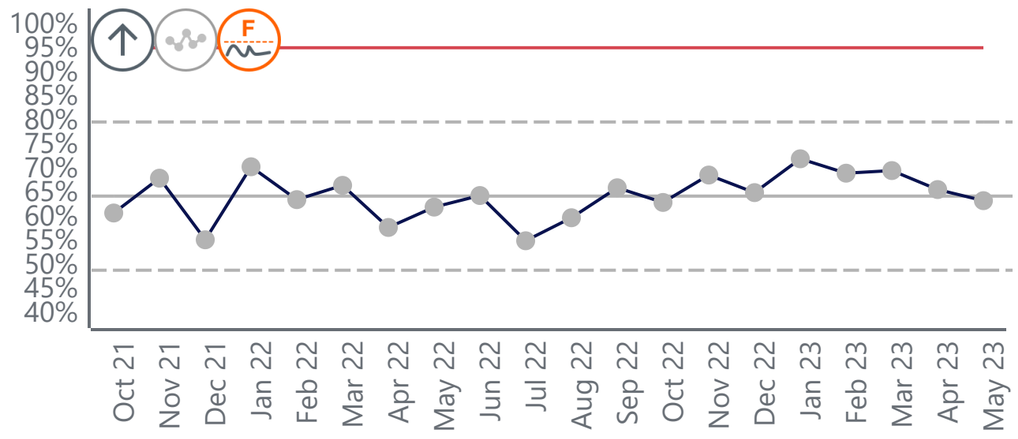
Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Accessible Services - Effective - Watch Metrics

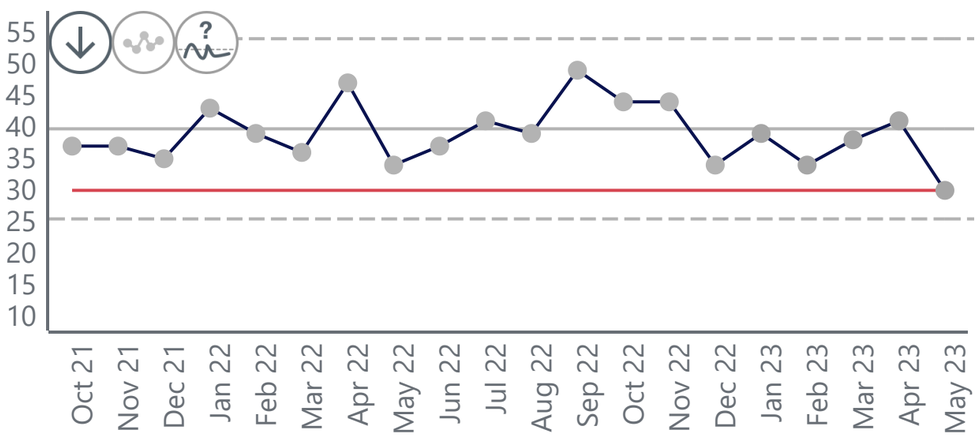
Number of Cancelled Operations (on day of admission for a non-clinical reason)



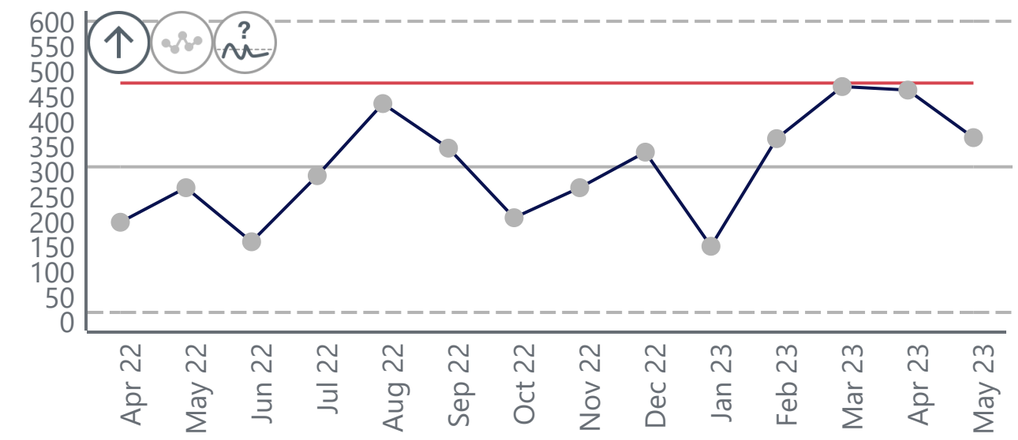
% of Clinical Letters completed within 10 Days



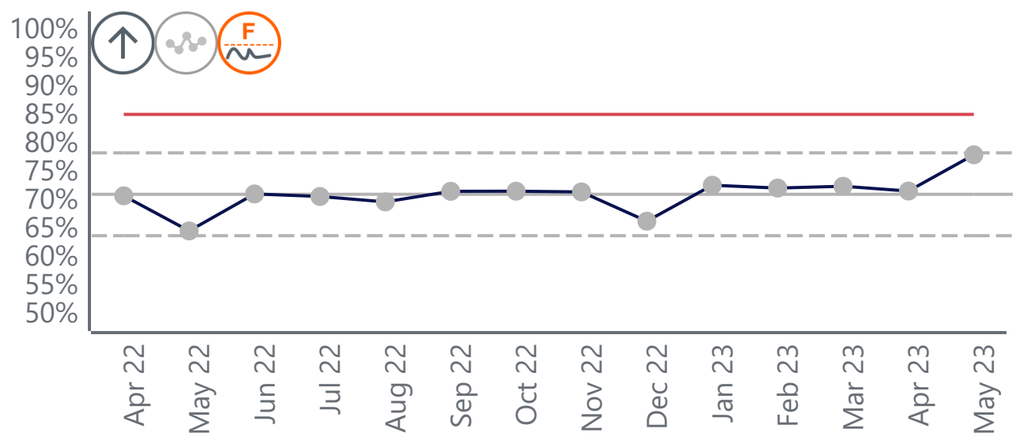
Number of Super Stranded Patients (21 days)



Virtual Ward Bed Days



Theatre Utilisation (Capped Touch Time)



Smartest Ways of Working - Accessible Services: Responsive

SRO: Adam Bateman, Chief Operating Officer

Highlights:

• Strong levels of Recovery (activity volume) - DC & Elec achieved the target of 106%; OP reached 140%, exceeding 126% target in May • Diagnostic Waiting times continue to improve, reaching the 90% target in May • 100% compliance with Cancer Access Standards

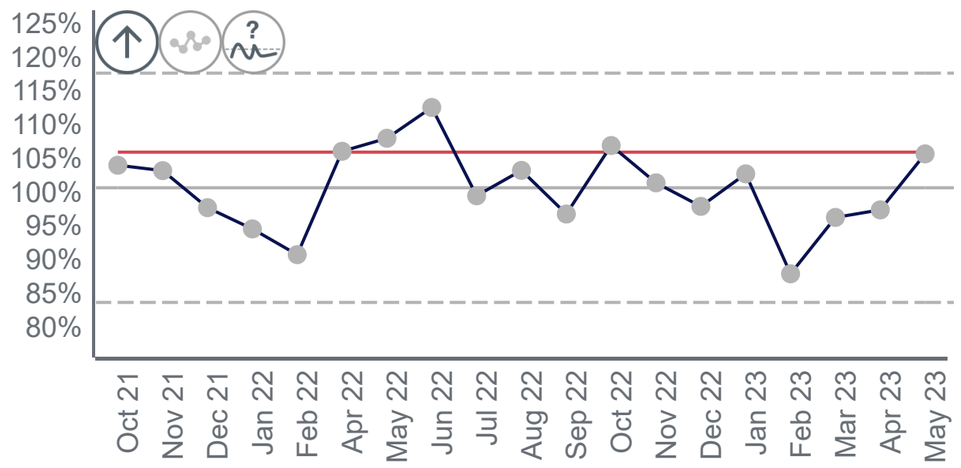
Areas of Concern:

• Increasing number of Children and Young People waiting >65 weeks for ASD & ADHD diagnosis, with continued high levels of demand • RTT Waiting List size is growing; although >65wk position is static the number of patients >52wks is increasing, driven by ENT • IHA completion within 20 days remains low, exacerbated by short term staffing pressures • Industrial Action in June creating additional pressure on access times.

Forward Look (with actions)

• RTT Access: investment approved in challenged specialties, including insourcing model in ENT • Theatre utilisation focus on 4 specialties to support additional cases per list • ASD & ADHD: Pathway Review led by Divisional Director in June, along with engaging commissioners for increased investment in services • Proposal for a pilot delivering IHAs including use of GPs shared with Designated Place professionals • CAMHS have filled vacancies with staff commencing and expect to achieve zero >52wk in Q2.

% Recovery for DC & Elec Activity Volume



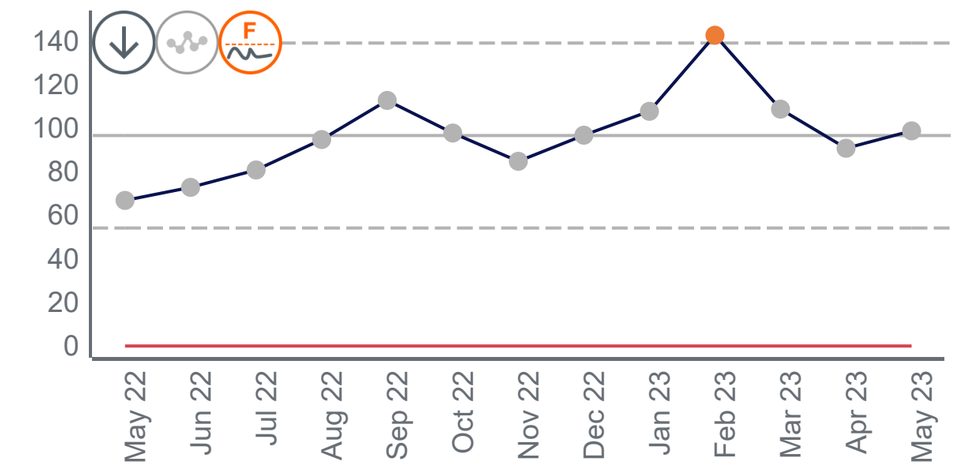
Technical Analysis:

May 23 performance of 106% by volume is above the target and improved performance from Apr 23 (97%). Monthly variation continues to demonstrate common cause variation.

Actions:

Further actions include extended theatre sessions from Q2 onwards & an increase in scheduled in week sessions. Dental continue to increase cases per list. Safe management of activity levels during Industrial Action in June

Number of RTT Patients waiting >65 weeks



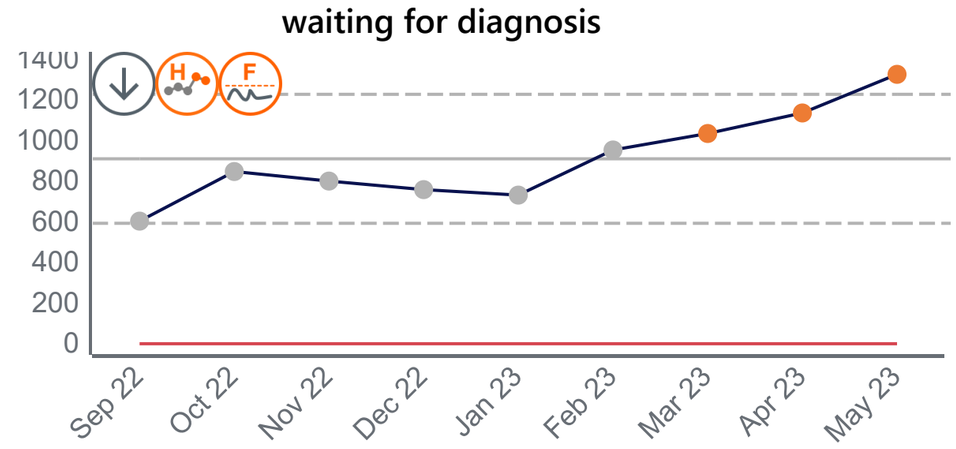
Technical Analysis:

Number of patients waiting > 65 weeks has increased in May to 99 patients from 91 in April. Dentistry (n = 65) and ENT (n=24) have 89 patients >65 weeks, 90% of the Trust total.

Actions:

Investment approved during May in our challenged specialties – Dental, Spinal and ENT (including insourcing model for ENT). Dental undergoing enhanced list planning meeting, to optimise theatre utilisation.

Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



Technical Analysis:

On average 910 patients are waiting for an ASD or ADHD diagnosis per month. May shows 1325 patients which is above the outer control limits, now showing special cause varation of concern. This is diagnostic pathways only for Liverpool, Sefton and Knowsley.

Actions:

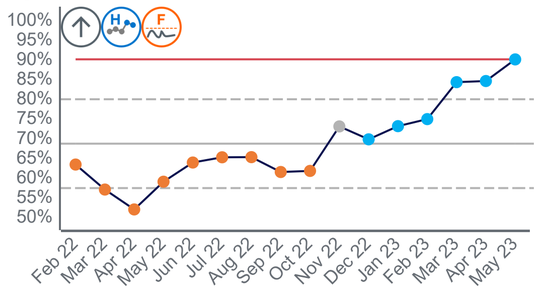
Continued work with commissioner colleagues to review opportunity for increased investment in services. Divisional review of pathways to be carried out during June led by Divisional Director.

Integrated Performance Report | June 2023

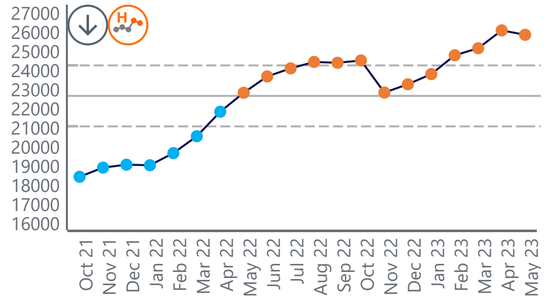
NHS
Alder Hey Children's
NHS Foundation Trust

Smartest Ways of Working - Accessible Services: Responsive - Watch Metrics

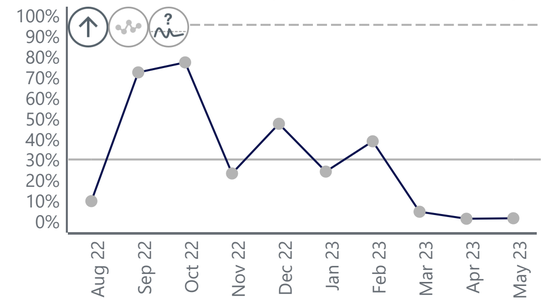
Diagnostics: % Completed Within 6 Weeks of referral



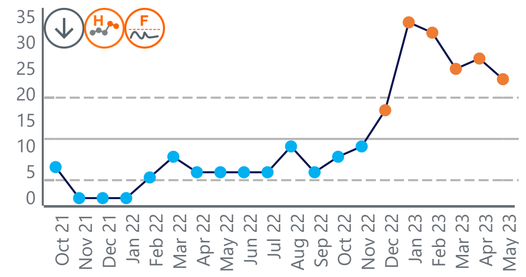
Waiting List Size



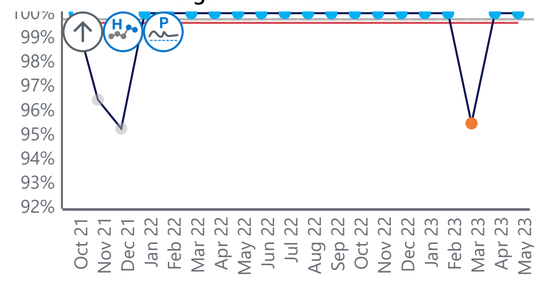
IHA: % complete within 20 days of referral to Alder Hey



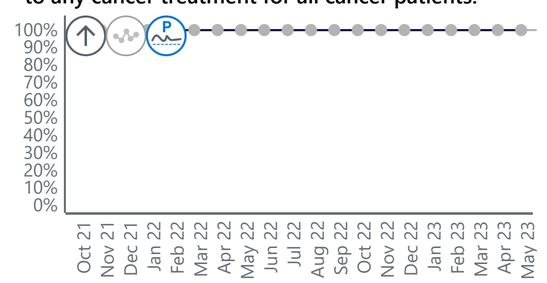
CAMHS: Number of children & young people waiting >52weeks



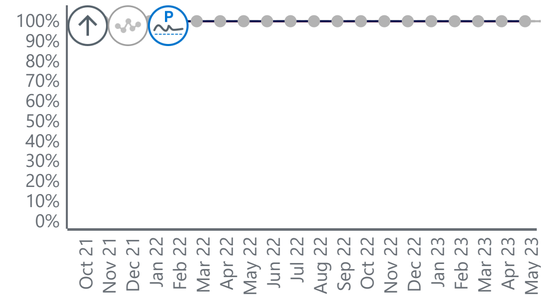
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



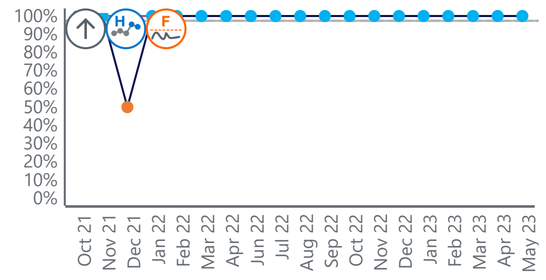
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.



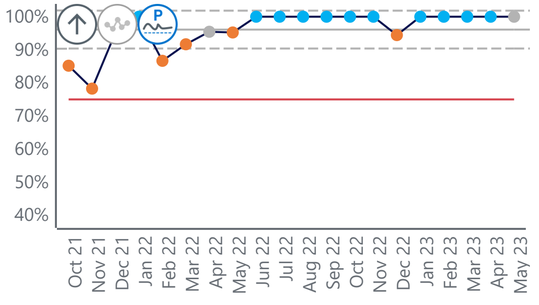
All Cancers: 31 day wait until subsequent treatments



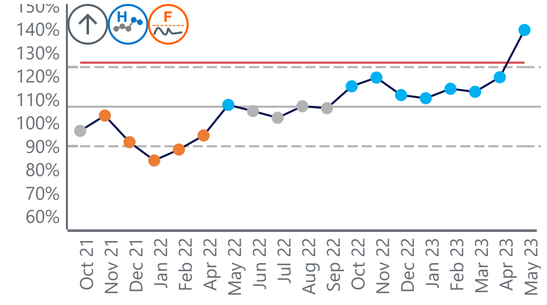
31 days from urgent referral for suspected cancer to first treatment (Childrens Cancers)



Cancer: Faster Diagnosis within 28 days



% Recovery for OP New & OPPROC Activity Volume



Collaborating for CYP - Reducing Health Inequalities: Responsive

SRO: Dani Jones, Director of Strategy and Partnerships

Highlights:

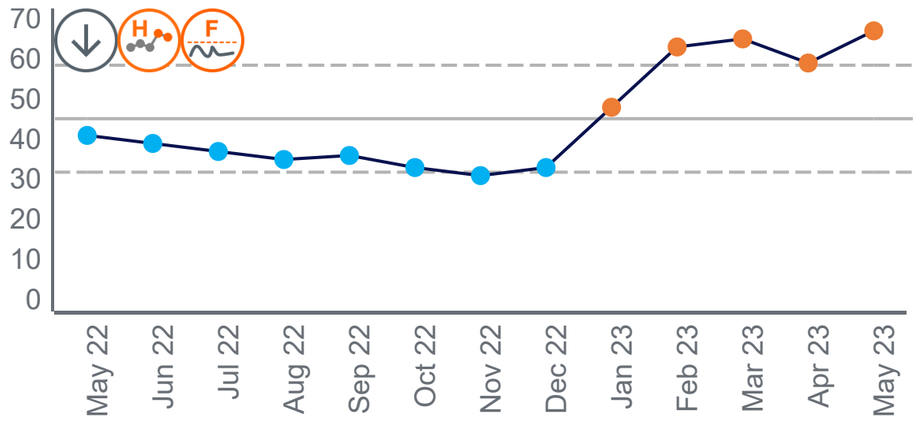
• This is a new direction of reporting for the integrated performance report, recognising both the Trust's ambitions in terms of reducing the impact of health inequalities and new strategic drivers such as Core20+5CYP. • A 'learn and shape' approach to these metrics will be undertaken, with programmed activities throughout the year. These metrics are 'owned' through the Trust's Health Inequalities and Prevention (HIP) Steering group, which reports to Safety and Quality Committee. • Quality improvement approaches will be assigned to drive positive change against these metrics during 23/24 – these are under development through HIP Steering group

Areas of Concern:

Forward Look (with actions)

• Prevention in pathways work mobilising (Mini Mouth Care Matters / Health Inequalities Toolkit and Advice on Prescription
•Liverpool City wide Oral Health Strategy in development supported by Beyond
•Alder Hey led Wellbeing Hub in scoping phase

Oral Health: Number of children <10 years old waiting >52wks for tooth extraction



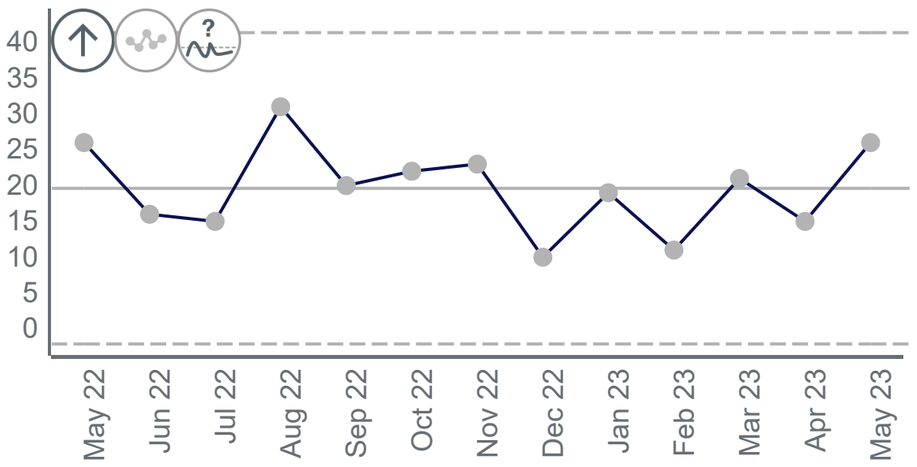
Technical Analysis:

Steady decline in children waiting >52 weeks up until Jan 23 where we have since seen a sudden increase, showing special cause varation of concern. Currently 67 children waiting >52 weeks, which increased from 59 in April 2023. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Paediatric Dental Hub mobilised at Whiston, which will run fortnightly until August, seeing a max of 8 patients per 4-hour session. Currently operating on Wirral community patients who have the biggest backlog

CAMHS: Number of CYP of BAME background referred



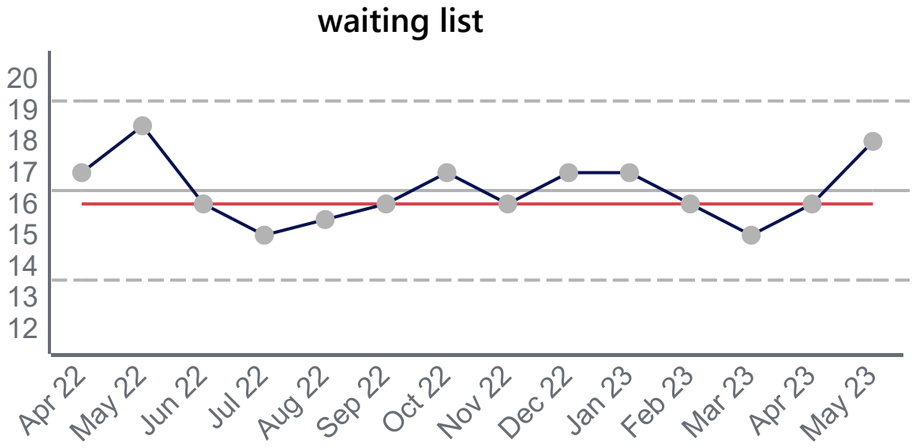
Technical Analysis:

New Metric which shows on average 20 referrals of BAME background are accepted per month, April shows 26 patients. Measure founded upon Core20Plus5 CYP Transformation programme

Actions:

Metric and associated improvement plan are work in progress.

Difference in Median Waiting time for patients with LD on the waiting list



Technical Analysis:

Metric shows median wait of Learning and Disability patients from our RTT Inpatient and Outpatient open pathways was 18 weeks as end of May. This is above the previous 12 month baseline target of 16 week median wait for non-LD patients, however waits for non LD patients seen an increase to 17 weeks during May also.

Actions:

Metric and associated actions are work in progress.

Well Led - Supporting Our People

SRO: Melissa Swindell, Chief People Officer

Highlights:

•Mandatory training compliance remains consistently above target, at 94% • Sickness absence is below the 5.5% target.

Areas of Concern:

• Staff availability remains an area of concern, particularly in relation to retention (with high levels of turnover), thus requiring a significant increase in recruitment activity. (Ongoing industrial action continues to impact on staffing and activity)

Forward Look (with actions)

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

Colleague Satisfaction – Thriving Index - In Development

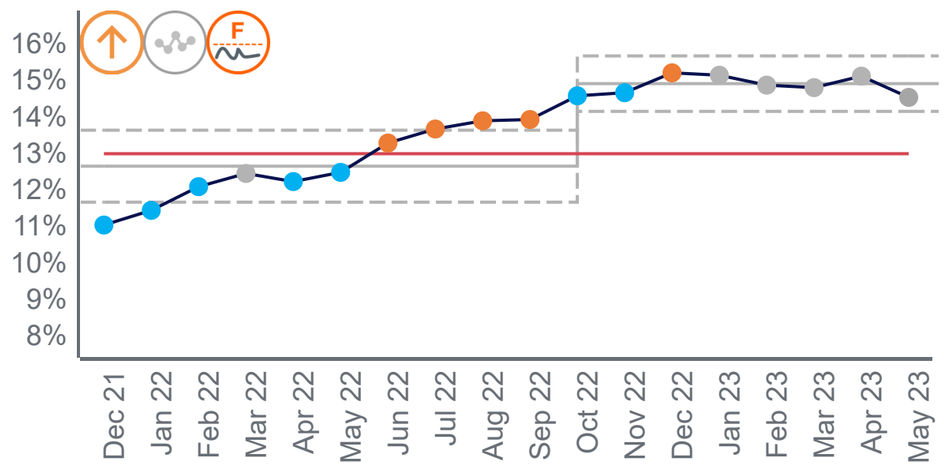
Technical Analysis:

Metric is in development

Actions:

In development

Staff Turnover



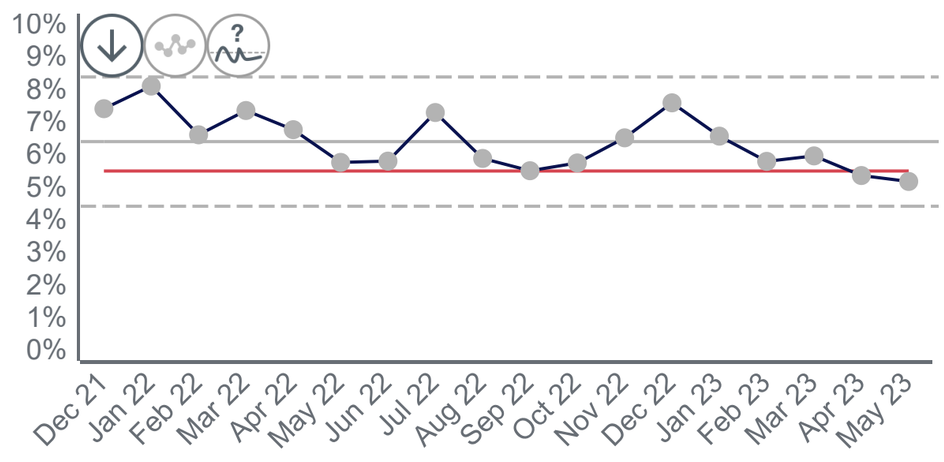
Technical Analysis:

Staff Turnover remains 15% in April and has been stable since December with no further increases. However this remains a significant concern and this level of staff turnover is creating substantial risk for the Trust.

Actions:

Monitored quarterly at PAWC. Task and Finish group continue to meet to review data and agree immediate interventions to reduce the rate of turnover- Turnover whilst still higher than the target of 10% has stabilised in recent months, with no further increases.

Sickness Absence (Total)



Technical Analysis:

Total sickness absence in April is 5.14% which is below the 5.5% target. A reduction from April at 5.32%. May performance comprises STS at 1.62% and LTS at 3.5%. Still demonstrating common cause variation, consecutive months below the target.

Actions:

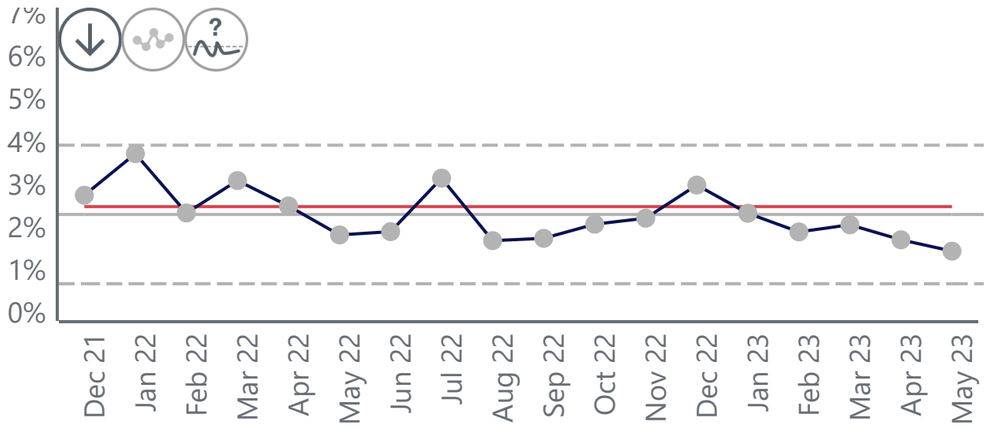
Ongoing support is in place through SALS, Occupational Health, HR guidance/training and regular reviews. Action plans in place for all sickness absence.

Integrated Performance Report | June 2023

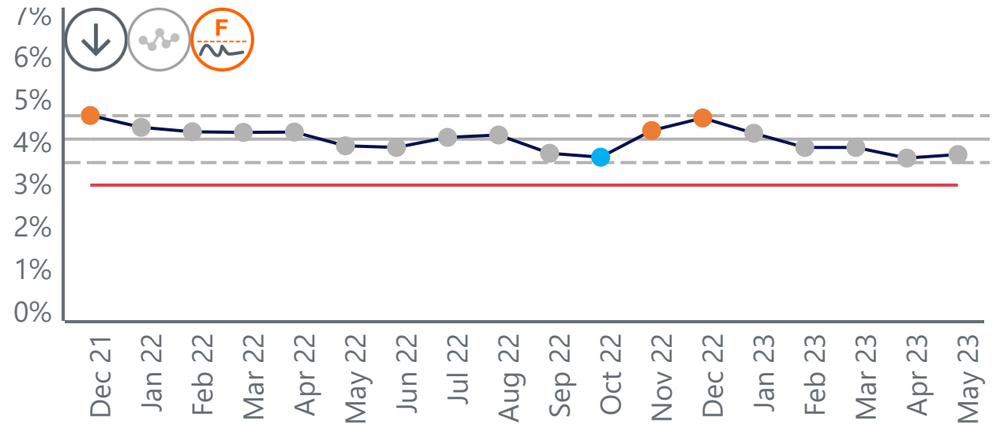
Alder Hey Children's NHS Foundation Trust

Well Led - Supporting Our People - Watch Metrics

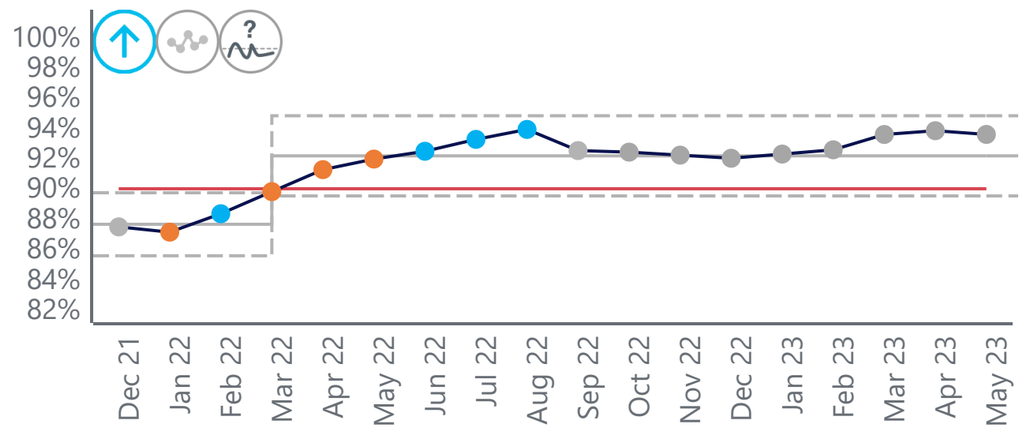
Short Term Sickness



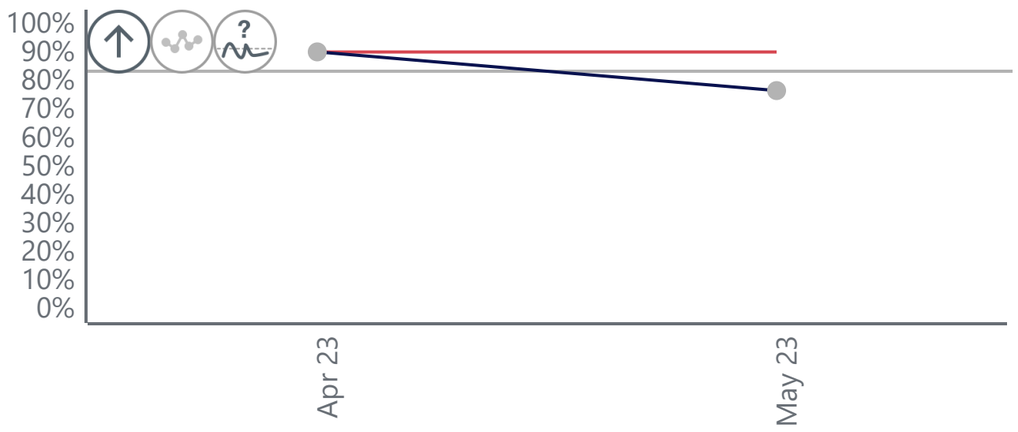
Long Term Sickness



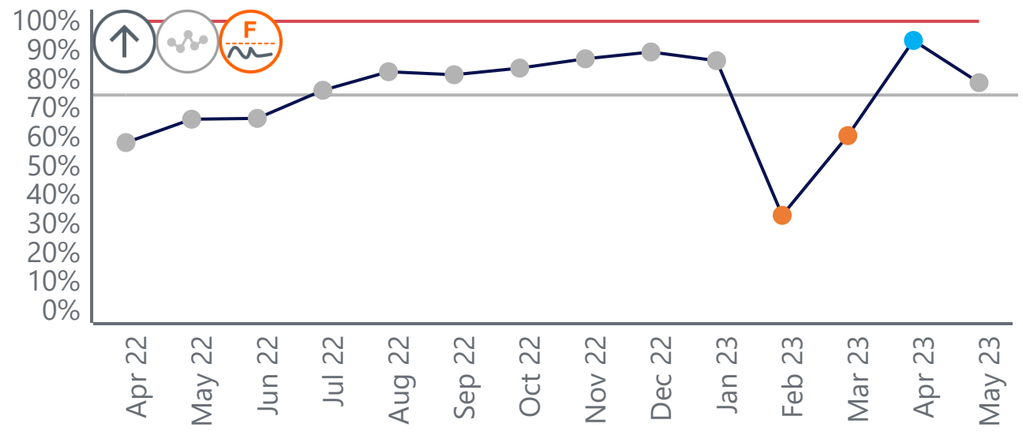
Mandatory Training



% PDRs completed (Rolling 12 months)



Medical Appraisal



Staff movement / Churn rate - In Development

Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led

SRO: Rachel Lea, Deputy Director of Finance

Highlights:

For May (M2), the Trust is reporting a deficit of £0.5m which is in line plan. The ytd position is £1m deficit in line with the plan approved. Forecasting to achieve £12.3m surplus however subject to risk around CIP delivery & activity levels. CIP delivery £1.7m behind plan ytd. Overall £3.2m CIP has been transacted with £3.5m in progress. Gap of £11m to be identified but includes £6.5m transformation schemes. Cash has remained high in line with plan & capital largely in line with expectations.

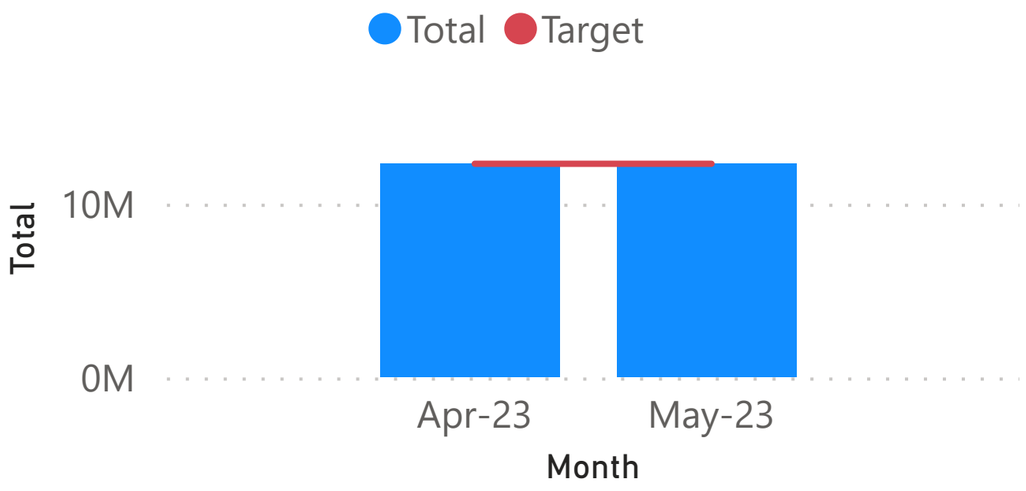
Areas of Concern:

Lack of CIP identified with transformational schemes still being worked up. Challenging £12.3m control total surplus plan by end of the financial year so delivery of CIP is essential along with achievement of activity targets.

Forward Look (with actions)

Continued cost control to reach the £12.3m surplus requirement by end of the financial year. Urgent focus required on recurrent efficiency. Further divisional finance panel meetings scheduled along with SDG to focus on Divisional CIP including enabler areas.

Revenue Position (Year End Forecast)



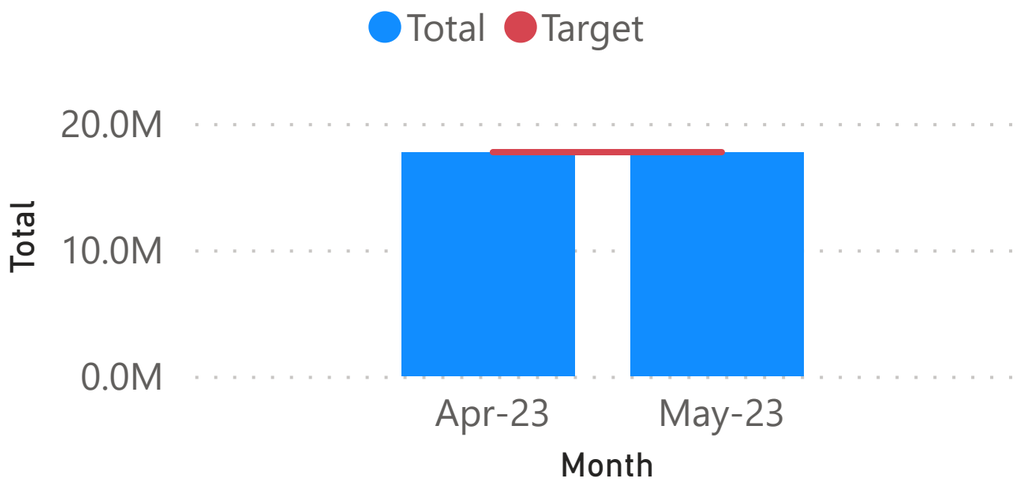
Technical Analysis:

Current forecast remains to achieve plan however risks to delivery of this is linked to achievement of CIP.

Actions:

Continue to monitor CIP schemes and cost control for arising pressures to be managed through SDG meeting.

CIP Position (Recurrent Full Year Effect)



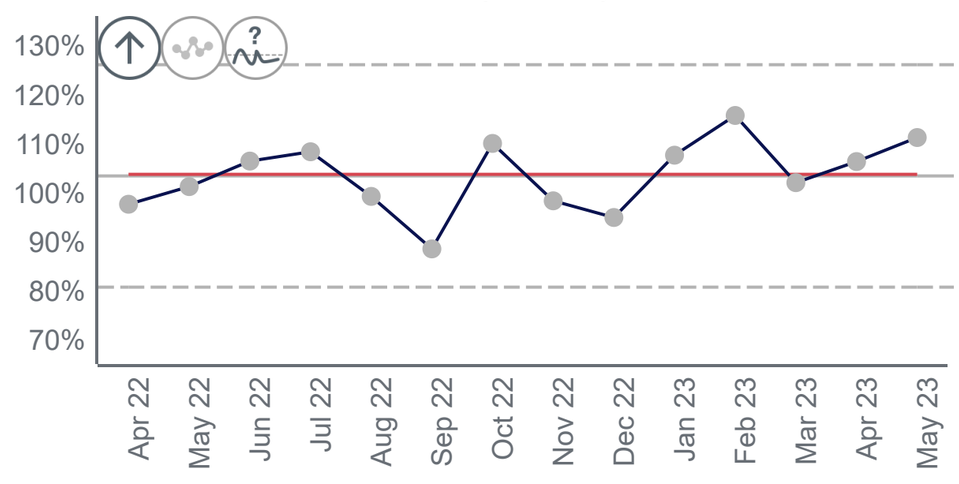
Technical Analysis:

In year CIP identified and in progress is £6.7m. Of this, £4.5m is recurrent.

Actions:

Support required with exec leads and transformation to identify the large scale opportunities through the Trust Strategic Initiatives. Divisions also focus on schemes including enabler areas. Letter to be sent to Trust in June outlining current position

% ERF Value (Income)



Technical Analysis:

Value weighted activity performance is 109.2% at M2 YTD (based on an estimate of May flex activity) against a mandated target of 105.1% across all commissioners. As alluded to above Apr was adversely affected by industrial action.

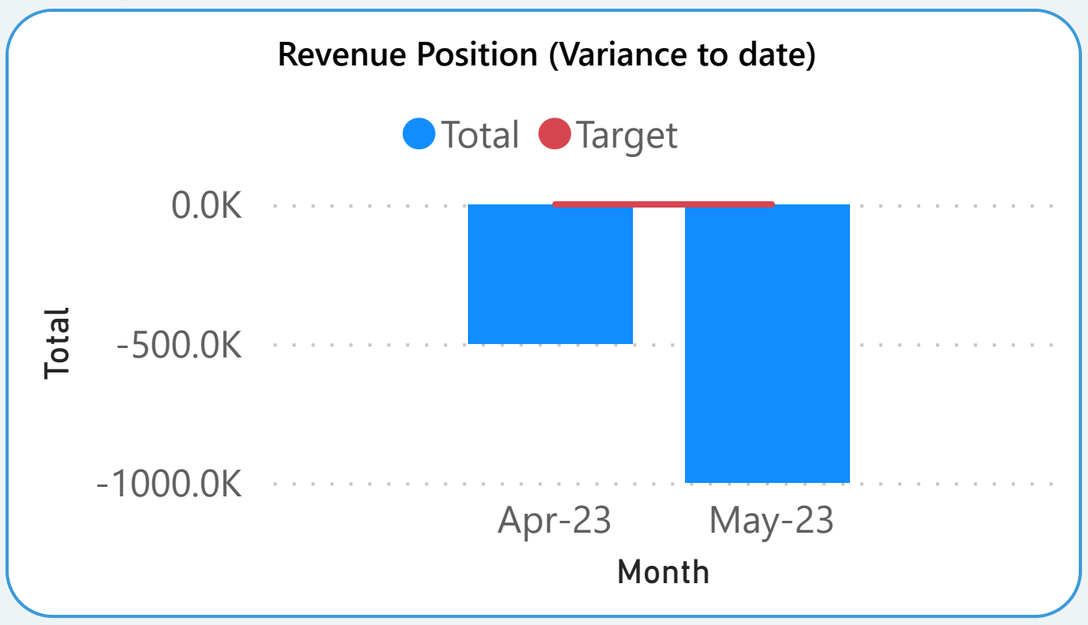
Actions:

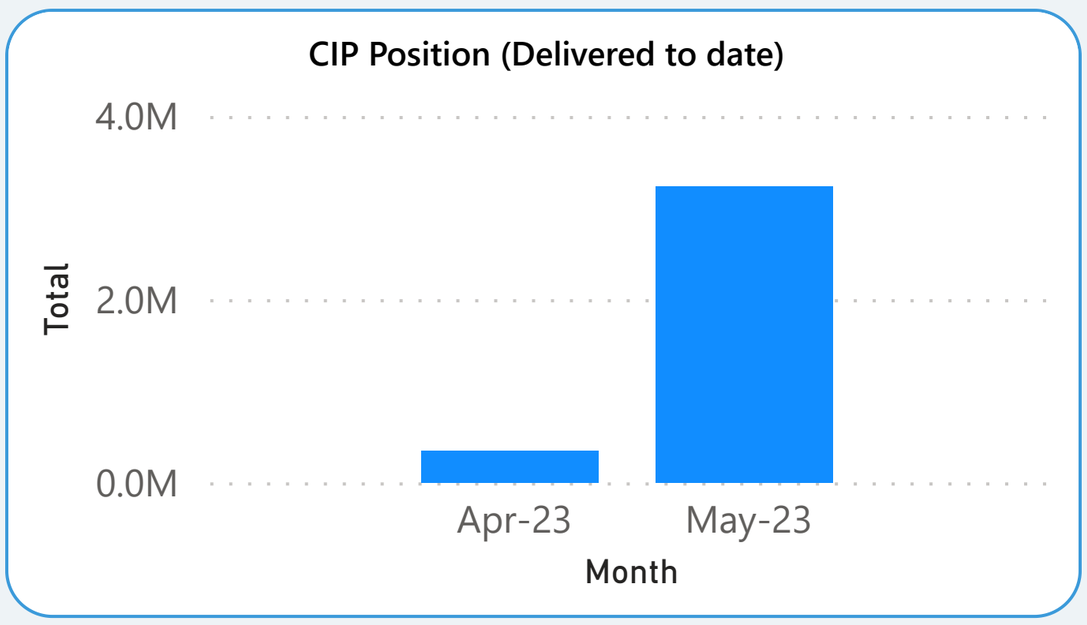
Continued focus on activity delivery.

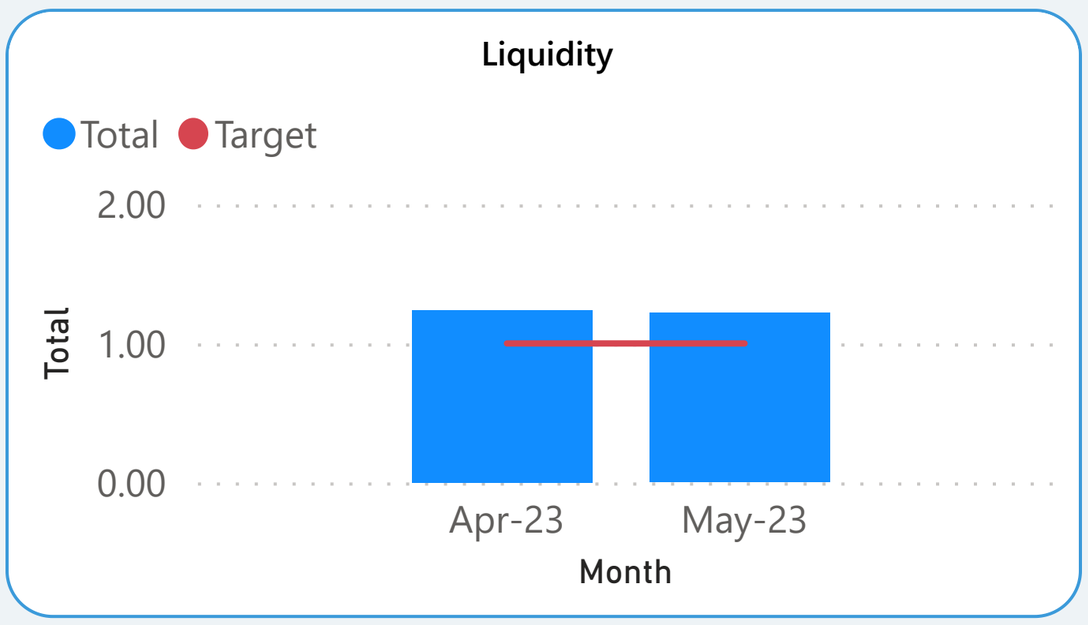
Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

Smartest Ways of Working - Financial Sustainability: Well Led - Watch Metrics







Well Led - Risk Management

SRO: Erica Saunders, Director of Corporate Affairs

Highlights:

• All risks now being managed via InPhase. Training on system provided by corporate/divisional governance leads plus on 121 basis with teams via the risk oversight meetings by corporate governance team

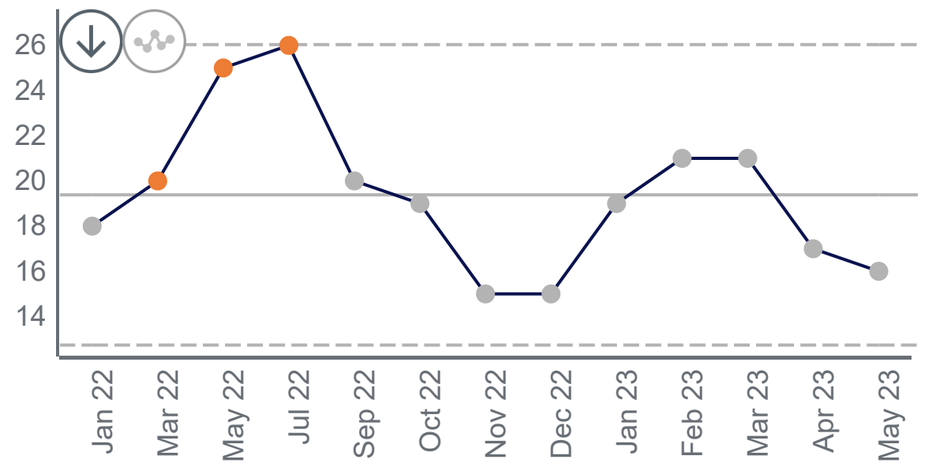
Areas of Concern:

• Several services requesting to postpone or cancelling attendance at monthly risk oversight meetings • Staff continue to navigate InPhase functionally which may temporarily affect updates to risk register • No automatic risk overdue notification function on InPhase which has been escalated to InPhase for rectification • Several limitations to the currently report functionality impacting on the ability to provide up to date accurate risk assurance reports escalated to InPhase exec team for urgent action. Added to risk register Risk No *22 risk score 9 (3x3)

Forward Look (with actions)

• All cancelled/postponed monthly risk oversight meetings rebooked Monitoring of cancelled/postponed risk oversight meetings inplace • Report functionality escalated to InPhase Executive team for urgent action • Oversight of InPhase report functionally • SRO/project deep dive at next RMF • InPhase functionality added to Digital weekly report for oversight • Focus on supporting services/teams with updating of risk narrative within InPhase

Number of High Risks (scored 15 and above)



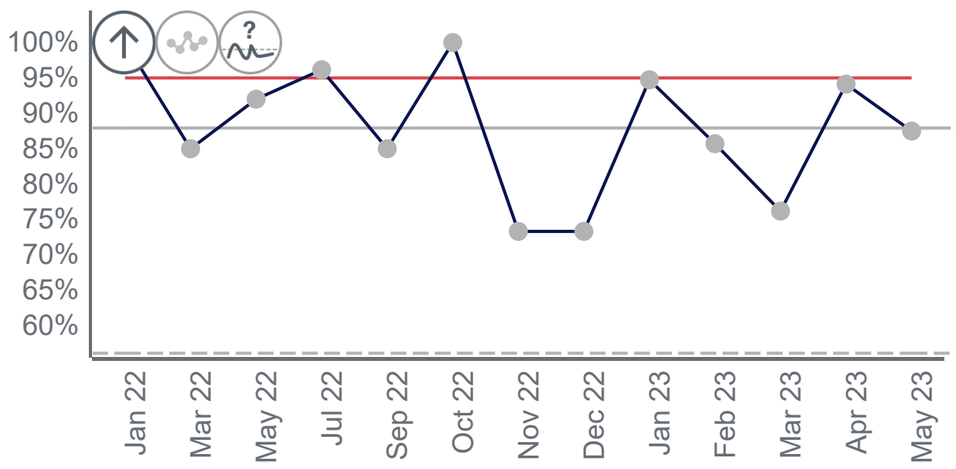
Technical Analysis:

There are 16 High Risks on the risk register at the end of May. Overall, this remains stable and is within the normal range. Risks are now managed in InPhase as of May 2023.

Actions:

16 high risks on register at end of May 23. Figure remains stable with all risks now being managed via InPhase

% of High Risks within review date



Technical Analysis:

Compliance of reviewing High risks within date is variable, with 2/16 risks overdue at the end of May. Action is required to ensure consistent compliance with the 95% target.

Actions:

2/17 high risks overdue update which have been escalated to risk owner.

Smartest Ways of Working - AlderC@re - Well Led

SRO: Kate Warriner, Chief Digital and Information Officer

Highlights:

• Gateway 3 completed for AlderCare Programme • Over 700 users now booked in for AlderCare Training • Development of IPR 'Flash Report' to fulfil Board reporting requirements • ISLA Care Business Case approved and contracted extended till 2024

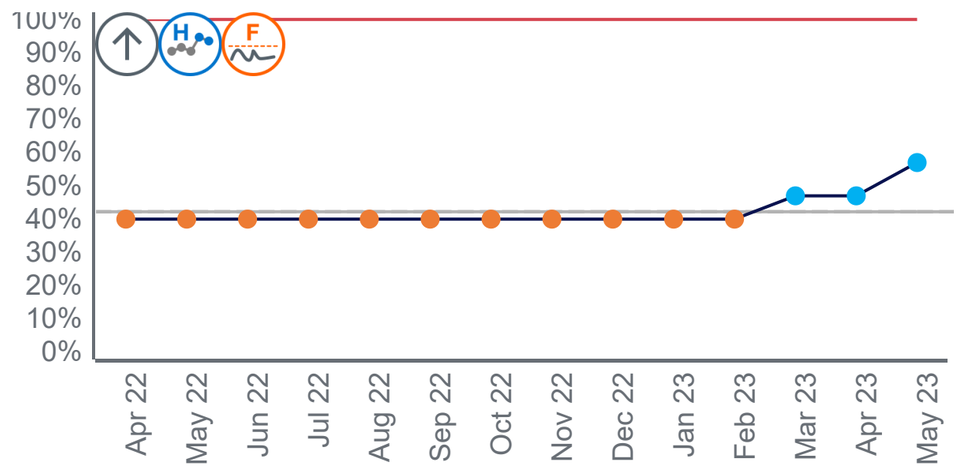
Areas of Concern:

• AlderCare reporting workstream recovery plan in place and working with Meditech to resolve technical issues • Tight timescales for AlderHeyAnywhere and Website deployment prior to change freeze

Forward Look (with actions)

•Launch of new external Trust Website • Launch of AlderHeyAnywhere Phase 1 • AlderC@re NHSE external readiness review • AlderC@re training to commence in July 2023 • Trauma App to be launched in Emergency Department

Alder Care - Divisional Critical Criteria



Technical Analysis:

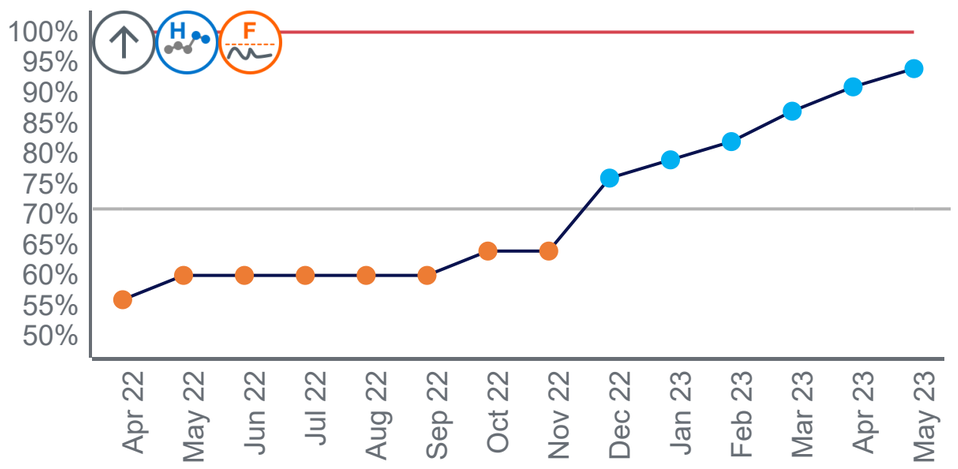
8/14 critical criteria complete. Remainder awaiting system build, or resolution of P1 issues. "WHO checklist" removed as criteria for AlderCare go live.

Actions:

1. Ongoing development for remaining items.

2. Resolution of P1 issues pending delivery of changes form Meditech.

Alder Care - % System Build Completion



Technical Analysis:

This metric monitors build across all workstreams. Build completion continues to increase in line with individual trajectories. Majority of core build due to complete by end of May, with theatres June and EPMA in July. Meditech readiness assessment completed.

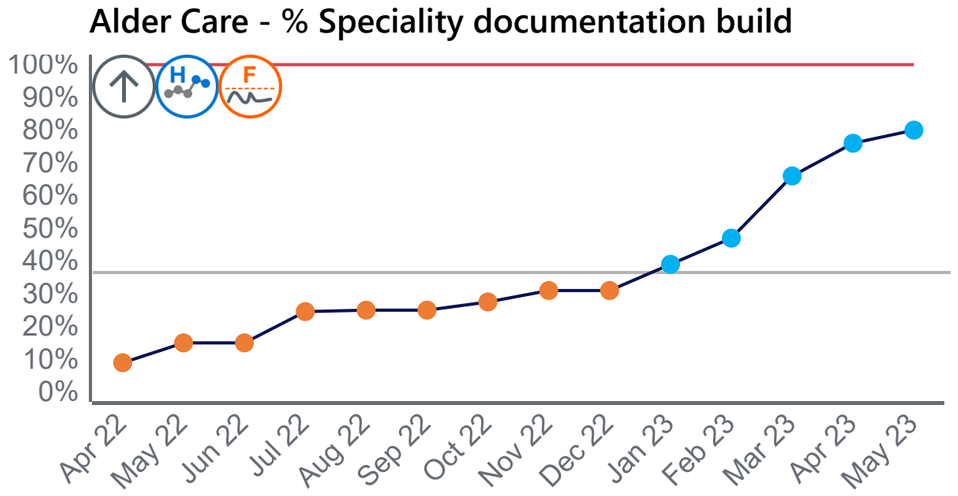
Actions:

1. Continue build.

2. Monitor progress on EPMA build (67%).

3. Undertake Gateway 3

Alder Care - % Speciality documentation build



Technical Analysis:

75% of specialty documents have now been completed, with others partially built. Programme Team working with Divisions to continue sign off process (53%).

Actions:

1. Continue build (80%) and sign off process (53%).

2. Work with divisions to sign off Specialty Packages build.

Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

Collaborating for CYP - Green Plan: Well Led

SRO: Mark Flanagan, Director of Marketing and Communications

Highlights:

LED project approved at RABD. Heating project also started. Long standing problem with external lights fixed.

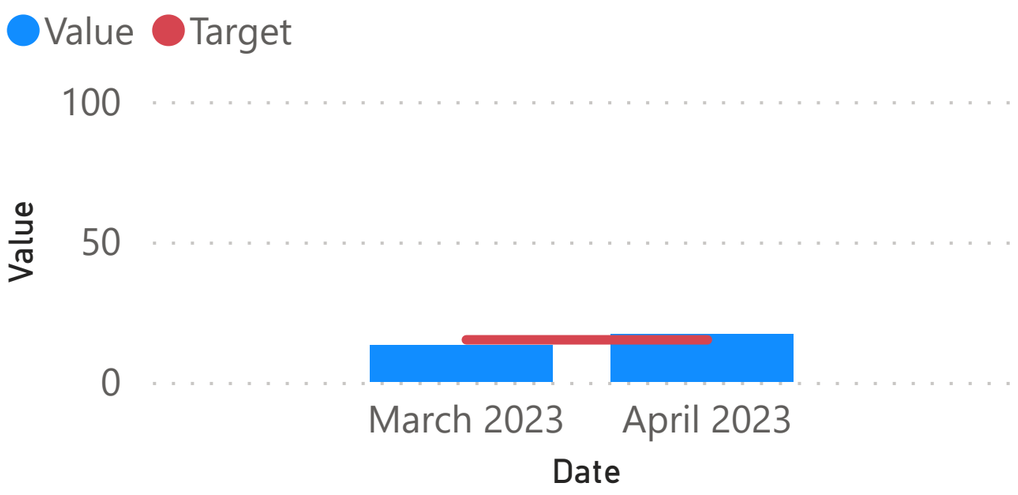
Areas of Concern:

Performance of key equipment – CHP (Combined heat and power) and GSHP (Ground Source Heat pump) continue to be below target. SPV developing plan.

Forward Look (with actions)

Solar panel project being developed and will go to June RABD.

Green Plan: Reduce Carbon Footprint



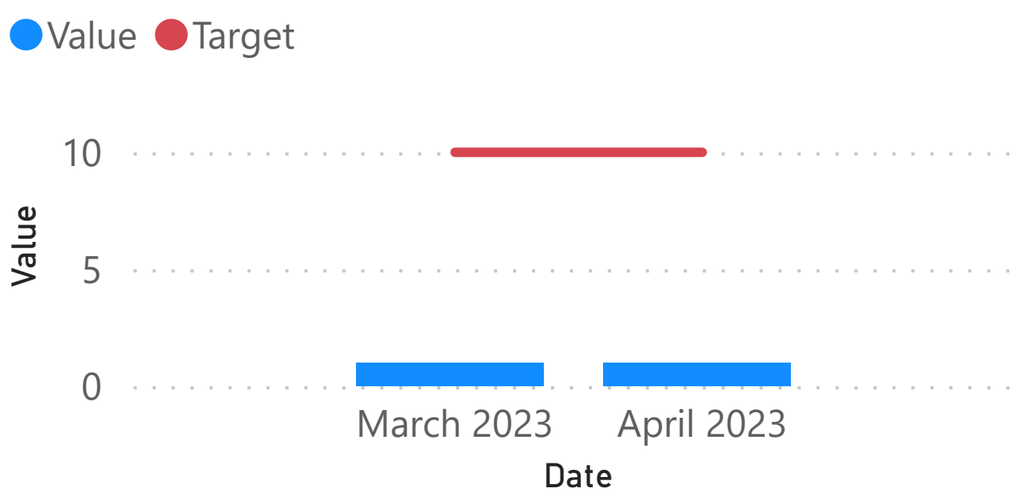
Technical Analysis:

17% reduction.

Actions:

- Improved CHP and GSHP performance.
- Deliver Solar project.

Green Plan: Reduce Energy Usage



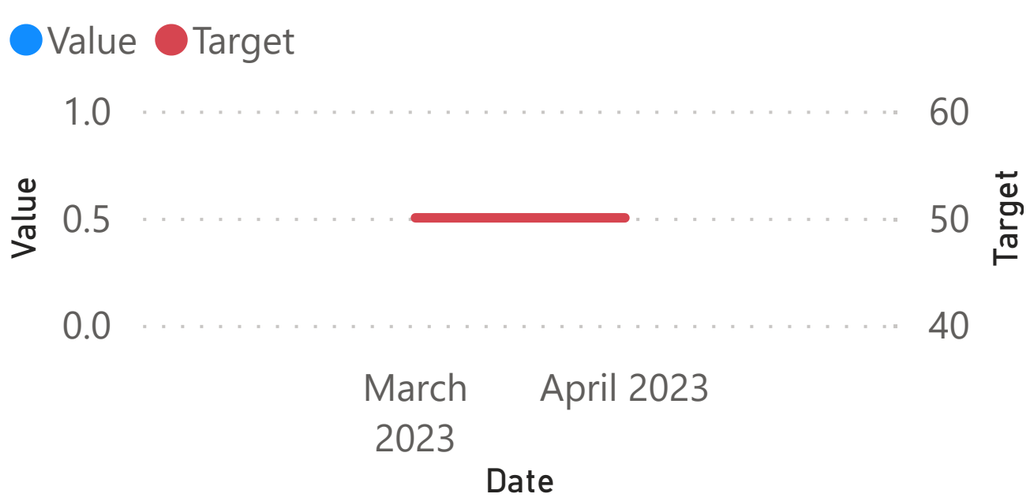
Technical Analysis:

0.01

Actions:

Heating project is key

Green Plan: Reduce Waste



Technical Analysis:

0

Actions:

Waste compactors works approved.

Divisional Performance Summary - Community & Mental Health

SRO: Lisa Cooper, Community & Mental Health Division

Highlights

• Waiting times : No children & young people waiting over 52 weeks for Community Paediatrics or Therapies. A significant and sustained reduction in children & young people waiting for a CAMHS partnership appointment over 52 weeks (23)

• Virtual Ward : Continued increased use of virtual ward with reduction during May in line with overall Trust bed occupancy

• Sickness absence : Continued reduction in sickness absence across the Division both in short and long-term sickness with improvements in compliance with Return to Work process

• Recruitment : Successful recruitment to Clinical Director SARC to support improvement plan and accreditation process.

• FFT : Maintenance of more than 90% recommendations for Community (94%), Outpatients (93%) and Mental Health services (94%) within FFT returns

Areas of Concern

• ASD & ADHD : Increase in children and young people waiting over 65 weeks to complete assessments for ASD and ADHD

• IHA assessments : Compliance with IHAs within statutory timescales (20 days from notification) remains challenged. 65% of notifications remain delayed from Local Authorities – ongoing discussions with Place leads. Business case submitted to Place regarding pilot and investment required.

• Restrictive intervention : Increase in use of restrictive intervention on T4 unit related to an individual child. All incidents are reviewed and reported via InPhase. Senior leadership team continue to support.

• WNB rate : WNB rate remains above Trust and Divisional target levels although improved in month. Project (ADHD & Community Paediatrics) to deliver changes in the models of specific appointment times and deliver improvements in attendance commenced with expected benefits from July.

Forward Look (with actions)

• ASD & ADHD : Continued work with commissioner colleagues to review opportunity for increased investment in services. Divisional review of pathways to be carried out during June led by Divisional Director.

• IHA : Proposal for a pilot delivering IHAs including use of GPs shared with Designated Place professionals. Significant interest from GPs to undertake this work.

• Clinic Letters : Compliance with clinic letter completed within 10 days remains static, actions have been taken to address the longest waits and reports shared weekly with clinical and operational teams.

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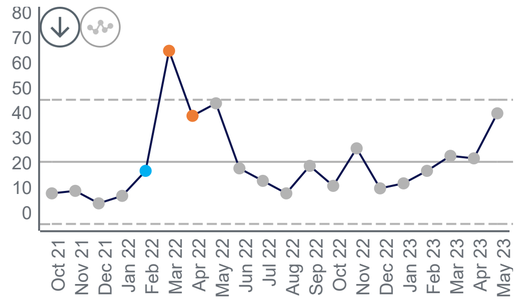
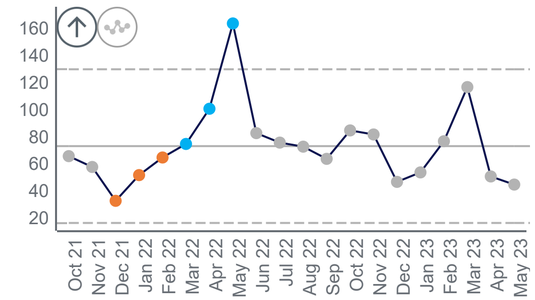
Divisional Performance Summary - Community & Mental Health

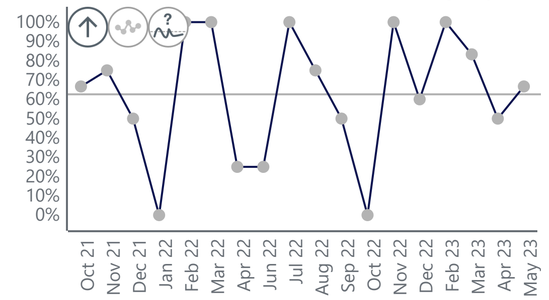
Number of Incidents rated Minor Harm and above



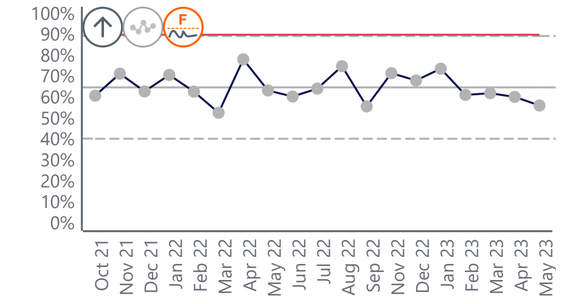
Number of Incidents rated No Harm and Near Miss



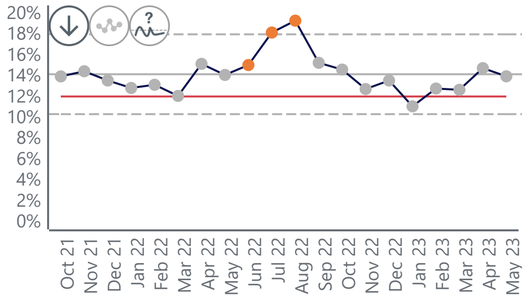
% Complaints Responded to within 25 working days



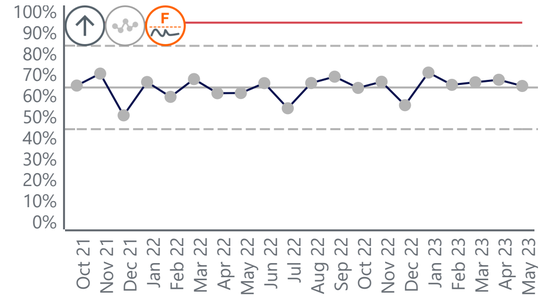
% PALS Resolved within 5 Days



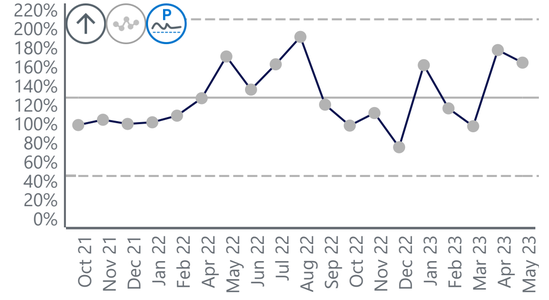
% Was Not Brought Rate (All OP: New and FU)



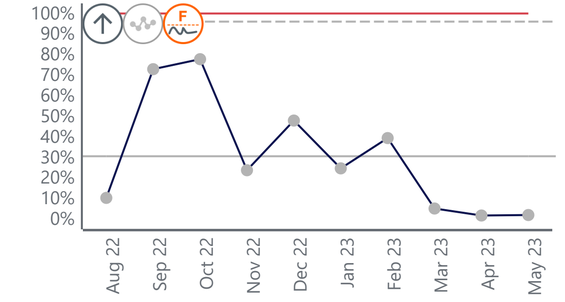
% of Clinical Letters completed within 10 Days



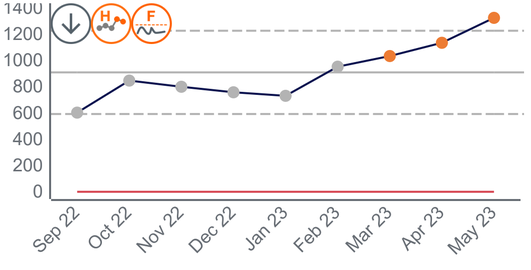
% Recovery for OP New & OPPROC Activity Volume



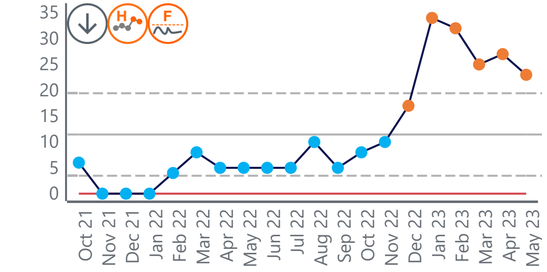
IHA: % complete within 20 days of referral to Alder Hey



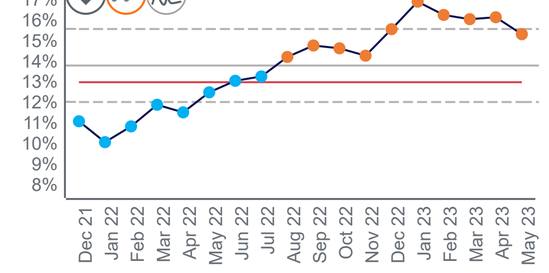
Number of ASD & ADHD children & young people >65 weeks waiting for diagnosis



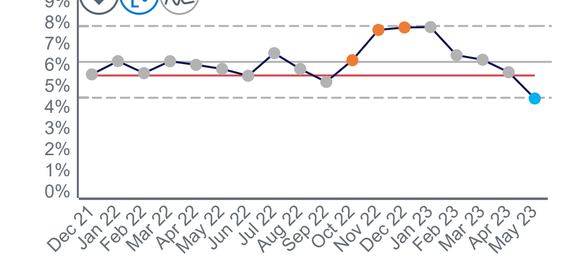
CAMHS: Number of children & young people waiting >52weeks



Staff Turnover



Sickness Absence (Total)



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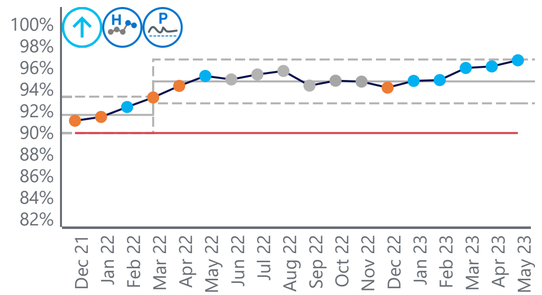
Divisional Performance Summary - Community & Mental Health

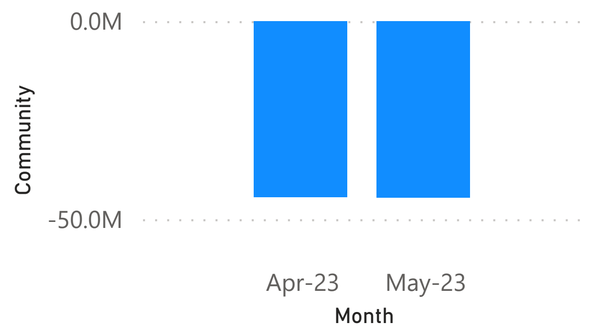
Mandatory Training



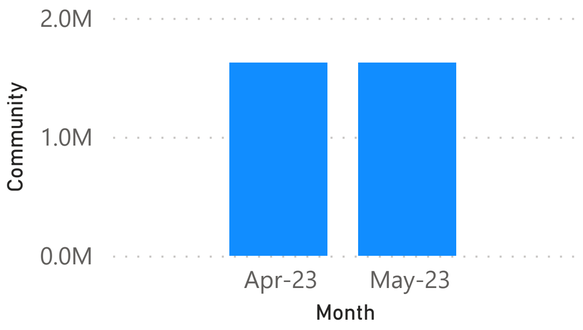
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

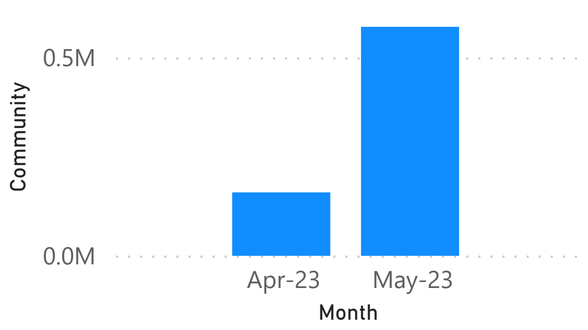
Revenue Position (Year End Forecast)



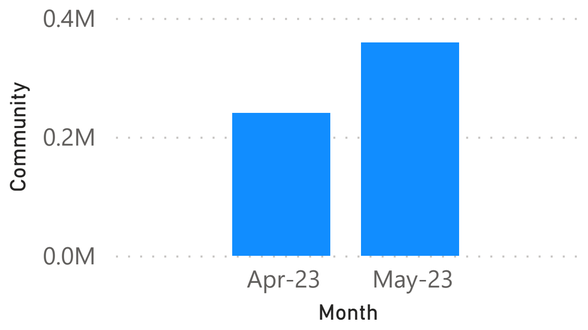
CIP Position (Recurrent Full Year Effect)

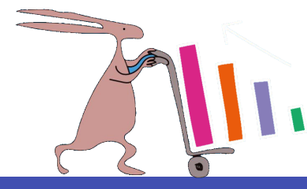


Revenue Position (Variance to date)



CIP Position (Delivered to date)





Divisional Performance Summary - Medicine

SRO: Urmi Das, Division of Medicine

Highlights

• Urgent Care : Continued improvement against the 4-hour emergency standard for 2nd concurrent month; sustained triage times well below national target of 15 minutes. Reduction in time to clinician for 2nd month, now within 13 minutes of national 60-minute standard. The PUTC has supported an overall reduction in the number of C&YP leaving before being seen for the 4th consecutive month; the senior nursing team presented the Alder Hey paediatric streaming tool at a national conference in May and this received national interest for roll out. Overall, ED F&F improved for the 2nd consecutive month. The PAU pilot scheduled for go-live late summer and scoping for the expansion of ward 3B Oncology continues.

• Recovery : Continued improvement against national EL, DC and OP recovery targets; with 5 specialities now meeting the 18-week RTT standard.

• Absence : Long term and short-term sickness absence continues to improve.

• Diagnostics : Recovery against the 6-week standard continues with performance above 91% by the end of May; only 2 children await scopes over 6 weeks and 30 children await a sleep study (all have scheduled appointments). Radiology, Neurophysiology and Home Sleep Studies are all 100%.

Areas of Concern

• Sepsis : Variable compliance in recent month both from an ED and a wards perspective

• Complaints Response times : Several issues presenting delays in maintaining the 25 working day response times.

• CIP Delivery and Financial Balance : M2 CIP in a favourable position, however plan remains a concern with relatively few schemes identified.
Renewed focus on Junior Doctor rotas with options for rota redesign being scoped with trainee representatives; the aim to reduce recurrent locum spend and improve resilience of OOH rotas.
HCA spend across ward areas remains an area of focus.

• Clinical Letters : Deteriorating trend continues; compliance being managed at individual clinician level by Clinical Directors; reports letters are utilised as failsafe for results management; CCIO reports Expanse will offer an enhanced results management system that will mitigate this issue in the long term; request for individual clinician BI report for responsiveness being explored.

Forward Look (with actions)

• Urgent Care : PAU Pilot launch scheduled for late summer along with an enhanced virtual urgent care offer to include virtual consultations.

• Winter planning : Preparation for escalation beds and expansion of Oncology ward 3B underway ahead of the autumn.

• Expansion of virtual ward offer being scoped with medical and surgical specialities.

• Junior Doctor Rotas : Review and co-redesign of junior rotas project team established with a view to go live in September 23

• Recovery : Continued focus on recovering waiting times for the 6 specialities of concern within medicine (Neurology, Endocrinology, Gastroenterology, Respiratory and LTV and Paediatrics)

• CIP : CIP Challenges set for each department; presentations requested for Divisional Finance Group in June.

• Expanse (Aldercare) : Preparations and training continue in advance of Expanse launch in September

• PDRs : Divisional Plan to conclude all PDRs (by grade) by 30th September underway; expects some variable compliance until this date.

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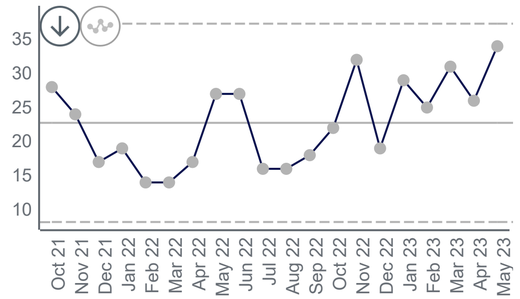
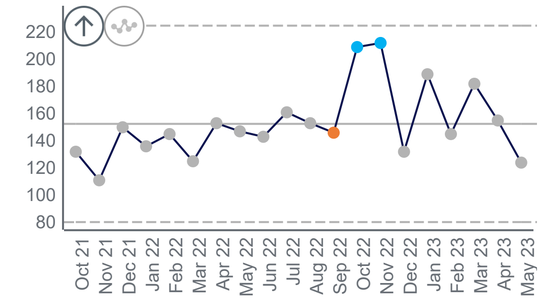
Divisional Performance Summary - Medicine

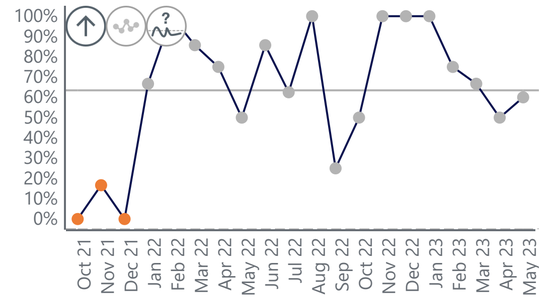
Number of Incidents rated Minor Harm and above



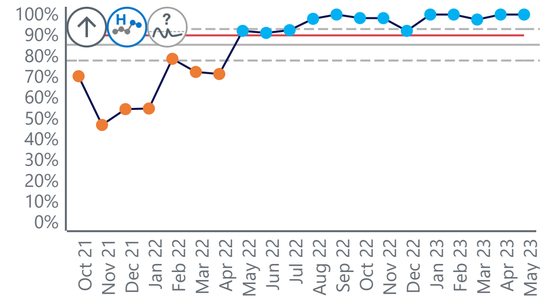
Number of Incidents rated No Harm and Near Miss



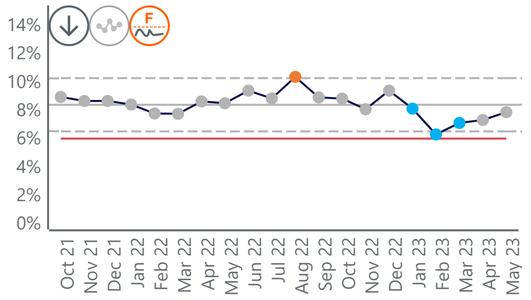
% Complaints Responded to within 25 working days



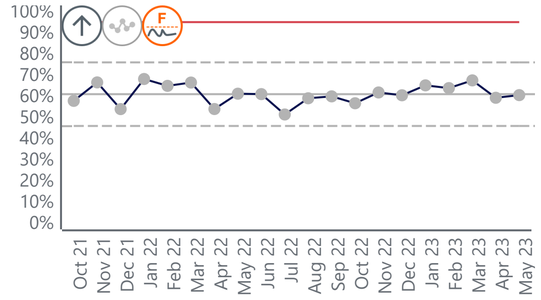
% PALS Resolved within 5 Days



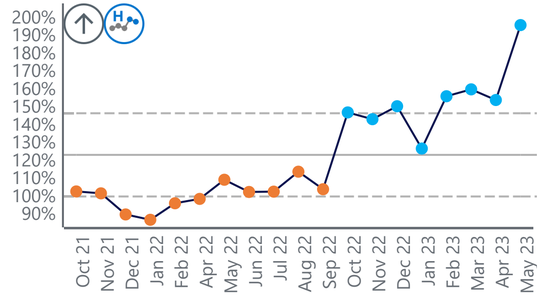
% Was Not Brought Rate (All OP: New and FU)



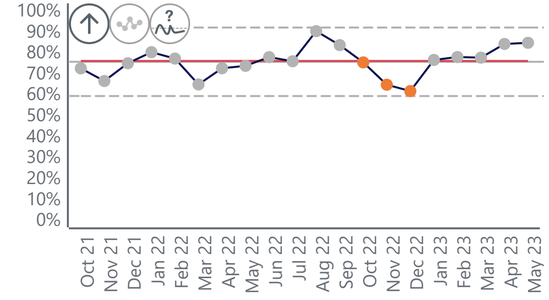
% of Clinical Letters completed within 10 Days



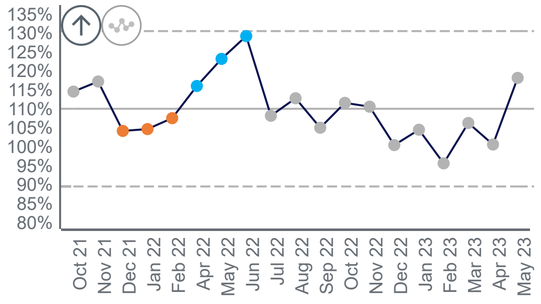
% Recovery for OP New & OPPROC Activity Volume



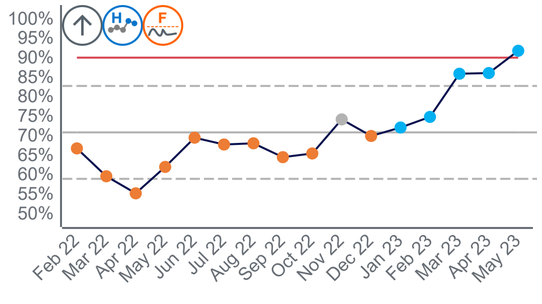
ED: % treated within 4 Hours



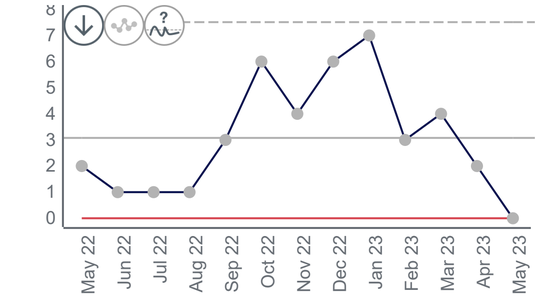
% Recovery for DC & Elec Activity Volume



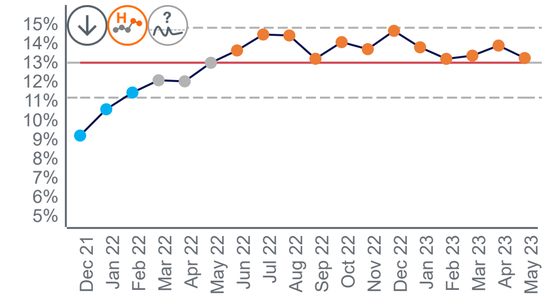
Diagnostics: % Completed Within 6 Weeks of referral



Number of RTT Patients waiting >65 weeks



Staff Turnover



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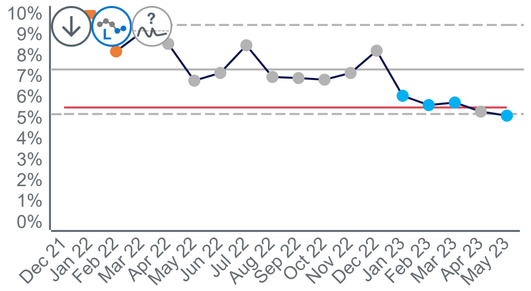
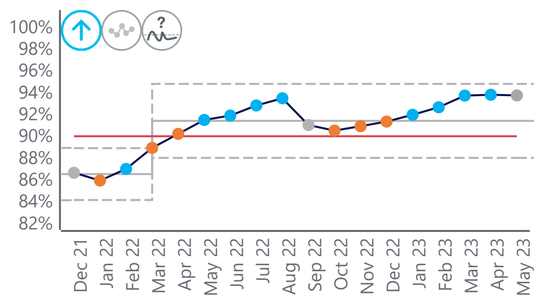
Divisional Performance Summary - Medicine

Sickness Absence (Total)



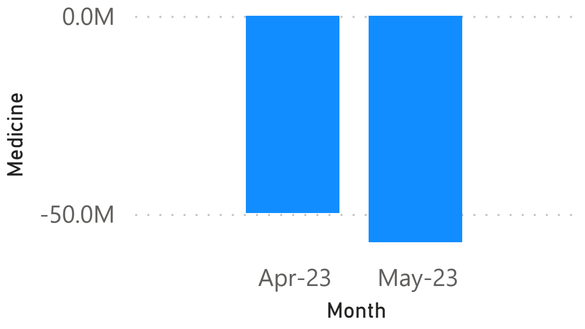
Mandatory Training



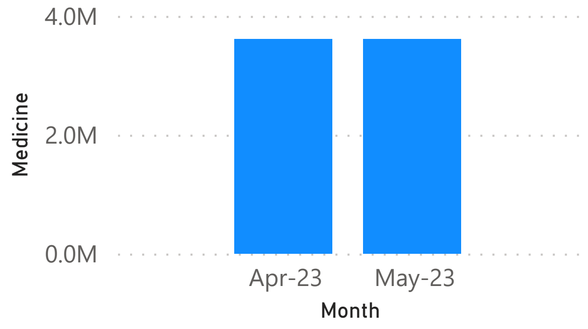
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

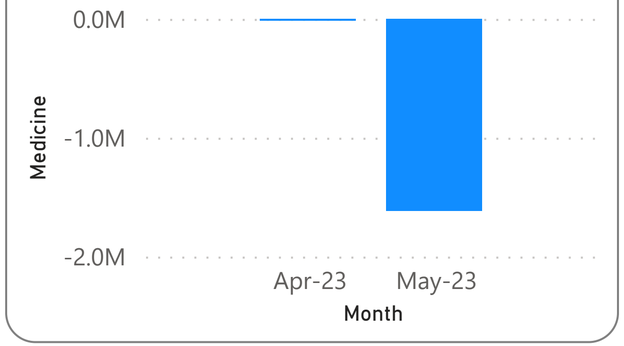
Revenue Position (Year End Forecast)



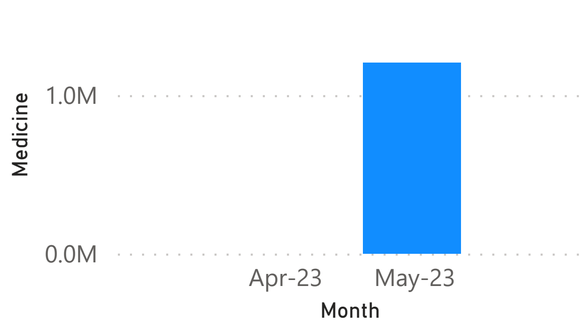
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Surgery

SRO: Benedetta Pettorini, Division of Surgical Care

Highlights

• Complaints Response : PALS response remained at 100% resolved within 5 days. Effective management via weekly meeting and direct calls with families from Head of Nursing. Although formal compaints response is not 100%- this is due to one agreed extension at complaint submission due to complexity and 1 previously extended complex complaint closing in month. Both were managed appropriately and to agreed timescales.

• % Recovery for OPNEW/OPROC Activity Volume : 112% delivered in May which was the highest in previous 12 months. Areas of significant overperformance include Neurosurgery, Dental, Plastics & Ophthalmology.

• Theatre Utilisation (Capped TT) : Surgery saw a signicant improvement of 6.4% in M2 with key improvements from Paediatric Surgery, Orthopaedics, Cardiology, Cardiac Surgery & ENT (who have also increased average cases per list). Key targets and actions are in place and reviewed via Productivity T & F and enhanced scheduling process.

• Mandatory Training : Remains above trust target in Month.

Areas of Concern

• Recovery DC/EL Activity Volume : 111 elective cases behind internal plan in Month 2. Areas of underperformance: ENT, Paediatric Dentistry, Urology, Orthopaedics & Cardiology. Also saw slight underperformance in high value areas of Spine & Cardiac due to IA and a workforce issue within Cardiac.
• WNB : Remains static at 22/23 target of 8%. Division have now undergone analysis of areas of focus relating to either a WNB rate of >10% or those that are in the FIVE element of the COREPLUSFIVE targeted conditions. These are Burns, Community Ophthalmology, Gynaecology, Oral Surgery & Dental. Some areas have commenced overbooking as an interim measure.

• RTT Patients > 65 weeks : Number of patients has increased in line with trajectory and remain in 3 key areas: Ent, Dentistry & Spine. We also have 10 Plastics patients we are treating as part of mutual aid agreement with RMCH who will be treated by the end of June. All specialties have associated actions plans including additional capacity & workforce. Insourcing is in place for Dentistry and will commence for ENT pending RABD approval.
• Clinical Letters : Deteriorating trend continues; compliance being managed at individual clinician level by Divisional Director & ACOO. Weekly speciality level report shared with speciality governance leads. Report being generated which highlights patients seen in clinic with no associated dictation. Process for review & escalation being support by BB approach.

• CIP : Delivered savings YTD against FY target of £518k and forecasting FY delivery of £2.2m. Risk remains around the £1.5m gap however number of wider schemes identified around coding, increase in peripheral work & drugs savings.

Forward Look (with actions)

• Recovery DC/ELEC : Looking ahead MTD ENT are overperforming via additional capacity & increased cases per list via productivity workstream which will narrow the varaince by end of Q1. Further actions include extended theatre sessions from Q2 onwards & an increase in scheduled in week sessions. Dental continue to increase cases per list & are on plan MTD. Cardiology Consultant gap to resolve in Q2 which will bring them in line with plan. Urology to feedback a clear recovery plan for DC activity based on nursing sickness & vacancies. Orthopaedics undergoing review of trauma pathway/capacity which is impacting elective performance.
• Theatre Utilisation TT : Areas of focus for improvement: Dentistry, Oral Surgery, Plastics & Gyane. All have scheduled discussions in with Theatre Leads to review how additional cases per list can be supported. Dental undergoing enhanced list planning meeting. Plastics elective lists are compounded by trauma capacity, meeting in June with team to review trauma provision & formulate action plan.

• WNB : Plans being formulated for key areas of concern within the division as highlighted. Patients in these 5 specialities are being targeted by the AI app and phone calls (patient having a >70% chance of WNB). Community Ophthalmology has clear action plan in place which has reduced WNB rate in Q1 however it remains a significant outlier. 'Opt in opt out' pilot to be processed in June with date for review & rollout.

• CIP : CIP programme launched in the divison which includes weekly CIP sprints with Income colleagues & workshops to identify transformational schemes. Letter from DD and ACOO being sent to Division with current position. Leads to present at June SPR on their plans to achieve specialty level targets.
• Virtual Ward : Being scoped within Surgical specialties to increase uptake.

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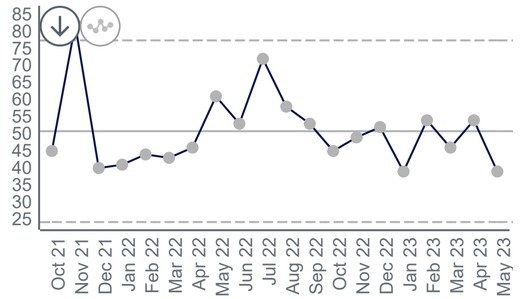
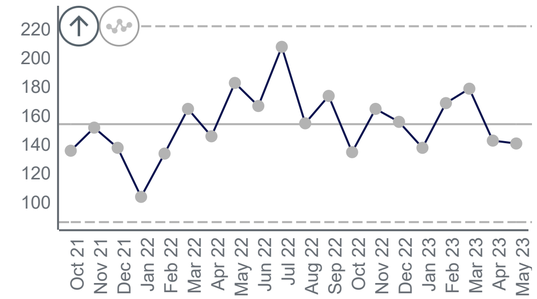
Divisional Performance Summary - Surgery

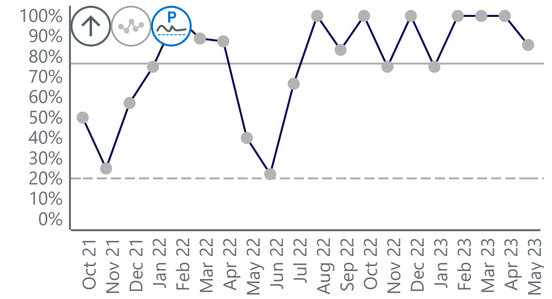
Number of Incidents rated Minor Harm and above



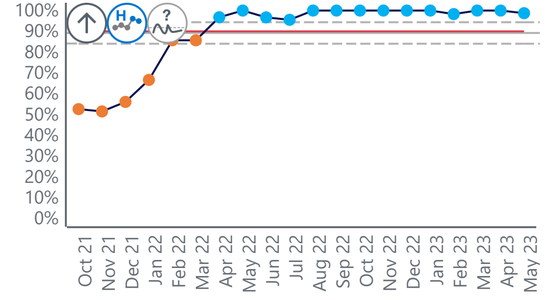
Number of Incidents rated No Harm and Near Miss



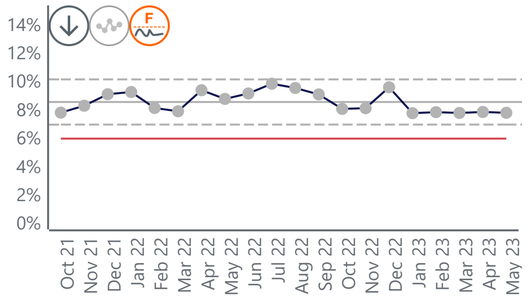
% Complaints Responded to within 25 working days



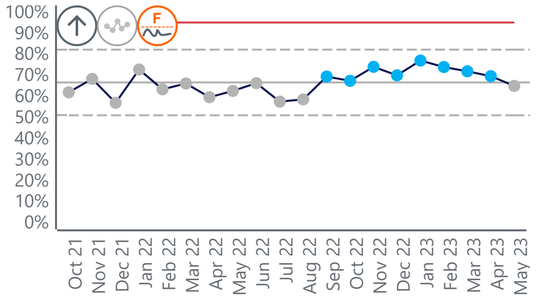
% PALS Resolved within 5 Days



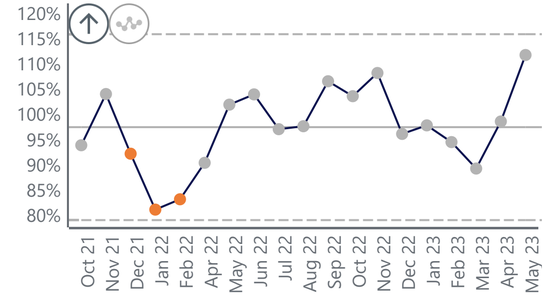
% Was Not Brought Rate (All OP: New and FU)



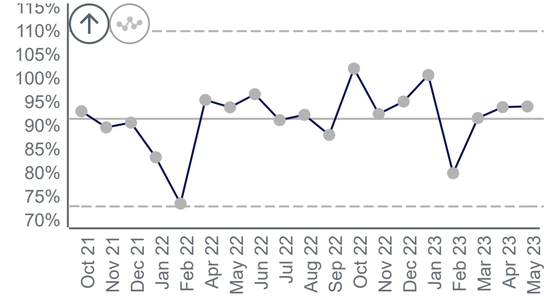
% of Clinical Letters completed within 10 Days



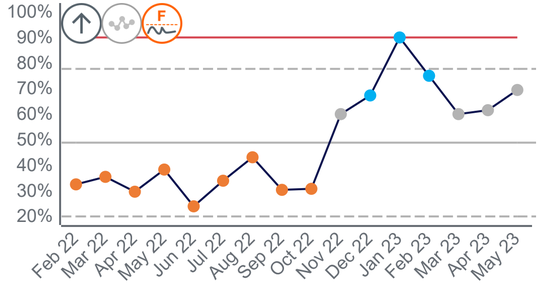
% Recovery for OP New & OPPROC Activity Volume



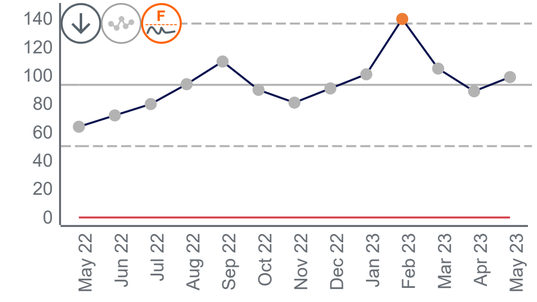
% Recovery for DC & Elec Activity Volume



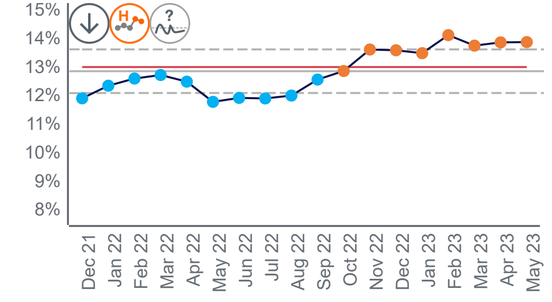
Diagnostics: % Completed Within 6 Weeks of referral



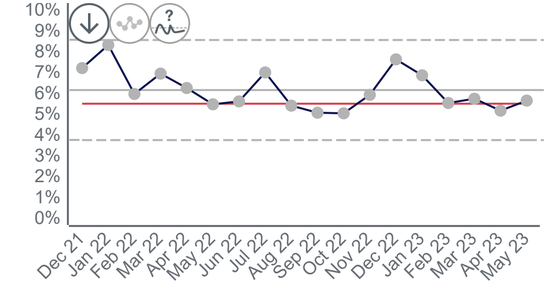
Number of RTT Patients waiting >65 weeks



Staff Turnover



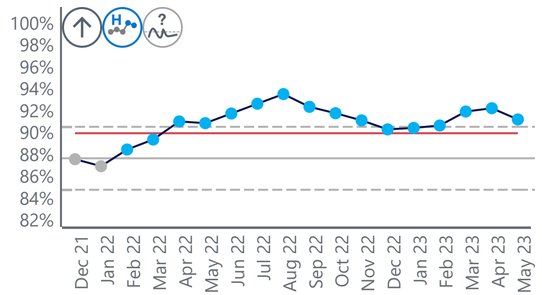
Sickness Absence (Total)



Integrated Performance Report | June 2023

Alder Hey Children's NHS Foundation Trust

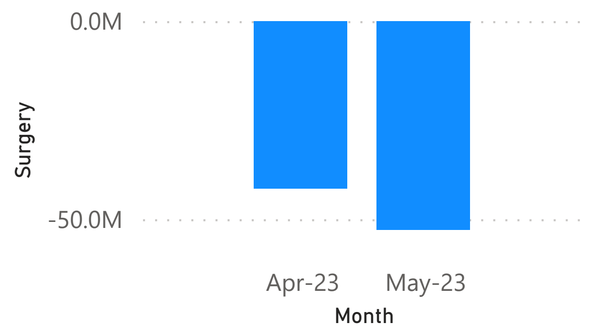
Mandatory Training



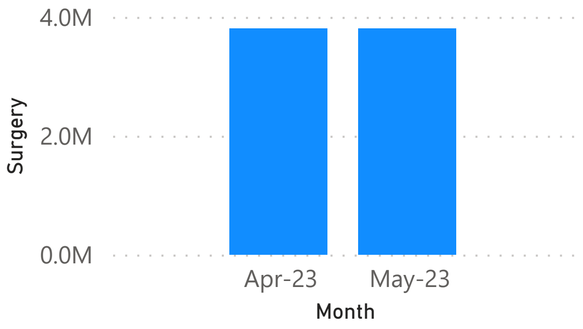
Colleague Satisfaction – Thriving Index - In Development

Staff movement / Churn rate - In Development

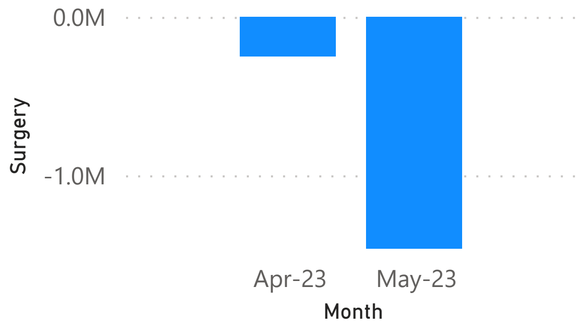
Revenue Position (Year End Forecast)



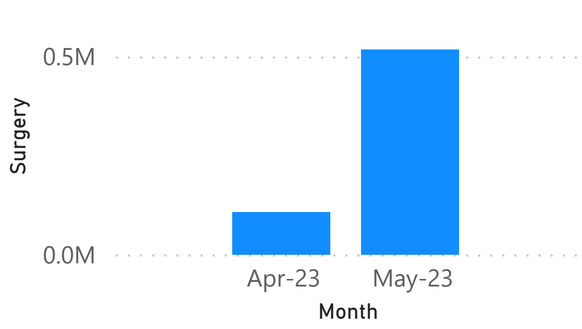
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Divisional Performance Summary - Research

SRO: John Chester, Director of Research and Innovation

Highlights

Areas of Concern

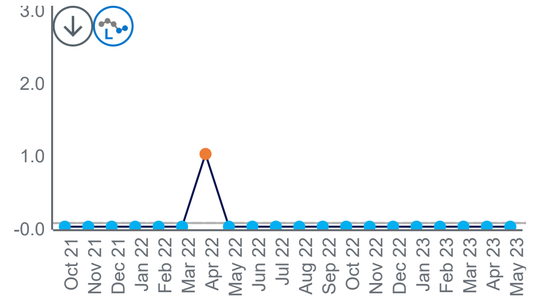
Forward Look (with actions)

Integrated Performance Report | June 2023

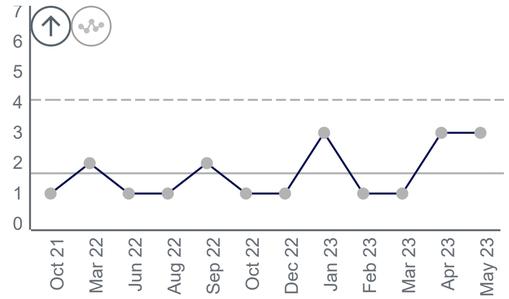
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Clinical Research

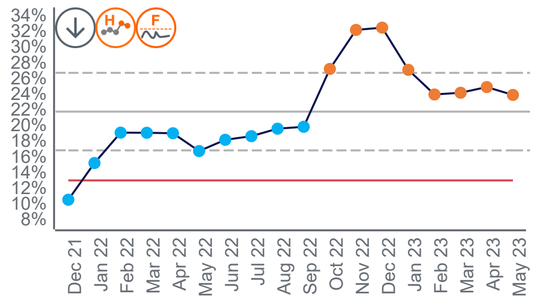
Number of Incidents rated Minor Harm and above



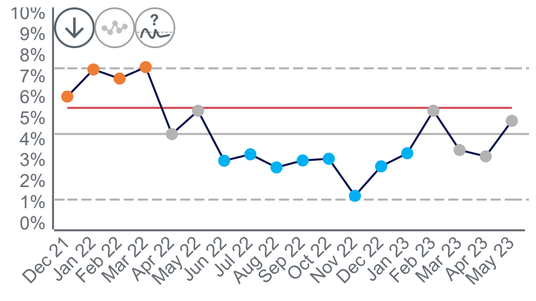
Number of Incidents rated No Harm and Near Miss



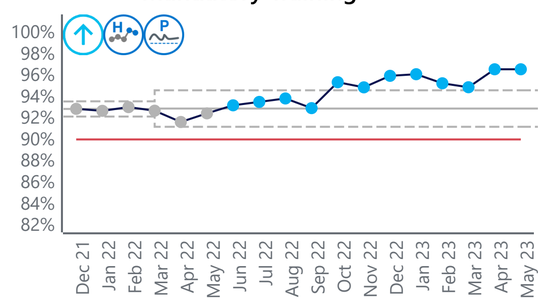
Staff Turnover



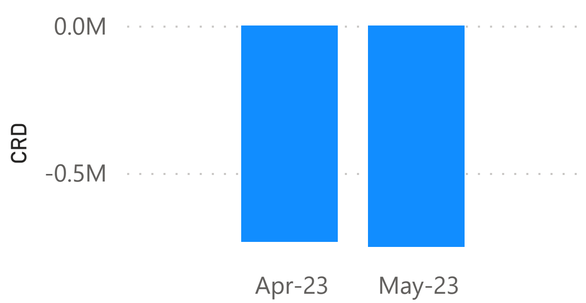
Sickness Absence (Total)



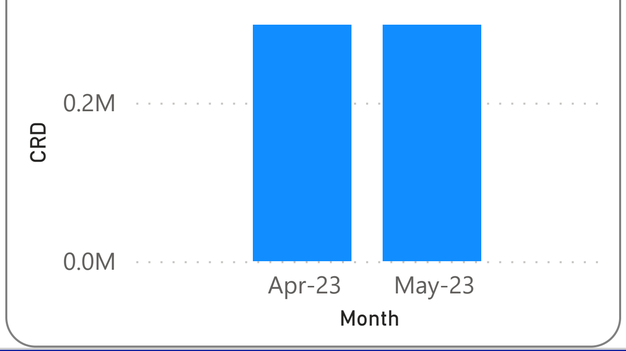
Mandatory Training



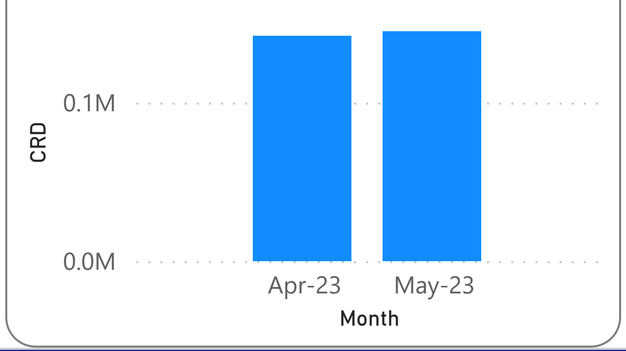
Revenue Position (Year End Forecast)



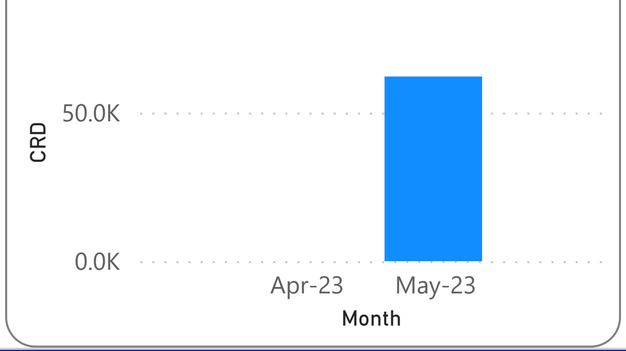
CIP Position (Recurrent Full Year Effect)



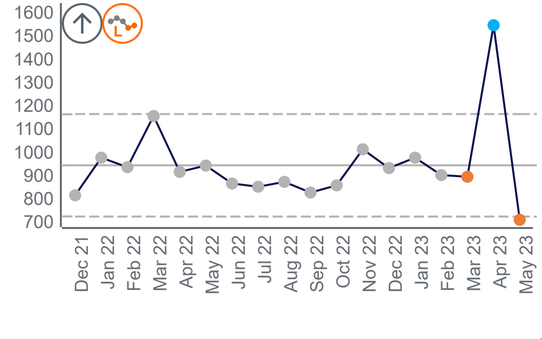
Revenue Position (Variance to date)

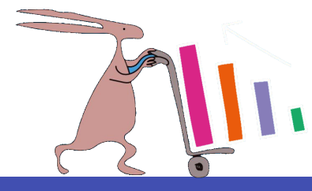


CIP Position (Delivered to date)



Number of Patients Recruited into Research Studies





Divisional Performance Summary - Corporate

SRO: Erica Saunders, Director of Corporate Affairs

Highlights

The Corporate Services Performance Review took place on 5th June, highlights from the performance review include:

It was positively received and agreed as an important route to the removal of silo working

Exec group asked the Corporate Services Collaborative to take away a number of areas for deep dives:

- Agency spend
- Opportunities for external collaboration
- Impact on divisional activity
- People segmentation with the People Strategy

Areas of Concern

Staff turnover rates remain an area of focus along with risks out of review date.

Forward Look (with actions)

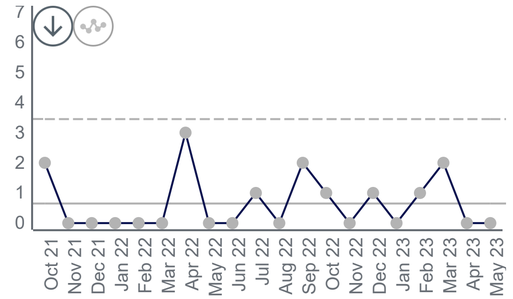
Ensuring all risks are reviewed within timescale • financial opportunities / efficiencies to be agreed by CSC

Integrated Performance Report | June 2023

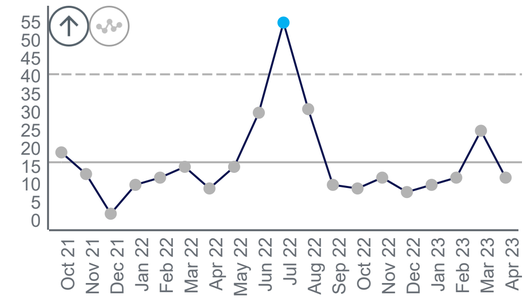
Alder Hey Children's NHS Foundation Trust

Divisional Performance Summary - Corporate

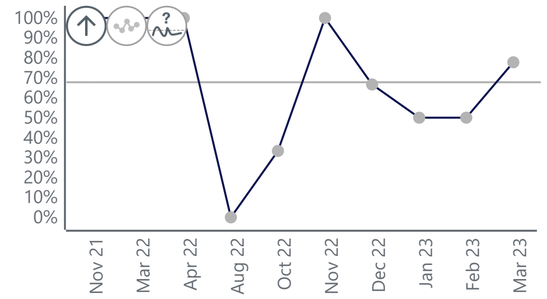
Number of Incidents rated Minor Harm and above



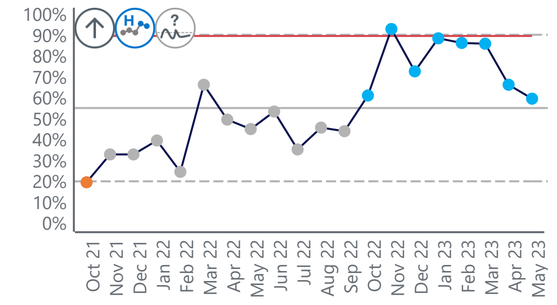
Number of Incidents rated No Harm and Near Miss



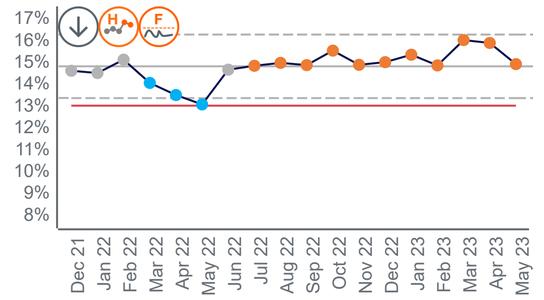
% Complaints Responded to within 25 working days



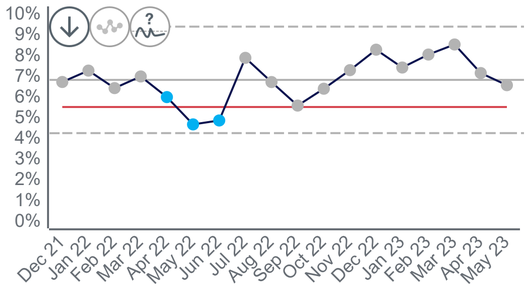
% PALS Resolved within 5 Days



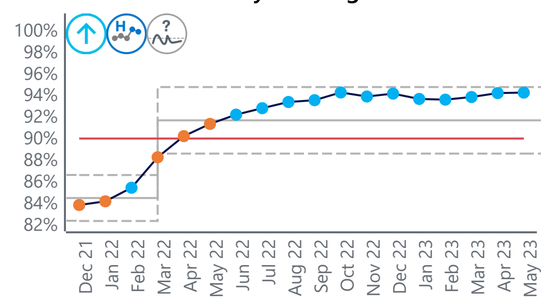
Staff Turnover



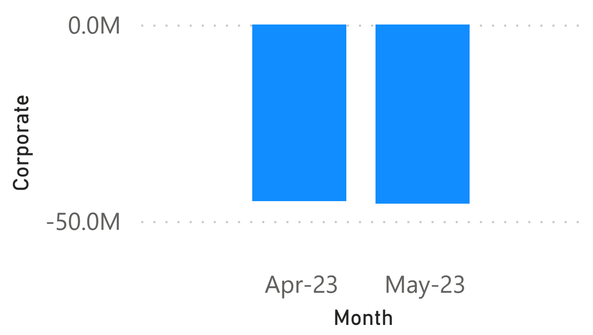
Sickness Absence (Total)



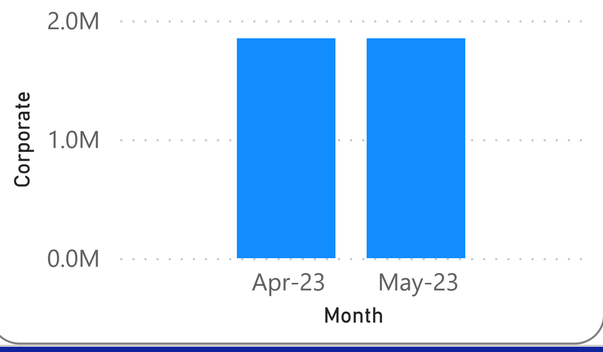
Mandatory Training



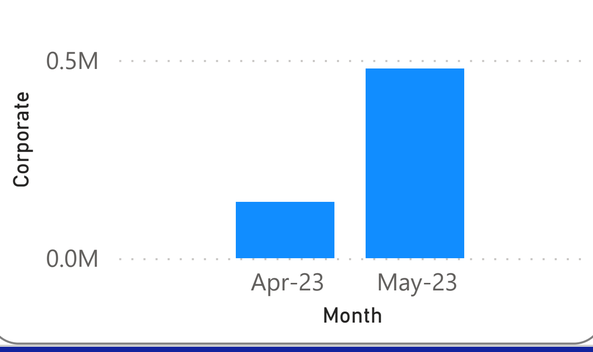
Revenue Position (Year End Forecast)



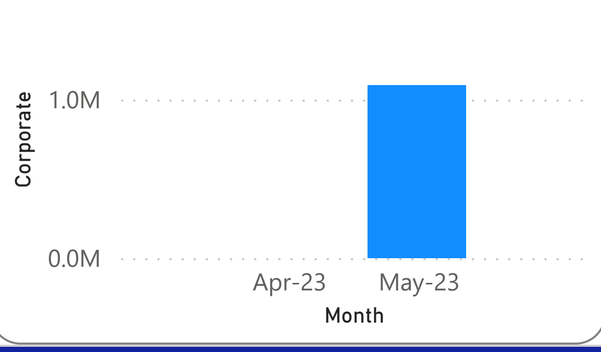
CIP Position (Recurrent Full Year Effect)



Revenue Position (Variance to date)



CIP Position (Delivered to date)



Safe Staffing & Patient Quality Indicator Report
February 2023 Staffing, CHPPD and benchmark
June 2023 Board Paper

	Day		Night		Actual hours	Patients	CHPPD	National benchmark	Vacancy		Turnover (Leavers)		Sickness		Medication incidents		Staffing Incidents		FFT			
	Average fill rate - registered	Average fill rate - care staff	Average fill rate - registered	Average fill rate - care staff	Total	Total count of Patients at Midnight	CHPPD Rate		RN - %	HCA - %	RN - %	HCA - %	RN - %	HCA - %	Month	YTD	Month	YTD	Number of responses	% Very good and good	Pals	Complaints
Burns Unit	92%	-	98%	-	1734	**78**	22.23	12.92	4.35%	47.00%	0.00%	0.00%	1.63%	0.00%	4	8	0	0	1	100%	0	0
HDU	65%	86%	63%	91%	7001	**230**	30.44	30.80	7.31%	-146.71%	0.00%	0.00%	6.00%	25.00%	5	10	2	2	2	100%	0	0
ICU	64%	74%	58%	23%	12492	**448**	27.88	30.80	4.64%	0.63%	0.00%	0.00%	6.42%	0.00%	15	27	0	0	3	100%	0	0
Ward 1cC	87%	71%	85%	100%	6382	**501**	12.74	12.61	4.60%	-39.77%	0.00%	0.00%	4.76%	16.85%	5	10	5	5	5	100%	1	0
Ward 1cN	61%	0%	66%	-	2663	**193**	13.80	13.33	3.86%	-23.46%	0.00%	0.00%	3.82%	17.86%	5	7	0	3	1	100%	0	1
Ward 3A	92%	99%	95%	134%	7494	**661**	11.34	10.63	-10.53%	14.33%	0.00%	0.00%	4.32%	9.49%	2	7	3	3	35	94.29%	0	0
Ward 3B	80%	112%	76%	-	4430	**317**	13.98	15.56	-10.08%	-65.59%	0.00%	0.00%	4.65%	0.00%	0	0	2	5	3	100%	0	0
Ward 3C	93%	90%	80%	163%	7951	**734**	10.83	10.24	1.56%	28.87%	0.00%	0.00%	1.65%	6.76%	9	11	0	0	12	91.67%	1	0
Ward 4A	80%	65%	83%	49%	7091	**694**	10.22	10.28	0.47%	9.05%	1.52%	0.00%	8.09%	6.12%	4	8	0	0	25	96%	1	0
Ward 4B	61%	92%	54%	94%	7391	**535**	13.82	9.98	9.27%	-10.49%	0.00%	0.00%	17.65%	9.03%	10	22	0	0	6	100%	2	0
Ward 4C	91%	135%	83%	121%	6860	**756**	9.07	11.00	7.62%	3.13%	0.00%	0.00%	6.73%	15.20%	13	32	2	2	35	94.29%	0	0

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

Medicine

Sickness has continued to reduce across the medical wards in February, however ward 4B remains high at 17.65% with no themes. HR drop-in sessions commenced w/c 13th February and a task and finish group has started to focus on staff wellbeing and retention. The over establishment on 4B for unqualified vacancies, includes the international nurses awaiting a pin which has also impacted the fill rate for registered as they are not yet counted in the numbers.

The over establishment on 3B for unqualified vacancies are the additional supernumerary staff who are awaiting a pin which has impacted the fill rate for registered as they are not yet counted in the numbers. The over establishment on the registered vacancies includes the supernumerary coordinator in post but not yet received the funding till May/June.

Surgery

Ward 1cN staffing is overseen by Liverpool Women's Partnership Programme. The ward also doesn't have a HCA but the housekeeper is included on the HCA line.

Ward 4A have HCA vacancies and sickness which impacted the fill rate. The ward regularly review 1:1 patients and use NHSP to cover any remaining HCA gaps.

Critical Care

HDU and ICU have had newly appointed supernumerary staff not reflected in the numbers whilst in training. Fill rate is based on planned hours required for 100% occupancy however current occupancy lower therefore quality and delivery of care not impacted.

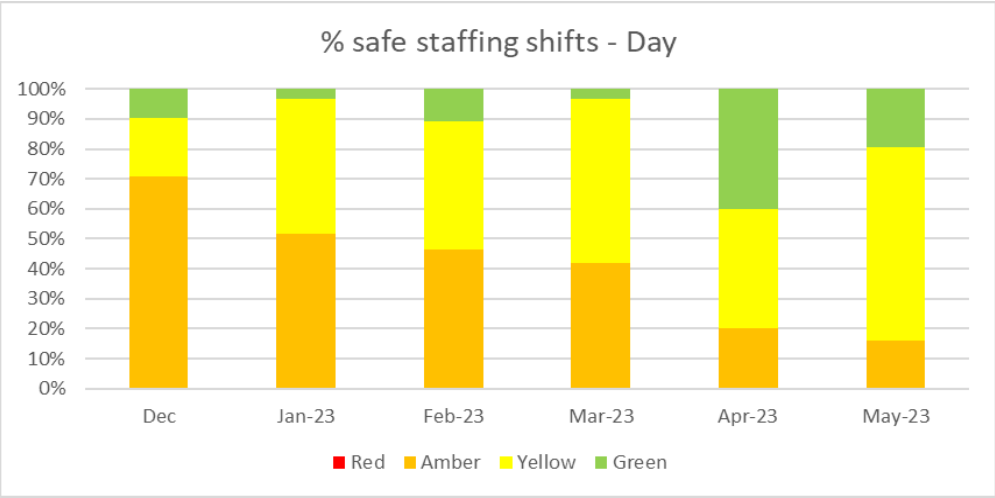
Summary

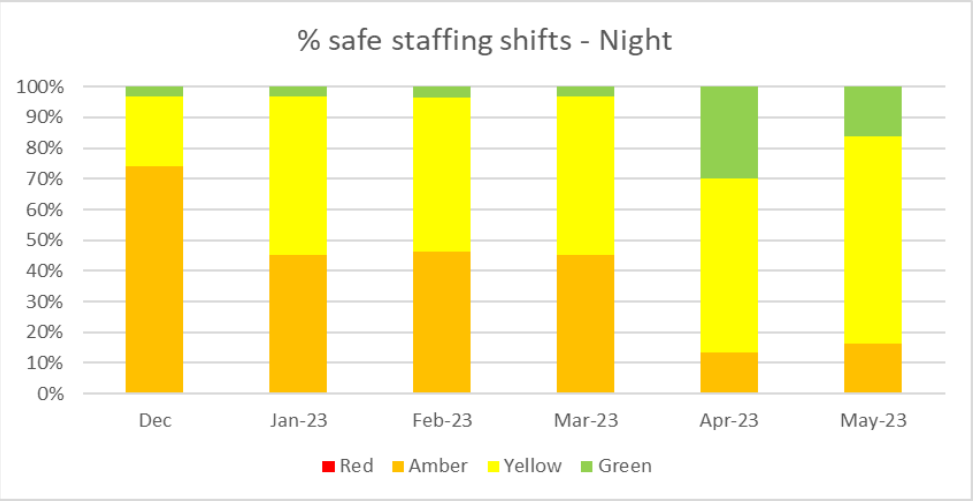
CHPPD benchmarks equally on most wards except for Ward 4C, Burns and 3B. 4C was particularly busy during this period and were at full capacity with high acuity patients. Burns CHPPD remains higher than the national benchmark. This is explained by Alder Hey incorporating a day case clinic nurse with the unit and numbers. Ward 3B CHPPD is slightly lower than the national benchmark despite over establishments due to supernumerary staff awaiting a pin and not included in the numbers.

During this period reported, staff moves on NHSP were not recorded on eRoster.

Summary of May staffing

Staffing rag has continued with high green and yellow days and nights. 0 red days have been recordered since November indicating an improvement in staffing levels.





Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

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

Alder Hey Children's NHS
NHS Foundation Trust

Campus Development Report on the Programme for Delivery

June 2023

1. Introduction

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

2. Key Risks

Project	Highlight Risk	Mitigation
Neonatal and Urgent Care	Delay and Cost Implications to Service Diversion Works	Further programme workshops undertaken. Additional survey works commenced 26.06.23. Mitigation proposal to be discussed in separate meetings with RABD and Trust Board.
Sunflower House	Fire Compliance; Sprinklers Water Safety Issues	Engineer engaged to prepare a performance specification; this is due to be issued July 2023. To be discussed, managed and monitored via monthly Facilities/Development Team catch up meeting. Joint tracker developed, linked to risk register. Pipework replacement completed. Water test results being monitored.
Elective Surgical Day Case	Challenge with space to accommodate Schedule of Accommodation (SOA).	Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.
Eating Disorder Day Case Unit	Current SoA including expanded scope, cannot be accommodated within footprint of the building. Full scope of works exceeds available budget.	Draft proposal developed between the Division and the Development Team to consider a phased development. First phase to include re-provision of EDYS, and essential enabling works. Second phase to include the completion of building works, final service re-provisions and development of the master site plan. Option appraisal currently being undertaken; Division to present a revised business case July 2023.
Main Park Reinstatement	Work Package Risks Affecting Phase 3 Reinstate Park.	Revised completion dates to be assessed with Trust advisors and Beech. Mitigation plan to be developed.

3. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2022-2024 (financial years).

Table 1.	22/23				23/24			
Scheme	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**
Neonatal and Urgent Care Blue Light Route (BLR)								
Neonatal and Urgent Care Service Diversions & Infrastructure								
Neonatal and Urgent Care Construction								
Neonatal and Urgent Care Occupation (Dec 2024)								
Sunflower House / Catkin Construction	**COMPLETE/CLOSED**							
Sunflower House Occupation	**COMPLETE/CLOSED**							
Temporary Modular Office (3SM)								
Temporary Modular Office (2SM)								
Police Station Design								
Police Station Construction								
Main Park Reinstatement (Phase 2/3)								
Demolition/Infrastructure (park)								
Mini Master plan (Eaton Rd Frontage) 3 phase plan								
Fracture / Dermatology								
Eating Disorder Day Case Unit (EDYS)								
Elective Surgical Day Case								

4. Project Updates

Neonatal and Urgent Care Development

Current Status	Risks/Issues	Actions/Next Steps
Delay and Cost Implications to Service Diversion Works.	Increased costs, delay to programme.	Further programme workshops undertaken. Additional survey works commenced 26.06.23. Mitigation proposal to be discussed in separate meetings with RABD and Trust Board.
Dependent infrastructure works will be managed in line with the construction programme. This will include: the water booster set, power connection alterations and the relocation of the 'green goddess' sub-station, all required to satisfy the site service master plan, to maintain services and to manage temporary installations currently in place.	Maintaining works in line with the construction programme. Ensuring robust engagement to support on-going business continuity.	Regular design team meetings and workshops. Escalation and monitoring via monthly FM & Development Team catch up/tracker.
Equipment transfer audit undertaken to assess new items required, and those deemed fit for transfer for the Urgent Care Centre.	Confirmation of charitable funding.	Requirements confirmed and costed. Draft charitable bid developed by Division and Development Team.

Sunflower House Construction & Occupation

Current Status	Risks/Issues	Actions/Next Steps
Finalising contract position.	Contract claim.	Development Team are in liaison with framework partner re: submission of final claim, due to be issued late summer '23.
Temporary car park in operation following closure of the under croft.	Fire compliance; sprinklers.	Engineer engaged to prepare a performance specification; this is due to be issued July 2023.

Sunflower House Construction & Occupation (Continued)

Current Status	Risks/Issues	Actions/Next Steps
		Once budget is proposed, Development Team will make preparation for the works and confirm programme details. To be discussed, managed and monitored via monthly Facilities & Development Team catch up meeting/tracker.
Move 3 final occupation completed 17.05.23.	GT Snagging & Defects.	Interface with GT aftercare team. Weekly staff 'huddle' to be continued for management of after care issues, for the duration of the 12-month defect period or as needed.

Modular/Office Buildings

Current Status	Risks/Issues	Actions/Next Steps
2 Storey Modular building (2SM) deemed not to be required.	Confirmation of cancellation fee by Portakabin in order to establish overall saving.	Meeting held with Portakabin 20.06.23. Recommendations paper drafted for discussion.
Commencement of the refurbishment to the police station cannot start due to the continued delay in legal sign over of the building to the Trust. This is a delay to programme.	Operational date currently assessed as February 2024, representing a two-month delay from previous programme. Cost impact to be assessed.	Delayed responses from police and legal advisors continuing to hinder progress regarding land ownership. This is being chased on a regular, almost daily basis. Mitigation proposed to commence enabling works ahead of legal sign off: soft strip out, asbestos removal, decontamination, etc.
.	.	

Modular/Office Buildings (Continued)

Current Status	Risks/Issues	Actions/Next Steps
The Development Team has submitted a proposal to Executive Directors for the management of office accommodation across the site.	Potential resistance from clinical teams to new ways of working, sharing space with other teams. Lack of funding for minor works/kit. Inability to grow services.	Discussions on-going. Consider site wide utilisation study, scope to be defined. Meeting held 22.06.23 with Executive Directors to discuss, plan to be developed.

Park Reinstatement

Current Status	Risks/Issues	Actions/Next Steps
Following a review of the land agreement/planning and agreed works, a schedule of required Non-Material Amendments has been developed. This is ready for submittal.		
Increased costs incurred with regards to orchard planting and the lighting scheme.	Budget review.	Lighting costs to be sought from Section 106.
Delay reported to the handover of the site of the catkin building following demolition has impacted on the scheduled installation of playground equipment. Possession expected to be provided to Horticon early July 2023.	Assess impact on overall handover date of the park.	Mitigation plan is being developed for alternative routes for any works impacted by this delay. Different working patterns, resequencing of work to be considered.
Positive discussions held with United Utilities regarding the Swales design.		Follow up meetings to be scheduled.
Grass seeding has been undertaken to repair the grassed areas. Planting generally has been maintained, and progress continues to be made on completion of the pathed areas. Progress within the park can be seen throughout.	Lack of rain and continued high temperatures could affect the planting and growth of the grass.	Maintenance to be maintained.

Fracture and Dermatology Outpatients

Current Status	Risks/Issues	Actions/Next Steps
Initial phasing proposal developed. Staff consultation concluded. Overall project programme, cost plan and risk register updated. The completion date is currently assessed as February 2024. Costs currently remain within budget. Detailed 'C sheet' room layouts (functionality & overall fit of fixed/loose items) reviewed and signed off in principle by clinical & senior leadership teams 09.06.23. Final equipment list to be confirmed, costed and procurement plan developed. Regular meetings established with Trust and the Special Purpose Vehicle (SPV). Planning has commenced on the development of the tender package submission for appointment of a construction contractor.	Trust governance/sign off. Timely appointment of a construction contractor. List of new items required exceeds available budget. Timely provision of detailed MEP and infrastructure information, and management of approvals.	Formal sign off achieved 19.05.23. Regular meetings. Close monitoring of critical risks. Equipment transfer audit to be undertaken to assess items fit to transfer. Regular meeting established to manage progress.

Mini Master Plan for Eaton Road Frontage – 3 Phase Plan

Current Status	Risks/Issues	Actions/Next Steps
Phase 1 - High level programme to be fully agreed. Phase 1 completion March 2024.	Phase 1 – planning approval, interface with Catkin/Sunflower building (works and access), and cost certainty. Budget to be identified for phases 2 &3.	Finance to confirm funding options.

Elective Surgical Day Case

Current Status	Risks/Issues	Actions/Next Steps
Budget and scope review, led by Divisional senior leadership team supported by Development Team and Day PM.	Programme, available budget.	Option appraisal currently being undertaken; Division to report re: next steps.

Communications

Current Status	Risks /Issues	Actions/Next Steps
Regular dialogue between Development Team and Communications department are now in place to cover key projects associated with the park development.	Lack of engagement internally and externally.	Maintain links with community and support their development work.
Community Open Day 02.07.23 - a forum to discuss park progress and the wider campus development.	Events budget to be confirmed.	Community sessions taken place with further provision and active engagement programme.
Regular engagement sessions have commenced with LCC and the Trust to manage overall list of actions required to complete the park.	Tasks completed to time by all parties.	On-going dialogue.

Eating Disorder Day Case Unit (EDYS)

Current Status	Risks/Issues	Actions/Next Steps
Draft proposal developed between the Division and the Development Team to consider a phased development. First phase to include re-provision of EDYS, and essential enabling works. Second phase to include the completion of building works, final service re-provisions and development of the master site plan.	Programme, available budget.	Option appraisal currently being undertaken; Division to present a revised business case July 2023.

5. Conclusion

Trust Board are requested to receive and acknowledge the update provided as of 30th June 2023.

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Confirmed Minutes of the meeting held on Monday 22nd May 2023 at 13:00, via Teams

Present:	John Kelly	Non-Executive Director (Chair)	(JK)
	Shalni Arora	Non-Executive	(SA)
	John Grinnell	Deputy CEO/CFO	
	Rachel Lea	Deputy Director of Finance	(RL)
In attendance:			
	Jenny Dalzell	Associate Director of Strategic Partnerships	
	Ian Gilbertson	Assistant Chief and Information Officer	
	Emma Hughes	Acting Manging Director for Innovation	
	Emily Kirkpatrick	Associate Director Commercial Finance	
	Graeme Montgomery	Business Accountant,	
	Andy McColl	Associate Chief Operational Officer, Performance	
	David Powell	Development Director	
	Clare Shelley	Associate Director Operational Finance	
	Erica Saunders	Director of Corporate Affairs	(ES)
	Mark Flannagan	Director of Communications	(MF)
	Gary Wadeson	Associate Director for Income, Costing and Commissioning	
	Julie Tsao	Executive Assistant (*minutes*)	(JT)
	Daryl Cassidy	Head of Financial Management *(Shadowing)*	
Agenda Item:	Katie Toolkit	Chief Procurement Officer	
	Richard Jolley	Procurement & Contract Manager	
	Graeme Dixon	PFI Manager	

23/24/23 **Apologies:**

Adam Bateman	Chief Operating Officer	
Melissa Swindell	Director of HR & OD	(MS)
Jim O'Brien	Associate Development Director	
Dani Jones	Director of Strategy and Partnerships	(DJ)
Kate Warriner	Chief Digital and Information Officer	(KW)

23/24/24 **Minutes from the meeting held April 2023**
The above minutes were approved as a true and accurate record.

23/24/25 **Matters Arising and Action log**
Financial Planning
AH submitted the second submission of the financial plan with a £12m surplus at the beginning of May as requested. JG confirmed Alder Hey wasn't in a position to increase the surplus any further and Alder Hey submission had been accepted. Going forward this would be monitored through monthly finance reports.
Action: Finance team

23/24/26 **Declarations of Interest**
There were no declarations of interest.

23/24/27 **Finance Report**
Month 1 Financial Position
As there is no requirement for external submission in M1 CS went though the internal position for M1, noting the planned deficit position.

Medicine, CAMHS division are on track, Surgery had an overspend in relation to temporary staffing, this is being monitored going forward.

Resolved:
RABD received and noted the M1 Finance report.

22/23/28 **Month 1 Integrated Performance Report**
AMc presented the IPR and highlighted:

Was Not Brought: An update was received on the work being held with families to support them attending appointments.

ADHD/ASD Diagnosis: Work being carried out to improve 65 week waiting times, AMc asked RABD to note that most patients in this category have been contacted and are waiting on a diagnosis.

Resolved:
M1 IPR report was received.

23/24/29 **CIP**
CS presented slides and agreed to circulate to RABD.
Action: CS

CS went through the process for monitoring CIP closely through regular SDG meetings, a further update would be presented next month.

Resolved:
RABD received and noted CIP 22/23 had been met with 23/24 annual planning in place.

22/23/30 **Campus update**
DP highlighted key risks within the campus update paper:
Sunflower House Campus: First patient on site at new campus.
Park: Revised completion dates are under review.

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

Neonatal Development – Commercial In Confidence
Resolved:
Following discussion RABD agreed a further extraordinary RABD meeting would be required with further detail as requested from the Development team.
Action: Development Team

22/23/31 **Aldercare**
IG presented the report to the committee and highlighted:

Programme progress continues with overall build at 92% and specialty packages build at 76%. Work continues with MEDITECH to resolve outstanding issues for the ePrescribing (EPMA) module, now down to 8 issues, and continued good progress on the EPMA build (62%). Positive results have been provided from the latest data migration testing for referrals and pathways that underpin our waiting lists and appointment booking processes.

Deploy AlderCare over the weekend 8th-11th September 2023. IG noted the programme would initially be deployed with ED before the wider Trust deployment began. Training is underway and departments are being asked to attend as a team where possible.

JK asked for assurance on benefits being monitored and tracked. RL confirmed that they were in line with the wider transformation programme.

Resolved:
RABD received the monthly update on Aldercare.

22/23/32 Innovation and Commercial Activity

EH presented the above paper highlighting activity from quarter 4 as well as looking ahead:

Neolook – Co-creation, clinical validation and test bed for Neolook telemedicine screen2screen and line of sight products for the Neonatal Department as part of the wider NICU of the future project.

Resolved:
RABD received the quarterly update on Innovation and Commercial Activity.

22/23/33 Procurement

KT presented an update on the shared service, key focus areas for 22/23, reflections and upcoming focus.

KT noted HPL getting more active with suppliers/companies externally in the near future to promote joint up working.

There was also reference to Procurement being more involved in activities upfront/earlier on so that we can support departments with procurement related activities.

Resolved:
RABD received the Procurement quarterly report noting progress on shared services and key areas of focus going forward.

22/23/34 PFI – Building report

GD highlighted:
General performance from Mitie was good in April achieving 99% PPM compliance.

On 19th April the Ground Source Heating pipework experienced four leakages, and this represents a level of leaks and disruption not seen on the contract for some time. The leaks were quickly contained, and Mitie worked with LO'R to replace the pipework in very quick time and delivered remedial works to the area with disruption to the hospital kept to an absolute minimum. Long term plan discussions are still ongoing in relation to pipework leaks.

Commercial discussions are ongoing about the failure of the permanent endoscopy decontamination unit and the cost of the portable. The new unit is still undergoing commissioning and the handover has been delayed. The portable unit is still on site and providing cover required.

Resolved:
RABD received the monthly update on PFI.

22/23/35 Board Assurance Framework

ES noted the transition period from the Ulysses to InPhase System.

Resolved:
RABD received an update on BAF risks noting a review for 2023/24.

22/23/36 Energy Investment

LS presented the above paper requesting support from RABD with three projects. Details were given on the first two projects:

Car park LEDs
Heating Analysis: RABD asked for further details on the purpose of the analysis due to there already being a fault with the service.
Action: AP

The third project was in relation to Solar Panels, this project was shared for information further updates will be provided on this next month.
Action: AP

Resolved:
RABD received the latest update and asked for further details on the need for the Heating analysis. RABD supported the Car Park LEDs project.

22/23/37 Any Other Business

No further business was reported.

22/23/38 Review of Meeting

The Chair noted good discussions on benefit realisation.

Date and Time of Next Meeting: Monday 26th June 2023, 1300, via Teams.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	Use of Restrictive Physical Interventions Annual Report 2022/2023
Report of:	Lisa Cooper Director Community & Mental Health Services
Paper Prepared by:	Dr Joann Kiernan, Consultant Nurse Learning Disabilities Andrea O'Donnell, Clinical Lead, Tier 4 Children's Inpatient Unit Jacqui Pointon, Associate Chief Nurse

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Previous annual 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:	Resource required to support ongoing training

1. Report Purpose

The purpose of this report is to:

- Provide assurance to Trust Board of activity in relation to the use of restrictive physical interventions across the Trust for the reporting period 01 April 2022 – 31 March 2023.
- Identify areas for improvement and actions for the Trust to take to support children and young people to access care safely.

2. Background

Children and young people receiving assessment and treatment from Alder Hey either within the Specialist Mental Health Services; acute hospital services (inpatient and outpatient) or wider community, may require the use of restrictive physical intervention or clinical holding. A safe and therapeutic culture should be provided for all children and young people receiving care and treatment including those who may present with behavioural needs and are detained under the Mental Health Act (1983).

Alder Hey has in place robust policy guidance updated and published in 2023 – Overarching restrictive practices policy for use with children and young people (C73) which is further supported in T4 CAMHS by (MH2), which clearly recognises that therapeutic environments are most effective for promoting both physical and emotional wellness in line with best practice.

Restrictive physical intervention is increasingly replacing the term ‘physical restraint’. This is any method which involves some degree of direct force to try and limit or restrict movement (Restraint Reduction Network, 2019). It should be necessary, proportionate, justifiable and only used to prevent serious harm. Any use of planned or unplanned restrictive physical intervention should be carried out using the least restrictive interventions and for the minimum amount of time. The physical restriction

or barriers which prevent a child or young person leaving, harming themselves, or causing serious damage to property are also included in the term restrictive physical intervention.

Clinical holding is a form of restrictive physical intervention and is using limited force to hold a child or young person still. It may be a method of helping children or young people, with their permission, to manage a health care procedure quickly or effectively. Clinical holding has been distinguished from restrictive physical intervention by the degree of force used, the intention of the hold and the agreement of the child (Bray et al., 2014), but should still be considered a restrictive physical intervention.

During 2022, work in this area has progressed across the Trust with the development of the Informed Consent for Clinical Holding for Planned Procedures leaflet and the Minimising Fear and Anxiety in Children Undergoing Diagnostic and Therapeutic Procedures policy. Further training is also in development to complement this work and is anticipated to be in place, following pilot evaluations, before the end of 2023. It is anticipated as part of this work that in the first instance an increase in reporting of clinical holding will be seen. This is to be considered as a positive step toward being open and transparent about the use and governance of this type of intervention.

For those children and young people who are being cared for under the Mental Health Act (1983) there is specific statutory guidance on different forms of restrictive intervention (and considerations for their use) detailed in the Mental Health Act: Code of Practice (2015). In addition, when providing care to young people aged over 16 years, staff should be aware of their professional obligations relating to the Mental Capacity Act (2005).

There are a number of publications regarding the use of restrictive interventions and clinical holding with children and young people (Mental Health Units (Use of Force) Act 2018 ; NICE guidance; RCN Guidance; DHSC), all of which clearly articulate the need for organisations to have a proactive approach to reducing the use of restrictive interventions but also to ensure that staff are appropriately trained and that there is a positive, transparent and collaborative culture when reporting of the use of restrictive interventions and clinical holding.

The identified Executive Lead for the Trust is the Chief Nurse who is supported to discharge these duties via the Director of Community and Mental Health Services.

3. Data regarding restrictive physical interventions

For the reporting period 01 April 2022 – 31 March 2023, the Trust reported **163** incidents regarding the use of restrictive physical interventions of children and young people accessing services at Alder Hey. This is an increase in the number **(152)** reported during 2021/2022 and lower than the number **(175)** reported in 2020/2021.

Table 1 below shows the recorded incidents involving restrictive physical interventions or clinical holding reported across the Trust per division for 2022/2023 compared with previous years.

Table 1: Recorded incidents involving restrictive interventions

Division	Restraint			Clinical Holding		
	2020/21	2021/22	2022/23	2020/21	2021/22	2022/23
Medical	44	30	76	1	4	14
Surgical	5	23	19	2	4	9
Community & Mental Health	34	88	68	80	3	13
Total	**83**	**141**	**163**	**83**	**11**	**36**

The reporting of the use of restrictive interventions reflects the continuing work undertaken across the Trust to support appropriate recording; awareness raising of the use of restrictive practice; training related to Positive Behaviour Support, bespoke awareness training sessions for departments e.g. Theatres, Outpatients and Phlebotomy and the introduction of the CALM physical intervention training.

In addition, work undertaken regarding the development of clinical holding guidance and consent (launched January 2021) has supported staff to recognise and report

appropriately. **Appendix 1** shows the recorded incidents involving restrictive physical interventions or clinical holding reported across the Trust per division.

4. Data regarding restrictive intervention incidents reporting harm

For the reporting period 01 April 2022 – 31 March 2023, no serious harm incidents were reported regarding the use of restrictive physical intervention and clinical holding in relation to children, young people or staff.

Table 2 shows the number of incidents reporting minor, non-permanent harm to children, young people and staff per division.

A total of **19** incidents were reported which is a decrease from **21** which were reported in 2021/2022. **Appendix 2** provides more detail regarding these incidents.

Table 2: Incidents reporting harm

Division	Total Number Incidents	Harm to child/young person	Harm to staff	Harm to other
Medicine	4	1	3	
Surgery	13	3	8	9
Community & Mental Health	2	2		
Total	**19**	**6**	**11**	**9**

The Trust provides support and assistance to children, young people and staff who are harmed following the use of restrictive physical intervention or clinical holding. This includes reflective practice, debrief sessions and access to Health Psychology support. Supporting children, young people and staff is paramount within this area of work to develop robust and transparent responses to need.

5. Staff Training

Education and training are central to promoting and supporting change. Staff who may be required to use positive behaviour support, restrictive physical interventions or clinical holding must have specialised training (including bank staff and security), with the focus on training being alternatives to restrictive physical interventions.

Alder Hey has provided Positive Behaviour Support (PBS) training for clinical staff since 2015 and formally embedded this into the Trust's Conflict Resolution training programme since January 2019 and since January 2021 is reported monthly to line managers as part of the Trust's mandatory training matrix.

In 2020, the Trust undertook a procurement exercise to secure an appropriate “BILD/ RRN compliant training provider” to provide accredited training across the Trust. The provider selected (CALM) is part of the “BILD Association of Certified Training” and have demonstrated their training services comply with the Restraint Reduction Network Training Standards, NHS England Standard Contract and CQC regulations.

Training commenced in January 2021 and consists of 12 hours of online learning followed by a 5-day face to face physical skills training and skills instructor training. Training is complete for staff on the Tier 4 Children’s Inpatient Unit and a “Train the Trainer” approach was initially adopted across the Trust to ensure staff continue to receive accredited training on a regular basis and so that they can cascade training across the site. However, after completing their training staff lacked confidence to offer training and the plan has been revised. Staff have continued to receive training to provide restrictive intervention. The Trust has now successfully recruited both a Nurse Specialist and Consultant Nurse Mental Health (the latter will also train to be the “CALM associate”) to support this area of practice across the whole Trust (inpatient and outpatient areas across all sites) and together these roles will provide both strategic leadership to this area of practice as well as offering training. This will include training others to become trainers. These roles will ensure there is a sustainable network that can provide confidence and assurance of the competence of the trainers and the practitioners.

The Practice Education Facilitator (Tier 4 Unit) is currently supporting staff Trust wide and co-ordinating further cohorts of staff training. In total **85** staff have been trained with 2 further cohorts planned in 2023 (approx. 30 staff). This includes Tier 4 children’s inpatient unit staff and additional areas of priority have been identified for the next cohorts. There have been some challenges for CALM in delivering the training over the past year due to staff sickness, which highlights the need for the Trust to develop its own training resource via the Consultant Nurse in Mental Health.

6. Reporting the use of restrictive physical interventions or clinical holding

Further improvements regarding the reporting of restrictive physical interventions and clinical holding have been made to the Trust’s incident reporting system, with further improvements planned during July 2022 to incorporate reporting in line with The Use of Force Act (2018) requirements.

All incidents should be reported within a maximum of 24 hours and both staff and children and young people provided with debriefs following the use of restrictive interventions. A debrief model is currently being piloted with Sunflower House staff and young people and once finalised will be implemented across the Trust as part of the wider training.

7. Reduction Programme

Alder Hey is fully committed to reducing the use of restrictive physical interventions and that when used they are proportionate, appropriate and within statutory and legal frameworks. Work is in progress and will continue as staff training is implemented across the Trust and pathways of good practice are developed.

The Trust's Tier 4 Children's Inpatient Unit has successfully completed the 'Safewards project' with positive success as part of NHS England/Improvement's 'Getting it Right First time' (2018) programme and the national quality improvement programme that is supporting best practice and guidance on the use of restrictive physical interventions.

The team are further developing resources regarding this area of work including the further development of the debrief model for the service as outlined above.

8. Next Steps

The Trust Board are asked to note the content of this report

Appendix 1: Recorded incidents involving restrictive physical interventions per division

Medical Division

Department	Number of incidents	
	Restraint	Clinical Holding
Ward 4C	75	13
Emergency Department	1	
Radiology		1
Total	**76**	**14**

Surgical Division

Department	Number of incidents	
	Restraint	Clinical Holding
Ward 3A	14	6
Ward 4A	2	1
Surgical Day Case Ward	1	
Theatre - In-Patient Anaesthetics Support	1	
Theatre - In-Patient Recovery		1
Theatres Day Case Recovery		1
Paediatric Intensive Care Unit	1	
Total	**19**	**9**

Community & Mental Health Division

Department	Number of incidents	
	Restraint	Clinical holding
Tier 4 Children's Inpatient Mental Health Unit	67	6
Children's Community Nursing Team		6
Developmental Paediatrics	1	
CAMHS - Liverpool		1
Total	**68**	**13**

NB: It should be noted that the incidents reported via the Tier 4 Children's Inpatient Unit relate to the care provided to one child who required Nasogastric feeding as part of their planned care when least restrictive options were ineffective. The child was detained under Section 3 Mental Health Act.

Appendix 2: Detail of incidents reporting harm to a child, young person, staff or other

Medical Division

Department	Incident no	Harm to patient	Harm to staff	Harm to other	Level of harm recorded
Ward 4C	63226		Patient grabbed hold of staff member's forearm and dug nails in. Small superficial marks obtained to right forearm.		C - Minor, Non-Permanent Harm
	64660		Staff nurse elbowed by patient to breast, erythema		C - Minor, Non-Permanent Harm
	65259		Patient hitting, punching and head-butting staff members.		C - Minor, Non-Permanent Harm
Radiology	60105	Red marks on wrist, back and legs where staff had tried to hold patient to complete the procedure			C - Minor, Non-Permanent Harm

Surgical Division

Department	Incident no	Harm to patient	Harm to staff	Harm to other	Level of harm recorded
Ward 3A	57673	Patient banging his head		Scratched his mum and he scratched and bit one of his carers on her left arm	C - Minor, Non-Permanent Harm
	57833		Scratches to staff. Pulled hair of one staff member,	Pulling mum's hair and biting	C - Minor, Non-Permanent Harm

	57851			Bit dad twice	C - Minor, Non-Permanent Harm
	57880	Pt latched onto staff member's arm and bit down for around 2 minutes then let go		Scratched dad	C - Minor, Non-Permanent Harm
	57824		Patient scratched and bit staff member	Patient took sister's lanyard and started whipping carer and sister and trying to bite sister.	C - Minor, Non-Permanent Harm
	63431		Patient managed to snatch walkie talkie off security and threw it at HCA who immediately bruised.	Patient physically attacking care home staff by biting, drawing blood from bites and hit one member of staff in the face.	C - Minor, Non-Permanent Harm
	64163			Patient bit one carer and then bit another once restraint was attempted	C - Minor, Non-Permanent Harm
	64179			1 carer had a bite to hand- hand. 1 carer had a bite to leg- skin broken, staff member had to leave the shift and go to A&E. 1 carer slipped during the incident and twisted his knee.	C - Minor, Non-Permanent Harm
	64606		One staff member bitten		C - Minor, Non-Permanent Harm

	64980	Caused minor injuries to herself (not specified)	Bit staff members and caused minor injuries to staff members (not specified)		C - Minor, Non-Permanent Harm
Ward 4A	60826		Patient aggressive and confused, punching, kicking, headbutting & scratching HCA and other staff member	Patient aggressive and confused, punching, kicking, headbutting & scratching mum..	C - Minor, Non-Permanent Harm
Theatres Day Case Recovery	59446		Injury to staff member's back as patient was combative, was throwing self around trolley and trying to jump off – staff member reacted to ensure patient safety and prevent them from self harm		C - Minor, Non-Permanent Harm
Surgical Day Case Ward	57545	Scratch to right foot. No treatment required. small scratch with a dot of blood evident.			C - Minor, Non-Permanent Harm

Community & Mental Health Division

Department	Incident no	Harm to patient	Harm to staff	Harm to other	Level of harm recorded
Tier 4 Mental Health Unit	57216	Mild friction burn on left leg from where child A had been			C - Minor, Non-Permanent Harm

		attempting to push back			
	57693	Patient pulled NG tube out and while she pulled ng tube the tape ripped her skin slightly on her right cheek. Not bleeding just looks red and sore.			C - Minor, Non-Permanent Harm

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	**QTR 4 DIPC Trust board report**
Report of:	**Director of Infection Prevention & Control**
Paper Prepared by:	DIPC /Lead Nurse IPC

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

1. Introduction – Summary of key risks and issues

Staffing issues led to business contingency measures being implemented during quarter 3 and quarter 4 2022-3 to ensure that that service priorities were delivered, and junior staff are supported.

Issues QTR 4

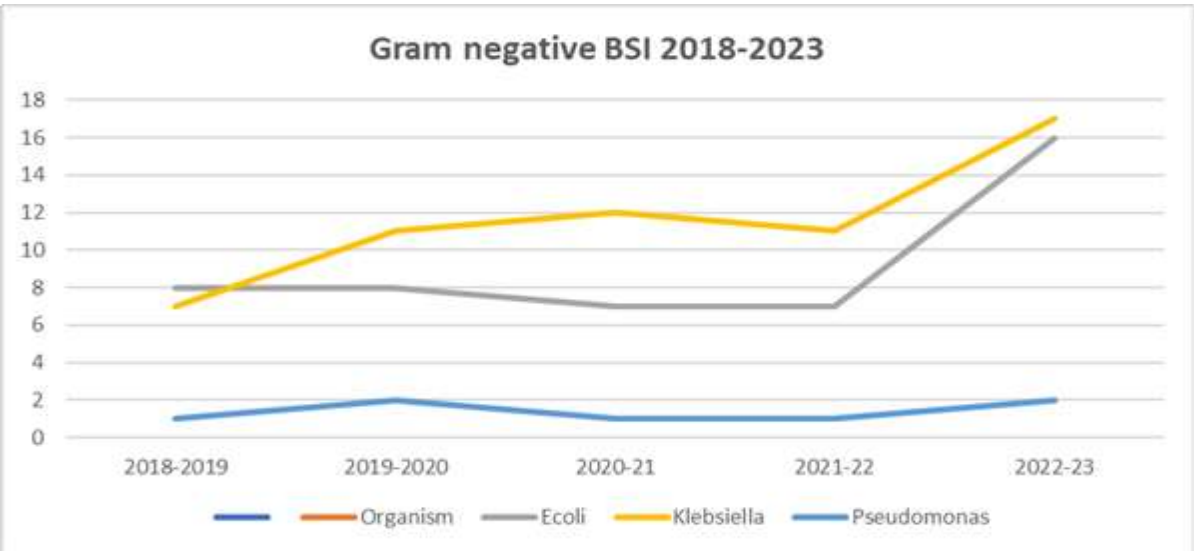
Increase in patients with HAI Multi antibiotic resistant Organisms

There were **6** cases of Hospital acquired CPE in 2022-3 (**2** in 2021-2) identified in Critical care, medical specialities, and cardiology. No link was identified between the cases and no additional cases were identified during contact screening or outbreak investigation.
Screening with CPE carriage outside of Critical care has been suboptimal so cases may be missed on patient admission. Consideration should be given to regular screening of frequent attenders and long- term patients although this will have implications for the Laboratory.

There were **7** cases of Hospital acquired VRE in 2022-3 (**2** in 2021-2). The cases were identified in Critical care, Oncology and General medicine. Surveillance screening for VRE carriage isn't undertaken routinely outside of critical care. Colonisation outside of critical care may not be readily identified. Consideration should be given to regular screening of frequent attenders and long- term patients outside of Critical care especially in Oncology and medical specialties, this would also have implications for the Laboratory in terms of increased screening.

The lack of real time clinical data about antimicrobial consumption means that we are unable to ascertain if these were related to antibiotic use.

Increase in GNB BSI



Year	2018-2019	2019-2020	2020-21	2021-22	2022-23
Organism					
E.coli	8	8	7	7	16
Klebsiella	7	11	12	11	17
Pseudomonas	1	2	1	1	2

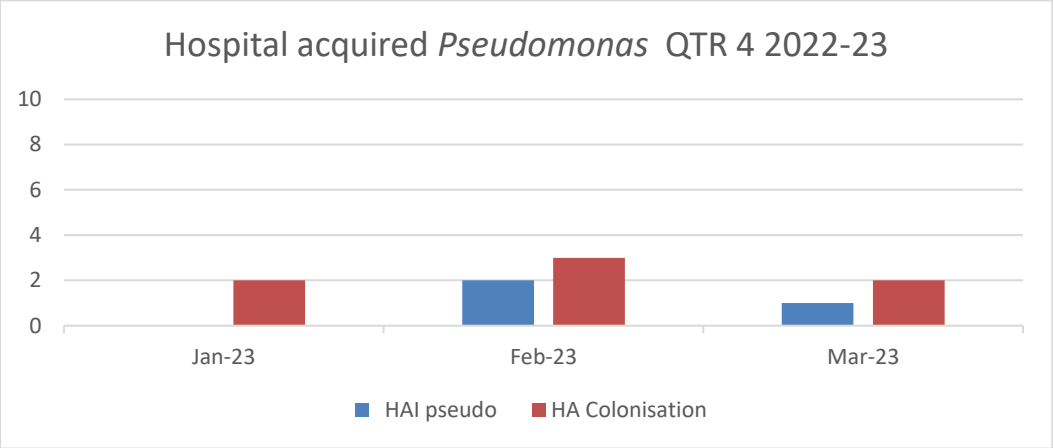
The increase in Gram negative blood stream infections continued in QTR 4 2023-4
The rate for the following

- *E.coli* rate 28.0 for 100,000 bed days
- *Klebsiella* 28 per 100,000 bed days
- *Pseudomonas* 0.0 per 100,000

The majority GN BSI cases in 2022-23 were from Gastroenterology & Paediatrics .
The source for most patients was thought to be their IV Lines but many of the children had gut dysmotility and 2 of the Oncology patients were on chemo so Mucosal Barrier Injury couldn't be excluded as a source. In one patient Urosepsis was thought to be the source of the BSI.

Increase in patient acquisition of *Pseudomonas*

QTR 4 2022-3 has seen an increase in the number of patients being identified as having HAI pseudomonas colonization and infection. Surveillance screening is only undertaken in high-risk areas such as Critical care, oncology and on 1C so colonization is more frequently identified in these areas. Investigations are being carried out to exclude the water outlets as source of *Pseudomonas* and cases are being managed as the Water safety plan.



<u>QTR 4 -Key risks</u>

Non delivery of IPC standards due to insufficient IPC staffing levels 2710
The impact of long- term sickness and new inexperienced staff continued to impact on the delivery of the IPC service into QTR 4. As staff have continued to return and support has been provided to the team, we have been able to expand the service we have been able to deliver from the contingency agreed in QTR 3. The team have been fortunate enough to secure the support of the 'Brilliant basics' team which will assist in the team in the development of a more streamlined effective service

IPC Policies are not up to date and not reflective of IPC current practice 2748
At the end of QTR 4 several IPC policies were out of date due to the staffing capacity. A recovery plan is in place with key policies due to approved once the IPCC is reinstated in QTR 1 2023-4.

Fit testing compliance 2788
The B5 Fit tester left the Organization at the end of QTR 4 which coincided with a dip in compliance as large numbers of staff were due for their 2 yearly fit testing. A Fit tester /Vaccinator has been appointed and undertaken training. Consideration should be given to this service reporting to Health & Safety.

Lack of data skills within the IPC team resulting in ability to monitor and recognise IPC standards across trust 2715
The lack of real time meaningful clinical data about the impact of nosocomial transmission of pathogens, antimicrobial consumptions means that we are unable to make informed decisions about where to focus resources.

2. Background and current state

Table 1 shows the targets set and the outcomes for 2022-23

Metric	Target 2022-23	Target figure	Actual figure	Status end of Q4
HA MRSA BSI	Zero tolerance	0	0	✓
C. difficile	Zero tolerance	0	0	✓
MSSA	Reduction from 2022-23	<9	8	✓
CLABSI(ICU)	Reduction from 2022-23	<21	12	✓
Gram negative BSI	Reduction from 2022-23	<19	35	X
RSV	Reduction from 2022-23	<7	12	X

3. Conclusion

The IPC service continued to experience insufficient staffing during QTR 4. Progress has been made to expand the service delivered as capacity has allowed. We have seen an increase in hospital acquired antibiotic resistant organisms compared to 2021-22. These have not been related to outbreaks of infection. We are unable to identify if this is related to antibiotic consumption or factors such as compliance with screening for multiantibiotic resistant organisms.
The Trust has also seen a significant increase in the numbers of Gram negative Blood stream infections especially due to *E. coli.* Hospital CLABSI rates per 1000-line days haven't been available prior to QTR 1 2023-4 to determine if this is significant increase or a reflection of increased activity or line days. Rates from UKHSA look at rates per 100,000 bed days.
There has also been an increase in the numbers of Hospital acquired *Pseudomonas in QTR* 4 which is being monitored by the Water safety committee.

4. Recommendations & proposed next steps

- Revision of IPCC and governance processes for IPC and reinstatement of IPCC in QTR 1 2023-4.
- Develop of IPC workplan for 2023-4 based on the Board assurance framework.
- Consideration to be given to IPC software to support the work of the IPC service
- IPC report on incidence of Pseudomonas cases and their management to be produced for Water Safety group.
- Implementation & dissemination of our new Isolation policy
- Review of IPC policies for the management and screening of Multiantibiotic resistant organisms and dissemination of policy .
- Working with Brilliant Basics team to change the way we work to provide a more effective service for our patients, staff, and visitors

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	Serious Incident, Learning and Improvement report 1st – 31st May 2023
Report of:	Chief Nursing Officer
Paper Prepared by:	Associate Director of Nursing and Governance Trust Risk Manager

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

1. Purpose

The purpose of this paper is to provide the Trust Board with oversight of those incidents that are considered as serious incidents following the guidance from the NHS England Serious Incident Framework (March 2015), and any associated learning for the reporting timeframe 1st – 31st May 2023.

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 Assurance Boards, Patient Safety Board and Safety Quality Assurance Committee (SQAC) so that learning can be shared, and improvements enacted. The Trust Board receives a monthly summary report.

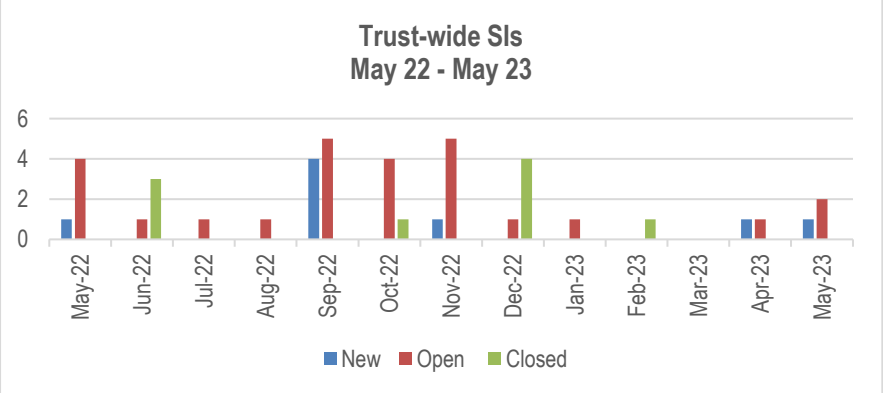
3. Local context

3.1 Never Events

The Trust declared **0** Never Events during the reporting period (1st – 31st May 2023).

3.2. Serious Incidents

Graph 1 Trust-wide StEIS reported SI status May 2023



3.2.1 Declared Serious Incidents

The Trust declared **1** StEIS incident during the reporting period (1st – 31st May 2023).

3.2.2 Open Serious Incidents

2 SIs were open during the reporting period as outlined in table 1.
0 SI investigations were completed in this reporting period (1st – 31st May 2023).

Table 1 Open SIs May 2023

StEIS reference	Date reported	Division	Incident	Summary
2023/7350	10/03/2023 (reported to StEIS 06/04/2023)	Medicine	Patient triaged to UTC GP stream with watering left eye. Seen by Go to Doc, discussed with ED Senior doctor and discharged home with oral antibiotics. Returned 6 hours later with swollen eye and signs of orbital cellulitis. Required emergency theatre overnight for drainage of collection.	Refer to appendix 1.
2023/10739	23/05/2023 (reported to StEIS 31/05/2023)	Medicine	Delayed diagnosis of bone malignancy.	Refer to appendix 1.

3.2.3 Serious incident reports

3.2.4 SI action plans

During the reporting period (1st – 31st May 2023), **1** SI action plan remained open which is within the expected date of completion.

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

3.3 Internal level 2 RCA Investigations

The Trust declared **zero** internal level 2 RCA investigations during the reporting period (1st – 31st May 2023).

3.4 Duty of Candour

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

2 initial Duty of Candour responses were required and completed within expected deadlines during the reporting period (1st – 31st May 2023).

4. Learning from serious incidents

Alder Hey Children's Hospital NHS Foundation Trust is committed to ensuring all our children, young people and their families receive the highest quality of care; responding

appropriately when things go wrong, demonstrating its commitment to continually improve the safety of the services it provides.

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

0 SI action plans were completed during the reporting period (1st – 31st May 2023).

Recommendations
The Trust Board is asked to note the contents and level of assurance provided in this report.

Appendix 1

Incident ID	Background	Immediate lessons learned (as identified via 72-hour review)	Immediate actions taken and progress to date
2023/ 7350 **InPhase ID - 279**	Patient triaged to UTC GP stream with watering left eye. Seen by Go to Doc, discussed with ED Senior doctor and discharged home with oral antibiotics. Returned 6 hours later with swollen eye and signs of orbital cellulitis. Required emergency theatre overnight for drainage of collection.	There is documentation regarding consideration of orbital cellulitis made but the relevant treatment plan, when following the ED guidelines, was not undertaken, due to clinical discretion to treat as mild periorbital cellulitis.	ED orbital cellulitis guideline has been reviewed by the ED team and it was felt the word “fever” should not be in the middle flow chart column. Ensured all pathways in ED handbook are readily available on all computers in the UTC and staff are aware of how to access. ED Sepsis Nurse/ID Consultant/Sepsis Lead to review both attendances to ensure sepsis status was correct. **May 2023:** Panels held, and report written. Report and evidence are currently with external ophthalmologist for review and comments.
2023/ 10739 **InPhase ID - 783**	Delayed diagnosis of bone malignancy.	Limping child guidelines should be followed. Number of attendances should be reviewed and taken into consideration. Multiple attendances resulted in no clear diagnosis even though there were ongoing symptoms.	Referred to Orthopaedics. Child has now been referred to the oncologist for a biopsy, staging and subsequent treatment. Potential amputation required as the tumour is extensive. **May 2023:** First panel to be arranged. Patient’s consultant is updating senior divisional management on the patient’s progress and treatment options.

Appendix 2

StEIS reference	Date incident reported	Date StEIS reported	Division	Incident	Total number of actions	Original date action plan due	Extension date agreed by division	Number of extensions
2022/23391	10/08/2022	02/11/2022	Research	Never Event – wrong side biopsy.	30 1 action outstanding.	30/09/2023		0

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	**Safety Quality Assurance Committee**
Date of meeting:	21st June 2023 – Summary 17th May 2023 – Approved Minutes
Report of:	Fiona Beveridge, Non-Executive Director
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 June 2023, along with the approved minutes from the 17th May 2023 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**

- SQAC received the Patient Safety Strategy Board update, which highlighted that the new Patient Safety Strategy Board is operating as intended, bringing a clearer focus on patient safety. The report outlined satisfactory in each of the work strands which had been reviewed in month, and a satisfactory level of assurance regarding Patient Safety Strategy Programme.
- SQAC received an update on ED MH Attendance & ED @ its Best update report; A higher % of ED MH attendances had been referred to Crisis Care (90%) and reporting had improved on patients not referred.
- SQAC received Sepsis Quarterly update. SQAC agreed that the Sepsis reporting plan would be reviewed to address whether Sepsis Team is reporting to SQAC in the correct sequence. SQAC agreed that Divisional Directors/Leads would lead the review of Sepsis training exemptions. Progress with data issues would be reviewed in month. Overall a good presentation and discussion of key issues was held at SQAC.
- SQAC received the Board Assurance Framework. Discussion took place regarding the impact of the Junior Doctor Industrial Action, with assurance being given that a safe level of cover was being maintained during Industrial action, whilst recognising the impact on access. The impact of budgetary pressures linked to cost of living matters was raised: this would be discussed at the forthcoming Non-Executive Away Day.
- SQAC received the Aggregate Analysis report, with strong assurance provided.
- SQAC received the Mortality Report/Mortality Annual Report which provided high levels of assurance, with associated learning and reflections within the report.
- SQAC received the CQUIN Quarterly Report.
- SQAC received the Clinical Audit Annual Report, which demonstrated good assurance, and considerable progress in this area, with further improvements identified for 23/24. SQAC noted the considerable level of improvement through 22/23 to ensure that effort expended on audit was directed into priority areas, and that audits were well-conceived, well-governed, and actioned appropriately; moreover, that lessons learned are shared appropriately and thematic learnings also drawn out. SQAC expressed their thanks to J Rooney and others for their efforts. The new Clinical Effectiveness and Audit Group would oversee this work from July and there has been good engagement from across the Divisions and Corporate Services.
- SQAC received the Divisional reports in the new format, with further refinement agreed regarding risk. SQAC were supportive of continued focus on deep dive process. Discussion was held regarding Friends and Family Tests deep dive, with further work required.
  SQAC were supportive of receiving a Deep Dive on Medication at the July 2023 SQAC meeting.
- SQAC received and approved the Clinical Audit Policy

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

None

4. Positive highlights of note

- SQAC received the Clinical Audit Report, which demonstrated good levels of assurance, SQAC were supportive of highlighting this improved assurance to the Board of Directors.

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 17th May 2023
Via Microsoft Teams

Present:	Fiona Beveridge	SQAC Chair, Non-Executive Director	(FB)
	Nathan Askew	Chief Nursing Officer	(NA)
	Adam Bateman	Chief Operating Officer	(AB)
	Lisa Cooper	Divisional Director, Community & Mental Health Services	(LC)
	Kerry Byrne	Non-Executive Director	(KB)
	Urmi Das	Divisional Director – Medicine Division	(UD)
	Bea Larru	Director Infection Prevention Control	(BL)
	Jo Revill	Non-Executive Director	(JRe)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Melissa Swindell	Chief People Officer	(MS)
	Cathy Wardell	Associate Chief Nurse – Medicine Division	(CW)
In Attendance:	Kelly Black	Matron, Division of Surgery	(KB)
	Dr. Matthew Neame	Locum Consultant General Paediatrician, Chief Clinical Information Officer -Medicine Division	(MN)
	Will Weston	Medical Services Director	(WW)
	Lesley Calder	Governance and Quality Assurance Facilitator	(LC)
	John Chester	Director of Research & Innovation	(JC)
	Dan Hawcutt	Interim Director of Research	(DH)
	Natalie Palin	Associate Director of Transformation	(NP)
	Jacqui Pointon	Associate Chief Nurse, Community & MH Division	(JP)
	Jill Preece	Governance Manager	(JPr)
	Laura Rad	Interim Head of Nursing – Clinical Research Division	(LR)
	Carla Thomas	Consultant Paediatric Intensivist, Critical Care, Organ Donation Lead	(CT)
	Linda Wain	Corporate Governance and Risk Manager	(LW)
	Julie Creevy (notes)	EA to Chief Medical Officer & Chief Nursing Officer	(JC)
Apologies:	Alfie Bass	Chief Medical Officer	(AB)
	Pauline Brown	Director of Nursing	(PB)
	John Grinnell	Chief Finance Officer/Deputy CEO	(JG)
	Christine Hill	Head of Operations – Laboratory Services, Safety Lead	(CH)
	Dani Jones	Director of Strategy	(DJ)
	Jackie Rooney	Associate Director of Nursing & Governance	(JR)
	Paul Sanderson	Acting Chief Pharmacist	(PS)

23/24/21 Welcome and Apologies
The Chair welcomed everyone to the meeting and noted the apologies received.

23/24/22 Declarations of Interest
SQAC noted that there were no items to declare.

23/24/23 Minutes of the Previous Meeting
Committee members were content to APPROVE the notes of the meeting held on the 19th April 2023.

23/24/24 Matters Arising and Action Log
The Action log was received and updated.

Assurance on Key Risks

23/24/25 Patient Safety Strategy Board update
WW provided an update on the work of the board:

- Patient Safety colleagues continue to apply careful scrutiny to workstreams 2, 6, 8, 10 and 21 with significant success in month with regards to the implementation of the new digital incident and risk management system Inphase. From a patient safety perspective this will allow a much easier and effective collation of data sources to inform the focus of the Patient Safety Board.
- Negligence and litigation – Clinical Legal Service Manager is now back in post and continues to monitor monthly claims data.
- Education and Training on Patient Safety level 1 mandatory training is now above 90%, with ongoing efforts to increase this further.
- Patient Safety and Human Factors Training master class is due to be provided by AQUA in June 2023, with a good update of registration to date.
- Patient Safety Strategy Board had received an update regarding Hospital Optimisation workstream, which had progressed at varying speeds. WW advised that this workstream is an incredibly complicated workstream which would cover out of hours issues and would ensure the realisation of benefits.
- Patient Safety Strategy Board colleagues attended Trust Board on 4th May 2023, high level timeline indicating various milestones had been shared, with support from the Board of Directors to progress the Patient Safety Strategy programme and interlinking with wider Trust strategies.
- Several meetings are planned with Trust Board colleagues to progress with business cases and to ensure that the Patient Safety Strategy is aligned to the Trust vision and various other strategies across the organisation, including the People Plan and the Digital Strategy.

SQAC welcomed the progress made in month, and were pleased to see the continued improvement across an array of workstreams.

FB on behalf of SQAC acknowledged the significant work undertaken to date, whilst also acknowledging the significant ongoing work required. FB highlighted the importance of the support from Executive Team and from the Non-Executive Directors.

FB sought clarity regarding the local risks requiring review, and requested detail regarding the timeline for review. WW advised that he is hoping to see significant progress towards the end of June 2023.

FB expressed thanks to WW and colleagues for ongoing efforts.
Resolved: SQAC received and **NOTED** the Patient Safety Strategy update.

Diagnostic Notifications in Meditech: Managing historic risk and developing safe and sustainable processes

Dr. Neame presented an overview of the Diagnostic Notifications in Meditech. Key issues as follows:-

- Task &Finish group had been established to risk stratify the backlog and develop a strategy and improve configuration of digital systems to support safer care.
- A consultation had been undertaken with consultants. A case note review undertaken, linked to 200 unacknowledged investigation results, clinical incident data had been analysed over previous three years, with no episodes of harm identified during case note review.
- Clinical incident review - 19 incidents over 3 years.
- Outpatient and radiology investigation disproportionately well represented.

Recommendations

- Low risk of harm in relation to backlog of unacknowledged notices and based on relatively low incident rate over the 3 year data review.
- Preferable approach is a clear communication plan and emphasis on acknowledging the most recent outpatient notification, prior to the changeover to Expanse (Meditech update September 2023).
- Colleagues are awaiting legal opinion/feedback regarding the backlog.
- Recommendations had been made with regards to reconfiguration of notification system, including notifications for all outpatient results, notifications to the ordering clinicians, rather than the named consultant. Standard Operating Procedure defining standards to acknowledge notification within 28 days.
- Analytical team to support development of reports and dashboards to monitor clinician compliance.
- Inpatient results to be managed using existing workflows and supported by new 'actioning' functionality within Expanse.

FB thanked MN for the robust work undertaken and stated that the recommendations seemed an appropriate and proportionate approach. FB sought clarity regarding the plan for monitoring, and that the ability to move the acknowledgements around within the team is critical. FB highlighted the importance of teams keeping this issue under review once implemented, to enable overview and review.

MN advised that he plans to work with the analytical team to develop a dashboard, this would enable review and would detail departmental compliance. MN provided an overview of escalation approach.
FB queried whether 28 days is the right number of days for every investigation and suspected that it is going to be under control of the relevant teams.

KB stated that this is excellent work, with a thorough review undertaken. KB advised that she is comfortable with MN suggestions regarding work undertaken to review the historic notices, and that KB is supportive of the recommendations made when moving to Expanse.

KB questioned whether there are any high risk notifications that require review.
KB sought clarity on the current process in terms of the plan until September 2023, given the challenges.

MN stated that this had not currently been specifically addressed, and that colleagues should be considering this when developing the communications strategy, which would involve working with divisions and teams. MN stated that he could include this within the communication plan in the summer if acceptable to SQAC. MN stated that it is difficult to provide a definitive response with regards to what happens between now and September 2023, as this has been an established issue for several years, and that it would be challenging to make changes over the coming months.

KB stated that she would like assurance with regards to colleagues reviewing whether there any high risk tests that had been requested and remain outstanding.

MN advised that he would give this some consideration and would provide feedback to colleagues.

JR expressed her thanks to MN for his detailed and clear report. JR referred to the notification that now goes to the ordering clinician and sought clarity regarding the escalation process, i.e. when the ordering clinician is away. MN stated that he anticipated that the reports are vital within departments to ensure monitoring through departmental and individual level, MN stated that it is extremely easy within Expanse to review someone else's notifications.

NA expressed his thanks to MN for ongoing support. NA advised that the majority of issues relate to the issue regarding the process of acknowledgement, and that from review clinicians undertake local practice of reviewing results. NA advised that following feedback at SQAC those tests or investigations that are considered high risk could be included as a recommendation to address through the Patient Safety Strategy Board.

FB confirmed that SQAC supported the proposed approach, subject to further thoughts regarding those high risk notifications, and accepting cultural evolvement in practice from now until September 2023 and that the team element would be addressed to ensure timely responses.

Resolved SQAC received, **NOTED** and supported the proposed approach subject to consideration of those high risk notification.

PSIRF- SQAC N**OTED** the PSIRF update within the meeting pack.

Delivery of Outstanding Care
Safe

23/24/26 Annual Assurance Report 2022/23 and Forward Plan for 2023/24 (Project Assurance)

NP provided the Annual Assurance Report 2022/23 and Forward Plan. NP welcomed feedback regarding longer term requirements required for programme delivery.
NP advised that the short and longer term DMO resources are pivoting to deployment to 2030 strategy.
NP stated that the assurance provided to Patient Safety is already reported at SQAC and that there is a

risk of a level of duplication when providing the same information to different agendas. NP advised on her sense of assurance and that any areas of concern would be addressed through a robust plan to ensure appropriate improvement. NP advised that WW presented that there is robust plan to address.

NP stated that the report provided assurance regarding direction of travel regarding the assurance framework.

NP welcomed views from SQAC with regards to what information is requested going forward.

FB stated that there are a couple of programmes that are Amber and sought clarity regarding what is required to get these programmes 'back on track', FB sought clarity on how this would be addressed. NP advised that this would be dependent on what elements of assurance programmes had been recorded as Amber, as for some elements it may be a failure to actually record progress that had been made, because this is evidence based. NP highlighted the importance of having a robust framework regarding change requirements which is part of the role of SRO.

FB referred to narrative on the final page of the report in terms of assurance, and the 2030 plan on a page, and sought clarity whether there is a need to identify which assurance committee supports the relevant programme.

ES advised that there is a further Board report due that should provide that oversight to ensure that there are no levels of duplication. ES referred to the Trust Board meeting held on 31st March 2023 which outlined the high level items. ES stated that this is the structure that colleagues are in the process of creating, with anticipated movement over the next couple of months, with some adjustments required regarding assurance committees, this would be shared at various forums including SQAC.

FB thanked NP for update.

Resolved: SQAC received and **NOTED** the Annual Assurance Report 2023/23 and Forward Plan for 2023/24 (Project Assurance)

23/24/27 DIPC Exception Report – including deep dive of DIPC cases and targets

BL presented the DIPC Exception Report:-

- BL advised that there had been a significant increase in the number of Gram negative blood stream infections. the Trust ended the year with 35 blood stream infections, majority of the gram negative cases related to e coli and Klebsiella which are pathogens that live in the gut. The Trust had seen an increase over the last year, particularly a sharp increase since July 2022.
- The Trust had started to see an increase in Klebsiella particularly in 2020, which has increased with both pathogens which had been more obvious over the last 2 years, particularly in 2022.
- Cases of pseudomonas had remained stable.
- BL alluded to E coli bacteraemia's, and stated that even though the Trust report such cases, that the cases are associated to a limited number of patients, i.e. 9 E coli cases in Gastroenterology, and the 9 cases related to 3 patients with repeated episodes.
- BL advised that in April 2023 there had been a case of hospital onset of c. difficile infection in an oncology child, this child was particularly a sick child in PICU. Following review of the case there were no additional actions that could have been taken by colleagues to prevent infection, as the child was immunocompromised, on chemotherapy, which precipitated the c.difficile infection.
- BL provided detail regarding the new NHS Standard Contract 2023/24: Minimising Clostridioides difficile and Gram-negative bloodstream infection and advised that the number of cases allowed for next year would be 23, and that the Trust is very likely to fail achieving this standard of 23 cases. BL provided an overview of how NHS treat adults to reduce Gram-negative bloodstream infections in terms of hydrating elderly patients. BL stated that this would not work at Alder Hey Children's NHS Foundation Trust as patients at Alder Hey are not dehydrated, and these patients have a very abnormal gut, as many of Alder Hey patients are born with issues in their gut or have congenital abnormalities that make them unable to digest food.

KB referred to the gram negative BSI target for the 5 prior years that this was under 20 every single year, with a significant increase to 35 in 2022. KB alluded to the allocated target for next year at 23, KB queried whether the 35 cases last year was extremities or whether the 35 is likely to be the new achievable level, and queried whether the target had been increased due to one abnormal year. BL stated that the local target is based on previous years. BL expressed concern that she does not envisage that this is going to be an isolated year, as the organisation sees a different population of patients and re-emphasised the importance of discussions with NHSE regarding the reality of achieving allocated targets.

KB stated that in setting Alder Hey internal targets that this should not be based on the previous year and queried whether there is a more sensible target. BL stated that this should not be based on a static target and should be based on a graphics whereby the data can be investigated and interrogated.

NA expressed his thanks to BL, NA welcomed review of the DIPC report, particularly relating to the CLABSI rate and other targets which had decreased. NA welcomed the need to move to a run chart style of reporting, to enable review of trends over time.

NA advised that a review of currencies is required, a move to the per 1,000 bed days, colleagues are working on this, and advised that the Brilliant Basics approach would help commencement of improvements.

FB expressed her thanks for comprehensive DIPC report and thought provoking discussion

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

23/24/28 DIPC Annual Report

- There had been no Healthcare Associated MRSA bloodstream infections at the Trust since January 2018
- There had been reduced cases of MSSA – 8 during 2022-23, in comparison to 7 in 2021/22
- The Trust had seen a decrease of CLABSI's in PICU patients
- BL noted the change from the majority of infections being present in the winter months to seeing increased infections in May and August.
- MRSA Non Blood Stream Infections – There were 4 cases of Hospital acquired non-Blood stream infection MRSA in 2022-23. 3 of these were acquired on 1C – Cardiology and were identified as different organisms. Screening for MRSA nonblood stream infections is in line with DH guidance.
- IPC Team are 94% compliance with audits
- Ongoing work required with regards to hand hygiene.
- IPC team had worked closely with domestic team to maintain functional risk and are working with the Water Flushing group to ensure water safety maintenance.
- BL advised that support is required from the Brilliant Basics Team to enable a change in the way IPC currently work to provide an enhanced IPC service for patients, staff and visitors.
- BL highlighted the importance of Alder Hey Children's NHS Foundation Trust driving the agenda forward for raising awareness nationally for paediatric infection control.

KB stated that the DIPC Annual Report is extremely useful and welcomed the move to standardised reporting against 1,000 bed days. KB stated that she hoped that these figures would be benchmarkable and asked whether this information could be included in next year's DIPC report. BL stated that this could be included, however this would be for only the mandatory public data on UKSA.

FB stated it is important to find the reference group to ensure appropriate benchmarking for inclusion in future DIPC Annual Report.
FB thanked BL for comprehensive update.

Resolved: SQAC received and **NOTED** the DIPC Annual Report

23/24/29 ED MH Attendance Quarter 4 Report

JP presented the ED MH Attendance Quarter 4 Report, key issues as follows:-

- There had been a decrease in the level of contact with Crisis Care from Emergency Department staff in February 2023, compared to Quarter 3 (88%)

- Section 136 room is being refurbished with appropriate plans in place during the work

FB welcomed the introduction of the new cover sheet included on the ED MH Attendance Quarter 4 Report, which provided detail on associated risks. FB welcomed comments, with regards to rolling out the cover sheet out for future meetings.

KB stated it was helpful to see the full risks within the cover sheet.

FB stated that she would not want to see risks detailed on the cover sheet with no narrative within the report on how risks would be addressed.

NP stated that it is useful to ensure that the risk description is included.

FB thanked LC and JP for good report with clear data, which clearly highlighted key issues and areas of active management.

FB stated that there is reference to ED reviewing cases that were not referred and queried whether UD could provide an update. UD advised that she would obtain background detail and would provide an update to FB offline.

Resolved: UD to provide FB with an update on background detail regarding ED cases that had not been referred to Crisis Care Team.

SQAC received and **NOTED** the ED MH Attendance Quarter 4 report.

23/23/30 ED Monthly update

SQAC **NOTED** the ED Monthly update.
NA proposed that the ED Monthly update, the ED Mental Health Attendance and the ED@ its best should be combined into one report for future updates, this was welcomed and supported by SQAC.

Resolved: SQAC **NOTED** the ED Monthly update and supported the proposal to combine the ED Monthly update, ED MH Attendance and ED@its Best reports into 1 combined report for the next update.

23/24/31 Changes to Trust wide mandatory Safeguarding Training report

SQAC **NOTED** the Changes to Trust wide mandatory Safeguarding Training Report.
Resolved: SQAC **NOTED** the changes to the Trust mandatory Safeguarding Training and **NOTED** the assurance with training compliance would be provided via the quarterly Safeguarding Assurance group SQAC **NOTED** that changes had been approved and embedded.

23/24/32 Quarter 4 Children & Young People Engagement Leads Report

SQAC **NOTED** the Quarter 4 Children & Young People Engagement Leads Report.
FB advised that the report highlighted a good level of engagement and maturity and highlighted how important children and young people had been with regards to the strategy development.

Resolved: SQAC **NOTED** the Quarter 4 Children & Young People Engagement Leads Report

23/24/33 Safe Waiting List update

AB presented the Safe Waiting list update, which provided an overview of progress made since the previous update, Status of the RCA, action plan and update on incident 61729 (relating to safe waiting list management) Safe waiting list management programme overview, distinct projects, and Safe Waiting List Management Oversight Group.

- AB advised that it had been a multiyear programme to ensure children and young people on waiting lists have the right data and accuracy, with over 130,000 patients on different waiting lists.
- Key changes relate to the re-established oversight group for Safe Waiting Lists Review, which is being chaired by C Talbot.
- Focus is on clinical letters which are unsigned, children who are not brought to appointments, data quality issues with some pathways still open, however the clock had stopped.

- There is further work required with regards to the follow up waiting list with 77,000 records to be validated, a high number of records could be validated through automated process.
- Data quality review had been completed of waiting lists in full, with the exception of the follow up waiting lists, which is anticipated to take a further 12 months given that there are 77,000 records to validate
- All ward discharge follow ups had been reviewed. AB alluded to previous issue in Urology and advised that there was no harm associated for those cohort of patients. Review undertaken identified that all had received follow up appointments when required, with 15 patients who had not received a follow up, these patients had since been followed up with no harm noted for these patients.
- 5,600 records had also been validated that had a data quality issue, with regards to the 'clock stock', and no further harm errors identified.
- AB reiterated that continued focus is to complete the full validation of the follow up waiting list, which is projected to take 12 months to complete.

JR sought clarity regarding the ward discharge process under development. AB advised that during covid some children in urology who were not followed up in a timely manner and that this highlighted that in some areas colleagues are still dependent on a paper process. AB advised that in June 2023 the plan is to launch a digital E follow up request within meditech, and also have a new power BI report to ensure a digitalised follow up request, and ensure an appropriate safety net, resulting in no follow up appts being missed following discharged.
FB thanked AB for comprehensive update.

Resolved: SQAC received and **NOTED** the Safe Waiting List update.
Clinical Governance Effectiveness

23/24/34 Quality Account

NA presented the Quality Account, and thanked colleagues for viewing the extensive report.
Special thanks were expressed to JR and colleagues for ongoing contributions in producing the Quality Account.

- Quality Account is due to be presented to the Integrated Care Board on 18.5.23.

FB stated that the Quality Account demonstrated how busy colleagues had been. FB alluded to some areas that could be strengthened in terms of innovation regarding access issues. FB stated that there was no detail on page 32 with regards to the symptom checker and the Mental Health referral and self-referral initiative.

FB referred to Page 26 of the Quality Account with regards to the clinical coding error rate. FB requested whether NA could confirm the forum that this issue is being reviewed and followed up.

FB referred to the Workforce section, - section on EDI and stated that this isn't referenced elsewhere and sought clarification whether this should be reviewed and reflected on in the future.
FB highlighted that the Quality Account did not include a reflection on work undertaken regarding Ockenden. NA advised that narrative regarding Ockenden could be included in the Quality Account and the other points raised would be reviewed before final submission.

AB referred to the clinical coding error rate and advised that colleagues would need to liaise with coding team to enable an update to be shared at SQAC at the June 2023 meeting.

KB sought clarity regarding the status of the Quality Account and referred to accounting timetables and queried whether any of the sections were audited by Ernst & Young as in previous years prior to COVID.
ES advised that the centre had agreed that this would no longer be required on a permanent basis. ES advised on the publication by 30th June.
FB thanked NA, ES, JR and colleagues for significant work undertaken.

NA welcomed any further comments for inclusion to be shared with him offline.

Resolved: SQAC received, **NOTED** and approved the Quality Account.

23/24/35 CQSG Annual Report

CQSG **NOTED** the CQSG Annual Report and were supportive of the disbanding of CQSG.
Resolved SQAC **NOTED** the CQSG Annual Report and **NOTED** that CQSG would be disbanding and replaced with the three sub-groups of Clinical Effectiveness, Patient Experience and Patient Safety to progress to an improved model of oversight and quality assurance

23/23/36 Quarter 4 2022/23 summary position report: National Institute for Health and Care Excellence (NICE) Guidance Compliance

LW presented the Q4 2022/23 summary position report: National Institute for Health and Care Excellence (NICE Guidance Compliance), key issue as follows:-

- A total of 64 NICE guidance publications were received during the reporting period, of which 3 were relevant to the Trust.
- There are 26 NICE guidance currently open across the Trust, compared to 34 from the last update.
- There are currently 8 open guidelines at assessment stage, - Medicine division – 6 and Surgery Division – 2.
- There are currently four baselines assessments that are out of compliance within the three month time scale which relate to NG14217 and 209, CG189.
- There are currently 18 open guidelines at Stage 2: Recommendations and action plan – 9 with community and MH Division, 5 within Medicine Division, 2 within Surgery Division and 2 within Corporate Services. All had been escalated to governance leads for immediate action and at time of reporting.
- CG189 had since been completed and closed.

KB stated that the report reflected an improved position from previous reports 12 months prior.
KB stated that she did not want to receive Appendix 1 within the report.
KB referred to chart 4 which details month 12-24 and 24 months and requested charts to be in months.
FB echoed KB comments regarding those items outstanding for an extremely long period and alluded to what action is undertaken for those areas with no progress for a sustained amount of time. Given the difficulty in a small number of guidelines with either no baseline assessment, or has been baseline assessment and actions not progressing as they should.

NA stated that as an assurance committee that SQAC would welcome a deep dive on those items with no progress, which required ongoing scrutiny by SQAC.

FB sought clarity from NA regarding who would undertake the deep dive, NA envisaged it would be Divisional Director/Divisional Lead and that the Divisions would receive written confirmation for clarity.

UD advised that there is a governance director in place within the Medicine Division, who has personally spoken to colleagues responsible for guidelines within the Division of Medicine. UD welcomed focus and scrutiny by SQAC.

JR alluded to a longstanding outstanding guidance relating to children who are diabetic and welcomed a deep dive of this guidance.

FB advised that offline discussion to be held to agree process.
FB welcomed an update on the plan at the July 2023 SQAC meeting and update on actions at the September 2023 SQAC meeting. SQAC would receive monthly updates thereafter until resolution.

Resolved: SQAC received, **NOTED** the report and **NOTED** the escalation of overdue assessment and lack of progression with plans to relevant Divisional Directors.

Resolved: SQAC agreed to receive monthly updates, with a detailed update on the plan at July 2023 SQAC meeting and an update on Actions at the September 2023 meeting followed by monthly updates thereafter.

23/24/37 Divisional Governance Monitoring – Closure Report

NA presented the Divisional Governance Monitoring Closure Report.

NA advised that this item had been on the SQAC action log for a lengthy time and had been updated periodically. NA advised that SQAC are now in a position to close this as an action and transfer the small number of residual actions into business as usual.
ES referred to previous discussion regarding how SQAC had progressed regarding safety culture and autonomy from divisions, whilst acknowledging the significant ongoing improvement work with regards to Inphase.

ES endorsed the closure of the Divisional Governance Monitoring - Closure Report.

Resolved: SQAC received, **NOTED** and APPROVED the Divisional Governance Monitoring - Closure Report and supported the move to business as usual.

23/24/38 National Confidential Enquiries Report – Quarter 4 2022/23 summary position report

LW presented the National Confidential Enquiries Report – Quarter 4 2022/23 summary position report, key issues as follows:

- The Trust participated in 4 National Confidential Enquiries and 1 national service improvement programme in Quarter 4.
- NCEPOD Transition from child to adult health services – data collection for this study had concluded, publication for this report is set for June 2023.
- NCEPOD Testicular torsion study – data collection for this study is completed. Publication date for the report had not yet been confirmed by NCEPOD/report is pending.
- MBRRACE-UK – last published perinatal mortality report was 2019, with recommendations relevant to the Trust and any identified associated learning is being actioned and disseminated as appropriate.
- LG had reviewed MBRRACE submission data and process undertaken and earlier notification from the clinical support team are in place to ensure compliance had improved with the 30 day submission target.
- Next steps -NCEPOD Confidential Enquiry on Testicular Torsion data had been included in Trust audit plan for 2023/24 and assigned to the Surgical division.
- Alder Hey Clinical lead supported NCEPOD with the development of aims and methodologies for the Juvenile Idiopathic Arthritis NCEPOD study. Data collection for this study is due to commence in the Summer of 2023.
- NCEPOD Transition from child to adult health services update will be provided regarding the Trust's response to the report once published.
- Future confidential Enquiries reports would focus on MBRRACE perinatal mortality recommendation and their integration within service level mortality reviews and the Trust Hospital mortality review process after discussion with Trust mortality lead.
- Suicide in children and young people (CYP) NNCSH) – Update of the Suicide and Self-Harm policy remains outstanding and had been escalated to policy leads. In the interim confirmation had been received from the Community & Mental Health Division that the current policy remains safe for use.

SQAC received and **NOTED** the National Confidential Enquiries Report – Quarter 4 2022/23 summary position report

Well Led

23/24/39 SQAC Workplan, Terms of Reference & Subgroup reporting structure and Terms of Reference

NA presented the four sets of Terms of Reference and 4 sets of Workplans.
NA advised on the proposal of disbanding CQSG to enable the formation of a clinical effectiveness group and a revised and refreshed patient safety group, patient experience group.

FB welcomed comments and feedback from SQAC.
KB referred to clinical audit and stated that the current workplan stated that SQAC would receive 1 report from clinical audit, KB proposed that SQAC receive and approve the Clinical Audit Annual Plan, with SQAC also receiving progress updates throughout the year. SQAC accepted the proposal to receive the Clinical Audit plan and regular updates throughout the year.

FB highlighted the importance of ensuring the correct timing of reports presented to SQAC to align with board reporting, which would be addressed.

NA referred to the Patient Experience Group which forms a significant part of the 2030 strategy, NA advised that the Terms of Reference had been reviewed and that the work of this group over the next 3 years would change significantly, which would be kept under review.

FB advised that this had been outstanding work undertaken to date, FB anticipated that there would be challenges regarding potential overlaps between reporting of groups, which would be kept under review.

Resolved: SQAC received, **NOTED** and APPROVED the SQAC Workplan, Terms of Reference & Subgroup reporting structure and Terms of Reference.

23/24/40 Organ Donation Annual Report

CT, Organ Donation Lead presented the Organ Donation Report, and provided an overview of performance, progress and recommendations key issues as follows:-

CT advised that organ donation in paediatrics is a fairly rare event. There is currently a large waiting list for transplants which equates to approximately 7,000 people, with 232 being paediatrics awaiting lifesaving transplants. Pressure noted in relation to heart transplantation waiting list, where there are currently 53 children awaiting heart transplant surgery. CT stated that this is relevant to Alder Hey given Alder Hey Cardiac centre, and the requirement for some of Alder Hey cardiac patients to be referred to transplant centres for cardiac transplantation.

- There had been 64 audited deaths at Alder Hey Children's NHS Foundation Trust
- Neurological death testing rate – 40%, CT advised that it would be extremely unusual across the region to reach 100% if patients do not meet the criteria, testing cannot be completed
- Donation after brain death (DBD) Referral Rate – 100%, compared to previous year which was 88.8%
- Donation after Circulatory Death (DCD) Referral Rate - 84% currently, compared to 43.3% the previous year, with ongoing scope to further improve
- Specialist Nurse Organ Donation (SNOD) Approach - 50%, this is an area for further improvement
- 2022/23 - 1 organ donor who had saved 5 lives, a young female child received a lifesaving heart transplant, a teenage boy received a liver transplant, a young female received vessels to assist with a lifesaving liver transplant and two young adults received lifesaving kidney transplants. CT advised on a recent paediatric patient who had received an adult organ donation earlier this week.
- 0 missed potential organ donors, although there were 5 patients who should have been reviewed Following retrospective analysis those patients had no potential eligibility to be able to donate organs. CT stated that colleagues are discouraged as intensivists to approach families to obtain consent for organ donation and that the approach should be completed by the by specialist nurses in organ donation (SNOD).
- CT advised that the Organ Donation Committee had re-established and is chaired by the Chief Medical Officer, The committee meet quarterly and had met 4 times over the last year.
- Organ Donation grand round presentation provided on 23rd September 2023, with communication across the Trust detailing local events.
- CT acknowledged the need to extend training into theatre to ensure training delivery.
- CT provided an update on recommendations regarding national policies organ donation training, promoting organ donation across the organisation and events to promote organ donation week during w/c 18th September -24th September.

CT welcomed feedback from SQAC.
KB alluded to the 50% of Specialist Nurse Organ Donation (SNOD) who were not involved in discussion, and the 5 referrals which did not take place, and should have. KB sought clarity on what is preventing colleagues reaching 100%. CT advised that this is multifactorial and a rare event at Alder Hey, CT advised that there is not an embedded Specialist Nurse Organ Donation (SNOD) who works within the Unit, with the need to ensure referrals in a timely manner. CT stated that the Specialist Nurse Organ Donation work closely with Alder Hey colleagues with ongoing engagement with continuing focus over the next year.

FB alluded to Clinical Ethics Committee and whether they are able to help support socialising the role of Organ Donation and whether this could be raised with the new Clinical Ethics Chair.

CT made a plea to promote organ donation across the organisation and promoting organ donation discussions.

JP queried whether there are any connections regarding organ donation and genomics, CT advised that this may be relevant as patients receive earlier genetic diagnosis.

CT sought clarity from SQAC with regards to national benchmarking data which is expected in September and sought clarity from SQAC whether future Organ Donation updates should be aligned to SQAC receiving Annual updated in December each year, to ensure up to date/ relevant benchmarking data can be shared with SQAC. FB advised that this would be considered and addressed offline, and that feedback would be provided.

JR referred to the cultural shift and stated that GOSH have significant detail on their website regarding organ donation and leaflets to different religious groups, and the importance of including relevant information on the Trust website to provide families with information. CT welcomed support from the Communications team to aid Organ Donation across the organisation.

SQAC acknowledged the organisations historical issues relating to organ retention and the sensitivities around this needed a slightly different approach to how organ donation awareness is raised.

ES alluded to reluctance and sensitivities, given previous historical issues, and stated that she is happy to help with efforts in this regard.

Resolved: SQAC received and **NOTED** the Organ Donation Annual Report

23/23/41 Board Assurance Framework

ES presented the Board Assurance Framework; key issues as follows:-

- ES advised that the BAF module had gone live on Inphase, this would aid the development of a much more sophisticated and sensitive BAF report.
- Focus on waiting list and access regarding controls this year and the thoughtfulness of the controls
- Access to Children & Young Peoples Mental Health global strategic risk – this risk had been reviewed and action closed.
- ES alluded to the Strategic risks attached to the 2030 vision workshop in July and advised that colleagues would start to see risks shifting and changing.
- Meeting had been held on 28th April 2023 regarding the risk tolerance, with agreement for a cover sheet which had been piloted by L Cooper, linking with Risk, expectation to formally report back to SQAC later in the year.

Resolved: SQAC received and **NOTED** the Board Assurance Framework

23/24/42 Divisional update/quality metrics

Responsive

Written divisional reports were received by SQAC and some key highlights presented by the respective leads.

NA advised that it would be beneficial that at future SQAC updates that Divisions considered the reports taken as read, with any questions coming from SQAC members.

NA proposed that the review of the Deep dive slides be deferred to June meeting, ensuring that each division provide a breakdown on numbers of responses and outcomes, e.g., wards will report 100% satisfaction however this could be based on 2 responses.

SQAC agreed to deferring the deep dive to June 2023 meeting, NA would review the slides ahead of SQAC meeting next month. ACNs to coordinate the slides to enable NA to review in sufficient time ahead of the SQAC June 2023 meeting.

Resolved SQAC received and **NOTED** the Divisional updates and agreed that the Deep Dive slides would be deferred to June 2023 meeting.

Resolved: ACNs to co-ordinate completion of the slides, to enable NA to review in sufficient time ahead of the next meeting.

23/24/43 Quarter 4/Year End 2022/23 Complaints, PALS & Compliments report

NA presented the Comprehensive Quarter 4/Year End 2022/23 Complaints, PALS & Compliment Report, the report demonstrated ongoing improvement, with additional actions for next year.

SQAC **NOTED** the good progress made regarding compliance in terms of responsiveness.
NA advised that the process in which experience is reviewed would be changing, and that this would develop further over the next 6 months, NA advised that the report would require an overhaul and review over the next 6 months period.

FB thanked NA for report.

Resolved: SQAC received and **NOTED** the Quarter 4/Year End 2022/23 Complaints, PALS & Compliments report

23/24/44 Annual Patient & Family feedback quarterly report

NA presented the Annual Patient & Family feedback quarterly report and advised that this was a comprehensive report which highlighted the phenomenal amount of work undertaken, with real focus on volunteers.

Resolved: SQAC received and **NOTED** the Patient and Family feedback quarterly report.

23/24/45 Any Other Business

None

23/24/46 Review the key assurances and highlights to report to the Board

- Patient Safety Strategy Board update
- Diagnostics Notification in Meditech: Managing historic risk and developing safe and sustainable processes' update, with clear recommendations which are proportionate and appropriate, clearly reflecting the learning within the report. SQAC commended this review as thorough and clear, and providing the required assurances.
- Annual Assurance Report 2022/23 and Forward Plan for 2023/24 which would now be aligned to the new strategy, with ongoing work required regarding the 2030 plan on a page to identify the assurance processes regarding the different strands. SQAC noted the substantial progress.
- DIPC Exception Report
- DIPC Annual Report, with good and interesting discussion held. Agreement to moving from a monthly reporting cycle to a quarterly DIPC report, with SQAC also receiving an Annual DIPC report.
- ED MH Attendance Quarter 4 report, which was extremely clear in the new format with risks identified, with the aim of all future reports presenting in this format.
- Assurance Emergency Department Activity Monthly update, noting the ongoing pressures within the Emergency Department, and the impact of Industrial Action and bank holidays.
- SQAC noted the Changes to Trust wide mandatory Safeguarding Training Report.
- Quarter 4 Children & Young People Engagement Leads report, which detailed a wealth of activities.
- Safe Waiting List update, and the indication regarding the new group which has been established to take this forward.
- Quality Account. SQAC commended the Quality Account as an interesting document, which clearly reflected the improvements made, and the range of activities undertaken over the year. SQAC noted that the Quality Account would be shared at various other relevant forums and into the public domain.
- CQSG Annual Report and noted the pending disbandment of CQSG.
- Quarter 4 2022/23 summary position report: National Institute for Health and Care Excellence (NICE) Guidance Compliance. SQAC noted the substantial progress made to provide assurance on compliance to most guidelines, and the much stronger process for timely review and response to new guidelines now in place. SQAC agreed that a deep dive would be required to review areas not making appropriate progress. SQAC agreed that this would be escalated to Board of Directors for awareness.

- Divisional Clinical Governance Monitoring Closure Report, and formally expressed thanks to colleagues, SQAC agreed that the report captures the changes that had taken place over the last 2-3 years across the organisation.
- National Confidential Enquiries Report – Quarter 4 2022/23 summary position report
- New SQAC Workplan, Terms of Reference and Subgroup reporting structure and Terms of Reference.
- Organ Donation Annual Report, with good discussion held, SQAC noted that the report required realignment to present future Organ Donation Annual Reports to SQAC and noted the substantial progress made to date.
- Board Assurance Framework
- Divisional update new template with good discussion held.
- SQAC received the Quarter 4/Year End 2022/23 Complaints, PALS & Compliments report
- SQAC received the Annual Patient & Family feedback quarterly report

Date and Time of Next Meeting: 21st June 2023 at 9.30 am

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 6th July 2023

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

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

1. Introduction

The purpose of this paper is to provide the Trust Board with a high-level overview of the key strategic and operational issues impacting the organisation in relation to the workforce during May/June 2023.

2. People Metrics

The detailed people metrics can be found within the Integrated Performance Report (IPR), however it is worth noting in this report that:

- Total sickness absence in May is 5.2% and below the 5.5% target, for the second consecutive month. Sickness absence levels have been falling consecutively, month on month since December 2022.
- May's 5.2% sickness absence comprises STS at 1.62% and LTS at 3.5%.
- Turnover remains high at 15%, however has remained stable since December 2022. Retention is a key workstream to be addressed in the Trusts People Plan.
- PDR's has seen a reduction in the month of May with a completion rate of 76%.

3. Industrial Action

The British Medical Association (BMA) has announced that 86 per cent of its consultant members that voted (a turnout of 71.07 per cent) have voted in favour of industrial action. The BMA has said, that unless Ministers come back with a credible offer, it plans to call 48-hours action from 7am on Thursday 20 July.

The form of strike action the consultants have voted on will provide 'Christmas Day' levels of care. This would ensure that emergency care would continue to be provided, but elective or non-emergency work would need to be cancelled.

This strike action would follow the junior doctors' five day walk-out between 7am on Thursday 13 July and 7am on Tuesday 18 July.

The Royal College of Nursing has announced that they have not reached the turnout required to undertake further industrial action. Although approximately 84 per cent of RCN members voted in favour of strike action, with an overall turnout of 43.4 per cent, the ballot fell short of the 50 per cent required for the result to stand.

The Trust continues to work closely with all staffside colleagues, as well as providing frequent Trust wide communications and updated FAQ's on industrial action. Gold/tactical command structure is in place, as well as ongoing staff support through the Trust SALS Service.

Sharon Owen
Deputy Chief People Officer
June 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	**Highlight report – Equality, Diversity, and Inclusion**
Report of:	**Melissa Swindell, Chief People Officer**
Paper Prepared by:	Angela Ditchfield, Head of Equality, Diversity, and Inclusion

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

1. Introduction

This paper aims to give the Board a high-level overview of the critical strategic and operational activity regarding Equality, Diversity and Inclusion (ED&I) during May/June 2023.

2. NHS Equality, Diversity, and Inclusion Improvement Plan

The Equality, Diversity, and Inclusion improvement plan was published in June 2023. The plan identifies six targeted actions to address direct and indirect prejudice and discrimination through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

This plan aims to improve the outcomes, experience and culture for those with protected characteristics under the Equality Act 2010 (although not limited to these groups) and links to the NHS People Plan. The plan prioritises six high-impact actions aligning with our People Plan

1. **Measurable objectives on EDI for Chairs, Chief Executives, and Board members**
2. **Overhaul recruitment processes and embed talent management processes**
3. **Eliminate total pay gaps with respect to race, disability and gender**
4. **Address Health Inequalities within their workforce**
5. **Comprehensive Induction and onboarding programme for internationally recruited staff**
6. **Eliminate conditions and environments in which bullying, harassment and physical harassment occurs**

We will use the improvement plan to identify targeted actions aligning with our people commitment. The improvement plan will provide us with a framework, which will guide us to implement the six high-impact interventions successfully—working alongside our key stakeholders and staff networks to improve and enhance staff experiences and establishing an equitable and inclusive working environment.

3. Equality Delivery System 2022

The Integrated Care Board held an EDS2022 workshop to provide regional NHS providers with information and support in successfully delivering the EDS2022. The workshop provided valuable information regarding the implementation and collection of evidence to support this. We will work with other regional trusts to gain insight into the process and peer support. We will identify three services we will work with key stakeholders to review.

The Head of EDI will work with the service leads to support data collection and analysis. We have started work reviewing our workforce health and well-being, which is part of Domain 2, which is an area designed to promote understanding of our workforce also being patients, exploring the importance of the health and well-being of our workforce.

The details of this work will be addressed through the EDI Steering Group.

4. Staff Networks

Our developing staff networks are growing from strength to strength and have been welcomed by our workforce.

- **LGBTQIA+** staff network continues to plan the activities leading up to Liverpool Pride. Some communications will encourage staff to join them on the 29th of July to represent Alder Hey. Everyone is welcome. The Navajo In Trust Charter Mark application has been accepted, and Alder Hey has successfully moved to stage two. This will involve the Navajo assessment panel visiting Alder Hey and appraising our policies, procedure, training, and culture. Supporting us to ensure we are an inclusive organisation which understands and supports our LGBTQIA+ staff
- **REACH** staff network will hold its first engagement event on the 18th of July. They are inviting staff to attend to learn about the network's aspirations. They have some ambitious plans, which will align with the Workforce Race Equality Standard data, looking to improve the experiences of our ethnic minority staff.
- **Armed Forces** staff network celebrated Reserves Day on the 21st of June, which recognises our Reservists' valuable contribution to our Armed Forces, ahead of Armed Forces Day on Saturday, 24th June. Armed forces day is a chance to show your support to all who make up the Armed Forces community, from currently serving troops to Service families, veterans and cadets.
- **Disabilities and Long-Term Conditions** staff network will hold its first meeting on Friday, 30th June. The first meeting will allow staff to learn more about the network and give them a chance to say what they would like from the network. It is an informal meeting and staff can drop in. There has been lots of interest, and we hope to support staff and develop an active network as we advance.

The network chairs and co-chairs have started on the development-training programme that will help provide them with skills and resources to build successful networks that will deliver positive changes for our staff. The Executive sponsors have also started their exec sponsors programme, designed for senior leaders who want to use their influence to drive change.

Angela Ditchfield
Head of Equality, Diversity, and Inclusion
June 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Thursday, 6th July 2023

Paper Title:	**Constitutional Change**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	• System Governance and the impact of Integrated Care Systems (ICSs) – December 2022 CoG • Code of Governance Update – March 2023 CoG
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

BOARD OF DIRECTORS

Proposed Constitutional Change

1. Purpose

The purpose of this paper is to confirm the changes to the Trust's Constitution required by the Health and Care Act 2022.

2. Background

The Health and Care Act 2022 (the Act) contains the biggest reforms to the NHS in nearly a decade, laying the foundations to improve health outcomes by joining up NHS, social care and public health services at a local level and tackling growing health inequalities.

The majority of the Act is focused on developing system working with integrated care systems (ICSs) being put on a statutory footing through the creation of integrated care boards (ICBs). It also moves the NHS away from competitive retendering by default and towards collaborative delivery.

The full Health and Care Act 2022 can be accessed HERE.

3. Foundation Trust Constitution

The Trust's Constitution is the central document which establishes the fundamental principles and processes the Directors and Council of Governors must follow and has been established since authorisation as a foundation trust in 2008.

All Constitutions must comply with statutory requirements. The recent changes to governance requirements for NHS Foundation Trusts (and Trusts) to work effectively in collaboration with partner organisations therefore requires a number of updates to the Trust's Constitution.

For ease, the changes required have been tracked.

4. Recommendation

The Board is asked to approve the changes to the Constitution including further and final updates to the list of Voluntary Organisations – Board Members are asked to consider the list detailed in ANNEX 4A (page 40 of the Constitution) and provide any updates.

5. Process and Next Steps

Under the terms of the Constitution any amendments must be approved by both the Council of Governors and the Board of Directors. This proposal was approved by the Council of Governors at its meeting on 7th June 2023 subject to approval by the Board of Directors. The amended document must be submitted to NHS Improvement to be published on its website and the amendment, as agreed, presented as part of the Governors' report at the next Annual Members' meeting.

Erica Saunders
Director of Corporate Affairs
July 2023

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS
Thursday, 6th July

Paper Title:	**Board Assurance Framework Report 2023/24 (May)**
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 ☐
Strategic Context **This paper links to the following:**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Does this relate to a risk? Yes ☒ No ☐		
Risk Number	Risk Description	Score
All BAF risks	This report provides an update on actions being taken to mitigate the how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives	

Board Assurance Framework 2023/24

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long-term objectives are being proactively managed, in accordance with the agreed risk appetite. The BAF for Alder Hey Children's Foundation Trust currently consists of a set of 14 principal risks aligned to the Trust's strategic objectives.

A properly used BAF will drive the agendas for the Board and its Committees. The Board Assurance Committees therefore review the BAF in advance of its presentation to the Trust Board and propose any further changes following Exec Lead monthly reviews to ensure that it remains current, that the appropriate strategic risks are captured and that the planned actions and controls are sufficient to mitigate the risks being identified.

The Risk Management Forum (monthly risk management meeting) is responsible for the Corporate Risk Register and for oversight of the Divisional Risk Registers and reports into the Audit and Risk Committee.

2. Review of the BAF

Strategic risks can often span across more than one area of accountability. The Board Committees are therefore provided with the whole BAF in case they need to refer to areas of potential overlap or duplication with other BAF risks ensuring a holistic joined-up approach. Responsibility to review and gain assurance to controls and any required actions are detailed below:

	BAF Risk	Reviewed By
1.1	Inability to deliver safe and high-quality services	Safety & Quality Assurance Committee
1.2	Children and young people waiting beyond the national standard to access planned care and urgent care	Resources and Business Development Committee
		Safety & Quality Assurance Committee
1.3	Building and infrastructure defects that could affect quality and provision of services	Resources and Business Development Committee
1.4	Access to Children & Young People's Mental Health	Resources and Business Development Committee
		Safety & Quality Assurance Committee
2.1	Workforce Sustainability and Development	People & Wellbeing Committee
2.2	Employee Wellbeing	People & Wellbeing Committee
2.3	Workforce Equality, Diversity & Inclusion	People & Wellbeing Committee
3.1	Failure to fully realise the Trust's Vision for the Park	Resources and Business Development Committee
3.2	Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children & Young People through leadership of 'Starting Well' and Children & Young People's systems partnerships.	Resources and Business Development Committee
3.4	Financial Environment	Resources and Business Development Committee
3.5	ICS: New Integrated Care System NHS legislation/system architecture; Risk of inability to control future in system complexity and evolving statutory environment	Trust Board
3.6	Risk of partnership failures due to robustness of partnership governance	Resources and Business Development Committee
4.2	Digital Strategic Development and Delivery	Resources and Business Development Committee
4.1	Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has a positive impact for Children and Young People.	Research & Innovation Committee

3. Summary of BAF - at 15th June 2023

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

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

4. Summary of May 2023 updates:

External risks

- ***Failure to deliver 'Our Plan' objectives to develop a Healthier Future for Children and Young People through leadership of 'Starting Well'and Children and Young People's systems partnerships (DJ).***
  Risk reviewed; no change to score in month. Evidence and actions updated per Trust Board update June 23.

- ***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. Progress in Strategy 2030 and CYP system updated to Trust Board June 23***.***

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

- ***Workforce Equality, Diversity & Inclusion (MS).***
  Risk reviewed, actions updated. No change to risk rating.

- ***Building and infrastructure defects that could affect quality and provision of services (AB)***
  Regular board to board meetings are in place to ensure progress and provide updates to exec leads. Weekly meetings with the SPV, LO'R & Mitie continue to discuss historical and newly identified risks, although the majority of historical defects are now resolved. The second phase of improving water quality within the closed loop system is underway. It is hoped that this will prevent further pipework from corroding. In response to out-of-range temperatures we have local mitigation's in place such as filters on water outlets, and later this year we will introduce an chemical dosing system across the site. The chiller works continue and we are awaiting a date for the removal of the temporary ones. The recent actions on the chillers and the gas CHP are both supporting energy efficiency and cost control. Monitoring of the green roofs is underway to ensure they are in line with the PCP's (project co proposals) and that no future leaks occur.

Internal risks:

- ***Children and young people waiting beyond the national standard to access planned care and urgent care (AB).***
  - Sustained improvement in Emergency Department (ED) performance: 85% seen in 4 hrs in May.
  - Alder Hey ED ranked 6th (of 124) for Type 1 performance in a recent national assessment
  - Growing number of patients waiting >52 weeks in ENT. Progress made with the recovery plan, including agreement for additional patients in clinic, investment in in-sourcing capacity and three session theatre days.
  - Impact of junior doctor industrial action
  - Significant waiting times in neuro-developmental pathways (>65wks). Division planning a pathway stock-take and investment case is with

commissioners.
- Further improvement in access to diagnostics: 90% of tests undertaken within 6 weeks in May.
- Elective recovery 105% in May 2023

- ***Inability to deliver safe and high-quality services (NA).***
  BAF risk has been reviewed including current controls and gaps. Added in the impact of industrial action amid uncertainty of potential continued IA from various unions and staff groups.

- ***Access to Children and Young People's Mental Health (LC)***
  Risk reviewed all actions completed. Additional review with services to be completed by 30 June 2023 and paper for execs to be presented.

- ***Financial Environment (JG).***
  Risk reviewed and risk score remains static. 2023/24 Plan approved and with areas of high risk managed through RABD and reported to Trust Board.

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

- ***Digital Strategic Development and Delivery (KW).***
  Risk reviewed, actions progressed in reporting period. Go live date for Aldercare agreed, change freeze progressed.

- ***Workforce Sustainability and Development (MS).***
  Risk score remains unchanged. All actions remain on track.

- ***Employee Wellbeing (MS).***
  Risk reviewed. 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 to risk score in-month. Financial Strategy in development in relation to Futures and Innovation Commercial opportunities.

Erica Saunders
Director of Corporate Affairs